

Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupation and Social Engagement (ATOSE) as assessment tools within Engo Residential Aged Care Facilities in the Free State province, South Africa

by

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Summary

Key terms: Residential Environment Impact Scale (REIS), Assessment Tool for Occupation and Social Engagement (ATOSE), Residential Aged Care Facilities, organisational culture, occupational justice, wellbeing, quality of life, occupational therapy assessment tools, person-centred care

Introduction: The occupational wellbeing of elders is influenced by the physical and social long-term care environments in which they live. Elders living in Residential Aged Care Facilities are often exposed to occupational injustices and become institutionalised as a result of an environment that does not provide adequate occupational opportunities, support and stimulation.

Purpose: The main purpose of this study was to investigate the feasibility of two occupation-based assessment tools, the REIS and ATOSE within Residential Aged Care Facilities affiliated with the Engo organisation. The REIS and ATOSE have not previously been used within the South African aged care sector or the Engo organisation.

Methods: An embedded mixed methods approach with a qualitative focus was employed. The research was conducted in two phases. The first phase saw the researcher administering the two assessment tools within three participating facilities and providing each participating facility with their report containing the REIS and ATOSE findings. The reports contained quantitative statistics as yielded by each assessment, supported with descriptive information yielded by qualitative notes made by the researcher during the assessment period of phase one. During the second phase a discussion group employing the nominal group technique, was held with leadership staff of the participating facilities. Leadership staff considered and deliberated on the findings presented in the reports in order to identify possible enablers and obstacles of using the REIS and ATOSE assessment tools. A thematic analysis was employed during data analysis.

Findings: The findings were categorised into two main themes, i.e. *organisational culture* and *occupational justice issues*. The findings of the REIS and ATOSE assessments (phase 1) and the nominal discussion group (phase 2) indicated an organisational culture which is dominated by a top-down management approach and distinguished by a medically-dominated care approach. Leadership staff struggled to directly conclude what enablers and

barriers exist for using the REIS and ATOSE assessments. The findings of the research process, however, indicate that the assessments yield practical and usable information but the current Engo organisational culture is not receptive to implement the findings.

Conclusions: The main contribution of this study is the exploration of two previously unused occupation-specific tools in the South African aged care sector, which presented information about elder communities that occupational therapists should consider when practicing in these environments to effect person-centred culture change.

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Declarations

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I, Melissa Kilian, hereby declare that the masters research thesis entitled *Feasibility of using the Residential Environment Impact Scale (REIS Version 4) and the Assessment for Occupation and Social Engagement (ATOSE) as assessment tools within ENGO Residential Aged Care Facilities in the Free State province, South Africa* that I have submitted at the University of the Free State, is my independent work and that I have not previously submitted it for a qualification at another institution of higher education.

I, Melissa Kilian hereby declare that I am aware that the copyright is vested in the University of the Free State.

I, Melissa Kilian, hereby declare that royalties as regards intellectual property that was developed during the course of and/or in connection with the study at the University of the Free State, will accrue to the University.

A handwritten signature in black ink, appearing to read 'Melissa Kilian', written in a cursive style.

Date: 31 July 2020

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List of acronyms

Below, in alphabetical order, is a list of acronyms used frequently in this dissertation. Please note that the first time the word appears it is written in full, thereafter the acronym is used.

ADL:	Activities of daily living
APA:	American Psychological Association
ATOSE:	The Assessment Tool for Occupation and Social Engagement
DCM:	Dementia Care Mapping
DRC:	Dutch Reformed Church
HSREC:	Health Sciences Research Ethics Committee
MOHO:	Model of Human Occupation
NGOs:	Non-governmental Organisations
NGT:	Nominal group Technique
RACFs:	Residential Aged Care Facilities ¹
REIS:	Residential Environment Impact Scale (Version 4.0)
SA:	South Africa
UFS:	University of the Free State
WHO:	World Health Organisation
WFOT:	World Federation of Occupational Therapists

¹ The singular form of this word will be written in full as 'Residential Aged Care Facility', also sometimes in this review intermittently used with words such as 'facility', 'long-term institution' or 'care home'.

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Concept Clarification

Below, in alphabetical order, is a list to clarify concepts related to this study. Some concepts are interpreted to illustrate their operational relevance in this dissertation.

Ageism: Ageism is described as stereotyping, prejudice, and discrimination against people on the basis of their age (World Health Organisation, 2018) and within the African context the following definition is fitting: “age discrimination is the systematic and institutionalized denial of the rights of older people by individuals, groups and/or organisations” (Nhongo, 2006: 3).

Pertaining to this study: Ageism is experienced by people of all ages in a variety of settings. However, societal prescriptions and expectations of becoming older render elders more susceptible to the negative associations of aging, such as being helpless and frail. In Residential Aged Care Facilities (RACFs), the ageist worldview of society along with the operational structure of many facilities render residents even more vulnerable to experience ageism (Nhongo, 2006: 11).

Apartheid: The Merriam-Webster definition of Apartheid describes a former policy of social, political and economic discrimination against non-European racial groups in the Republic of South Africa. This policy was suspended in 1994 followed by South Africa’s democracy.

For the purpose of this dissertation: Most care staff working in long-term RACFs are black South Africans who were marginalised by apartheid policies and/or as a result of the apartheid system still experience social and economic disadvantages. In addition to the high unemployment rate in South Africa, the social and economic disparities, along with cultural differences between carers and residents being cared for, need to be acknowledged. The possible impact of these phenomena on the operations of South African RACFs need to be cogitated and are discussed in this dissertation.

Assessment tools: Refers to occupational therapy specific tools that are used to assess the key areas within RACFs influencing occupational participation and engagement of individuals or groups.

Pertaining to this study: In this study the assessment tools most frequently referenced refers to the paper copy and electronic assessment tools used in this research project, namely the

REIS (Residential Environment Impact Scale) (Fisher *et al.*, 2014) and *ATOSE (Assessment Tool for Occupation and Social Engagement)* (Morgan-Brown, 2014), described in more detail in the introductory section of this dissertation (c.f. 1.3.). The REIS (version 4.0) is the latest version of the REIS, specifically adapted for use in RACFs. Previous versions of the REIS (version 2.0 and version 3.0) was designed for adults with mild to moderate intellectual disabilities living in residential communities. Throughout this dissertation the researcher refers to the REIS (version 4.0) simply as the 'REIS'.

Autonomy: Generally refers to the ability of having self-governance and opportunities to decide for oneself and make choices throughout daily activity patterns.

With reference to this study: Autonomy is classified as one of the Eden Alternative's seven domains which residents in long-term care require in order to experience wellbeing (The Eden Alternative, 2012: 6). Elders often lose autonomy when moving into RACFs due to overly structured rules and regulations of the facility.

Culture of care: Refers to the caring approach used in facilities. The structure and routines of a facility, roles of staff and policies on which care is based in RACFs in South Africa are mostly dominated by a medical care approach. In the last 30 years there have been initiatives, known as *culture change movements*, to reconceptualise these structures, roles and processes to transform long-term care facilities into person-centred homes for elders needing support with daily life tasks (Grabowski, O'Malley, *et al.*, 2014; Power, 2010; Thomas, 1996).

Pertaining to this study: The care culture of many long-term care facilities in South Africa is based on the biomedical care culture, which have been adopted from hospitals. No national policies or guidelines currently exist that prescribe, guide or advocate for culture change towards person-centred care in South African RACFs.

Classification of racial groups: In Chapters 4 and 5 of this dissertation (c.f. 4.2.1, 4.4.1, 4.4.2, 5.3.2, 5.3.3, 5.3.4), the researcher references the composition of the staff body at Engo RACFs and refer to the racial classification of employees as black, white and/or coloured. This is done to illustrate the hierarchical arrangement of staff in Engo as it has relevance when considering the political history of racial discrimination in South Africa. Racial classification is still readily used for statistical purposes in the diverse country of South Africa and is not used in a prejudiced manner.

Eden Alternative: An international movement established by an American general medical practitioner, Bill Thomas, advocating for nursing homes to be transformed from sterile, hospital-like environments to human habitats. The Eden Alternative has an established training guide for the transformation of long-term care organisations directed by ten principles. The first principle is the problem statement, which accounts for the bulk suffering among elders in RACFs as being helpless, lonely and bored. The rest of the Eden Alternative principles (numbers two to nine) are the solutions to the problem statement (The Eden Alternative, 2010: 2–7, 8; Thomas, 1996).

For the purpose of this study: The Eden Alternative is frequently referenced as a theoretical practice-based approach in this dissertation when discussing the culture change movement and the positive effects of transforming RACFs.

Elders: The term refers to older adults in recognition of their status as leaders in longevity (Power, 2010: 60; Thomas, 1996).

Pertaining to this dissertation: Throughout this dissertation, the term elders is used in recognition of the researcher's stance and personal conviction that society should value and embrace the skills and knowledge of elders, irrespective of whether they live independently or need additional support as those who live in long-term care facilities. The term elders is sometimes used interchangeably with older adults. Please note that the researcher explicitly uses the term elder, without the pronoun, *the*, as to avoid labelling. Elder, in this dissertation does not refer to the religious role of elders in the Church of Christianity.

Engo: Engo is the faith based, non-governmental organisation in the Free State province of South Africa with which the RACFs in this study are affiliated. Engo is not an acronym and the central letters 'ng' alludes to the Afrikaans acronym of the Dutch reformed church (*Nederduits Gereformeerde Kerk*). The Engo organisation is detailed in the introductory section of the research setting in this dissertation (c.f. 1.3).

Feasibility study: Such studies aim to produce a set of findings which can determine whether an intervention should be recommended for efficacy testing. Generally there are eight focus areas addressed by feasibility studies. Feasibility studies are indicated when community partnerships need to be established and there are few previously published studies using the specific intervention technique (Bowen *et al.*, 2009).

With relevance to this study: This particular study will focus on the acceptability and applicability component, which is one of the initial phases of feasibility studies, to enquire to which extent the REIS and ATOSE assessment tools are apt and suited within the existing operational culture of care of Engo RACFs. The use of neither of the assessment tools have previously been investigated within the residential aged care setting in South Africa.

Geriatrics: Refers to a branch of medicine that deals with the problems and diseases of old age and the medical care and treatment of aging adults (Merriam-Webster Dictionary, n.d.).

Gerontology: Refers to the study of the social, psychological and biological aspects of aging (Merriam-Webster Dictionary, n.d.).

Institution: Refers to a facility or establishment that provides care and support for people who are not completely independent. An institution is typically a confined setting.

Pertaining to this dissertation: In this dissertation *institution* refers to long-term RACFs with a particular set of operational procedures based on the biomedical care culture model in which employees deliver a care service to older residents, who are often viewed and treated as incapacitated after moving into such institutions. Throughout this dissertation the term ‘institution’ is sometimes used interchangeably with the term ‘facility’.

Institutionalisation: Refers to an institutional culture which attributes specific behavioural traits to residents and staff living and working at the institution.

Operational relevance: Institutionalisation within long-term RACFs are usually associated with keeping stringent guidelines that maintain order and structure in facilities, which unintentionally disempowers residents as mere care recipients within the facility and disables active participation. Residents’ and staff’s behaviour become overly structured and monotonous:

“Institutionalisation is like tunnel vision, you don’t see any other way of doing things. I suppose it’s the environment that makes you institutionalised. We used to think that we weren’t institutionalised, but now you look back and you see it” (Morgan-Brown, 2013).

Institutional constraints: Refers to the stringent rules, policies, regulations, systems and operational procedures that disempower residents and staff towards implementing and

participating in a person-centred care culture where residents experience autonomy, meaning and joy in daily activity patterns.

Non-traditional facilities: Refers to long-term RACFs based on a person-centred model of care. These facilities place the resident at the centre of the care planning process and evaluate and plan interventions in accordance with the family members and the residents' needs (The Eden Alternative, 2010). Non-traditional facilities incorporate features of *home* rather than *hospital* (Richards, Cruz, Harman, & Stagnitti, 2015).

Occupation: Generally refers to a profession or an activity within a person's field of interest with which they occupy themselves. Within the occupational therapy profession, facilitating engagement in occupation is the profession's core assumption and competency to promote health and wellbeing, and it refers to participating in a meaningful activity of one's choice (Christiansen & Townsend, 2010: 4-5).

In this research study: In this research project occupation refers to any type of meaningful activity that elders and staff in RACFs do that promotes their wellbeing. The level and extent to which they do or engage with the activity is irrelevant, but differs due to the impact of general aging conditions such as dementia and/or poor sensory and motor abilities. In traditional RACFs there are usually limited opportunities to engage in meaningful occupation as many of these activities are done 'to' or 'for' residents 'by' staff.

Occupational engagement: A term often used as part of occupational science literature. The attributed value of an occupation by the participant distinguishes occupational engagement from occupational participation. Occupational engagement refers to people doing occupations in a way that fully involves their effort, drive and attention (Christiansen & Townsend, 2010: 8)

With regards to this study: Within the scope of this research project, occupational engagement of elders in RACFs were found to be limited as operational features of facilities presented barriers to engage in activities of residents' choice, rendering residents' daily activity patterns monotonous and often derived of meaning for the individual.

Occupational justice: Pertains to a form of social justice and is defined as "the right of every individual to be able to meet basic needs and to have equal opportunities and life chances to reach toward her or his potential but specific to the individual's engagement in diverse and meaningful occupation." (Wilcock & Townsend, 2009: 193). It specifically refers

to available opportunities or a lack thereof, to participate in meaningful occupations and the inherent human right of all human beings to execute autonomy with regards to choosing occupations that enable health and wellbeing. When people are not afforded opportunities for participation in this manner, occupational injustice occurs. It encompasses several categories including occupational marginalisation, deprivation, apartheid, alienation and imbalance (Townsend & Wilcock, 2004). People who are vulnerable to experience occupational injustice include women, children, older people, and ethnic or religious minority groups. Occupational therapists advocate for occupational justice to ensure that clients' occupational rights are fulfilled (Whalley Hammell & Iwama, 2012).

Relevance to this study: Occupational justice issues were one of the main themes identified in this research project. Considering that the foundation of occupational therapy is health and wellbeing through doing and participating in meaningful occupation, the occupational injustices in RACFs are very important considerations for therapists practicing in long-term environments. Stadnyk, Townsend and Wilcock (2010) suggest that the occupational determinants of a country, such as the economic, political and cultural environment and policies, influence the opportunities for occupational engagement.

Organisational culture of care: One of the themes that emerged from the findings of this research project. It encompasses the operational features of Engo RACFs that are promotative and preventative to enable operational culture change towards non-traditional aged care facilities.

Participants

REIS and ATOSE participants: Refers to staff and residents at participating RACFs during phase 1 of the study that participated by engaging with the researcher via informal interviews, discussions and/or were part of observation areas during the REIS and ATOSE assessments as part of the criteria of the assessment tools.

Discussion group participants: Refers to leadership staff that participated in phase 2 of the study in discussing the findings from the REIS and ATOSE assessment tools in order to establish their feasibility.

Person-centred care: Based on the seminal works of Professor Tom Kitwood. Person-centred care distinguishes itself by adopting a behavioural rather than a medical approach, as first suggested by humanistic psychologist Carl Rogers. It specifically refers to people

living with dementia. Person-centred care advocates for placing yourself in the shoes of the person living with dementia and attempting to experience life from their perspective. Kitwood suggests that the environment has as a profound effect on the brain, which again has an effect on a person's abilities. Person-centred care promotes caring that honours and emphasises the abilities, skills, history and interests of elders and this care approach is not possible if they are not well known by care providers (Kitwood, 1993).

Pertaining to this research study: In this dissertation, person-centred care is often used as the theoretical approach when discussing the transformation of long-term care environments as it is considered the gold standard of providing care to elders, and specifically those with dementia, living in long-term care facilities (Love & Pinkowitz, 2013).

Quality of life: A term used throughout literature which describes the subjective experience of experiencing one's life as satisfactory with regards to available opportunities, despite cognitive inabilities, to exercise choice, control, independence and engage in meaningful occupations (Fisher *et al.*, 2014). Quality of life is often used interchangeably in literature with 'wellbeing' and the psychological experience of 'wellness'.

Pertaining to this dissertation: In this dissertation quality of life and wellbeing are used interchangeably. Quality of life has relevance as it is the ultimate outcome for occupational therapy interventions with elders living in long-term care facilities (Causey-Upton, 2015). The lack of choice and opportunities to engage in personally meaningful and fulfilling occupations are violations of occupational rights and have detrimental consequences for quality of life and wellbeing (Whalley Hammell & Iwama, 2012).

Residential Aged Care Facilities (RACFs): A long-term care and living facility for elders living with varied levels of independence in activities of daily living (ADL). Throughout this dissertation Residential Aged Care Facilities are referred to by the acronym RACFs. The word is also written in full when the singular form is used. RACFs are used interchangeably with the words 'facility/facilities', 'institution/institutions', and 'home/homes'.

Staff: This concept is indicative of two categories of staff within Engo RACFs, namely 'operational' and 'leadership' staff. In this dissertation the researcher often distinguishes between operational staff and leadership staff. Staff refers to employees who are paid a monthly salary and does not include volunteers.

- **Leadership staff:** Refers to managers or employees in senior positions who supervise other employees. Leadership staff refers to the manager of the facility, registered nurses who supervise a team of nursing care workers (operational staff) or supervisors within the cleaning, kitchen or household or other services employed at the RACFs.
- **Operational staff:** Operative employees are staff that directly produces services or goods and does not supervise the work of others. Operational staff refers to the nursing care workers (carers), general assistants, cleaners and kitchen workers and any other operative staff members who provide a specific service within the Residential Aged Care Facility but are not in a supervisory position.

Traditional care facilities: Long-term RACFs based on the traditional biomedical model of care, originally found in hospital settings, where nursing care of residents is considered the most important aspect of the residents' care plan, irrespective of the presence of illness or the residents' needs (Richards *et al.*, 2015).

Ubuntu: An African social and humanistic philosophy which emphasises 'being human through other people'. The term was originally used by former Zambian President, Kenneth Kaunda in describing an African worldview of togetherness and perspective of '*I am because you are*' (Mugumbate & Nyanguru, 2013). Ubuntu cannot be directly translated into English but it is a notion of collectivity through which the individual is part of the community and vice versa (Membe-Matale, 2015).

This concept is relevant for this study because in addition to the experience of togetherness, it may be argued that the Ubuntu ethic resonates strongly with the democratic value of human dignity in the South African Constitution and Bill of Human Rights (Government of the Republic of South Africa, 1996). One of the ways to 'practise' human dignity is to include people in decision making, especially in decisions which affect people when they are part of a system (Rauch van der Merwe, 2020).

1 Introduction and Orientation

1.1 Introduction

The South African Bill of Rights is exalted as the cornerstone of the endeavours to promote human dignity, equality and freedom to all citizens, irrespective of age (Constitution of the Republic of South Africa, 1996). Additionally, the South African Older Persons Act (13 of 2006) emphasises the rights of elders to live in an enabling and supportive environment that promotes their “optimal level of social, physical, mental and emotional wellbeing” (Republic of South Africa in Government Gazette, 2006: 10). Long-term care environments that assert the management of physical needs and pathology as the most important factor to wellbeing leaves few opportunities for elders to exercise autonomy, active citizenship and experience dignity in their daily routines. This results in occupational injustices, institutionalisation and violations of human dignity (Causey-Upton, 2015; Whalley Hammell & Iwama, 2012; Townsend & Wilcock, 2004). Exclusion from even the most basic Activities of Daily Living (ADL) results in feelings of helplessness, loneliness and boredom, the three plagues associated with aging in long-term care facilities (The Eden Alternative, 2010: 8). The aging population in South Africa necessitates increased and advanced support services to older adults. Long-term aged care is one such support service, and moving from independent living to a long-term care facility is often regarded as an inevitable part of the aging journey. Older adults move into long-term aged care, such as Residential Aged Care Facilities (RACFs) for various reasons. This is more often than not met with disdain from the elderly person who has to move (Crawford, Digby, Bloomer, Tan & Williams, 2015; Graneheim, Johansson & Lindgren, 2014). Dementia is considered to be one of the leading causes of institutionalisation due to the deteriorative effect on independence and the inability to live self-sufficient (Hope, Keene, Gedling, Fairburn & Jacoby, 1998). South African RACFs are mostly regarded by elders as institutions that debilitate and steal quality of life from their residents. The physical and social environments in RACFs are often overly structured and controlled by staff, and embody a hospital environment, rather than home. This causes distress to residents, and expedites staff to adopt a task-oriented approach in their interaction with residents.

“Occupational therapy as a profession has progressed extensively in terms of rethinking the unique contribution our profession can make... To be successful in assisting clients in new environments, occupational therapists must be courageous in negotiating new methods for intervention/service delivery if they are to succeed in making a difference in their clients’ lives” (Brodrick & Barry, 2016: 440).

In South Africa (SA), occupational therapists are occasionally part of the therapeutic team providing services to institutionalised older adults. However, due to financial constraints and the very few occupational therapists practicing within the field of geriatrics in SA, evidence-based research is necessary to support and expand their practice. Intervening at a community or population level has become imperative, specifically due to this limited number of practicing occupational therapists and the financial constraints hampering the elders in dire socio-economic conditions to access occupational therapy services (Brodrick & Barry, 2016: 440). One of the hallmarks of best practice in gerontological occupational therapy is the integration and application of i) *evidence from research*, ii) *evidence from the client in context* and iii) *evidence from reflective clinical experience* (Krieger, Tao & Royeen, 2016: 53). Evidence-based research ensures that older clients in RACFs receive the best services and care available. Furthermore, evidence-based research can be viewed as a “toolbox of methods to aid clinical reasoning” (Tickle-Degen, 1999: 537). Many occupational therapy practitioners in marginalised countries are challenged to provide therapeutic services in conditions of systematic marginalisation, where environments result in clients experiencing everyday occupational deprivation (Brodrick & Barry, 2016). A world-wide aging population demands more occupational therapy published research in gerontology (Krieger et al., 2016: 70) and even more so in developing economies such as that of SA.

A core belief of the occupational therapy profession is that participating in activities (doing) that are personally meaningful will result in the participant experiencing a sense of wellbeing, which successfully positions them for living a quality life, by their own standard (Whalley Hammell & Iwama, 2012; Toledano-González, Labajos-Manzanares, & Romero-Ayuso, 2018). As occupational therapists shift their focus from individual therapy to include the aging community as a whole in order to have a lasting effect on the level of engagement and wellbeing of residents, staff and the community, it remains a challenge within the constrained South African economic context to convince stakeholders in the aging sector of the benefit of such a collective approach without scientific evidence.

The structures, routines and institutional practices in RACFs often create environments where opportunities to engage in meaningful occupations are limited. And as people living with dementia are extremely sensitive to the environment they live in, they are even more in danger of experiencing occupational deprivation as they have limited abilities for typical cognitive processes such as integrating experiences and reacting toward them in a self-serving manner. Culture change in SA are in its infancy (Du Toit *et al.*, 2020) and most RACFs presumably still operate according to a care culture based on the operations of traditional facilities (c.f. Concept Clarification). Person-centred care, generally associated with a non-traditional approach, is a well-known term within geriatric communities in SA. However, the introduction and enrolment of person-centred care can be tricky, and requires an insightful understanding of the current culture of care within an organisation, as well as knowledge regarding the process required to shift the current care culture towards a person-centred care culture (Grabowski *et al.*, 2014). Occupational therapists inherently understand the approach of person-centred care due to their studies of occupational sciences (Whalley Hammell & Iwama, 2012). To refrain from unsubstantiated adaptations when introducing person-centred care as a new culture of care, scientific evidence is needed to inform and guide changes that will have a lasting effect on residents and staff in RACFs. The transition to person-centred care requires organisational, physical and personal transformation (Power, 2010; Thomas, 1996).

Therefore, therapists need to promote occupational justice within RACFs. Evolving from the interdisciplinary term social justice, which is inherently embedded in the core values and philosophy of occupational therapy, occupational justice is seen as the “rights, responsibilities and liberties of enablement” (Briller, Paul-Ward & Whaley, 2016: 78). When people are not afforded opportunities for participating in meaningful occupation, occupational injustice occurs (Briller *et al.*, 2016; Causey-Upton, 2015). Institutional practices in RACFs are hardly ever the intentional choice of staff to deprive residents of opportunities, but it forms part of the structure of institutional operational procedures that have been inherited from a system rooted in medical care. The wellbeing of older adults is traditionally contingent on providing for their physical and medical needs, and appraised as the most important consideration of a quality life.

Occupational therapists have an ethical and professional duty to consider the long-term aged care environment as a potential facilitator or threat to the wellbeing of the institutionalised elders (Whalley Hammell & Iwama, 2012), as the cumulative effect of

numerous environmental factors may deprive residents from doing activities which are meaningful to them and signify human dignity. Occupational therapists are uniquely equipped to influence and co-create environments that eliminate exclusion and facilitate engagement that enable autonomy, counter institutionalisation, and promote human dignity and occupational justice for older people living in RACFs. In order for occupational therapists to propose environmental adaptations, sufficient scientific evidence is needed to understand the dynamics of how residents and staff experience day-to-day occurrences in their residential environment at long-term care facilities and whether these routines contribute to enabling or disabling occupational engagement (Briller *et al.*, 2016: 417; Du Toit, Casteleijn, Adams & Morgan-Brown, 2019).

1.2 Contextualising the assessment needs of residential aged care environments in South Africa

Age discrimination, known as ageism is a form of prejudice (World Health Organisation, 2018) and older people tend to be stereotyped as a homogenous group known as passive dependents of mental and physical health . The ancient debate on whether old people receive the same quality of care as younger people is ongoing. There is evidence that suggests elders are more likely to receive poorer quality care as they have had their 'fair innings' and thus are less deserving of constrained health resources (Roberts, 2000). Within the Western perspective of aging, dependency should be viewed as a human condition and concepts within occupational therapy that solely focus on independence and autonomy in line with Eurocentric and austerity perspectives should be reviewed and critically reflected upon (Bullen, 2016: 336). Fineman (2008) proposes that humans' interconnectedness and state of dependency are irrefutable, as humans are all born and die while living with the threat of injury, disease or natural disasters beyond their control.

Occupational therapists have a part to play in advocating for an alternative perspective to Eurocentric views, where the individual rights of only an elitist group are supported and promoted (Bullen, 2016; Owens, 2010). An alternative view to society is necessary to promote political, social and occupational rights for all, and especially for vulnerable groups such as older people living in RACFs and staff from disadvantaged circumstances which are inherent to the unique South African social, political and economic context.

The COVID-19 pandemic brought the vulnerability of RACFs its elders to light. Elders are considered as part of a vulnerable population who might be more susceptible to contracting

and dying from infection due to the novel coronavirus (Centers for Disease Control and Prevention, 2020). The interdependence of staff and residents are definite during the COVID-19 pandemic. On the one hand residents are dependent on staff to remain healthy and able to provide sufficient care to them. On the other hand, staff are dependent on residents to remain healthy and alive to ensure that the facility can retain the workforce, ensuring carers' continued employment.

During the world-wide COVID-19 pandemic the ethical concerns regarding the use of scarce ventilators have been vehemently debated and it seems that elders might be on the losing end of the debate, in which many advocate for allocating ventilators to younger people without comorbidities, confirming the notion that there has been little improvement in the Eurocentric, ageist views attributed upon elders. This brings about a discourse on how a pandemic illuminates the injustices which elders face daily due to ageist views that have infiltrated most sectors of society. 'The new normal', a term used in mainstream media referring to changes in daily life as a result of the COVID-19 pandemic and people's responses to being locked down and socially detached as infringements of human rights, illuminates the innate human need for connectedness.

The first case of COVID-19, was documented in South Africa on 5 March 2020. This was followed by a five week lockdown of the entire country by the President, Cyril Ramaphosa, from 27 March to 30 April 2020 in an attempt to decrease the exponential spread of the virus, with the gradual re-opening of the business and economic sectors from May 2020 (South African Department of Health, 2020). The COVID-19 pandemic has affected countries worldwide and the South African government proposed a \$26 million plan to minimise the effects of the COVID-19 pandemic (Government of the Republic of South Africa, 2020). Austerity programs have been proposed by the South African finance minister, Tito Mboweni, such as cuts in government expenditure and encouraging private sector competition in the infrastructure section. Many South Africans have and will continue to lose their jobs and livelihoods in the aftermath of the lockdown.

The gravity of the COVID-19 pandemic will substantially differ between developed and developing countries. The demographics of a country's population, living arrangements and solutions for the care of the frailest elders are crucial in calculating the ability of societies to successfully combat the COVID-19 virus (Reher, Requena, De Santis & Padyab, 2020).

Currently, the focus of most RACFs in SA is presumably on keeping the COVID-19 infection out of the facilities at all cost to ensure survival of its residents and subsequently financial viability of the facility, as the death rate are disproportionally higher for older people, especially those with comorbidities. Navigating the space between precautionary measures to protect elders against the COVID-19 infection and promoting their autonomy and agency is challenging as it “shines a blinding light on our inherent ageist default mode – that older people should be protected at all costs...like with an archive or a herbarium or museum, we want to preserve them, not noticing that we might actually be killing them in the process” (Stroebe, 2020)². Many South African RACFs have implemented a lockdown of the facility prior to the national lockdown, prohibiting visits from friends and family. The case of residents living with dementia in a dementia-specific unit at a Residential Aged Care Facility in Cape Town, SA, dying due to COVID-19 infection, illustrates just how vulnerable people living in RACFs are, and even more so people living with some form of cognitive impairment. Despite the facility’s best efforts to protect residents by restricting visits, the necessary emergency COVID-19 policies also deprived them from opportunities for invaluable social connection with loved ones in their final days, which in itself is an unavoidable infringement on human rights. In Italy and Spain some residential care facilities have become “veritable death traps” for elders. In Stockholm, Sweden, one third of all care homes in the country have been affected, presumably by the asymptomatic spread of the disease from care staff to residents (Reher *et al.*, 2020).

Enso, the organisational setting in which this research project was conducted, is a non-governmental organisation. Non-governmental organisations (NGOs) such as Enso and its affiliated RACFs receive some subsidy from the South African Government, Department of Social Services. Considering the immense economic impact of the pandemic, it is very likely that any support to NGOs such as Enso and support to state-subsidised old age homes will be drastically reduced and located to economic relief in other sectors. Additionally, the weak economic situation in SA might force families to continue home caring for older adults that might need more support than the family has the capacity for. This might expose already vulnerable elders to unintentional neglect and even possible abuse. Moreover, the global economic impact of COVID-19 might affect fewer residents being able to afford long-term care, creating a huge financial risk threatening the longevity of RACFs.

² This quote is from an entry made to a Facebook page, Mind Matters.

But perhaps the biggest consideration and contemplation of the COVID-19 pandemic is in contemplating, for some, perhaps for the first time ever, what it must feel like to be an elder living in a Residential Aged Care Facility and moreover the need for assessing the quality of environments of RACFs were emphasized, especially when situations changes such as the case with the COVID-19 pandemic. The increased isolation brings about many considerations regarding older people's mental health in long-term care. Being locked down in an environment that is not conducive to experience dignity, and which exasperates feelings of loneliness, helplessness and boredom is a human right violation. By having a glimpse of what it must feel like to be permanently locked-down, as many elders in RACFs are, dependent and losing control in their daily lives, we are forced to deliberate topics such as power, agency and citizenship and perhaps what it must feel like to "become living dead" (Feil, 2012). To effect change in RACFs statistical data and efficacy testing of environmental assessment tools are needed to demonstrate the supposed human rights violations.

1.3 Research setting and assessment tools

This research project investigated the environments of RACFs in the Free State based Engo organisation in SA. Engo is a non-governmental faith-based organisation that oversees services to vulnerable South African populations such as institutionalised older people and people living with dementia. Engo guides the practice of providing care services to elders in 23 RACFs throughout the Free State province (Engo, 2020). A concise definition of NGOs such as Engo, was first used by Vakil (1997) and defined NGOs as self-governing, private, not-for-profit organizations that are geared to improving the quality of life for disadvantaged people. The three participating RACFs, referred to respectively as Facility 1, 2 and 3 in this study, are all affiliated with the Engo organisation. The Engo organisation constitutes the meso study context, as the governing organisation of the participating facilities. Engo is only active in the Free State province of SA. The Free State province, for local government purposes, comprises one metropolitan municipality and four districts, boasting a total population of 747,431 residents. It is the third largest province in SA, per km², and is only 2nd to the Northern Cape for having the smallest population number of all nine provinces in SA. Two of the three participating RACFs are situated in the Thabo Mofutsanyane district of the Free State province, and the third is in the larger Mangaung metropolitan area. Engo, historically a social service of the Dutch Reformed Church (DRC), provides social services which are divided into the following categories:

- aged care (mostly in the form of institutionalised care facilities for elders),

- child care and care for people with disabilities, and
- family care

The name 'Engo' is not strictly an acronym, but the name itself has meaning. Based on the Christian faith, the letter 'E'(ngo) indicates eternity, originally referred to as *ewigheidswaarde* (literally: that which has value in eternity) in Afrikaans, and, the view of God as the sovereign and almighty of the Christian faith and of the Engo organisation. The meaning of the 'ngo' in the Afrikaans-originated word '**Engo**', has a dual purpose. It firstly indicates that it is an ngo – non-government organisation. Secondly it refers to its Christian religious roots, specifically to the denomination of the Dutch Reformed Church (in Afrikaans: *Nederduits Gereformeerde Kerk*).

There are 23 RACFs affiliated with Engo dispersed throughout the Free State province. Although each facility functions independently, managed by a board of trustees and a full-time appointed manager or management committee, Engo policy guides operational procedures at each facility and adherence to Engo operations and procedures remain imperative. (Engo, 2020, personal communication with managers of participating Facilities). This specifically refers to the nursing care provided at each facility, but also includes housekeeping, kitchen services and laundry services. Most Engo-affiliated RACFs operate according to the same routines and structures regarding documentation, training and daily operations. The Department of Social development remains the legislative body to which all Engo-affiliated RACFs should adhere. The Older Persons Act (13 of 2006), and specifically chapter four, alludes to residential facilities. The act guides inspection and adherence to legislation from the Department of Social Development.

Engo was previously known as the NGMD (*NG Kerk Maatskaplike Dienste*). It provides healthcare services to older people in RACFs. In SA, most old age homes have adopted the healthcare model used in hospitals to care for sick and frail older persons. Engo is no exception. This biomedical model focuses on the physical and nursing care when planning the care of an older person. All Engo RACFs employ registered nurses and nursing carers as the primary service providers. The shift towards a person-centred approach within this model is difficult, since the scope of practice for the nursing profession stems from a biomedical approach. In SA, a person-centred approach to caring for older adults is not regulated by any laws or policies. Most RACFs operate from a biomedical approach to caring. Person-centred care is often seen as a system of 'extra work' in a sector that is

already grossly understaffed and not familiar with the international shift to best dementia care practices. The participants in this study are typical of the population that are found within South African RACFs. As indicated in the explanation above, all residential care facilities need to employ nursing staff registered at the South African Nursing Council. Limited regulation applies to the nursing care workers, and they usually do not have any formal or officially recognised nursing education qualifications.

Two assessment tools, namely the Residential Environment Impact Scale (REIS) and the Assessment tool for Occupation and Social Engagement (ATOSE), were used in three different Engo-affiliated RACFs in the Free State province. These assessments had been specifically developed to systematically document and provide objective evidence regarding the residential environment. The researcher provided leadership employees from the participating RACFs with the relevant information concluded from the assessment tools, and explored their perceptions regarding the operational usability of the findings of these two tools. The REIS investigated the entire environment in a facility and specifically examines the everyday spaces used by residents and staff, the objects and equipment available, the relationships between people, and the activities that take place at the facility. The second tool, the ATOSE, investigated one specific communal area where residents spend time throughout the day, and documents the level of social and occupational engagement of people using the particular space.

Each Residential Aged Care Facility were visited for a period of three consecutive and identical weekdays (Monday to Wednesday) where the researcher assessed the environment using the REIS and ATOSE assessment tools. The ATOSE prescribes assessing the communal area on specific, unchanging time slots each day, while the REIS suggests that a single day is adequate for assessment.

1.4 Problem statement

In South African RACFs enabling environments are limited and elders are often deprived of a dignified existence. Institutionalised older adults become alienated and deprived of the opportunities to exercise control over their daily lives, and to maintain engagement in meaningful occupations (Causey-Upton, 2015; Du Toit *et al.*, 2019). Residents living with dementia specifically, are incapacitated by the fixed daily operations in RACFs as they lack the capacity to retain some control in the structured and medically-focused routines ascribed

by operational policies of facilities (Morgan-Brown, Brangan, McMahon & Murphy, 2018; Morgan-Brown, Ormerod, Newton & Manley, 2011).

It is estimated that by 2050, 165 million older people will be living in sub-Saharan Africa, and a significant percentage of these will need long-term care (World Health Organisation, 2017b). In SA, there is low political priority for the development of an already struggling long-term care system, and few national or regional frameworks exist to guide the provision of long-term care services (De Jager, Joska, Hoffman, Borochoowitz, & Combrinck, 2015; Prince *et al.*, 2008; World Health Organisation, 2017b).

Occupational therapists struggle to differentiate their invaluable professional contribution in long-term aged care from more inexpensive service providers. Although the occupational therapy profession has seen an international drive toward shifting focus from individual intervention to a collective approach in community settings such as RACFs (Du Toit *et al.*, 2019; Dupuis, Gillies, Carson & Whyte, 2012; Barney & Perkinson, 2016: 417), no occupation-focused evidence-based research exists in the South African context to guide occupational therapy practice.

The REIS (Fisher *et al.*, 2014) and ATOSE (Morgan-Brown, 2014) assessment tools have been proposed as two tools to investigate the environment in RACFs regarding how the cumulative physical and social environments in RACFs impact on residents' dignity, experience and opportunities for meaningful engagement. These assessment tools have not previously been investigated in the South African context, as far as could be established. Exploring these two assessment tools within the Engo organisation could provide valuable evidence-based research to substantiate and develop the occupational therapy scope of RACFs in SA.

1.5 Main research question

The overarching research question of this study is: *Are the Residential Environment Impact Scale (REIS) and the Assessment Tool for Occupation and Social Engagement (ATOSE) applicable³ assessment tools within identified Engo Residential Aged Care Facilities in South Africa?*

³ Within the context of feasibility studies distinctions are made between different types of feasibility studies. Applicability studies are one such type (c.f. Concept Clarification).

1.6 Research aim

The purpose of this research study is to investigate the feasibility of the REIS and the ATOSE as assessment tools within identified Engo RACFs. The proposed objectives of the study are as follows:

1.7 Research objectives

- To describe and interpret the findings of the REIS and ATOSE results obtained within the participating Engo RACFs.
- To investigate whether the findings from the REIS and ATOSE can be synthesised to provide usable, practical feedback to the participating Engo RACFs.
- To investigate the RACFs leadership staff's perceptions regarding the enablers and barriers to the applicability of the REIS and the ATOSE.

1.8 Research design and methodology

This research study is rooted within the pragmatic paradigm and uses an embedded mixed methods approach (Creswell, 2014; 2015). The emphasis is on the qualitative data generated from the narrative notes in phase 1 of the study (cf. 0) while executing REIS and ATOSE assessments, and also qualitative data gathered during the nominal group discussions in phase 2 of the study (cf. 0). Quantitative data gathered from the results of the REIS and ATOSE assessment tools, during phase 1, are used for descriptive purposes in support of and to illuminate qualitative findings. Figure 1 illustrates the two consecutive phases of data collection and analysis.

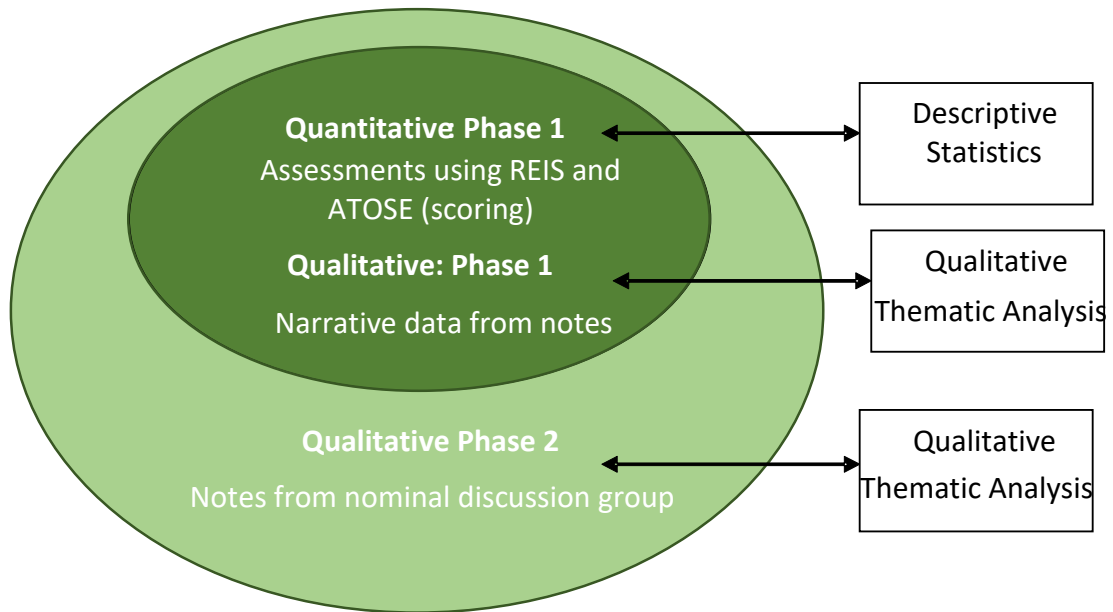


Figure 1.1: The embedded research design of the study

1.9 Significance of the research study

The REIS and ATOSE assessment tools have been chosen for use in this study because of the tools' assessment of not only visually stimulating features but also the insight gained from the findings relating to the social environment and opportunities to participate in meaningful occupation (Fisher *et al.*, 2014; Morgan-Brown, 2014). Collectively, these tools may offer insight into the perceptions of staff and residents regarding the current environment's capacity to meet their daily needs. Meaningful transformation towards person-centred care should always be approached via the people found in the specific environment, and haphazard changes to the environment is not the answer. These assessment tools and the findings aim to offer the participating RACFs an accurate reflection of how the current environment meets the needs of residents and staff to be meaningfully engaged and part of the facility.

Internationally, occupational therapists permanently employed in RACFs are limited, and this is even more so in SA. Despite financial pressure to keep South African RACFs afloat, there has been recent interest and endeavours to provide person-centred care in RACFs.

Potential contributions of this research study includes the possibility that the findings could provide a baseline from which Engo leadership can build and plan appropriate training, or plan environmental modifications to the benefit of residents and staff. The REIS and ATOSE assessment tools, as occupation-based assessment tools, have the power to support the

culture change movement in SA and provide occupational therapists with evidence-based research to support therapeutic partnership interventions in communities of older adults. The evidence from this study might inform internal practices within the Engo organisation to promote the occupational wellbeing of elders and staff and possibly provide evidence to inform national policies relating to RACFs. Furthermore, the findings of this study might contribute to the manner in which occupational therapists practice within elder communities and could emphasise the role and contributions of involving an occupational therapist in an ongoing consultation capacity.

1.10 Outline of the chapters

Chapter 1 introduces an overview of the literature associated with the research problem and relevant concepts to this study such as the research setting and the two assessment tools used. The research design is introduced along with the overarching research question and subsequent objectives. The significance of the research is also declared.

Chapter 2 presents an overview of the literature related to this study. Electronic research tools were used, mainly from *EBSCOhost* databases such as *CINAHL* and *Medline*, along with *Google Scholar*. The researcher obtained books from different branches of the University of the Free State Library and Information Services in addition to books already owned or provided to her by the supervisors of this research project. The prominent literature that influenced this research project is on occupational justice and current international and national care practice in RACFs.

Chapter 3 provides a detailed overview of the research methodology used in this study. The research paradigm informing the method of enquiry is presented with reference to the study design, the research context and the position of the researcher. Data collection, data analysis and data management are comprehensively discussed, concluding with comments on the trustworthiness and ethical considerations of the study.

Chapter 4 presents all the findings of the research project in two sections. Section 1 presents the homogenous findings of the operational processes that influences the environment in each facility. Thereafter, the findings from the REIS and ATOSE assessments are presented per facility. Section 2 presents a description of the nominal group participants and the priorities identified during this group relating to the applicability/usability of the two assessment tools. The chapter is concluded with the presentation of the combined findings

regarding the enablers and barriers to implementing the findings and suggestions of the REIS and ATOSE assessment tools.

Chapter 5 presents an interpretation and discussion of the findings triangulated with relevant literature to establish valuable conclusions which is further elaborated on in Chapter 6.

Chapter 6 states the limitations of the research project, and the reflexive conclusions and recommendations for future research in SA within the context of this study. A closing reflection concludes the dissertation.

1.11 Dissertation style

Throughout the dissertation the researcher writes in the third person. Whilst qualitative researchers' subjective involvement is entangled throughout the research process, writing in the third person offers the researcher the opportunity to continuously inspect and critically examine information produced for possible bias. Considering the intimate involvement of the researcher in the research setting, as an employee of one of the participating facilities of this study, writing in the third person is used as an additional attempt to distance the researcher, aid objectivity and contribute to the trustworthiness of this study.

In chapter 4 and chapter 5 the researcher references some comments and observations as part of the findings of this research study that were originally made in Afrikaans. The statements were translated verbatim and is presented in parentheses, following the original statement.

British English is used as the grammatical writing style in this dissertation. Pertaining to referencing, the 'American Psychological Association' (APA) style of referencing, as automated by the *Mendeley Cite-O-Matic* plug-in on the *MS Word* program, is used throughout the dissertation. Page numbers are indicated in occurrences of direct or paraphrased citations to other authors.

1.12 Conclusion

Chapter 1 presented an overview of the research study by briefly introducing key concepts to identify relevant gaps. The prominent gap in relevance to this study, is the limited evidence-based research within the South African context to support and guide occupational therapists practicing in RACFs in expanding their professional therapeutic service to have long-term effects on the communities in which they work. The research problem was argued considering the rapidly aging population needing dignified long-term residential care and

ensuring the future of occupational therapy services within this setting. In Chapter 2, a more comprehensive investigation of literature is provided to ensure a thorough composition of theoretical concepts related to this research project.

2 Literature Review

2.1 Introduction

Chapter 1 presented an introduction and overview of this study. In the second chapter of this dissertation, relevant literature relating to the main concepts associated with this study will be presented and discussed. An introduction to aging theories provides insight into aging being associated with loss and diminished capacity. Thereafter an overview of the current state of South African aged care facilities are reviewed, with a focus on people aging in RACFs who live with neurocognitive decline, commonly referred to as dementia. Culture change philosophies are presented towards consideration of applying an occupation-centred approach to promote the wellbeing of older adults. The literature review is concluded with an introduction to the REIS and ATOSE assessment tools and an overview of the developing scope of occupational therapy practice in collective community environments such as RACFs.

2.2 Introduction to aging theories

Aging is inevitable - a statement that rings true, but proclaimed with very little cognisance of the implications of aging and the lived experiences of elders. The study of aging – gerontology - and aging theories have been investigated since the 1940's and aim to explain the biological, psychological and social processes of becoming older (Nilsson, Bülow, & Kazemi, 2015). Aging can be conceptualised from multiple paradigms, for example as a biological progression, a developmental process, a social phenomenon and/or a lived experience. Efforts have been made to merge the different perspectives toward a holistic understanding of aging (Hocking & Meltzer, 2016: 41).

Physical aging is a complex interaction of genetics, chemistry, physiology and behaviour, and is generally associated with decline, usually categorised as i) programmed theories, which explain aging as a natural process of human life, pre-determined by genetics, or ii) damage theories, which explain aging due to environmental toxins causing cumulative damage to the body. Physical aging theories are deemed exclusive and insufficient in explaining the holistic aging process that humans experience (Davidovic *et al.*, 2010) and, in recent years, decline models of aging have given way to life-span developmental models.

Previously, gerontologists have theorised disengagement from society as a natural process that occurs when humans age. The disengagement theory was the first aging theory proposed by gerontologists. Although the disengagement theory is nowadays mostly rejected as inappropriate and too accepting of the biomedical model characterising aging as an inevitable decline of pathological processes, it illuminates ageist perceptions prevalent in Western societies. Such perceptions contribute to the marginalisation of older people as a burden to society, framing elders as having less to offer than younger people (Hocking & Meltzer, 2016: 42).

Life span developmental models, also referred to as gerontological and psychological models of aging, suggest a more balanced theory of aging, and consider the psychological effects of aging and its influence on humans as holistic beings, which are more aligned with the principles of occupational therapy (Hocking & Meltzer, 2016; Nilsson *et al.*, 2015). These balanced theories emerged from findings that suggest improved self-regulation. There is also the distinct favouring of more meaningful activities for older people as important considerations that link with but challenge previous beliefs that old age equals psychological improvements, but also equals physical deterioration (Charles & Carstensen, 2010). Two such theories are the concepts of 'active aging' and 'successful aging', which oppose the disengagement theory. They emerged due to the demographic revolution through which populations continue to rapidly reach higher age ranges. This presents increased economic strain and necessitates active aging policies and programmes (World Health Organization, 2002).

'Successful aging' and 'active aging' are sometimes used synonymously, and although both aging theories are scientifically grounded in the 'activity perspective', they are not the same. Active aging refers to continued participation in social, economic, cultural, spiritual and civic affairs, and aims to increase quality of life as healthy life expectancy for elders are increased. Additionally, active aging theories refute stereotypes of aging as becoming passive and dependent, and alternatively place emphasis on autonomy and participation (Foster & Walker, 2015; World Health Organization, 2002). 'Successful aging' was first introduced by Rowe & Kahn (1997), who described successful aging as the ability to maintain three key behaviours: low risk of disease and disease-related disabilities, high mental and physical function, and active engagement with life (Hocking & Meltzer, 2016: 43). Both theories have been criticised as having an overtly productivist and utilitarian vision, where older adults are only successful or active if they are able to contribute to economic growth and age without

chronic conditions (Foster & Walker, 2015). The failure of the theories to account for the individual experiences of structural issues such as unemployment, racism and older women's history of restricted vocational opportunities, which impose financial and societal barriers to active and successful aging (Hocking & Meltzer, 2016: 45), have been criticised.

The theories of active and successful aging have been contested due to their exclusionary criteria. Recently the World Health Organisation (WHO) has introduced the concept of 'healthy aging'. The concept of healthy aging recognises that some older adults are excluded from aging in an active and/or successful way due to poor health, gaps in national health and care services and other physical and social barriers that exclude them from active community participation (World Health Organization, 2019). Healthy aging entails "developing and maintaining the functional ability that enables wellbeing in older age" (World Health Organization, 2020: 3). Functional ability refers to and includes the intrinsic capacities of an older adult (combination of physical and cognitive abilities), the environment in which the individual lives (physical, social and political) and the dynamics between these. It is more inclusive to elders from various societies and different abilities, and provides a realistic and holistic perspective of aging.

2.3 Aging in South Africa

Despite the contribution of evolving holistic aging theories, the conviction that evolution and growth can be maintained in old age is not necessarily the reality that older people, especially elders in South African RACFs, live with. Elders are dependent on facility staff to support their aging process in a dignified manner (Mondaca, Johansson, Josephsson, & Rosenberg, 2019). The awareness and readiness of staff to engage with residents in this process have however been queried (Fjær & Vabø, 2013; Mondaca, Josephsson, Katz, & Rosenberg, 2018).

Ageism, freely described as stereotyping, prejudice, and discrimination against people on the basis of their age (World Health Organisation, 2018), is exceedingly prevalent and usually unchallenged due to its subconscious nature (Officera & de la Fuente-Núñez, 2018). In the African context, ageism is exacerbated and without a doubt directly linked to the absence of policies and legislation to protect the interests of elders (Nhongo, 2006: 13). For example, the South African Older Persons Act (13 of 2006) exists to maintain and promote the rights, wellbeing and security of elders - a noble undertaking that aims to effectively banish discrimination against older adults, but the act and its regulations are often

unsuccessfully implemented (Samson Institute for Ageing Research, 2016; South African Human Rights Commission, 2015).

Furthermore, despite the fact that the act was passed in parliament in 2006, the regulations for this act was only published in 2010. The Human Rights Commission of South Africa launched an investigative report of systematic complaints relating to the treatment of elders. The report found that there is still no overarching coordinating mechanism to ensure that all stakeholders providing aged care in SA execute their mandates and ensure that the Older Persons Act and its regulations are adhered to and implemented. An audit conducted by the South African Department of Social Development in 2010, identified that the majority of state-funded RACFs in SA do not comply with the Older Persons Act. In addition, many non-profit organisations who manage RACFs complain about lacking funds or the government's failure to pay subsidies that have already been approved (South African Human Rights Commission, 2015: 14). Despite the Department of Social Development being viewed as the responsible body for elders and their rights, it is not their sole purpose, and therefore the implementation of the Older Persons Act remains slow, if not lacking (South African Human Rights Commission, 2015: 16).

Moreover the marginalisation of older adults as passive recipients of welfare and charity due to the neoliberalist view of this group of people's inability to meaningfully contribute to society, makes them highly vulnerable to poverty, social isolation, depression and abuse as they age, especially those living with dementia (Morgan-Brown et al., 2018; Samson Institute for Ageing Research, 2016). Poverty and poor living conditions drastically exacerbate the degenerative effects of ageing, which again increases the prospect of cognitive decline and disability (Prince *et al.*, 2008). In addition to this, inequalities in ageing in SA are largely mapped along racial lines. This is due to the current population of elderly black people having faced discrimination and disadvantages during Apartheid, which continues due to racially-defined socio-economic disparities in the country (Samson Institute for Ageing Research, 2016). Coincidentally, there is a general understanding in many African cultures that it remains the responsibility of the family to care for elders, recognised as the concept of *Ubuntu* (Gurayah, 2015). Many older black South Africans who remain in their homesteads, being cared for by family members, may be at risk of living with dementia without the necessary support services available to them, due to the family being uninformed about the condition.

Although elderly people are entitled to free health care in the South African public health system, they struggle to access *quality* care because of health system capacity constraints and age-related barriers to access. Health services tend to be clinic-based with a lengthy and tedious referral system. South Africa's current healthcare system does not have the capacity to deal with the complex needs of older people with multiple chronic conditions, specifically dementia (World Health Organisation, 2017), and the system is geared for focussing on primary healthcare conditions (De Jager *et al.*, 2015; Gurayah, 2015; Steyn, 2010, Hoffman & Pype, 2016; World Health Organization, 2017). Many healthcare professionals, including private healthcare providers, do not provide older people with adequate care, or they struggle to identify frailty and dementia due to little or no dementia training in healthcare disciplines. Despite this fact, organisations such as Dementia South Africa and Alzheimer's South Africa continue rallying for dementia awareness and action, but lack major funding which in turn diminishes the scope for effective operation (Benade, 2012; Kalula & Petros, 2011; Samson Institute for Ageing Research, 2016).

The inadequate support services for elders and especially those living with dementia, calls for immediate action to ensure that their human rights are considered, protected and advanced as a societal and ethical responsibility. Advocating and supporting an awareness of ageism should be more than 'the next best social movement' to support, as older adults around the world are living longer. Real systemic change is needed to ensure a better and more dignified life for elders. Developing countries have the largest elder population and in 2019, five percent of older people in the world, were living in Sub-Saharan Africa (World Health Organization, 2020) and there is little evidence that they are living in better health than their ancestors; particularly in developing economies where elders are more likely to experience poor health and correspondingly low levels of wellbeing (Samson Institute for Ageing Research, 2016). In SA the notion exists that the South African healthcare system is "hell-bent on keeping people alive for much longer, but they haven't thought about what to do with us when we're old" (Smallhorne, 2017).

2.4 Dementia and Aging in South African Residential Aged Care Facilities

It is as if a radical divide has been made between 'us' (the cognitively intact, and fundamentally sound members of society) and 'them' (the damaged and deficient). The problem of dementia is attributed to 'them', while 'we' are let off the hook. The dementia sufferer is thus a kind of alien, and caregiving tends to be viewed as action by superiors - a modern version of old-time charity (Kitwood 1993: 53)

Dementia is one of the leading global health challenges of current and future generations (World Health Organisation, 2017b; World Health Organization, 2020). It is estimated that by 2050 the number of people living with dementia worldwide will be more than 100 million. Seventy-one percent of these cases will be people living in underdeveloped countries, such as SA (World Health Organization, 2017). These statistics estimate that one in three people older than 65 years of age will live with some form of irreversible dementia (De Jager *et al.*, 2015; World Health Organisation, 2017). Dementia is a progressive brain disease with an unknown cause, negatively influencing cognitive functions such as memory, orientation, thinking, reasoning abilities and behaviour, and ultimately negatively influences the ability to connect to self, others and the physical environment. It is not a normal part of aging and to date there is no cure for any of the irreversible dementias. People living with dementia struggle with independence and continuous participation in important ADL such as self-care, managing their environments, execution of important life roles, work and recreation activities. Because older adults living with dementia have increased needs, guidance and care is needed to maintain participation in daily life and even basic ADL. Institutionalisation in a Residential Aged Care Facility is usually an inevitable part of a dementia diagnosis.

Despite the many challenges faced by RACFs and unregulated residential care practices, younger people in SA, prior to the COVID-19 pandemic, view institutional care as a viable option, which is in contrast with other sub-Saharan African countries where families choose to care for elders at home (Hoffman & Pype, 2016). RACFs are generally distinguished as traditional or non-traditional facilities (Richards *et al.*, 2015). The South African government only subsidises a small number of residential care facilities, and makes no distinction between traditional or non-traditional care facilities since the application of the Older Persons Act is insufficient and not well regulated.

The gold standard of institutionalised residential aged care is considered to be a person-centred approach to care that extends beyond superficial, usually merely aesthetic, changes, providing the impression of a resident-centred home (Grabowski *et al.*, 2014). Traditional facilities incorporate features and approaches that are based on a nursing model of care, where the medical approach, and a person's disease, is regarded as the most important consideration. Non-traditional facilities incorporate more home-like features in their physical environment, and the care culture is focused on the person rather than his or her disease. Various care philosophies have been proposed to support culture change towards non-traditional facilities within organisations. Meaningful care culture change in

most South African RACFs remains elusive due to the predominant nursing approach being followed in South African RACFs, the under-prioritisation of dementia and the financial constraints that cause injustices to institutionalised elders (De Jager *et al.*, 2015; Du Toit *et al.*, 2018)

The shift towards developing frameworks for dementia-friendly environments within RACFs has seen a boom over the last two decades (Sharkey, Hudak, Horn, & James, 2010; Slaughter, Calkins, Eliasziw, & Reimer, 2006; Woodbridge *et al.*, 2016), although no dementia-specific guidelines or policies exist in South African facilities. RACFs are infrequently audited by the Department of Social Development, and these audits are merely based on adherence to the basic rights of older people as described in the Older Persons Act (act 13 of 2006). They do not account for any consideration of person-centred principles that promote culture change within the facility. The ATOSE assessment, detailed in section 2.8.3 of this literature review, were designed specifically to assess the occupations and social engagement of people living with dementia within a particular environment.

An increasing need for specialised dementia environments has prompted private care providers to create such facilities within existing traditional nursing homes. This has led to regulators, family members and researchers questioning the authenticity and quality of these 'environments' (Slaughter *et al.*, 2006). With this practice, a need evolved to evaluate the effectiveness of so-called 'specialised' dementia environments. Research has found that in SA, nursing homes remain focused on the traditional model, where medical care dominates and little consideration is given to transforming long-term care environments for elders (Du Toit *et al.*, 2019; Thomas, Du Toit & Van Heerden, 2014).

2.5 Culture change philosophies applicable to Residential Aged Care

Culture change surpasses mere home-like adaptations to the physical environment, and requires genuine personal and organisational transformation. The vision of dementia-friendly environments entails the use of psychological features that relate to factors associated with improved quality of life, including privacy, autonomy, personalisation, safety and support for physical impairments (Slaughter *et al.*, 2006). Besides the environment being a central concept to the theory of occupational therapy (Causey-Upton, 2015; Morgan-Brown *et al.*, 2018; Teitelman, Raber & Watts, 2010), it is indisputable that the environment plays a vital role in the engagement and participation of people living with dementia in RACFs (Marquardt, Bueter & Motzek, 2014; Pot, 2013; Richards *et al.*, 2015; Slaughter *et*

al., 2006; Teitelman *et al.*, 2010; Woodbridge *et al.*, 2016). Large-scale studies reviewed by Woodbridge and Sullivan (2016) provided evidence that the physical environment assisted with more independent functioning in ADL, and that the holistic environment may decrease the rate of cognitive decline. In agreement with these findings, the built environment contributes to increased orientation, 'normal behaviour'⁴ and an increase in functional social abilities (Marquardt *et al.*, 2014; Woodbridge *et al.*, 2016).

2.5.1 Person-Centred Care

The theory of person-centred care emerged from the limited psychological and psychiatric theory to support dementia care practice. Person-centred care is a philosophy that is constructed in acknowledging the preferences and needs of an individual, dependent on knowing them through an interpersonal relationship (Fazio, Pace, Flinner & Kallmyer, 2018). The philosophy was first introduced by Tom Kitwood, based on the seminal works of Carl Rogers promoting the adoption of a client-centred approach in mental healthcare (Dupuis *et al.*, 2012; Kitwood, 1993). Despite evidence-based research supporting the need for culture change, advancing dementia-friendly environments and adopting a person-centred care approach, many residents living with dementia in RACFs are still imprisoned by the emphasis placed on their diagnosis and its progressive decline. Often residents are seen as tasks that need to be accomplished, e.g. 'time to go to bed' or 'time to eat', and their personhood is neglected (Heggestad, Nortvedt & Slettebø, 2013). Residents are continually seen in communal lounge areas, sitting for hours on end staring into space, or waiting around aimlessly for staff to abide by the structured routines and tasks to be completed (Morgan-Brown *et al.*, 2018). This is even more applicable to people living with dementia, who are unable to regulate and act upon their sensory needs. When a person is treated as a frail item, they become part of the immediate environment and is no longer recognised as

⁴ Please note that the term 'normal behaviour' is contested within the occupational therapy profession and the person-centred care framework. These words are quoted directly from the literature source. Normal behaviour in this context refers to societal norms that are placed on people living with dementia. People living with dementia sometimes exude behaviour that cannot be analysed or interpreted correctly by other people due to their lack of understanding of their personhood, and therefore they are labelled as displaying 'difficult/abnormal' behaviour (Rogers, 1983: 105).

an autonomous being (Du Toit, Shen, & McGrath, 2018; Du Toit & Surr, 2011). Such an approach does not promote or support 'healthy aging'.

Kitwood (1993) stood firm in his theory and belief that person-centred care requires insight and a deep understanding of the personhood of the human who is cared for. Simply put, person-centred care shifts the emphasis from cognitive impairments to acknowledging the feelings and emotions of the person living with dementia. In order to acknowledge these feelings and emotions, insight is needed into the history, experiences, preferences and personal and moral views of the old-aged person, in other words *their personhood*.

Despite person-centred care being regarded as the gold standard in long-term aged care, there is criticism towards the approach, which includes it being devoid of recognising the autonomy of elders. Additionally, person-centred care could be perceived in contrast with the community perspective of collectivity. The concept of interdependence has been proposed to capture the necessary conditions for collaborative practice with resident living in RACFs (Mondaca *et al.*, 2019). Research indicates that what often transpires in RACFs are according to institutional needs and operations, and staff practices do not necessarily regard the needs, preferences or capabilities of the residents (Du Toit, Chan, Jessup & Weaver, 2019; Mondaca *et al.*, 2019; Vassbø *et al.*, 2019). Furthermore, the person-centred climate in a Residential Aged Care Facility is directly linked to staff's experience of job satisfaction and providing more ethically sound care to institutionalised residents. The reality for many residents living in South African RACFs is that institutional environments direct the care approach (Du Toit & Van der Merwe, 2013; Du Toit *et al.*, 2019). This, together with insufficient national legislation and care audits (South African Human Rights Commission, 2015), often results in conflicted ethics of care in these facilities, and residents may consequently bear the brunt of injustices.

In recent years there has been a boom of dementia care models and culture change philosophies that support the anti-psychiatry movement. To some extent all of these are rooted in the person-centred care theory that strive towards dignified care for older people living in long-term care facilities. These movements include the Green House Project and Eden Alternative, amongst others. Internationally, the Eden Alternative has gained abundant support with regional co-ordinators and a presence in Australia, Austria, Canada, Denmark, Germany, Iceland, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and SA (The Eden Alternative, 2016). The Eden Alternative is a non-profit

organisation that aims to shift the ‘sterile environments’ and medical-based culture of care in long-term residential care facilities (Power, 2010; Thomas, 1996) to “human habitats where life is worth living” (The Eden Alternative, 2010: 10).

2.5.2 The Eden Alternative and its Domains of Wellbeing

Ten principles guide the Eden Alternative’s approach to changing the culture of care. Principle one is known as the problem statement of the traditional culture of care in RACFs, and is presented as: “The three plagues of loneliness, helplessness and boredom account for the bulk of suffering among our Elders” (The Eden Alternative, 2009: 8). The nine principles following this problem statement offer solutions to the major problem of helplessness, loneliness and boredom. The Eden Alternative advocates for an environment that is stimulating, ‘elder-centred’ and provides close and continuing contact with animals and plants as well as people of all ages and abilities (The Eden Alternative, 2009: 10). Care partners is a term that is used within the Eden Alternative framework and refers to carers who enter into a care partnership with an elder. Care partners are encouraged to have a trusting relationship with elders and are seen as an important part of the elders’ support system, and not merely someone that provides physical care. The Eden Alternative suggested an all-important rule, namely *as management does onto staff, staff will do onto elders* (The Eden Alternative, 2010: 25). This ‘golden rule’ of the Eden Alternative, as it is known, should be the cornerstone from where organisational transformation is approached.

The Eden Alternative introduced seven domains of wellbeing to provide pioneers of culture change in long-term aged care facilities a way to measure wellbeing (The Eden Alternative, 2012: 3), which remains elusive and subjective. The ultimate goal of culture change in RACFs is wellbeing for all, and the Eden Alternative promotes a care partnership that ensures the wellbeing of everyone involved in the care partnership. This includes the care partners (elders, employees, family members and volunteers), the organisation, and ultimately the community (The Eden Alternative, 2012: 3). The concepts of wellbeing, coined as domains of wellbeing by the Eden Alternative, encompass identity, connectedness, autonomy, security, meaning, growth and joy.

Table 1: The Eden Alternative's seven domains of wellbeing

Domain of Wellbeing	Interpretation
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Identity	Identity means to become well-known, a hallmark of the Eden Alternative, and is the opposite of being known by a job title or a disease process. Identity as a social construct is sometimes homogenised in RACFs to favour group identity. This means that residents' needs, preferences and history are often generalised and reduced to a collective experience.
Connectedness	Connectedness refers to having deep and meaningful relationships with others in your environment, and also being connected to important people who might not be around constantly. It involves connection that confirms and attached one to past places, relationships and personal possessions.
Autonomy	Autonomy refers to having the opportunity and support to make choices, but stretches beyond basic decision-making or having a choice between pre-selected options or a choice which only benefits ('good-for-you' options) the chooser. Top-down organisational structures often diminish autonomy and the possibilities of creative approaches to daily obstacles and opportunities. Paternalistic approaches in RACFs are typically devoid of any autonomy experienced by operational staff and residents.
Security	Security means that one's basic human safety needs, as theorised by Maslow (1943), are met. These include physical safety in one's home, financial stability and being free from anxiety or fear. With regards to the Eden Alternative's domains of wellbeing, the concept of security is expanded to include privacy, dignity and respect, and the avoidance of involuntary or intimate situations with strangers.
Meaning	Meaning is highly subjective as each individual and community will experience meaning differently. Meaning entails having a purpose, being spontaneous and looking forward to daily life.

Growth	Growth refers to opportunities to develop as a human being and entails identifying the strengths, abilities and goals of individuals, and sharing and utilising these within the community.
Joy	Joy refers to an emotion that is provoked unintentionally. It refers to the feelings of contentment and delight at happenings in daily life. Efforts to create joy is futile, but experiencing joy can be supported by being known within the community.

2.6 An occupation-centred approach to residential aged care

2.6.1 Elders as occupational beings

As occupational beings, humans have the instinctive need to 'do'. Occupations are the practical ways in which humans exert choice, empowerment and control, and produce health, wellbeing and justice (Townsend & Wilcock, 2004). The lack of opportunities for participating in valued and meaningful occupations within any community, is an occupational and social injustice that has a detrimental effect on quality of life. The essence of occupational therapy with regards to our role as advocates for a supportive environment is captured in the following statement;

The history of occupational therapy documents the fact that occupational therapy's roots lie in providing a normalizing environment for individuals experiencing disruptions in daily occupations as a result of severe and chronic conditions. To act as an environmental manager for eliciting occupational behaviour, therapists must understand the environment and how it influences occupation (Briller et al., 2016).

The human need for connectedness to something or someone other than oneself is a universal phenomenon, and the need for freedom of choice, connection and belonging is interwoven into the subjective experience of dignity for people living with dementia (Heggestad et al., 2013). The concept of connectedness relates directly to the quality of life of people living with dementia in long-term care facilities, and encompasses the need for a positive link between the experience of themselves, their relationships, agency and physical environment (O'Rourke, Duggleby, Fraser & Jerke, 2015). There is not a point in a person's

life where they do not have the need to feel connected or be embedded as part of a larger social structure. Moreover, the devastating and detrimental effects of isolation does not decrease with age (Charles & Carstensen, 2010). In fact, many studies show that the effects of loneliness and isolation increase the risk for cognitive decline (Andel, Hyer, & Slack, 2007; Du Toit, Böning & Rauch Van Der Merwe, 2014; Wilson *et al.*, 2007).

In addition, occupational engagement can effectively be facilitated if employees of RACFs have a good understanding of the occupational capacities of people living with dementia, and structure the physical and social environment in such a way that it supports their capacity for occupational performance (Richards *et al.*, 2015).

2.6.2 The environmental impact on elders' occupations

The fundamental assumptions of occupational therapy are based on the humanistic approach of moral treatment, a humanitarian philosophy of the 18th and 19th centuries (Kielhofner & Burke, 1983). As occupational therapy developed, an occupational paradigm was needed to explain and ultimately ensure the survival of occupational therapy as a unique and much needed specialised health profession (Kielhofner & Burke, 1980). Kielhofner and Burke (1983) first proposed the Model of Human Occupation (MOHO) and developed the MOHO as a conceptual framework to bring coherence to the diverse scope of occupational therapy. The core premise of the MOHO is in explaining how occupations are encouraged, organised and performed in the everyday situations in which people find themselves (Kielhofner, 2008). The environment is described as a macro system in the MOHO, and emphasises the constant interaction of humans with the people, events and objects within this environment. The environment can be seen as ‘the most important tool that occupational therapists have’ (De las Heras, Llerena & Kielhofner, 2003: 10). The environment can be defined as the physical, social, occupational, economic, political and cultural components of the context of a person which impacts their performance of occupation and motivation. The MOHO envisions the environment as consisting of three dimensions, namely the physical, social and occupational (Kielhofner, 2002: 99, 103–111). In addition to these dimensions, the economic, political and cultural factors, as well as social attitudes, also impact on occupations. Within these dimensions, people engage with different physical **spaces, objects, activities** and encounter different **relationships**, expectations and opportunities for doing things (Fisher, Parkinson & Haglund, 2017: 93). It is these aspects of everyday spaces, everyday objects, everyday activities and enabling relationships that are evaluated using the REIS (Fisher *et al.*, 2014).

Facilitating change without accounting for the co-influence of the environment on a person and the person on their environment, is impossible. The environment in which a human performs occupations is inextricably connected with his or her performance, actually “to the point of being inseparable” (Fisher *et al.*, 2017: 93).

Occupational therapists who use the MOHO contextual framework on which the REIS assessment is based theoretically, can facilitate the creation of environments that align with a person’s capacities, skills, interests, values, roles, habits and ability for occupational adaptation (Fisher *et al.*, 2017). When doing a comprehensive analysis of the environment by using a tool such as the REIS, the occupational therapist can evaluate the impact of the collective environment on the collective population’s occupational performance and participation, and recommend and support adaptations within the environments of RACFs (Fisher *et al.*, 2014, 2017).

Environments encourage certain behaviours while impeding the performance of others (Fisher *et al.*, 2017). Furthermore, environmental constraints and requirements influence the development of human habits and roles (Fisher *et al.*, 2017: 97). The constraints and requirements of an environment can negatively influence the actions and behaviours of people within those environments. Many examples have been documented on how the rules, events and staff, specifically in dementia and residential aged care environments, hinder residents’ attempts to spontaneously engage, while amplifying passivity and inactivity (Jackson *et al.*, 1998; Lorimer, 1984; Marquardt *et al.*, 2014; Richards *et al.*, 2015; Teitelman *et al.*, 2010; Teitelman, Raber & Watts, 2017). Environmental impact refers to the “opportunity, support, demand, and constraint that the environment has on a particular individual” (Fisher *et al.*, 2017: 97-98). Modifying the environment will influence participation in occupation, but considering how the environment impacts on residents and how residents interact with their environment is essential to suggest environmentally focussed modifications (Fisher *et al.*, 2017: 104) which can enhance the collective participation of elder communities.

2.6.3 Residential Aged Care Facilities as communities

The term ‘community’ is often associated with multiple meanings, but can be fundamentally defined as a cultural or social group in a shared space or setting with a similar purpose and/or identity (Jewkes & Murcott, 1996). RACFs should be viewed as micro-communities, since they consist of an elder population that is interrelated within a confined setting. The

people living and working in these facilities have common purposes, either due to having increased care needs or a shared goal of providing care and support for elders. The collective experiences of residents and staff living and working in RACFs necessitate community-centred practice and the investigation of the i) community identity, ii) community occupations, iii) community resources and barriers, and iv) participation enablement, as suggested in the conceptual framework for community-centred practice by Hyett, Kenny and Dickson-Swift (2018). The conceptual framework for community-centred practice enables occupational therapists to advance collective occupational justice if their approach is occupation-centred. Transformation towards an occupation-centred intervention approach is possible through the use of practice-based enquiry processes (Whiteford et al., 2020), which can be afforded by using occupation-based assessment tools such as the REIS and the ATOSE.

2.7 So what now? The ‘Decade of Healthy Aging’

Recently, the *Decade of Healthy Aging (2020 – 2030)* was proposed by the WHO as an “opportunity to bring together governments, civil society, international agencies, professionals, academia, the media, and the private sector for ten years of concerted, catalytic and collaborative action to improve the lives of older people, their families, and the communities in which they live” (World Health Organization, 2020: 1). ‘*The Decade*’, as it is referred to by the WHO, was informed by the World report on ageing and health of 2015. According to the WHO the elder population is growing at the fastest rate in Africa, and it is estimated that the number of people aged 60 years and older are increasing most rapidly in developing countries, which will accommodate up to 17 billion people by 2050 (World Health Organization, 2020). The decade of healthy aging provides a promising opportunity for occupational therapists to position themselves as an integral part of this movement towards a society that honours elders for who they are as occupational beings.

2.8 The role of the occupational therapists in promoting an occupational identity and promoting *healthy aging* for elders living in Residential Aged Care Facilities

Although statistical data is unavailable, occupational therapists are typically not employed in South African aged care facilities. However, there are increased opportunities for occupational therapists to strengthen their practice in such community settings (Du Toit, Chan, Jessup & Weaver, 2019; Hyett, Kenny & Dickson-Swift, 2018). In contrast to other

sub-Saharan African countries where family members take care of elders for as long as possible, South Africans, especially younger generations, are increasingly accessing institutional care for family members (Deist & Greeff, 2015; World Health Organization, 2017). Despite challenges regarding funding, lacking infrastructure and poorly regulated residential aged care practices in South Africa (Mapira, Kelly & Geffen, 2019; Thomas, Du Toit & Van Heerden, 2014), a growing number of elders enter long-term residential care (Gurayah, 2015; Kalula & Petros, 2011; World Health Organization, 2017), ensuring the sustainability of residential care in South Africa and the opportunities for occupational therapists to empower these communities. Community-centred practice is characterised by practice with communities (not *in* or *on* or *for* them), necessitating partnership and collaboration (Hyett, Kenny & Dickson-Swift, 2018).

Occupational therapists consistently use a client-centred approach, taking into account each client's context and evaluating and planning treatment accordingly. Within RACFs occupational therapists need to be able to analyse how cultural care systems and structures in nursing homes contribute to each client's context, either by providing or limiting opportunities for engagement in meaningful occupations that contribute to the experience of quality of life of the person living with dementia. Occupational justice in the collective settings of RACFs are therefore an important consideration for occupational therapy practice in aged care communities. When residents in RACFs are denied opportunities for participating in meaningful occupation, access to social networks and participation in everyday activities occupational injustice occurs (Briller *et al.*, 2016; Causey-Upton, 2015; Morgan-Brown *et al.*, 2018). This has resulted in occupational therapists shifting their focus towards the impact of the physical and social environments.

Older people living in RACFs are often subjected to occupational injustices which flow from institutional constraints due to the organisational culture and social systems of traditional facilities (Causey-Upton, 2015; Whiteford *et al.*, 2020). A common occurrence in busy long-term care environments is staff 'taking over' activities of daily living, such as personal care or environmental tasks, in order to get the job done faster and more efficiently. Residents are deprived of participation in meaningful activities, and opportunities to stay engaged within their environment become very limited. Well-intended practices in task-oriented long-term care environments ultimately create dependence and passivity of residents, contributing to the violation of residents' dignity and personhood (Du Toit *et al.*, 2019; Mondaca *et al.*, 2019). Occupational and social engagement are inherent needs of all

humans, irrespective of age, and tasks, activities and social interactions positively influence the aged population's health and quality of life.

The environmental culture can be viewed as the beliefs, perceptions, values, norms and behaviours of the different groups within a particular environment, and it is omnipresent (Kielhofner, 2002: 99). Within most cultures there are also many subcultures, such as rural, ethnic and urban cultures. In physical environments such as RACFs in SA, there are usually one or two dominant cultures. The workforce in RACFs are dominated by carers, of which a large proportion is black South Africans (Perold & Muller, 2000; Western Cape Department of Social Development, 2015). This has particular relevance, as South Africa and the environments in which people existed were controlled by Apartheid policies until democracy in 1994. This resulted in insulated and homogenous cultural experiences of South Africans, many of which are now working or living in RACFs. The blending of cultures in RACFs and the historic impact of racial classification in SA have resulted in unique occupational influences between staff and residents, considering the history of ascribed occupational patterns of different race groups in South Africa. The mixing of diverse groups of people in communities such as RACFs necessitates the community members to find ways to meaningfully engage and interact with each other toward "collective story-making" (Kronenberg & Ramugondo, 2011: 195).

Promoting a professional occupational identity for carers in South African RACFs poses challenges as they are often stigmatised as "bum cleaners" (Mapira *et al.*, 2019), and were exploited due to apartheid policies which resulted in occupational injustices. Coordinating the daily occupations of black carers and white residents in RACFs towards collaborative occupations that promote meaning, independence and build relationships for both parties, remain a challenge. Occupational therapists need to be aware and sensitive to every facility's care culture in order to act as a change agent for transformative long-term care (Briller *et al.*, 2016) and contribution to the unique "collective story-making" of the key stakeholders of the facility.

2.8.1 The community-centred practice framework

Occupational therapists have the expertise to provide community-centred services to improve occupational performance, participation, justice, health and wellbeing (World Federation of Occupational Therapists, 2019). Hyett *et al.* (2018) proposed the community-centred practice framework to provide the occupational therapy profession with a practice-

focused approach for working in communities. This framework conceptualises the community in four facets.

The first facet of the framework guides the therapist to investigate who the community clients are and to develop an understanding of the social actors and fields, the place and the setting of the community. The authors postulate that the community identity is linked with socio-cultural factors, the natural and built environment, and the population within the setting. They describe the social actors (population) as being fluid, changing over time and having specific social roles (Hyett *et al.*, 2018).

The second facet of the community-centred practice framework investigates the occupations and the shared or co-occupations of the community, and questions what the community's occupational goals are. Conceptualising occupational performance and participation at community level affords the therapists the opportunity to investigate the levels of interdependency of the members of the community and the synchrony of these occupations, and acknowledges the heterogeneity of communities. It can further illuminate whether the roles and occupations are complimentary, and working towards a shared and mutual purpose (Hyett *et al.*, 2018).

The third facet of the community-centred practice framework guides therapists to question the barriers and resources of the community that prevent or promote occupational participation. This includes economic and non-economic resources, but more importantly, this facet of the framework obligates the therapist to understand power relations within the community and facilitate a process of power redistribution (Hyett *et al.*, 2018).

The fourth and final component of the community-centred practice framework focuses on the processes used for community participation, and on considering the enabling role of the occupational therapist. During this facet the framework suggests investigating what participation is already occurring, and to understand historical or current participation obstacles. Additionally, the therapist should acknowledge the strengths of the community and further enable participation via strategies such as building partnerships, education and support of members of the community, and negotiating and advocating with those who hold the power in the community (Hyett *et al.*, 2018).

2.8.2 The participatory occupational justice framework

The participatory occupational justice framework aims to provide therapists with a conceptual tool to “do justice as opposed to only acknowledging or thinking about it”

(Whiteford & Townsend, 2011: 65). This framework uses the foundational approach of collaborative occupational enablement, and emphasises community development, occupational participation and the need for the therapist to be vigilant to power and inequity within the everyday life of these communities. The participatory occupational justice framework is presented as a non-linear interconnected process that entails an increased awareness and raising consciousness of occupational injustices, engaging collaboratively with community partners, deciding on a plan or agreement of how occupational therapy can support the community's goals, strategising resource funding, supporting and evaluating the implementation, and inspiring and advocating for sustainability (Whiteford & Townsend, 2011).

Utility of the environment is an important tool for occupational therapists in RACFs, as they assist their clients with engaging in occupations that sprout from the physical, social, cultural and organisational environment (Richards *et al.*, 2015). The role and practice of occupational therapists are especially challenging in SA where dementia awareness is poor. There are also very little support services available for people living with dementia, especially in rural areas where 40% of the population reside and elders are mostly cared for by family members (De Jager *et al.*, 2015). The limited demographic research relating to dementia, conducted in less-developed countries such as SA, contributes to a lack of awareness and prioritisation, leading to inadequate social and healthcare dementia policies. Dementia is generally gravely under-prioritized (De Jager *et al.*, 2015; Gurayah, 2015; Kalula & Petros, 2011; Prince, 2000; Prince *et al.*, 2008).

In SA the occupational limitations that flow from institutional and organisational constraints are definitely still present in many RACFs. Occupational therapists need to be sensitive to these cultural constructions and act as change agents for transformative long-term care (Briller *et al.*, 2016). Occupational therapists have an ethical obligation to identify and address occupational injustices which occur in RACFs. Occupational therapists practicing in RACFs in SA have an obligation to adapt their scope of practice and clinically reason the best possible approach to facilitate quality of life for people living with dementia. Measuring engagement and participation in RACFs is an effective way to do this. Many audit tools exist for evaluating the physical environments of dementia facilities, but only a few seek information regarding the experience of the actual people living and working at the facility by focussing on elements of participation and engagement.

2.8.3 The ATOSE as a collective occupation based environmental assessment tool

One such tool that focuses on participation and engagement is the ATOSE. The ATOSE (c.f. Appendix J: ATOSE Assessment Tool) a direct observational tool that evaluates and offers “real-world” quantitative statistics on how much time residents spend engaged and non-engaged in communal areas in RACFs (Morgan-Brown, 2014; Morgan-Brown *et al.*, 2018, 2011). An electronic version of the ATOSE is available, on which scoring can be done directly. Alternatively, paper copies can be printed out and data can be uploaded to the computerised program after the evaluation timeslots. The tool provides an easy-to-use ‘snapshot observational method’ of visually scanning the room in a clock-wise direction every five minutes, and recording tasks of engagement and non-engagement of each person in the room, whether a resident, visitor or staff member. Every person’s action in the room contributes to the ‘occupational space’, a term used in the ATOSE, referring to the room environment, and indicating to what extent the communal area facilitates participation in meaningful activity.

The ATOSE protocol proposes observational recording in a seven-day consecutive timeframe, with four recording hours per day divided into two sessions between meal times. It is recommended that the observational times be consistent throughout the seven-day period. Interactive occupation is recorded as being an occupation performed by oneself, an occupation performed with another person, informal interactive occupation or interactive occupation in a structured group. Care tasks also form part of social engagement, and refer to care tasks being done ‘to’ residents. Non-engagement aspects of the ATOSE are passive engagement with the surroundings and passive or agitated behaviours which can either be recorded as eyes closed, agitated or self-stimulation. During most five-minute observational snapshots, time will be available to make narrative notes on the room, which provide clarity on recorded data and also give valuable insights that can be communicated to stakeholders (Morgan-Brown, 2014).

The ATOSE tool is therefore useful in acquiring information from people living with dementia, and who have difficulty expressing themselves and their subjective experiences. The tool is straight-forward to use and does not require any additional training for occupational therapists. Furthermore, the ATOSE does not report or interpret the behaviour of individuals, which is an ethical dilemma for many research projects requiring informed consent from people living with dementia (Morgan-Brown, 2014). One limitation identified by the author of

the ATOSE is its lack of identifying exactly what needs to be addressed in order to facilitate change (Morgan-Brown *et al.*, 2018).

The ATOSE was developed as part of the PhD research project of an Irish occupational therapist, Mark Morgan-Brown. The tool has been used in RACFs in Ireland and Australia. The reliability and validity of the ATOSE have been described, with reliability having been established through interrater agreements of over eighty percent (Morgan-Brown, 2014; Morgan-Brown *et al.*, 2018).

2.8.4 The REIS as a collective occupation-based environmental assessment tool

The REIS (c.f. Appendix I: REIS Assessment Tool) is another paper-based, semi-structured assessment tool that was developed to assess group home living environments for adults with intellectual disabilities, but has been found useful in nursing homes and Residential Aged Care Facility contexts. The REIS was developed as part of the MOHOST organisation, and REIS (version 4.0) specifically developed for residential aged care was co-created in 2013 and 2014 by Gail Fisher of University of Illinois at Chicago and the Queen Margaret University team in Scotland, headed by Doctor Kirsty Forsyth (Fisher *et al.*, 2019). The REIS is a standardised assessment tool and has been researched and used extensively internationally, but not in the South African context.

The REIS (version 4.0), provides occupational therapists with a tool to assess the impact of the environment by focusing on how well the environment addresses the occupational needs of residents, and ultimately their quality of life (Fisher *et al.*, 2014). The Model of Human Occupation (MOHO) was used as theoretical basis for the development of the REIS due to the comprehensive way in which Kielhofner, the main developer of MOHO, described the influence of the environment on volition and participation in occupations (Fisher *et al.*, 2014).

The REIS scores four areas of the facility (i.e. *everyday space*, *everyday objects*, *enabling relationships* and *structure of activities*) according to a four-point scale which yields quantitative data. A score of four indicates that the specific area of the environment *strongly* support people's identity and provides ample opportunities for participation while a score of *one* indicates that the environment strongly interferes with people's sense of identity and restrict opportunities for participation. The four sections are scored. The summary of all collected data can be used to improve the qualities of the home and the routines associated with the home to ultimately impact the occupational participation of residents. The REIS can

be used as an independent tool or in association with others, as suggested in the REIS Manual (2014).

The REIS takes approximately eight to twelve hours to administer and is implemented in four flexible stages, scored on a four-point scale. It includes multiple methods of information gathering, such as observation of activities in the facility and interviews with staff and residents.

Stage one comprises a *walk-through* of the facility and enables the therapist to organise observations of the environment according to the 20 items of the rating form. These include *Everyday spaces, Everyday objects, Enabling relationships* and *Structure of the activities*.

In the second stage, which can take place in conjunction or adjacent to the first stage, the therapist needs to *observe* three everyday activities, taking special notice of the staff/resident and resident/resident relationships and the amount of support provided. The observation should take place in a more natural/informal way, and not be structured.

The third stage requires *interviewing* the *residents* which, can be done in a formal or informal way. The interviews should provide the therapist with additional information on the environmental features from a resident's point of view.

The fourth and final stage of the REIS assessment is *staff interviews* which can also be done in a formal or informal way. The purpose of the staff interviews is to give opportunities to staff to comment about their working environment, giving the therapist further insight into the environment and how it impacts the daily routines of staff. A detailed interview guide accompanies the REIS manual, with four global questions to facilitate and stimulate discussion. These are:

- *What do you think the home does well?*
- *What areas do you think need improvement?*
- *What are the barriers to improvement? (e.g. finances, governing policies)*
- *What changes would you suggest to help make the home a better place for the people who live here?*

The aim of these questions is to stimulate discussions with the interviewees. These questions serve as a guideline to the assessor as part of the assessment tool.

The REIS can be used independently or in association with other tools, as suggested in the REIS Manual. Both the ATOSE and the REIS were created by qualified occupational therapists, and are to be administered only by qualified occupational therapists.

Limited publications are available relating to the REIS. The REIS has been adapted for use in the Swedish context as the REIS-S (Svensson, Kåhlin & Kjellberg, 2018). The main adaptation to this version is the labelling of the quantitative scores. Originally, scores 1 to 4 respectively indicated that the environment ranges between strongly supporting (4) and strongly interfering (1) with people's sense of identity and competence. The adapted REIS-S re-labelled the scores to indicate that the environment needing major improvement (1), some improvement (2), is appropriate (3) or is a strength (4) of the facility. Additionally, a recommendation guide was developed which, enables the assessor to suggest recommendations and strategies for environmental adaptations according to the lowest scores (1 and 2) to support residents' occupational participation (Svensson *et al.*, 2018). The REIS-S also suggests a timeframe of eight hours for conducting the assessment, while the original REIS suggests only three hours (Fisher *et al.*, 2014). The Swedish study, conducted with 22 Swedish occupational therapists working in residential care, found that the REIS-S is an appropriate assessment tool to use, as it provided a structured and systematic procedure for environmental assessment and recommending changes. Its feasibility was however limited by the amount of time it took to administer the assessment, and the large amount of text guiding the assessment (Svensson *et al.*, 2018).

2.9 Conclusion

Chapter 2 provided an overview of relevant concepts associated with this research project. The rapid aging population necessitates policies and practices that promote elders' human rights and dignity, to prevent them from being subjected to further marginalisation. The importance of considering long-term care environments, in which many elders around the world live, and the transformation of these environments to enable continued occupational identity and participation, were deliberated from an occupational justice framework. The REIS and ATOSE were introduced as two assessment tools that can provide evidence for the need to do so. No research have been published on the use of the ATOSE nor REIS within South African RACFs. The current international aspiration towards person-centred care aligns well with the international trends surrounding the profession of occupational

therapy practicing within the geriatric and dementia communities. Due to limited professional human resources and possibilities of employment in SA, occupational therapists need to position themselves to effectively address these issues as environmental influencers, in order to have an evident and long-term impact on the person-centred drive surrounding dementia care. To support evidence-based practice, more information is needed regarding the applicability of collective environmental assessments within these geriatric communities and the results that these tools yields. This study aims to investigate the feasibility of two such collective assessments, namely the REIS V 4.0 and the ATOSE within the Engo organisation in the Free State province.

The following chapter will introduce the methodology employed to investigate and answer whether the REIS and ATOSE are feasible assessment tools to use within the Engo organisation.

3 Research Methodology

3.1 Introduction

In Chapter 1 the rationale and aim of the study were discussed, while Chapter 2 provided a theoretical perspective from literature on the most prominent concepts related to this study. In this chapter, the methods employed to answer the main research question and objectives are presented and explained.

3.2 Research paradigm

This study adopted the pragmatic paradigm to support a mixed methods methodology, as the main research question enquired about the applicability of the REIS and the ATOSE as occupational therapy assessment tools. This study is embedded within a mixed methods research approach, with priority given to the qualitative nature of this study. Within the ambit of study design, mixed methodologies can be understood in terms of four methodological choices. These are the sequence of implementation (3.2.1), priority given to each method (3.2.2), the level of integration (3.2.3) and the theoretical perspective (3.2.4) (Creswell, 2014b). The central premise of a mixed methods approach is that the use of both quantitative and qualitative approaches affords a greater insight and understanding and answering of the research problems (Creswell, 2014b, p. 218; Delport & Fouchè, 2011: 435). For occupational therapists there are two significant advantages to using mixed method enquiries in their research. Firstly, it enables theory generation and verification, and secondly it enables the researcher to address multi-faceted phenomena such as health, illness and occupation from many different perspectives (Mortenson & Oliffe, 2007). With relevance to this study, the quantitative data generated by the REIS and ATOSE assessment tools can be supported by qualitative notes which illuminate the statistical data. Additionally, it can also provide a baseline from which the feasibility and possible use by occupational therapy practitioners can be evaluated.

Mixed methods researchers usually adopt one of three paradigmatic positions:

- i) the 'a-paradigmatic stance', as described by Teddlie and Tashakkori (2009), which promotes the stance that paradigms and methods are not permanently merged, and that mixing paradigms is acceptable,

- ii) the underlying paradigms of the quantitative and qualitative need to remain separate, to benefit from the strengths of each, and
- iii) a single paradigm should be the basis for a mixed method research

3.2.1 The sequence of implementation

This research study commences with collecting qualitative and quantitative data by means of two assessment tools, namely the REIS and ATOSE. They provide a structured procedure in which data is to be collected. Both of these tools eventually produce quantitative statistics that indicate environmental factors within RACFs. However, the quantitative results will be elucidated and supported with qualitative, descriptive notes gathered during the assessment, using the REIS and ATOSE tools. All this information is then compiled into a report for each facility that explains the findings of these two assessments within the particular facility. The aim of the assessments and the subsequent reports is to answer the research question and objectives of whether the assessment tools and the information it yields is applicable and useful within Engo RACFs, ultimately alluding to the feasibility of the use of both these tools.

3.2.2 Priority given to each method of inquiry

Priority is given to the qualitative data which were generated by descriptive and narrative notes taken during the assessment process using the REIS and ATOSE assessment tools, and the notes taken during the nominal discussion group discussion of phase 2.

3.2.3 The level of integration between the quantitative and qualitative data

The point of integration is during data collection and data analysis, as both quantitative and qualitative data are collected during both phases of data collection. The type of integration, however, is purely the embedding of the data, where the qualitative data support the quantitative statistics from the assessment, but are also used as the main source of data to answer the research question and objectives (Creswell, 2015; Ivankova, Creswell, & Plano Clark, 2016: 323).

3.2.4 The theoretical perspective

In order to gain a better understanding on the feasibility regarding the applicability of the ATOSE and the REIS assessment tools, it is necessary to involve stakeholders within Engo RACFs to answer this question. Their perspectives are of the utmost importance towards illuminating the research purpose. The researcher acknowledges that these may differ from her own perspective. From a pragmatic point of view, the primary consideration is the

research question relating to the feasibility of the assessment tools, which is more important than the methodology or the theoretical lens through which the study is viewed (Delpont & Fouchè, 2011: 438). On a practical level, drawing from both quantitative and qualitative data from the completed assessments, will ensure that the research discussion group participants have a better understanding of the research problem (Ivankova *et al.*, 2016: 312).

3.3 Method of Enquiry

The method of enquiry will be discussed with consideration to the study design (3.3.1), research context (3.3.2), study population (3.3.3), data collection (3.3.4 and 3.3.5), data management (3.3.6 and 3.3.7), data analysis (3.3.8 and 3.3.9) and trustworthiness (3.3.10).

3.3.1 Study design

The **pragmatic paradigm** aligns well with this research study as the researcher is concerned with 'what works' and the 'practicality' thereof (Creswell, 2015: 16). This research study is an embedded mixed methods approach. As Creswell (2016) delineates, the data in this study were collected during sequential phases. The quantitative data were used to build on the qualitative findings. This study design is often adopted by researchers who wish to administer a new instrument (i.e. REIS and ATOSE assessment tools) to a sample population (i.e. participating Engo RACFs), thus aligning with the purpose of this study (Creswell, 2015). Mixed methods entail the integration or combination of qualitative data, which tend to be open-ended, and quantitative data, which include closed-ended responses (Creswell, 2014: 14). A mixed methods approach to research originated around the late 1980's and early 1990's based on work from disciplines including education, management, sociology and health sciences (Creswell, 2014). Although a relatively new approach, mixed methodology in the social and human sciences is popular, and many research studies within the field of occupational therapy (Lysack & Krefting, 1994; Mortenson & Oliffe, 2007; Rudman, 2015) and specifically occupational therapy dementia care (Du Toit & Buchanan, 2018; Du Toit *et al.*, 2019; Weitzman & Levkoff, 2000) have been published that incorporate a mixed methods approach .

In the context of this study, data were collected in two separate but consecutive stages. During phase 1, the researcher visited three RACFs and executed two assessments (i.e. REIS and ATOSE) according to a systematic process as suggested by the authors of the two assessment tools (detailed in Chapter 2, c.f. 2.8.3 and 2.8.4). This yielded both quantitative and qualitative data. After completion of phase 1, a report (c.f. Appendix K: REIS

and ATOSE report to Facility 1, Appendix L: REIS and ATOSE report to Facility 2, Appendix M: REIS and ATOSE report to Facility 3), supported by both the qualitative data and the quantitative data gathered from the assessments, was compiled for each participating Residential Aged Care Facility. Leadership staff of each Residential Aged Care Facility were required to read the report and provide feedback on the usefulness of the information yielded by the assessment tools during a focus group discussion in the second phase, guided by the nominal group technique (NGT). The discussion group concluded the data collection phase.

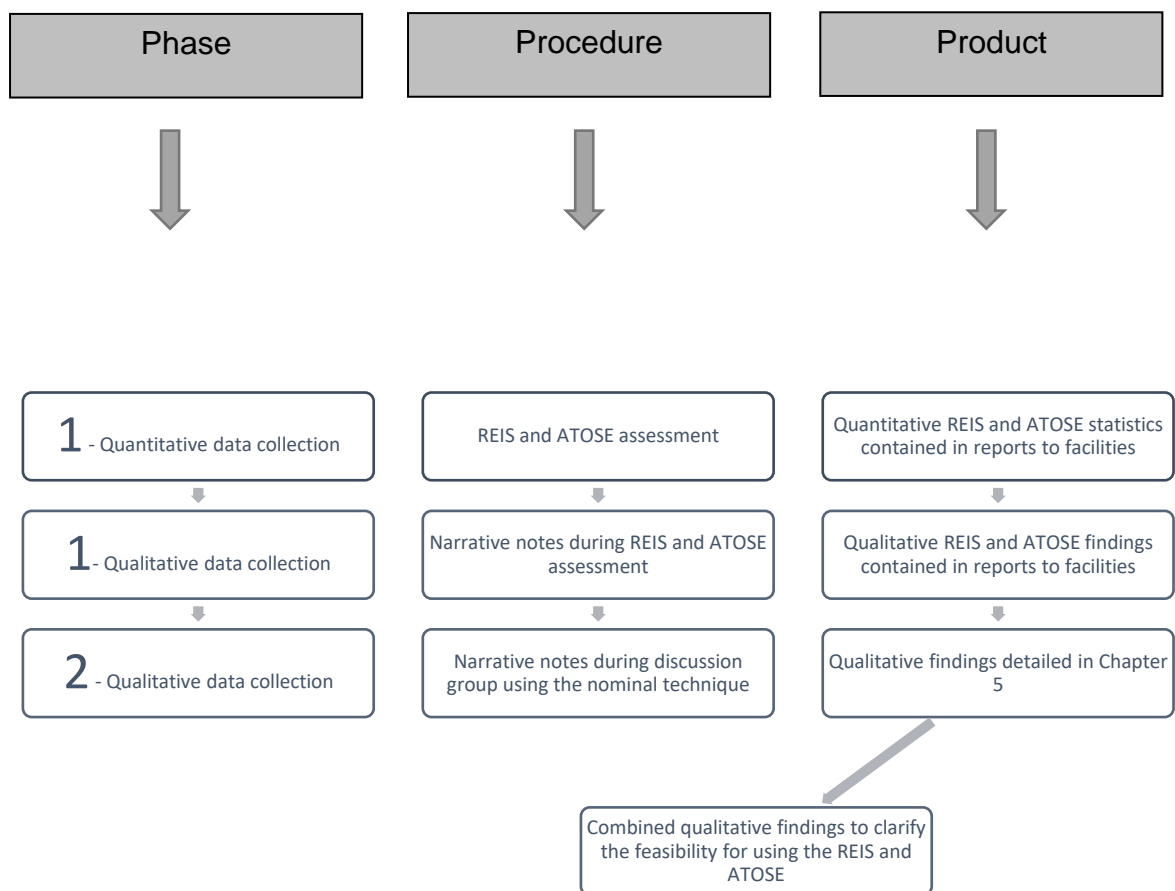


Figure 2.1: Visual diagram of the design procedure of phase 1 and phase 2

The focus in this embedded research design is on the qualitative data derived from the descriptive narratives in phase 1 as well as the narratives gathered during the discussion group in phase 2. The quantitative statistical data derived from the REIS and ATOSE assessment, although having a crucial function in orientating the leadership staff as research partners, provide a secondary role concerning the quest to answer the research question and objectives.

3.3.2 Research context

The Engo organisation was detailed in Chapter 1 (c.f. Research setting and assessment tools). Of the 23 RACFs in the Free State province, 17 traditional Engo-affiliated RACFs were approached to participate in this study (c.f. Inclusion criteria). Six of the 23 affiliated facilities were excluded from this study because they are either day care centres or facilities for aged residents with severe disabilities.

The researcher anticipated limited response from the introductory email explaining the study and inviting the RACFs to participate. Seventeen RACFs affiliated with Engo were initially approached. Five RACFs eventually agreed to participate in the research study, but only three RACFs were included in the final research study. One facility indicated that they met the inclusion criteria, but while visiting the facility during the data collection phase, the researcher found that it did not fully meet the inclusion criteria. This facility was therefore only included in the exploratory part of this study. Despite not being selected for this study, a report with the results of one of the assessment tools was presented to this facility. This would allow the facility to still benefit from the research. The data from that report were not, however, included in this study. Another facility initially agreed to participate in the study, but withdrew from the research before phase 1 commenced. Two of the 17 homes indicated that they preferred not to participate in the research study, while 10 facilities provided no response.

Positionality of the researcher within the research context

The researcher is employed at Facility 3 and is the only occupational therapist permanently employed at any Engo affiliated Residential Aged Care Facility. Annual inspections take place at the Engo-affiliated RACFs, executed by the Engo Aged Care Director. To mitigate any possible suspicion of the research process being linked to an annual Engo facility audit, the researcher explicitly stated this on the information document initially sent to the facilities.

Initially, the researcher wanted to exclude Facility 3 as a participating facility in the research study, considering possible research bias as an obvious reason to do so. But, due to the few responses received, one facility choosing to withdraw and another only partially eligible, Facility 3 was included. In section 3.3.10 the researcher explains how she managed this possible bias in discussing the trustworthiness of this study. The advantages of including Facility 3 in this research project, operating as a Residential Aged Care Facility since 1984, should be noted. Facility 3 has offered occupational therapy intervention since 1993, either via pre-graduate student involvement from the University of the Free State (UFS) or by employing a qualified occupational therapist. Since December 2016 the facility has also housed a specialised dementia unit. This champions non-traditional operations and care services according to person-centred care principles and the Eden Alternative philosophy. It is the largest Residential Aged Care Facility affiliated with the Engo organisation, and employs experienced staff. The facility is also located in the most populated and well-resourced urban area of the Free State province.

3.3.3 Study population and sampling

The researcher made use of opportunistic and convenience sampling. The convenience sampling were based on the original criteria as communicated with the facilities (c.f. Appendix G) to informally interview and converse with residents and staff. The facilities were required to identify and gather consent from individuals who were willing to participate as REIS and ATOSE participants, which they did. However, despite the leadership staff assisting to identify possible residents and staff to converse with, the researcher decided to use the list of names only as general guidance. Therefore she adopted an opportunistic sampling approach during field visits. With opportunistic sampling the researcher takes advantage of unforeseen opportunities during the course of the field visit, and moulds the sample around the context as it unfolds, while convenience sampling is used for its ease of access (Nieuwenhuis, 2016: 86-87). Eventually, the researcher included residents and staff with who she incidentally engaged during field visits as she adopted a flexible approach. This method ensures the anonymity of staff and residents, as the leadership staff could eventually not identify the staff and residents that the researcher spoke to or observed in order to gather information to complete the assessment tools.

This study employed a dual study population, linked to the two phases:

- a) participating facilities and their staff and residents (as part of the ATOSE and REIS assessments), and
- b) leadership staff participating in the group discussion using the NGT

During phase 1 of the research study, the researcher visited three RACFs and executed the REIS and ATOSE assessments, discussed in the previous section of this chapter (c.f. 3.3.1). The assessments are done by interviewing and observing residents and staff at each facility. Feedback is then provided. The interviews with staff and residents were informal and do not form part of the formal data analysis. These interviews supported the assessments, and allowed the researcher a holistic view of each facility (c.f. Addendums K, L and M).

Detailed description of the sample: Facility 1

Facility 1 is in the Thabo Mofutsanyane district, more specifically the Dihlabeng local municipality. The town in which it is situated can be described as an urban community, and it is the fastest growing town in the Free State province. The facility accommodates 50 residents with varying abilities and needs. There are five different wings in the facility, referred to as corridors, and labelled corridors A to E. Corridors A to C are mostly rooms only with shared bathrooms, while Corridors D and E, which have recently been renovated, provide en-suite accommodation. The town is surrounded by farms who provide the facility with support in the form of financial aid or commodities such as meat and vegetables, aiding the operational survival of the residential aged care facility. All 50 residents living in the facility are white older adults, and most of the residents' first language is Afrikaans. Because of the section of the SA population that Engo resonates with (white, older South Africans), most of the residents participate in religious activities such as bible study, holy communion⁵, and church services, which are predominantly coordinated by the DRC. The researcher had informal discussions with five residents (10% of total residents) as part of the REIS assessment tool. Additionally, the researcher used other opportunities as they occurred during the three-day visit to gather various opinions on the guiding questions in the REIS resident interview guide. These questions were:

- (i) *do you like living here?*
- (ii) *what do you like about living here*

⁵ Communion refers to the Christian-faith based activity of worship by which bread and wine are consecrated and shared

(iii) in your opinion what changes do you think should be made to make this a better place for you to live?

There are 36 staff members employed at Facility 1, excluding security staff, as these are outsourced. The 36 staff members include nursing personnel (registered nurses and caregivers), administrative personnel (receptionist, financial clerk and manager), and service personnel (domestic supervisor, kitchen staff, cleaning staff, general maintenance and grounds staff). The researcher consulted with four staff members in order to obtain the information necessary to complete the REIS assessment. The four consultations were supplemented by informal discussions with other staff members during the course of the three-day visit to the facility. The questions posed were:

- (i) what do you think the home does well?*
- (ii) what areas do you think need improvement?*
- (iii) what are the barriers to improvement?*
- (iv) what changes would you suggest to help make the home a better place for the people who live here?*

Detailed description of the sample: Facility 2

Facility 2 is also located in the Thabo Mofutsanyane district, but in the Setsoto Local Municipality. The facility is based in a town in a largely rural area, compared to the towns in which the other two facilities are located. The town is one of the smaller towns in the Free State province. The Residential Aged Care Facility accommodates 16 residents. Facility 2 accommodates not only white Afrikaans-speaking residents, as is the case at Facility 1, but also other groups, as two Sesotho-speaking residents reside in the home. There are currently nine unoccupied rooms at the facility. There are 24 staff members and the services include nursing personnel (registered nurses and caregivers), administrative personnel (manager, who is also responsible for administrative duties), and service personnel (domestic supervisor, who sometimes assist the manager with some admin tasks, kitchen staff, cleaning staff and grounds staff). Considering the intent to include 10% of staff members and residents to assist with the REIS assessment, the researcher deemed consulting only two staff members and two residents as inadequate. Accordingly, four staff members and four residents were consulted, supplemented by informal discussions with other staff and residents during the course of the three-day visit to the facility.

Detailed description of the sample: Facility 3

Facility 3 is based in an urban community and is the largest of the facilities with 185 residents currently accommodated. It has the most additional services such as occupational therapy and physiotherapy, a library service entirely run by volunteers, which includes a mobile library service, goodwill services (for residents in the frail care unit and in the retirement village), transport services and a church, based on the premises of the facility. The facility is divided into eight corridors, which are colour coded, and includes a dedicated dementia unit. The dementia unit, referred to as a dementia home (keeping in line with the person-centred language) which remains part of the facility, operates somewhat differently regarding daily routines. The routine of the dementia unit provide more flexibility for the residents and staff to facilitate a homelike atmosphere. It should be noted that the corridors are divided according to financial abilities and not physical abilities. Three of the eight corridors are private, en-suite rooms, one corridor provides private rooms but shared bathrooms, three of the corridors are shared rooms with shared bathrooms, while the last corridor is the dementia home. This corridor boasts a combination of shared rooms, private en-suite rooms and private rooms with shared bathrooms.

The following eligibility criteria applied for each of the populations and each of the phases:

Inclusion criteria (phase 1): to be eligible to participate in the study, there were considerations on both organisational and individual levels:

- Participation had to be voluntary and participation could not be prescribed by Engo. Consent for conducting this study in an Engo-affiliated Residential Aged Care Facility was obtained from the Engo Director of Aged Care. In addition to this the manager of each participating facility had to consent to the participation of the facility.
- Consent from the leadership of the facility for participation in this study included consent for the researcher to conduct a three-day field visit while interacting with staff and residents.
- The facility had to have a communal area or wing where people living with dementia spend some time during the day. The absence of this element was the reason that one of the facilities which was initially included, to only be part of the exploratory study.
- Consent to participation also signified the facility's agreement to assist the researcher in actively recruiting staff and residents as interviewee participants (c.f. Appendix G:

Criteria presented to facility leadership for identifying staff and residents to partake in informal interviews).

- Inclusion of the facility manager in the discussion group during the second phase of data collection was required.

Eligibility criteria (phase 1): Interview participants during phase 1 had to comply with the following criteria:

- For staff and residents, proficiency in speaking and understanding Afrikaans or English was a pre-requisite for including them in the interviews as part of the REIS assessment.
- Participants had to give verbal consent to be informally interviewed as part of the REIS assessment. Consent for participation from the facility permitted the researcher to interact with residents and staff, but interaction with the researcher was voluntary. The researcher was attentive to resident and staff behaviour, and interacted with them in a conscientious manner. If any staff member or resident appeared to be uncomfortable with the researcher's presence, she relinquished any form of contact with them.
- The interviewee participants had to be able to follow a coherent conversation and answer questions appropriately, regardless of a neurological or cognitive disability such as dementia.
- The researcher initially constructed an inclusion guide (c.f. Addendum G) indicating how residents and staff were to be chosen as interviewee participants. Essentially residents' circumstances had to be diverse regarding physical abilities, shared or independent living, and their daily repertoire of activities. Staff inclusion in the interviews was determined by staff being from different divisions such as nursing care, kitchen, maintenance etc. The researcher realised that the trustworthiness of this study could be influenced if interviewee participants were chosen by the facility. To eliminate this, the researcher used convenience sampling, interacting with residents and staff who she encountered by chance and not purposively selected after an initial walk-through and observation at the facility as mentioned in this section.

Inclusion criteria (phase 2): discussion group participants had to comply with the following criteria:

- Participants had to hold a senior position at the facility. It was imperative that the manager of the participating facility was included in the group.
- Participants were required to read through the report, based on the findings of the REIS and ATOSE assessments, produced by the researcher.

Sample size

The sample size in qualitative research is based on criteria rather than numbers, as in the case in quantitative research. Some scholars argue that there are no rules for sample size, as it depends on what you want to know, the purpose of the inquiry, and what is useful and will have credibility (Nieuwenhuis, 2016: 84). With regards to the quantitative focus using the REIS and ATOSE assessments, the researcher sampled 10% of the resident and staff population at each of the three participating RACFs. The qualitative focus of this research study was in understanding and describing the perceptions of representatives of Engo RACFs on the applicability and usefulness of the REIS and ATOSE results, ultimately alluding to the feasibility of the REIS and ATOSE within the South African context.

With regards to the qualitative focus, two representatives of each facility was included. Only one representative of Facility 2 could attend the nominal discussion group, while two participants of Facility 1 and three participants of Facility 3 attended.

3.3.4 Data collection: phase 1

Data collection was divided into two separate but consecutive stages, referred to as phase 1 and phase 2 in this research dissertation (c.f. Figure 1).

Phase 1 of data collection commenced with the researcher visiting three Engo-affiliated RACFs and conducting two assessments during a three-day visit to each facility. The assessment tools were developed by different authors and both tools have a unique focus on different aspects of the Residential Aged Care Facility context and environment, described in more detail in the following section.

The Assessment Tool for Occupation and Social Engagement (ATOSE)

The ATOSE is described in Chapter 2 (c.f. The ATOSE as a collective occupation based environmental assessment tool). Due to time constraints the researcher could not visit the RACFs for seven consecutive days. The researcher communicated with the author of the ATOSE, however, and confirmed that three consecutive days would still be sufficient for the

purpose of this study. The researcher attempted to maintain consistency by executing the REIS and ATOSE assessments on the exact same days at all three RACFs, i.e. Mondays, Tuesdays and Wednesdays. Engo prescribes operational procedures in its affiliated RACFs (c.f. Homogenous factors in terms of operational activities and demographic information of the three participating Residential Aged Care Facilities) which aided consistency. The researcher observed each day between 09h00 to 11h00 and 14h00 to 16h00. Scoring was done directly onto the computerized ATOSE program, developed by Ciaran O'Raghallaigh.

The Residential Environment Impact Scale, Version 4.0 (REIS V 4.0)

The REIS is described in Chapter 2 (c.f. The REIS as a collective occupation-based environmental assessment tool). The researcher printed out the paper copies of the REIS assessment tool and scoring of the facilities were done on the paper copy form. Following the three-day visit to the three Engo RACFs, the researcher compiled a user-friendly report (c.f. Appendix K: REIS and ATOSE report to Facility 1, Appendix L: REIS and ATOSE report to Facility 2 Appendix M: REIS and ATOSE report to Facility 3), explaining the assessment tools and presenting the findings of the assessments to each facility.

3.3.5 Data collection: phase 2 –NGT Discussion group

Phase 2 concluded data collection with a discussion group, using the NGT, held with a total of six leadership representatives from the three RACFs. The NGT is a method originally developed by Delbecq and Van de Ven (1971), and can be described as a structured brainstorming meeting that provides a systematic method for obtaining qualitative information from the participants (Hanekom, Van Aswegen, Plani & Patman, 2015; Van de Ven & Delbecq, 1972).

The representatives each held one of the following positions: manger, nursing service manager or registered nurse. The group was facilitated by a scholar in the School of Nursing at the University of the Free State, who is an accomplished facilitator of qualitative data collection methods, including the NGT. The researcher assumed the position of observer, making narrative notes during the group process, and co-facilitating to a certain extent when it was necessary to explain a comment or question. From observing participants during the course of the group discussion, the researcher was able to note proceedings and responses with more rigour, which contributed to richer data.

The researcher took responsibility for the following actions during the discussion groups:

- Arranging and setting up the venue

- Ensuring that whiteboard, markers and sticky notes were available
- Checking up on the attendance of all confirmed participants
- Ensuring that the list of previously allocated codes were available, in order to ensure confidentiality and to ensure that names were not written down in field notes
- Welcoming and introducing the external facilitator
- Confirming the purpose of the study and the invaluable input of all participants
- Taking field notes during the course of the group discussion
- Taking photographs of the ranking and sticky notes

The group discussion was held in the boardroom of the Engo-affiliated Residential Aged Care Facility in Ventersburg, Free State, South Africa. The Ventersburg Engo-affiliated facility was not a participant in this study. The site was chosen because it was a convenient location accessible to leadership staff who attended an Engo managerial meeting at a nearby location earlier on the same day.

The researcher chose to include only one question (McMillan *et al.*, 2014) during the discussion group, namely; '*What do you see as the potential factors to consider for implementing the REIS and ATOSE at your facility?*'. The NGT process followed the following steps: *introduction, silent generation of ideas, round robin, clarification and ranking.* (Hanekom *et al.*, 2015; Van de Ven & Delbecq, 1972; Wainwright, Boichat & Mccracken, 2013)

Step 1:

The group process commenced with a brief overview of the two tools used during phase 1 of data collection, and the purpose of the study. McMillan *et al.* (2014) state that it is less confusing to clarify the procedure as the group progresses through each stage of the NGT. The participants were informed about the process at the start of the session, and were subsequently reminded about the structure when necessary. This was needed when one of the participants spoke out of turn to discuss a comment made by another during the round robin phase, for example.

Step 2: The following question was posed to the group:

What do you see as the potential factors to consider for implementing the REIS and ATOSE at your facility?

Step 3: Silent generation of ideas

Participants were given 10 minutes to reflect on the question and record, in silence, by themselves, as many ideas as possible regarding the question on sticky notes. During this phase literature suggests that the facilitators remain silent, which is what happened.

Step 4: Round robin

During this phase each participant was provided with an opportunity to contribute one idea at a time regarding the posed question without the group discussing the idea. This phase continued until no new ideas emerged, lasting between 15 to 30 minutes. Delbecq *et al.* (1975) recommend that no discussion takes place during this process, although McMillan *et al.* (2014) find it useful and culturally appropriate for some population groups to discuss. In some instances it was necessary for the researcher to clarify questions about the findings contained in the reports, as not all participants had read the reports with intent, as required.

Step 5: Clarification

The purpose of the clarification phase is to ensure that all participants understand the meaning of each idea, and to eliminate and group certain ideas and/or the generation of themes. Although clarification of ideas commenced throughout, the *clarification* stage of the nominal group was used for eliminating some ideas and merging others together for the purpose of theme generation in order to simplify the process of ranking ideas. The facilitator rewrote the clarified ideas on the flipchart in a different colour. The clarification phase also aided the introductory distinction between the REIS and ATOSE as two different environmental tools as discussed at the start of the NGT, as some participants couldn't distinguish between the respective findings of each tool.

Step 6: Ranking

Participants were granted the opportunity to rank the clarified ideas in terms of the five most important on an individual ranking sheet. This was done privately. The group facilitator guided the group ensemble to rank the five ideas as indicated from most important to least important. The facilitator recorded the five ideas in order of importance, according to the group, on a blank page of the flipchart.

Field notes were taken during the procession of the group discussion, and the researcher took the role of complete observer, not participating in the discussion generated during the

nominal groups. The ranking of ideas on the whiteboard was also photographed with the researcher's smartphone (c.f. Appendix O: Discussion group codes).

In addition, reflective journaling served the purpose of establishing a systematically sound way in which the researcher could order her thoughts, experiences and observations. The information in this reflective journal is not for analysis purposes, but might add to creating an intellectual space as described in the literature. This contributed to the critical thinking about the research process and purpose and writing skills of the researcher (Liuolienė & Metūnienė, 2009).

3.3.6 Data management: phase 1

The hard copies of the REIS assessment forms were scanned and saved to a password-protected Dropbox file to which only the researcher and her two study supervisors have access. The hard copies were filed in the researcher's office in a private filing cabinet to which only the researcher has access. The information obtained during the observations using the ATOSE assessment is done directly on a computerised program. Simultaneously, the researcher took narrative notes on an MSWord document. All of these are stored on a password-protected computer as well as a Dropbox folder to which only the supervisors and researcher have access.

3.3.7 Data management: phase 2

During the nominal group, posters were used to list and group the feedback from the participants. The information contained on these posters were transferred by the researcher onto an MS Word document, which is stored on a password-protected computer. The original hard copies are kept in the researcher's office, to which only she has the key.

3.3.8 Data analysis: phase 1

It is important to note that the focus of the data analysis of this research study is the qualitative thematic analysis of the narrations made during phases 1 and 2, which are the descriptive reports produced after completion of the assessments done in phase 1 (c.f. Appendix K: REIS and ATOSE report to Facility 1, Appendix L: REIS and ATOSE report to Facility 2, Appendix M: REIS and ATOSE report to Facility 3), as well as the narrative notes taken during the nominal discussion group in phase 2 (c.f. Appendix O: Discussion group codes).

Phase 1 was concerned with quantitative statistical analysis. Analysis of the REIS assessments was done manually by the researcher, as suggested in the user's manual

(Fisher *et al.*, 2014), as this is a straightforward process of allocating a score of 1, 2, 3 or 4 to the criteria for each section. The analysis was initially done on the paper copy of the REIS assessment, and then transferred to an electronic copy. The statistical analysis of the ATOSE was done by an independent Irish-based coder, Ciaran O'Raghallaigh⁶, on a computerised program which he developed himself. The researcher emailed the coder the condensed version of all the data generated by the electronic computer program. The electronic program analyses and produces results were converted into a pdf document, which was then emailed back to the researcher. This was then condensed into a table format, and presented in Chapter 4, section 4.2.3, 4.2.5 and 4.2.7.

Additionally in phase 1, qualitative thematic data analysis was used to analyse the three separate reports containing the REIS and ATOSE results. This included the statistical results and observational narratives taken during the assessments, to give richness to the quantitative data. The researcher did the analysis manually and transferred the themes and categories to an Excel file.

3.3.9 Data analysis: phase 2

Qualitative thematic analysis was used. An inductive coding analysis during phase 2, also known as emergent or open coding, was used to allow the views and opinions of all participants to be objectively conveyed without any prior identified codes. The four-step process suggested by Creswell was applied as follows (Creswell, 2014: 180-187):

Organisation

The narrative notes taken electronically during the nominal group discussion were organised according to each stage of the nominal group. Notes were organised and filed electronically on the researcher's personal computer. Additionally, the researcher had time for a reflective discussion with the facilitator after the nominal group, on the drive back to her hometown from the venue. This assisted the researcher in organising her thoughts.

Perusal

The researcher read through all the notes taken during the discussion group and added reflective notes within two days. The researcher highlighted sections

⁶ A LinkedIn profile can be found at <https://www.linkedin.com/in/ciarano/>

specifically relating to the research question, which relates to the barriers and enablers of implementing the REIS and ATOSE.

Classification

During this stage the researcher interpreted the data by using descriptive coding for significant notes made during the group discussion.

Descriptive coding summarises in a word or short phrase – most often as a noun – the basic topic of a passage of qualitative data... it is important that these codes are identifications of the topic, not abbreviations of the content. The topic is what is talked ... about. The content is the substance of the message (Saldaña, 2009: 70).

Synthesis

The codes were organised into categories, subcategories and themes in order to analyse and interpret the data. Addendum N contains the amalgamated coding and themes.

3.3.10 Trustworthiness

In qualitative research, trustworthiness is considered as the gold standard to ensure the quality of qualitative research and prominent authors suggest four specific strategies to ensure trustworthiness (Botma, Greeff, Mulaudzi & Wright, 2010: 232; Delport & Fouchè, 2011: 420–422; Lincoln & Guba, 1986). These four strategies include credibility, transferability, dependability and confirmability. The researcher will discuss how she ensured trustworthiness according to the suggested strategies.

Credibility

The credibility or truth value (Botma *et al.*, 2010: 233) of a study is enhanced when there is an early familiarity with participants or participating organisations and the detailed data collection procedures that supports the study (Lincoln & Guba, 1986). In addition, the researcher, being an employee of Engo, offers the advantage of a better understanding of the history, dynamics and operating procedures of affiliated RACFs. The researcher has a broad understanding of the care systems and operating procedures in these Engo RACFs, which grants her the ability to approach the participants in a non-threatening manner for authentic responses. Reflective journaling during both phases of data collection served as a mode of data triangulation when data analysis was done. During phase 2 the participants rated their own responses, which may be argued as a form of member checking (Botma *et*

al., 2010). In addition, one of the supervisors, Dr Sanetta Du Toit, is internationally regarded as an expert in this field of study. Adding credibility of this study regarding participants was the extended period that the researcher spent in each facility during phase 1. This vast amount of time applied to data collection, and regular exposure to being observed negated the possibility of staff altering their behaviour for the researcher's benefit. Moreover, the researcher had the opportunity of piloting the assessment tools prior to the start of data collection at one facility that was not eligible for inclusion, which the researcher only determined after a site visit.

Dependability

Dependability or consistency refers to what extent the findings will be congruous if the study is to be repeated (Botma *et al.*, 2010: 233). The dependability/consistency of this study will be ensured by the detailed description of the process of data collection and analysis, the high level of method triangulation, and peer examination of the data analysis, including the coding of the qualitative data analysis during phase 2. In addition, the reflective journaling during the data collection and analysis of phases 1 and 2 were approached in an organised and transparent manner, so that the reader is clear on the thought and reasoning processes of the researcher.

Confirmability

Confirmability refers to the degree of neutrality (Botma *et al.*, 2010, p. 233; Lincoln & Guba, 1986), which in this study refers to the absence of researcher bias. The researcher kept personal reflective journals which enabled her to critically reflect on possible biases at each facility she visited that might distort data analysis. Due to limited interest from other Engo facilities, the researcher was compelled to include Facility 3 (in which she is employed) for data saturation purposes. The researcher employed the following strategies to promote confirmability:

- During the writing of this dissertation, observation notes and reflective journals, the researcher attempted to write in the third person so as to constantly be aware of the information, and how it is interpreted and phrased.
- The researcher attempted to keep the observations and informal interviews (as part of the REIS and ATOSE) neutral and factual, and to put staff and residents at ease. Confidentiality was assured throughout the discussions.

- The researcher attempted to not use too many examples when explaining or discussing topics (according to the REIS) with staff and residents as to not coerce their perception or frame of reference.
- This reports offered to the facilities contained suggestions which are not necessarily dependent on the services of an occupational therapist to improve service delivery towards a person-centred approach of caring in RACFs.

Transferability

Transferability is also seen as applicability of the findings to similar settings (Botma *et al.*, 2010: 233).

Regarding Engo RACFs, policies and procedures provide guidelines for the operations of care, and a thorough description of the organisation will therefore provide merits for transferability of the data to other Engo-affiliated RACFs, and possibly similar non-Engo RACFs in the Free State or SA.

3.4 Ethical Considerations

The South African *National Health Act* (61 of 2003) requires all research conducted with human participants in South Africa to be approved by an institutional and registered ethics committee. This study was approved by the Health Sciences Research Ethics Committee at the University of the Free State in June 2018 (Ethics number: UFS-HSD2018/0605/1906). After approval from the ethics committee at the UFS, the researcher sought approval from the Director of Aged Care, representing the Engo organisation, to continue with the study in the selected facilities. Approval from the Engo organisation was granted in June 2018 (c.f. Appendix B: Information and consent document to Engo for conducting study in affiliated RACFs).

Ethical considerations were also informed by the Declaration of Helsinki and South Africa's Older Persons Act (13 of 2006). In addition, the researcher chose to advocate the principles of the person-centred framework as suggested by Kitwood (1993) throughout interactions with vulnerable, institutionalised older adults and the staff members who care and support them in the various RACFs she visited during data collection. Examples of this include the way she approached and interacted with them, the way she spoke of residents, and the person-centred language she used.

There are no predicted risks associated with this study. Participation in this study is likely to positively influence the way in which the leadership of the facilities view and interpret the

physical and social environment of nursing homes, and its impact on the residents' and staff's levels of engagement, and ultimately their quality of life. Both assessment tools and the results they yield could provide Engo RACFs with measurable outcomes in the pursuit of organisational care culture transformation.

The researcher acknowledged the possibility that staff and residents could feel exposed or experience distrust towards her. Before each individual interaction with either staff or residents, the researcher assured the participant of the confidentiality agreement. The researcher reminded the participants that although there might not be immediate changes within the facility, their contribution was irrefutable for possible future improvements. The researcher remained honest and impartial at all times.

All participating RACFs received the exact same benefits of this assessment, which include a report on the findings of the REIS and ATOSE assessment tools. These results can possibly influence operational policies and procedures, which might eventually benefit all Engo-affiliated RACFs in the Free State province.

Below, presented in Table 2, is an overview of the ethical principles and how they were applied to this study.

Table 2: Ethical considerations applied to this study

The researcher would like to acknowledge Janse van Rensburg (2015: 95–98) for informing the layout of this table, supplemented by the work of Creswell (2014: 93-94).

Universal Ethical Principles			
Autonomy and respect	Justice	Beneficence	Non-maleficence
Research ethics			
Informed consent	Voluntary participation	Avoidance of harm	
Specific strategies employed in this research process			
Research stage	Ethical principle	Strategy to ensure adherence	
Planning the study	Obtain ethical clearance	Ethical clearance was obtained from the UFS (ethics number UFS-HSD2018/0605/1906).	
	Obtain permission from Engo	The Engo Aged Care director gave permission for this study to be conducted in Engo-affiliated RACFs pending final permission from each participating facility. Permission was granted after ethical clearance was obtained in June 2018 (c.f. Appendix B: Information and consent document to Engo for conducting study in affiliated RACFs).	
	Negotiate authorship of the study	The researcher holds the main authorship of this research project. The study leaders that supported this research project are Dr Tania Rauch van der Merwe from the University of the Witwatersrand (as of 1 June 2020), who is the main external	

		supervisor, previously employed by the UFS. The external supervisor affiliated with the UFS as a research fellow is Dr, Sanetta du Toit.
	Negotiating with affiliated RACFs for permission to execute the study and enter the facility as researcher	Only 17 of the 23 Engo-affiliated RACFs (reasons explained in sampling section) were contacted via email to introduce the study and to invite them to participate. Five of the 17 RACFs indicated their willingness to participate, two were unwilling and ten did not respond to the invitation. The researcher did not question the reasons of facilities unwilling to participate, and did not harass the facilities that did not respond to the invitation. The researcher negotiated with the managers of the participating facilities for suitable dates for her visit, and requested written permission for participation in this study before evaluation commenced during phase 1.
	Disclosing the purpose of the research	The purpose of the study was explained verbally on various occasions (during the visit to each facility, when obtaining informed consent, and before, during and after the interviews supporting the REIS evaluation). A written information document stating the purpose of the study was given to each facility manager before obtaining their consent to participate in the study

		The purpose of the study was also explained in layman's terms to people who seemed unsure, or had more questions regarding the study. Additionally, the researcher indicated to all participants that the study was not part of an Engo audit or annual inspection.
	Voluntary participation	All facilities were aware that participation in the research was voluntary, and not prescribed or required by Engo. In support of the REIS assessment, all interviewee participants were reminded before and after the interview that participation was voluntary.
	Informed consent	All interviewee participants, in support of the REIS assessment, were asked for consent. Most residents did not want to or see the need to sign a consent form, but provided verbal consent.

	<p>Sensitivity to the needs of vulnerable older adults, specifically people living with dementia</p>	<p>The researcher did not include any residents who did not or could not understand the scope or reason for the interaction with the researcher. The researcher was also vigilant of possible power imbalances between the staff and residents at the facility. Additionally, the researcher was vigilant of residents' behaviour in the presence of the researcher, and removed herself or tended to the needs of the residents when a situation where it was needed, arose. During observational periods the researcher took on the role of observer, and positioned herself for easy observational access but without being intrusive. The researcher attempted to be kind and supportive and did not assume a demeanour of being overtly critical or inquisitive.</p>
<p>Data collection</p>	<p>Respect the RACF and limit disruptions during phase 1 of data collection</p>	<p>The researcher and her behaviour was non-intrusive. She attempted to cause the least amount of disruption to staff and residents. When approached by residents and staff, the researcher truthfully and in layman's terms explained the purpose of her presence at the facility, without being intimidating. In communal spaces the researcher actively avoided drawing attention to herself by observing from a distance, as far as</p>

		possible. Questions posed to staff and residents were neutral so that the person would not feel uncomfortable. The researcher was approachable and friendly to all staff and residents that she made contact with, to put the stakeholders of the facility at ease.
	Confidentiality, respecting resident and staff privacy	No observations were made in private spaces such as bathrooms. The researcher only entered residents' rooms upon their suggestion or invitation. The researcher asked staff/residents which spaces they preferred for interviewing purposes.
	Being truthful regarding the purpose of the study and the use of the information	The researcher confirmed to all staff and residents that any information they shared would remain anonymous. This is another reason that the researcher chose to use convenient and opportunistic sampling, so that no one would be able to identify the staff and residents that shared information with the researcher.
	Avoid exploiting residents and staff	The researcher was sensitive to behaviour indicating discomfort which residents might have been unable to express verbally.
	Not using residents and staff by gathering data and just leaving the RACFs	The residents and staff were informed that meaningful change and the improvement of day-to-day operations might not be imminent. The REIS and ATOSE reports provided to facilities were structured in a user-friendly and pragmatic manner as to

		aid leadership to identify and be able to make changes that were possible with their current situation and resources.
Data management and storing	Ensure confidentiality of information	The raw data was only handled by the researcher and the research supervisors. Each facility only received a report containing the information for the specific facility. No information that was shared in confidentiality with the researcher was relayed to the leadership of facilities or included in the research project without consent from the person. All information was anonymised, and identifying details of the facilities were not included in this dissertation document.
Data analysis and interpretation	Authenticity: disclose both positive and negative results	In order to execute and use the REIS and ATOSE assessments, the researcher had to do a critical investigation of the environment at each facility. The strengths and weaknesses of each facility were identified, and the researcher had to be truthful in presenting this information. The researcher attempted to present weaknesses as opportunities to ensure that the information was useful. With regards to the second phase of data collection (discussion group using the NGT), the yielded information was not what the researcher anticipated. The participants required an opportunity to brainstorm and share common obstacles. The collected data did not relate directly to the question posed to the participants during this group

		discussion. This was truthfully declared in Chapter 4 and discussed in Chapter 5.
	Avoid subjective association with residents' and staff's problems	The researcher attempted to ask questions by adopting a neutral stance and being aware of the phrasing of questions. Topics brought up by staff or residents that did not have relevance to the study were not entertained, as no emphasis was placed on them and the researcher did not ask any follow-up questions relating to the topic.
Writing and reporting on the research data	Avoid plagiarism	The researcher used the Mendeley program for referencing purposes and the <i>Mendeley Cite-O-Matic</i> plug-in in MS Word. This program assisted the researcher to reference sources immediately. The researcher used quotation marks and referenced the specific page number from the source in instances where she used the words from the original author, or when original words were only slightly rephrased.
	Avoid disclosing sensitive information that could harm facilities or participants	No sensitive information was noted down during interviews or observations. The researcher only included information that could aid the facility in delivering a better service or re-organising the environment to ensure more opportunities and the involvement of staff and residents. Additionally, constructive phrasing was used to point out gaps in the facility and environment.

	Share data with others and ensure transparency to all stakeholders associated with the research process	The information shared with the stakeholders of each facility can be found in the respective reports. All information and photographs which had relevance to the study were included and presented in a constructive and supportive manner.
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3.5 Conclusion

Chapter 3 detailed the methods of enquiry to investigate whether the REIS and ATOSE are applicable assessment tools in three Engo-affiliated RACFs. An embedded mixed methods approach was used, where the focus was on analysing the qualitative data of narrative notes, while the quantitative data derived from the assessment tools were used for descriptive purposes. The quantitative statistical data were mainly used to provide the participating facilities with a quantitative measurement of how supportive the environment is to enable meaningful occupation of staff and residents. The qualitative data provided rich descriptions towards understanding the findings of the assessment tools (i.e. the quantitative statistics) and answering the main research question. A thematic analysis was used which allowed the researcher to holistically focus on the numerous data sets. It also afforded the opportunity to search for meaning and relevance towards answering the research question across data sets. Universal ethical principles such as autonomy and respect, non-maleficence and doing justice, all based on the Older Persons Act and the researcher's personal conviction of honouring elders, guided the researcher to be constantly aware of her ethical practice during collecting and analysing data.

Chapter 4 will present the findings of this research project in three sections. The first section provides the findings of the REIS and ATOSE at the three participating RACFs. The second section presents the findings of the nominal group discussion, where leadership staff represented each participating facility and discussed what they perceived to be barriers and enablers to use the findings of the REIS and ATOSE. Chapter 4 concludes with the third section, in which all the coded qualitative data of phases 1 and 2 are presented

4 Presentation of Findings

4.1 Introduction

As discussed in the previous chapter, a mixed methodological approach was used to investigate the feasibility of using the REIS and ATOSE assessment tools within three Engo affiliated RACFs in the Free State province of South Africa. In this chapter the results from the two concurrent phases of data collection are presented. The research objectives in this study were: (a) *to describe and interpret the findings of the REIS and ATOSE results obtained within the participating Engo RACFs*, (b) *to investigate whether the findings from the REIS and ATOSE can be synthesised to provide usable, practical feedback to the participating Engo RACFs* and (c) *to investigate the RACFs leadership staff's perceptions regarding the enablers and barriers to the applicability of the REIS and the ATOSE*.

Data were collected in two consecutive phases; (1) by means of administering the REIS and ATOSE assessments at three aged care facilities, reflecting on the execution thereof, combining and presenting these results to the leadership of each facility in report format, and (2) concluding with a process of consensus where leadership staff reflected and brainstormed on the results obtained by the REIS and ATOSE during a nominal group discussion.

This chapter is organised in two sections, by keeping in line with the flow that the research process followed as indicated in Figure 4.1, below. In the first section, the findings from the REIS and ATOSE assessments per facility are presented. In the second section the findings from the nominal group discussion are presented. The thematic analysis of all data sets are then presented to consolidate the integrated findings from each phase of the research process.

Figure 2 summarises the research process and presents an overview of each participating Residential Aged Care Facility and an overview of the nominal group participants.

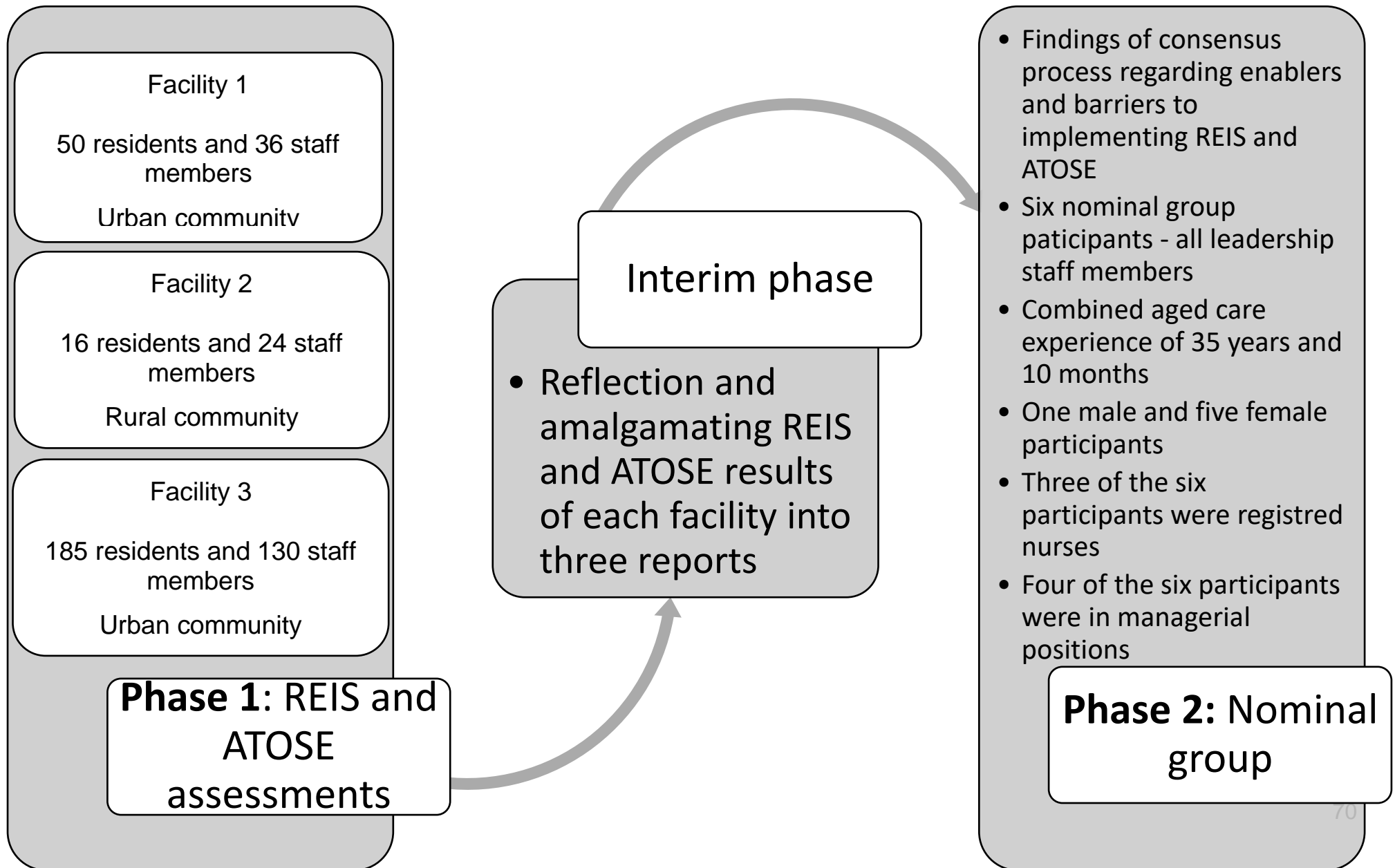


Figure 4.1: An overview of the research process

Phase 1

4.2 REIS and ATOSE findings

An overview of the similarities of the three participating facilities are presented in conjunction with the data that describe the unique operational processes and contexts of each facility.

4.2.1 Homogenous factors in terms of operational activities and demographic information of the three participating Residential Aged Care Facilities

Engo as an organisation, prescribes operational procedures in its affiliated facilities as referred to in Chapter 3 (cf. 3.3.2). For this reason, albeit not exclusively, all three facilities (the facilities are referred to as Facility 1, 2 and 3, respectively) had near identical schedules regarding the following activity clusters:

Mealtimes: Breakfast was served at 08h00, lunch at 12h00 and dinner was served at 17h00. Similarly, at all three facilities residents spent quite some time waiting for meals to be served, and dining rooms were often occupied for 45 minutes up to an hour before the commencement of the activity.

Tea times: Morning tea was served at 10h00 and afternoon tea was served at 15h00. Similarly to meal times, residents often spent quite an amount of time waiting for tea to be served in a communal lounge or dining area. Additionally, tea time was the collective activity that elicited the most engaged and participatory behaviour from residents, as observed and noted at all three facilities, but swiftly tapered off after 15 to 20 minutes.

Caring tasks: Early mornings were the busiest times of the day regarding physical care tasks (washing, showering, finer self-care, caring for residents' continence needs). At all three participating facilities the night staff assisted with the very early (between 03:30 to 5:30) morning bed bathing of some residents. All three facilities (the dementia unit of Facility 3 excluded) had 'bath lists' i.e. a roster indicating which residents are assisted in the shower or bath on specific days of the week. Words such as 'top 'n tail' were used by operational care staff at all three facilities, referring to only washing a resident's bottom, face and underarms.

Religious activities: At all three participating facilities the religious activities were held on Wednesdays and yielded a high number of participants. Religious activities were predominantly organised and facilitated by the local or nearest DRC. Engo is a faith-based organisation founded as a social service extended by the DRC in the Free State.

Daily routine: At all three facilities the routines were almost identical regarding 'busy' and 'quiet' times. Mornings were usually busy and afternoons were very 'quiet' and uneventful. The same residents used the communal areas, while many residents remained in their rooms. Monotonous activity patterns were observed at all three facilities. This included residents either wandering about or looking around, knitting, reading, socialising, sitting with closed eyes or sleeping. Social interaction with staff or visitors was rare. Staff were mainly occupied with professional tasks and avoided being observed by the researcher as far as possible.

Staff shifts: The administrative staff's working hours were from 07h30 – 16h00 at all the participating facilities. This included the manager, financial clerks, reception staff and support service supervisors (kitchen and household supervisors). The operational housekeeping staff worked in shifts from 07h00 to 18h00. Nursing staff, which include the registered or senior nursing members and the caregivers, worked in shifts from 07h00 – 19h00, two days on shift, two days off shift, and three days on shift, two days off shift (Example: Monday and Tuesday on shift, Wednesday and Thursday off shift, Friday to Sunday on shift and vice versa). At all three facilities carers rotated on a bi-monthly schedule between working on day and night shift.

In addition to the similarity of activity clusters, there were some structural characteristics and other comparable considerations in all three facilities. They were:

Placement according to financial position: Placement of residents were done according to their financial position. This related specifically to the size of the room, availability of an en-suite bathroom and whether a resident had a shared or private room.

Layout of facility: Facilities were arranged in separate wings, usually referred to as corridors or units. Corridors were structurally almost identical, being long walkways with rooms on both sides of the corridor. Two of the three facilities have recently constructed additional corridors that are modern and more accessible to residents living with disabilities due to age-related conditions.

Hierarchical arrangement and staff positions: The structure of the staff body at all three RACFs was nearly identical. Each facility was managed by a single person in the position of general manager, supported by administrative staff who doubled as financial clerks and/or executive assistants. A senior registered or staff nurse supervised a team of carers, referred to as organisational staff in this dissertation. The cleaning and kitchen services were usually

organised as two separate departments, supervised by a leadership staff member with the organisational staff either working in the kitchen or cleaning department. Occasionally some staff would be switched between the household and kitchen departments, depending on the staff member's performance, personal request or the facility's need. At Facility 3 this practice had recently been revoked and staff were not switched between departments anymore. Uniformly, all the leadership staff were white and Afrikaans-speaking, while the organisational staff were black and Sesotho-speaking, apart from a few coloured⁷ organisational staff members at Facility 3.

Table 3 provides an overview of the demographic data and specialised services of each facility, in support of the REIS and ATOSE findings presented below the table. Thereafter, each participating facility and the findings from the REIS and ATOSE assessment tools are presented.

⁷ In South Africa the term 'coloured' refers to persons of mixed race, Khoi or Asian descent. The term emerged as a result of the Apartheid classification system, but is still commonly used today and is not considered to be pejorative. The term is also used in the formal demographic racial classification system for e.g. census surveys towards addressing historical inequalities.

Table 3: Demographic information of participating Engo RACFs

	Facility 1	Facility 2	Facility 3
Size of the facility (m²)	Unknown	Unknown	8159 m ² .
Urban/rural	Urban	Rural	Urban
Number of residents	50	16	185
Number of staff	44	24	130
Racial composition of residents	White – 100% (n=50) Black – 0 Coloured – 0 Indian – 0 Other – 0	White – 87,5% (n=14) Black – 12,5% (n=2) Coloured – 0 Indian – 0 Other – 0	White – 99,4% (n=184) Black – 0,54% (n=1) Coloured – 0 Indian – 0 Other – 0
Racial composition of staff	White – 25% (n=11) Black – 75% (n=33) Coloured – 0 Indian – 0 Other – 0	White – 16,6% (n=4) Black – 83,3% (n=20) Coloured – 0 Indian – 0 Other – 0	White – 14,6% (n=19) Black – 83,7% (n=108) Coloured – 2,3% (n=3) Indian – 0 Other – 0
Dedicated dementia unit	No	No	Yes
Additional services available	Transport ✓ Tuck shop x Religious services ✓	Transport x Tuck shop x Religious services ✓	Transport ✓ Tuck shop ✓ Religious services ✓

	Facility 1	Facility 2	Facility 3
	Mobile food service x	Mobile food service x	Mobile food service ✓
	Assisted living services x	Assisted living services x	Assisted living services ✓
	Volunteers ✓	Volunteers ✓	Volunteers ✓
	Occupational therapy Intermittent	Occupational therapy Intermittent	Occupational therapy ✓
	Physiotherapy Intermittent	Physiotherapy Intermittent	Physiotherapy Intermittent
	Medical doctor x	Medical doctor x	Medical doctor ✓
	Recreational activity program x	Recreational activity program x	Recreational activity program ✓
	Goodwill services for underprivileged residents x	Goodwill services for underprivileged residents x	Goodwill services for underprivileged residents ✓
	Hairdressing services ✓	Hairdressing services ✓	Hairdressing services ✓
	Mobile library service x	Mobile library service x	Mobile library service ✓

From Table 3 it is evident that the three facilities vary in size. Facility 2 has the smallest number of residents (n=16) and staff (n=24), and the least amount of additional human and non-human resources and services. Additionally, it is the only facility located in a rural community. Facility 3 is the largest of all three facilities in terms of occupation (n=185) and staff (n=130), also boasting the most diverse additional services and resources such as a mobile library service and an occupational therapy department.

The imbalance of the cultural diversity of residents and staff at all three facilities are clear. On the one hand, most residents at the three facilities are white and Afrikaans-speaking. There is a combined total of only three black residents out of a total of 251 residents at the three facilities. On the other hand, the staff at the facilities are mostly black and Sesotho-speaking.

Facility 3 is the only facility with a dedicated dementia unit, although there are residents with dementia who reside in one of the other seven corridors, as the dedicated dementia unit can only accommodate 20 residents. Facilities 1 and 2 accommodate residents living with dementia in any of their corridors, based on the residents' financial position as there are no allocated dementia units. Table 13 provides a collective overview of the quantitative data gathered by the REIS and ATOSE assessment tools of the three participating facilities.

		Facility 1		Facility 2		Facility 3	
		Score out of 4		Score out of 4		Score out of 4	
Residential Environment Impact Scale (Version 4.0)	Everyday Space	Accessibility of space	3	Accessibility of space	2	Accessibility of space	3
		Adequacy of space	2	Adequacy of space	2	Adequacy of space	3
		Homelike qualities	3	Homelike qualities	3	Homelike qualities	3
		Sensory Space	2	Sensory Space	3	Sensory Space	3
		Visual supports	2	Visual supports	2	Visual supports	2
	Everyday objects	Availability of objects	2	Availability of objects	2	Availability of objects	3
		Adequacy of objects	3	Adequacy of objects	2	Adequacy of objects	3
		Homelike qualities	2	Homelike qualities	3	Homelike qualities	3
		Physical attributes of objects	3	Physical attributes of objects	3	Physical attributes of objects	3
		Variety of objects	2	Variety of objects	1	Variety of objects	3
	Enabling relationships	Availability of people	2	Availability of people	2	Availability of people	3
		Enabling respect	2	Enabling respect	2	Enabling respect	2
		Support and facilitation	2	Support and facilitation	2	Support and facilitation	2
		Provision of information	3	Provision of information	2	Provision of information	3

		Empowerment	2	Empowerment	2	Empowerment	2	
	Structure of activities	Activity demands	2	Activity demands	2	Activity demands	3	
		Time demands	1	Time demands	1	Time demands	2	
		Appeal of activities	1	Appeal of activities	1	Appeal of activities	3	
		Routines	2	Routines	2	Routines	2	
		Decision making	2	Decision making	2	Decision making	3	
		Facility 1		Facility 2			Facility 3	
Assessment Tool for Occupation and Social Engagement	Percentage of total (100%) observed behaviours	Residents	93.05%	Residents	89.26%	78.04%	Residents	93.07%
		Staff	5.74%	Staff	1.41%	21.95%	Staff	4.31%
		Visitors (family, volunteers)	1.20%	Visitors (family, volunteers)	9.32%	0	Visitors (family, volunteers)	2.60%
	Percentage of engaged behaviours	Residents	79.32%	Residents	85.44%	54.68%	Residents	60.8%
		Staff	100%	Staff	100%	100%	Staff	100%
		Visitors (family, volunteers)	100%	Visitors (family, volunteers)	100%	0	Visitors (family, volunteers)	94.28%
	Percentage of non-engaged behaviours	Residents	20.67%	Residents	14.55%	45.31%	Residents	39.2%
		Staff	0	Staff	0	0	Staff	0
		Visitors (family, volunteers)	0	Visitors (family, volunteers)	0	0	Visitors (family, volunteers)	5.7%

Table 13: REIS and ATOSE quantitative results

4.2.2 Facility 1: REIS findings

Facility 1 accommodates 50 residents, all white and Afrikaans-speaking, although the home is registered to accommodate 70 residents and is therefore not occupied to its full capacity. It is the second largest facility but also has the lowest occupancy rate of all three facilities. It is located in an urban community and the farming community of the town provides the facility with financial support and commodities such as meat and vegetables, aiding its operational survival.

The facility employs 44 staff members which include a manager, administrative personnel, a supervisor overseeing the household services, registered nurses, care staff, cleaning staff and kitchen personnel. A general worker and supervisor are also employed, and they tend to the maintenance of the facility and garden services. The home has security services at the gated entrance. Notably all supervisors or staff in senior positions are white. The operational staff at Facility 1, specifically the caregivers and cleaners, are quite verbal about their dissatisfaction with their working conditions, such as the remuneration and toilet facilities for staff. A few comments alluded to tension between ‘them’ and ‘the supervisors’.

Table 4 contains the REIS scores of Facility 1, indicating that the home on average scored 2 or 3 out of a maximum total of 4 in all of the categories. The scores suggest that the environment, as found by the REIS assessment, either interferes or supports residents’ wellbeing, but it does not strongly support or promote wellbeing in any of the four assessment categories.

Table 4: Scoring of environment at Facility 1 according to REIS assessment

Everyday Space					Everyday Objects					Enabling Relationships					Structure of Activities					
Accessibility of space	Adequacy of space	Homelike qualities	Sensory space	Visual supports	Availability of objects	Adequacy of objects	Homelike qualities	Physical attributes of objects	Variety of objects	Availability of people	Enabling respect	Support and facilitation	Provision of information	Empowerment	Activity demands	Time demands	Appeal of activities	Routines	Decision-making	
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
Rating Scale		4			Environment strongly supports people's sense of identity and competence by providing exceptional opportunities, resources and demands to engage in meaningful and culturally appropriate activities.															
		3			Environment supports people's sense of identity and competence by providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.															
		2			Environment interferes with people's sense of identity and competence by providing limited opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.															
		1			Environment strongly interferes with people's sense of identity and competence by not providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.															

Everyday Space

As indicated by Table 4, Everyday Space rated either 2 or 3 out of 4, with Accessibility and Homelike qualities as the best features in this category. Various adaptations were noted that addressed potential falls risks and contributed to the safe mobility of residents:

“Tiling in corridors are non-slippery which reduces the falls risk of the residents. The lightning is adequate, with bright white base lights in corridors in addition to a few windows in Corridors A, B and C” [REIS report, Facility 1]

“The ramps in the facility are according to national guidelines with regards to the width and the degrees of incline. It is easily manoeuvrable with grip-strips to reduce the risk of falling when moving up or down the ramp” [REIS report, Facility 1]

However, some bathrooms lacked the effective placement of assistive devices, but due to the layout of the building, replacement will have no effect. Additionally, bright luminous lightening, in the absence of natural sunlight in the corridors, may cause confusion and distort the visual perception for some of the residents:

“I can’t walk there, look at how the water covers the floor” [resident’s comment, researcher’s observations, Facility 1]

In two of the five corridors at Facility 1, a small sitting nook was accessible, mostly decorated with vintage objects, culturally appropriate paintings or embroidered handwork. The sitting area was usually located in the middle of the corridor but not used by anyone. The aptly decorated spaces suggest attempts to create a homelike and relatable space for residents.

Additionally, other communal spaces, such as the lounge area, foyer and outside areas were rarely used by most residents. Residents may have felt disconnected from the communal areas due to signs stipulating ‘staff only’ to areas such as the kitchen space.

The facility entrance had a good ambience, overlooking the well-maintained gardens. The frequent entry of visitors contributed to a homelike atmosphere. Large aluminium-framed windows invited an abundance of natural light into the open-plan dining room and foyer, resulting in residents choosing the foyer as a communal lounge to spend time in.

“Considering that there are 50 residents living at [Facility 1] and the largest amount of people observed in the room at the same time was 17 residents ...” [REIS and ATOSE Report, Facility 1]

And,

“On average there were about two to eight people in the [communal] room” [REIS and ATOSE Report, Facility 1]

All household and kitchen tasks were executed by staff and usually done on an industrial level rather than household level as there are 50 residents who need to be catered for.

On the one hand, institutional trademarks were present such as a nurse’s station and long uninviting corridors which resemble a hospital rather than a home. On the other hand, there are also beautiful outside spaces, although residents were rarely spotted outside making use of the outside space.

“The lush grassy area outside corridor A is not used by residents (or staff or collaboratively)” [REIS and ATOSE Report, Facility 1]

There were attempts to orientate residents with visual support cues in the home, although they were not used throughout. Certain spaces could do with more visual cues as corridors have been extended, connecting spaces to each other, which were confusing when trying to find one’s way in the facility.

“The personalisation of room doors with photographs and name cards seem to affirm the feeling of belonging and orientation [of residents]” [REIS and ATOSE Report, Facility 1]

Despite this observation, not all residents in the home had an identifying name docket or photograph indicating who lived in the room.

One male resident noted that the machine used for shredding incontinence wear was located next to his room. The noise from this sometimes woke both him and his wife, who has Alzheimer’s, disrupting their sleeping pattern. The same resident was of the opinion that care staff slept on the job during the night, as call bells from the surrounding rooms often rang unanswered “for hours on end” (REIS notes, Facility 1).

The REIS assessment highlighted both positive elements of the Everyday Space and also many elements not considering or supporting the wellbeing and personhood of residents.

Everyday Objects

Mixed scores regarding Everyday Objects were noted for Availability of objects (2/4), Adequacy of objects (3/4), the Homelike qualities of everyday objects (2/4), Physical attributes of everyday objects (3/4) and the Variety of objects (2/4) at Facility 1 (see Table 4).

Residents were responsible to provide their own furniture, assistive devices, utilities in the room and consumable products such as toiletries. One resident commented on the limited personal storage space available and mentioned the things she had to leave behind when moving from the retirement village into her private bedroom. There was for example no space for her piano and other sentimental furniture. Through saying this she hereby alluded to feeling disconnected from the environment, where residents viewed the bedroom as their only sacred and private space.

“No-man’s land” (the communal spaces in the home) [Observational notes, Facility 1]

Generally, the basic objects needed to engage in ADL were available. Assistive devices such as gait mobility assistive devices were usually obtained through personal funds, although some facility-sponsored devices were available to residents who did not have the funds to obtain a device for their personal use. In the bathrooms grab rails and raised toilet seats were available. ‘Sophisticated’⁸ assistive devices such as manual handling and electronic equipment (e.g. hoists) were not available, and staff manually transferred and assisted residents. Assistive devices such as tap turners, plate guards, adapted cutlery or adapted personal care devices such as magnifying nail clippers were not available at Facilities 1 and 2, but were available at Facility 3, where an occupational therapist was employed.

One of the few leisure activities that were enjoyed by two residents were Rummikub, which was the personal possession of one of them. A 1000-piece puzzle was available in the communal room but not used, probably due to residents struggling with aging conditions

⁸ ‘Sophisticated’ assistive devices refer to devices other than basic mobility aids commonly found in Residential Aged Care Facilities, such as walkers, wheelchairs and commodes.

such as poor eyesight, impaired finer hand grasps and diminished concentration abilities. No other objects for leisure were available.

Culturally appropriate objects were present in the home and some objects had the potential to facilitate reminiscence, such as a vintage sewing machine, crockery and armchairs.

“The condiments, preserve jars and water jugs on the dining room tables are lightweight and easy to handle and also culturally appropriate with a vintage flair” [REIS and ATOSE Report, Facility 1]

Some vintage armchairs in the communal areas, albeit serving a reminiscent and aesthetic purpose, did not support safe sit-to-stand transfers, as the chairs were worn out or very low, and residents struggled to get up and out of specific chairs.

Enabling Relationships

There were contrasting views about the inclusiveness at the facility, and the opinions of residents and staff regarding the extent to which the relationships were supportive, varied across the board.

*“There are a few (carers) that shouldn’t (be allowed) to work with humans”
[REIS resident interviews, Facility 1]*

Some answers by the residents regarding staff relationships alluded to indifference on the side of the staff, but were also interpreted as residents not feeling comfortable to answer the question.

“The staff are O.K”

“She (the manager) told me not to speak to the staff directly but address any problems with her (the manager)”

Furthermore, the operational staff had many issues they wanted to discuss. Despite the researcher’s best efforts, such as asking specific questions as suggested by the REIS interview guide and redirecting the focus to the purpose of the research project, staff kept on diverting to unrelated issues during the interviews.

“Staff interpreted the researcher’s visit as an opportunity to moan and air grievances about issues unrelated to the research project... Salary negotiations are (imminent)” [Reflective notes of researcher, Facility 1]

The leadership staff had different opinions about the residents' levels of autonomy, inclusion in decision making and degree of collaboration. One staff member mentioned the resident committee in support of these views. However, the residents living in the care unit confirmed that the committee was representative of only residents in the retirement village, and not of those in the care unit too. Two residents specifically asked for the researcher to note that they recommended formal meetings between staff and residents to discuss the issues that residents experience. The residents' comments on their sense of disempowerment are evident in the interview and reflective notes:

"I can't answer that (what changes in the facility would you suggest) as I've never heard them (residents) complain" [Care staff interview, Facility 1]

"Some care unit residents feel their opinion to be insignificant when compared to the residents of the retirement village" [Researcher's notes, Facility 1]

"Staff seem very concerned with their own needs (and comments from staff during interviews allude to the idea that) not necessary to improve circumstances of residents, as they are old" [Researcher's notes, Facility 1]

In contrast, though, one resident noted that she liked living at Facility 1, because:

"I don't have to do anything (household related) by myself and the carers are friendly" [REIS resident interviews, Facility 1]

Some residents experienced feelings of camaraderie, and one resident mentioned a special relationship she had with a specific carer:

"I wait for (carer) to come onto shift and then I ask her for help. I trust her. She helped me walk again after hospitalisation" [REIS resident interviews, Facility 1]

Observations revealed that residents spending time in the communal areas were seeking interaction with anyone passing by, especially staff members.

“Staff’s presence elevated the awareness of residents and they enjoyed the time that staff took to interact with them, even if only in passing” [REIS and ATOSE Report, Facility 1]

However, it appeared that nursing care staff avoided the observational spaces in which the researcher was present. When not attending to physical needs of residents, which was observed to be mostly during mornings, staff spent time in their tearoom, situated in one of the corridors. People living without dementia seemed to feel more satisfied with the availability of staff, the engagement with them and the level of help they received.

Senior nursing staff, as well as the facility manager spent most of their time in their respective offices. It seemed that operational staff are sometimes unavailable, especially during the afternoons, when a very quiet atmosphere descended on the facility. The observational notes also indicate that there was a limited movement of people in the afternoons.

It was observed that residents cared for and assisted one another where they could. For example, one older gentleman assisted the ladies getting up out of the low armchair in the communal lounge area, and assisted when residents with mobility devices entered the room and struggled to manoeuvre the devices as space are limited. He did this throughout the three-day period. However, it was evident that residents’ lack of knowledge regarding dementia caused them internal conflict when witnessing the behaviour of people living with dementia:

“There aren’t any discipline and she has no table manners” [Resident interview, describing a fellow resident living with dementia, Facility 1]

Structure of Activities

The only formal activities observed during the REIS assessment were breakfast, lunch and tea times. No other structured activities took place during the three-day visit.

An occupational therapist, employed by the department of health, visited the facility every two weeks, as part of a community outreach project. However, time and resource constraints resulted in her often being unable to visit the facility. According to the manager, residents thoroughly enjoyed the activities presented by the therapist, and during an interview one of the residents mentioned that when the occupational therapist visited, he and his wife diligently attended the groups.

Furthermore, during the researcher's visit, the manager of Facility 1 asked her to meet with a potential volunteer for some guidance. The volunteer requested ideas and advice regarding group activities for residents. This was an indication that the facility had reached out to a volunteer to perform these tasks, and may indicate that Facility 1 wished to explore ways in which the interest and engagement of residents could be stimulated.

Due to the limited opportunities for engaging in stimulating and meaningful occupations, it seemed that tea times, although it could be structured to elicit more interaction and engagement, provided a valuable daily routine for the residents.

"Tea times were the most active times in the social space when the largest number of people was present in the communal space" [Reflective notes, Facility 1]

"The energy of tea times only lasted about 15 minutes" [Reflective notes, Facility 1]

Residents often fell asleep in the communal room - especially after lunch. Some residents presented with repetitive and institutionalised behaviour such as continuously checking their watches, or repeating the same comments every day:

"I can't believe it is only three o'clock"

Some of the interviewed residents kept themselves busy with crossword puzzles or by making cards in their bedrooms. Most residents expressed an interest in expanding activities such as exercise and walking groups, and the screening of old movies.

In terms of the REIS assessment (see Table 4), the findings indicate that the environment at Facility 1, in terms of the everyday space, the everyday objects available, the relationships between people at the facility and the structure of activities, is partly supportive although also partly interfering with people's sense of identity. The facility mostly scored a combination of 2 or 3 in terms of the criteria out of 4, suggesting that there are resources and opportunities available at the facility to engage in meaningful activities. These resources and opportunities are, however, not always effectively identified or employed towards the wellbeing of residents and staff.

4.2.3 Facility 1: ATOSE results

In contrast to the REIS, the ATOSE supported observation and quantification of behaviours, specifically the engagement levels of people living with dementia in the communal lounge, and how the environment impacted on the levels of engagement during certain periods. In the table below, the total number of behaviours are documented as observed during all the observational periods over three days.

Table 5 ATOSE results from three-day observational period at Facility 1

	TOTAL OF BEHAVIOURS OBSERVED OVER 3-DAY PERIOD	TOTAL OF ENGAGED BEHAVIOURS	TOTAL OF NON-ENGAGED BEHAVIOURS	% OF TOTAL BEHAVIOURS	% OF ENGAGED BEHAVIOURS	% OF NON-ENGAGED BEHAVIOURS
RESIDENTS	924	733	191	93.05%	79.32%	20.67%
STAFF	57	57	0	5.74%	100%	0%
VISITORS	12	12	0	1.20%	100%	0%
TOTAL	993	802	191	*	*	*

As the quantitative results in Table 5 indicate, over a three-day period (12-hour observation in total) 993 behaviours were observed and interpreted. Of the 993 behaviours, 733 were recorded as being of an engaged and 191 of a non-engaged nature.

The quantitative ATOSE results in Table 5 correlate with the REIS observations that staff tended to avoid observational spaces and rarely spent time with residents in a social way. Notably, the behaviours of staff and visitors, which accounted for less than seven percent of the total 12-hour observational period, were all recorded as engaged behaviours. Staff and visitors usually entered the space for a brief period and during this period they were either socially engaged with other people in the room (mostly the visitors) or they were engaged with a caring task (mostly the staff). The caring tasks included monitoring blood pressure and assisting with transfers from a wheelchair to an armchair or couch.

As both daily tea times were within the frame of the observational periods, the build-up and aftermath of the energy created surrounding tea time accounted for heightened awareness and the recording of engaged behaviours. The energetic period facilitated by the activity of drinking tea, did not last very long, however. Additionally, after the second morning's observational period, there were no unfamiliar residents who entered the communal lounge for the remaining observational periods, and the room was generally only used by the same two to eight residents at any given time, while tea time accounted for the most residents present in the room at a specific time.

“The same people generally seem to use the space. After the second morning observation period no new (previously unobserved) residents entered the room to spend time in the space in the following days. This might shed some light on the fact that the quantitative data portray that residents were engaged during 79% of the observations” [ATOSE narratives, Facility 1, Day1]

Furthermore, Facility 1 has no dedicated dementia wing, and residents living with dementia are not isolated. The behaviours as presented in Table 5 are therefore a combination of people living with and without dementia. Narrative notes indicate that those residents possibly living with dementia, as inferred from their behavioural patterns, were prone to isolation and disengagement more often than those residents without dementia.

“Two residents specifically presented with repetitive behaviour - continually looking at their watches and repeating the same comments every day” [ATOSE narratives, Facility 1, Day1]

4.2.4 Facility 2: REIS findings

In contrast to Facility 1, Facility 2 is located in a rural town of the Free State province and it is one of the smallest Engo affiliated RACFs. It is the smallest of the three facilities that were included in this study, with only 16 residents and 24 staff members. It must be noted that although the staff to resident ratio seems unbalanced, care staff work shifts, so not all 24 staff members are on duty at the same time. Additionally, Facility 2 accommodates not only white Afrikaans-speaking residents, as is the case at Facility 1, but also other groups, as two black Sesotho-speaking residents reside in the home. Both Facility 1 and Facility 2 have unoccupied rooms and are struggling financially.

Facility 2 has fewer staffing departments and additional services. The manager of Facility 1 is responsible for administrative and financial tasks in addition to managerial duties. In Facility 2, one supervisor manages the kitchen and cleaning services, supported by the registered nurses in the facility. One employee coordinates the maintenance service of the facility, and a gardener is employed on an ad-hoc basis.

The surrounding retirement village is in closer proximity to the frail care facility than at Facility 1. Contrastingly, residents living in the surrounding retirement village, are more involved with the residents of the facility, with two of them being committed volunteers involved in the weekly activity program. Additionally, residents from the surrounding retirement village are served lunch daily in the communal dining room, which contributes to the retirement community being more connected as a whole.

Table 6 displays the REIS scores for Facility 2. The general score in most assessment categories were 2 out of 4. The scores suggest that the environment, as found by the REIS assessment, mostly interferes with residents' wellbeing, although some of the findings suggest that the environment sometimes supports residents' wellbeing.

Table 6: Scoring of environment at Facility 2 according to REIS assessment

Everyday Space					Everyday Objects					Enabling Relationships					Structure of Activities					
Accessibility of space	Adequacy of space	Homelike qualities	Sensory space	Visual supports	Availability of objects	Adequacy of objects	Homelike qualities	Physical attributes of objects	Variety of objects	Availability of people	Enabling respect	Support and facilitation	Provision of information	Empowerment	Activity demands	Time demands	Appeal of activities	Routines	Decision-making	
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
Rating Scale		4	Environment strongly supports people's sense of identity and competence by providing exceptional opportunities, resources and demands to engage in meaningful and culturally appropriate activities																	
		3	Environment supports people's sense of identity and competence by providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.																	
		2	Environment interferes with people's sense of identity and competence by providing limited opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.																	
		1	Environment strongly interferes with people's sense of identity and competence by not providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.																	

Everyday Space

As evident in Table 6, Facility 2 had a mixed score profile (2/4 or 3/4) relating to Everyday Space, Everyday Objects, Enabling Relationship and the Structure of Daily Activities.

Accessibility issues included cupboard railings used as grab rails in the corridors, some bathrooms that were inaccessible to residents due to the height of the toilet, and the placement of grab rails. Staff members commented that the newly renovated and accessible showers are not used, as they themselves become wet in the process of assisting or showering a resident. One of the showers also had a very steep incline towards the walk-in shower.

“The placement of some grab rails to assist sit-to-stand from the toilet is not effective” [REIS and ATOSE report, Facility 2]

“Fully adapted bathroom and toilet with a walk-in shower is apparently not being used by staff because staff become wet in the process of assisting residents” [REIS observations, Facility2]

There were visual cues in the facility, but it is recommended that the placement height is adjusted to ensure eye-level placement. A few bedroom doors had name cards and photographs on them, which contributed to the homelike atmosphere of the environment. Not all bedrooms had this feature, however, and it was pointedly missing from the door to the large hospital-like bedroom shared by six residents.

The corridors were very narrow. This might be one of the reasons for using a smaller, less sturdy option along the wall, equivalent to cupboard railing, instead of a handrail. During the visit the cleaning equipment congested the corridor, making it difficult to mobilise with assistive devices in the narrow space. There were attempts to decorate the facility with culturally appropriate décor. The dining room had a vintage sideboard, which stimulated discussion. There were crocheted covers on the armrests of some communal couches and chairs:

“Wood-like appearance of the sheet flooring at the entrance and communal dining décor room contribute to a home-like aesthetic” (REIS and ATOSE report, Facility 2)

The shared bedroom did not have enough space to move around in with ease, especially with a wheelchair, and it was structured in a hospital-like fashion. The residents in the shared

room lacked private cupboard space. One cupboard served the purpose, of which the shelves were shared between the residents. The sensory levels in this room were not regulated, which influenced the residents' activity patterns:

“During some informal discussions one resident who lives in the room remarked on another resident who grinds on her teeth when sleeping, and specifically referred to the other resident (with dementia) who woke up singing Christian hymns in the middle of the night. As a matter of fact, due to the open-plan unit, sounds of other people at night will be very likely, especially for a light sleeper or someone that has a particularly restless night” [REIS interview notes, Facility 2]

“One large wooden cupboard for all the residents' belongings”

“Curtains divides each bed with their (hospital) bedside table.”

Everyday Objects and Enabling Relationships

Basic assistive devices were available, although the same care culture was observed at both Facilities 1 and 2. This care culture is marked by staff rather doing something *for* the residents than providing an assistive device, adapted method or extended time to complete a task.

“Focus on residents with lower levels of engagement - only by volunteers. No involvement from staff regarding any form of pleasurable stimulation (despite required care tasks) were observed” [Researcher's notes, Facility 2]

Facility 2 has a manual hoist to assist with transferring residents, but this device was not used and is stored in one of the unutilised bathrooms.

No leisure activity objects were observed. Some residents kept to themselves and knitted.

“Care staff not spending their time optimally. Lots of sitting around in the seven bedroom, supervising frail residents” [Researcher's notes, Facility 2]

“The first time that the manager was seen in the frail care unit was when she entered accompanying Engo staff who were doing an annual audit”

She later confessed to the researcher that it upsets her when she enters the facility:

“Ek kry sommer so swaar gevoel”

“[I get this heavy feeling in my heart (when entering the frail care unit)]”

Structure of Activities

During the duration of observation, staff were generally not engaged with residents and did not assist with or attend any of the activities that the volunteers and community service therapists facilitated.

“Additionally she [volunteer] also stated that she would like more help from staff members as they (assuming the volunteers) sometimes are made to feel as if intruding and creating more work for the staff members”

“The volunteers aren’t very positive regarding their (the staff’s) motivation to be involved in anything other than their list of work tasks”

One resident mentioned that he felt left out regarding the sharing of information with residents of the frail care unit. He said that information was often only shared with residents of the retirement village:

“Soms hoor ons eers na die tyd dat iemand hier kom sing het” (sometimes we only find out afterwards that someone came to perform at the facility)

“[An] information board is available at the entrance in the dining room but is currently used to display the names and room numbers of the residents living in the Frail Care Unit”

One resident without dementia mentioned that she’s not sure whether the concerns of care staff members are taken seriously or actually considered

Volunteers presented an activity group of singing, bible study and basic chair exercises on Monday mornings. The volunteers asked the researcher to assist them in motivating more residents to participate:

“One resident seemed a bit irritated with the group but chose to stay and participate passively in what was happening”

“From the researcher’s perspective this specific group will not be appealing to residents functioning on a higher level of ability. The reasons for this observation are that the volunteers’ facilitation is somewhat childlike, there is little to no flow during the group activity, little spontaneous interaction [and] few elements of enjoyment”

“An evaluation by an occupational therapist, and indicating functional levels of residents together with an appropriate training program for volunteers might empower them more”

4.2.5 Facility 2: ATOSE results

The ATOSE assessment at Facility 2 was executed during the same time slots; i.e. 09h00-11h00 and 14h00-16h00 over three consecutive days. The communal lounge in which the observations were executed was a 30m² room in the centre of the unit. Due to the small number of residents living at the facility (16), the room was often underutilised as there were either only one or no residents present in the room. Similar to Facility1, many residents chose to spend most of their time in their bedrooms, indicating a possible disconnectedness with their immediate surroundings. Matching the setup of Facility 1, there is no isolated dementia wing at Facility 2. The communal areas are therefore used by residents both living with and without dementia. The researcher identified that some residents, due to their immobility or impaired volition, spent their days in the large seven-bedroom unit at the back of the facility. The researcher subsequently decided to conduct a brief assessment (one hour) using the ATOSE observation tool in this room. Tables 7 and 8, respectively, indicate the statistics regarding behaviours as observed in these two rooms.

Table 7 ATOSE results from three-day observational periods in communal lounge at Facility 2

	TOTAL BEHAVIOURS OBSERVED OVER 2 DAY PERIOD	OF TOTAL ENGAGED BEHAVIOURS	OF TOTAL NON- ENGAGED BEHAVIOURS	% OF TOTAL BEHAVIOURS	% OF TOTAL ENGAGED BEHAVIOURS	% OF NON- ENGAGED BEHAVIOURS
RESIDENTS	316	270	46	89.26	85.44	14.55
STAFF	5	5	0	1.41	100	0
VISITORS	33	33	0	9.32	100	0
TOTAL	354	308	46	*	*	*

Table 8 ATOSE results from brief observational period in shared bedroom ("the hall") at Facility 2

	TOTAL BEHAVIOURS OBSERVED OVER 1 HOUR PERIOD	OF TOTAL ENGAGED BEHAVIOURS	OF TOTAL NON- ENGAGED BEHAVIOURS	% OF TOTAL BEHAVIOURS	% OF TOTAL ENGAGED BEHAVIOURS	% OF NON- ENGAGED BEHAVIOURS
RESIDENTS	64	35	29	78.04	54.68	45.31
STAFF	18	18	0	21.95	100	0
VISITORS	0	0	0	0	0	0
TOTAL	82	43	29	*	*	*

Regarding the total number of observations (n= 316, n=64), it is evident from Tables 7 and 8 that Facility 2 is a smaller facility. At times during observational periods there were no residents present in the communal room that served as the observational space for the ATOSE assessment.

In the communal room, residents were engaged for more than 85% of the total behaviours, while in the shared bedroom space, also known as *the hall*, only 54.68% of the total observed behaviours were engaged. The percentage of non-engaged behaviours was much higher at 45.31%.

Part of the observational snapshots was two activity groups presented and facilitated by volunteers and community service therapists, respectively.

“Volunteers, in close proximity to the residents, could easily touch their knee or shoulder to maintain engagement”

Contributing to the high percentage of engaged behaviours is the smaller-sized room (30m²). This assisted in volunteers and therapists to maintain close proximity to the residents, and residents to each other. Awareness and attention could more easily be stimulated and attained. When someone entered the small space in the communal room, the residents showed awareness. Additionally, residents spending time in the communal lounge usually did so by their own choice and had more engaged behavioural patterns than residents spending time in the large seven-bedroom unit.

During the observational period in the shared seven-bedroom unit, residents were mostly seated around the table (as it was close to dinner time). Two were seated with portable trays in front of them. Some of the residents in the room did not live in this unit, but were brought to the room in the morning for staff to keep a watchful eye over them.

“(It) seems that some very frail residents living with dementia also have their meals in this room and are not included in the dining room, even though they are able to perform the task of eating independently” [ATOSE observational notes, Facility 2]

Most of these residents were not able to initiate activities or interaction. Some could answer questions from staff but generally residents were observed to be sitting, staring out in front

of them, while staff conversed with each another. After dinner the residents were assisted to brush their teeth and get into bed at just after 17h20.

“Directly following dinner, which was a mere ten to twelve minute sensory experience, caregivers assisted residents to brush teeth and prepare for bed” [ATOSE observational notes, Facility 2]

Consequently, staff’s behaviour was interpreted as being 100% engaged, because they were either conversing with each other or tending to the physical needs of the residents during and after dinner. There were no visitors during this one-hour period.

4.2.6 Facility 3: REIS results

Facility 3 differs from the other two facilities in the sense that it is much larger, accommodating 185 residents. It also has a dedicated dementia wing. Facility 3 is the least culturally diverse in terms of the resident population, and the most culturally diverse in terms of personnel.

Table 9 indicates the REIS scores achieved by Facility 3.

Table 9: Scoring of environment at Facility 3 according to REIS assessment

Everyday Space					Everyday Objects					Enabling Relationships					Structure of Activities				
Accessibility of space	Adequacy of space	Homelike qualities	Sensory space	Visual supports	Availability of objects	Adequacy of objects	Homelike qualities	Physical attributes of objects	Variety of objects	Availability of people	Enabling respect	Support and facilitation	Provision of information	Empowerment	Activity demands	Time demands	Appeal of activities	Routines	Decision-making
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rating Scale		4	Environment strongly supports people's sense of identity and competence by providing exceptional opportunities, resources and demands to engage in meaningful and culturally appropriate activities.																
		3	Environment supports people's sense of identity and competence by providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.																
		2	Environment interferes with people's sense of identity and competence by providing limited opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.																
		1	Environment strongly interferes with people's sense of identity and competence by not providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.																

Facility 3 is the largest RACF with 185 residents living in the facility. It has the most human as well as non-human resources, and is surrounded by a large retirement community housing 1 000 independent residents who provide a constant influx of new residents into the facility as permanent residents. Because of its size, there are more professional service providers employed at the facility, and the ratio of family members and volunteers involved is also the highest.

The exterior of the facility is well-kept and provides a serene and inviting feeling. Throughout the home there are grab rails for residents to hold on to when mobilising. All except one corridor are wide enough for two wheelchairs to mobilise past one other with ease. In one corridor that provides shared rooming, mobility devices are kept outside the room due to limited space inside the bedroom, as this might present a fall hazard and decreased accessibility and increased traffic in the corridor.

“Handrails are positioned throughout the corridors on an appropriate height level”

“Residents in the corridors are free to decorate and personalise their rooms as they wish”

“The [X] corridor serves as sub-economic, mostly shared accommodation, and the residents are subsidised by donations. Rooms are very small and bathrooms are shared”

“Automatic sliding doors at two entrances to the facility add to accessibility for residents, especially those who use wheelchairs or walkers”

“Name cards and photographs of residents on each door create a sense of home and familiarity” [This is also done in accordance with the colour scheme of the corridor in which the residents live]

“The décor has hints of the colour [colour of the corridor] that contributes to orientation of place”

There are inconsistencies regarding the visual supports, as some corridors provide inadequate orientation in terms of legibility and placement of orientation cues. One example

is that Facility 3 has reduced accessibility, as especially visitors and residents living with dementia struggled to find their way in the large facility.

“Signs are two-dimensional, however situated high up against the wall and not particularly visible” [REIS notes, Facility 3]

More assistive devices are available as an occupational therapist is employed on a full-time basis at the facility. However, it was observed that these devices are used inconsistently in the various corridors:

“The facility has a lifting hoist available and staff were trained to use this effectively and safely [the device is used but unfortunately not for all residents that it might benefit as some staff mentioned that the distance to other corridors, in order to fetch the hoist, is too far”

There are numerous homelike qualities and objects. There are, however, areas in which the décor and objects are not on par with the rest of the home, and more reminiscent of hospital-like features.

“There are many sitting nooks and smaller lounges present”

“Culturally appropriate décor items such as hats, pianos, vintage couches, coat hangers, paintings and plants”

“The flooring still speaks to an institutionalised floor (sheeting that glares [visual impairment], but can easily be cleaned)”

Two dedicated recreational activity rooms are available, although one is locked during weekends and after 16h00 in the afternoon. A weekly activity program is followed, although it is not utilised to its full potential by all residents and staff members.

Family members and volunteers visiting Facility 3 provided residents with opportunities for social and occupational participation. Additionally, a mobile library service drops off books to residents, which provides a valuable opportunity for residents to maintain meaningful occupations.

“...guest room [available] that can be rented by families” [this provides more opportunities for family members to spend time with relatives living

in the facility as the rooms are affordable and in close proximity to the facility]

Residents provided mixed reviews regarding the services they received, and there were some residents who indicated that they feel unheard, and often struggle to find a caregiver to assist them with daily activities.

“Residents seem to trust the medical and nursing care provided at the facility”

[‘hulle wil nie mens help nie’ (they don’t want to help us)]

“Resident calls out to student nurse who walks past her – no answer”

“Some residents do not understand the challenges faced by people living with dementia”

It was evident to the researcher that although there were perhaps more professional staff working at Facility 3, the culture of physical care was seen as the most prevalent and dominant consideration, as was the case at both Facilities 1 and 2. The privacy and dignity of residents were sometimes observed as being of little importance:

“[Carer] brings resident in wheelchair some water and a banana and tells her [in presence of other residents] to eat and drink so that she can have a bowel movement”

“[Carer] brings LV into sitting room. Assists her to the chair. She is wearing pyjamas on [time 14h30]”

“[Carer] takes of pants of resident [in lounge area] seemingly still left after changing into pyjamas”

Residents are involved in each other’s lives. This has both positive and negative results. In some cases residents do not understand or handle the behaviour of people living with dementia correctly, which renders the people living with dementia as outcasts due to the unsupportive environment.

“Resident [with dementia, poor perception] asking another resident (very frail, non-engaged, immobile) to take cups to kitchen (‘agtertoe’). This

angers a third resident in the room who comments to the first that staff will fetch the cups” (ATOSE observations, Facility 3)

“It is clear that the residents do not realise/are ignorant that the resident with dementia has poor cognition and is not purposely being ignorant towards the frail resident. Residents commented that ‘she can’t even walk, how do you expect her to take cups’. Other residents seem irritated with her: “L, jy’s nou weer links van die regering, jy’s deur die blare” (“L, you are being difficult on purpose, you are confused”) (ATOSE observations, Facility 3)

“[Resident] makes a hand gesture to [another resident] – about [resident living with dementia] – indicating she is [stupid]” (ATOSE observations, Facility 3)

4.2.7 Facility 3: ATOSE results

The ATOSE assessment at Facility 3 was executed during the same time slots; i.e. 09h00-11h00 and 14h00-16h00 on three consecutive days, as was the case at the other two participating facilities. The communal area in which observations were done was the lounge of one of the eight corridors in which residents mostly share rooms and bathrooms. There are also individual rooms that share bathrooms. There are 28 residents residing in this corridor, although the largest number of residents observed in the lounge, which was during bible study, was 18 residents. Similar to the other two facilities, both morning and afternoon tea times were part of the observational periods. Other than the bible study session, no other formal activities were observed.

The results obtained from the ATOSE assessment is presented in Table 10.

Table 10: ATOSE results from observational period at Facility 3

	TOTAL BEHAVIOURS OBSERVED OVER 3 DAY PERIOD	OF TOTAL ENGAGED BEHAVIOURS	OF TOTAL NON- ENGAGED BEHAVIOURS	% OF TOTAL BEHAVIOURS	% OF TOTAL ENGAGED BEHAVIOURS	% OF NON- ENGAGED BEHAVIOURS
RESIDENTS	1250	760	490	93.07	60.8	39.2
STAFF	58	58	0	4.31	100	0
VISITORS	35	33	2	2.60	94.28	5.7
TOTAL	1343	851	492	*	*	*

In line with the ATOSE results obtained at Facilities 1 and 2, residents mostly occupied the lounge, while the percentage of staff behaviour only accounted for 4,31% of the total behaviours observed during the three-day period. During one altercation between two residents, which became violent when one resident threw a broomstick at the other, there were no staff present or nearby, and the researcher was forced to intervene.

“A fight ensued about the birds. [Resident] throwing [another resident] with broomstick because she fidgeted with bird cage and the fight getting somewhat physical. [Resident] saying that it is her house and wanting to tend to the birds” (ATOSE observations, Facility 3)

“Staff member puts in eye drops for LV in lounge”

“Staff can be heard chatting [very loudly] further down in corridor – Sesotho”

The staff seemed uncomfortable with being observed, and all actions were in a professional capacity only. These included transferring a resident, cutting toenails and measuring blood pressure. Instances of positive interactions related to residents enjoying the time that staff took to interact with them, even if it was only sharing a comment or making a joke:

[Resident] joking with the carer about ‘kicking her’ [Both laughing and seemingly enjoying the interaction]

“Room seems more alive all of the sudden” [after staff enter to do the nails of residents]

“Staff member asks if she can open window”

The percentage of non-engagement of residents were 39.2% in comparison to the 60.8% of engaged behaviours. This percentage of non-engaged behaviour is significantly higher than that observed at the other two facilities. This could be ascribed to the lounge area being used as a space where residents are sometimes taken because families requested that they spend more time outside of their bedrooms. Residents with varying physical and cognitive abilities used this shared space.

“Residents living with dementia were generally more non-engaged than those living without dementia [and were often observed] sitting with their eyes closed or falling asleep”

“Due to the constant influx of people there were always some form of stimulation present in the room [which some residents seemed to enjoy, and discussed the people walking past]”

“Residents mostly non-engaged seemed to be indifferent to this form of stimulation”

Phase 2

4.3 Perceived enablers and barriers to implementing the REIS and ATOSE findings

The quantitative statistics from the REIS and ATOSE, as presented in Tables 4 to 10, were interpreted and consolidated into three separate reports, as found in Addendums K, L, and M. These reports were integral in phase 2 of data collection, which involved leadership staff members from each of the three participating facilities reading and reflecting on the findings in the reports, and participating in a nominal group discussion. During the nominal group discussion, this question was posed to the group-

What do you see as the potential factors to consider for implementing the REIS and ATOSE at your facility?

The intended purpose of this nominal group question was to obtain information in order to answer the research objectives relating to the perceived barriers and enablers to implementing the REIS and ATOSE findings at each of the three facilities. The findings from the nominal group discussion are presented in the following section of this chapter.

4.3.1 Description of nominal discussion group participants

The eligibility criteria for nominal group participants are described in Chapter 3 (c.f.0). Basic demographic information of the nominal group participants is presented in table 11.

Table 2 Demographic information of the NGT participants

	Facility 1		Facility 2	Facility 3		
Participant	MA	ER	AD	JA	EZ	EL
Time employed at facility	6 y	5 y	9 m	22 y	1 y 6 m	4 m
Position at facility	Manager	Registered nurse	Manager	Manager	Nursing manager	Registered nurse
Gender	Female		Female	Male	Female	
Race	White					
First language	Afrikaans					

Six participants were included in the nominal group discussion. Only one leadership staff member from Facility 2 could attend the session. Facility 3, the largest of all the participating facilities, had three staff members attending the nominal group discussion.

Only one of the participants, a retired social worker, was male and had been working at Facility 3 for 22 years, which was a longer period than the combined years (>14 years) of the other five participants. It was evident that he was respected among his peers, and he was authoritative during the nominal group discussion.

Three of the six participants had a nursing background. One participant specifically noted that the background of staff involved in the nominal group would have an impact on the focus of the group discussion:

“If there were more social workers in this group then numbers 1 and 2 (of the identified priorities) would have won, but now there are too many nurses and they are task-oriented” [comment documented as part of narrative notes, nominal group]

Prior to working at Facility 3, one participant had worked at Facility 2. This potentially provided a unique perspective as she was familiar with the operations and routines of both facilities.

One of the participants had recently been appointed as the manager of Facility 2 and during the initial phase of the group discussion she was visibly uncomfortable. The researcher had to convince her of her invaluable input prior to the discussion, as she at first did not want to attend. The participant mentioned her limited experience in the aged care sector a few times during the nominal group discussion.

4.3.2 Priorities as identified of the value of the REIS and ATOSE assessments for Engo RACFs

Table 12 summarises the identified priorities, with the number of votes received, during the consensus process on the value of the REIS and ATOSE.

Table 3 Priorities identified during the nominal group

Priority	Total number of (votes)	Identified priority <i>What do you see as the potential factors to consider for implementing the REIS and ATOSE at your facility?</i>
1	5, 5, 5, 4, 5, 4 (28)	Staff development Needs analysis (skills analysis) “warming the soil” – (as mentioned by a participant) Skills exchange
2	5, 5, 3, 4, 2 (19)	Considering residents’ specific needs Identifying residents’ needs - guides the leadership staff’s reaction/understanding on what is a universal need and what is a more specific need within aged care
3	3, 4, 4, 2 (13)	Focusing on the relationships between care staff and residents rather than carer vs resident. Equalisation (<i>‘gelykmaking’</i> meaning residents and staff are equal) can aid each other with daily tasks such as serving tea
4	1, 1, 4 (6)	Optimal use of space vs homelike qualities Using everything that you have or identifying how you can re-use something more effectively

5	3, 2 (5)	Proposed activity program with specific time and place, and making participation optional. Critical evaluation of and reaction to the residents' needs to ensure feasibility of activity programs
	1,1, 3 (5)	Effective use of existing resources, and use that as a starting point to advance and improve existing features
	2, 3 (5)	Identifying gaps. REIS especially gives meaning that leads to further planning

The top priority identified by the participants was the need for staff development. All six participants voted for this as the most important or second most important consideration for implementing the REIS and ATOSE findings.

Although staff development was identified as the top consideration to implementing the findings of the REIS and ATOSE assessments, the participants did not specify the needed development opportunities. This was interpreted as uncertainty about the operational staff's existing skills. Discussion of this issue provided the realisation to the group that an audit was necessary to identify the current level of staff skills at each facility.

Thematic analysis of combined data from phase 1 and phase 2

4.4 Barriers and enablers to REIS and ATOSE implementation

The thematic analysis of all of the combined narrative data (the REIS and ATOSE reports, reflective and observational notes made during the REIS and ATOSE assessments periods, and narrative notes of the nominal group discussion) generated two overarching themes associated with the barriers and enablers to implement the findings of the REIS and ATOSE tools. The two overarching themes are Theme 1: *the organisational culture* and Theme 2: *occupational justice issues*.

Furthermore, two categories are connected to the *organisational culture* theme and two categories are connected to the *occupational justice issues* theme. Each category was linked with subsequent subcategories with their respective codes (see the expanded grid in Appendix N). Figures 4 and 5 provide an overview of the categories and subcategories associated with each theme that are presented sequentially. Figure 4 depicts the *organisational culture* and Figure 5 demonstrates the *occupational justice issues*.

Operational features presenting barriers to culture change (4.4.1.1)

- (a) Predominating biomedical care culture
- (b) Environmental risk factors
- (c) Top-down management approach
- (d) Limited collectivity between stakeholders
- (e) Unfavourable attitudes of operational staff
- (f) Limited knowledge regarding dementia
- (g) Passive resistance towards culture change and person-centred care

Operational features enabling culture change (4.4.1.2)

- (a) Supportive environmental factors
- (b) Leadership promotes a collegial support system
- (c) Successful person-centred care approaches
- (d) Interest in process of culture change

Figure 4.2: Categories and sub-categories associated with the theme of ORGANISATIONAL CULTURE

Unsupported areas of wellbeing (4.4.2.1)

- (a) Social isolation and disconnect
- (b) Disregarded personhood and identity
- (c) Meaningful stimulation disregarded

Supported areas of wellbeing (4.4.2.2)

- (a) Meaningful stimulation enabled
- (b) Social inclusion and connection

Figure 4.3: Categories and subcategories associated with the theme OCCUPATIONAL JUSTICE ISSUES

4.4.1 Organisational culture

Two categories are associated with the theme of organisational culture. They are *operational features presenting barriers to culture change* and *operational features enabling culture change*. Each category with relevant codes is presented and interpreted in the following section.

4.4.1.1 Operational features presenting barriers to culture change

The theme of operational barriers to culture change relates to the limited progression and opposition of Engo RACFs toward culture change. These present a barrier to implementing the findings of the REIS and ATOSE findings. The data also showed that there were enablers to implementing the findings of the REIS and ATOSE assessment tools. This was the second category of this theme, labelled as the operational enablers to culture change.

Seven subcategories were identified in relation to the existing barriers towards culture change within Engo RACFs. A prime subcategory is the a) *biomedical care culture* present in the participating facilities which related to, and shaped, the other identified subcategories: b) *environmental risk factors*, c) *top-down management approach*, d) *lack of collectivity*, e) *unfavourable attitudes of operational staff*, f) *lack of knowledge regarding dementia* and g) *passive resistance toward culture change and person-centred care*.

a) The predominating biomedical care culture in Engo Residential Aged Care Facilities

The facilities are predisposed towards the 'traditional' way of doing things associated with the biomedical care cultures usually present in hospitals. This includes structure, inflexible routines and a stern focus on physical care. The daily activities and routines of management and operational and leadership staff, indicate that staff are task-oriented. Care practices focus on rules, maintaining order and residents' disabilities, rather than emphasising the residents' abilities and occupational needs.

"...rules, obviously, need to be very strict" [comment, nominal group participant]

Two of [the residents] do not live in the (room) but have private bedrooms. They are brought to the (room) by the caregivers to keep a watchful eye over them [REIS observation notes, Facility 2]

All three facilities display qualities and trademarks that are reminiscent of a hospital environment rather than a home for retired elders. The hospital-like features are present in sounds, smells and objects at the facilities. One facility welcomes visitors with an entrance sign that reads *'the frail care unit'*.

Multi-bed rooms are present at all facilities. At one facility a hospital bed is automatically prescribed or provided when someone moves into the shared space. The hospital beds at one facility are accompanied by hospital side tables and curtains screening the beds from each other. Other hospital-like features in the bedrooms include call bells for residents to signal that they require help, and the high-pitched alarm is sounded in the nurse's office. However, residents with dementia are not able to use this as they usually forget what the call bell is for. Call bells are assigned to each room nonetheless, as they are deemed to be essential (Department of Social Development, 2010) as documented in the updated regulations for complying to basic norms and standards by the Department of Social Development, regulating RACFs in SA.

At all three facilities a nurse's office is located at the centre of the corridors, where the senior registered nurse spends most of his/her time tending to medication or administration. The larger the facility, the more notable the long and hospital-like corridors with white bright base lights in the absence of natural light and windows. Trolleys can be heard throughout the day, either serving meals or tea and coffee. Other institutional sounds are those of the routine clearing of dishes and cutlery and a bell that rings signalling lunch. At Facility 3 announcements can be heard through the centralised intercom system in the home.

b) Environmental risk factors

Residents and staff at all three facilities do not use all the available resources and infrastructure such as lounges, outside areas, activities presented, assistive devices and training opportunities. At Facility 2 a fully accessible and newly renovated bathroom is not used:

"Fully adapted bathroom and toilet with a walk-in shower is apparently not being used by staff because staff become wet in the process of assisting residents" [observation notes, Facility 2].

At Facility 3, an available hoist and draw sheets to minimise the impact on residents' skin and carers' joints are seldomly used due to self-imposed time constraints, and staff noted

that *“they do not have time to fetch the device and there are many residents to help in (my) corridor”*.

Environmental risk factors were associated with auditory stimulation, uneven walk surfaces, inaccessible bathrooms, inadequate grab rails, furniture which does not support safe sit-to-stand mobilisation and flooring which presents a fall-risk. It also includes disorienting qualities for people living with dementia:

“Auditory stimulation – birds chirping (afternoons – very vocal), radio is on. The call bell rang three times. It rings quite loudly in the sitting room and visibly upsets residents, one even putting her hands over ears. Visual – TV, but it is a small TV and the sound is off. TV could just as well be switched off as residents sometimes look at the screen, but only if very visually stimulating. Olfactory – in the morning, during self-care routines there is often an unpleasant smell of human gasses but staff do try to eliminate the odours with air spray” [ATOSE narratives, Facility 3]

Some paved outside areas are not level [REIS notes, Facilities 1, 2, 3]

Some outside furniture is not supporting safe sit-to-stand mobilisation and is not very comfortable [REIS notes, Facilities 2, 3]

Some residents identified specific bathrooms that they do not use due to accessibility issues [REIS notes, Facilities 1, 2]

The flooring still speaks to an institutionalised floor (sheeting that glares [visual impairment], but can be cleaned easily) [REIS notes, Facilities 1, 2, 3]

“Grab rail material along the corridor walls are actually cupboard railing which is not ideal for the purpose of grab rails” [REIS notes, Facility 2]

“Please note that the width of some toilet walls is not congruent with the placement of grab rails to assist sit-to-stand from the toilet. This is due to the structure of the buildings” [REIS and ATOSE reports to all facilities]

“Large glass door opens onto a closed cement terrace with a very steep slope, which certainly can’t be used to wheel people up and down in a wheelchair” [REIS notes, Facility 2]

c) Top-down management approach of leadership staff

Management and leadership staff are consumed with administrative and managerial duties, which warrant very little time for interaction with residents:

“I seldom spend time with the residents” [NGT data collection notes]

During the discussion group, the participants agreed that they, as leadership staff, are often immersed in daily to-do-lists, which left them with very little time for meaningful interaction with residents. The participants alluded to this as a possible reason for losing touch with residents’ needs due to becoming so immersed in management tasks and maintaining operations in the aged care facility toward a business-like model. This has a negative effect on the person-centred focus.

“’n inwoner reageer op ‘n bepaalde manier maar ons kyk nie wat veroorsaak of wat stimuleer hom nie” / “A resident reacts in a certain manner, but we do not investigate what causes the behaviour/reaction”

“Want as ek dit (reaksies op sekere insidente) weet kan ek hom beter hanteer”/ “If I know this (reactions to specific incidents) I can manage him better” [NGT data collection notes]

Most activities performed by operational nursing staff members seem to focus on nursing care and not promoting personhood. Although operational staff members revealed an interest in further training, the topics were focused on clinical skills relating to dementia care, vital signs, wound care, leisure activities and assisting residents with self-care. In conversation with some staff members it was notable that staff referred to residents as patients and not residents. All registered nurses commented on how the managing of medication was of the utmost importance, and that it took up most of their time. This prevented them from spending quality time with the residents.

At Facility 2 operational nursing staff members voiced many concerns and frustrations which are not voiced or attended to. Despite staff partly exploiting the situation of an external researcher asking their opinion, some concerns were voiced with urgency. The researcher noticed the helplessness and frustration which operational staff experience as they feel their

opinions and concerns are disregarded. Evidence indicates a distancing between leadership staff and subordinates, which is strengthened by an attitude that subordinates are disposable:

“I didn’t hire you, you are not my people” [REIS notes (verbatim statement of an operational staff member, presumably made by a leadership staff member), Facility 1]

Some operational staff appeared to be intimidated by management:

“(The manager) said that the ‘gate is open’ if we - the staff - are unhappy” [REIS notes (verbatim statement of an operational staff member, presumably made by a senior leadership staff member), Facility 1]

The facilities are managed according to the traditional approach of a hierarchical system where management is viewed as the executive body of power, decision-making and teaching:

“If you study the report you can really identify training needs... that’s an advantage of the feedback {from the tools}”

“To give more responsibility to a ‘strong’ carer/staff member”

“Beautiful uniforms of staff members – indicating hierarchies among staff members (different uniforms for different services)”

“The first time that the manager was seen in the frail care unit was when she entered with Engo staff that was doing an annual audit”

The management staff of all three facilities display a problem-based approach to operational challenges. Comments which indicated this include:

From there (the challenges the ATOSE and REIS reports identified) planning will commence...“I must assess the needs and work accordingly” [NGT data collection notes]

Due to financial constraints and high workloads (one manager even having to divide her time between two separate positions at the facility), the facilities do not function proactively. Challenges are handled as they arise. The current traditional care culture is viewed as the status quo, and not a problem or something that needs changing:

“I’ve been working at the (facility) for 22 years and (the REIS and ATOSE) report still stimulated new insights”

As part of the barriers to culture change, underlying power relations influence the interaction between staff members:

“Now I’m the big boss” [NGT data collection notes]

Furthermore, the power relations extend to the experience of residents, as they seem to fear vindication. They indicated that they preferred to refrain from providing specific answers during the assessment, and would not elaborate on comments relating to their satisfaction with certain services at the facilities:

“ek sê eerder niks / I’d rather not say anything” [REIS notes, Facility 2]

“moenie sê dat ek so gesê het nie / don’t say it was me who said that” [REIS notes, Facility 2]

During the field visits to the facilities, nursing care staff members used the opportunity to either air their grievances or expect input from the researcher that was not part of the agreement of the research project. Care staff at Facility 1 voiced dissatisfaction with their salaries and other working conditions. One manager requested the researcher to meet with a potential volunteer in her capacity as occupational therapist, to guide the volunteer with setting up an activity program.

Some nursing care staff seemed very pre-occupied with their own needs. Many comments from staff during interviews and informal discussions alluded to their viewpoint that they do not see the necessity to improve the residents’ circumstances. Staff seemed very concerned with their needs, such as requesting more staff capacity on night duty, updating their working uniforms, providing better infrastructure e.g. staff toilets, and refurbishing the staff tearoom.

d) Limited collectivity between stakeholders of Engo Residential Aged Care Facilities

Two main subcategories were identified relating to the limited sense of community and collectivity at the facilities. These are the ***disengagement between staff (operational and leadership staff) and residents*** and the ***disengagement between staff and volunteers***.

The ***disengagement between staff and residents*** was evident from the lack of collective participation in meaningful tasks, other than self-care. Staff occasionally brought residents to the activities and left them in the communal room. They did not, however, collaborate with residents to participate in the activities together. Transfers, a basic mobility ADL, were not

initiated with residents but rather done for or to residents. As previously mentioned, staff rarely spent any time in the communal lounges socialising or interacting with residents, and the interaction observed was mostly due to professional or domestic tasks being executed by staff. Residents, however, were observed to seek out interaction with staff. When staff entered the room residents were suddenly more aware by looking up at staff or initiating a conversation. One example where a staff member's presence elevated the levels of engagement of residents, was when she sang to them while serving the tea and coffee:

"I always take extra food to (my) room even though I know am not allowed to, but I tell the kitchen staff it's for myself, to eat later during the evening and then I give it to the carers working on night shift in the corridor" [REIS notes, Facility 3]

Despite an apparent need for connection with staff, some residents do not enjoy the interaction with operational black staff members as they are seen as 'helpers'. During the visits to the facilities, the researcher came across residents at all facilities who seemed to regard the staff as 'less human'. This attitude is suggestive of lifelong social constructs of racial bias built during Apartheid, and the segregated society in which the aged residents grew up, and was accustomed to.

Leadership staff had limited conscious engagement with residents, and were seemingly confronted with their misconception about residents' needs, wants and challenges:

"One easily forgets how it must feel for older knees to walk on the cement"

"I seldom have time to interact with residents on a daily basis" [NGT data collection notes]

Leadership staff had generalised assumptions based on limited engagement with residents about what they perceived to be important for the residents living at the facilities. However, they did acknowledge their uncertainty about the lived experiences of residents, confirming the limited collectiveness between staff and residents:

"If staff are frustrated and agitated it has a subconscious impact on the residents and their reactions... and I believe that (the reaction of residents) is something we ignore/do not acknowledge" [NGT data collection notes]

The disengagement between staff and residents at all three facilities is visible in the monotonous daily routine. There is a lack of spontaneity, and care staff's interaction with residents is, mainly, in a professional capacity such as assisting with self-care or mobility needs:

Other engagements of staff included fidgeting to switch on the radio, taking blood pressure of residents, providing nail care or assisting with a transfer [ATOSE narratives, Facility 3]

...behaviours of staff were either those of catering tasks such as serving tea or clearing up dishes, or it was professional nursing or caring tasks [ATOSE narratives, Facility 1]

Directly following dinner, which was a mere ten to twelve minute sensory experience, caregivers assisted residents to brush their teeth and prepare for bed (at 17h15 in the afternoon) [ATOSE narratives, Facility 2]

In general, staff and residents in all three facilities displayed signs of institutionalised behaviour. The same behavioural patterns were followed and both parties seemed resistant to any changes from the comfortable and known routines. Residents for example commented when the chair that they usually sat on, was occupied by someone else. Moreover, most residents spent their time in their private bedrooms and rarely made use of the shared spaces. During some observational periods ascribed by the ATOSE assessment, there were no residents present in the communal spaces.

The task-oriented manner in which operational staff executed tasks emphasised the institutional routine being followed day in and day out. One observation made the institutionalised manner in which operational staff execute tasks extremely clear:

Directly following dinner, which was a mere ten to twelve minute sensory experience, caregivers assisted residents to brush their teeth and prepare for bed (as to complete all tasks before the end of staff's shift) [ATOSE narratives, Facility 2]

Operational staff seemed comfortable with mostly providing care or serving residents, and residents were the recipients of such services, even to the point of expecting and being accustomed to it:

(Resident) calling out for nurse to throw away the banana peel [ATOSE narratives, Facility 3].

Residents were not encouraged to engage in previous meaningful occupations such as housekeeping tasks. Despite many residents having the skills to perform or assist with these tasks in the facilities, it is done by operational care staff as one of their tasks to be executed for the day. Tea time was one such example at all three facilities where residents were seated and one or two staff members served the residents tea from a large aluminium tea pot, specifically nursing carers [combined reflection from researcher's reflective notes during visit to all three facilities].

The nursing and physical health focus seems to also have cascaded down to residents as many conversations were about their blood pressure or bowel movements. A basic activity such as eating a banana was intended to ensure a bowel movement in order to meet the expected outcomes associated with a nursing care routine:

(Caregiver) brings resident in wheelchair water and banana and tells her to eat and drink so that she can have a bowel movement [ATOSE observations, Facility 3]

The focus on residents' inabilities rather than their abilities supports the biomedical care culture present in Engo facilities. In discussion with staff members, it was clear that they either classified residents as needing no assistance or needing full assistance. Staff mentioned self-imposed time constraints as one of the main reasons for 'doing for' rather than 'assisting'. Staff were not able to distinguish between different steps of activities, and merely stated that they do everything for the residents. Some of the nursing care staff who deliver direct and hands-on caring to residents, have no formal training in caregiving. In addition, when the researcher visited the facility, staff were uncomfortable when entering spaces while the researcher was there. The interpretation is that staff felt nervous about being observed while doing something 'incorrectly'. At all the facilities residents mentioned that they had preferred carers for assisting them with various ADL:

"I wait until (carer) comes onto shift, as she knows exactly how to do it (help me in the bathroom)" [REIS notes, Facility 1]

In contrast, residents were very involved in each other's physical health. One resident at Facility 3, for example, occupied herself with caring for another resident, who was visibly more frail than herself:

"I loves you so much, your face looks so bright today" [ATOSE narratives, Facility 3]

And:

"Shouldn't we put on your jersey? Are you not cold?" [ATOSE narratives, Facility 3]

Leadership staff were aware of inconsistencies in staff's level of operational skills and the associated discrepancies in the level of care that staff provided:

"They can learn from each other, not necessarily only from a leadership staff member" [NGT data collection notes]

And:

"To give more responsibility to a strong carer/staff member" [NGT data collection notes]

In terms of the **disengagement between staff and volunteers**, volunteers were of the opinion that staff disregarded their services because sometimes volunteers expected help from staff. Staff perceived this as an increase of their workload, even though they did not participate in any of the activities facilitated by volunteers. During the time that volunteers or community therapists presented leisure activities, staff retreated to the staff room.

Additionally she [volunteer] also stated that she would like more help from staff members as they (the volunteers) sometimes are made to feel as if intruding and creating more work for the staff members [REIS notes, Facility 2]

e) Unfavourable attitudes of operational staff

At none of the facilities staff spent their time effectively. When the 'job was done', operational staff, specifically observed to be the carers, sat around socialising with each other, using their personal cell phones or merely supervising residents.

Afternoons were generally very quiet and operational care staff retreated to their tea room. The exception was at Facility 2, where the staff remained in the communal room and kept a watchful eye over residents, who were either asleep or visibly unaroused. There seemed to be an undercurrent of negative attitudes towards their caring duties, which might be ascribed to the frustrations they experienced in their working environment and its conditions.

*There seems to be an occasional unavailability of care staff [REIS notes,
Facility 1]*

At Facility 3 some operational staff and residents commented on the highly-strung attitude of staff working in various departments. Observations at Facility 3 illustrated that specifically reception staff have to deal with the issues of residents, staff members, family members and outsourced service providers, as the human resources are limited. There was little respite during the day as there is a constant influx of people and situations that demand attention.

The operations regarding service rosters and shifts were vexatious to care staff at Facility 3, as staff are shifted to work in different corridors. At both Facilities 2 and 3, staff requested more night staff as they experienced a heavy workload. Additionally, at Facility 2, staff members were displeased with staff being moved to different service departments due to a shortage of staff or poor performance. Wages were discussed (despite the researcher not addressing the topic as it is highly sensitive), staff were uncertain about the pay scales and other logistics, which confirmed their frustration due to a lack of knowledge and understanding. The infrastructure was also regarded as insufficient, with only one toilet for all operational staff members. Staff mentioned, however, that the white staff were using a different toilet. There were many comments that, per implication, pointed to the next subcategory, namely *race and class politics*.

Some residents at all three of the participating facilities made racist comments. Leadership staff confirmed this suspicion of discrimination by the older white residents towards black care staff. One care staff member has worked at Facility 2 since 1991 (pre-democracy SA), and her comments during an informal discussion suggested that she and other care workers experience a distinct division between the white people (residents and senior nursing staff) and the black people (mostly nursing care staff). Sesotho-speaking staff were observed to deliberately speak and answer to Afrikaans-speaking residents in Sesotho, which created a communication barrier, especially for residents living with dementia.

f) Limited knowledge regarding dementia

The lack of knowledge about dementia as an undercurrent of the organisational culture at the facilities was evident in the comments made by both staff and residents. Residents without dementia found the behaviour of other residents with dementia irritating, and expected them to be moved to a separate dementia-allocated wing. Residents' comments also alluded to the fear they have of dementia, as it is regarded as a terrible disease.

During one observational period where the researcher had to intervene due to the absence of staff, the disoriented behaviour of a resident resulted in a physical altercation, and the resident presenting with the disoriented behaviour being isolated and labelled as 'stupid' (c.f. ATOSE narratives, Facility 3). Care staff's inability to adequately respond to some residents was noted:

“Some care staff asked researcher about specific residents moving to (dementia unit), as they are ‘difficult’ to handle or ‘they have dementia’ and they do not belong in the corridor. Also indicating their misconception about the capacity in which the resident converses and interacts with them” (REIS notes, Facility 3)

The conclusion was drawn that staff feel contempt towards residents who require more attention. They expect the residents to be confined to an isolated unit, as these residents allegedly increase their workload. Commonly, the residents referred to in this regard were residents living with dementia.

g) Passive resistance toward culture change and person-centred care

Staff displayed passive resistance towards culture change as denoted by hesitancy, uncertainty and ambivalence.

Some leadership staff displayed resistance towards participating in the research process by not reading the content of REIS and ATOSE reports in a timely manner, and displaying discomfort with the process and findings. One participant enquired whether this particular study has been done at other Engo homes. Another exhaustingly enquired, albeit somewhat tongue-in-the-cheek, whether they as participants would be awarded certificates for their participation.

The discomfort experienced by leadership staff was evident in the comments they made, periods of silence and body language. This was noted in the NGT reflective notes and during

the research discussion session, as management was confronted to think and reflect outside of their usual managerial framework. Leadership staff were also disconnected from their responsibility towards facilitating culture change, and hinted towards this process being the responsibility of an occupational therapist. A comment from one participant confirmed this notion:

“I am glad I am not the occupational therapist because she has her work cut out for her” [NGT data collection notes]

The leadership staff at the facilities presented with a basic level of knowledge and ideas regarding person-centred care. Leadership staff had been exposed to the concept of person-centred care, but their interpretation and implementation of it was incorrect, and not demonstrative of the awareness that person-centred care is about promoting culture change.

Many comments from leadership and operational staff indicated that residents are viewed as a business commodity within the aged care sector. In reflecting on the research process, the level of disengagement and ignorance (as interpreted by the researcher) of staff towards residents, and how they are often ignored and treated as objects, were undeniable. Reflective notes from all facilities mentioned the comments of residents indicating that they feel unheard, and that their opinions are not regarded as important. Some staff members referred to residents as ‘our’ residents, indicating possession, which related to the limited autonomy experienced by residents.

The issue of financial capacity was cited as the main barrier to the attainment of person-centred care and culture change. Furthermore, residents’ institutionalisation was offered as a reason for person-centred care not being implemented, as ‘residents prefer things the way it has always been’ [NGT data collection notes]. This suggests previous failed attempts of implementing superficial person-centred care changes. Staff’s comments suggested that they strongly associate person-centred care with recreational activities and a feasible activity program at the facility:

“You should determine why it (participation in the activities) decreases because you want the activities to be feasible, person-centred... PCC... It’s not easy... I don’t know” [NGT data collection notes]

Some comments by senior management indicated familiarity with terminology supportive of culture change, however the concept of person-centred care appeared not to be fully understood:

“One should evaluate why it decreases (participation in activities) because we want it to be feasible for the resident, person-centred”
[NGT data collection notes]

Although in the minority, two participants appeared to have a negative response when confronted with the subject of care-culture in the facilities:

“Must I add something?”

“Can my colleague and I work together?”

Then I can't write down anything at the moment... I didn't have time to read the (ATOSE and REIS) report in detail” [NGT data collection notes]

The disconnected perception of leadership staff regarding the role and responsibility towards facilitating culture change could indicate an attempt to defer this responsibility:

“I am glad I am not the occupational therapist because she has her work cut out for her” [NGT data collection notes]

Leadership staff indicated that there was lack of and need for opportunities to liaise, discuss, collaborate and support each another. They indicated that they wanted to use the research group discussion to discuss challenges specifically relating to the culture change movement, and attempted to divert the discussion from the defined data collection process they agreed to engage in:

“Will there be time to discuss?” [NGT data collection notes]

The group discusses ideas and seems to be stimulating each other's thought processes. They enjoy sharing stories and find many similarities/obstacles in residential aged care. Laugh about a few stories
[NGT reflective notes]

However, the research group discussion proved to be a positive and meaningful opportunity for all the participants. They requested that the process be repeated with the rest of the management team at each facility:

Participants agree and corroborate that group was very interesting and the information in the report was very valuable [NGT data collection notes]

Other comments recorded during the discussion group indicated that participation in the group connected the leadership staff to each other as they found common ground with people facing the same challenges.

The seven categories and sequential findings associated with the theme of organisational culture were presented in the preceding section. The following section will present the findings associated with the second identified theme in this research project.

4.4.1.2 Operational features enabling culture change

As opposed to the barriers toward culture change, four subcategories were identified to illuminate the operational features enabling culture change, and supporting the potential of implementing the REIS and ATOSE. They are a) *supportive environmental factors*, b) *leadership which promotes a collegial support system*, c) *successful person-centred care approaches* and d) *interest in the process of culture change*.

a) Supportive environmental factors

At all three facilities there were supportive elements present in the environment used by residents and staff (c.f. Appendix K: REIS and ATOSE report to Facility 1, Appendix L: REIS and ATOSE report to Facility 2, Appendix M: REIS and ATOSE report to Facility 3). These included communal rooms that were sunny and inviting, smaller spaces that promoted engagement with people and the environment, culturally-appropriate vintage pieces and décor that facilitated reminiscence, and personalised cues which promoted orientation and belonging. Other features included assistive devices which ranged from basic to more sophisticated devices, and structural features of the environment which contributed to the safety and wellbeing of residents.

b) Leadership promotes a collegial support system

Examples were mentioned of one of the facilities' inclination to consider staff needs. Staff at Facility 3 specifically mentioned the pleasure they experienced from a new cafeteria where they spend their lunch and tea times:

“This space offers respite to staff members who previously did not have access to a tea or lunch room. It is a beautiful space with lockers,

couches, TV, dining tables and chairs, a boiler, microwave, kettle and fridge [REIS notes, Facility 3]

Facility 3 also provided office staff with a free afternoon once a month. This motivational incentive was appreciated by the office staff. Moreover, Facility 3 had the financial means to fund an active wellness program for staff, which included paid-for visits to a general practitioner, assistance with health devices such as glasses and hearing aids, access to medication for lower-income staff members and a weekly exercise class.

The nominal group discussion provided an opportunity for leadership staff members from different facilities to interact and discuss the enablers and barriers to implementing the REIS and ATOSE findings. They experienced the process as positive, and provided acknowledgment and encouragement to each other. They could also exchange ideas, creating a collegial support system, even though it was only for a short period:

“So bek moet jê m kry”⁹ / “Such words are like music to my ears”
[NGT data collection notes]

“How will one ensure a positive outcome for all parties involved?”
[NGT data collection notes]

c) Successful Person-centred care approaches

Despite the predominant biomedical model of nursing care directing the care culture in the facilities, there were examples of successful person-centred care approaches that indicated that staff realised the uniqueness of residents and considered the individualised needs of residents:

“We must understand that it is their home, we work in their home, if I can say it such” [NGT data collection notes]

“It’s not my legs doing the walking... it is as if (with the REIS and ATOSE reports) someone opens your eyes” [NGT data collection notes]

“It’s absolutely true, every person is unique... and if I know that then I can understand the residents much better” [NGT data collection notes]

⁹ Afrikaans statement made in recognition and approval of another’s statement or action.

d) Interest in the process of culture change

Leadership staff showed an interest in the process of culture change by enquiring whether feedback will be received on the final results of this research project (c.f. Appendix O: Discussion group codes). Additionally, they were curious about the other facilities' results and requested an opportunity to discuss the challenging process of culture change. Despite limited understanding of the core concepts of person-centred care, the facilities had aspirations to promote the dignity of residents. Facility 2, for example, plans to divide a seven bedroom into smaller private rooms. Additionally, at one facility staff presented meaningful leisure activities on an individualised basis to residents, breaking down the activities step-by-step to promote better engagement in the activities.

4.4.2 Occupational justice issues

The second theme of the combined narrative data analysis were distinguished by two categories, namely *supported* and *unsupported areas of wellbeing* and their sequential codes. Below, an overview of each category and associated subcategories is presented.

4.4.2.1 Unsupported areas of wellbeing

The findings suggested that residents' domains of wellbeing were unsupported due to issues arranged into three subcategories relating to occupational justice: *a) social isolation and disconnect*, *b) their disregarded identity and personhood* and *c) limited opportunities for meaningful stimulation*.

a) Social isolation and disconnect

Residents at the facilities were isolated, and mostly only had access to fellow residents in their respective units. Few visitors and community members entered the communal spaces to spend time with residents (c.f. 0). Although residents had access to staff employed by the facility, there was little social and spontaneous engagement between them other than having formal interaction through the physical care relationship they shared, as indicated by the ATOSE findings and relevant observational notes of all three facilities.

In some corridors residents calling out to care staff were often not acknowledged while staff were passing by. Despite repetitive actions, such as calling out to someone, residents' needs and personhood were often not acknowledged.

At one facility, a few residents were isolated in a dedicated dementia wing. Staff from the particular facility suggested that residents whose behaviour towards staff had become demanding, should also be moved to the separate dementia wing. People living with

dementia experienced occupational marginalisation as staff had segregative care expectations due to the residents being labelled as *'difficult to handle'* or *'they have dementia'*.

Staff seems very concerned with their own needs (and comments from staff during interviews allude to the idea that) not necessary to improve circumstances of residents [Reflective notes, Facility 1]

Apart from operational staff's limited tolerance for people living with dementia, some residents displayed condemnation of these residents due to the fear and lack of knowledge regarding the pathology.

The disregard for residents' dignity were particularly present for residents living with dementia. These residents often need more care, which is done in a task-oriented manner at a suitable time for care staff. Moreover, residents with dementia do not always have the ability to voice their dissatisfaction with the assistance and care they received. In many cases they do not even recall such instances:

"Most residents sitting with eyes closed" [ATOSE narratives, Facility 1, 2, 3]

Wandering, a common behavioural symptom associated with people living with dementia, was often not treated with the necessary urgency to validate the person's need at that moment. Due to poor cognitive abilities, residents with dementia cannot always voice their needs, and as a result experience occupational alienation.

Residents, especially those living with dementia, display repetitive and haphazard behaviour, and staff often interpret this as a lack of engagement in social and occupational activities.

Two residents specifically presented with repetitive behaviour - continually looking at their watches and repeating the same comments every day.

[ATOSE narratives, Facility 1]

Residents' behaviour included aimless wandering, being restless and discussing either their health or the visitors and staff entering the communal spaces. The staff's presence elevated the awareness of residents, and they enjoyed the time that staff took to interact with them,

even if only in passing. Residents sought connection and interaction with other residents and staff.

[Resident] calls student nurse and checks student's name badge. Clear that she seeks social interaction with the staff specifically (as she is a younger resident and at times seems irritated with other residents; behaviour in the communal lounge) [ATOSE narratives, Facility 3].

One resident displayed a need to care for a fellow resident throughout the three-day observational period, despite receiving no acknowledgement or feedback. She would continually comment on the resident's appearance, facial expressions and basic needs:

'Moet ons nie jou jersey uittrek nie?'

"Should we not take off your jersey?"

And:

"I loves you so much", 'jou gesiggie lyk so helder vandag"

"I love you so much, your little face seems so bright today"

b) Disregarded personhood and identity

Residents displayed many signs of having occupational imbalances in their daily activities and routines. Very few structured or informal activities took place in this room during the three-day period, and none of the activities were facilitated by staff members. At Facility 2 the community service occupational therapist and physiotherapist, as well as two volunteers, facilitated participation in leisure activities. At Facility 1 there were no structured activities, except bible study, which is an extended service of the DRC. Facility 3 employed an occupational therapist who coordinated a therapeutic service. No care staff, however, were involved in any recreational or leisure activities in the observed corridor as indicated by the ATOSE recordings of Facility 3.

Limited meaningful stimulation was a recurrent observation at all three facilities. The routine and people in the space remained relatively monotonous, and the people living with dementia were generally more non-engaged than those living without dementia.

Often residents would be observed sitting with their eyes closed or falling asleep. Some residents attempted to combat their boredom by adopting behavioural patterns such as taking their seat at the dining table 60 to 90 minutes before the meal was to be served.

Can you believe it is only quarter past three? It's a long day, huh?

[ATOSE observations, Facility 3]

Residents at Facility 1 preferred an unofficial communal area close to the facility entrance where passive engagement with the environment was possible, as opposed to a designated lounge a few metres away. This particular area provided stimulation as there was a constant influx of people moving about. Residents observed to be mostly non-engaged seemed indifferent to this form of stimulation as it could be experienced as overwhelming, resulting in sensory overstimulation and residents subsequently disengaging.

At all three facilities residents experienced limited privacy, having their dignity disregarded and interactions based on a care task focus:

(Carer) brings (resident) into communal room and assists her to the chair.

She has pyjamas on (time 14h30)... carer takes off pants of resident in lounge area, seemingly forgotten to take off her pants when undressing into pyjamas [ATOSE narratives, Facility 3]

At all three facilities residents mentioned limited space in their bedrooms, and reminisced about objects and sentimental pieces they had to leave behind when moving into the smaller spaces of the live-in rooms of the facility. These residents' reflections on moving from their homes to a long term care-facility demonstrate the negative impact of having to part with personal belongings that had been important to them.

c) Meaningful stimulation disregarded

Traditional care routines resulted in residents being alienated from previously meaningful and important occupational roles and routines. These included activities such as dressing and making a cup of tea. In all three facilities staff worked according to a 'bath list', which indicated the day residents were assisted to bath or shower. In one instance this institutional feature i.e. a bath list negatively influenced a resident's mood and experience of the activity:

Resident went for bath, screaming at staff, facial expression somewhat unhappy... Should be noted that the corridor in which observations was done has a weekly bath list [ATOSE narratives, Facility 3].

Staff complained of time constraints. During informal interviews as part of REIS observations, some operational nursing staff at Facilities 1 and 2 suggested that more care staff should be employed. In most instances a care approach of 'doing-for' residents instead of 'doing-with' residents was recorded [c.f. Appendix K: REIS and ATOSE report to Facility 1, incident mentioned where staff brushed residents' teeth directly following dinner to ensure they can leave shift on time]. This emphasised the occupational alienation that residents experienced as they became accustomed to staff doing basic tasks for them, such as taking tea cups to the kitchen and discarding a banana peel.

Many residents were oblivious to their own needs. They were unable to identify areas for improving the facility or daily life within the facility, during the REIS assessment:

“Many answers were vague and reverted back to their (residents’) basic needs being met such as commenting on the nice food the kitchen makes, staff being good to them etc.” [Researcher’s reflective notes, Facility 1]

At Facility 2 there are only two black residents, of which one is an elder and one a younger resident with intellectual impairment. Activities did not meet the residents' occupational needs, as the cultural focus and language in which activities were presented were not matched with these residents' abilities and interests.

“She makes a lot of noise (comment about younger resident who is intellectually impaired)... that is why we close the (bedroom) door or she sits outside in the garden” [REIS observations, Facility 2]

Tea time, a potential culturally meaningful activity to promote occupational and social engagement, was reduced to a mere 15-minute hydration task. At all three facilities it was observed that tea time elicited the most engagement and interaction, but residents were alienated from natural steps in the activity, such as pouring themselves tea, adding sugar and milk, and stirring the cup. What transpired during tea time was staff pouring tea from a large industrial-size tea pot and serving residents while they were seated on a couch.

Volunteers requested the assistance of the researcher to motivate more residents to participate in the activities that they facilitate. One resident, despite being irritated and not wanting to actively participate, stayed in the communal room as a passive participant. Volunteers' well-intended activities were not presented well, due to an infantile approach to

the residents and not taking into account various levels of functioning. This prohibited rather than encouraged the participation of the residents.

From the researcher's perspective this specific group will not be appealing to residents functioning on a higher level of ability. Reasons being: the facilitation from the volunteer is a little childlike, little to no flow during the group activity, little spontaneous interaction, and few elements of enjoyment (noted) [REIS notes, Facility 2]

Despite the availability of many sitting nooks and outside areas in all three facilities, many of the residents chose to spend most of their time in their bedrooms. Only a small number of residents used the communal spaces and spent time outside of their rooms. This was interpreted as residents feeling disconnected from the physical and social environment.

4.4.2.2 Supported areas of wellbeing

Many findings suggested that residents' domains of wellbeing are not always supported at the participating facilities. Despite this, indicators of wellbeing were also acknowledged and supported. The category of areas of wellbeing supported was subcategorised as a) *meaningful stimulation enabled* and b) *social inclusion and connection*.

a) Meaningful stimulation enabled

All the facilities were investigating opportunities and resources to provide more meaningful stimulation to residents on a daily basis. At Facility 3, the care partners working in the dementia home provided opportunities for residents to continue with domestic tasks such as folding laundry and washing dishes. Additionally important self-care activities were presented in manageable chunks, which facilitated increased participation. One such example was able-bodied residents having the opportunity to dish up lunch for themselves, with staff merely observing for safety precautions (burning from the bain-marie), or ensuring that residents dish up a healthy portion.

b) Social inclusion and connection

Other situations indicated that there are relationships where camaraderie is experienced by both residents and staff.

Staff member asks (residents in communal lounge area) if she can open window [ATOSE narratives, Facility 3]

And:

Resident joking with the carer about 'kicking her' (both laughing and seemingly enjoying the interaction) [ATOSE observations, Facility 3]

In contrast to the other facilities, dedicated care partners working in the dementia unit at Facility 3 create the opportunity for residents and staff to build positive and trusting relationships with each other, and supporting their experience of security in the relationship. On the other hand, the other sections in the facility do not allocate dedicated care partners, and this hindered the camaraderie between staff and residents. Staff often could not identify the specific needs of individual residents, and residents couldn't identify the carers working in the unit. Some residents verbalised their preference for a specific carer, often waiting for assistance in specific tasks until their preferred care worker was on shift.

4.5 Conclusion

In this chapter the findings of the research project were presented in three sections. The first section presented the findings of the ATOSE and REIS assessments at each facility. These results indicated that there are many similar approaches, routines and environmental features at each facility which present barriers for residents and staff to be active and autonomous stakeholders toward experiencing meaningful engagement within their environment. Section 2 presented the findings of the focus group discussion directed by the NGT. The data presented in section 2 of this chapter indicated that leadership staff did not fully consider the enablers and barriers to implementing the findings of the REIS and ATOSE assessment tools as presented in the report to each facility. They rather used the opportunity during the nominal group to discuss operational challenges within the respective RACFs. The final section, section 3, presented the qualitative thematic analysis of all narrative data, which was grouped into two themes, i.e. organisational culture and occupational justice issues.

In Chapter 5 the major findings of this study will be interpreted, discussed and triangulated with relevant literature. The significant literature sources which inform the discussion chapter are occupational science and long-term residential care culture change theory and models.

5 Discussion and Recommendations

5.1 Introduction

The purpose of this mixed methods study was to investigate the operational applicability of the REIS and ATOSE as assessment tools within Engo affiliated RACFs. This chapter includes an interpretation and discussion of the major findings as presented in Chapter 4, which were organised into two distinct but connected themes, namely **organisational culture** and **occupational justice issues**. These two themes are explored within the scope of the assessment tools' feasibility, specifically the applicability, acceptability and practicality of the REIS and ATOSE as assessment tools for i) the Engo organisation and its current position within its culture change journey, ii) the occupational therapy profession in SA, and iii) the scope of occupational therapy in the aged care sector.

5.2 Overview of the key findings

True to the nature of qualitative research, the study evolved in response to the input from the participants. After the reporting on the residential environment and occupation and social engagement (phase 1), the researcher had a group discussion with the leadership staff from the facilities. The aim of this discussion was to gain insight from the participants regarding the applicability of using the two tools. The participants, however, redirected the focus to discussing common operational obstacles. It was clear that the participants focused on issues associated with the current organisational culture and care culture within the Engo RACFs, rather than directly addressing the applicability of the REIS and ATOSE assessment tools as per the study's original aim.

The findings of the first phase of data collection (c.f. Appendices K, L, M), the REIS and ATOSE assessments completed at facilities, suggested a number of occupational injustice issues that needed attention. The physical and social environments in the Engo RACFs were inadequate to support resident and staff wellbeing. Furthermore, the institutional and bureaucratic behaviour within the organisational culture negatively impacted a collective approach between staff, within the historically *a priori* construed hierarchical system, and residents. It was apparent that the Engo RACFs experienced passive resistance towards culture change, and limited opportunities to discuss operational challenges toward culture change. This seemed to extend to prohibiting, and in essence, re-directing participants'

considerations during the second and final phase of data collection. During this phase the following issue was considered: to what extent “*Are the Residential Environment Impact Scale (REIS, Version 4) and the Assessment Tool for Occupation and Social Engagement (ATOSE) applicable assessment tools within identified Engo Residential Aged Care Facilities in South Africa?*” The data from the second phase of data collection were indicative of how the current culture of care in Engo RACFs was not receptive to interpreting, reflecting and effectively using the opportunities identified by the REIS and ATOSE results (c.f. Appendix O: Discussion group codes, Appendix N: Expanded grid of coding).

The following section (c.f. 5.3) discusses the findings aligned with the three objectives of this research study put forward in Chapter 1 (c.f. 1.7: Research objectives). The findings of the REIS and ATOSE assessments are interpreted and discussed with a specific focus on the occupations and social engagement of the staff and residents of the participating Engo RACFs (objective 1). The researcher discusses the social actors and factors of the key stakeholders in the RACFs toward illuminating whether the REIS and ATOSE provide applicable and practical feedback to the facilities (objective 2) and to discuss the perceptions of leadership staff regarding the enablers and barriers of the REIS and ATOSE (objective 3)

Section 5.4 and 5.5 proposes the integration of the community-centred practice framework (Hyett *et al.*, 2018), participatory occupational justice framework (Whiteford & Townsend, 2011) and the domains of wellbeing of the Eden Alternative (illustrated in Figure 5.1), as a collaborative process from which the findings of this research study can be interpreted. Additionally, the researcher proposes this as an evidence-based approach in which RACFs can be guided on their culture change journey.

5.3 The community's care culture identity: clients; their occupations, barriers, resources and enablers

One of the greatest failures of the biomedical model is our tendency to treat the body when people suffer from diseases of the spirit (Power, 2010: 49)

Although the community-centred practice framework distinguishes the community's identity and occupations as separate entities, the researcher chooses to discuss them conjointly. This is done as the findings indicated that historically construed hierarchal systems of the aged care system and the unique political situation of South Africa, designated the stakeholders in the RACF specific roles. The community-centred practice framework describes a community as encompassing a range of social actors that are broadly categorised in one of four groups: individuals, groups, organisations and networks (Hyett *et al.*, 2018). The Engo organisation and its history and characteristics should therefore be viewed as a social actor. Management and leadership staff (as a group) is another social actor, operational staff (as a group) is a social actor and residents (as a group) is also categorised as a social actor.

5.3.1 The Engo organisational culture as barrier/enabler to implementing the REIS and ATOSE findings

The findings of investigating the applicability of the REIS and ATOSE within an organisation who is still embarking on their culture change journey, indicated that many of the current operational features do not allow for the recognising and valuing of the findings of the REIS and ATOSE as assessment tools. In the preceding chapter, the operational features of the organisation were presented. The predominant biomedical care culture, standing in the way of organisational culture change, was the significant organisational trait of Engo RACFs. This was seen in institutionalised attitudes, behaviours and routines of residents and staff in addition to the lingering hospital-like environmental features. The daily operations and routines at the RACFs were monotonous, and did not vary significantly from one facility to the next or from one day to the next. There were many indicators of boredom and a lack of spontaneity by residents and staff. Repetitive behaviours such as continuously checking a wristwatch or commenting on how slow time passes were normal behaviour in communal lounges.

Collectively, services at all participating RACFs were compartmentalised, i.e. kitchen services, cleaning services and nursing services. Each service made sure that specific tasks were completed, which were subsequently executed in a clinical, task-oriented manner. The Engo RACF community's social fields were consequently compartmentalised, with each social actor enacting specific prescribed roles. Residents mostly spent their time passively in the communal areas, either aimlessly walking or looking around, engaged with an individual activity such as knitting (if they had the occupational capacity to do so), or spending time alone in their bedrooms. These routines are characteristic of a traditional care culture that erodes meaning by using generic and cost-effective approaches to daily life. In this way elders become dependent on carers and experience limited autonomy in their daily lives (Power, 2010: 45, 52).

Occupational justice in Engo-affiliated RACFs is limited and fuelled by an organisational culture which is not conducive to enabling meaningful occupational participation between residents and staff. The operational features of Engo RACFs were characteristic of a top-down management approach and a biomedical care culture, which dominates the organisational culture of the facilities. Undoubtedly, such an organisational culture causes many occupational injustices which within Engo RACFs. These injustices manifest themselves through a disregard of residents' identity and personhood, especially residents with dementia being socially isolated, and meaningful stimulation disregarded.

In all societies the dominant culture defines which stakeholders become valued and which become marginalised (Whalley Hammel, 2008: 62-63). Occupational justice implies that people have equal and adequate access to occupational opportunities. However, in practice all people do not experience occupational justice, as marginalised groups are perceived as having less social, cultural, political and economic value than the dominant group (Gupta & Garber, 2010). Within the research setting, residents of Engo RACFs can be viewed as the non-dominant group, and management and operational staff exert power over them.

In discussing and interpreting the organisational barriers and enablers of Engo RACFs, it is imperative to recognise that the organisational culture consists of social actors and factors, and are greatly influenced by the individual residents and staff, who apart from being unique and complex human beings, have various contexts considering the political history of South Africa and obviously do not have a singular lived experience. The barriers and enablers to implementing the REIS and ATOSE assessment tools therefore need to be deliberated from

the perspective and contextual delimitations of the key stakeholders. These include the management/leadership staff, organisational staff and residents, who constitute the human resource component of the Engo organisation. These categories will therefore be discussed from their standpoint, guided by the theoretical perspectives mentioned in the introductory section of this chapter and discussed in chapter 2 (c.f. The community-centred practice framework and The participatory occupational justice framework).

5.3.2 Social actors and their factors: leadership staff

Insight into the disposition of the Engo organisation and history is essential in positioning the operational features hampering culture change within the scope of investigating the applicability of the REIS and ATOSE. The findings of the operational features, as presented in Chapter 4, shed light on Engo and its managerial approach, as a somewhat decontextualised organisation, out of touch with residents' and staffs' needs. Perhaps it can be argued that much of the observed decontextualisation may be attributed to the perpetuation of taken-for-granted historical patterns. These are often undergirded by organisational reflection that is delimited by a historical frame of reference, and which enables the continuous reproduction of certain taken-for-granted ways of thinking, speaking and doing (Foucault, 1966; Rauch van der Merwe, 2019). Nevertheless, the findings indicate that Engo RACFs, perhaps almost in a Protestant vein (Pierce, 2003: 58–63; 39–49), generally make do with limited human and non-human resources, often to the detriment of residents and staff. It cannot be ignored that despite the challenges associated with the care industry, Engo RACFs need to remain financially viable within the developing economy of South Africa, and perhaps even more so with the compounded global economic pressures on account of the 2020 COVID-19 pandemic.

The history of the Engo organisation as a religious social service in the Apartheid era of South Africa

The history of Engo documents the first social service by the DRC in the Free State province in SA, established in 1902, following the Anglo Boer War. The primary goal of this service was to provide in the needs of orphaned children. In 1953 this social service was formalised, mainly providing to the physical and social needs of poor, white Afrikaans-speaking South Africans. From 1967 the service was referred to as the *Sinodale Kommissie vir die Diens van Barmhartigheid* (Sinodical Commission for Social Services) and from 1990 the service was merely referred to as *NG Maatskaplike Dienste* (NG Social Services) (Engo, 2020). In the 1990's, NGOs rose to international prominence as two differentiated services. Firstly, as

services to people in need and secondly, for policy advocacy and public campaigns in pursuit of social transformation (Lewis, 2010). In 2013 the organisation's name was changed to Engo, as introduced in Chapter 1 (c.f. 1.3) and detailed in Chapter 3 (c.f. 0). The name change did not affect the mission of the organisation, and its focus remain on the "planning, coordination and facilitation of social services in order to enhance the social welfare, care, development and treatment of individuals, families, groups and communities in the Free State" (Engo, 2020).

However, Engo's history as a faith-based social service, which was organised by the DRC to benefit poor Afrikaners, needs to be critically viewed within the political context of the apartheid era of SA in order to interpret the modern-day significance on aged care facilities and the people living and working in these facilities. It is the researcher's opinion that in acknowledging this, greater insight and perspectives on the neo-liberal agendas of the operational staff and the top-down inclination in managing Engo RACFs, are gained by both the researcher and the reader.

Afrikaner nationalism was once equated with Christianity and developed, to a great extent, due to British oppression and authority in SA, following the colonial period. This manifested in protecting the Afrikaans language, and the Afrikaner culture and economic wellbeing at all cost. This eventually led to segregative policies between the minority white and majority black people living in SA, a governing period known as Apartheid (Van der Westhuizen, 2007: 12, 56, 183). During apartheid the DRC policies and practices were aligned with the government ideology of segregation, and the church received financial support from the government to set up social institutions such as hospitals and old-age homes (Kgatla & Magwire, 2015). It is the researcher's assumption that many Engo RACFs in the Free State province originated from the entanglement of State and Church during Apartheid, which set the tone for some of the disabling operational features that were found in this research project.

In an extended vein of the welfarist ideology of religious organisations, the work undertaken by NGOs are usefully divided into three categories by Lewis (2007) as that of implementer, catalyst and/or partner. The implementer role, as adopted by Engo, is concerned with service delivery and the mobilisation of resources (Lewis, 2010). In RACFs the mobilised resources are usually concerned with reducing the health risks of elders.

The influence of historic political and societal assumptions on modern-day operations in Engo RACFs

The REIS category of *enabling relationships* suggested that a degenerative and diseased operational cycle was present regarding day-to-day operations at the Engo facilities. Residents often feel marginalised by operational care staff (*“I’d rather not say anything”* and *“they don’t want to help us”*) (c.f. Appendix N: Expanded grid of coding). Care staff feel unappreciated and unheard by management (*“you are not my people”* and *“the door is open”*), and management staff are inundated with administrative duties. This prohibits them from spending time with residents. One of the institutional operational hallmarks of nursing homes are a “top-down decision-making hierarchy” (Power, 2010: 51), which is detrimental to facilitating and promoting growth and volition of staff members. The Eden Alternative golden rule prescribes that “as management does onto staff, so staff will do onto elders” (The Eden Alternative, 2010: 25, 174). Management of Engo RACFs felt disconnected from the culture of care. They remained mostly confined to their offices, and blamed time constraints as the main factor for being and feeling disconnected. The findings of the top-down managerial approach and the subsequent injustices experienced by residents and operational staff, affirms the golden rule of the Eden Alternative in an unexpected way. Similarly to management’s top-down approach to operational staff, operational staff were disconnected from residents’ needs. They often treated them and their needs as just another task to be completed, serving the biomedical care culture.

Furthermore, the conceptualisation of aging in modern society, especially aging viewed as a debilitating disease, determines the quality of service delivered and the attitudes of staff and their behaviour towards residents (Engel, 1977). The paternalistic and institutionalised environment in aged care facilities is a result of aging being viewed as pathological. The care of elders then begin to revolve around their illness and inabilities (Power, 2010). Fisher *et al.* (2017) rightly point out that although the environment can provide opportunities and resources, on the other hand it might also have debilitating consequences for individuals. In particular, institutionalised aged care environments often over-compensate for residents’ care needs by providing too much assistance and support, overwhelming residents and rendering them helpless (Fisher, Parkinson, & Haglund, 2017: 68). Two of the categories of the REIS assessment that investigate the level to which relationships are enabling, is *enabling respect* and *empowerment*. At Engo RACFs, organisational and management staff often referred to residents as *“our residents”*. Although probably proclaimed to indicate

tenderness and care for the residents, the findings of the REIS and ATOSE assessments, rather indicate a sense of 'possession' in two ways. In the first, residents are viewed and treated as a business commodity. In the second, residents are no longer treated as equally valued adults, but framed within a paternalistic episteme, as 'children' who are no longer able to reason as adults, and who are no longer able to make autonomous choices like adults (Causey-Upton, 2015; Power, 2010; The Eden Alternative, 2012). Support, respect and facilitating independence through enabling relationships are therefore not enabled at Engo RACFs. This was indicated by the facility scores in this category of the REIS, which were mostly 2/4, indicating limited empowerment of residents and the environment generally interfering with their identity and capacity, as presented in the MOHO (Kielhofner, 2008).

Moreover, the general limited awareness and disregard of residents' needs (other than their physical needs) by most staff at Engo RACFs, supported other findings which suggested an intense focus on a biomedical approach to aged care (c.f. 4.4.1a). The predominant biomedical care culture is a common international phenomenon in aged care settings. Residents are treated as business commodities, which in the case of RACFs transpired as *residents equates patients*. This is in dire contrast with a person-centred care approach and the culture change movement. It speaks to the biomedical model adopted by RACFs, and which is still deemed to be the best indicator of sound health care. Since the mid-1990's there has been an international drive towards introducing culture change in aged care facilities (Sharkey, Hudak, Horn & James, 2010). However, a regimented nursing care focus remains dominant in South African residential care homes (Du Toit & Surr, 2011; Thomas *et al.*, 2014), as is the case at Engo RACFs.

Culture change is the common name for a global initiative focused on transforming care for elders and individuals living with different occupational capacities in long-term care. Culture change advocates for a shift from institutional models of care to person-centred values and practices that put the person first. Through a person-centred approach, decisions and actions around care honour the voices and choices of care recipients, and those working closely with them (The Eden Alternative, 2012: 3). The WHO defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (World Health Organization, 2018), and endorses healthy aging as a basic human right of elders (World Health Organization, 2002). The definition of health was entered into force as part of the WHO constitution in 1948, and yet in 2020 still, the results of this research project indicate that many residents in Engo RACFs do not experience holistic health.

Person-centred care in Engo Residential Aged Care Facilities

The institutional operational culture is always efficiency- and time-driven, and culture change is viewed as something to be done, a task to be completed (Power, 2010: 52 ; Du Toit *et al.*, 2019; Grabowski *et al.*, 2014). While discussing the findings of the REIS and the ATOSE during the discussion group, leadership staff were hesitant about their understanding of the concept of culture change and person-centred care. They were constantly seeking recognition and acknowledgement from the researcher and group facilitator about comments or statements that they made. The researcher perceived this as the leadership staff viewing her, as the employed occupational therapist who continuously advocated for person-centred care, as the sovereign power of knowledge and understanding person-centred care and culture change. Alternatively, their response could also be seen as an extension of a paternalistic culture. Management had an automatic response of adding training opportunities to address some suggestions of the REIS and the ATOSE findings documented in the reports. An international investigation of leadership staff's perception of person-centred care, which included South African participants, found that they generally do not trust subordinate staff to promote and expand person-centred care (Du Toit *et al.*, 2020). Although residential facilities might claim to 'do' person-centred care, the understanding of person-centred components are usually limited (Du Toit & Buchanan, 2018).

Although one leadership staff member referred to "PCC" (an acronym commonly used to refer to person-centred care), she could not elaborate or interpret what it meant. It was apparent that the management of the RACF had been exposed to the concept of person-centred care and culture change, but in voicing their frustration with failed attempts of introducing change, it was clear that their approach showed lack of knowledge. This failed attempt of creating an inclusive environment and facilitating a care culture and a social and physical environment that empowers residents and staff was supported by the findings of the REIS and ATOSE. Although the *everyday space* did include homelike qualities, as all three facilities scored 3/4 in this category, the structure of most activities and the meaningful and enabling relationships between all stakeholders at the facilities were inadequate to promote a culture of person-centred care. The statistical data of the ATOSE indicated very low levels of staff and resident interaction, as the percentage of staff presence in communal areas ranged between 5, 74% (Facility 1), 1, 41% (Facility 2) and 4, 31% (Facility 3).

Person-centred care and culture change are not and cannot be viewed as a task to be completed, but starts with a personal transformation. A paradigm shift towards viewing

elders as meaningful human beings who can contribute within their environment is the first step in this transformative journey. Leadership staff need to guide operational staff on this transformative journey, which requires positive professional relationships (Du Toit *et al.*, 2020).

The term '*seeing white*' was first introduced by Nelson (2007) when she explored the cultural significance and worldviews of the therapist and the client, and the implications of this on the therapeutic process. '*Whiteness*' does not necessarily refer to skin colour, but rather to the ideologies of Western culture as a form of ethnocentrism, where knowing, thinking and experiencing the world is based on a Western belief system (Owens, 2010: 194). The notion of leadership staff suggesting training (giving knowledge to improve quality of service) is perhaps indicative of how their '*whiteness*' are embedded in the managerial approach followed as part of the operational culture of Engo RACFs.

The lack of collectivity between management and operational staff and the role of class politics in an already fragile environment, present a threat toward introducing culture change in Engo RACFs. Recognising and becoming aware of one's own epistemological and ontological assumptions, and how they influence the way in which you '*manage*' a facility such as a Residential Aged Care Facility, and how key stakeholders are affected by it, is crucial in becoming aware of personal convictions and the maintenance and reproduction of operational barriers towards culture change. Institutional injustices extend beyond subconscious racism between management and operational staff. It encompasses the power imbalances between management, operational staff and residents, and may ultimately cause occupational injustice to each of the stakeholders. (Du Toit *et al.*, 2020; Dwyer, 2011; Paul-Ward, 2010).

Scholars such as Rudman (2005) and Galvaan (2015) have powerfully illustrated that occupation is a transaction with historical, political and cultural forces. This was corroborated by the findings of this research study corroborated. Examples include residents' reluctance to socialise with some nursing staff due to historical forces ascribing relationships between races, or expecting certain tasks to be performed by organisational staff as residents were accustomed to that. In addition, hegemony was defined by Gesler (1992) as ways in which a dominant group exert control over others by fostering ideologies that promote their own interest. Hegemony is often entrenched in the institutional culture of an organisation, and employers have a vested interest to maintain things as they are (Galvin & Wilding, 2010:

176, 177; Owens, 2010: 195). Patterns of hegemony that maintain the adverse operational culture of Engo RACFs are partly due to aged care services rooted within the biomedical model. Both the biomedical model and the preservation of Engo as a religious organisation of services, provided from a position of power, are stringed with e.g. paternalist sentiments (Engel, 1977). Power differentials shape social processes, and dominant ideology and practices associated with medical systems are often affected by authoritative ideologies outside of medical systems, such as religious or political systems (Paul-Ward, 2010: 311). The history of the DRC and its previous political attachment might shed light on how the Engo organisation has subconsciously refrained from entering a dialogue of promoting collectivity between all stakeholders in order to collectively fight the “institutional monster” (Power, 2010: 50).

5.3.3 Social actors and their factors: operational staff

Mapira *et al.* (2019) investigated the policies and structural factors which influenced and created the adverse experiences of ground staff care workers¹⁰ in long-term residential aged care facilities in Cape Town, South Africa. The findings of their study suggest that aged care workers’ experience derive from a lack of clear policies and structural context of care-giving in the aged care sector in SA, as illustrated by Hoffman and Pype (2016). Role ambiguity, restricted opportunities for potential for career growth, employment conditions, work-related stress and the subjective experience of being unappreciated negatively impacted on care workers’ motivation, and their abilities to cope with the demands of long-term aged care. The authors suggest that this presents barriers to implementing quality long-term care (Mapira *et al.*, 2019). Although investigating care worker satisfaction was beyond the scope of this study, findings from the REIS and ATOSE assessments suggest that staff experience dissatisfaction and marginalisation in certain aspects of their jobs. Additionally, residents alluded to inconsistencies in staff skills, and the researcher’s interactions with staff suggested inadequate expertise to performing a holistic care service, as person-centred care would entail, specifically to residents living with dementia.

An essential element of quality long-term aged care, such as care in residential facilities, is a competent aged care workforce (World Health Organization, 2017). Despite the regulations and policies set forward by the South African Health and Safety Sector Education and Training Authority to provide training and support for aged care workers, no

¹⁰ The term ‘ground staff care workers’ in the referenced literature refers to nursing caregivers in long-term aged care facilities in Cape Town.

standardised training programmes exist for aged care workers. The South African Department of Social Development's Policy on Social Service Workers was proposed in 2013 to regulate care work, develop an occupational framework and establish a regulatory body for care workers, but this is yet to be implemented (Mapira *et al.*, 2019). This results in caregivers, and specifically aged care workers, being subjected to unregulated conditions of service, unclear professional mandates, and non-standardised practice.

Caregivers' experiences occur at three levels. On a micro level it refers to their caregiving context, on a meso level the organisational context and their broader societal context, and finally on a macro level, the policy and structural context of the sector in which they work (Ananias & Strydom, 2014; Mapira *et al.*, 2019; Schiamburg *et al.*, 2011). In addition the socio-economic barriers experienced by many operational staff, there are also personal barriers, which certainly influence their experience of their daily occupations, including the experience of their job (Du Toit, 2012; Innes & Surr, 2001; Thomas *et al.*, 2014).

Systemic influences on the interdependence of operational staff and residents

Care staff have a constant impact on the lives of residents in long-term aged care facilities, and are therefore the key stakeholders to successfully introduce culture change to promote the wellbeing of elders (Thomas *et al.*, 2014). However, the high unemployment rate of SA, currently estimated to be 29,1% (Statistics SA, 2020) and the perceived low skills level needed to perform care work, establish an aged care workforce who, in the researcher's opinion, *do* the job but do not necessarily *enjoy* the job. In the latest edition of *Occupational Therapy without borders: Integrating justice with practice*, Bailliard and Aldrich (2017: 85) confirm the notion of having a political orientation. This is the ability to recognise occupational injustices as a result of understanding that everyday occupation is political, and shaped by decisions and power relations that structure society. Many South Africans are employed as care workers without the necessary training as they, as employees, are desperate for any work, while employers are able to maintain financial viability of the organisation by paying employees the minimum wage.

Thomas (1996), the pioneer of the Eden Alternative, likened the *institution* and its practices to "*a dragon sleeping in the corner*", referring to a persistent, almost threatening, presence that guides care decisions. The *institution* stretches beyond the physical structure of aged care facilities. It encompasses three elements – the physical, operational and interpersonal (Power, 2010: 50).

The personal convictions of an institutional operational culture are often the least visible but can potentially do the most harm (Power, 2010: 54) as it refers to the mind set and beliefs of the employees based on an ageist frame of reference (Kitwood, 1993), perpetuated by the biomedical model (Engel, 1977). The personal convictions of the operational staff at Engo RACFs became apparent during informal interviews and observations investigating the environmental factors of the homes. Residents were divided into two distinct, albeit illusive groups, either needing full assistance with care tasks or no assistance at all. There was no room for any deviation between these two imposed groups, and caregivers labelled residents accordingly. Consequently, activity demands were not always a “just-right-fit” for residents. This paternalistic perspective causes further disablement and sets in motion a cycle of functional deterioration, which feeds into the biomedical care culture. Based on a reading by Andrews (1999) on apartheid in nursing, Rauch van der Merwe (2019: 212) remarks on the reification of paternalism within the biomedical model in South Africa:

“... the Victorian trinity of the strict medical doctor (father), the nurturing, submissive ‘para-medical’ female health carer (mother), joining together in maintaining their authority over the ignorant and child-like patient”

Systemic barriers such as government policies exert power over certain populations and communities (Gupta & Garber, 2010; Paul-Ward, 2010). It could be argued that the paternalistic perspective of staff at Engo RACFs is a result of the limited recognition and support of aged care in the South African context. It might also be the result of inadequate policies to promote wellbeing in residential facilities in addition to the perceived low social standing of people working in this sector (Mapira *et al.*, 2019; World Health Organization, 2017). Managers and leadership staff at Engo RACFs, mostly white people, were inclined to only ‘seeing white’ (Owens, 2010: 194) and expecting operational staff to conform to their Eurocentric viewpoint (Owens, 2010: 195, 198). This included suggesting clinical training of operational staff to improve the injustices identified in the REIS and ATOSE reports. Operational staff experienced marginalisation by leadership staff, which was evident in a comment made to the researcher suggesting that the manager of the facility views operational staff as disposable and easily replaceable. The political history of South Africa and the oppression of black people, many of whom are still experiencing social injustices as a result of apartheid policies in addition to the marginalisation in the workplace, might explain the neo-liberal agendas displayed by operational staff, such as being concerned with their own needs rather than the needs of the elders they care for (Sakellariou & Rotarou, 2017).

Institutionalisation creates a pathological care system which has a particularly negative impact on carers, often causing burnout, helplessness and isolation (Horton, 2005). In Enago RACFs, the operational staff, who for the most part were caregiving nursing staff, displayed unfavourable attitudes towards management, their working circumstances and facilitating occupation-based care. Staff's primary concerns were based on understaffing, underpayment, experiencing racial marginalisation, and frustration dealing with responses from people living with dementia, as previous studies by Du Toit & Surr (2011) and Du Toit *et al.* (2012) also found. A cultural gap became apparent regarding caring for a vulnerable group. Staff seemed content and satisfied with the institutionalised care culture focusing on providing physical nursing care for 'helpless, old' residents, but dissatisfied with the care culture that did not serve their personal needs, such as management having executive power. Some residents picked up on this attitude (c.f. "they don't want to help us"), as found in a research study conducted in Cape Town with community-dwelling elders (Kelly, Mrengqwa, & Geffen, 2019). Operational staff expected their working conditions to be considered by management, as there were many factors with which they were unhappy. They themselves, however, afforded little to no consideration to the living conditions and quality of life of the residents they cared for. Staff were either disengaged from the individual needs of residents, unsure what their needs and wants were as they had not previously considered it, or implied that they did not see the point of changing the circumstances of residents, as the residents were old and satisfied with what they had.

Residents in long-term aged care facilities depend on care staff to engage in everyday activities. The frustration that staff experienced transpired in behavioural patterns of spending time ineffectively, mostly on private cellular phones, socialising with each other while disregarding or merely supervising residents, being unavailable to tend to residents, and inconsistencies in their level of skills. Authors have advocated for collectivity and the concept of interdependence, which might create conditions for collaborative practice with elders and reduce frustration (Mondaca *et al.*, 2019). During Apartheid in SA, black people often worked in a servant capacity, especially black women, who worked as domestic servants in the homes of white middle-class women. Staff's frustration and expectations could be interpreted as a neo-liberal agenda to experience equality in modern-day society. However, this agenda hampers collectivity, and in order to create culture change, researchers have increasingly focused on staffing practices (Du Toit *et al.*, 2019; Thomas *et al.*, 2014). Mondaca *et al.* (2019) suggest creating opportunities for dialogue to mutually

influence and develop new understandings about interdependence so as to transform everyday practice. Perhaps in following a similar approach in Engo RACFs, a conversation about past political and current occupational injustices can be started, and might provide insight of how the injustices are connected with and influence each other, and how these still influence current care practices.

Engo's care culture creating occupationally unjust conditions

Although culture change in RACFs does not necessarily promote or refer to a racial transformation of the facility, one cannot deny the influence of the individual lived experiences of employees from marginalised racial groups on the process of care culture change. Unfavourable attitudes and neo-liberal agendas, as elaborated on above, of operational staff at Engo RACFs, present barriers to culture change. Acknowledging that operational staff are also imprisoned by occupational injustices due to socio-economic and political factors, provides the researcher with a better understanding of why occupational therapists working in long-term care need to adjust their practice in order to effectively and collectively influence staff in the aged care sector.

Occupational therapists and scientists need to ensure contextual conditions that provide possibilities for elders to participate in meaningful occupations within their unique communities or contexts. This can only be done by being politically aware of power and societal relationships that create and sustain occupational injustices (Rudman, 2015). Facilitating participation in occupation is largely the responsibility of carers, who have the most contact with residents and ample opportunities to facilitate engagement in meaningful activities, such as ADL. The occupational choices of black people were limited because of Apartheid policies. Occupational choices are co-constructed through their transactional relationship with the context (Galvaan, 2012: 153,154), which historically, were shaped by the segregative policies of SA. One could argue that many black people were/are victims of structural violence, a theory within critical medical anthropology which describes constraints of one's potential because of political and economic structures (Winter & Leighton, 2001). The result of this is unequal access to education, economic security and political participation (Paul-Ward, 2010: 312). Attempting to facilitate the occupational participation of residents in long-term care via operational staff, needs to be reconsidered. This should be done by firstly attempting to understand occupation from the perspective of operational staff, taking into consideration current cultural and previous political influences. Investigating the perceptions and experiences of their own occupations and that of institutionalised elders,

might afford occupational therapists a better understanding of why carers often have an inclination to 'do for' rather than 'do with'. The perceived lack of status of operational nursing caregivers (Mapira *et al.*, 2019) and aged care workers in general, is not only present in South Africa but extends on an international level. It remains a stumbling block within the aged care sector, even in developed economies. The care of older people is generally not seen as an attractive career path, and has been referred to as a 'Cinderella service' because of resource constraints leading to impoverished elder care environments (Kydd & Wild, 2013). The poor remuneration of nursing home workers, and experiences of being understaffed, have been documented (Cornwell, 2012; Mapira *et al.*, 2019).

Resource constraints

A supposed lack of, human (indicated by operational staff, suggesting a need for more care workers) and financial resources (indicated by leadership staff during the discussion of the REIS and ATOSE) at Engo RACFs created a regimental focus on maintaining order and enabling organisation. The central conviction of institutionalised operations in RACFs is employees of the organisation placing tasks before people (Power, 2010: 52). The management of the Engo RACF indicated that they spent little time with residents. However, during the discussion group, leadership pertinently pointed out that the REIS and ATOSE assessments do not consider the financial position and constraints of the facility, which they regarded as a negative element of the assessments. Although finances remain a crucial issue for aged care facilities, the discussion surrounding financial constraints was interpreted by the researcher as leadership trying to find absolution for maintaining the care culture as status quo.

Some interactions between residents and staff confirmed camaraderie in the relationship between the two parties, and residents' behaviour showed increased awareness when staff interacted with them while domestic tasks were done. Residents were often observed to seek connection and interaction with staff, even superficially, by making a joke or calling out to them for no particular reason. This supports literature that suggests that care staff have the greatest potential to influence the social and occupational participation of institutionalised residents (Thomas *et al.*, 2014).

Despite situations and examples where residents' domains of wellbeing were supported, the situations in which residents' domains were unsupported were paramount. This confirmed and illustrated how the operational features in Engo RACFs present a barrier to a person-

centred culture change. The ability to engage in ADL is closely linked to the experience of wellbeing, especially for people living with dementia, and it can reduce the care burden and care burnout experienced by care staff (Mondaca *et al.*, 2019; Woodbridge *et al.*, 2016). Although this research project did not intend to explore caregiver burnout, the results suggest that care staff are unmotivated, bored and ultimately their domains of wellbeing are not supported within their working environment. Motivation, growth and development of staff are critical when attempting to create nurturing environments for staff and residents. Leadership needs to take responsibility for promoting and creating such an environment (Du Toit *et al.*, 2019; Thomas *et al.*, 2014), which Enjo RACFs are not actively working towards at this stage.

5.3.4 Social actors and their factors: Residents

In institutionalised and task-oriented long-term aged care environments, the personhood of residents is often disregarded (Kitwood, 1993; The Eden Alternative, 2009; Thomas, 1996). Loneliness, helplessness and boredom have been identified as the three plagues that corrode the human spirit, and are often associated with aging in long-term care facilities (The Eden Alternative, 2009). The negative effects of institutionalisation are even more prominent for residents with moderate to advanced dementia, as they have a diminished capacity to make others aware of their needs (Du Toit, Böning & Rauch van der Merwe, 2014; Du Toit, Shen & McGrath, 2018). An institutionalised care culture often cascades down to residents in the form of learned helplessness.

At the Enjo facilities, residents were inclined to discuss their medical health issues. The phenomenon of learned helplessness was evident in their interaction with care staff. As one example, witnessed by the researcher, a resident called out to a carer to discard a banana peel for her, despite having to wait for quite some time for the carer, and having the capacity to actually do it herself. Care partners have a substantial influence on ensuring that residents experience doing, being and belonging, which promote their right to meaningful engagement (Townsend & Wilcock, 2004). The theory of learned helplessness was first explored by Maier and Seligman (1976), who found that organisms quickly learn when the outcomes of specific situations are not affected by their response. They often become seriously debilitated by this knowledge (Maier & Seligman, 1976). In RACFs, learned helplessness is often the result of task-oriented staff doing *for* residents, rather than *with* residents (Du Toit & Van der Merwe, 2013). Residents feel powerless, in effect, resulting in them adopting and even embracing the role of *patient*.

Providing opportunities to participate, albeit not necessarily completing all steps independently, provides a sense of achievement and autonomy for residents, confirming their identity, acknowledging their personhood and positively influencing their experience of wellbeing (Du Toit & Van der Merwe, 2013; Du Toit *et al.*, 2014). At Facility 3 there were instances when operational care staff facilitated engagement in activities in manageable chunks. However, these observations were overshadowed by the general approach of staff at Engo RACFs of doing tasks for residents, instead of motivating or facilitating independence. From an occupational science perspective, this practice of doing *for* the residents, rather than *with* the residents, is an example of how the form and function of domestic activities that residents should be doing for themselves become distorted and lose meaning. The American 'Well Elderly' study by occupational therapists Clark *et al.* in the 1990's employed the use of customised individual lifestyle redesign plans, through which participants were facilitated by occupational therapists to creatively use occupation in a personalised manner to adapt to the age-related obstacles which they faced. The findings of the large-scale study indicated that preventative occupational therapy is effective in reducing the health risks of elders and improving their quality of life. Additionally, the findings indicated that by using occupational science, innovative occupational therapy practice is promoted, which is based on science and not mere empirical data or clinical experience (Clark *et al.*, 1991; Jackson, Carlson, Zemke & Clark, 1998). Occupations occur within defined socio-cultural settings, but are modified by the persons doing the occupations, as past emotional and personally defined systems of meaning bring a personal dimension to the occupation (Jackson *et al.*, 1998). For many of the residents living at Engo RACFs, domestic ADL or environmental management is a personally meaningful occupation, as many of the female residents' main occupation was running a household and tending to domestic tasks. When residents are unintentionally deprived of such activities, usually by staff who are perhaps unable to identify the personal meaning of it, a valuable occupation is lost.

By adopting a life-course perspective (Paul-Ward, 2010), the same phenomena, such as some behavioural patterns of residents (e.g. calling out to a staff member to discard used coffee cups) or refusing to participate in occupation within their means (such as staff mentioning that they wash the residents from head to toe because the residents expect it) can be ascribed to the social structures which shaped elder residents' occupational participation earlier in their lives. Policies which were in existence during Apartheid might

explain why white elders, the majority racial composition of elders at Engo RACFs, expect organisational staff, from a majority black racial composition, to do activities for them as they are 'old and paying their salaries'. Comments such as these were perceived by the researcher to have an immensely negative impact on organisational care staff, as it was mentioned by many operational staff members at the participating facilities. This has the effect of dividing organisational staff and residents, rather than promoting collectivity.

The organisational care culture of Engo RACFs are institutionalised and aggravated by a deficient national aged care system where elders are marginalised. The 2012 United Nations Report (United Nations, 2012) on Human Rights of Older Persons called international attention to the plight of older adults being vulnerable to abuse and exploitation and the many social and economic disadvantages that elders face. Internationally, but even more so in South Africa, there is a low priority to investigate and promote health and wellbeing policies for elders, specifically institutionalised elders (Barney & Perkinson, 2016: 483; World Health Organization, 2017b). Systemic issues make culture change much harder to address, and in South Africa there are layers of these which permeate the care culture from a national level all the way down to the interaction between care staff and residents.

The right to occupational participation is a human right (Townsend, 2015; Townsend & Wilcock, 2004; Wilcock, 2006), and occupational participation is necessary for healthy aging, which is a human right of elders (World Health Organisation, 2017; 2018). As institutionalised elders are often restricted from participating in meaningful occupations, as the data suggests is also the case at Engo RACFs, occupational therapists are challenged to research the occupational disparities and injustices prevalent in the communities in which they work. An individualised therapy approach will not suffice, and occupational therapy practice needs to expand to include community-based interventions, which explains a growing interest in issues of social and occupational justice.

5.4 Setting the scene for interpreting the findings: Engo Residential Aged Care Facilities as communities

All three participating Engo RACFs experienced similar challenges with regards to operational features presenting barriers to culture change and occupational injustices as experienced by staff and residents. The similarities experienced in the respective facilities require consideration and interpretation of the findings at a community-level for social,

cultural, political, economic and environmental determinants. The researcher synthesised the findings generated by the REIS and the ATOSE, and interpreted these as part of a collaborative process that incorporated the fundamental concepts of the community-centred framework (Hyett *et al.*, 2018), the participatory occupational justice framework (Whiteford & Townsend, 2011) and the domains of wellbeing of the Eden Alternative (The Eden Alternative, 2012). By employing this integrated approach (illustrated in Figure 5.1), the therapist can use evidence-based research to guide RACFs on their culture change journey and create elder-centred communities.

Dovetailing with the concept of community as introduced in chapter 2 (c.f. Residential Aged Care Facilities as communities), the community-centred practice framework and participatory occupational justice framework along with the domains of the Eden Alternative was introduced in the literature review (c.f. 2.8.2). The following section (c.f. 5.4.1) provides an overview of how the researcher drew upon the fundamental concepts of each framework, and merged the concepts and frameworks to create a process (Figure 5) to discuss the findings of this research study and answer the research question, and possibly provide a structure for future research and evidence-based practice.

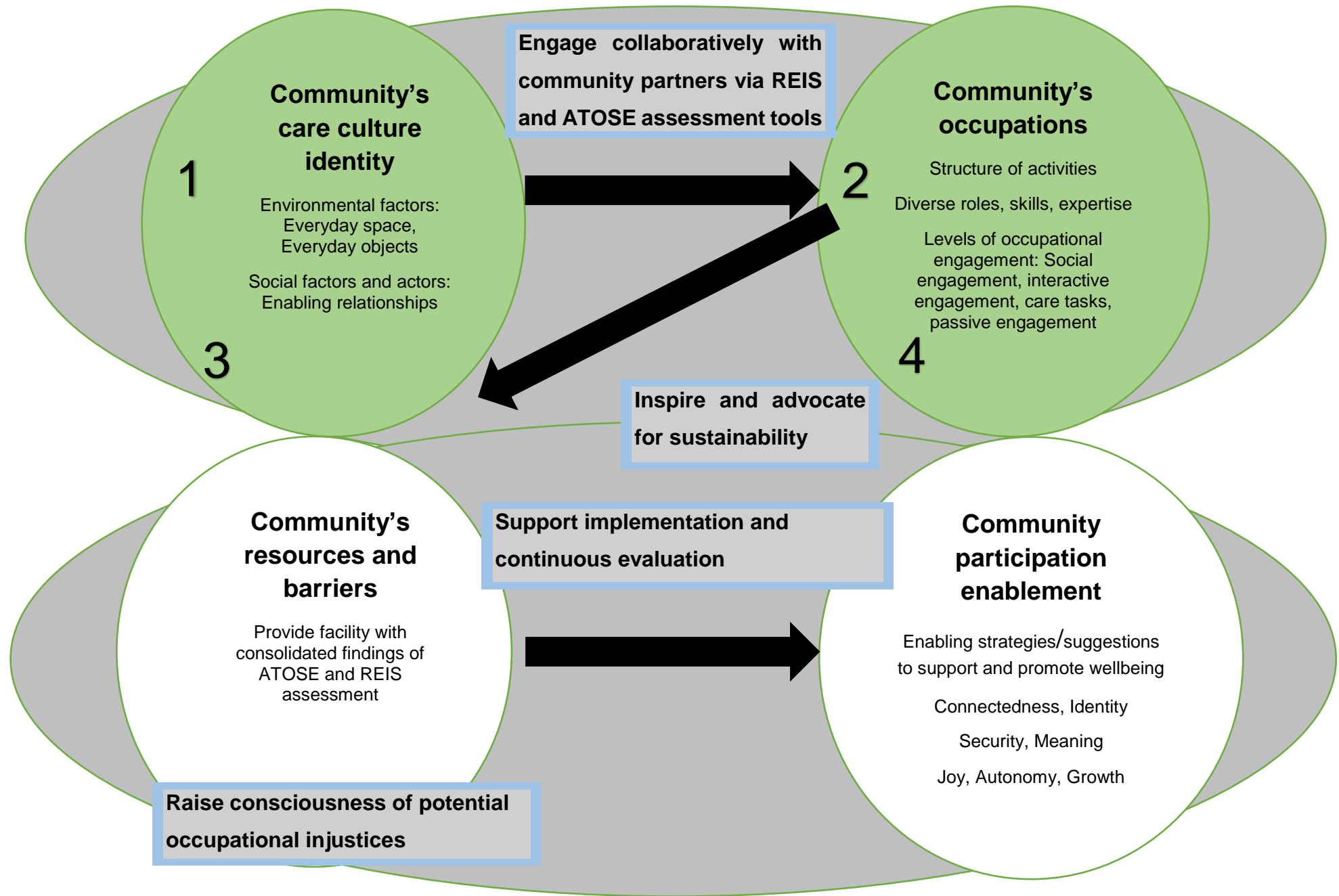


Figure 5.1: Collaborative process of guiding organisational growth using the REIS and ATOSE tools

5.4.1 The REIS and ATOSE as assessment tools to facilitate organisational culture change

This study identifies both the REIS and ATOSE as potential practice-based enquiry assessment tools that could map occupational injustices, promote occupational justice as an outcome of occupational therapy intervention, and guide organisational culture change through a collaborative, enabling process with the stakeholders of an elder community.

Promoting wellbeing, the ultimate outcome of culture change in aged care, can be regarded as facilitating occupational justice within communities, such as RACFs, as both occupational justice and wellbeing require a consciousness and critical reflexivity of enablement. Enablement is a core competency of occupational therapy, and enablement means that occupational therapists use participatory and empowerment-oriented strategies to work with people and organisations (Whiteford & Townsend, 2011: 68). Occupational therapists must be critically aware of power distribution within communities, as successfully enabling participation requires access to power and influence (Hyett *et al.*, 2018). It also calls for partnerships over hierarchical relationships (Whiteford & Townsend, 2011). Power distribution extends between the stakeholders within communities but also includes the power relationship between the therapist and the community. However, Whalley Hammel (2013) argues that enablement “implies a hierarchical relationship in which the powerful allow opportunities and bestow abilities on the powerless” (Whalley Hammell, 2013: 175). This prompted the researcher to critically examine and reflect on her practice as an occupational therapist, and also on how research regarding vulnerable populations such as elder communities are presented. This was done so as to not contribute to further marginalisation, or unknowingly indulging societal and academic ageism.

In this research study the findings indicated that the Engo organisation’s operational culture was mostly geared towards a top-down management approach and biomedical care practices of operational staff. This dissuaded collectivity between the various stakeholders of the RACFs and resulted in an occupationally unjust care culture (i.e. care culture identity). By employing the community-centred practice framework, these predominating characteristics could be identified as the community’s *identity*. It would be futile to discuss the findings without embracing a collective lens. Although the REIS and ATOSE are collective assessment tools that provide information about the extent to which the environment (physical and social) enables residents of aged care facilities to experience wellbeing in their daily lives, the researcher required an integrated framework to adequately

position and discuss the findings that would be mutually beneficial to all stakeholders of the RACF.

This was the reason for the integration of the community-centred practice framework, the participatory occupational justice framework and the Eden Alternative domains of wellbeing, as illustrated in Figure 5. By shifting the focus from residents as the primary clients/beneficiaries of this research study, towards comprehension that the facility, as a community albeit in complexity, is the client, might advance the profession's capacity to provide useful intervention strategies for aged care facilities.

This chapter is organised in three sections, as per the fundamental concepts of the community-centred practice framework. The community's **care culture identity** and the **community's occupations** will be discussed in conjunction with the community's **resources and barriers** (c.f. 5.3), as found by the REIS and ATOSE assessments and the findings from the discussion group regarding the REIS and ATOSE findings. The concluding section of **community participation enablement** (c.f. 5.5) will serve as the recommendations for occupational therapy practice.

The community refers to the RACFs that participated in this research project. The findings of this study, generated by the REIS and ATOSE assessment tools, will be integrated with these four concepts, while the researcher will continually interpret and discuss the findings by drawing upon the participatory occupational justice framework. In addition, the researcher also draws upon critical race theory, the life course perspective, and elements of critical medical anthropology to understand, interpret and discuss the findings.

5.5 Discussion regarding community participation enablement using the REIS and ATOSE

As the participatory occupational justice framework was central in guiding the discussion of findings in this chapter, the researcher connected the last concept of the framework, i.e. community participation enablement to discuss the use of the REIS and ATOSE as tools to enable community participation and promote occupational justice in RACFs.

5.5.1 The role of occupational therapists in Residential Aged Care Facilities

Internationally, the scope and focus of occupational therapy practice in RACFs remains largely on individual intervention and specifically dementia care. The goal of occupational therapy in residential aged care settings, to date, has been to maintain and enhance the

ability to perform ADL and maintain participation in social and other meaningful activities, in addition to training and support of nursing care staff to promote co-occupation (Du Toit, Shen, & McGrath, 2019; Se Yun, Eun Young, Min Ye, Park & Park, 2012). Co-occupation, a concept original to occupational science, was initially introduced by Pierce and Marshall (2004) and refers to the interdependence and reciprocity of occupations of two or more people. Du Toit *et al.* (2018) critiques the practice of therapists where co-occupation is generally only facilitated between staff and residents, and there is an opportunity to promote co-occupation between residents themselves. The systematic review by Se Yun *et al.* (2012) regarding the efficacy of individual occupational therapy interventions such as sensory stimulation and performing functional activities, revealed small effects on the behavioural challenges experienced by people living with dementia in long-term RACFs. Occupational therapy practice is underpinned by the assumption that quality care can only be provided if it is person-centred, and observational tools to investigate the person-centred approach to residents' occupational patterns, affect and social interaction are frequently used in RACFs (Du Toit *et al.*, 2018).

Assessment tools and occupation-specific models available for use by occupational therapists are confined to an individualised scope of practice (Du Toit *et al.*, 2019). Dementia Care Mapping (DCM) is one such modality used by occupational therapists. DCM captures the process and outcomes of care as experienced by the individual resident, and is associated with the person-centred care approach. The efficacy of DCM as an assessment tool has been documented (Innes & Surr, 2001; Du Toit *et al.*, 2012; Surr *et al.*, 2020). The approach of DCM remains focused on the individual experience, however, and there has been a growing critique of person-centred care as unattainable within the limited resource constraints of most RACFs (Harding, Wait & Scrutton, 2015) and not acknowledging the agency of people living with dementia (Birt, Poland, Csipke & Charlesworth, 2017; Boyle, 2014). Townsend (2015) and Du Toit (2019) emphasise the need for occupational therapists to be critical of our practice with elders and aging communities, and have a more strategic and comprehensive approach to elder residential populations. Changing the occupational therapy focus of practice to collectively promote social and environmental change in aged care settings can influence policies, and ultimately facilitate the process of moving beyond the current socio-political definition of aging (Barney & Perkinson, 2016).

Occupational therapists are typically not employed in South African aged care facilities, and geriatrics is generally not a field that therapists choose to explore and upskill themselves in,

especially in a global south/developing economy context, due to the focus on primary healthcare. As the occupational therapy profession struggles to solidify an approach that distinguishes itself from other, less expensive, therapeutic modalities in RACFs (Du Toit et al., 2019). Research needs to focus on evidence-based practice to facilitate collective approaches in facilities that support person-centred care, and ensure the longevity of occupational therapy in partnership with RACFs, an endeavour supported by the World Federation of Occupational Therapists (WFOT) identified research priorities (World Federation of Occupational Therapists *et al.*, 2017).

The WHO is advocating for holistic health to be recognised as being primarily concerned with how people take charge and agency of their health. This is a client-centred approach which enables people to experience wellbeing, and is congruent with occupational therapy values of meaningful engagement (Cockburn & Trentham, 2002). In order to address inequalities, occupational injustices and promote health and wellbeing for all in RACFs, occupational therapists need to influence the elder community's societal values by illuminating the importance of citizen partnership (agency), equity (occupational justice), quality of life and social inclusiveness (Cockburn & Trentham, 2002; Du Toit *et al.*, 2019; Galvaan & Peters, 2017;). Citizenship for people living with increased care needs, such as elders in RACFs, is defined by self-determination, participation and contribution. Adopting a citizenship model of care obligates stakeholders of elder communities to ensure that vulnerable elders are not deprived of opportunities to engage in meaningful occupations (Causey-Upton, 2015).

5.5.2 Residential Aged Care Facilities as communities and the existing opportunities for occupational therapists to adopt a collective approach within these communities

Occupational therapists are irrevocably challenged to take on a political perspective of the profession's contribution to these communities, which is an approach deeply rooted in occupational justice (Bailliard & Aldrich, 2017; Galvin & Wilding, 2010; Owens, 2010). Continuing to provide occupational therapy in RACFs based on an individual needs basis "fails to champion systemic change which means that social and environmental conditions of people with disabilities are not improving..." (Hocking & Mace, 2010, : 229). Providing individualised occupational therapy within a micro-community such as an Enego Residential Aged Care Facility, distinguished by an occupationally unjust organisational culture, is counterproductive and ineffective. There are increased opportunities for occupational

therapists to strengthen their practice in community settings (Hyett *et al.*, 2018; World Federation of Occupational Therapists, 2019; World Federation of Occupational Therapists *et al.*, 2017).

Central to the participatory occupational justice framework is the assumption that occupational therapists should be catalysts to enable occupational justice, but that the professional service provided by therapists should only be temporary. Work in communities and employing an occupational justice approach should be committed to explicitly point out population inequities and power relations, and focus on adapting environment structures so that the ultimate occupational justice outcomes are empowerment, social inclusion and participatory citizenship (Whiteford & Townsend, 2011).

Community-centred practice is characterised by practice with communities (not *in* or *on* them), necessitating partnership and collaboration (Hyett *et al.*, 2018). Townsend (2015), for example, introduced the proactive construct of *societal enablement* versus *caregiving* for application to elders who are not able to live independently. Caregiving implies a state of dependence, while societal enabling implies support services or measures to enable maintained occupational participation (Barney & Perkinson, 2016; Townsend, 2015). Adopting an *enablement* mind set, supported by a community-centred approach, reduces the power that occupational therapists undoubtedly exert over elder communities. Enablement is recognised in the occupational therapy profession as being part of a continuum. Effective enablement empowers and serves transformative change, while ineffective enablement reinforces co-dependant behaviour, which includes dependence on professionals such as occupational therapists (Whiteford & Townsend, 2011: 68).

Unlike DMC and other individual-based assessment tools, the REIS and ATOSE generate findings that can be applied to the community at large. The ATOSE and REIS assessment tools provide therapists with a modality to focus on collective factors that discourage and hinder occupational justice. It offers occupational therapists, specifically those that practice within the South African aged care sector, an opportunity to strengthen their professional practice and provide RACFs with findings which can promote co-occupation, agency and the wellbeing of key stakeholders in their communities.

5.5.2.1 The ATOSE as instrument to promote occupational justice

The ATOSE was developed to investigate the impact of the environment in real-time on occupation and social engagement, and has mainly been used and investigated, as

proposed by the author, to quantitatively judge the success and failure of environmental adaptations in a pre- and post-adaptations evaluation process (Morgan-Brown, 2014). The quantitative results portray a clear picture of how residents actually spend their time, and the extent to which they are engaged. For the purpose of this research project, the ATOSE was not used as a comparative tool before and after environmental changes. Morgan-Brown supported the research team to design a template to record narratives for supporting codes that would be used for an additional narrative analysis.

The results of this study indicated high levels of engagement in the communal areas designated to the researcher for observation (c.f. 4.2.3, 4.2.5, 4.2.7). Facility 1 scored 79.32%, Facility 2 scored 85.44% (lounge) and 54.68% (seven-bedroom unit) respectively, and Facility 3 scored 60.8%. These quantitative statistics, however, do not necessarily provide a true reflection of all residents' levels of engagement, as the thematic analysis of supportive narratives paints a picture of many occupational injustices and poor collectivity between stakeholders of the community.

The discrepancy between the quantitative data and the qualitative narrative analysis is due to the fact that the communal areas were not used by all residents at the facilities, and it became apparent that the same residents used the area day after day. The statistics do not account for residents spending time in their rooms or in other parts of the facility, for example. Additionally, the quantitative data showed very few visitors and staff members spending time in communal areas, as was also found by Morgan-Brown (2018). When staff, volunteers and family members were present, it was only for short periods of time. In cases where they were present they were mostly occupied with goal-directed tasks, which presented a higher quantitative number for engagement levels. The qualitative data, however, indicate that staff left the communal areas as quickly as possible, that there was little collectivity between staff and residents, and that staff often sat around in other spaces which was not part of the observation area. The institutional biomedical care culture of Enago RACFs were evident by staff being occupied with professional tasks and the absence of family members due to the hospital-like atmosphere, similar to what Yamamoto-Mitani, Aneshensel and Levy-Storms (2002) found.

Management at the facilities identified the areas in which the researcher could do observations. It seems as if they purposefully chose the more appealing areas with regards to the aesthetics and residents who entered the space, confirming a top-down approach

where management attempted to exert power over the research process in order to control the contextual conditions in which the research was executed. This is an example of how the dominant group (management) controls the social and contextual factors, which became apparent during this research project (Gupta & Garber, 2010: 155). This influenced the quantitative statistics, which seemed to speak to a positive experience of occupational justice, but are in fact in contrast to what was found from the qualitative data. It was also in contrast to the researcher's experience and reflections, both during and after observations. This presents a risk factor toward achieving true occupational justice (Morgan-Brown, Brangan, McMahon & Murphy, 2018; Morgan-Brown & Chard, 2014). Moreover, the areas identified by management in which the researcher could execute the ATOSE assessment, were not the only communal areas in which residents spent time. The researcher had to add a brief observational period in a seven-bedroom unit at Facility 2 to quantify her informal observations, which were in stark contrast with that from the identified communal area, indicating much lower levels of engagement (54.68% vs 85.44% at Facility 2). Despite this discrepancy pointed out in the report to the facility, leadership staff did not interpret, question or reflect on it.

With Engo RACF management reflecting on the findings of both tools, the data was unsuccessful in showing the extent to which leadership staff view the ATOSE as a usable tool. One of the reasons why this is the case, is that the quantitative statistics and description of what happened in the communal rooms were not interpreted by leadership staff with the necessary earnestness. This might be due to them being accustomed to the status quo, not clearly understanding the significance of the ATOSE results, not having any previous data regarding occupational and social engagement to compare the ATOSE findings with, or the researcher's interpretation of the data in the reports might not have been sufficient in illuminating the occupational and social injustices observed by the researcher and experienced by residents. It seemed that management could not associate the levels of engagement with limited collectivity between residents and staff. Interpreting ATOSE results in the light of pre- and post-environmental adaptations might validate the quantitative data in a more central light.

5.4.2.2 The REIS as instrument to promote occupational justice

The main purpose of the REIS is to provide occupational therapists with a systematic measurement of the environment and the facility's capacity to support wellbeing (Fisher & Kayhan, 2012), specifically optimal functioning and occupational role development.

The feasibility of the REIS in the context of this study was not investigated with occupational therapists but rather with leadership staff of RACFs. As mentioned in the introduction of this chapter, during the discussion group the leadership staff reflected on the findings presented in the report, and not necessarily on whether recommendations could be implemented or how feasible they were. The REIS scores of the facilities ranged between 1 and 3, and no facility scored a 4/4 in any of the categories (c.f. 4.2.2., 4.2.4, 4.2.6). This indicates that the collective environments of the facilities need further deliberation and adaptation to ensure that the needs of residents and staff are met. Furthermore, the thematic data analysis indicated that the organisational culture of Engo RACFs are not receptive to considering the feasibility to implement REIS findings, as there are currently too many operational barriers. The opportunity to discuss the respective findings of the REIS, and reflect upon these with collegial leadership staff of affiliated Engo RACFs, did provide the staff with valuable reflective insights. Their experience of receiving the REIS findings in report format and participating in a discussion group was mostly positive and thought-provoking.

The REIS proved to be an ideal assessment tool to illuminate disabling physical features in Engo RACFs, which included many institutional trademarks such as long hospital-like corridors with centrally located nurses stations, call bells, shared rooms with little or shared cupboard space, large hostel-like dining rooms, large fluorescent lights throughout corridors and at one facility, prescribed hospital beds and curtain divisions.

The findings of the REIS contributed to a clearer understanding of the organisational culture and its influence on residents' wellbeing, as the method of assessment included observations and informal interviews with staff and residents. During the discussion, the leadership staff identified that the REIS does not account for a facility's financial position, and noted that as a weakness of the assessment. This confirms the top-down approach adopted in Engo RACFs, and confirms their limited knowledge about person-centred care. The passive resistance toward culture change in Engo RACFs and the business-like model that guides operations inhibits the immediate potential of the REIS tool.

5.5.3 Conclusion

Conclusively, the findings indicated that:

- i) Engo Residential Aged Care Facilities' current care culture is dominated by a biomedical approach to caring and a top-down management approach in

leadership, which renders an unreceptiveness to use the REIS and the ATOSE tools' findings,

- ii) the facilities' current operational procedures are not conducive to promoting occupational participation and quality of life for the residents. The information yielded by the REIS and ATOSE present many opportunities for an occupational therapist to provide a service to an aged care facility to address these injustices, and
- iii) when amalgamating the results from the REIS and ATOSE, and presenting these to an aged facility through a critical occupational science lens, the occupational therapist has the opportunity to strengthen her professional identity as a community partner and keep up with the international movement towards strengthening occupational therapy practice in all spheres of community life.

Power and justice lie at the heart of the dissonance that therapists and clients experience in society (Gupta & Garber, 2010: 155). Whiteford, Townsend, Bryanton, Wicks and Pereira (2017) suggest that the occupational therapy profession lacks power due to its perceived subordinate status to medicine and health systems. The findings at Engo RACFs suggest a predominant biomedical culture, and a resistance from the side of management to introduce culture change. This leads to occupational injustices to many of the stakeholders, including management themselves. This presents an ethical dilemma to the occupational therapist, as justice for her clients seems unattainable due to systemic influences. This might also shed light on why only a few occupational therapists choose to practice in long-term aged care.

The REIS and ATOSE assessment tools have the potential to support the occupational therapy profession in shifting the emphasis from an individual to a community approach. By focusing on collective participation, the health and wellbeing of residents will be promoted (Du Toit *et al.*, 2019). Disengaged and demotivated staff can also be prevented by including meaning and promoting occupational identity in daily care tasks (Du Toit *et al.*, 2019; Thomas *et al.*, 2014). When the occupational therapist partners with community stakeholders into weaving the experiences of joy, meaning, identity, growth, autonomy, connection and security (The Eden Alternative, 2012: 4–9) into the systems and practices of the community, wellbeing and meaningful occupation of all the social actors can be facilitated. Conclusively, occupational therapists practicing in long-term aged care, especially in the South African context, are provided with two assessment tools that can

solidify the therapeutic contribution of the occupational therapy profession and secure a consultation capacity to reclaim professional identity.

6. Conclusion and Recommendations

6.1. Introduction

Chapter 6 is the final chapter of this dissertation. The researcher concludes this dissertation by reflecting on the achievement of the research purpose as set out in Chapter 1 (c.f. 1.6 and 1.7). The researcher further reflects on culture change in SA and the Engo organisation, and make recommendations for implementing the findings of this research project. The researcher discusses implications for occupational therapy practice, and recommends future research topics relating to this project. The limitations of the research study are discussed, to conclude and reflect on the research approach and the trustworthiness of the study.

6.2. Answering the research question and objectives

This study's main purpose was to investigate the feasibility of the REIS and the ATOSE as occupation-based assessment tools yielding applicable results for Engo-affiliated RACFs. Three research objectives were addressed:

- 1) To describe and interpret the findings of the REIS and the ATOSE results obtained within the participating Engo RACFs.
- 2) To investigate whether the findings from the REIS and ATOSE can be synthesised to provide practical usable feedback to the participating Engo RACFs.
- 3) To investigate the RACFs leadership staff's perceptions regarding the enablers and barriers to the applicability of the REIS and the ATOSE.

During phase 1 of the data collection process the focus was on Objective 1. During this phase the researcher visited each of the three facilities for three consecutive days, administering the REIS and the ATOSE assessments at each facility. Objective 1 was met and the findings of the REIS and ATOSE are documented in Chapter 4 of this dissertation (c.f. REIS and ATOSE findings). These findings were succinctly composed into three separate reports provided to each facility (c.f. Appendix K: REIS and ATOSE report to Facility 1, Appendix L: REIS and ATOSE report to Facility 2, Appendix M: REIS and ATOSE report to Facility 3). The findings of the REIS, as presented in the reports, indicated that the environments of the three participating Engo RACFs were generally not promoting people's

sense of identity by providing enough opportunities, resources, demands and constraints to meaningfully engage in their environment. The findings of the ATOSE, as presented in the reports, indicated that residents spend the most time in communal areas, while staff and visitors rarely spend time in these environments. The findings further suggest that residents who are engaged are mostly occupied on their own. Additionally, the same residents spent time in the communal areas, creating quantitative statistics in the context of this study that are not representative of the entire residential community, as many residents cannot (on their own accord) or do not want to spend time in the communal areas.

Objectives 2 and 3 were explored during phase 2 of data collection, although data derived from the assessment period also informed the inquiry. A discussion group using the nominal group technique was employed to identify leadership's perceived enablers (objective 2) and barriers (objective 3) for using the REIS and ATOSE results as presented in Table 12 (c.f. Chapter 4) and detailed in the reports (c.f. Appendix K: REIS and ATOSE report to Facility 1, Appendix L: REIS and ATOSE report to Facility 2, Appendix M: REIS and ATOSE report to Facility 3). Leadership staff struggled to distinguish between the REIS and the ATOSE results, and hardly commented on the significance of the ATOSE results. The participants rather utilised the discussion group as an opportunity to discuss operational challenges. The factors that could have contributed to objectives 2 and 3 only being partly met, are;

- culture change as a collective priority in the Engo facilities is in its infancy. A much higher level of investment, if not a paradigm shift, is needed to promote a relationally-focused, person-centred approach between leadership and operational staff, and between all staff and residents.
- the organisational culture and top-down management approach suggested by the findings of this study, indicate that leadership staff are task-oriented and unconcerned with concepts such as occupation, participation and engagement, and did not give themselves adequate time to critically consider the results contained in the reports.
- the presentation of the REIS and ATOSE results in the reports were incomprehensible to the participants, and/or the participants did not have the capacity to fully consider possible barriers and enablers. This indicates a recommendation to consider the way in which REIS and ATOSE results are communicated.
- the question posed to the group might have been unclear or misinterpreted.

Despite objectives 2 and 3 not being illuminated directly as the researcher had anticipated, the findings of the REIS and ATOSE (phase 1) confirmed the limited insight of leadership as shown by the findings from the discussion group during phase 2 of data collection. Ultimately, taking into consideration the main research question on the one hand, and the purpose of the research on the other, (c.f. 1.5 and 1.6), the answer discovered in this study, are equally dual. On the one hand, yes, the use of the REIS and ATOSE are applicable as the results were significant, useful and practical. These tools are especially applicable, if we want to adhere to person-centred care and human dignity of older adults in RACFs toward social and occupational justice. On the other, considering the current culture change level of Engo RACFs and the insight of leadership staff, the REIS and ATOSE can probably not be used with impact as tools within the Engo organisation at this time, and are therefore not feasible for use within Engo facilities. The current organisational culture of Engo RACFs are dominated by a medical approach, mostly void of any person-centred care approaches. Along with limited collectivity and connectedness between staff and residents, culture change within Engo RACFs are in its infancy. So although the REIS and ATOSE have relevance and the possibility to promote and substantiate transformation, their feasibility are constricted.

6.2. Implications of the research

The findings that indicate the constricted feasibility of the REIS and ATOSE assessments have implications for occupational therapy practice in the South African context. This is however based on the presumption that the concept of culture change is discussed and negotiated with all key stakeholders of facilities prior to the assessments. This section will address the implications for the practice of occupational therapists working in aged care settings, by referencing and offering suggestions to Engo RACF.

6.2.1. Recommendations for occupational therapy practice in aged care settings

The Urban Dictionary, tongue in cheek, defines occupational therapists as follow:

“Among the most over-worked and beleaguered of the helping professions, occupational therapists tend to get stuck dealing with the problems that even the social workers can’t solve” (The Urban Dictionary, 2010).

This definition is clearly satiric. But perhaps by critically reflecting on it the researcher is also confronted with some hard truths. As the profession is inextricably linked with human rights

and social justice, occupational therapists, often attempt interventions to address contextual issues, as they are acutely prevalent (and relevant) in the aged care sector. This research showed that occupational therapists practicing in the South African aged care sector, however, need to tread thoughtfully and not rush in attempting to 'problem solve' organisational culture change issues that stem from a systemic culture that have not changed much over the years.

Occupational therapists have an important role to play in supporting the initiation, expansion and modification of quality residential facilities for elders (Fisher *et al.*, 2014; Fleming Cottrell, 2005). The residents of such facilities are often subjected to long-term care environments that limit autonomy and occupational choices, reducing elders to mere care recipients who are no longer active stakeholders in their communities. This was corroborated by the findings of this study, as presented in Chapter 4 and discussed in Chapter 5. Transitioning from a medical to a person-centred care and organisational culture requires personal transformation, which is pointless if not accompanied by physical transformation. Without personal transformation organisational transformation is unattainable. The REIS and ATOSE assessments will need to be preceded by "warming the soil" (The Eden Alternative, 2010: 28), within Engo RACFs for any transformative practice to be able to take place.

The Eden Alternative suggests that true culture change is never completed as it is an ongoing process that requires wise leadership, commitment and continued input. Thomas (1996) likens culture change to tending a garden. First the soil needs to be prepared (i.e. "warming the soil"), which includes the process of getting to know and trust the people who are with you on this culture change journey. Then, a seed can be planted (i.e. introducing culture change), and eventually the crop (i.e. successes and improved quality of life for staff and residents) can be harvested. However, to continue harvesting a healthy crop, the garden needs to be tended regularly and repeatedly.

The REIS and ATOSE are tools that can be used by occupational therapists to facilitate the second phase of gardening ("planting the seed" – introducing what needs to change). But the findings indicate that Engo facilities, and possibly other unaffiliated RACFs in SA, are not ready to commence with the second phase of culture change. By "warming the soil" and promoting an engagement culture in the facility and community prior to evaluating and presenting the results of the REIS and ATOSE, better understanding of the findings of the

two assessment tools and approaching the implementation of the findings might be effected. “Warming the soil” is a prerequisite for successful team building (The Eden Alternative, 2010: 166). Engaging with the aged care community to facilitate a deeper understanding of culture change might advance personal transformation of the key stakeholders in the community, without which culture change will never happen.

To legitimise their suggestions for modifying long-term care environments such as old-age homes, occupational therapists previously had to rely on their clinical observation skills and labour-intensive individual assessment tools to demonstrate how occupation or the lack thereof impacts health and wellbeing . The REIS and ATOSE present a newly created opportunity to use metrics in support of suggestions for environmental modifications, as part of an evidence-based approach for occupational therapy practice development. During this research project and the process of amalgamating and reflecting on the findings, the researcher was confronted with her own therapeutic practice and the assertion that occupational therapy practice in aged care in the South African context needs to be better defined, substantiated and re-directed. This must be done to ensure the sustainability of the profession in this sector. The REIS and the ATOSE are two tools that can determine the direction for the scope of occupational therapy practice in facilities, and provide the therapist with measurable outcomes and statistical evidence which are often more acceptable for other team members of RACFs.

6.2.2. Recommendations for future research

The findings indicated that the participants re-directed the focus of this study to discuss operational obstacles with the researcher. The assumption can therefore be made that certain concepts within South African RACFs, such as operational procedures and daily practices, need decisive further investigation. The research participants, as valuable partners in this research project, inspired the researcher to consider future research recommendations based on the two main themes; *organisational culture* and *occupational justice issues*.

6.2.3. Longitudinal possibilities

Engo will benefit from a larger-scale study by increasing the sample size of participating facilities. This would promote the transferability of findings to all Engo-affiliated RACFs and other non-governmental South African RACFs or facilities based on a comparable organisational model. In addition to the leadership staff of facilities, the management and

directors of the Engo organisation should be included in order to offer insight in how Engo's policies can be adapted to promote an organisational culture in support of culture change and holistic wellbeing . Furthermore, Engo, as an organisation, can build pathways to pioneer person-centred practice in all RACFs in SA, not only Engo-affiliated facilities. This has the potential to influence deficient national policies relating to RACFs.

If this study were to be replicated on a larger scale, the intricacies and complexity of the research process would require additional input from experienced researchers, which would in turn contribute to the reliability of the data and the validity of the study. The perceived enablers and barriers to implement the findings of the REIS and ATOSE were individually appraised by the individuals who participated in the nominal group discussion. The relevance of this study and the perceptions of facility representatives (i.e. leadership staff) might change over time, and continuous investigation could provide better insight into Engo as an organisation.

6.2.4. Recommendations for research relating to organisational culture

This research project was conducted in Engo-affiliated facilities that are exclusive to the Free State province. The opportunity exists to investigate the organisational culture of private facilities, non-governmental facilities and government-funded facilities. Investigating the organisational cultures of aged care facilities in the South African context on a larger scale with a specific focus on occupation and community-based practice, presents an opportunity for occupational therapy practitioners to advocate for national policies that enable continued occupational participation that would ensure the wellbeing of staff and residents and ultimately contribute to the 'decade of healthy aging' (c.f. So what now? The 'Decade of Healthy Aging') (World Health Organization, 2020). The following suggested research questions can be investigated, either as follow-up research within Engo or in other provincial/national facilities:

- What are the occupational patterns of residents and staff living and working in South African Residential Aged Care Facilities, and how do their occupations and the operational practices collectively contribute to the organisational culture?
- What are the significant occupational adaptations of elders transitioning from independent living to South African long-term aged care facilities, and what is the influence of the organisational culture on this

- To what extent does the organisational culture promote the occupational balance of the residents and staff living and working at the facility?
- Which concepts of community-centred practice and facilitating occupational participation are acceptable and feasible within South African Residential Aged Care Facilities?
- How can the results of the REIS and ATOSE tools be amalgamated with a community-centred approach to provide occupational therapy intervention in aged care settings that is useful and relevant?

6.2.5. Recommendations for research relating to occupational justice issues

This research project identified many occupational injustices, many of them as a result of the organisational culture experienced by staff and residents living and working at Engo RACFs. Findings indicate that operational and leadership staff are content with the operational status quo. Along with residents, all key stakeholders of the Engo RACFs are institutionalised and are not actively working towards addressing occupational injustices. The researcher is of the opinion that staff dissociate between daily operations and their tasks, and the responsibility of continuously practicing in ways that promote occupational justice, ascribing the pursuit thereof as another task to be done. The following research questions can be investigated to address this:

- What are the views of staff working in Residential Aged Care Facilities regarding the occupations of the elders living at the facility?
- What is staff's understanding of occupational justice?
- What are the opinions of staff regarding their responsibility in enabling occupational participation, and promoting occupational justice?
- How do staff and residents at the Residential Aged Care Facility perceive their level of occupational wellbeing?
- What is the perceived co-influence of staff and residents' occupations on each other?
- What is the perception of staff and residents regarding the influence of generational and racial diversity on their occupational options?

6.2.6. Recommendations for using the REIS assessment tool in practice

The researcher suggests that should the REIS be used exclusively, especially in larger facilities, the therapist should visit on more than one occasion, and on different times of the

day. Additionally, larger facilities should be evaluated per unit to provide the facility management with information and suggestions that would ensure that the goals for the specific unit are specific and measurable. The different sections of the REIS provides the occupational therapist with confined limits within which she can adjust goals to ensure their feasibility. The researcher spent more than the suggested three hours to gather enough information to ensure that the report is as comprehensive as possible. This idea is supported by the adapted Swedish version, REIS-S, which also suggests a longer time period for evaluation, specifically eight hours (Svensson *et al.*, 2018).

For the sake of assessment, the researcher recommends that larger facilities are subdivided and assessed per unit. In doing this, more accurate and specific information per unit can be provided in manageable chunks. If not done in this way, the collective report might be optimistically misleading and overwhelming, if management and leadership staff are not able to determine the relevance of collective information to specific units within the facility. Facility 3, for example, has eight different units, referred to as corridors that are separate from each other but still connected as a whole. During some activities, such as dining and recreational activities, the corridors integrate with each other. One corridor, the dementia unit of Facility 3, operated on principles of person-centred care, and so the environment as evaluated by the REIS is more supportive towards residents' needs. The score of this unit could have inflated the collective score of Facility 3.

6.2.7. Recommendations for using the ATOSE assessment tool in practice

The ATOSE provides therapists working in aged care with an occupation-specific assessment tool to embrace and take charge of the profession's niche to collectively influence human rights, occupational rights and citizenship in elder community settings. If utilised with authority and contextual insight, it positions occupational therapists to reclaim their expertise within RACFs. Application of a new tool often diverts the user from focusing on the potential contribution of the tool, as the focus is on following guidelines for collecting information.

Further development to ensure that it is a practical and user-friendly tool for occupational therapists from the get-go is suggested. In addition to the current structure of the ATOSE, the assessor should explicitly detail the immediate environment, apart from the area assessed, and provide a more detailed context on the residents and staff using the communal area and the rest of the immediate environment. In doing so, the data might be

more impactful, and eventually drive change towards more inclusive and enabling environments. The ATOSE has the potential to inform care planning with residents, if the data can, in addition to the collective, show how individual engagement levels are influenced by the environment. Additionally, a three-day period of observation was deemed insufficient in showing the extent to which engagement in Engo RACFs are monotonous and derived of meaning for staff and residents. Lastly, the researcher would suggest the ATOSE to be developed to ensure inter-rater reliability.

The ATOSE quantitative results need to be accompanied and interpreted with substantial and specific qualitative data. The researcher is of the opinion that a therapist who is familiar with the operational routines and policies of a facility would be able to provide a more contextual interpretation of the results, which in turn can prompt a greater appreciation for the findings. Additionally, being familiar with the environment prior to using the assessment tool will aid the contextual interpretation for the therapist. This is the case especially in facilities where the biomedical status quo regarding the organisational culture is accepted, as staff become accustomed to residents spending time in a passive manner.

The researcher is of the opinion that the ATOSE findings, specifically in the case of Engo RACFs, would carry more weight if the pre-adaptations and post-adaptations are presented in conjunction with each other. This is because it seemed as though senior Engo staff could not identify the significance of the findings in this research study where only one set of evaluations were done. It is important to note the number of residents and staff working and living in the unit, and to make a distinction between residents who spend time in communal areas and those who don't. Perhaps this might provide an opportunity to facilities with residents who are in serious need of additional support, to experience wellbeing and occupational justice.

Future research initiatives should focus on enriching the potential of the ATOSE by investigating the effects of higher engagement levels on other areas of occupation and performance patterns throughout the day, and ultimately its influence on the levels of care required by residents.

The REIS and the ATOSE can be used more meticulously in Engo facilities. Staff and residents can be involved more actively throughout the process to ensure complete transparency of the findings. This might set in motion the process of community members facilitating and being in charge of their own wellbeing and healthy aging.

6.3. Limitations of the research methodology

6.3.1. Adequacy of the sample size

Only three of the 17 Engo-affiliated aged care facilities that met inclusion criteria participated in this study. One of the reasons is that annual audits are done by the Director of Engo's Aged Care Services at each affiliated facility, and the researcher's initial contact with facilities indicated a reluctance of leadership staff for *their* facility to be subjected to any additional scrutiny. The implementation potential of an innovation refers to transferability, feasibility and the benefits of the innovation (Polit & Beck, 2004). It may therefore be argued that on the one hand, the contextual nature of the participating facilities, which is rooted in Engo's philosophy and framework (c.f. the section in Chapter 2), poses limits in terms of the transferability of the findings to other Engo-affiliated RACFs. However, on the other hand, the hesitation for participation from the rest of the facilities, supports one of the major categories of this research project: *the operational features presenting barriers to culture change*. This discourse may very well be relevant for the rest of RACFs in South Africa, at least.

6.3.2. Research context and positionality of the researcher

The researcher is permanently employed as an occupational therapist in one of the participating facilities. It is incidentally also the largest of the residential aged care facilities, and the only one that employs an occupational therapist. The researcher had visited some of the affiliated facilities as part of her scope of practice as employee, but unrelated to this research project. In addition, the researcher had, on previous occasions, met with some staff members from other Engo-affiliated facilities through training opportunities etc. This could have impacted the researcher's objective assessment of the facilities, and the manner in which reports were presented to participants who were known to the researcher.

As an employee of one of the participating facilities, the researcher might have been overtly critical during the assessment period, or because the facility is well known, might have not included important information, as she has become accustomed to it.

Furthermore, the initial contact with facilities were done via electronic mail from the researcher's professional email account, which bears the Engo signature. In hindsight it might have been better if the researcher had used her personal email account. The institutional email might have suggested to the facilities that the research was part of the

annual audit done by the Engo Director for services to older persons. This might have contributed to the smaller sample size than was anticipated.

Prior to the nominal group discussion, one participant was reluctant to attend the group as she felt she could not contribute to the process. Another participant did not read the report containing the findings of the REIS and ATOSE in time and did so just prior to the start of the session. These cases are indicative of how the participants' personal experience and interpretation could influence their reporting and contribution during the nominal group process.

6.3.3. Use of the REIS and ATOSE assessment tools

Part of the REIS assessment tool is an informal interview component with residents and staff to elucidate the observations of the assessor and to gain a better understanding of the environmental impact on residents and staff. It would be impossible to interview every employee and resident of every facility, which is something that the researcher anticipated during the planning stage. The researcher consequently decided to sample 10% of the resident and staff community (c.f. Inclusion criteria) at each facility. Undoubtedly, the personal experiences of staff and residents influenced their responses. However, the nature of the REIS assessment tool is not to specifically describe and report on resident and staff experiences, but merely to supply supportive data for the quantitative scoring of the four sections: *everyday space*, *everyday objects*, *enabling relationships* and *structure of activities*.

Upon reflection and with some experience after implementing the assessment tools as part of this research project, the researcher can value and acknowledge the strengths of both the REIS and ATOSE as assessment tools. Initially, the researcher was sceptical to use the ATOSE as it provided less structure than the REIS. Moreover, the ATOSE was developed as a pre- and post-assessment tool of the effect that environmental changes have on the occupational and social engagement of residents, staff and visitors in a facility, which was not how the tool was used in this study. Although the researcher did have virtual practice runs in scoring the ATOSE, together with its creator, Morgan-Brown, her personal biases (i.e. initial scepticism of using the ATOSE) might have impacted the quantitative scoring. Additionally, inter-rater reliability could not be established with a fellow therapist in a face-to-face practice run, as no therapist in SA is familiar with or had been trained to use the ATOSE. However, the researcher had virtual support and practice opportunities from the

author of the ATOSE. The researcher also had access to a narrative template which supports the quantitative observations.

Furthermore, the observations at two of the three facilities were not done in dementia-specific areas, as the smaller facilities only had communal areas used by residents with and without dementia. Additionally, the qualitative notes that support the quantitative data could have been more descriptive and specific to ensure that the quantitative data could come to its full right. The ATOSE was applied for three consecutive days at each facility, a shorter period than the suggested seven-day assessment period for pre-and post-environmental modifications. As the ATOSE was not used in this capacity, Morgan-Brown gave permission for using the tool as was done in this study.

After the evaluatory visits to each facility, the researcher combined the data in a report format and presented the findings of the REIS and ATOSE in an understandable and user-friendly manner to the facilities. The reports were received well by the leadership staff at the facilities. Upon reflection, during data analysis, the researcher conceded that the research question '*are the REIS and ATOSE applicable assessment tools in Engo RACF?*' was not elucidated by the data collected. The findings from the discussion group indicated that leadership reflected on the question according to the current level of culture change at the particular facilities. They have been confronted with person-centred care and have a vague appreciation for it, but have limited insight into the requirements of true and purposeful culture change. Their level of insight into the REIS and ATOSE reports reflected this. During the nominal group discussion, which was the second and final phase of data collection, leadership staff were asked what they perceived to be the barriers and enablers of implementing the findings of the REIS and ATOSE as presented in the reports. The data suggested that the question was not, and could perhaps not be, fully considered by the participants. The researcher however accepts that the phrasing of the question influenced the results of the nominal group discussion. Nevertheless, the fact that the question could not be assimilated, may also underline a limited framework for collectively, focusing on culture change through person-centred care.

6.4. Value of the study

To ensure the sustainability of the occupational therapy profession in the aged care sector, occupational therapists need to establish a service that adds value to the business and the lives of key stakeholders of RACFs, i.e. residents and employees. Occupational therapists

have struggled to establish the profession as an essential service within long-term aged care, distinguishing it from more affordable service providers focusing on activity participation. Critical investigation into the diverse scope and perceived efficacy of practicing therapists within the aged care sector is necessary to establish a baseline. Perhaps it is now the time to investigate an occupational therapy service model, or framework that guides sound, theoretically-based practice in aged care. This is specifically relevant within the unique South African context, encompassing private, non-governmental and governmental facilities.

The value of this study can be found in that it adds to the body of knowledge of the occupational therapy profession specifically for therapists practicing in the South African aged care setting. This study introduces two new, previously unused occupation-based assessment tools that have not been utilized within the South African context. This provides occupational therapists with tools to strengthen evidence-based clinical practice and provide meaningful community intervention.

But apart from introducing and establishing the feasibility of the REIS and ATOSE, this study serves as a valuable reminder for occupational therapists to not “do” intervention, but to enable community intervention from within the community itself. This research study introduces concepts of organisational culture and how daily operations influence the occupational choices and possibilities of residents living in these facilities. Perhaps the discussion regarding the politicising of occupation and the occupational histories of key stakeholders in residential aged care communities causes South African occupational therapists to employ a political lens when critically considering and reflecting on empowering the aged care community as a whole. “Warming the soil” as suggested by the Eden Alternative Framework serves a suitable approach to attempt de-politicisation of tasks and activities within RACFs and elder communities, as a precursor to true culture change. Any physical and operational changes remains subservient to personal transformation.

6.5. Final reflections

Engo is still embarking on its culture change journey, and is only now becoming aware of some injustices within their aged care facilities. This research study set out to investigate whether two previously unused assessment tools were feasible within Engo RACFs. Although the process to answer this question was not linear, and the REIS and ATOSE are

not feasible for use within the Engo organisation currently, the REIS and the ATOSE were found to be applicable for use in RACFs as they provide valuable information for occupational therapists to strengthen their community-based practice. From an occupational perspective, the REIS and the ATOSE findings and suggestions provide practical solutions to elements of the environment that deprive residents of important occupations. It also provides a collective assessment tool for the South African occupational therapy workforce. This in itself empowers therapists to influence the wellbeing of more residents and communities than the conventional therapeutic approach of individual or group therapy. The REIS and the ATOSE should not be compared to one another as they present unique perspectives of an aged care facility. If used in conjunction they provide insight into the intricacies of aged care communities.

Although societal stigmas assume elder communities such as RACFs to be inactive and stagnant, I know the opposite to be true. Oscar Wilde, an Irish poet, said that “to live is the rarest thing in the world, most people only exist”. I believe that elder communities are bursting with opportunities for occupational therapists to assist in creating thriving, self-sustainable communities, where people of all ages, races and personalities can exemplify unity and *live Ubuntu* and not merely exist from one day to the next. In order to authentically and effectively stimulate change and growth in elder communities, much more research is needed to truly understand the needs, strengths and challenges of aged care communities.

6.6. Conclusion

The aim of this research study was to investigate whether the ATOSE and REIS assessment tools were feasible for use within the Engo organisation. Although the data explicitly detailed the organisational culture of three affiliated Engo RACFs and the occupational justice issues associated with the operational features, it did not directly demonstrate the feasibility of the tools. This is mainly due to the fact that the Engo organisational culture is not currently receptive towards it.

As far as the researcher is concerned, neither of these tools have previously been investigated in this regard within South African Residential Aged Care Facilities. Despite their limited feasibility in this context, the researcher remains of the opinion that the REIS and ATOSE are relevant tools for expanding the scope of occupational therapy practice in aged care settings, and validating occupational therapists as valuable team members.

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8. Appendix A: Ethical clearance from UFS HSREC



Health Sciences Research Ethics Committee

14-Jun-2018

Dear Mrs Melissa Kilian

Ethics Clearance: Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupational and Social Engagement (ATOSE) as assessment tools within ENGO Residential Care Facilities in the Free State province, South Africa

Principal Investigator: Mrs Melissa Kilian

Department: Occupational Therapy (Bloemfontein Campus)

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is: UFS-HSD2018/0605/1906

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act, No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00006240; REC 230408-011; IORG0005187; FWA00012784



9. Appendix B: Information and consent document to Engo for conducting study in affiliated RACFs

INFORMATION and CONSENT DOCUMENT

Directorate of ENGO Residential Aged Care

I, Melissa Kilian, wish to conduct research in partnership with ENGO Residential Aged Care Facilities in the Free State. With this document, I would like to present the information regarding this study. If you, as representative of the directorate of ENGO Aged Care consent for this study to be executed within ENGO affiliated Residential Aged Care Facilities; please complete the consent section found at the end of this document.

WHAT IS THIS STUDY ABOUT?

Constantly improving quality of care that addresses both the needs of residents and identifying training requirements and support for staff, is a challenge. This study explores the potential of two different assessments tools for use in residential care facilities within the South African setting. These tools are designed to collaboratively identify current strengths as well as potential areas for improvement within care facilities in conjunction with staff and residents.

The two assessment tools that will be used are:

1. REIS: Residential Environment Impact Scale
2. ATOSE: Assessment Tool for Occupation and Social Engagement

WHAT WILL THE STUDY INVOLVE FOR THE FACILITY/HOME INVOLVED?

This study comprises **two phases**.

Phase one (I) involves the researcher visiting the home/facility for three (3) days and completing the REIS and ATOSE assessments. Thereafter the researcher will offer each facility the results of both assessment tools in a summary report, accompanied by a discussion to clarify any uncertainties. Please see more details below.

Phase two (II) will follow with a once-off group discussion to be held in Bloemfontein. During this group the researcher and leadership participants will discuss their thoughts on the REIS and ATOSE assessment tools. The manager, and one leadership staff member of their choosing, will be invited as participants in this phase. Please see more details below.

Phase I: Administration of the REIS and ATOSE

The assessment of the REIS will take about two (2) hours in total and involves the researcher walking through the facility, observing some daily activities and a few interviews with residents and staff members. Residents can be people living with/without dementia; but should be able to hold a conversation and answer question.

The assessment of the ATOSE takes a bit longer and will be done throughout the three (3) days that the researcher visits each facility. The ATOSE requires the researcher to observe a social space, like a lounge, in a specific section in the home, where people with dementia live.

After the three day visit, the researcher will compile a report and discuss the findings with the management representative of each facility. It is important to note that the participants (residents and staff) for the REIS and ATOSE assessments differ.

Phase II: Discussion group after the assessments has been completed

After completion of the assessment phase at all the involved facilities, the researcher will organise a suitable date with facility managers/leaders for partaking in a discussion group. The researcher will attempt to do this on a date that corresponds with a scheduled ENGO meeting. During this discussion group the opinion of managers on these tools will be asked. This group meeting will take up to one and a half hours at most.

All staff and residents who participate in the study will need to provide written consent prior to their involvement. Consent from a proxy may be required for people with advanced dementia who will be included in observations during the ATOSE assessment. Process consent and verbal assent will be asked for people living with dementia. This means that the researcher will continuously ask for assent prior to observation or interview during the research-period. The researcher will be sensitive toward distressed behaviour. A poster will also be placed in the observation areas to alert staff, residents and visitors of the research in progress. It remains the choice of each person approached to give consent to participation or not and will be respected by the researcher at all times.

If a facility accepts participation in this project; the researcher will need their assistance with the following:

- ⇒ The researcher will contact the manager prior to her visit and require some assistance regarding orientating staff and residents who will be involved. This will entail
 - i) Distribution of an information document. This information must be available to all people who might visit/work at the RACF during the researcher's three-day visit.
 - ii) Canvassing for staff/residents who will be interviewed according to the eligibility sheet (attached to this document).
 - iii) Informing staff, residents and visitors of periods and areas where observations will take place. Posters will be provided to assist with this process. The information will be sent to you via e-mail.
 - iv) Identifying a suitable communal room, where people with dementia spend time on a daily basis.

- v) Assisting the researcher with gaining written proxy-consent from guardians of people living with dementia, who will be observed.
- ⇒ Prior to commencement of the three-day research period at each facility, the researcher will send the manager/leadership a PowerPoint to explain the assessment tools that will be used, namely the REIS and ATOSE. It will be beneficial for their understanding and clarity to familiarise themselves with this information. The researcher will follow up with each facility to straighten-out any uncertainties, per phone call.
- ⇒ After the visit of the researcher, a summary report of the assessments will be emailed to management/leadership of each facility. The findings of the assessments needs to be shared with other leadership staff who agrees to support exploring how relevant and usable these findings are for your facility, specifically the staff member who will also be participating in the discussion group (phase II) about the assessment tools.
- ⇒ The researcher will host a group session in Bloemfontein where two (2) representative leaders will need to attend; including the facility manager and a chosen professionals may include, but are not limited to a:
 - Care manager
 - Registered Nurse
 - Physiotherapist
 - Allied health assistant
 - Leisure Coordinator

The date for this session will coincide with an ENGO Aged Care managerial meeting to ease logistical arrangements and accommodate participants to ensure that no additional costs will be incurred by the residential facility.

It should be noted that there are no foreseen expenses to ENGO, as organisation and no losses to be incurred by this research project.

HOW MUCH TIME WILL THIS STUDY REQUIRE OF EACH FACILITY?

- Reading the information and completing the consent form will take up to twenty (20) minutes to complete.
- Familiarising themselves with the PowerPoint, explaining the assessments will take about thirty (30) minutes.
- Furthermore the researcher will require some assistance with identifying staff/residents for interview purposes and other administrative tasks, such as reminding staff, residents, family members and visitors of the researcher's visit.
- During the researcher's visit, she will require twenty (20) minutes of the manager's time for the assessment tool purposes.
- The discussion group in Bloemfontein will take up to one and a half hours.

WHO CAN PARTICIPATE IN THIS STUDY?

For the REIS, a minimum of 10% of the total number of residents, and the equivalent number of staff, will be required in the interview process. For example; if the facility is home to 50 residents, the researcher will need to interview 5 residents and 5 staff members. Please see the eligibility sheet that accompanies this information document.

For the ATOSE; no interviews will take place, the researcher will only observe a communal room-environment in two-hour slots. This communal room should be part of a wing/section that is dedicated to people living with dementia. The number of people is irrelevant but visitors and staff should be aware of the assessment process. The researcher will not be intentionally interacting with any person in the room.

CAN A FACILITY WITHDRAW FROM THIS STUDY?

Yes, they can. Participation is completely voluntary. The decision whether to participate will not affect the facility or ENGO organisation's current or future relationship with the researcher or anyone else at the University of the Free State. If the manager/leader of the facility, initially choose to not want to participate, that particular facility, can unfortunately not be included in this study.

If the facility decide to take part in the study and then change their mind later, they are free to withdraw at any time. They can contact the researcher. There will be no penalties involved. However, once the project have started and the information has been added to the results of the project, the facility's responses cannot be withdrawn because they are anonymous and therefore we will not be able to tell information apart.

The facility manager/leader are free to withdraw from the discussion group at any time. They may also refuse to answer any questions that they do not wish to answer during the discussion group. Any information that have already been collected, however, will be kept in our study records and may be included in the study results.

WHAT ARE THE RISKS ASSOCIATED WITH THIS STUDY? ARE THERE ANY COSTS INVOLVED?

Apart from spending some time on this project, there are no any other foreseeable risks associated to any facility or ENGO, as whole organisation. There aren't any costs associated with this project. Please note that the discussion group to be held, will be organised around a suitable date in order to ensure no additional expenses to the facility.

WHAT ARE THE BENEFITS FOR PARTICIPATION IN THIS STUDY?

Results of the REIS and ATOSE can be used to identify areas for improvement within the residential environment of each ENGO affiliated facility and guide inputs for improved service delivery that support the aspirations toward a person-centred aged care facility and organisation. Please note that no remuneration will be offered for participation in this study.

WHAT WILL HAPPEN TO THE INFORMATION THAT IS COLLECTED IN THIS STUDY?

All information will be stored securely and kept strictly confidential. Findings of this study might be published but the facility's name and participants' names will never be published. Please note that the findings from the REIS and ATOSE assessment tools might also be published but the facility and the people involved will by no means be identifiable.



You may contact Melissa Kilian (primary researcher) at any time with any queries relating to the research study or if you require any further information. You are also welcome to contact the research supervisor, Tania Rauch van der Merwe.

Melissa: 051 407 7247 // melisburger@gmail.com

Tania: 051 401 2829 // ydmraucht@ufs.ac.za

If you, as representative of ENGO Directorate consent for this research study to take place; please undersign below. Please note that each facility that are recruited for participation in this study will retain the executive right to consent or decline participation in this study.

I, {INSERT NAME HERE}, as representative of ENGO Directorate in the capacity of {INSERT POSITION} give permission to the researcher of this study; ***Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupational and Social Engagement (ATOSE) as assessment tools within ENGO Residential Care Facilities in the Free State province, South Africa***, to execute phase I and phase II of this project within ENGO affiliated Residential Aged Care Facilities in the Free State province.

.....

Signature ENGO Directorate representative

.....

PRINT name

For any further queries and/or concerns you are welcome to contact the Health Sciences Research Ethics Committee of the University of the Free State. Contact details below

Health Sciences Research Ethics Committee

Office of the Dean: Health Sciences

T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za

IRB 00006240; REC 230408-011; IORG0005187; FWA00012784

Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) |

Bloemfontein 9300 | South Africa

You may contact Melissa Kilian (primary researcher) at any time with any queries relating to the research study or if you require any further information. You are also welcome to contact the research supervisor, Tania Rauch van der Merwe

Melissa: 051 407 7247 // molisburger@gmail.com

Tania: 051 401 2929 // vdmraucht@ufs.ac.za

If you, as representative of ENGO Directorate consent for this research study to take place, please undersign below. Please note that each facility that are recruited for participation in this study will retain the executive right to consent or decline participation in this study.

I, Rika Wolmarans, as representative of ENGO Directorate in the capacity of Older Persons give permission to the researcher of this study; *Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupational and Social Engagement (ATOSE) as assessment tools within ENGO Residential Care Facilities in the Free State province, South Africa*, to execute phase I and phase II of Dr's project within ENGO affiliated Residential Aged Care Facilities in the Free State province.

The final decision/permission of each Aged Care Facility that took part in this study lies with the Governing Board of that Facility.

R. Wolmarans

Signature ENGO Directorate representative

R. WOLMARANS

PRINT name

For any further queries and/or concerns you are welcome to contact the Health Sciences Research Ethics Committee of the University of the Free State. Contact details below

Health Sciences Research Ethics Committee

You are welcome to keep this information document

10. Appendix C: Information document to RACFs

INFORMATION DOCUMENT

Leadership of ENGO Residential Aged Care Facilities

I, Melissa Kilian, am conducting research in partnership with ENGO Residential Aged Care Facilities in the Free State. The facility that you represent have been invited to participate in this research study.

WHAT IS THIS STUDY ABOUT?

Constantly improving quality of care that addresses both the needs of residents and identifying training requirements and support for staff, is a challenge. This study explores the potential of two different assessments tools for use within the South African setting. These tools are designed to collaboratively identify current strengths as well as potential areas for improvement within care facilities in conjunction with staff and residents.

The two assessment tools that will be used are

REIS: Residential Environment Impact Scale

ATOSE: Assessment Tool for Occupation and Social Engagement

WHAT WILL THE STUDY INVOLVE FOR YOU AND YOUR FACILITY/HOME?

This study comprises **two phases**. Phase one (I) involves the researcher visiting your home/facility for three (3) days and completing the REIS and ATOSE assessments. Thereafter the researcher will offer you the results of both assessment tools in a summary report, accompanied by a discussion to clarify any uncertainties. Phase two (II) will follow with a once-off group discussion to be held in Bloemfontein. During this group we will discuss your thoughts on the REIS and ATOSE assessment tools. You, and one leadership staff member of your choosing, are invited as participants in this phase.

Phase I: Administration of the REIS and ATOSE

The assessment of the REIS will take about two (2) hours in total and involves the researcher walking through the facility, observing some daily activities and a few interviews with residents and staff members. Residents can be people living with/without dementia; but should be able to hold a conversation and answer question.

The assessment of the ATOSE takes a bit longer and will be done throughout the three (3) days that the researcher visits. The ATOSE requires the researcher to observe a social space, like a lounge, in a specific section in the home, where people with dementia live.

After the three day visit, the researcher will compile a report and discuss the findings with you. It is important to note that the participants (residents and staff) for the REIS and ATOSE assessments differ.

Phase II: Discussion group after the assessments has been completed

After completion of the assessment phase at all the involved facilities, the researcher will organise a suitable date with you for partaking in a discussion group. The researcher will attempt to do this on a date that corresponds with a scheduled ENGO meeting. During this discussion group your opinion on these tools will be asked. This group meeting will take up to one and a half hours at most.

All staff and residents who participate in the study will need to provide written consent prior to their involvement. Consent from a proxy may be required for people with advanced dementia who will be included in observations during the ATOSE assessment. Process consent will be asked for people living with dementia. This means that the researcher will continuously ask for assent prior to observation or interview during the research-period. The researcher will be sensitive toward distressed behaviour. A poster will also be placed in the observation areas to alert staff, residents and visitors of the research in progress. It remains the choice of each person approached to give consent to participation or not and will be respected by the researcher at all times.

If you accept participation in this project; the researcher will need your assistance with the following:

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 - vi) Distribution of an information document. This information must be available to all people who might visit/work at the RACF during the researcher's three-day visit.
 - vii) Canvassing for staff/residents who will be interviewed according to the eligibility sheet (attached to this document).
 - viii) Informing staff, residents and visitors of periods and areas where observations will take place. Posters will be provided to assist with this process. The information will be sent to you via e-mail.
 - ix) Identifying a suitable communal room, where people with dementia spend time on a daily basis.
 - x) Assisting the researcher with gaining written proxy-consent from guardians of people living with dementia, who will be observed.
- ⇒ Prior to commencement of the three-day research period at your facility, the researcher will send you a PowerPoint to explain the assessment tools that will be used, namely the REIS and ATOSE. It will be beneficial for your understanding and clarity to familiarise yourself with this information. The researcher will follow up with you to straighten-out any uncertainties, per phone call.
- ⇒ After the visit of the researcher, a summary report of the assessments will be emailed to you. The findings of the assessments needs to be shared with other leadership staff who agrees

to support exploring how relevant and usable these findings are for your facility, specifically the staff member who will also be participating in the discussion group (phase II) about the assessment tools.

⇒ The researcher will host a group session in Bloemfontein where two (2) representative leadership will need to attend ;including yourself as facility manager and a chosen professionals may include, but are not limited to a:

- Care manager
- Registered Nurse
- Physiotherapist
- Allied health assistant
- Leisure Coordinator

The date for this session will coincide with an ENGO Aged Care managerial meeting to ease logistical arrangements and accommodate participants.

HOW MUCH OF MY TIME WILL THIS STUDY REQUIRE?

Reading the information and completing the consent form will take up to twenty (20) minutes to complete. Familiarising yourself with the PowerPoint, explaining the assessments will take about thirty (30) minutes. During the researcher's visit, she will require twenty (20) minutes of your time for the assessment tool purposes. The discussion group will take up to one and a half hours. Furthermore the researcher will require some assistance with identifying staff/residents for interview purposes and other administrative tasks, such as reminding staff, residents, family members and visitors of the researcher's visit.

WHO CAN PARTICIPATE IN THIS STUDY?

For the REIS, a minimum of 10% of the total number of residents, and the equivalent number of staff, will be required in the interview process. For example; if the facility is home to 50 residents, the researcher will need to interview 5 residents and 5 staff members. Please see the eligibility sheet that accompanies this information document.

For the ATOSE; no interviews will take place, the researcher will only observe a communal room-environment in two-hour slots. This communal room should be part of a wing/section that is dedicated to people living with dementia. The number of people is irrelevant but visitors and staff should be aware of the assessment process. The researcher will not be intentionally interacting with any person in the room.

CAN I WITHDRAW FROM THIS STUDY?

Yes, you can. Participation is completely voluntary. Your decision whether to participate will not affect your current or future relationship with the researcher or anyone else at the University of the Free State or ENGO as an organisation. If you, as manager/leader of the facility, initially do not want to participate, your facility, can unfortunately not be included in this study. Your input is of huge value

and necessary for the successful commencement and completion of the project in your specific facility.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can contact the researcher. There will be no penalties involved. However, once we have started the project and the information has been added to the results of the project, you and your facility's responses cannot be withdrawn because they are anonymous and therefore we will not be able to tell which one is yours.

You are free to withdraw from the discussion group at any time. You may also refuse to answer any questions that you do not wish to answer during the discussion group. Any information that we have already collected, however, will be kept in our study records and may be included in the study results.

WHAT ARE THE RISKS ASSOCIATED WITH THIS STUDY? ARE THERE ANY COSTS INVOLVED?

Apart from spending some time on this project, there are no any other foreseeable risks associated. There aren't any costs associated with this project. Please note that the discussion group to be held, will be organised around a suitable date in order to ensure no additional expenses to you or your facility.

WHAT ARE THE BENEFITS FOR PARTICIPATION IN THIS STUDY?

Results of the REIS and ATOSE can be used to identify areas for improvement within the residential environment and guide inputs for improved service delivery that support the aspirations toward a person-centred aged care facility.

WHAT WILL HAPPEN TO THE INFORMATION THAT IS COLLECTED IN THIS STUDY?

All information will be stored securely and kept strictly confidential. Findings of this study might be published but your name and the facility's name will never be published. Please note that the findings from the REIS and ATOSE assessment tools might also be published but the facility and the people involved will by no means be identifiable.



You may contact Melissa Kilian (primary researcher) at any time with any queries relating to the research study or if you require any further information. You are also welcome to contact the research supervisor, Tania Rauch van der Merwe.

Melissa: 051 407 7247 // melisburger@gmail.com

Tania: 051 401 2829 // ydmraucht@ufs.ac.za

11. Appendix D: Informed consent forms to leadership of RACFs

Consent Form for Leadership of RACF

I, _____ [NAME] _____ agree to take part in this research study project.

I consent to the following:

- I have read the Leadership Information document pertaining to this research project.
- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have had the opportunity to discuss any uncertainties with the researcher, Melissa Kilian.
- I understand that participation is voluntary and I choose to participate in this study out of my own free will. I am aware that I can withdraw from the study at any time.
- I understand that I may withdraw from the discussion group at any time. I am aware that all information of my participation that has already been processed as part of the results will not be removed.
- I am aware and comfortable that all information will be handled confidentially and stored securely.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

Would you like to receive feedback about the overall results of this study?

YES

NO

If you answered **YES**, please state your email address:

Email: _____

I give permission to the researcher of this study; ***Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupational and Social Engagement (ATOSE) as assessment tools within ENGO Residential Care Facilities in the Free State province, South Africa***, to execute phase I and phase II of this project within the Residential Aged Care Facility that I represent.

.....

Signature of leadership representative

.....

PRINT name

.....

Print name of ENGO Residential Aged Care Facility

12. Appendix E: Informed consent forms for operational staff and residents participating via informal interviews

Participant Consent Form for Staff and Residents

I, _____ [NAME] _____ agree to take part in this research study project.

I consent to the following:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have had the opportunity to discuss any uncertainties with the researcher, Melissa Kilian.
- I understand that participation is voluntary and I choose to participate in this study out of my own free will. I am aware that I can withdraw from the study at any time.
- I understand that I may withdraw from the interview at any time. I am aware that all information of my participation that has already been processed as part of the results will not be removed.
- I am aware and comfortable that all information will be handled confidentially and stored securely.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

Would you like to receive feedback about the overall results of this study?

YES

NO

If you answered **YES**, please state your email address:

Email: _____

I consent for participating in a confidential interview with the researcher, Melissa Kilian.

I am aware that information will be used to support the following research project:

Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupational and Social Engagement (ATOSE) as assessment tools within ENGO Residential Care Facilities in the Free State province, South Africa

Signature of interviewee

PRINT name

13. Appendix F: Reminder notice to staff and residents of researcher's site visits



As part of a study project, observations will be taking place on {INSERT DATE and TIME HERE + ACTIVITY, if relevant} to determine how the physical environment of {INSERT HOME's NAME HERE} is supporting the needs of people who live and work here.

Nothing will be required from you during this time. The researcher will be observing what is happening in and around this room.



If you do not wish to be part of this observation, please refrain from joining in the {INSERT ROOM/ACTIVITY NAME} on this date, or feel free to inform the researcher,
Melissa Kilian

14. Appendix G: Criteria presented to facility leadership for identifying staff and residents to partake in informal interviews

REIS		ATOSE	
Inwoners	Personeel	Inwoners	Personeel
<ul style="list-style-type: none"> • Ability to provide informed consent. • Willing to undersign consent document. • Residents should be able to understand and speak English and/or Afrikaans. • The participants' levels of independence should vary. Examples of different residents that should be included: <ol style="list-style-type: none"> 1) A couple that lives together 2) A resident that is totally independent but only makes use of the household support services like meals that are served and washing that is done 3) A resident that receives some nursing care on a daily basis 4) A resident that spends most of their days in bed/in their room 	<ul style="list-style-type: none"> • The manager of the facility should be willing to participate. The successful commencement of this project will require the leadership to be on board. • Willing to undersign consent document • Staff should be able to understand and speak English and/or Afrikaans. • Interviews will need to take place during the shift of the staff members. The interview will last between 20 – 30 minutes. • Staff members should preferably be employed in different sections of the facility and with varying levels of contact with residents. Examples include: <ol style="list-style-type: none"> 1) Kitchen staff member 2) Cleaning staff 3) Registered nurse 4) Care staff member 5) Leisure co-ordinator 6) Allied health professionals such as Physiotherapists 	<ul style="list-style-type: none"> • Residents do not need to give written consent but process consent will be asked during the observations • Residents should be diagnosed/and or living with dementia within a dementia wing or section in the home. • Resident's guardians need to give written proxy consent, where possible and be informed of their loved one being in a 'observational situation'. 	<ul style="list-style-type: none"> • Care staff that work in the dementia specific wing will be included in the observational activities of the researcher, although no interview or specific interactions will take place between staff and the researcher. • Willingness to undersign written consent. • Should be informed about the process of administering the ATOSE and comfortable with it.

15. Appendix H: Canvassing poster to RACFs

Feasibility of using the REIS and ATOSE as assessment tools within ENGO Residential Aged Care Facilities in the Free State, South Africa

I am an occupational therapist, conducting a research project together with ENGO Residential Aged Care Facilities in the Free State. This project aims to identify areas which can be improved to positively influence the daily life of people who work and live in aged care facilities.

The home where you live and/or work, Huis _____ has been invited to participate in this project, and they have accepted the invitation.



What does this mean?

We want to hear what you think. Melissa, the researcher of this project want to have a short interview/discussion with you.

Remember that all information will be handled confidentially.

You will never be forced to speak with Melissa it should be out of free will, if you choose to do so.

If this sounds interesting, please inform {INSERT NAME HERE}.

Look out for a poster with the date and time for Melissa's visit.



Primary researcher
Melissa Kilian

16. Appendix I: REIS Assessment Tool

REIS (Version 4.0)

REIS Rating Form

REIS v.4.0 CHAPTER 6

REIS RATING FORM

Rating Scale

The 4-point rating scale functions as follows:

4 = Environment *strongly supports* people's sense of identity and competence by providing exceptional opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.

3 = Environment *supports* people's sense of identity and competence by providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.

2 = Environment *interferes* with people's sense of identity and competence by providing limited opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.

1 = Environment *strongly interferes* with people's sense of identity and competence by not providing opportunities, resources, demands and constraints to engage in meaningful culturally appropriate activities.

For each item, the therapist is required to assign a rating of 1, 2, 3, or 4 as an indication of how the environment supports people's identity and competence.

Note: the ratings from the rating form on pages 23-26 will automatically be copied in to the REIS Summary Ratings section of the sample report on page 53.



17. Appendix J: ATOSE Assessment Tool

SEGMENT SEQUENCE NO:	SEGMENT START TIME	DATE of OBS	
RESIDENTS	VISITORS	STAFF	
<u>ENGAGED</u>	<u>ENGAGED</u>	<u>ENGAGED</u>	
Social Engagement	Social Engagement	Social Engagement	
1-2-1 verbal	1-2-1 verbal	1-2-1 verbal	
Non-Verbal	Non-Verbal	Non-Verbal	
Informal Group	Informal Group	Informal Group	
Structured Group	Structured Group	Structured Group	
Interactive Occupation	Interactive Occupation	Interactive Occupation	
Occupation Solitary	Occupation Solitary	Occupation Solitary	
With Another	With Another	With Another	
Informal Group	Informal Group	Informal Group	
Structured Group	Structured Group	Structured Group	
Care Task	Care Task	Care Task	
Receiving care	Provid care with resident	Provid care with resident	
<u>NON-ENGAGED</u>	<u>NON-ENGAGED</u>	<u>NON-ENGAGED</u>	
Passive Engage: Surroundings	Passive Engage: Surroundings	Passive Engage: Surroundings	
No interact or engage	No interact or engage	No interact or engage	
Passive / Agitated Behaviours	Prep and Organise Tasks	Work tasks	
Eyes closed	Organise refresh	Catering tasks	
Agitated	Moving in room	Domestic tasks	
Self-stimulation	Prep for other activity	Professional tasks	
TOTAL TICKS	TOTAL TICKS	TOTAL TICKS	

18. Appendix K: REIS and ATOSE report to Facility 1



[Facility 1] Sentrum vir Bejaardes, [Town]



This report gives feedback on the evaluation done by Melissa Kilian on 28, 29, 30 January 2019. The focus of the evaluation was to investigate the impact of the physical and social environments of people living in residential aged care facilities using the **Residential Environmental Impact Scale (REIS v 4)** and the **Assessment Tool for Occupation and Social Engagement (ATOSE)**. The results of these tools could assist in providing resident-directed care in aged residential care settings as it highlights the strengths of, and challenges faced by, the facility.

Background information of Bergprag:

This facility is home to 50 residents living in five different wings (referred to as Corridors A to E). The accommodation is mostly room-only with shared bathrooms. Corridors D and E have en-suite bathrooms and a small kitchenette area in each private room. There are 36 staff members, excluding security personnel. The services at Bergprag include administrative staff at the reception, a financial officer, nursing staff, kitchen and laundry staff as well as maintenance and management staff. Care staff is available at the facility but not all residents make use of the care service as residents range from very independent to mostly dependent on staff for basic needs (the latter includes people living with various degrees of dementia). Evaluation was done, as directed by the REIS and ATOSE tools, by means of observation of activities and observational periods in the communal room; interviews with residents and staff; spending time with residents; and spending time at the facility.

19. Appendix L: REIS and ATOSE report to Facility 2



[Facility 2], Sentrum vir Bejaardes, [Town]



This report gives feedback on the evaluation done by Melissa Kilian on 8, 9 and 10 April 2019. Please note that this report is part of a Master of Research study at the University of the Free State (ethics number: UFS-HSD2018/0605/1906) and therefore presented in English. The focus of the evaluation was to investigate the impact of the physical and social environments of people living in residential aged care facilities using the **Residential Environmental Impact Scale (REIS v 4)** and the **Assessment Tool for Occupation and Social Engagement (ATOSE)**. The results of these tools could assist in providing resident-directed care in aged residential care settings as it highlights the strengths of, and challenges faced by, the facility.

Background information of Cloc-In:

This facility is home to 46 residents either living in one of two corridors in a frail care unit, named A and B respectively or in one of the surrounding flats on the premises of Cloc In. The flats are mostly bachelor-type units with a bedroom, kitchenette and a bathroom. The accommodation in the frail care unit is room-only with shared bathrooms. There are 24 staff members providing services that include management who is also responsible for some financial and administrative duties, nursing staff, kitchen and laundry staff as well as maintenance and domestic staff. Care

20. Appendix M: REIS and ATOSE report to Facility 3



[Facility 3], Sentrum vir Bejaardes, [Town]

This report gives feedback on the evaluation done by Melissa Kilian at the facility. Please note that this report is part of a Master of Research study at the University of the Free State (ethics number: UFS-HSD2018/0605/1906) and therefore presented in English. The focus of the evaluation was to investigate the impact of the physical and social environments of people living in residential aged care facilities using the **Residential Environmental Impact Scale (REIS v 4)** and the **Assessment Tool for Occupation and Social Engagement (ATOSE)**. The results of these tools could assist in providing resident-directed care in aged Residential care settings as it highlights the strengths of, and challenges faced by, the facility.



Background information of Ons Tuiste:

The facility is home to 198 residents living in one of eight corridors distinguished by a colour and includes a dementia home, called Lavender Laan. The accommodation in the various corridors consist of private en-suite rooms, private rooms with shared bathrooms, shared rooms with shared bathrooms and flat-like units adjoined to one of the corridors. The surrounding retirement village accommodates about 900 residents living in different housing options available which varies from large three bedroom flats to smaller bachelor units with shared bathroom facilities. The shared spaces at Ons Tuiste includes lounges in most corridors, a recreational room, a sensory room, a large church

21. Appendix N: Expanded grid of coding

Codes	SUB CATEGORY
<p>MA- [rushed] reading report [before start of group]</p> <p>Participant was reading the report (possibly for the first time, as she telephonically admitted to not having time to read the report the previous day?) when the researcher arrived</p>	Research project is not a
<p>AD (participant working less than one year in aged care- mentions this a few times). Initially she <u>did not want to attend NGT</u> Researcher had to telephonically persuade and ascertain valuable contribution a few days prior. Additionally, AD mentioned a few times that she is holding two positions in a half-day post</p> <p>Discontent detected from one participant's [AD] facial expression</p>	Lack of commitment and in research project
<p>Discontent detected from one participant's [AD] facial expression</p>	Fear and uncertainty reg research project
<p>AD (participant working less than one year in aged care- mentions this a few times). Initially <u>she did not want to attend NGT</u> [as she verbalised telephonically to the researcher that she does not feel she can contribute + does not have time]. Researcher had to telephonically persuade and ascertain valuable contribution a few days prior. Additionally, AD mentioned a few times that she is holding two positions in a half-day post</p>	Inability to identify the v the research towards cul change
<p>"Ja (laughs), ek weet nou nie of dit meer te doen het met wat EZ gesê het nie" <i>I don't know if this has more to do with what EZ added- referring to developing carers strengths and using this in each corridor</i></p>	Seeking external encoura
<p>AD mentions how she involved volunteers at previous place of employment (as she's never worked in aged care previously, (which she mentioned)</p>	Uncertainty about the ag sector
<p>During discussion phase JA often speaks up and gives opinion <u>but often looks to researcher</u></p>	Uncertain of PCC status f
<p>During discussion phase JA often speaks up and gives opinion <u>but often looks to researcher</u></p>	

22. Appendix O: Discussion group codes

1. Belangrijk - Personeelontwikkeling
 ↳ Behoeftebepaling (Stijl, analyse)
 ↳ 'Warming the soil'
 ↳ Uitrusten van waardigheid
 werk na persoon anderszins de zorg.

- Bepaal opleidingsbehoeftes.
- Lid konink met bepaalde sterk punten
 uit om ander ⊕ te beïnvloeden.

2. ^(Belangrijk) Identificatie van inwoners de
 specifieke behoeftes - verschillende
 personeel. Eensgezindheid
 Ook identificatie van hulle
 behoeftes → bij reactie op
 Wat is 'universele behoefte'
 en wat is meer specifiek.

3. Voorgestelde programma van
 activiteiten → tijd, plek →
 uitbreiden en die keuze gaat
 met voortaan krijg bij personeel
 de insiatieven.
 Kritische evaluering + reactie op
 personeel zelf. Persoonlijkheid
 → beschikbaarheid van activiteiten.
 Kan ook gerichtheid → kan zien wanneer
 belangstelling afneemt → bepaal hoe
 sal daarmee verbeter.

4. Naar beste gebruik van wat
 reeds beschikbaar is, als vertrekpunt
 + brei uit + verbeter.

5. { Structure → ruimtes, raubels, tuin
 bv. naar bank in tuin of herposi-
 sioneer.

5. Identificeer leemtes
 kennis word geen betekenis - lei
 tot beplanning
 ↳ aanvaardbaar

6. Verhouding tussen versorger
 en inwoners te fokus op 'n
 jaar eerder als versorger vs.
 inwoner → aelykoming
 Kan risico de role aanpak, bv.
 toe bedien

7. Gebruik van deze, muziek &
 tuin in programma's. Moet
 effectief gebruik word. Als
 therapie gebruik word, ook als
 activiteit. In niet in achtergrond.

Handwritten notes in red and orange:
 - 'Inwoners' (circled)
 - 'aanpak' (circled)
 - 'toe bedien' (circled)
 - 'effectief gebruik' (circled)
 - 'therapie' (circled)
 - 'activiteit' (circled)
 - 'achtergrond' (circled)

8. Aanspraak van kwelpunten, bv
 buite kopareas. Is oft
 moontlik om in storm bij
 gebou te kom; Kestrolle na
 inwoners te neem, en is
 ↳ Toegankelijkheid.
 ↳ Raak aanbord om iets
 + sien, oft nie naer raak nie.
 ↳ Kan risikos veroorsaak.
 ↳ Identificeer/evalueer 'everyday
 spaces'

9. Aanspraak van finansies →
 leemtes binnerte van die
 begroting. Gemeenskap betrek
 by aktiviteite van beplanning →
 lei tot projek → funksionering
 tussse geselsk nne finansies aan unie
 ↳ leemte van toets

10. Betrokkenheid van vrijwilligers en familie
 (Gevilligheid, voor van familie, rendert, eerder as om van vreemdelingen te benut. Kinderen het ook verantwoordelijkheid te geven)

11. Identificering van inwoners
 de gading en reflectie op eie gedrag. vooral by domeste.
 Kan hantieren verbeter. (Aangewij) Stimuli → effect op inwoners.
 Keuze van de domeste hier tegenoor persoon met domeste gedrag te kiezen.

12. Oriëntatiebode, voor in nieuwe inwoners (worden, voert - self no benoeding) U
 ↳ Finansiële implicaties

13. Optimalise gebruik van spaste vs. huislikheid
 ↳ Staan
 ↳ Tafels
 ↳ Belating.

Gebruik alles wat jy het.
 Herbenutting/anders aanwend.
 Identificeer domastes ruimte/geredde, by klein bode of on-dep in verband met

14. Inwoners & versorgings = persoonel te leer hoe 'assistie devices' te gebruik.

1. 5, 5, 5, 4, 5, 4 (28)
2. 5, 5, 3, 4, 2 (19)
3. 3, 2 (5)
4. 1, 1, 3 (5) } 5
5. 2, 3 (5)
6. 3, 4, 4, 2 (13)
7. (0)
8. 1 (1)
9. 2, 2 (4)
10. 1, 3 (4)
11. (0)
12. (0)
13. 1, 1, 4 (6)
14. (0)

5. Identifiseer leanties
 REES voor gee betekenis - lei tot beplanning
 ↳ aankoopplan.

↳ Verhouding tussen versorgers en inwoners te fokus op 'n jaan eerder as versorger vs. inwoner. → gelykmaking
 Kan natuur se rolle aanval, by toe bedien

7. Gebruik van dore, instrek & tuin in versorgingsplan. Moet effektief gebruik word as terapie benut word, ok as aktiwiteit. In net 'n agtergrond.

23. Appendix P: Editing Declaration

To whom it may concern

This is to state that the Master's degree dissertation by Melissa Kilian titled *Feasibility of using the Residential Environment Impact Scale (REIS) and the Assessment for Occupation and Social Engagement (ATOSE) as assessment tools within ENGO Residential Care Facilities in the Free State province, South Africa* has been language edited by me, according to the tenets of academic discourse.



B.Bibl.; B.A. Hons. (English)

30-07-2020