Chapter 19
Promoting Resilience in Small-Scale, Homelike Residential Care Settings for Older People with Dementia: Experiences from the Netherlands and the United States

Hilde Verbeek, Rosalie A. Kane, Erik van Rossum, and Jan P.H. Hamers

Supported by a cultural change movement, resilience in long-term dementia care has become increasingly relevant and important. The process of cultural change promotes resident-directed care and quality of life, with the care-based relationship between the resident and direct care workers emphasized (Foy Whithe-Chu et al. 2009). Examples of this cultural change include care settings in a homelike environment focusing on residents' autonomy, opportunity for choice, and sustaining a sense of self and control. This chapter illustrates characteristics and experiences with homelike dementia care setting in the Netherlands and United States.

Although the majority of people with dementia live at home, long-term institutional care is often inevitable as the disease progresses, and is especially likely for those without family members available to provide care. Traditionally, long-term care for people with dementia was based on a medical-somatic model of care, emphasizing illness and treatment of underlying pathology. Basic nursing and medical care services were emphasized in a protected setting where the resident would be safe. Physically long-term care facilities often resemble hospitals, with long double-loaded corridors, a nurses' station and staff uniforms. Their rules and routines governing daily life permit little individualization. Currently, there is a shift toward strength-based and person-centered care for people with dementia living in care facilities: care aimed at building on a patient's personal strengths and supporting the overall well-being of the individual (e.g. Foy White-Chu et al. 2009).

Implementation of person-centered care required changes in environmental design practices to promote greater autonomy, privacy, personal identity and personhood, and socialization (Calkins 2001; Cutler et al. 2007; Zeisel et al. 2003). Guiding principles for these environmental changes can be traced back to Lawton's ecological model of a supportive and stimulating care environment (Lawton and Nahemow 1973). Additionally, it was suggested that people with dementia thrive best in small settings that are similar to homes where they have lived during their

H. Verbeek (✉)
CAPHRI School for Public Health and Primary Care,
Maastricht University, Maastricht, The Netherlands
e-mail: H.Verbeek@ZW.unimaas.nl

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lives rather than in complex organizations that are hotel-like or hospital-like, and therefore, hard to navigate.

Together, conceptual and environmental design changes have resulted in the development of new long-term care settings for older people with dementia: small-scale, homelike settings, in which normal daily life is emphasized. These facilities correspond with a common and desirable policy trend in many countries towards making institutional dementia care as homelike as possible and enabling residents as much as control over their lives as possible (Moise et al. 2004). Internationally, various small-scale, homelike dementia care settings have been established (Verbeek et al. 2009a). Examples include small-scale living in the Netherlands (te Boekhorst et al. 2009; Verbeek et al. 2009a), Green Houses® in the United States (Kane et al. 2007), group living in Sweden (Annerstedt 1993), residential groups in Germany (Dettbarn-Reggentin 2005) and group homes in Japan (Funaki et al. 2005).

In this chapter, we discuss types of small-scale, homelike nursing-home settings in two countries: the Netherlands and the United States. In the latter, small-house nursing homes are emphasized, some of which are known as Green House® settings. After presenting descriptive information and research findings about programs, physical environments, staffing, and family involvement, we conclude the chapter with some general implications for further research, practice, and policy development.

Experiences from the Netherlands

Dutch Nursing Home Care

Dutch nursing home care is delivered mainly through the non-profit sector and covered by insurance mandated by the Exceptional Medical Expenses Act. Nursing home care is primarily provided for people with chronic somatic (i.e. physical) diseases or with progressive dementia; they are cared for within specialized somatic or psychgeriatric wards (Schols et al. 2004). Residents in psychogeriatric wards, also known as dementia care units, usually live in the nursing home until death.

The majority of nursing home care for people with dementia is provided in psychogeriatric wards located within traditional nursing homes. These wards can be compared with specialized Alzheimer units in the United States (Schols et al. 2004) and normally house around 20–30 residents. Although the environment is adapted for people with dementia, the wards often have an institutional character (Verbeek et al. 2009b). Institutional features may include long corridors, staff wearing uniforms, the nurses' station, and daily life organized by routines of the nursing home.

Long-term care for older people with dementia is currently in a transformation phase in the Netherlands (Schols 2008). Socialization of care has resulted in deinstitutionalization and normalization of long-term dementia care. Values such as preserving residents' autonomy, offering a familiar and homelike environment, enabling residents to continue their own lifestyles and promoting overall well-being hold a

prominent place in long-term care. Therefore, dementia care is increasingly organized in small-scale and homelike settings, also referred to as small-scale living or group living (te Boekhorst et al. 2007; Verbeek et al. 2009a). It is estimated that by 2010, about one-fourth of all psychogeriatric nursing home care will be organized in these small-scale settings. The Dutch government stimulates the development of these care settings by adjusting policies and financial support.

Small-Scale Living in the Netherlands

Small-scale living promotes domesticity, familiarity, sense of belonging, trust, and normality. These values should be equally reflected in both the physical environment and care giving philosophy. Residents are offered opportunities to perform tasks for themselves (increasing autonomy) and have as much control over their own lives as possible (increasing empowerment) (Van Audenhove et al. 2003).

Definition of Small-Scale Living. Although small-scale living is rapidly expanding, there is debate about its precise definition. Te Boekhorst et al. (2007) used Concept Mapping analysis to define small-scale living. Their analyses resulted in six clusters, which reflect the essential elements of small-scale living: (1) a home for life; (2) normalization of daily life (activities are centered within household daily life); (3) resident autonomy and choice; (4) nursing staff as members of the household; (5) the social environment resembles a family; and (6) small-scale living is situated in an archetypical house. The emphasis in all clusters is to provide opportunity for residents and their family members to sustain a sense of self, preserve identity, and exert control over daily life. Normalizing activities of daily life, engaging in meaningful activities, and including nursing staff as members of the household all contribute to the resilience of the residents.

In everyday practice, daily routine in small-scale settings is mainly determined by household chores, in which residents are encouraged to participate. In general, domestic features such as a kitchen, dining area, bathing room and laundry area are present in all small-scale living settings. However, there is a large variety in scale, location, and other physical features of small-scale living in the Netherlands.n investigation of physical characteristics, of small-scale living in the southern part of the Netherlands (Verbeek et al. 2008a) revealed that the majority of small-scale living settings served a small number of residents (M = 32 residents). Most small-scale living settings included a clustering of units, ranging from three to eight per location, situated within the community or as part of a larger service facility. A broader service facility might offer, in addition to these specialized dementia care units, a home for frail elders, or assisted living care for people with psychiatric problems or intellectual disabilities. The majority of all care settings are purpose-built. Although stand-alone settings reduce the institutional look of the care setting, they often are difficult to maintain due to financial and organizational constraints. All small-scale living care settings used technology support – in the Netherlands referred to as "domotica." The main goals of domotica are mobile communication among staff (nursing staff as well as other staff), safety, and increasing resident's well-being, comfort, and ease.

Nursing staff consist of nursing assistants (NAs), certified nursing assistants (CNAs), and registered nurses (RNs). Staff members may also include specialists other than nurses, such as social work, and may receive extra trainings such as in medication administration. To ensure that daily life is as normal as possible, personal care is integrated in daily routines. Nursing staff are responsible for personal and medical care and performing domestic chores (i.e. cooking, cleaning) and organize recreational activities (te Boekhorst et al. 2008b). In small-scale living only one or two nurses are usually present during the day to manage all tasks. A traditional psychogeriatric ward requires many more staff members.

The nursing home physician, an officially recognized medical discipline in the Netherlands, supports the nursing staff. Consultation is also provided by psychologists, physiotherapists, dieticians, occupational therapists, and recreational therapists. While physicians are considered central employees of regular psychogeriatric wards, all supplemental medical specialists are regarded as visitors to the small-scale care setting.

Residents

Small-scale living is regarded as an alternative care setting for regular psychogeriatric wards in a traditional nursing home, and therefore does not require additional admission criteria. All residents require a nursing home level of care, although residents' level of cognitive and functional performance may be higher in small-scale living (te Boekhorst et al. 2009; Verbeek et al., 2010).

Van Audenhove et al. (2003) argue that small-scale living settings may not be appropriate for all residents. Relationships with others (residents, family, and nursing staff) are very personal and intimate. Residents who prefer to be alone, or who are sensitive about privacy, may not find small-scale living appropriate. In addition, it might not be suitable for residents who have extreme behavioral problems (Verbeek et al. 2008a) or need to walk around a lot or need a lot of space. Admission decisions need to be made very carefully and require experience and knowledge from staff and management.

Findings from the few studies that have assessed the effects of small-scale living suggest several resilience-promoting outcomes for residents (de Rooij et al. 2009). For example, residents of small-scale living were more socially engaged, have more things to do, and enjoy more aspects of the environment than residents living in regular psychogeriatric wards (te Boekhorst et al. 2009). In addition, physical restraints were used less with residents in small-scale living than with residents of psychogeriatric facilities. Declercq (2009) found that residents in small-scale living compared to those residing in traditional psychogeriatric wards interacted more with nursing staff and residents in advanced stages of dementia and initiated more frequent non-verbal communication. However, most studies suffer from methodological limitations such as a small sample size and base-line differences between residents. Verbeek et al. (2009b) have designed a study to tackle these issues and investigate effects on residents, family caregivers and nursing staff.

Family Caregivers

In small-scale living, family caregivers are a part of the household. They can visit at any time, help with daily activities and household chores, join residents for dinner, and are actively involved with all residents. To investigate the experiences of family caregivers with respect to small-scale living settings, Verbeek et al. (2008a) conducted interviews with family members of residents. Almost all family members were very positive about small-scale living. They felt the needs, wishes, and beliefs of their residents were very well respected and residents were encouraged to live their lives as they were accustomed. Staff members were very involved with both residents and family members. This personal attention and compassion was highly appreciated. Additionally, family members appreciated their involvement with care and the household in the small-scale care setting. All settings were perceived as very homelike; the atmosphere and ambience played a crucial role. Collective meal preparation was highlighted as a crucial component of this special, homelike environment. Other daily activities such as reading the newspaper and playing games increased the feeling of being at home. Family members also valued physical characteristics of living rooms, kitchens, and the residents' private rooms. They also appreciated residents being allowed to bring their own furniture and other personal belongings into the house. Finally, families found it very important that small-scale living had a home-for-life principle. Once admitted, residents should not be transferred to another care setting, even when the disease progresses because of the potential stress and negative outcomes for the residents.

Family caregivers of people with dementia often experience high level of stress. Te Boekhorst et al. (2008a) investigated the effects of small-scale living settings on three aspects of family caregivers' psychological distress: burden, psychopathology, and competence. No location effects were found: family caregivers in small-scale living did not experience less psychological distress compared with those in traditional nursing homes. These findings conflict with previous research which reported group-living care to be more effective in reducing caregiver burden compared with other types of nursing home care (Colvez et al. 2002). However, differences were identified in how caregivers in small-scale living and traditional nursing homes experienced the care delivered and contact with nursing staff (te Boekhorst et al. 2009). Family in small-scale living felt that nursing staff had more respect for a residents' perception of the environment, asked more frequently for former habits, and appeared less hurried. Additionally, they perceived more personal attention from staff as family caregivers.

Staff's Perspective

Working in a small-scale living setting is very different from employment in a regular psychogeriatric ward. Small-scale living resembles family life and only 1–2 nurses manage the household each day. What does this mean for the nursing staff?

To investigate this, we interviewed nursing staff and managers working in four small-scale living settings in the southern part of the Netherlands (Verbeek et al. 2008a). Most staff members had deliberately chosen to work in a small-scale living setting. Personal contact with residents was the main reason for making this choice. They had more time for personal attention in small-scale living than in a regular psychogeriatric ward. Additionally, they appreciated the broadening of their tasks and the freedom to plan their day, thus promoting creativity among nursing staff.

The nursing staff also indicated that working in small-scale living is physically less intensive than the work in a regular psychogeriatric ward. Mentally and psychologically, however, small-scale living is demanding. It can be stressful to work and live with demented residents for 8 h a day. Nevertheless, nursing staff say that living together with the residents is also very satisfying. They feel a large commitment to their work, which is considered as very important. Residents can return a lot as well, for example, when residents react to positive attention.

Management indicated that nursing staff was specifically recruited. Their attitudes and visions of care giving were considered as very important. Treatment and direct contact with residents, for which communicative and social skills are essential, were paramount in small-scale living. Furthermore, staff members need to be able to work independently, be flexible, and have good organizational skills.

Te Boekhorst et al. (2008b) investigated differences in nursing staff's job characteristics in traditional nursing homes and small-scale living and the influence on well-being. Their results indicate that professional caregivers in small-scale living settings experienced a higher job satisfaction and less burn-out symptoms than those working at regular psychogeriatric wards. The nursing staff members were less emotionally exhausted, and experienced less depersonalization and an increased sense of personal accomplishment. These findings suggest that small-scale living facilities may have a positive effect on resilience for both nursing staff and residents.

Mediating job characteristics, including job autonomy, social support, and job demands may help explain these differences (te Boekhorst et al. 2008b). Nursing staff in small-scale living experienced more autonomy in their work; they had more control and decision authority. Furthermore, they experienced more social support from colleagues, although working alone more often. This is explained by a higher quality of contacts: the team shares responsibility for the residents' care and therefore interaction revolves around the residents, possibly increasing social support. Finally, staff in small-scale living experience less job demands, as measured in work and time pressure. Small-scale living is not guided by the routines of the organization, but by the needs and wishes of the residents.

Experiences from the United States

With the enactment of Medicare and Medicaid in 1965, nursing homes expanded rapidly and became the dominant modality for publicly funded long-term care in the United States. Nursing homes are licensed by the states in which they are

located and certified to receive federal payments. They are expected to provide a broad range of services to a wide range of residents, including rehabilitation, end-of-life care, and ongoing long-term services for people with physical disabilities, cognitive impairment, or both. Considerable variation can be found across states, but the model nursing home has about 100 beds and is operated as a proprietary organization; most residents live in shared rooms. Although in the 1950s and early 1960s, elderly persons with Alzheimer's disease or other dementias often received custodial care in geriatric wards of state psychiatric hospitals, financial incentives operating since 1965 have led to the virtual elimination of long-stay care in psychiatric hospitals. Partly in response to quality problems, nursing homes have become strictly regulated; standards have been developed, nursing homes are inspected for compliance with those standards, penalties have been affixed, and comparative quality information has been made available to the public. Nursing homes have been criticized for the quality of their care, their regimentation, and the poor quality of life experienced by many residents (Shields 1988). Much of the critique can be summarized by the term "bed and body work," introduced by Gubrium (1975) to describe the task-oriented focus of the direct care workers. Three trends have influenced Alzheimer's care in nursing homes in the United States.

Dementia Special Care Units

Beginning in the 1970s, traditional nursing homes began to establish dementia special care units (SCUs). These units were ideally characterized as a defined section of the nursing home that is secure and locked and has a physical design suited to persons with dementia, staff specially trained in dementia care, specific programs designed for people with dementia, and defined admission and discharge criteria (Lawton 2001). In practice, by the mid-1990s, almost 25% of nursing homes had one or more dementia SCUs. These SCUs varied enormously, however, in their goals, target populations, and programs; they also differed in the extent to which the special training and programming occurred (see Maslow and Ory 2001). Most were not small, but rather home to approximately 40 people, comparable to other units. Some were designed to work with people who had few nursing needs, but exhibited so-called behavior problems with the plan that unit residents be discharged to a different unit for end-of-life care.

Residential Care and Assisted Living

A second trend in dementia care was that individuals with dementia began to utilize alternative residential programs rather than licensed nursing homes. Persons with dementia appeared to thrive in small group settings, such as family care homes or adult foster homes (Kane et al. 1991), perhaps because the settings were so similar to familiar living situations, were small, and easily negotiated because of the size.

Residential care settings, freed of the regulatory constraints associated with nursing homes, also developed dementia SCUs or dementia-specific settings organized into small living units in pods or small connected buildings. Apartment-style assisted living settings emerged in the late 1980s and expanded rapidly. Development were driven by an ideal of providing older people who needed the nursing-home level of care with normal living quarters and a program of services that emphasized individuality, choice, dignity, privacy, and normal life-style (Wilson 2007). Considerable work has been done to summarize accomplishments in assisted living, sometimes with special reference to dementia care (Kane et al. 2007; Zimmerman et al. 2001, 2005). In general, assisted living and other residential settings not licensed as nursing homes have become laboratories for new models of care.

Assisted living for old people has also been vigorously critiqued. First, depending on state regulations and the preferences operators, residents may be discharged to nursing homes when their acuity reaches some specified level (Mead et al. 2005). The smallest assisted living settings, including those licensed as adult foster homes in some states, are often literally in private home settings, and may be better able to retain residents when their health or cognitive conditions deteriorate, but, paradoxically, they may also have more rules governing the daily lives of residents (Eckert et al. 2009). Second, although assisted living settings have often managed to provide normal community living conditions, they rarely provide the organized health care services needed by so many older people (Kane and Mach 2007). Third, those assisted living settings for seniors that live up to the conceptual ideals of privacy, individualization, and function-enhancing amenities tend to exclude most low-income people and reject subsidization by the Medicaid program (Hernandez and Newcomer 2007).

In the last decade, most state governments have moved toward reducing their dependence on institutions for all populations needing long-term supportive services. There has been some critique, however, that residential care settings in the community can easily take on the qualities of institutions. A recent analysis suggested five criteria that could render a setting less institutional and more community oriented, namely: smaller scale; more residential physical features; more control, choice, and individualization for residents; more ability for residents to integrate with the larger community outside the setting, particularly on an individualized basis; and control over when and whether the person leaves the setting to go elsewhere, including to a more intensive care setting (Kane and Cutler 2009). Some analysts speculate that nursing home and residential care sectors will converge. If so, the hope is that the best elements of assisted living environments will be combined with the greater care capacity of nursing homes (Calkins and Keane 2008).

Culture Change Movement

A third influence on the development of small-scale nursing homes is broadly known as the culture change movement (Weiner and Ronch 2003). In general, the

culture change movement is directed towards improving everyday life in nursing homes in such a way that residents experience more individualized care and have a better quality of life. This culture change is initiated through changes in architectural design to create more homelike normal environments and promote better functioning; changes in staff training and hierarchical roles based on the belief that frontline staff with greater power can offer improved flexibility to residents; and changes in programs and policies to minimize routines.

The environmental elements of culture change have often involved creating households of 8–10 people and structuring neighborhoods (i.e. clusters of households); residential kitchens and laundry areas may also be made available to residents. Private rooms are becoming more prevalent in nursing homes in general, partly because of the competition from other settings like residential care and partly because of the strong preferences that residents and family show for private rooms even for people with dementia (Kane et al. 1998). Some claim that people with dementia are calmer with private rooms. When residents have private rooms and private in suite bathrooms, some authorities argue that separation of people with dementia from those without dementia is less important.

The trend in nursing homes in the United States is towards more management at the unit level and replacement of large-scale dining with dining on specific units or choices of dining venues in a facility. A related trend is to permanently assign nursing staff, especially front-line nursing assistants, to particular units, and even to particular residents, for continuity of services.

Small-Scale Living in Nursing Homes in the United States

In the remainder of this section, we discuss just one type of small-scale nursing home emerging in the United States, the small-house nursing home, and its trademarked prototype, the Green House® setting. It is the most dramatic manifestation of small-scale nursing home because entirely separate buildings are used for each house, though several small houses can be linked administratively and hold a single nursing-home license. With a few exceptions, implementation to date has not been specific to dementia care, but many people with dementia have been served in the Green Houses and small-house nursing homes.

In 1991, William Thomas founded the *Eden Alternative* to combat what he called the scourges of nursing-home life – loneliness, boredom, and lack of meaning. The Eden Alternative envisaged a nursing home full of plants, animals, and children, but more importantly a setting with empowered frontline staff, flattened hierarchy, flexible routines, and room for spontaneity in residents' lives (Thomas 1994, 1996, 1999). Many care settings and state nursing-home trade associations became captivated by the ideals and values inherent in the approach.

Thomas came to believe that although the Eden Alternative correctly diagnosed a problem with nursing homes, its solution was insufficient, and that a complete transformation and de-institutionalization of the nursing home was required.

The articulation of the Green House idea began with that insight. The details of the model are highlighted in the next section, with more details available elsewhere (Rabig et al. 2006).

The Green House®Setting. The Green House, now a trademarked name, is a self-contained small house that is licensed as a nursing home or part of a nursing home and that serves no more than ten nursing-home residents. *Self-contained* means that the Green House should not be linked to any larger facility but be free standing with its own mechanical engineering systems, its own doors to the outside, and its own core staff. The physical environment includes a large family-style kitchen and dining area, and a living room with a fireplace (called the hearth). Meals are prepared in that kitchen, which is open to residents, and consumed in the dining area at a large family-style table. Each resident has a private room and en suite bathroom with a shower, an office/study for staff, a smaller sitting room (called a sunroom or a den), a patio, and an area with a whirlpool tub and hair dressing facilities complete the original plan. In an initial slogan, the physical setting was to be "warm, smart, and green." The latter referred to vegetation and growth, and "smart" referred to the plan that a variety of technologists would be employed to enhance care, functioning, and overall quality of life for the elders (the term for residents). The main manifestation of technology in the original prototypes was ceiling lifts that enabled one person to assist a transfer in and out of bed and from bed to toilet. Another mantra for the building was that nothing should be found in the Green House that would not be found in a private home. Institutional hallmarks such as medication carts were to be abolished. Most medications are, in fact, stored in a lockable wall cabinet in each elder's room.

The Green House transformed care arrangements as well as environmental plans. The core staff members of each Green House were the CNAs, who received additional training and had markedly expanded roles. Besides fulfilling all the ordinary responsibilities for personal care to meet ADL, IADL, and cognitive needs and assisting nurses with routine nursing care, they were charged to develop menus, prepare meals, serve meals, perform light housekeeping, and do the residents' personal laundry. They were also deemed resident *development specialists* who would know each elder well, implement plans to meet individual resident needs and fulfill personal preferences. In the Green House, this new type of personnel was called a Shahbaz (plural Shahbazim), a term suggested to remove all historical baggage associated with the designation "nurse's aide." In other models, they are sometimes called resident assistants or elder assistants. The Shahbazim were responsible for the life of the house. All professional staff required by law in nursing homes (e.g. nurses and director of nursing, medical director, activities director, social work director, dietician, therapists, etc.) were considered a clinical support team who visited the residents in the houses to provide direct care and support to Shahbazim. In clinical areas where they had legal responsibility (especially nursing), the clinical support team members provided direction and oversight to Shahbazim and otherwise acted as resource persons for the frontline staff. Adapted from work done by Yeatts et al. (2004) to establish functional work teams in traditional nursing homes, the frontline staff were constituted as self-directed work teams, and were responsible

for their own scheduling and problem-solving (Rabig 2009). Rotating roles were assigned through the team, including house coordinator, coordinator for food, coordinator for housekeeping, scheduling coordinator, and later, quality of life coordinator. The Shahbazim did not report to nursing staff but to an administrator, known as a guide.

The final component of the model was an emphasis on quality of life, individualization of care, and integration with the community. The model envisaged a "sage," or wise community resource-person that would be an additional sounding board for Shabazim. Overall, the entire model emphasized quality of life outcomes. The Green House was not specifically an intervention designed to change the delivery of care, but to facilitate the Green House model some homes have streamlined medication regimens and improved communication about health-related changes.

Implementation of the Green House®Setting. The first implementation of the Green House was in a 140-bed traditional nursing home within a multilevel retirement community. The sponsor downsized its original setting and relocated 40 nursing-home residents to 4 Green Houses, which were constructed in a residential section of the campus. Two of these Green Houses were occupied by the former residents of a locked dementia SCU, and the other two were occupied by residents in the general campus, selected from volunteer applicants in order of their length of time in the retirement community.

This program was evaluated through a longitudinal study of quasi-experimental design that compared resident outcomes with those of two comparison groups – residents in the parent nursing home from which the Green House residents came and residents from a nursing home in another non-profit retirement campus about 90 miles away. The investigators hypothesized that Green House residents would have better quality of life, based on the 11 domains of quality of life measures developed specifically for nursing homes, than the two comparison groups and that Green House elders would be more satisfied with their care and would not suffer any deterioration of health and functional outcomes as measured by standardized quality indicators based on the minimum data set (Kane et al. 2003). All hypotheses were confirmed, and in fact some of the quality indicators were statistically significantly better for the Green House than the comparison groups, particularly the indicator on minimizing decline in physical functioning (Kane et al. 2007).

Family and staff members also benefit from involvement with the Green House. For example, family members maintained greater involvement with their relatives in the Green Houses and were more satisfied with their relatives' care than families with relatives in the other living facilities (Lum et al. 2008). Compared to the control groups, the CNA-level staff believed they knew their residents, had more sense that they could positively influence outcomes, and had great intrinsic and extrinsic job satisfaction.

Since the original implementation of the Green House model, the sponsoring nursing home in Tupelo has built additional Green Houses. The two Green Houses (Laney House and Page House) that were originally developed as dementia settings have retained their identity. Five years after implementation, most of the original residents in the houses were still living, though some had lost their ambulatory

status or become less verbal. Staff turnover in those houses was also low. Newly admitted residents who might have qualified for the dementia SCU because of moderately advanced dementia with behavior issues tended to be admitted to those original dementia homes. But other Green Houses on the campus also served many elders with dementia, and no effort was made to relocate people who deteriorated.

In 2005, the Robert Wood Johnson Foundation funded a large 5-year project for rapid replication of Green Houses with the goal of implementing 50 new Green House programs and having widespread presence in most states. Counting the Mississippi programs, as of July 2009, at least 15 nursing-home Green House projects are operating in 11 states, and many more are in construction or under development. From review of the website, it appears that only one is planned to be a dementia-specific Green House.

In addition to the Green House projects, other firms are developing variations on the small-house theme that are similar but do not carry the Green House trademark. One such program has been developed by the Otterbein Retirement Homes of Ohio, a non-profit firm that operates a multi-level retirement campus. Two variations in this Otterbein initiative, called Avalon Neighborhoods by Otterbein, are noteworthy. First, the small-house nursing homes are situated away from the larger campuses in regular housing areas; and second, the projects designate 1–2 houses for post-acute care and short-stay rehabilitation. The long-stay houses tend to have a majority of residents with dementia, although they also serve residents without dementia. Four 5-house Avalon neighborhoods are already operating, and one of this chapter's authors (Kane) is leading a study particularly devoted to exploring lessons for Alzheimer's care emerging from the Avalon neighborhoods.

Conclusions and Implications

This chapter illustrated small-scale, homelike dementia care settings in the Netherlands and the United States, both examples from a cultural change movement in long-term care. The core values of various new models bear a strong resemblance to each other, emphasizing normalization of daily life, residents' autonomy and choices, individuality in service provision, and empowerment of front-line staff. Upholding these values provide opportunities to promote and enhance resilience.

Differences in implementation of small-scale living also exist between countries. This may be partially related to disparities in organization of health care services in general, and dementia care specifically. Additionally, some differences exist with respect to residents and staff. In the Netherlands, the development of small-scale living is mainly focused on people with dementia, although settings for other groups, such as people with traumatic brain injury or physical disabilities, have been created. Developments in the United States have created settings for frail people in general. Staffing levels may vary between both countries, although the core values of all-round nursing staff – providing personalized care – are similar. These developments result in certain challenges for clinical practice and future research.

Clinical Implications

There are several clinical implications for promoting positive growth and resilience in small-scale living. First, small-house models have shown "proof of concept"; they are operating successfully, they are liked by residents and their families, and tend to have waiting lists. Second, extraordinary skill development and empowerment has been observed among the CNAs and other nursing staff who work in these settings. Third, training of all personnel is essential to implement and sustain the model. Obviously the new elder assistant (referred to as the Shahbaz in the Green Houses) requires front-end training in a wide variety of topics, including culinary skills, managing kitchens laundries, housekeeping to conform to infection control standards, and team-building skills. Skills for effective communication with teammates, other nursing home personnel, families, and the general public are also crucial. Creativity, flexibility, and independence are important qualities for nursing staff in fulfilling these tasks.

Activities directors and occupational therapists are required to reinvent themselves and their programs because many of the large-group programs of conventional nursing-homes were no longer viable. Furthermore, although the small-house settings themselves permit a more normal rhythm of daily activity for each resident, activities personnel need to help frontline staff determine ways to take advantage of opportunities afforded by the physical settings, small community, and relaxed routines. New avenues for cooperation and negotiation of roles need to be sought in the future. Creative approaches to activities that build on the preferences and biographies of the residents, particularly those with dementia, are especially needed. Although the natural rhythms of the house, including cooking, provide a focus of interest, some residents with dementia seem not to have enough to do, and frontline care providers need suggestions for how they can trigger meaningful solo activities or interactions among residents who have more difficulty initiating activities because of cognitive impairment.

Future Research

The small-house and small-scale living models are now operational, and have proven their feasibility. Future research – both quantitative and qualitative – is necessary to refine the models. Based on our experiences, we recommend the following research areas:

1. Study of residents' characteristics and research into which residents reside best in small-scale, homelike settings. It is important to study how particular mixes of residents based on their physical and cognitive impairment influence the well-being of everyone in a small house. Additional studies of family members and staff, as well as the collective perspectives of all stakeholders also are warranted.
2. Examination of the appropriateness of small-scale living for late-stage dementia residents.

3. Post-occupancy evaluations to determine which aspects of the physical designs, fixtures, and furnishings and social and organizational environment work well and what could be improved. Additionally, greater detail and clarification of the concept of what constitutes small-scale, homelike settings is needed.
4. Investigation of the construction and operational costs of small-house nursing homes under differing assumptions of spaciousness, amenity level, and staffing.

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