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Care Villages

Over the past decade, several versions of a 'Village Model of Care' have emerged that sometimes are referred to as 'dementia villages'. The term 'Care Village' is used in this article in order to emphasize that the Village Concept is not limited to persons with dementia, and that the essence of this approach is much more than just the 'village style layout and physical environment'. This article examines six of these currently operating Villages.

By Bill Benbow

Methodology

For this article, an online search was conducted to elicit articles and news reports mentioning 'villages', 'dementia' and 'care'. Specific leads were followed-up once a 'Care Village' was identified.

A ***survey form*** was developed and sent to eleven currently operating 'Care Villages' around the world. Six Care Villages completed the survey either on-line or were interviewed by phone.

Two of the Villages, The Hogeweyk in the Netherlands, and Langley in British Columbia, have been visited by the author.

From the survey, six factors emerged as significant for understanding the Village concept:

- Admission Criteria;
- The Household model in terms of number of residents and principles for grouping;
- A Community Hub of Amenities;
- Outdoor access;
- A Psychosocial Approach; and,
- Security/Community Permeability.

Admission criteria

Some Care Villages admit residents with a broad range of Assisted Living and Chronic Care needs while others have developed a specialty for dementia residents, and some target a particular segment or stage of dementia.

The 'Household Model'

The main 'building block' of a Care Village is the 'Household Model', also known as the Small House Model. This model reduced the number of residents in Nursing Home units down to approximately 6 to 20 residents. Some proponents feel strongly that 15 should be the upper limit, and others feel that 6 is the ideal. This lower figure is sometimes referred to as 'The Small Group Model'.

Underlying principle

For this article we will use the term 'Household Model' as it encompasses the residents in their Home. The underlying principle is the provision of a 'human scale environment' where residents can live their lives as normally as possible.

The 'Household Model' customarily includes private resident rooms with ensuites, domestic kitchens with dining area, and lounges.

An 'empowered Household', specific and often with multi-tasking staff, is an important component, as is the inclusion of residents in every-day activities such as assisting with food preparation, laundry, cleaning, etc.

An important aspect of the 'Household Model' is the composition of the residents: i.e., how residents are grouped. Some facilities group residents into Households by their functional abilities and disabilities, usually related to disease stage.

Other facilities group residents by their personal values and historic lifestyles.

Some facilities have combined several Households into Neighbourhoods of two or more Households, sometimes sharing an adjacent activity and walking area as in Evergreen's Creekview Center in Wisconsin. This has been found to be more economically viable and better for staff support than stand-alone Households and led to the Care Village Model **(Benbow, 2012).**

A community hub of amenities

A community hub of amenities, such as a café, general store, hair dresser, activity rooms, theatre, etc., provide opportunities for outings, activities and a safe walking zone for residents. "We all need to get out of the house on occasion to meet with others and participate in a wider range of activities than may be available within our immediate 'family group' **(Nelson, 2009).**

Outdoor access

Outdoor views and easy access are critical to Quality of Life. There is growing research that supports spending time outdoors both pas-

sively and actively, exploring, gardening, walking along a path, or just sitting to soak up the sun. Benefits include a positive impact on mental health, mood, reduced agitation and aggression and reduced behavioural medications, and better sleep **(Chaudhury, Caukins, Benbow, 2014).**

A psychosocial care approach

From the beginning, these Household units were based on a person-centred approach as espoused by Kitwood with his emphasis on psychosocial needs.

Kitwood's key concept is that personhood is bestowed through relationships and meeting social and emotional needs **(Kitwood, 1997; Jenkins, et al., 2013).** These needs are basically Belonging, Occupation, and Self-identity, and meeting these needs is a critical component to Quality of Life for residents **(Benbow, 2019).** Without this attention to Care in terms of residents' individual needs, interests, emotions and relationships, the Household model often fails to improve Quality of Life relative to larger units **(Eden Website, Benbow, 2019).**

Security/permeability

Facilities that specialize in dementia care, and those with Special Care Units, traditionally utilize some form of exit controls to provide a safe and secure environment and prevent elopement.

Recently, some authors have raised concerns about. . .

1. Segregating persons with dementia, and
2. Detaining persons with dementia against their will.

These authors note that, often people with dementia move into a Care Home under duress or unwillingly.

Also, segregating people living with dementia, from residents without dementia, with locked doors and fences, often means they have limited access to social activities, the outdoors, and the broader community.

The authors argue that this is a violation of their human rights; people with dementia continue to want choices and a say in their living conditions, lifestyle and independence **(Steele, 2019; Power, 2016).**

Evolution of the 'Village Concept'

Of course, the Village concept developed and evolved to provide greater independence and freedom of movement and experience for residents. For persons with dementia it was always intended to be an open society with minimal reliance on restraints for people who need the protective care and support of a nursing home.

All Care Villages try to minimize the intrusiveness of locked doors and fences with an array of strategies such as camouflaging exits, out of sight and around the corner egress doors, landscaping to mute fences, and other distractions such as busy outdoor squares, walking paths, activities and seating in beautiful gardens.

Technology is helping to meet some of the security needs with GPS tracking, door and floor sensors to alert staff of residents' movements, cameras, etc.

In addition, Care Villages are making concerted efforts to mitigate the gated community connotation and make their Nursing Home more permeable by welcoming the surrounding Community into Village life.

Hence, in our analysis of the following six Care Villages, we shall note both the degree of permeability with the surrounding community and the measures taken to provide a safe and secure environment.

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Sherbrooke Village, Saskatoon

One of the earliest Care Villages, The Sherbrooke Community Centre composed of the Kinsmen and Veterans Villages, opened in Saskatoon, Saskatchewan in 1999.

An internal street links eleven bungalow style houses in two groups, the Kinsmen Village of seven Households of 9 residents each and the Veterans Village of four Households each with 10 residents. This is considered the optimum number of residents as any more makes it difficult for both residents and staff to form relationships. Larger groups result in staff being more task-oriented and less focused on relationships. A Household of 20 residents can mean as many as 30 staff involved with a resident. *(Personal communication, Suellen Beatty).*

Moving-in criteria includes all Complex Care including dementia, especially the more complicated residents with unmet needs. Originally, two of the Sherbrooke Village Households were dedicated ***'Memory Care for Persons with Dementia'.***

Segregation of dementia residents is wrong

Sherbrooke now believes segregation of dementia residents is wrong as it stigmatizes residents with dementia: the label 'dementia' connotes something to fear and avoid'. Both staff and residents become isolated. Fear and prejudice grow: persons with dementia are seen as potentially dangerous.

Persons with dementia do better when integrated with residents who do not have dementia. They benefit

from the role models of cognitively intact residents.

Fully integrated!

One of the dementia specific Households at Sherbrooke has been fully integrated with the general Complex Care population, and the remaining specialized Household is reserved for residents with challenging, unmet needs.

Currently approximately 65-70 percent of residents have a dementia diagnosis which is on par with other complex care nursing homes in Canada. Residents are grouped by individual care needs and compatibility. ***(Personal Communication, Suellen Beatty).***

The houses of the Veterans Village at Sherbrooke have ten private bedrooms each with their own two-piece ensuite, while the houses of Kinsmen Village each have five private and two semi-private bedrooms that share washrooms.

The houses are bungalow style, with their own front door and a backdoor into a backyard. Each House has a domestic kitchen with a stove controlled by a keyed switch where 90% of food is prepared. A designated and locked cupboard stores medications and records.

Off the kitchen is a domestic scale dining room. There is also a living room adjacent to the dining room with access to a patio and garden.

Pairs of houses are joined through a service corridor with storage, housekeeping and bathing spa.

Connecting the 'Villages'

The Internal Street connects the villages to a wide variety of services and amenities including a café, spiritual care centre, multipurpose rooms, the Tumbleweed Gift and Thrift shop, art studio, accessible computer room, farmers' market, hair salon and access to 'at grade' gardens. With frequent minus 20-degree winter temperatures the Internal Street is quite necessary.

Multi-skilled daily living assistants work in the houses. The staff are qualified, special care aides with additional training in housekeeping methodology, food safety, and medication administration.

Sherbrooke is committed to consistent staffing, meaning that all care staff belong to a specific 'neighbourhood' and group of elders.

Nurses are available in a model that resembles Home Care. In addition, Sherbrooke utilizes the assistance of about 400 volunteers.

The Eden Alternative®

This Village Model espouses the Eden Alternative philosophy of

W.H. Thomas - which makes the fine distinction between person-centred care and person-directed care, namely, that rather than decisions being made by a group of caregivers, decisions belong with the elder or as close to the elder as possible.

The Eden Alternative is based on Seven Domains of Well-Being: security, autonomy, growth, meaning, connectedness, identity and Joy. These 'domains' are critical to addressing the individual's loneliness, boredom and helplessness.

The Sherbrooke approach maintains that their approach entails much more than just a change to the physical environment - it also requires organizational culture change to make it work. . . And the need for ongoing staff monitoring and training to ensure the change sticks ***(Sherbrooke Community website).***

Range of security

Sherbrooke's Care Village is moving towards a dementia inclusive community where there is a range of security and mitigated risks but reduced detention, i.e., external doors are locked evenings and nights, and for inclement weather.

GPS monitoring/tracking

Open egress prevails Monday to Friday daytime for most residents: those at risk have a wrist band that locks exits only for them. Some residents are equipped with GPS and other tracking aids. In addition, exits are well covered by cameras.

Only the one Household for residents with challenging, unmet needs is secure most of the time. Risks are mitigated through a comprehensive program to educate the broader community to offer assistance to residents who are exploring the town and appear to need assistance.

"In our world at Sherbrooke, if people want to leave, we look for what it is they are seeking that is not in the environment and try to provide it, or alternatively, what it is they are trying to get away from and try to remove it; usually, it is one of these two things.

Often people are looking for 'home,' which can be more a feeling than a reality. It could be their childhood home or a place they like to be, or just somewhere else other than where they are. It is usually somewhere where they feel safe.

I think their seeking is very purposeful and underlying that activity is an unmet need." ***(Personal communication, Suellen Beatty).***

Sherbrooke strives to include the community in village life by encouraging friends and guests to have meals with residents.

Visitors with school kids are welcome; a children's Day Care, a cat rescue program, and an Art Shack with community artists, are also part of Sherbrooke's inclusiveness.

Sherbrooke is operated by the Saskatoon District Health Region.

Below - Key Landmarks of The Hogeweyk

(Also See following page)

The Hogeweyk, The Netherlands

One of the most well-known Care Villages is the Dutch model, The Hogeweyk, located in Weesp, near Amsterdam, The Netherlands.

Mr. Eloy van Hal, senior advisor and one of the founders of the Hogeweyk, states that "there are many misunderstandings about what The Hogeweyk Concept is about...".

"Dementia villages differ a lot, and although we might be the inspiration, some are really completely different, and others completely according to the model. The Hogeweyk provides high level, licensed, Long Term Nursing Home Care."

The Hogeweyk success

An excellent analysis of what makes The Hogeweyk a success can be found in a *Report* by Tony Jones, an Australian Behavioural Consultant who visited The Hogeweyk in 2014. He saw no occurrence of BPSD (Behavioural and Psychological Symptoms of Dementia) during the more than four days he worked there as an Activities Volunteer. He was told that BPSD are very rare there **(Jones, 2014)**."

The founders of The Hogeweyk began devising their innovative model as early as 1993 in an older nursing home with person-centred care support, small-scale household living lifestyles, activity clubs and events, and central amenities. This concept was the basis for the on-site new building replacement opened in 2009. **(See illustration previous page)**

A licensed LTC home

The Hogeweyk is a licensed non-profit Long-Term Care Nursing Home for people with severe dementia, some with psychiatric aspects. This includes Stages 5 to 7 on the Global Deterioration Scale *(GDS/Reisberg Scale)* which includes middle and late stage dementia. Residents stay until death and receive palliative care. Approximately 40 percent are wheel chair dependent. ***(Personal Communication, Eloy Van Hal).***

A life of 'normalicy'

The Hogeweyk, started with 152 residents in 23 apartments, each with 6-7 residents in typical brick, two story row-housing buildings arranged with streets, squares, gardens and a town centre or hub of shops, cafés, restaurants, theatre and other amenities. It has grown to 169 residents in 27 apartments.

The intent of the founders and designers was to provide residents with the ability to live their life as 'Normally' as possible in the lifestyle they enjoyed prior to their need for care.

The building design and layout is like a typical Dutch Village where residents shopped daily for food and supplies and walked or biked to village amenities. The critical difference is that the houses form the perimeter and the squares, gardens and streets are on the inside so that residents have the opportunity to be engaged, safely, in all aspects of a normal life, including shopping, enjoying the outdoors and going for a walk throughout the Village.

Few resident limitations

Outdoor gardens, squares and paths comprise 50% of the 15,310 square metre site.

The only limitation to the freedom to wander is that, unless accompanied, residents do remain in the village. There is one main entrance controlled by a receptionist.

Each Apartment Household is family scale with 6 to 7 residents, all with their own private room, sharing two washrooms and toilets, a domestic kitchen, dining area, and lounge.

Six is considered the ideal number of residents in a Household based on the staffing model of one senior Caregiver in each of the morning and afternoon/evening shifts and an assistant caregiver in the morning.

Senior advisor, Eloy van Hal feels that, in their experience, more than 6-8 residents do not work well for the social care needed. Households have different internal layouts and exteriors as cues and landmarks to aid in wayfinding.

The 'Six Pillars' of the Hogeweyk Model of Care

Hogeweyk follows a social model of care with Six Pillars. They are:

1. 'A Favourable Surrounding' designed to provide a setting of a normal and familiar household.

2. 'Life's Pleasures' so that residents can continue to live their lives as they are used to, with opportunities for social activities and relationships within the Household and in the 30 different kinds of clubs and events inside and outside the neighbourhood.

Government funding covers a minimum of 30 minutes of activity and events for each resident per week, with the option available for residents to purchase additional activity clubs and events.

3. 'Health' with highly qualified medical care and support and an emphasis on well-being and a social-relational system to ensure Quality of Life.

4. 'Lifestyle' which includes surroundings, environment, interior design, social behaviour, daily routines, preparation of meals, and norms and values.

5. 'Employees and Volunteers' are trained to share this vision, and whenever possible include residents in their activities such as for grocery shopping and preparing meals.

6. 'The Organization' actively supports this vision to de-institutionalize, transform and normalize.

Uniqueness of Hogeweyk

What makes The Hogeweyk model unique is its focus on compatibility by providing a familiar and harmonious environment through 'Lifestyle' groupings of residents into Households that resemble discrete Dutch culture expression.

Originally seven life-styles were utilized; this has evolved to four distinct household designs and interest groupings:

- Urban (City),
- Traditional (artisans and farmers),
- Formal (well to do), and
- Cultural (cosmopolitan).

In Hogeweyk, residents can continue their daily life as it would be outside a nursing home with like-minded well-suited people in a way that is safe and familiar to how they have been living. Each Household can have residents with a range of functioning as they are not grouped by degree of dementia or behaviour.

Community inclusion

An important element of the Hogeweyk concept is the inclusion of the surrounding community. The on-site restaurant and theatre are open for the local community - and school children are involved every week in Village activities.

Residents leave the Village on bike tours, day-trips, and walks so that the surrounding neighbourhood is part of their lives.

Community access

Mr. van Hal, has indicated that next time he would design the entrance of the restaurant so that it is more directly connected to the street to facilitate community access. In our visit we saw numerous visitors and groups using the Village resources.

The Hogeweyk is a not-for-profit facility which cost 19.3 Million Euros to build with Government funding and some additional fund raising.

Operating costs are subsidized by government on a par with traditional nursing homes, with additional funding from residents for supplementary activities and events.

Bryghuset, Svendborg, Denmark

Bryghuset opened as a Care Village in November, 2016, after considerable renovations of an older 2 - 4 story Nursing Home that had once been a brewery. The facility is fenced with one main entrance.

Admission critieria includes moderate to severe dementia.

Currently 125 residents

The buildings now include 125 residents each with their own apartment, including 56 apartments for advanced stage residents in 7 Household-like sub-sections of 9 to 10 residents each, another section of 43 apartments for moderate stage residents in assisted living accommodation, 7 temporary guest homes, and 19 guest homes for younger people with disabilities.

The residents' accommodations are one or two-room apartments with a kitchenette and large disability-friendly ensuite; they are large by nursing home standards, with an average of 55 to 90 square meters.

Open-plan kitchens

Each Complex Care Sub-section/ Household has a common living room with an open-plan kitchen/ dining area, a laundry room and a small nurses station. Food is cooked in a central commercial kitchen for hot meals, with lunch and deserts prepared in-house.

Outdoor garden area

An adjacent property of 6300 sq. metres was purchased in order to add a large outdoor garden area with a network of paths, raised beds and a barn with chickens and rabbits.

Residents have access to an activity centre with a hairdresser, podiatrist, general store, second-hand shop, restaurant and café, as well as a 'gentlemen's cave', a music library, a country kitchen, physical training facilities and a hobby room all on the ground floor within a one and one-half metre fenced perimeter.

Moderate stage residents can navigate the lifts successfully and find their way to amenities - but the majority of residents need to be accompanied by staff, volunteers or family (70% to 80% of residents).

Grouping and function

Bryghuset does not follow the Lifestyle Model of grouping residents; instead, it places residents according to assessed functioning into Assisted Living for moderate stage dementia, or Care Residences

Bryghuset Care Village, Denmark

for advanced dementia, and by age and/or friendship.

There is some use of older reminiscence type furnishings, but this is not a major emphasis. Wayfinding is assisted by 'artistic signage'.

Person-centred approach

Bryghuset's model of care is based on Kitwood's Person-centred approach which promotes relationships as key to conveying personhood. The aim is to offer a safe and familiar way of living for people with dementia, so that they can still feel part of the local community. Everyday life is what matters, and still being part of life outside the village is promoted.

The town of Svendborg is quite involved in Bryghuset and covers the cost of additional outings and activities. The Activity centre is open to seniors from the local community and visitors, including children, are welcome to enjoy the park and gardens. Residents are taken on Rickshaw-style electric bicycle tours around town by volunteers.

Denmark prohibits the confinement of dementia residents. The perimeter fence at Bryghuset is limited to 1.5 meters - so, easy to scale.

The one main entrance is normally not locked, but rather is hidden from view. Residents who have a tendency to leave the home and get lost wear a GPS tracer in a pocket or bag and are distracted from wandering by the diversions and amenities afforded by the park-like setting.

The Project Manager has specifically recommended that the 'dementia' label for this type of Care Village be replaced with something less demeaning: ergo the 'Care Village' designation. ***(Personal Communication, Annette Soby).***

Bryghuset is a not for profit facility which receives the same operating subsidy from government as traditional nursing homes in Denmark.

The Village Langley, B.C.

The Village Langley, aka, 'The Village at Anderson Creek', opened in August, 2019 as the first Care Village in BC. It offers supportive living for persons with dementia.

A cluster of 6 single story cottage style homes (3 duplexes) are set on five acres of park-like grounds.

Connected households

A main paved walking street connects the Households to a Community Centre and garden areas, including sensory gardens, a farmyard with barn and veggie patch, outdoor activity terraces, a games lawn, natural meadows and a village plaza.

Two of the Households are for Complex Care and four are Assisted Living. They are identical in design except for the Complex Care having ceiling lifts and contrasting toilet seats.

7000 sq. ft. households

The Assisted Living cottages can be easily modified for Complex Care as rooms are designed to bear 'ceiling lift tracks' if required. Grouping is by need: Assisted Living or Complex Care, and to some degree, by age, and preferences.

Each 7000 square foot Household has 11 single rooms and 1 double, each with their own *ensuite*, which

includes a European style shower. The double room's design lacks privacy, which could be problematic.

Open plan layout

The overall layout of the Household is quite good with an open plan domestic kitchen, dining area, living room, activity/rec room, sunroom/den, short corridors with no dead-ends, and excellent visual access to amenities from resident rooms. A public washroom is adjacent to the dining area.

A service area connects pairs of Households with a soiled utility room, laundry, and bathing spa, as well as storage.

Main hot meals are provided to the Households by a central commercial kitchen. The Households provide breakfast and baking in the well equipped domestic kitchen. Of special note is the 'Rationale Oven' in each Household kitchen which is WiFi linked to the Village chef.

A second fridge is just off the kitchen and is easily accessible by residents for snacks and drinks.

The Community Centre houses shops, art and wood working areas, a barbershop and spa and a large activity area which residents are free to visit when they go to their local town centre. The community amenities are open to the public to create a continuity with the surrounding neighbourhood.

Life-styles paramount

The Care Model is very much person-directed where the joy, happiness, and lifestyle needs of each unique resident are paramount.

A modified 'Maslow type' 'well-being' pyramid is used to illustrate Intrinsic Needs (Psychological) and Extrinsic Needs (Physical) based on Dr. Power's approach. **(2016).**

Well-trained, 'Enriched Living Facilitators' (ELFs) staff the Households, and services of other professionals are offered centrally.

Variety of activities

A good variety of activities are available in the Community Centre and grounds, but Elroy Jespersen, Project Leader and a main force behind the Village, believes that 75% of activities will occur in Households. ***(Personal communication)***

The Village uses a *Concierge-controlled*, out of sight, main entrance in the Community Centre, and a perimeter fence around the entire

Village Langley, Langley, B.C.

Village. It also employs Blue Willow GPS technology which locates, tracks and records all residents and staff as they move about the Village.

Free movement issues

The concept of the free movement of residents is often a challenge for health authorities. In The Village Langley's case, the authority that licenses Complex Care facilities in that Health Region insisted that a secondary perimeter fence be installed around the patio gardens of the two dementia higher Care cottages; and even this had to be raised to a higher height than initially installed. So, security concerns trump even modest risk for some authorities, which effectively negates the main point of the Village Concept,

'. . . to allow residents the freedom to wander and access community amenities within a protected environment.'

Village Langley is a private facility with no subsidized beds. Monthly operating costs are estimated to be $7,300 for Assisted Living and $8,300. for Complex Care.

CareBright, Ireland

CareBright opened Ireland's first purpose-built community for people living with dementia in Bruff, County, Limerick, Ireland, in March, 2018, on a 4 acre site with a total complement of 18 residents.

The village has three T-shaped modern bungalows and a 'Community Hub', with extensive gardens and paths

Admission criteria

Admission criteria is early- and mid-stage dementia, as the operators found that this group can best benefit from village opportunities.

In the experience of the operators, those with more advanced stage dementia require more assistance and cannot benefit as much from the opportunities of the Community Hub. Still, residents stay for life as their needs increase.

The three bungalows each contain six one-bedroom apartments along the main branch of the 'T,' each with a large bedroom, an ensuite with shower, a sitting area and private patio garden.

These apartments connect to the communal living spaces, which include a domestic kitchen, dining, living room, and social nooks. Meals are prepared in house with resident assistance.

Interior décor is designed to help residents connect with memories.

An out of sight utility room contains a med cabinet and laundry.

'A social day club'

The Community Hub is a 'Social Day Club,' also open to the broader community which offers a wide variety of social activities including a forty-seat Café open to the general public, a sensory room, hair dressing salon, arts, crafts, gentle exercise, husbandry and gardening.

The garden pathways are like little roads, wide and paved, leading to a large kitchen garden with raised beds, a sensory and remembrance garden, and lots of seating areas. There is also an animal sanctuary with pygmy goats.

'Lifestyle Cultural Model'

The Village follows a 'Lifestyle Cultural Model' with people living together who share the same ideas and values in life.

Some grouping is emerging as residents age, with one Household geared to residents in advanced dementia stage.

CareBright's ethos is to live life in an environment which focuses on social interaction, peace and autonomy.

'Household Model of Care'

The client is at the centre of an activity-based 'Household Model of Care' with the aim of helping residents live as well as possible with dementia.

Residents are encouraged to participate in activities of daily living such as making breakfast, a daily wash, and making their bed.

Staff sensitivity essential

The importance of staff attitude is emphasized with an understanding that achieving the 'goals of the model' is dependent upon staff being sensitive to the needs of persons with dementia.

Life in CareBright is meant to feel open and free, with the Village style encouraging residents to interact, and take advantage of the amenities.

Gated community

Even so, it is a gated community with a perimeter fence and one main entrance controlled by key pad.

Cameras cover the front entrance to ensure resident safety.

The main difference with other models is the smaller scale of CareBright: a total of 18 residents in the Village, with six to a Household considered the "magic number;" and the acknowledgement that the

village model is most suitable for early and mid-stage dementia.

One particular feature to the CareBright approach is the insistence on family involvement: families must commit to visit residents a minimum of three times a week. *(Personal communication, Manager Majella Murphy, CareBright website).*

CareBright is a not-for profit social enterprise and cost approximately 5.6 million Euros to build - with ongoing fundraising for amenities. Operating costs are eligible for government subsidy through the Fair Deal Program.

The Care Village, New Zealand

The Care Village, New Zealand, formerly known as *'Whare Aroha CARE'*, opened in 2017 on a 1.3 hectare site (3 acres) situated on the edge of Lake Rotorua, about 200 kilometers south of Auckland, NZ.

Hogeweyk inspired

The Care Village New Zealand is inspired by and based on the concepts of The Hogeweyk and asserts that it is the first in the southern hemisphere.

However, similar to Sherbrooke, The Care Village NZ admits residents of a range of care levels from Resthome, Hospital level (high level care), and Secure Dementia Level care. They do not admit the very high psycho-geriatric care level residents. However, Thérèse Jeffs, the chief executive, estimates that 80 to 85% of residents have a level of dementia. *(Thérèse Jeffs, personal communication).*

The Village consists of 13 single-story, mid-century style households, themed according to the lifestyle of that era, with 6 - 7 residents each.

Private bedrooms

Residents have private bedrooms and many share washrooms between three residents, a domestic kitchen, dining area and lounge.

There are some ensuites. Residents, if able, assist staff in purchased food at the village store and preparing meals in-House.

Five New Zealand 'lifestyles'

Similar to The Hogeweyk, residents are grouped according to five New Zealand 'Lifestyles' so that they share similar backgrounds: Rural Living, Urban Living, Cultural (indigenous peoples), Simple Living and Classical Living. These have evolved from an original seven and been adjusted over time. As a result The CARE Village, New Zealand, has a mix of levels of care in their Households.

Residents may remain in their house as they progress through levels of care as their condition deteriorates to end of life. "It doesn't cause a problem. Six residents (no matter what the mix) living normally in a house based on lifestyles has little confusion, residents are happy and safe" *(personal communication, Thérèse Jeffs, The CARE Village, New Zealand).*

Like small town New Zealand

The village is like 'Small Town New Zealand' with the community amenities of a village grocery store, tearoom, orchard, and gardens.

The CARE Village, New Zealand's model of care, is based on preserving lifestyle, independence and community in order to enable residents to live as normal a life as possible, in familiar surroundings, doing normal activities, with freedom to roam shops, cafés, club rooms and a community hall.

Staff organize activity programs and resident outings. Volunteers are a key component to keeping alive the huge variety of things people love to do, which includes baking, gardening, woodwork, fixing cars, studying art, sports, visiting with children, music, cycle rides, reading and knitting.

Community centre open to the public

A planned community centre on the site will be open to the public, giving residents of the Village the opportunity to socialize with people outside the facility.

The CARE Village, New Zealand is protected by a secure perimeter and CCTV (close-caption TV) throughout the village.

Residents are monitored by smart technology wrist-bands which alert staff to resident locations and prevents the opening of external doors for those identified as needing secure level care. All other residents are free to come and go from the village. External doors are locked overnight. Although the houses are locked at night to 'entry only', egress is not limited.

Cutting costs

Capital cost was similar to that of a traditional nursing home, with savings achieved by reducing utilities such as commercial kitchen, laundry and sluicing rooms, and by utilizing used furniture to reflect earlier times.

See following pages for 'resarch into care villages', a 'Discussion' of the issues involved, and References.

"The village model of care"

Quite a lot of research exists regarding the Household model **(Dyer, Nelson, 2018)**; but very little has been undertaken on the Village Model. As Fagan notes in his article on The Hogeweyk, it is important to see if such neighbourhood environments have any beneficial effect on behaviour, functional ability, and cognition **(Fagan, 2014)**.

Positive influences

The Vivium Group that operates The Hogeweyk references research, not specific to their facility, that has shown positive influence on the brain and a decrease in agitation and aggression by a number of features, which include: Exercise, Fresh Air and Day Light, Views of Nature, Social Contacts, Pleasant Physical Surroundings, and Small Groups. **(The Hogeweyk Care Concept)**.

They also point out that The Hogeweyk scores above average on residents and family satisfaction in biennial reviews.

Observations are also made that residents socialize more, eat better, use less meds, and stay longer; an average stay of two to three years **(CNN, 2013; Daily Mail, March 4, 2012; Eloy van Hal, 2014)**.

No behavioural issues

Similarly, Thérèse Jeffs of The Care Village, New Zealand, noted in 2017 that in the short time the village had been open there had been a marked decline in behavioural incidents and falls **(Residents' Behaviour Changes, Kai Tiaki, 2017)**. She adds in 2019 that "the model works, it is amazing. The residents and staff are happy, and there is virtually no behavioural issues and limited use of medication intervention." **(Thérèse Jeffs personal communication)** A PHD student is following up with research on The CARE Village, New Zealand. **(Kay Shannon personal communication)**

Village concept research

Research specific to the Village Concept is limited to a few scientific papers. The most interesting is a 2018 Danish study of Bryghuset. The researchers found that the main theme for this approach is to "enable a familiar and meaningful everyday life". However, they also found that "people with advanced dementia may not be able to benefit from the activities and possibilities provided by the dementia village, since this required resources beyond what could be provided."

Basically, the expanded opportunities of the Village approach primarily benefited residents with moderate dementia. More advanced dementia residents required assistance to access going for a walk in the garden or to the Community amenities.

Late dementia. . . 'Passive Participation'

Most of the everyday life of the residents with advanced dementia took place within the Households. For more people with dementia to take advantage of these opportunities requires more staff and volunteers than are normally available **(Peoples, 2018)**.

Eloy van Hal has commented that, in his experience, residents with Late Dementia can still benefit through passive participation in activities by experiencing the sounds, sights, smells of interesting happenings and supportive surroundings.

A 2012 study of The Hogeweyk provides an excellent description of the history of the concept and development of the Village Model.

Self-esteem, autonomy, and independence

This study emphasizes the strong significance placed on the background and lifestyle of the residents prior to admission to the Village. They found that the collaboration of the design and care program promotes self-esteem, autonomy, and independence within a safe environment. It is noted that the external façade of this facility is somewhat less than inviting to outside community members. This is acknowledged by the operators who do wish to increase participation of the broader community **(Anderzhon, 2012)**.

A case study based on The Hogeweyk in 2018 analysed the dementia village concept as an architectural hybrid between healthcare and hospitality facilities. They found that the dementia village operates under two principles: to reduce anxiety and to increase quality of life by focusing on capabilities rather than disability: i.e., a prosthetic environment. The study praised the automated smart lift and lack of locks for unobstructed movement to outdoors and amenities.

Community interaction

Their main criticism was the potential for isolation due to the Villages' remote location and reduced integration with the broader town community.

Eloy van Hal, one of the founders, has stated his preference and ongoing efforts for greater community interaction **(Eloy van Hal, 2014)**.

Care Villages: Discussion/Conclusion

Care Villages are multiplying and appearing in many iterations across the world, including Tonebon am See in Hamelin, Germany, Villaggio Emanuele Bufalotta in Rome, Bellmere MicroTown in Queensland, Australia, and soon to open Village Landais Alzheimer in Dax, France, and in Comox on Vancouver Island.

The similarities

Similarities among Care Villages are basically the self-contained village composed of several small households linked to outdoor gardens and a community Hub.

The Village approach generally encompasses a person-centred or person-directed psychosocial model of care, with an emphasis on involving residents in normal household activities so they can live as they did before requiring care. Differences are admission criteria which varies from a wide range of Assisted Living and Complex Care needs to one or more stages of dementia.

The size of the Households range from 6 to 15 or more, with differing opinions on the most ideal group size. Also, how the residents are grouped into Households can be based on resident's historic Lifestyle as in Hogeweyk.

Segregation and dementia

The issue of segregation of residents with dementia is important to address: the antidote may be to integrate persons with dementia with other persons either within the Village or by welcoming visitors from the broader community and to educate both the Village community and the broader community to accept, and be sensitive to persons with dementia; otherwise nobody recognizes or knows persons with dementia, which means they are actually less safe, i.e., less likely to be recognized as needing assistance. **(Personal communications: Suellen Beatty).**

Care villages & security

How Security is managed is a critical issue. As noted in an earlier article by this author, it is critical for nursing homes to have clear security guidelines, policies and procedures in place and ensure resident and family involvement in determining the degree of supervision required in managing risk of elopement **(Benbow, 2017)**. It may be necessary to have a doctor's order for the person to live in a secure living area **(Calkins, 2018)**.

Like Denmark the Netherlands is considering legislation in the coming year to address confinement of residents in Nursing Homes.

Operating costs

A concern regarding the emerging Village Care model is the capital and operating costs relative to Traditional Nursing Homes. As indicated above, most of the Care Villages are non-profit and have been built based on Government funding or subsidy with some additional fund-raising to cover enhanced amenities.

Capital cost savings are achieved through the elimination of some utilities such as commercial kitchen, laundry and sluicing facilities which are Household-based and more residential in cost.

Multi-tasking care staff

Operating costs are reduced and reorganized through the staffing models that utilize multi-tasking care staff that often are responsible for cleaning, laundry, shopping and cooking for their individual Households, eliminating centralized staffing of commercial kitchen, laundry and Household cleaning services.

Similar budgets

Also, Activity Staff utilize volunteers to assist in coordination, transportation and support. Through these efficiencies, the non-profit Care Villages manage with the same budgets as traditional Nursing Homes. **(Personal communication: Eloy Van Hal, Therese Jeffs).**

Research is quite limited; so much needs to be done to establish effectiveness of Quality of Care and Quality of Life and cost benefits for this model relative to other approaches. As new versions open and more of these Villages build up experience, we can anticipate greater research interest.

Late Stage Dementia

Of particular concern is what can be done to assist residents with Late Stage Dementia to participate in the opportunities that a Village model offers. The Hogeweyk experience, with this most challenging group, is noteworthy. Jenkins and Smythe observed after their visit to The Hogeweyk that this supportive environment enabled people with severe dementia to carry out roles and activities that are not usually associated with levels of functioning of people in the later stages of the disease **(Jenkins & Smythe, 2013)**.

Normal living

The Care Village concept enables dementia residents to live as normally as possible in a human-scale home and still utilize the opportunities of outdoor gardens,walkways and community services.

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