THE ROLE OF THE SOCIAL AND PHYSICAL ENVIRONMENTS IN INFORMAL SOCIAL INTERACTION AMONG PEOPLE WITH DEMENTIA RESIDING IN SPECIAL CARE UNITS

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ABSTRACT

The purpose of this study was to explore the nature of informal social interaction among people with dementia residing in special care units and to provide insight into the role of the social and physical environments in facilitating or hindering these spontaneous interactions. An ethnographic approach was used including in-depth interviews with staff members and resident observations. Findings revealed that residents within special care units engage in several types of informal social interactions including: 1) active verbal communications, 2) brief verbal communications, 3) touching, 4) gesture, 5) glancing, 6) attention seeking, and 7) other non-verbal communication. This study also found that social environmental factors such as staff work roles and resident group size as well as physical environmental features such as the presence of multiple sightlines, transitions spaces, low noise levels, and the nursing station location play a crucial role in influencing informal social interaction within a dementia care setting.

Keywords: Dementia; informal social interaction; social engagement; special care unit; long-term care; physical environment
DEDICATION

To my family –

This work would not have been possible without your unconditional love and inspiration. You have always encouraged and supported me in all of my endeavours and I am truly grateful for this. Thank you!

And to the many individuals living with dementia who have inspired me through sharing their lives and experiences with me.
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TABLE OF CONTENTS

Approval .......................................................................................................................... ii
Abstract ........................................................................................................................... iii
Dedication....................................................................................................................... iv
Acknowledgements ........................................................................................................ v
Table of Contents ........................................................................................................... vi
List of Tables .................................................................................................................. viii

Chapter 1: Introduction ........................................................................................................ 1
  1.1 Importance of Social Interaction in Long-Term Care Facilities ...................................... 2
  1.2 Social Interaction in Relation to Institutionalized People with Dementia ......................... 4
  1.3 Purpose of Study ........................................................................................................... 5
  1.4 Defining Informal Social Interaction ............................................................................... 5

Chapter 2: Literature Review ................................................................................................ 8
  2.1 Individual Attributes Associated with Social Interaction ............................................... 9
    2.1.1 Resident Needs and Wants ....................................................................................... 9
    2.1.2 Physiological and Psychological Characteristics ..................................................... 10
  2.2 Organizational Attributes Associated with Social Interactions ....................................... 12
    2.2.1 Social Environment ............................................................................................... 12
    2.2.2 Institutional Care Philosophies .............................................................................. 13
  2.3 Role of the Physical Environment in Influencing Social Interaction ................................. 14
    2.3.1 Space Use and Patterns ......................................................................................... 14
    2.3.2 Dining Room and Kitchen ..................................................................................... 15
    2.3.3 Corridors and Walking Paths .................................................................................. 16
    2.3.4 Living Rooms, Activity Spaces, Green Space, and Other Common Spaces ............... 17
  2.4 Discussion ................................................................................................................... 19

Chapter 3: Conceptual Framework ...................................................................................... 23
  3.1 Theoretical Background ............................................................................................... 23
  3.2 Conceptual Framework of Social Interaction in SCUs .................................................. 27
    3.2.1 Organizational and Social Environmental Influences on Informal Social Interaction ................................................................. 27
    3.2.2 The Physical Environment on Informal Social Interaction ..................................... 28
    3.2.3 Individual and Psychological Factors on Informal Social Interaction .................... 29
    3.2.4 Situational Factors on Informal Social Interaction ................................................ 30
  3.3 Research Questions ...................................................................................................... 31
LIST OF TABLES

Table 1: Description of Research Settings ........................................................................... 36
CHAPTER 1: INTRODUCTION

Socializing and developing relationships with others not only brings a sense of satisfaction and meaning to our everyday lives, but it is also something that is often taken for granted. The importance of social relationships and social support networks for seniors’ well-being has garnered considerable attention in the research literature (Pinquart & Sorensen, 2000). More specifically, this body of research has shown the importance of both social relationships and support within residential care settings (Street, Burge, Quadagno, & Barrett, 2007; Powers, 1988).

Despite the many challenges older adults face in moving into long-term care facilities, these facilities pose unique opportunities in terms of their ability to meet new people, becoming engaged within the community, and ultimately in expanding their social network. Street and colleagues (2007) suggest that individuals in residential care facilities have the capacity to form new support networks and that the relationships within these facilities become even more important to well-being than past relationships with family and friends.

Unfortunately, while social interaction and integration are goals of many residential care facilities (e.g. Long-Term Care Homes Act, 2007), a majority of the focus has been put on developing recreational activities and programs for residents in achieving these goals. While there is no doubt that these activity programs are beneficial and serve an important purpose in promoting social
interaction (i.e. Romack, 2004; Buettner, 2001), very few researchers have
directed their attention at comprehensively understanding ways to provide
opportunities for social interaction on a regular basis (outside of recreational
therapy) among residents. Consequently, it is important to provide insight into
how this can be achieved in residential care environments. In particular, the
proposed study will focus on exploring informal social interaction among
residents with dementia in residential care settings.

1.1 Importance of Social Interaction in Long-Term Care Facilities

Although research aimed at understanding social interaction among
residents in long-term care facilities is scarce, this avenue of research is of
utmost importance for several reasons. These include its impact on alleviating
loneliness, maintaining a sense of self-identity, and most notably, the ability to
increase quality of life.

Living in a long-term care facility is associated with higher levels of
loneliness (Pinquart & Sorensen, 2001). Similarly, with regards to older adults in
general, both the quality of social networks and contact with friends in
comparison to family members is more strongly associated with loneliness
(Pinquart & Sorensen, 2001). Hence, examining social interaction may also be
beneficial in providing insight into the development of social ties and friendships
within long-term care facilities as a means of combating loneliness.

Furthermore, maintaining a sense of personal identity is a major challenge
for nursing home residents (Tobin as cited in Kane, 1995). This is especially true
for men residing in these facilities, as it is more difficult for them as opposed to women, to maintain past social roles, which are critical to their identity (Moss & Moss, 2007; Powers, 1988). In fact, a positive self-concept mediates the relationship between social support and a positive psychological and physical well-being (Kim & Nesselroade, 2003). Consequently, understanding the factors that influence social interaction within residential care facilities can potentially provide insight into addressing these challenges and ultimately in improving the health and well-being of residents.

Additionally, although it is often not well articulated, it is evident that social interaction is a crucial component of quality of life. A considerable amount of attention in recent years has focused on addressing the psychosocial aspects of quality of life within institutionalized seniors (i.e. Kane, 2001; Cohn & Sugar, 1991). According to Lawton (2001), social interactions and relationships with others act as indicators of quality of life in residential care settings. Lawton (1991) also outlines that quality of life is comprised of four domains: a) behavioural competence, which is an evaluation of a person’s functioning on several domains including social behaviour, b) perceived quality of life, c) the environment, and d) psychological well-being. Interacting with others and being engaged within a residential care setting has been shown to influence a variety of these quality of life domains. Street and colleagues (2007) suggest that positive relations with others in long-term care facilities is associated with significantly higher life satisfaction. Similarly, perceived social support is associated with increased psychological well-being (Cummings, 2002), whereas social
integration and cohesion (Mitchell & Kemp, 2000), as well as social interaction and engagement (Jang, Mortimer, Haley & Borenstein Graves, 2004; Mor et al., 1995) all appear to be critical in achieving quality of life within long-term care facilities.

1.2 Social Interaction in Relation to Institutionalized People with Dementia

According to recent figures, over 196,000 older adults in Canada reside within long-term care facilities (Statistics Canada, 2008) and it has been estimated that the prevalence of dementia among those residing within these facilities is over 50% (Moser et al., 2003; Graham et al., 1997; Hill, Forbes, Berthelot, Lindsay & McDowell, 1996). Thus, as the proportion of institutionalized seniors with dementia continues to increase, it is important that care environments are responsive to the needs and preferences of these residents.

In relation to people with dementia in general, Kitwood and Bredin (1992) suggest that initiating social contact is a key indicator of overall well being. Unfortunately, institutionalized seniors, especially those with dementia, are quite susceptible to decreased social engagement and thus spend very little time interacting with others (Schroll, Jonsson, Mor, Berg & Sherwood, 1997). For example, several studies have indicated that with regards to residents with dementia, a large proportion of their time is spent alone, not engaged in any activity, and with little social interaction (Schreiner, Yamamoto & Shiotani, 2005; Diaz Moore & Verhoef, 1999). However, new evidence suggests that people with dementia are not only capable of communication, but invest a great deal of time
attempting to meaningfully engage with others around them (Ward, Vass, Aggarwal, Garfield & Cybyk, 2008).

1.3 Purpose of Study

In response to the needs of people with dementia, special care units (SCUs) have gained prominence in recent years. SCUs attempt to provide people with dementia with a therapeutic environment through the implementation of various prosthetic design features (US Congress, 1992). More specifically, one of the main objectives in guiding their design is to enhance social interaction and encourage communication among residents within these environments (Stevens, 1996; U.S. Congress, 1992). Considering that social interaction appears to play a crucial role in positively influencing the quality of life of institutionalized seniors, and the continuous focus on creating therapeutic and supportive environments for people with dementia, it is surprising that there is relatively little research available examining the ways to facilitate informal social interaction in residential care environments.

As a result, the purpose of this investigation is two-fold. First, it attempts to investigate the nature of informal social interaction among people with dementia residing in special care units, and second, this study will provide insights into the role of the physical environment in facilitating informal social interactions.

1.4 Defining Informal Social Interaction

It is important to address the meaning of informal social interaction within a long-term care setting. This is especially true given the vast amount of variation
in residents, both regarding cognitive and physical functioning. According to Bath and Deeg (2005), social interaction is oftentimes described in terms of participating in activities that have a social component. In essence, social interaction is a dynamic interplay between two or more individuals, where these individuals interpret and react to each other. This may include verbal behaviours such as having a conversation or non-verbal behaviours such as engaging in an activity together (i.e. playing cards or throwing a ball).

However, within a special care unit setting, the formal definitional boundaries of social interaction are oftentimes blurred. In particular, when considering social interaction in people with dementia, behaviours as simple as a gaze can be considered as an example of social interaction. Social interactions in this population include verbal expressions such as short or sustained conversations, and to a much greater extent, non-verbal behaviours such as adjustments in body posture, making eye-contact, acknowledging others, touch or coming into physical contact with others, and facial expressions (Hubbard, Tester and Downs, 2003; Hubbard, Cook, Tester and Downs, 2002; Kelley, 1997).

Although a considerable amount of attention has been provided toward facilitating social interaction through planned activities in special care units, the focus of this investigation is in looking at and facilitating more casual interactions among residents. This includes resident-resident, resident-staff, and resident-visitor interactions outside of planned activities and formal care practices.
Thus, for the purpose of this investigation, the term ‘informal social interaction’ will be operationalized as any spontaneous contact between two or more individuals, outside of planned activities and formal care practices, which includes interpreting and reacting to the other actor in a verbal or non-verbal capacity.
CHAPTER 2: LITERATURE REVIEW

A review and examination of studies addressing social interaction within residential care facilities was undertaken in order to develop an understanding of the topic and to provide guidance on research directions. In order to identify studies for review, a keyword search was conducted in several academic databases including: Ageline, Academic Search Elite, Alt HealthWatch, CINAHL, PsychINFO, Scopus, and Web of Science. Keyword terms searched included: “social interaction”, “social engagement”, “social integration”, “social relationships”, “socialization”, “friendship”, “long-term care”, “residential care”, “nursing home”, “sense of community” and “physical environment.” In addition, reference lists for relevant studies were also examined and key articles were included for this review. Relevant articles were identified and assessed by title and review of the abstract.

Articles meeting the inclusion criteria were obtained; however those unavailable through the Simon Fraser University Library System were not reviewed for this investigation. Inclusion criteria for this study was as follows: (a) a report of empirical research, (b) written in English, (c) address social interaction or relationships in a residential care setting, and (d) preferably focuses on informal social interactions (i.e. studies that focused solely on the resident-staff interactions during planned activities and relationships were not reviewed).
Although there is an abundance of literature detailing the positive effects of social interaction on quality of life, well-being, and health, there has been relatively little research specifically documenting the key factors influencing social interaction within a residential care setting and consequently the development of new social support networks. The following section attempts to bring some clarity to these factors by providing an overview of the key research findings. Specifically, several themes were identified throughout the literature, which are critical to understanding the issue at hand. They have been included in two broad categories, individual attributes and organizational attributes which encompass both the physical and social environment of a care facility.

2.1 Individual Attributes Associated with Social Interaction

Individual factors are critical in determining whether or not a person engages in a relationship or interaction with others; however these attributes are oftentimes overlooked. Several studies have attempted to examine these factors and are reviewed accordingly.

2.1.1 Resident Needs and Wants

There is a consensus amongst researchers that older adults living within residential care settings do in fact value social contact with others, despite the apparent lack of interaction in common spaces. According to Counsel and Care (as cited in Squire, 2001), residents in residential care settings were keen on having adequate privacy, choices, and being treated as friends as opposed to patients; however these needs were rarely being met. Similarly, in interviewing
several nursing home residents, it was found that establishing a sense of community and supportive relationships within these homes is of importance for these residents (Taunton, Coffland, Pedram, Piamjariyakul & Bott, 2006). Additionally, older adults residing in these facilities engage in different activities and relationships for various purposes. In a longitudinal study conducted by Iwasiw and colleagues (2003), it is noted that these people participate in daily activities to fit in, but also maintain previous relationships with family and establish new ones with peers in an attempt to maintain former identities. However, residents do not want to engage in social contact all the time. Hauge and Heggen (2008) found that residents are often forced into relationships and interaction with others. Those who were mobile and able to withdraw from these situations did so, while those who were not mobile were restricted and could not escape these situations.

2.1.2 Physiological and Psychological Characteristics

Research literature also identifies certain physiological and psychological attributes of a person which are important in determining a person’s decision to engage in interactions with others. Physical frailty and immobility not only frame where residents interact, but also influence the ways in which people interact (Hauge & Heggen, 2008; Hubbard et al., 2003). Similarly, residents with impairment in activities of daily living become more dependent on supervised activities and programming in order to remain engaged within the immediate community (Yee, 1999). In terms of hearing acuity, it has been found to decrease with age, ultimately impairing social interaction (Rule et al., 1992).
Likewise, Resnick and colleagues (1997) found that visual impairment, severe hearing impairment, and low levels of communication ability are associated with low social engagement in nursing home residents. This last point is especially true in people suffering from aphasia. These people cannot verbally express themselves and are often isolated and subject to hostile behaviours from other residents (McAllister & Silverman, 1999). Additionally, Cook, Brown-Wilson, and Forte (2006) also note that sensory impairment, especially loss of vision, severely impacts the ability of residents to maintain social interaction and develop social relationships with other residents. Specifically, residents who are aware of failing to acknowledge others following initial introductions and discussions due to visual impairment may even withdraw and refrain from future social contact with others.

Some research has even discussed the degree to which residents are able to participate in social interactions and relationships. Street and colleagues (2007) suggest that individuals within care facilities have the capacity to form new social relationships. However, according to McAllister and Silverman (1999), this depends on several factors including cognitive status, health status, environmental design, and programming design. Mor and colleagues (1995) agree with this assessment, as they hold the perception that the capacity for social engagement is influenced by physical and cognitive impairment. Yet, other lines of research have looked at the social-cognitive functioning of nursing home residents, both those with and without cognitive impairment (Washburn & Sands, 2006). Washburn and Sands conducted a pilot study comparing nursing
home residents on various measures of social cognition. Although there were differences between the two groups in terms of facial processing, person perception, and social reasoning (i.e. the cognitively intact group scored higher), no differences were found on tests of affect recognition and recognition of social situations, indicating that even people with dementia are able to engage socially and maintain personal relationships.

Finally, there are other intrinsic factors which have been recognized as influencing social interactions. While the research in this domain is limited, McAllister and Silverman (1999) suggest that a person’s emotional state, ability to cope with these feelings, and their personality are all determinates of social interaction in long-term care facilities.

2.2 Organizational Attributes Associated with Social Interactions

In the present attempt to understand the factors contributing to social interaction among residents in long-term care, it is important to examine the institutional facility and how it can both promote and deter these social interactions. Two important components of institutional care facilities, the social environment and the physical environment, are reviewed.

2.2.1 Social Environment

Historically speaking, although there has been an interest in improving quality of life via social interaction and support, much of this has focused on increasing the number of planned activities employed (Ice, 2002). As Ice
suggests, while the quality of these activities has improved drastically, informal social interaction amongst residents has not. This may be attributed to the fact that despite being in close proximity of other residents, a majority of the actual interactions occur between the resident and staff (DePoy, 1993). However, in McAllister and Silverman’s (1999) comparative study of community formation within a special care unit and a traditional nursing home, it was found that certain attributes of programming are more conducive to interaction amongst residents and consequently to the formation of a sense of community. These attributes include providing activities in smaller groups, providing a variety of activities for residents to choose, and encouragement of informal interactions.

2.2.2 Institutional Care Philosophies

Beyond programmed activities, institutional care policies and philosophies have also been identified in the literature as influencing informal social interactions (Hubbard et al., 2003; McKee, Harrison & Lee, 1999). One of the major deterrents of social interactions is the medical model of care typically found in traditional nursing homes (i.e. Diaz Moore, 1999; McAllister & Silverman, 1999). These models typically emphasize resident safety in a physical and medical sphere and efficiency from a nursing perspective (McAllister & Silverman, 1999). Taking this approach to care has been shown to negatively influence social engagement, especially within the dining room (McAllister & Silverman, 1999). In this study, despite a physical environment conducive to social interaction, residents cease their conversations during dinnertime once staff enters the room as a way of adapting to the staff’s perception of efficiency.
In contrast, a social model or resident-centered model of care, which promotes autonomy and choice among residents, is associated with social interaction and community building (Diaz Moore, 1999; McAllister & Silverman, 1999; Yee, 1999). For example, institutional facilities that operate under this model of care put the residents’ needs at the forefront and are more apt to encourage residents to become involved in various activities such as housekeeping (McAllister & Silverman, 1999).

2.3 Role of the Physical Environment in Influencing Social Interaction

A majority of the studies reviewed looked either directly or indirectly at the effects of the physical environment on social interactions within long-term care facilities. Specifically, many of these studies tended to focus on SCUs in comparison to other types of residential care settings. Social interaction was found to be associated with several physical environment locations and attributes.

2.3.1 Space Use and Patterns

In determining which locations in a long-term care facility are best suited for social interaction and relationship building, it is important to examine the spaces used by residents and their actions in these spaces. People living in residential care facilities spend a majority of their time doing little or nothing, much of which is within the confines of the person’s own room (Ice, 2002). However, in the public sphere of the facility, they can be found spending time within a variety of spaces including dining areas, living areas, corridors, activity
rooms, and in gardens. Although there are discrepancies in the exact proportion of time spent within these spaces, there is a consensus that significant amounts of time are spent within the dining room, living room, and in corridors or hallways (Ice, 2002; Diaz Moore & Verhoef, 1999; McKee et al., 1999). In contrast, the amount of time spent in activity rooms, outdoor space, or in other spaces is relatively minimal (Ice, 2002; Diaz Moore & Verhoef, 1999). Researchers have also noted that within these public spaces, residents are generally not engaged in social interaction, instead participating in solo or passive activities, such as sleeping or television watching (Diaz Moore & Verhoef, 1999; McKee et al., 1999). Conversely, it has been calculated that residents may spend on average, only between 12% and 17% of their time engaging in active social interactions or activities such as conversations with others.

2.3.2 Dining Room and Kitchen

Given that residents within the dining room spend a significant amount of time in this location, some researchers have focused their efforts towards assessing the relationship between this space and social interaction. In fact, in Diaz Moore’s (1999) case study of a dementia care unit identifies dining rooms as key places for residents to form friendships and relationships. Despite this, much of the time spent in the dining room is not spent interacting with others (Diaz Moore & Verhoef, 1999). This was attributed to dynamics involving the presence of staff members during meal times (Diaz Moore, 1999).

Although scarce, some researchers have looked at specific features within the dining room and their impact on social interaction. More specifically,
Gotestam and Melin highlighted the importance of non-institutional dining, that is, dining at small tables, as a person would at home, as opposed to off of trays in bedrooms and in corridors (as cited in Day, Carreon & Stump, 2000). Similarly, Diaz Moore (1999) also emphasizes the importance of small scale seating arrangements as important to social interaction. In addition, he also identifies the potential of the kitchen in promoting therapeutic activities by having counter space within this area.

2.3.3 Corridors and Walking Paths

Walking paths may also be beneficial in facilitating social interaction. More specifically, one of the defining features of SCUs is a continuous walking path designed to facilitate wandering behaviour in people with dementia. Passini, Rainville, Marchand, and Joanette (1998) suggest that walking paths, with appropriate wayfinding cues, may play a role in decreasing social isolation in people with dementia, as disorientation appears to be a major factor associated with isolation. These authors also suggest that alcoves along these walking paths may help to facilitate social interaction among residents as they provide the opportunity for a small gathering place. However, it is also important to note that walking paths and corridors may also encourage social interaction by providing residents with the opportunity to come into contact with each other on a much more frequent basis. For example, in comparison to traditional long-term care units, residents of SCUs spend a smaller percentage of their time in bedrooms and more time in hallways (Kovach, Weisman, Chaudhury, & Calkins, 1997).
2.3.4 Living Rooms, Activity Spaces, Green Space, and Other Common Spaces

Living rooms and common spaces within residential care facilities are also important in facilitating social interaction. One element in doing so is having a balance between private, small group, and larger public spaces (Rule, Milke & Dobbs, 1992). This underscores the importance in having a variety of spaces in which residents are able to negotiate. However, it appears that common spaces, and in particular, common living rooms, must be both adequately defined and contain elements within them that encourage social relationships. According to Hauge and Heggen (2008), due to the ambiguity of common living rooms and the lack of commonalities, residents remaining within the common area did not interact once staff left the room. Thus residents may have found it difficult to know how to behave within these common areas. For example, on one hand, the living room may have looked similar to what one would find in their home, while on the other it may have looked like a waiting room, void of items which are typically found in home environments and that help define the space such as photographs or knick-knacks.

In addition to defining spaces for social interaction, it is also important to incorporate features within these spaces that are conducive to these interactions as well. Implementing focal points within various spaces defines these spaces and has been suggested as a means of prompting residents to engage in different activities (Marsden, 2005). Several researchers have also commented on the spatial arrangement of furniture within common spaces. According to Sommer and Ross (1958), social interaction can be increased by altering the
arrangement of chairs within a room, more specifically, by arranging them around small tables as opposed to the neat rows in which they previously existed. Along similar lines, other researchers have documented that arranging chairs at right angles and allowing for flexibility in how these chairs are arranged is most conducive to social interactions (Brawley, 1997). Moreover, noise within these facilities is also an important consideration in affecting social interactions (Rule et al., 1992) and should be minimized.

It is also important that long-term care facilities provide residents with the opportunity to do something or participate in an activity that they enjoy. The physical environment plays an important role in providing this opportunity. For example, the creation of walking paths and porches has been shown to facilitate social interactions and consequently the formation of community (McAllister & Silverman, 1999). In addition, the implementation of indoor gardening areas has also shown that social interaction might be increased, and in turn, can lead to increases in social integration and decreases in loneliness (Brown, Allen, Dwozan, Mercer & Warren, 1999).

Activity spaces and green spaces have been shown to provide the most amount of social contact; however they are often the least used spaces (Diaz Moore & Verhoef, 1999). Although this relationship may be due to the amount of programmed activities that are facilitated in these spaces, other researchers have highlighted the importance of visual access to these spaces from hallways and other common areas (McAllister & Silverman, 1999) as a means of encouraging socialization and community development.
2.4 Discussion

It is clear from this review that residential care facilities have the potential to be environments that promote social well-being and quality of life. However, one of the serious concerns with these facilities is the apparent lack of interaction among residents throughout the day (i.e. Diaz Moore & Verhoef, 1999). In developing ways to encourage these informal interactions, we can provide residents with a means of improving quality of life. However, as we have seen in this review, there are several factors and considerations that we must both address and be cognizant of in attempting to intervene.

In looking at the personal factors which impact a person’s ability and desire to interact with other residents, it is evident that there are several physical and psychological factors that cannot be altered easily. However, it is encouraging to see that residents in various types of long-term care facilities have both the desire and capacity to engage in social interaction. Unfortunately, beyond interviewing residents and eliciting the response that they do desire social interaction, very little research has been conducted looking at the specifics of these desires. In particular, determining exactly where they want to interact, who they want to interact with, and what they will do in interacting. Perhaps in investigating these questions and by being open to resident input, as opposed to guessing at what they want or even worse, doing nothing, we can provide a better quality of care to residents and design facilities better suited to their needs.

Furthermore, the organizational factors outlined in the literature review raises some important issues. Although socialization in residential care facilities
has received a considerable amount of attention in recent years, relatively little has been done beyond the implementation of programmed activities to facilitate the psychosocial needs of residents. In fact, activity programming may have some unintended negative effects on the well-being of long-term care residents, especially when considering social functioning and interaction. It has been well documented in the research literature that the phenomenon of learned helplessness is common in care institutions (Kane, 1995). With regards to social interactions and functioning, activity programming which focuses on socializing residents may exacerbate the residents’ feelings of learned helplessness. More specifically, as the care giving staff assumes the role of social facilitators for residents upon institutionalization, residents may begin to relinquish control over their social lives. Instead of seeking these interactions on their own, they become dependent on care giving staff to facilitate these contacts or as some researchers have found, they may be more apt to only interact with staff (DePoy, 1993). Thus in this regards, activity programming may actually hinder informal social interactions. However, this dynamic does highlight the role of staff members and the need for staff to be trained as facilitators of social interaction as opposed to directors of social interaction. Specifically, teaching them how to introduce residents to each other and finding common interests between residents as opposed to acting as a mediator between them, as is the case when directing an activity, is of critical importance if we are to be serious about facilitating informal interactions among residents. Ultimately this all hinges on the organizational level policies and practices. As we have seen, implementing a care philosophy which
emphasizes a social model of care is better suited for social interaction as opposed to a medical model (McAllister & Silverman, 1999). However, unless the appropriate policies and procedures which reflect the philosophy values are implemented within the organization, it is very difficult to sustain an environment which promotes interaction among residents on a regular basis. This relates back to staffing since staff members are an intermediary between the facility administration and the residents themselves. Consequently, these policies and practices should clearly define the role of staff, that is to oversee the physical care needs of residents exclusively (i.e. bathing, toileting, etc… only), or to oversee all care needs including physical, social (i.e. interactions with others including other residents and family), and psychological needs (i.e. emotional needs). In addition, care philosophy and policies also affect the implementation of the design guidelines highlighted.

However, all of these factors including physical and social environmental transformations cost money. Not surprisingly, reforming an existing facility to incorporate all of the guidelines found within the literature may prove difficult, especially without the motivation and perseverance of the organization’s administration. This brings us to the question of how do we actually bring about changes to existing facilities that are in need of reform. First, it is of utmost importance that staff, family, and residents all have the opportunity to express the needs and desires of residents. Second, researchers also play a pivotal role in informing policy makers and facility administration by documenting the benefits of policy and environmental changes, and by providing guidelines to make these
changes. Last, there needs to be incentive at an organizational level to follow through with these changes. A genuine concern for the well-being and quality of life of residents will surely influence these changes; however resource incentives from government and non-governmental sources may also be effective in directing facilities to take residents’ social needs into account.
CHAPTER 3: CONCEPTUAL FRAMEWORK

The purpose of this section is to present a framework to assist in conceptualizing the relationships between the various factors that influence informal social interaction in SCUs. It takes into account existing theories, research literature, and the researcher’s own insights gained from previous experience and interactions with people with dementia.

3.1 Theoretical Background

In considering informal social interaction in people with dementia, it is important to take into account the plethora of external factors influencing these behaviours. Particularly, Gibson’s (1977) concept of ‘affordances’, which highlights the contribution of an environment in guiding the behaviours individuals perform within them, lends itself well to this phenomenon. Thus, the affordance of an environment and the abilities of the individual within such an environment are interconnected where both of these components are essential in developing a more holistic representation of informal social interaction within a residential care setting. Accordingly, the conceptual framework presented primarily draws upon Lawton and Nahemow’s competence-environmental press model (referred to as the competence-press model hereafter; as cited in Lawton, 1982) and Moos’ social ecological model of health-related behaviour (as cited in Sallis & Owen, 2002). Both of these models are beneficial in describing the conceptual basis of this investigation as they highlight the importance of the individual and their
surrounding environment (including the physical and social) in influencing behaviour.

According to the competence-press model, behavioural and affective outcomes are determined by a person’s capacity to function (competence) and the demand that the environment exerts on the individual (press). More specifically, Lawton (1982, p. 38) defines competence as “the theoretical upper limit of capacity of the individual to function in the areas of biological health, sensation-perception, motoric behaviour, and cognition” and press as “an environmental stimulus or context [that] is seen as having a potential demand character for any individual if empirical evidence exists to demonstrate its association with a particular outcome for any group of individuals” (p. 39). In addition, Lawton (1982) also goes on to classify environments as a means of understanding how the environment impacts behaviour. Four categories have been detailed including: the personal environment (i.e. family members and friends); the suprapersonal environment (the common characteristics of people within close proximity); the social environment (norms and values influencing an individual’s subgroup or culture); and the physical environment (non-personal, non-social aspects of the environment).

Consequently, this model suggests that older adults who experience functional or cognitive decline, such as people with dementia (i.e. lower competence), are impacted by their environment to a greater degree than those who are not affected by significant declines. However, while the environment may create several challenges for individuals with dementia, strategically
designing a more supportive living environment can positively impact their activities and behaviours, including their ability to socially interact with others.

Similarly, an ecological model approach can also be used to understand informal social interaction among people with dementia in SCUs. This type of approach asserts that: behaviour is influenced by multiple levels of factors, including multiple levels of the environment; in order to alter these behaviours it is best to intervene at multiple levels of organization; and that modifications specific to the behaviour sought are most useful in attempting to achieve this change (Sallis & Owen, 2002). According to Moos’ (as cited in Sallis & Owen, 2002) social ecological model, there are four categories of the environment that are relevant to health. Specifically these include the physical environment (the natural and built environment), the organizational environment (the size and function of a facility), human aggregate (the socio-demographic and other characteristics of the people inhabiting the environment), and the social climate (social norms with a setting that influence behavioural choices).

Accordingly, an ecological model emphasizes the importance of the individual and their surrounding milieu. In taking into consideration individuals with dementia and the varying levels of cognitive impairment which may be found in these people, such a model highlights the increased role that both the physical and social environment may play in facilitating or hindering social interaction behaviour.

The role of the individual must also be regarded. In particular, considering social behaviour from a life-course perspective sheds light on the importance of
one’s life-history. According to this perspective, human development is a
dynamic process whereby behaviours and experiences during previous stages of
one’s life helps shape subsequent behaviours (McPherson, 1998). Consequently,
the degree to which one socializes with others may be a result of previous
experiences and behaviours. For example, a resident who was quite social
during previous stages in their lives may be more apt to socializing with other
residents and vice versa.

However, it is also important to look at social interaction from a
psychological perspective. According to Carstensen (1995), socioemotional
selectivity theory contends that social interactions are motivated by a variety of
goals, each of which become more salient depending on a person’s perception of
the future. For example, when the future is perceived as limited, as in old age, it
is the goal of emotional regulation that motivates people to interact with others.
These feelings may be exacerbated within a long-term care facility given the
approaching reality of life’s finiteness. However, it is important to note that when
emotional regulation comes into play, people are more selective in choosing the
people they interact with, primarily choosing those who they are more familiar
with, such as a family member. In recognizing this, the social and physical
environment plays a critical role in providing a forum to express their emotions.
Thus, having an environment that is open to the residents’ emotional needs and
provides private space for them to express these needs is important both for the
resident’s well-being and in allowing for social bonds to develop among residents
sharing similar emotional experiences.
Consequently, applying these principles to better understand the
phenomenon of informal social interaction in SCUs allows for a more
comprehensive understanding of the factors and issues that may either facilitate
or impede social behaviour among residents of these care settings.

3.2 Conceptual Framework of Social Interaction in SCUs

Meaningful informal social interaction in residents in an SCU could be
conceptualized as a precursor to achieving social integration in the facility, and
more distally, achieving an increased quality of life. A diagram of the conceptual
framework informing the proposed investigation is provided in Appendix A and is
described below. As can be observed, organizational, individual, and situational
factors ultimately influence the onset of informal social interaction.

3.2.1 Organizational and Social Environmental Influences on Informal
Social Interaction

Organizational factors are an important consideration since the
overarching philosophy of care, the policies employed, and the practices
undertaken, all can exert significant influence in creating opportunities for social
interactions among residents. For example, care facilities that subscribe to a
social model of care (i.e. value resident choice and autonomy) and that have
implemented policies in the care home that are conducive to providing residents
with opportunities for socialization (i.e., staff trained in facilitating social
interactions, policies shaping a conducive environment for social behaviour, and
providing appropriate resources to facilitate social interaction), would appear to
be most successful in optimizing social interaction.
The social environment provides the social context in which interaction takes place. In particular, how staff members are trained and view their roles within the institution is important. More specifically, those who view themselves as important to all aspects of quality of life, as opposed to only important to quality of care may be better suited to help facilitate social interaction. Likewise, there needs to be an effort to train and educate staff, not only in directing programmed activities, but also in facilitating social interaction outside of these activities. In facilitating informal interactions among residents, it is important for staff to learn about each resident’s life history, preferences, attitudes and past behaviours related to her/his social life. In this regard, family members play a critical role in providing staff and administration with insights into a resident’s past history of social interaction (i.e. was a person a social person prior to being institutionalized?), past interests (what activities did a person previously engage in?), and past social roles (what occupation did a person previously hold?). In addition, staff should also be committed to accepting resident input, interpreting their needs and wants, and respecting their decision to engage in social situations.

3.2.2 The Physical Environment on Informal Social Interaction

The physical environment may be the most crucial determinate of informal social interaction as it provides the opportunity to engage socially and is modifiable. According to the literature reviewed, there are several attributes of the environment that are conducive to social interaction. At the very basic level, an environment needs to be safe and secure. Once this is established, it is
important to have a variety of different spaces and visual access to these spaces. This includes private, semi-private, and public spaces. Each of these spaces must be defined, meaning that each space should have a purpose and that this purpose is salient to the resident (i.e. reading room, living room, music area, etc.). This is important in providing environmental cues to the residents about activities that could be done within the given space (e.g., objects that offer tactile stimulation, residential scale kitchen). In addition, each space should display a non-institutional (homelike) character, focus on small group furniture arrangement, and minimize the amount of background noise, such as televisions, in order to accommodate residents with auditory impairment in their interactions.

3.2.3 Individual and Psychological Factors on Informal Social Interaction

Individual and psychological factors such as a person’s ability to communicate and perceive a situation as a social one must also be taken into account since some residents may need more assistance than others in participating in social activities. The resident’s level of disability (functional and sensory) and mobility must also be taken into account. Staff should be flexible in moving people into environments of their choice and environments should be designed to minimize disability (e.g., reduce glare) and maximize mobility (e.g., providing adequate and appropriate seating throughout the facility and installing accessible handrails throughout the building) as a means of facilitating interactions among residents.
3.2.4 Situational Factors on Informal Social Interaction

In addition, the framework presented here outlines the importance of situational variables in facilitating social interactions. Situational factors call attention to the importance of respecting the person’s desire to engage in an interaction, after all, a facility may be exceptionally suited for social interaction, but if a person has no motivation or desire to engage, the behaviour will simply not occur. In the model presented, this desire is influenced by several factors including having common interests with others or by the presence of other actors within the environment. More specifically, it has been shown that across the various types of residential care facilities, social partners influence each other's behaviour (Rose & Pruchno, 1999). However, in addition to being in close proximity with others, having something in common, beyond living in the same facility, is important in initiating an interaction. An examination of this factor truly underscores how all of the aforementioned factors influencing informal social interaction are interrelated. For example, the social environment plays a crucial role in identifying common interest. In some cases, proximity alone enables people to discover these interests, whereas in other cases, a staff member could be pivotal in providing this opportunity. In addition, the physical environment also provides an opportunity for people to discover common interest. This is primarily achieved through having a variety of spaces within the facility that cater to residents’ interests and past identities. For example, having a music area, knitting area, or a wood working area could potentially facilitate these interactions. Organizational policies may also have an influence on enabling people with commonalities to interact. This is especially true in facilities that have
residents with distinct ethno-cultural backgrounds. Although not all people in this type of facility are necessarily of the same background, those who are, have many cultural commonalities which can be used to initiate interaction. However, it is also important to consider those facilities that have a more heterogeneous composition. In these facilities, generational commonalities may be important in initiating interaction.

Consequently, an environment which addresses and caters to all of these factors is best suited to facilitate meaningful social interactions among residents. Through multiple interactions with the same person or group of people, residents may begin to feel integrated and develop a sense of community with each other. This results in the development of social roles within the facility (e.g., a companion, advisor, etc.) and ultimately the maintenance or formation of new relationships among residents. This formation of relationships is one mechanism by which quality of life can be improved.

### 3.3 Research Questions

In an attempt to better understand how the care environment can help facilitate informal social interactions among residents with dementia, a series of research questions has been formulated to direct the current investigation. Of particular interest is to gain a better understanding of the types of informal social interactions occurring in SCUs and to understand the role of the physical environment in enabling these interactions. The following research questions are addressed in this study:
1. What is the nature of informal social interaction among people with dementia residing in special care units?
   
a. What are the types of informal social interaction that occur within special care units?

b. What are the levels of interaction that occur within special care units?

c. How are these interactions expressed among people with dementia in special care units?

2. What is the role of the physical environment in informal social interaction among people with dementia residing in special care units?
   
a. What characteristics of the physical environment enhance social interaction (i.e. walking paths, type of activity spaces, etc…)?

b. What characteristics of the physical environment hinder social interaction?
CHAPTER 4: METHODS

This chapter presents the research methods that were employed in addressing the research questions previously outlined. Specifically, this chapter will provide a discussion on the study design, data collection, data analysis, and other important considerations regarding the proposed study.

4.1 Research Design

The study attempts to gain insight into the experience of informal social interaction among people with dementia who reside in special care units within long-term care facilities. Given the complexity of social interaction patterns in people with dementia and the difficulty in constructing meaning from these patterns, the opportunity for prolonged engagement within a long-term care setting is required to address this issue. Similarly, in order to better understand this phenomenon, it is important to conduct an inquiry that will take into account the myriad of contextual factors which impact social interaction, including both the physical and social environments within the care settings in which these behaviours occur. As a result, an ethnographic approach is used in this study. This type of approach is particularly useful for this study as it affords the opportunity for a more holistic analysis by drawing on a wide range of informational sources, including observations of the participants and interviews with key informants (Hammersley & Atkinson, 1983). Additionally, data collection and analysis was conducted concurrently throughout the research process. This
iterative approach is most appropriate for this investigation as it goes beyond providing descriptive insight into the phenomenon at hand, enabling the researcher to remain open-minded, and via ongoing reflection throughout the data collection process, to conceptualize the experience of informal social interaction embedded within the data.

4.2 Study Settings

Design interventions aimed at creating therapeutic environments for people with dementia have gained considerable attention in recent years (e.g. Day et al., 2000). While the primary goal of these modifications to the physical environment includes managing problematic behavioural outcomes of dementia, improving social engagement through these interventions has also been cited as a critical goal (Bourgeois & Hickey, 2009). In terms of facilitating social interactions among residents with dementia, the quantity and quality of activity spaces available in the SCU is of importance. For example, according to Zeisel and colleagues (2003), greater variability in the common spaces within SCUs (i.e. having several different spaces – kitchen, dining room, lounge, etc.) is associated with reduced social withdrawal among residents. Similarly, research has also shown that environments which are more homelike in character, as opposed to institutional in character, as well as those with private and personal spaces for residents are more conducive to social interaction (Bourgeois & Hickey, 2009; Zeisel et al, 2003).

Given the importance of the physical environment in this investigation, the SCUs selected for this investigation were selected via purposive sampling based
on the quality (e.g., ambiance and homelike character) and quantity (e.g. variations in the types) of common spaces available to residents. Consequently, two SCUs in Vancouver, British Columbia were selected for this study (Table 1). The first SCU, Meadowcrest Lodge (pseudonym), is a 26-bed unit within a 117-bed, not-for-profit residential care facility. Opened in 1987, it does not have a continuous indoor walking path; however the unit has a large common activity area, segregated into several spaces, along with two alcoves at the ends of the walking path for resident use. Overall, Meadowcrest Lodge was determined to be somewhat homelike in character based on the guidelines outlined by Therapeutic Environment Screening Scale for Nursing Homes (TESS-NH; Sloane et al., 2002) and the Professional Environmental Assessment Protocol (PEAP; Norris-Baker, Weisman, Lawton, Sloane, & Kaup, 1999). Specifically, the variety of wall hangings, larger size and institutional feel contributed to this assessment, however, further details are provided in the results section. The second SCU, Guildwood Village (pseudonym), is an 18-bed unit within a 72-bed not-for-profit residential care facility. Opened in 2000, this unit provides a continuous walking path along the perimeter of the facility, a medium sized dining area, and small lounge for resident use. Overall, Guildwood Village was deemed to be moderately homelike in character based on the guidelines set forth by TESS-NH and PEAP. Particularly, the variety of wall hangings, smaller size and extensive carpeting throughout contributed to this and are further elaborated on in the results section. Both of these facilities were operated under the same
management and board of directors and subscribe to the Gentlecare philosophy of care (Jones, 1996).

<table>
<thead>
<tr>
<th>Table 1: Description of Research Settings</th>
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<tbody>
<tr>
<td><strong>SCU Name</strong></td>
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<tr>
<td><strong>Ownership</strong></td>
</tr>
<tr>
<td><strong>Maximum # of Residents</strong></td>
</tr>
<tr>
<td><strong>Private Rooms</strong></td>
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<tr>
<td><strong>Common Spaces</strong></td>
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<tr>
<td><strong>Overall Character of Unit</strong></td>
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<tr>
<td><strong>Resident Health</strong></td>
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<tr>
<td><strong>Philosophy of Care</strong></td>
</tr>
</tbody>
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**Refers to overall level of care required, determined in consultation with unit care staff**  
*Does not include hallways and accessible outdoor spaces*

### 4.3 Data Collection

A multi-method approach to data collection, known as triangulation, was used for the purpose of this investigation. Triangulation not only enriches the understanding of the phenomenon being studied, but also assists in strengthening the study by increasing its rigor, validity, and reliability (Patton, 2002; Taylor & Bogdan, 1998).

Data collection for this study was conducted in three phases. During the first phase, relevant contextual data regarding each of the SCUs/facilities was collected to help inform subsequent data collection and interpretation within the study. During the second phase, ethnographic observations were documented to
gain insight into the informal social experiences of those residing within SCUs. The final phase of data collection included in-depth interviews with key informants to gain an insiders’ perspectives of informal social interaction within the SCUs, followed by another round of observation. This three-step process enabled the researcher to gain insight on the topic at hand in earlier stages and further explore the salient concepts and processes during later ones. Data collection was completed over a nine-week period between July 2009 and September 2009.

4.3.1 Environmental Assessment

In the initial phase of the data collection process, environmental characteristics of each SCU were documented. This included an archival search within each facility to obtain information on key policies and procedures which shape the opportunity for residents to engage in informal social interaction. Additionally, this search provided architectural floor plans used to inform the observation phase of this study.

Formal assessments of the physical environment of each SCU was conducted in order to provide a set of baseline observations which can be used to compare each of the SCUs and highlight key environmental features which may be crucial in facilitating social interactions. Two established environmental assessment instruments were used including TESS-NH (Sloane et al., 2002) and PEAP (Norris-Baker et al., 1999. Both of these instruments are routinely used in assessing the environments of SCUs for people with dementia (Lawton, Weisman, Sloane, & Calkins, 1997) and are useful for this study as they are
relatively quick to complete and require minimal training. Additionally, both TESS-NH and PEAP are complementary instruments and beneficial when used in conjunction as they provide insight into how the discrete features and global dimensions of the physical environment influence the residents’ experiences. In this study, PEAP achieves this by evaluating how well social contact and interaction is facilitated within a SCU, whereas TESS-NH surveys environmental features relevant to social interaction such as the provision of seating throughout activity areas and the non-institutional character of the SCU. This information was used to guide observations and interviews and the analysis of this study. Two iterations of each instrument were completed and averaged to compile a baseline score for each facility and measure.

4.3.2 Ethnographic Observations

A series of systematic, non-participant observations within both SCUs was completed to provide insight into the nature of informal social interaction and the relationship between the physical environment and the experience of these interactions for people with dementia. This is a common method used in SCUs to understand the phenomenon of social interaction (e.g. Diaz Hubbard et al., 2002; Moore, 1999) and is beneficial as it allows for the researcher to document the daily interactions of SCU residents in an unobtrusive manner. As a result, this study used four observational tools to collect detailed data on informal social interaction among residents including qualitative field notes, a behavioural mapping instrument, annotated floor plans, and photographs to provide an in-
depth understanding of the informal social interactions in the selected SCU settings.

Qualitative observations were conducted in all common spaces within each of the research settings. These spaces included dining areas, activity areas, walking paths, and any other common space; however resident bedrooms and bathrooms were excluded. These observations were conducted in both SCUs at various times each day, with the earliest beginning at 8:00 am and the latest ending at 9:00 pm on weekdays and weekends. It is important to note that social interactions during personal care and planned activities were not documented in detail as this was outside the scope of the current study, which focuses on the spontaneous social interactions which occur throughout the residents’ day. Observations were conducted continuously and throughout the various spaces within each facility to ensure that interactions in each part of the unit were adequately documented. In addition, these were completed concurrently at both facilities such that significant observations made within one facility can be used to inform subsequent observations at the other (and vice versa), while controlling for the influence time. In total, 70 hours of observation was completed during the study period with 35 hours per facility.

Field notes were completed to document detailed observations regarding informal social interactions between residents, residents and staff, and residents and visitors. Particular attention was paid to recording both verbal and non-verbal interactions, the context behind each interaction, and how residents are using or interacting with the physical environment. Additionally, casual conversations
between the researcher and staff or visitors, other events within the unit, and pertinent contextual information was documented in these field notes. At the end of each observation day, field notes were reviewed and memos along with concept maps were appended, highlighting key observations and the relationships between them for consideration and development during subsequent observation days.

4.3.3 Behavioural Mapping Instrument

In addition to the ethnographic observations, a more structured observation method, behavioural mapping, was also completed throughout observation days. Behavioural mapping is beneficial for this investigation, not only because it allows data to be collected in a more systematic and organized fashion, but also because it enables objective comparisons to be made between the SCUs and provides insight into new avenues of observation through the data-reflection process.

These structured observations consisted of using the Behavioural Mapping Instrument (Adapted from Copeland, Crosby, Sixsmith & Stilwell, 1990; Appendix B) to document each resident, care staff, volunteer, and visitor within a particular space and time. A description of each individual's behaviour, albeit socially engaged with others or not, was recorded along with any informal interactions between individuals to provide snapshot of resident behaviours and interaction type during a particular physical environment and context. At the end of every observation day, each entry within the behavioural mapping instrument was coded according to a social interaction checklist (see Appendix C) which
was developed prior to the commencement of this study, in consultation with the Dementia Care Mapping (DCM) tool (Kuhn, Ortigara & Kasayka, 2000) and previous literature regarding social interaction among people with dementia (e.g., Hubbard et al., 2002; Diaz Moore, 1999; Kelley, 1997). To supplement the information collected within the behavioural mapping instrument and to increase the salience between each interaction and the physical environment, architectural floor plans of the care settings were annotated documenting the location of residents, care staff, and visitors during social interaction events (Zeisel, 2006). The behavioural mapping instrument was pilot tested during the first few observation periods and the social interaction checklist codes were revised to provide more descriptive coding (see Appendix D). For example, items such as verbal communication were separated into ‘active or prolonged verbal conversation’ that includes talking in coherent sentences throughout the duration of an interaction and ‘brief verbal communication’ that included very short verbal interactions or mumbling vocalizations. Another example is with regards to facial expressions. This code was separated to include the valence of an interaction, specifically ‘facial expression – positive’ such as a smile and ‘facial expression - negative’ such as a frown were used to delineate the nature of informal social interactions.

A behavioural mapping instrument was completed approximately once every hour during the ethnographic observations and included behaviours occurring within the 10-15 minutes timeframe during these observations.
4.3.4 Photographic Analysis

Photographs were used as a means to visually document and analyzing the spaces being observed in order to better understand the degree to which common spaces facilitate social interaction. According to Zeisel (2006), by detecting physical traces through systematically observing the physical surroundings of an environment, environment-behaviour researchers are able to infer how its users use the environment and whether or not it meets their needs. In terms of the current investigation, digital photographs of the various common spaces in each SCU were taken at the beginning of the research project and provided an initial overview of the research setting by focusing on more general environmental factors such as the type and arrangement of furnishings, ambiance, and the character of the facility as these are all important elements influencing social interaction. Additionally, photographs were also taken on occasions where furniture or other elements of the environment were changed to assist in analyzing subtle changes that occurred throughout the day which had the potential to either enhance or limit social interaction among residents.

4.3.5 Key Informant Interviews

In-depth interviews were conducted in order to gain insight into the social interactions of residents and the role of the environment in these interactions from a caregiver’s perspective. Five frontline facility staff members, including Licensed Practical Nurses, Care Aides and Environmental Staff from each SCU were interviewed face-to-face. Each interview was scheduled to accommodate staff members’ schedules and was audio recorded upon receiving consent. In
total, each interview lasted approximately 20-25 minutes, with the longest lasting approximately 1 hour and 15 minutes.

These interviews were completed after approximately 15-20 hours of ethnographic observations had been conducted. The reason for this sequencing of the methods is two-fold. First, emergent themes generated from the observations were addressed and used to guide the interviews. Second, this delay allowed the researcher to establish a rapport with facility staff, consequently gaining access to a greater number of potential key informants. Semi-structured interviews were conducted as this approach allows for the conversation to be guided by key questions, yet offers enough flexibility to the participant and researcher with regards to exploring new or unexpected issues (Hesse-Biber & Leavy, 2006). An interview guide (Appendix E) was developed to elicit participants’ perspective regarding informal social interactions, the organization’s role in facilitating social interaction, the spaces in which these interactions occur, and how the physical design of the SCU helps facilitate interactions among residents. Field notes were also taken during and after the interview process. Finally, the interview guide was pilot tested during the first two interviews and modified. Specifically, the first question related to the policies and procedures was relocated as the final question, as starting off with this question created a pretence whereby interviewees felt that the interview was focused on policies and procedures of care, as opposed to the physical environment and other aspects of the social environment in the context of informal social interactions. This was evidenced during both pilot interviews where for each
subsequent question, the interviewees would attempt to revisit or structure their response within the framework of the facility’s care policies and procedures. Additionally, it was evident in informal conversations with staff and during these first two pilot interviews that terms such as ‘physical environment’ and ‘informal social interaction’ would need to be explicitly defined and contextualized within a dementia care setting. For example, physical environment was often conceptualized by staff as resident care pertaining to their physical well-being as opposed to resident’s surrounding environment. Consequently, during the interview each of these terms and appropriate contexts (e.g. within this SCU or dementia care setting) were verbally defined to interviewees and examples were provided. Lastly, issues discussed within the interviews were further investigated in subsequent observations and in some instances, with staff during informal conversations. These informal conversations were not tape recorded, but instead documented in separate field notes.

4.4 Data Analysis

Data analysis within this project was an ongoing and iterative process that occurred both during and after data collection. Throughout this investigation, data was analyzed to identify key concepts and themes through a process of constant comparison (Miles and Huberman, 1994). This involved continuously looking for similarities and differences between observations to help categorize and understand each event. During data collection, observations and field notes were continuously reviewed to identify these concepts and direct further observations and interview questions. Additionally, memos were recorded throughout this
process to identify concepts and relationships within events, observations, interviews and to document the analytic process. In order to facilitate data analysis, observations, behavioural mapping field notes, and interviews were transcribed as digital text documents. Furthermore, photographs and annotated floor plans were sorted by location and stored for reference. All data collected was organized and analyzed using NVivo 8, a qualitative data analysis software tool capable of analyzing text, audio, and digital photographs.

A thematic analysis of observations and interview transcripts was completed by coding the various types of data. This involved an initial phase of line-by-line coding where each line of data was labelled and categorized, followed by a focused coding procedure which involves organizing, synthesizing and developing key themes from these categories. During the coding process, close attention to the nature of social interaction engaged in and the impact of the physical environment on these interactions was considered. The following chapter presents key findings from this investigation with regards to the nature of informal social interaction among residents within each of the two SCUs and the role of the physical and social environment in facilitating or deterring these interactions.
CHAPTER 5: RESULTS

The first section of this chapter begins with an overview of each SCU by providing key contextual information used to interpret the findings, including a summary of social and physical environmental factors within each facility relevant to the informal social interaction patterns to be discussed. In the following two sections, salient themes are highlighted in the context of the research questions. It is important to note that for the purpose of this investigation, the two care units were treated as unique entities. Results are intended to provide an overview of informal social interaction patterns and were treated as separate cases. While several similarities and differences emerged, it was not the intention of this investigation to compare both SCUs against each other. All facility and individuals’ names used in the following sections are pseudonyms.

5.1 Study Setting Overview

This section describes the key features of the two units under investigation with a particular focus on elements within the social and physical environments, which may influence the opportunity for informal social interaction. As was noted previously, both units belonged to larger not-for profit facilities, which were managed by the same organization and operated under a Gentlecare philosophy of care. A diagram of the main common area and photographs of the spaces where observations occurred for both Meadowcrest Lodge (Appendix F) and Guildwood Village (Appendix G) are provided below.
5.1.1 Guildwood Village

During the observations period at Guildwood Village, 17 out of the 18 resident beds were occupied. The 17 residents included nine males and eight females with the age range of residents being between 30 to 90 years old. The average age within this unit was approximately 82 years old (according to care staff). All residents within this unit were diagnosed with some form of dementia (e.g. Alzheimer’s, frontotemporal, vascular) or dementia-like symptoms except for two for the residents (1 male and 1 female) who were diagnosed with other mental health issues. Observations of interactions involving either of these individuals and residents with dementia were not excluded from this study. Additionally, at the beginning of week six during the observation period, two residents (both male) died in short succession of each other (over a 2-3 day period). Two additional residents moved into the unit in the proceeding days (both males, one with dementia and another with a mental health-related issue). This provided a unique opportunity for the researcher to observe informal social interaction within the same facility, however with a slightly different mixture of residents (which generally speaking, had a lower level of cognitive and functional impairment).

The ratio of residents to staff fluctuated throughout the day with a minimum of one nurse and two care aides on the unit at all times. The number of staff increased during certain times throughout the day such as at lunch time, when dietary aides would assist in serving the residents. Additionally, certain aspect of the care routine occurred at the same time each day. In particular,
breakfast, lunch and dinner were served at 8:30 am, 12:00 noon, and 5:00 pm respectively. Residents who were more mobile entered and left the dining room at their leisure during mealtimes; however, those who were confined to a wheelchair did not have this flexibility and were dependent on care staff’s routines to move about the unit. In terms of seating arrangements, each resident had an assigned seat, which, as described by one staff member, was determined by an attempt to minimize conflict between the residents and then according to a residents’ personal choice. Additionally, the staff also had a shift change at 3:00 pm each day and would normally consult with each other for 15-20 minutes in the nursing station around this time.

In terms of recreational activities, some activities were scheduled throughout the week ranging from friendly visits, group singing, to gardening sessions. However, it is important to note that these within-unit activities were rare and that willing residents were more frequently taken outside of the unit by recreational staff to participate in larger scale activities with the general facility population. Although assessing social behaviour during recreational activities was outside the scope of this investigation, observing social interaction behaviours before and after recreational activities was made difficult and was limited in this unit. Another unique feature of Guildwood Village was the presence of one hired companion. This person was hired by a group of family members for individual residents within the unit. The purpose of the companion was to socialize with residents for whom they were hired. Typically, this was the same person each day and that person spent approximately 30 hours per week in the
unit. Most of their time was focused on the individual resident they were hired to socialize with and rarely engaged the resident in interactions with others in the unit while they were together.

There were several public spaces available for residents to socialize in at Guildwood Village. An annotated diagram of the main common area, which includes both the dining room and lounge, is provided in Appendix G. With regards to the dining room, this space was quite large, with dining tables and seating arranged a couple of feet away from the two interior walls. Each table seated four individuals, however not all table places had a chair available to sit in. This was done to accommodate residents with wheelchairs. In total, approximately 16 chairs (each of which was light enough in weight for residents to re-arrange) were available to residents and staff in the dining room. In addition, the dining room also featured a serving area, with a large island. Although this space was primarily used by staff, residents were able to move in between the island and appliances (refrigerator and sink). Despite this, the countertop of the island and sink was often too high for resident use, especially for those confined to wheelchairs or who had mobility difficulties. Thus, this arrangement limited the usability of the space for residents as a gathering space for socialization. Additionally, the nursing station entrance was located in the middle of the dining room. The entrance had a half-sized door, allowing staff visual access to the common areas and residents to peer into the nursing station. It was not uncommon for the area in front of the nursing station to be occupied by a resident wanting to chat or receive help from care staff.
Lastly, in terms of the ambience within the dining room, several attempts were made to provide a more homelike setting. For example, several knick-knacks, paintings, wallpaper, and other objects were mounted on the walls. However, given the large amount of space in-between table arrangements on both sides of the room and the institutional character of the furniture (i.e. tables and kitchen area) and flooring (i.e. indirect glare and institutional finish) as well as the frequent presence of serving carts, this area was considered to be only somewhat-homelike in character.

Guildwood Village also featured a small lounge area with a walkout (sliding door) for residents to access an enclosed garden/patio area. This door was typically left unlocked by care staff and residents were free to roam outside. These large sliding doors allowed a fair amount of natural light and residents were able to view the aesthetically pleasing garden area from inside the unit. Although the unit was located on the main floor of the facility and near the street level, the actual street was not visible from the lounge (or garden area) due to the wooden fencing. Within the lounge area, ample seating was available for residents. In total seating for 11 residents was available, including a medium sized (2-3 person) couch, four lounge chairs (moveable), and several regular chairs (moveable). A coffee table was placed in the centre of the seats. The space also featured a piano in one corner, a fireplace with mantle along the wall opposite of the couch, a bookshelf beside the fireplace, and a television in the opposite corner of the piano. However, it is important to note that the main focal point of this area was indeed the television as indicated by a majority of the
seating being positioned in direct sight of it. Overall, the lounge area was quite homelike in character. The seating and furniture appeared inviting and non-institutional, the floor was carpeted, picture hangings were found on the walls, the windows were curtained, and the various accents including the piano, fireplace, bookshelf, and television all contributed to a more homelike environment.

The hallways were also an important space for socialization. The hallway at Guildwood Village was designed as a continuous loop around the perimeter of the unit. The entrances to resident bedrooms are located on the outside walls of the hallway only and each entrance includes a memory box with photographs and other objects meaningful to the respective resident. The hallway also intersects the unit entrance/exit, which has been disguised by a mural and may act as a small alcove for residents. The interior wall of the hallway (along the entrance side of the unit) had two large cut-outs, providing visual access for wandering residents to the dining room and other areas of the facility from that side of the hallway. The opposite side of the hallway did not have this feature, as several rooms were present. Specifically, separate resident and staff washrooms, a bathing room, a storage room, the nursing station, and a quiet room were present. Although the quiet room was available to residents, residents rarely used it as the door was often kept closed or locked. The room itself had a small couch, chairs, a credenza, and some artificial plants. According to the care staff at Guildwood Village, residents would occasionally use this space during visits with family members, although this situation did not arise during the observation.
period. The hallway was carpeted and had various paintings, stimulation boards for residents, and other objects (e.g. large clock, collage of photographs) hanging from the walls. The hallway was typically clear of clutter, with the exception of the occasional Hoyer lift (during early morning or evening) and the laundry separators (always present); however, no seating was readily available for residents in the corridors.

5.1.2 Meadowcrest Lodge

During the observation period at Meadowcrest Lodge, all 28 beds were occupied by residents including five males and 23 females. The age range of residents was between 68 and 102 years old, with an average age of approximately 85 (according to care staff). All residents within this unit had varying degrees and forms of dementia. The ratio of residents to staff also fluctuated throughout the day at Meadowcrest Lodge. A minimum of two nurses (one shared with another unit on the same floor of the facility) and three care aides on the unit at all times. The number of staff increased during certain times throughout the day such as at lunch time, where kitchen staff, environmental staff, and supplementary care aides would come to the unit assisting in serving, monitoring, and feeding residents.

At Meadowcrest Lodge, breakfast is served between 8:00 am and 8:30 am, lunch is served between 11:30 am and 12:00 noon, and dinner is served between 4:30 pm and 5:00 pm. Residents were seated at their respective dining table approximately 30 minutes before each meal was served, with a few residents (typically the more mobile ones) occasionally arriving only a few
minutes before each meal is served. Within this unit, residents had a preferred seat (especially during certain meals - e.g. dinner), however there was some flexibility regarding seating. According to the care staff in this unit, seating arrangements were primarily dependent on a resident’s preference (or routine in some cases), staff assessment of which residents would get along with each other (in the case of residents with high levels of impairment), and lastly, in an arrangement that minimizes agitation behaviours within the dining room.

During informal conversations with staff, it was indicated that residents were most active, (e.g., with physical activity such as wandering and socialization behaviours), prior to lunch at 10:00 am and again between 3:00 pm and 4:00 pm. This latter range of activity was attributed (by staff) to sundowning effects – a period of time described by caregivers as when the symptoms associated with dementia are exacerbated later in the day in comparison to in the mornings (Cavanaugh & Blanchard-Fields, 2006). Additionally, a staggered staff shift change began at 3:00 pm, with a new staff member leaving or arriving every 30-45 minutes until 4:30 pm. In terms of recreational activities for residents, all are scheduled within the Meadowcrest Lodge. These activities are scheduled throughout the week and included musical activities and baking activities among others. No hired companions were identified within this unit, although one volunteer was present from time-to-time during the observation period. This person would arrive during dinner and would occasionally help one particular resident eat.
A variety of public spaces providing opportunities for socialization were found throughout Meadowcrest Lodge. An annotated diagram of the main common space, including the kitchen, dining room, and lounge is provided in Appendix F. This area is a ‘L-shaped’ area, with exits out into the hallway at each end.

The dining room within Meadowcrest Lodge was very large and extended throughout the main common area. Seven dining room tables were placed around the perimeter walls of the area. These tables varied in shape including rectangular, square, and round tables. They also varied in the amount of people able to sit around them, with the smallest setting (pushed up against the wall) being for three people and the largest table accommodating up to six people (round table located next to the lounge area), however a majority of the tables were suitable for four people. Since several of the residents were wheelchair-bound, not all table settings had a chair available. In total, approximately 24 easily moveable, chairs throughout the dining room were available to residents and staff. Additionally, a kitchen including a sink, refrigerator, counter space, a microwave, and an oven was present. Although this area was primarily used as a serving area during meal times, residents and staff did use this area to congregate while socializing. In terms of the dining room’s environmental character, it was classified as somewhat homelike. Despite the walls throughout the kitchen being decorated with art, knick-knacks, and other objects, the table settings being small (three to six people), decorated with a centre-piece (artificial flowers) and the seats being mostly at 90-degree angles from each other, the
dining area had an institutional feel to it. For example, the dining room was quite large, with some tables very far away from each other or secluded and the furniture (i.e. tables) was not homelike.

Smaller spaces were also incorporated into the larger common area. At the vertex of the room was a lounge, which included a carpeted area with seven chairs and a small coffee table (with a radio on top) around the perimeter. Although within the larger common room, this lounge was a focal point for residents, the lounge itself did not have a nearby focal point. All chairs were set up facing either of the two hallway entrances and connecting walkways throughout the dining room. Additionally, a majority of the chairs in this area were side by side (i.e. not 90-degrees from each other), thus acting as a barrier to social interaction. Despite this, the lounge area was well lit with natural lighting as large windows overlooking the garden/patio surrounded the perimeter of the lounge. It should also be noted that this lounge area did not have an affixed television, although on approximately five occasions during the observation period, a television was transported into this area for residents and placed along the outer-edge of the lounge area.

Another social space within the larger common area was a living room, opposite to the kitchen area section. This area was partially secluded by two walls, although visible from certain viewpoints in the hallway, lounge, and dining room. Within this space were three reclining sofa chairs (facing the dining room walkway), one non-reclining sofa chair, a credenza for rummaging, a laundry basket, book-shelves, and a piano. In comparison to lighting in other parts of the
unit, this space was generally darker. In addition, due to the positioning of chairs and the large quantity of furniture relative to the size of the space, gaining access to the activity props (e.g. credenza or bookshelf) would be quite difficult for residents. Despite this space being the most homelike in the unit, it was rarely used by residents during the observation period. On a few instances, residents were given a break from their wheelchairs and placed in the reclining sofa chairs to rest/sleep temporarily. Beyond this, the space was rarely used for social activities or otherwise.

The hallways in Meadowcrest Lodge were typical of a more traditional long-term care facility built around its time. More specifically, this unit had long narrow corridors on either side of the main common area. Throughout the researcher's observations, it became clear that many residents did not walk to the ends of the hallways while wandering. Instead, they would follow the walking path through the dining room, thus creating a pseudo-walking path that was continuous. Throughout the hallways, handrails were present on both sides (excluding doorways), and several paintings, art, stimulation boards, and a board with resident biographies with pictures were present. Resident rooms were located on both sides of each corridor section (double-loaded rooms) and room numbers were located on the doors with a small picture of each resident mounted to the right of each room.

Along the hallways, several rooms (non-bedrooms) were found. Particularly, the nursing station and a medication room were located near the entrance to the unit, along the outside walls of the hallway. Further down the hall were a resident
washroom and a bathing room. Additionally, a medium-sized quiet room was also available to residents. This room was used by residents to rest occasionally or during family visits. The door was usually left open with lights on. This space included carpeting, a sofa chair, small round table, several chairs, a dresser, wall hangings, a small coffee table, window coverings (decorative as there are no exterior windows in this room) and a large artificial plant. However, at times this space was also used as a storage closet as evidenced by the fan, television with extension cord, and commode.

At the ends of corridor were two alcoves, one at either end of the hallway. Both alcoves had large glass windows, one overlooking the street level at the front of the facility and the other overlooking the back of the facility. Initially, both alcoves included a sofa chair (with one having an artificial plant), however one was removed during the observation period due to complications with a resident being unable to define the space. Consequently, this space was left open, with a large plant in the corner. From the observations taken, residents did not seem to stop and use this space very often.

Lastly, a large garden area and patio was connected to the unit. This space was all outdoors, self-contained, and included various planting boxes, seating, and shaded areas. It could be accessed by four doorways, two in the dining room (keypad locked, one door on either side of the lounge) and one on either side end of the hallway near the alcoves (key locked). At times, each door entrance at the end of the alcoves was left unlocked and open, creating a continuous path for residents to wander and to explore the garden.
5.2 The Nature of Informal Social Interaction

The primary focus of this study is to gain an understanding on informal social interaction among people with dementia in a special care unit setting. In particular, understanding the range and nuances of informal social behaviours expressed within the context of a dementia care population is of importance and will be delineated in the following sections. In doing so, various aspects of these behaviours will be discussed including who residents are interacting with, the types of informal social interactions observed, how each type of interaction is expressed by residents, and finally the level of informal social interactions exhibited by residents in each of the units studied. Here, the ‘type’ of informal social interaction refers to the broad categorization of these interactions, the ‘expression’ of informal social interaction refers to the description of individual behaviours within each type of interaction, and the ‘level’ of interaction refers to the presence or absence of informal social interaction, including the degree to which these interactions are expressed by residents.

5.2.1 Interactions Between Residents and Other Individuals

This study takes into account informal social interaction between residents and co-residents, residents and care staff members (care aides, nurses, environmental staff) in each facility, and residents and visitors including volunteers. Consequently, prior to discussing each type of interaction discovered in proceeding sections, an overview of who residents are interacting with will be discussed to help provide additional context to the types and expression of informal interactions.
5.2.1.1 Resident-Resident Interactions

No interaction occurred between residents and others in over 60% of formal observations taken at both Guildwood Village and Meadowcrest Lodge (Figure 1). Among the remaining observations, a majority of informal interactions occurred between residents and other residents. Specifically, 20.6% and 31.2% of observations in Guildwood Village and Meadowcrest Lodge respectively were classified as informal interactions and occurred between residents (Figure 1). Interestingly, this indicates that in roughly 60-70% of all informal interactions, residents engage with their peers. This also indicates that residents are indeed capable and willing to interact with other residents. Further details on the types of informal interactions between residents and other residents will be discussed in more detail in the subsequent sections of this chapter.

5.2.1.2 Resident-Visitor Interactions

In addition, informal interactions between residents and visitors or family members were quite limited. During formal observations taken, only 2.9% of all observations at Guildwood Village and 1.8% at Meadowcreast Lodge were classified as interactions with visitors/family members. This is likely due to a combination of two factors. First, it reflects the lack of visitors residents receive; typically the same few residents receive visitors and the same visitors or family members come to visit. Second, these low numbers are also a reflection of the spaces where residents interact with visitors. Primarily, these spaces included residents’ bedrooms and spaces outside the SCU (both within the facility and offsite), which were excluded from observations in this study.
Within each SCU, the interactions between residents and visitors often included a social and care related component. At both Guildwood Village and Meadowcrest Lodge, it was not uncommon to observe family members who would come visit their loved ones during mealtimes. During these interactions, the visitor may sit at the dinner table with a resident and would try to chat with them, sometimes receiving a response, while at other times they would not. Simultaneously, they may try to feed the resident, help keep the person clean by wiping their mouth, or try to coax the person to eat their meal. An example of such an interaction occurred at Meadowcrest Lodge during one lunch period where a son came to visit his mother. Both were seated at a table with the resident sitting in front of her lunch (brought by the visitor). She was facing the hallway (her back to the lounge) and the son to her right, approximately 90-degrees from one another:

“The son is helping his mother eat, by feeding her soup. He says something to her in [their native tongue]. She giggles and laughs, picks up the cup and starts to eat. [The son] is also talking to [her] as he feeds her. She doesn’t seem to be commenting back. Instead she opens her mouth and eats, [while looking away]” – Field Notes, Meadowcrest Lodge

5.2.1.3 Resident-Staff Interactions

Interactions between residents and staff were the second most common form of informal interactions that were observed. In considering all observations made, 11.8% and 6.2% of these were considered as informal interactions between residents and staff, respectively in Guildwood Village and Meadowcrest Lodge (Figure 1). These results did not include informal-type interactions during formal care practices between staff and residents such as
when a staff member was feeding (or giving medications) and simultaneously speaking or socializing with a resident. Although residents surely find some meaning in these quasi-informal interactions, this decision was made as the focus of this investigation is on the spontaneous interactions between individuals. In situations where formal care was being given, the care activity created an underlying pretence for the interaction (thus undermining spontaneity), which often involved socializing with residents as a means of directing a resident’s behaviour in the care process (e.g. getting the person to eat, or take their medication).

Informal interactions between care staff and residents were quite unique as it was often the staff members who initiated informal interactions with residents such as when passing through the unit or between residents. These were generally brief and included a short greeting (e.g. “hello [name], how are you?”) prior to moving on. An example of an informal interaction which was slightly more involved with the resident was seen in Guildwood Village, as one member of the nursing staff headed to the washroom. The staff member approached one resident who was sitting in the dining room directly across the room, in front of the nursing station where he recently exited:

“[Nurse] walks out of nursing station and heads out to the washroom. However, along the way he stops beside [Resident Name], who is sleeping. He says hello, she opens [her] eyes, he holds her hand and says, ‘You’re beautiful, how are you?’ She is looking at him and puts on a huge smile with a small laugh, she continues to smile as [he] fixes her hair. [He] walks away and she goes to sleep” – Field Notes, Guildwood Village
However, not all interactions between staff and residents were initiated by the staff. Oftentimes a resident would approach a staff member just to talk, while at other times they would seek their help. For example, during an interview with one of the environmental staff (maintenance staff) people at Meadowcrest Lodge, it was indicated that although this particular person initiated most interactions with residents, they did approach him regularly:

“They do follow me sometimes soon as they have questions, and they wanna go out. They wanna go to the bank and so they wanna ask you questions. They think that you can help them. So to them in their mind it’s like the next person they come up to me maybe I can help them out or something ... Some of them sometimes will just stand next to you. You know, they just wanna, yeah...have attention” – Interview, Environmental Staff, Meadowcrest Lodge

In addition, it is important to note that in using the term “staff”, caution needs to be taken as this is not a homogeneous group. Particularly, not all staff members have an equal opportunity to interact with residents informally. While individual staff members may resonate more or less with a particular resident, it was found that the motivators that shape informal interaction which do occur, and subsequently the type of relationship that develops between staff and residents, varies across levels of staff (i.e. nursing staff vs. care aides vs. environmental staff). This may be due to the amount of time a particular staff member is in contact with residents and the circumstances of their job, and is not necessarily a reflection of their willingness to interact with residents as all staff members (as reflected in each facility’s philosophy of care) did attempt to interact with residents.
In considering care aides, these are the individuals whose jobs deal with the hands-on care of the residents. Thus, they are in close contact with residents throughout the day. According to interviews with various care aides, engaging in informal interactions is oftentimes motivated by building a rapport with residents in hopes of making personal care easier. For example, one care aide from Guildwood Village discusses this relationship:

“...We try to talk to them. Usually, in the...in the lounge, you know, or in the rooms... you have to communicate so they’ll get your trust and they’ll be able to do what you want them to do. Then like in the dining room when we’re waiting for the meal, for the food to come, we talk to them. So...we develop...how do you call it...[a relationship]... And then sometimes we share jokes with them, you know, and we want to know what they did before so we ask those questions...” – Interview, Care Aide, Guildwood Village

Alternatively, nursing staff (Licensed Practical Nurses and Registered Nurses) typically have a moderate amount of formal contact with residents throughout their daily routine such as when giving out medication or observing health-related issues. However, during other times in the day (i.e. meal times), nursing staff frequently interact with residents on an informal basis by socializing with them prior to eating. These interactions were usually brief and tended to be verbal forms of communication.

Interestingly, staff who had the least contact with residents as part of their job routines and responsibilities appeared to play a more critical role in socializing with residents on an informal basis. More specifically, within both Guildwood Village and Meadowcrest Lodge, environmental staff viewed themselves and their commitment to socialize with residents as crucial to
resident well-being. They clearly noted that although their job is to housekeep, their obligation is to the residents first. For example, one environmental staff member from Meadowcrest Lodge describes this dynamic during an interview:

“See my job is a housekeeper ... with myself I make time for the residents. Like I’ll do something for them. You know, just take them for a walk around, ‘cause some of them get very agitated and stuff. Or like you know, sometimes I put a movie on for them, which they enjoy. So....you know talk to them, you know you need to make time for them. So...stuff like that. We have our jobs too, but you know, still, we do it for the residents. Then they feel like they’re appreciated and they’re more [calm] ...” – Interview, Environmental Staff, Meadowcrest Lodge

This excerpt provides a general overview of the types of interaction environmental staff engage in with the residents and highlights the fact that a majority of these interactions are informal and meaningful to residents. This is reflected in the quality of interactions observed within each SCU when environmental staff and residents interact. For example, these interactions seem to be more friendly or social in nature, where the motive for engaging in these interactions does not appear to be a means of achieving a cleaning task.

Consequently, the key point here is that informal social interaction between staff and residents does not occur as frequently across all staff levels (relative to the amount of time they are in contact with residents) due to various job-related factors. However, while all staff members play an important role in facilitating informal social interaction with residents, environmental staff may play an especially significant role in this process.
5.2.2 Type and Expression of Informal Social Interactions

Previous research investigating social interaction within a dementia care population tends to focus on simply identifying the typologies of social behaviour, primarily those that are non-verbal (e.g. Hubbard et al., 2002). While the purpose of this investigation includes refining these typologies within the context of informal social interaction, the present study goes beyond and attempts to detail how each type of informal social interaction is characterized and expressed.

Among observations indicating that some form of informal social interaction occurred, a set of seven behavioural categories emerged that describe the type of informal social interaction exhibited by residents in both participating SCUs (Figure 2). These categories include: 1) active verbal communications, 2) brief verbal communications, 3) touching, 4) gesture, 5) glancing, 6) attention seeking, and 7) other non-verbal communication.

It is important to note that the social behaviours documented in this investigation are not mutually exclusive from one another, as within the observation period from which all figures were generated, it was possible that residents were simultaneously engaged in several behaviours during this timeframe. For example, a resident may be engaged in multiple types of informal social interactions at the same time, such as gesturing and verbal communication.

5.2.2.1 Active Verbal Communication

Verbal communication accounted for approximately 42% of all informal social interactions identified during formal observations taken (Figure 2). Within
these verbal forms of communication, two distinct patterns emerged within the data, one of which was termed ‘active verbal communication’. In several instances, residents would verbally communicate with other residents, staff, or visitors by carrying on a conversation with them. Generally speaking, conversations where residents engaged in active verbal communication encompassed two key elements not observed in other forms of verbal communication. First, speech between conversation partners was exchanged more than once or twice and often included more than a few words per sentence. Second, speech between a resident and their conversation partner was sustained over a period of time greater than 30 seconds.

Approximately 15% of all informal social interactions observed within both SCUs were active verbal communications (Figure 2). More specifically, 11.8% of informal social interaction observations made in Guildwood Village and 15.8% of those made at Meadowcrest Lodge were classified as such (Figure 2). This accounts for the fourth largest proportion of informal social interaction types that were observed.

Active verbal communications were evident in both Guildwood Village and Meadowcrest Lodge. In both SCUs, this type of verbal communication was not demonstrated by all residents. Typically, it was the same few residents or groups of residents within each facility who were capable of initiating and sustaining longer conversations with others. These residents appeared to be those who were less cognitively impaired or in the earlier stages of their dementia. Whereas in Guildwood Village most of these active verbal communications were between
staff or residents who did not have dementia and residents with dementia, in Meadowcrest Lodge, a larger proportion of observations that involved active verbal communication were between the residents themselves. This may be a result of the overall health of residents in each of the two facilities, where those in Guildwood Village tended to be in lower health than those in Meadowcrest Lodge. Alternatively, this may be a reflection of the opportunity (or lack of opportunity) for residents to engage with one another. Particularly, within Guildwood Village, due to the fewer number of residents and the opportunity for residents to leave the unit for recreational activities, this left very few residents present in the main common space at any given time. In considering both of these factors, it was not uncommon to only find four to six residents in the entire common space at any given time, thus thwarting the opportunity for residents to engage verbally with one another.

Among informal interactions residents engaged in, two types of active verbal communication patterns were evidenced. The first pattern was characterized by active verbal communication where the content of these conversations, although repetitive at times, was quite coherent and easily understood by any outside observers. For example, as one resident (Frank) was being brought back into the unit after a recreational activity outside the unit at Guildwood Village, the staff member began a conversation as they walked together. They begin chatting about where Frank would like to go in the world:

**Staff** – “Where would you like to go – maybe Hawaii?”

**Frank** – “Oh no, I couldn’t afford going there”
**Staff** – “That’s okay, it would be nice to go there through”

**Frank** – “Oh, it must be getting late because I’m hungry, what time is it?”

**Staff** – “It’s 3:00, what are you craving? [Resident looks at her], A banana, orange…”

- Field Note, Guildwood Village

The staff member leaves to get the resident a fruit and the resident continues to walk and sits down in front of the television (directed by staff member). On a separate occasion, this same resident had a lengthy conversation with a female resident (Alicia). He (Frank) was seated on the couch in the lounge. The television was on and another resident was seated beside him. Alicia approaches Frank and says: “How is my love doing, how are you?” Frank replies “What have you been up to?” Next, Alicia seats herself between the two residents on the couch (beside Frank), they turn slightly inwards towards each other and chat for a bit:

**Alicia** – “I’ve been making fans”

**Frank** – “Why you doing that?”

**Alicia** – “Well, I’m making one for you?”

**Frank** – “Well, that’s nice. Where are you going to do that – at home?”

**Alicia** – “yes!”

- Field Notes, Guildwood Village
The conversation continues on as they speak about a range of topics, including their past home lives. Frank frequently turns his head towards Alicia from time to time, but his eyes are semi-shut. Susan, another resident, is reclined back with her feet on the table in front of her as she is also watching television as they chat. Although the speech repeats itself, neither of the residents seem to mind. After approximately five minutes, the conversation comes to an end. Similarly, these informal active verbal communications were also evident in Meadowcrest Lodge between residents.

The second pattern of active verbal communications was characterized by sustained conversations between residents, where both residents were speaking in different languages from each other (i.e. each resident was speaking a language different from the other within the dyad) or speaking non-coherently (i.e. each resident is speaking about a topic relevant to them, as opposed to a common topic). As an observer, these interactions looked quite similar to the first pattern of active verbal communications from afar. For example, social norms of communication such as taking turns were adhered to by both residents during these conversations (i.e. one resident would speak, let the other person speak, and then speak again). However, it was not until these interactions were more closely observed, that this differentiation from the first pattern was discovered. For example, in Meadowcrest Lodge two female residents in the dining room were seated beside each other. Shortly after, they began chatting with one another and this was detailed in a set of field notes:

“Two residents are chatting to one another. The first resident is speaking softly, but in broken English, whereas the second resident
is speaking Spanish to her while trying to find something. Each of them speaks one at a time and their conversation lasts for several moments. It is unclear if these two individuals understood each other” – Field Notes, Meadowcrest Lodge

This appeared to be a common form of active verbal communication as was described by several staff members during the interview process. For example, a staff member at Meadowcrest Lodge indicated:

“Sometimes Mrs. [A] who has a second language ... sometimes you see her sitting with another resident talking in her language and then the other resident’s just speaking in [their] language, so they’re both thinking that they’re communicating to each other. But it’s just how they are talking to each other that they think they understand each other. You see that quite a bit.” – Interview, Nursing Staff, Meadowcrest Lodge

Similarly, a staff member at Guildwood Village also described their experience of such situations:

“... I’m not sure whether it’s negative or positive, but when they answer it’s not related to what the person was talking [about]. I’ve seen it many times” – Interview, Care Aide, Guildwood Village

In all, these findings indicate that some residents within these SCUs are able to carry on a sustained conversation with others, albeit with staff, other residents, or visitors. Furthermore, these conversations do not necessarily have to be ones where the words make sense to outside observers. Instead, it appears that through the act of conversing with other, residents are able to gain meaning from the activity of active verbal communications.

5.2.2.2 Brief Verbal Communication

A second form of verbal communication also emerged from the data and was termed ‘brief verbal communication’. This type of informal interaction was
characterized by verbal communication, which occurred very quickly, at times in passing such as while residents were wandering or walking through the dining area, but more often while residents were simply seated near each other throughout all spaces in the facility. While words (i.e. coherent) or mumbles (i.e. non-coherent or inaudible) were spoken, the hallmark of this type of informal social interaction is that these were limited to either a few words, mumbles or a sentence or two.

In considering all formal observations taken at both Guildwood Village and Meadowcrest Lodge, brief verbal communications represented 27.9% of all informal social interactions (Figure 2). Within Guildwood Village, this accounted for 30.9% of informal social interactions, which was by far the largest proportion of interactions observed in this SCU (Figure 2). In comparison, the next largest proportion of informal social interactions at Guildwood Village was via gesture, representing only 18.4% of such observations (Figure 2). In contrast, 26.1% of all informal social interactions were classified as brief verbal communication in Meadowcrest Lodge, second only to gesture which was the largest proportion of informal interactions observed at this SCU (28.4%; Figure 2).

Several types of brief verbal communications were expressed within both SCUs, the most frequent expressions of this type of behaviour being through the act of mumbling. One example depicting this type of informal social interaction occurred at Meadowcrest Lodge one afternoon. Several residents were engaged in various activities throughout the unit, including resting, sleeping, and wandering. However, one of the residents (Pauline) was standing in the doorway,
outside of the kitchen area, watching others in the hallway. Occasionally, she greeted passersby:

“Herman is wandering throughout the hallway. As he turns the corner, Pauline makes eye contact and mumbles something. Herman approaches and comments back (mumbling) [briefly] while walking ...he immediately continues on around the hall” – Field Notes, Meadowcrest Lodge

Another example depicting residents who spoke very briefly or mumbled while communicating occurred in the lounge area. One resident, Laura, was seated at a dining table chatting with another resident. After finishing their conversation, Laura rose and walked over to the lounge. She sat down in between two other residents and turned to her right facing Nancy. Nancy turns as well and looked at Laura as she sits. Laura greets her:

Laura – “Hello, how are you?”

Nancy – “Hi” [followed by a head nod and some additional speech which was barely audible]

- Field Notes, Meadowcrest Lodge

Laura replies back. After a few minutes however (no interactions during this time), she gets up and leaves the main common area.

In both of these examples, residents acknowledged each other verbally, however, the interaction itself is very brief. Additionally, these brief verbal interactions were quite spontaneous in how they developed. They tend to occur across a broad range of situations including ones where residents had been in close proximity to one another for a lengthy period of time and in many instances where a resident would enter a room and encounter another person as they
passed by or sat down near them. Unfortunately, it was very difficult to assess the content of many of these vocalizations; however, in general they appeared to be positive and were often accompanied by other forms of non-verbal communications such as nodding in response to others’ verbal communication attempts. One example of this is from observations taken at Guildwood Village, where brief verbal communications and gestures were used concurrently by residents during an informal interaction sequence:

“Meghan gets up from chair in lounge and walks directly over to Jack ... As Meghan approaches, Jack mumbles something. Meghan stops at the corner of the table and begins speaking back (barely audible, words are unclear). As she is speaking, she looks down at the table and rubs her finger across the edge of it, where the rubber edges and table top meet. Jack appears to be saying something aloud, however Meghan nonchalantly mumbles back. Jack occasionally glances over at her, at one point he nods his head and attempts to lift his right arm motioning it towards the chair across from him (as to offer it to her). She continues to stand at corner. After a few moments she stops all movement, her eyebrows furrow and she decides to walk away. Jack watches on as she exits the room” – Field Notes, Guildwood Village

In the example above, it was unclear what caused Meghan to rise from her seat and to walk away from the lounge to the kitchen. However it was clear that Jack’s attempt to interact with Meghan (by calling out) did attract her attention enough for her to stop and briefly socialize. These observations and those similar to it indicate that people with dementia residing in SCUs are willing to interact with one another, as long opportunities to do so exist. This also calls attention to the importance of recognizing that even these short communication attempts between residents are meaningful to them.
Residents also frequently had brief verbal conversations with care staff. In some cases these were initiated by the residents themselves and stemmed from their curiosity or a desire for some type of help. For example, on several occasions, residents would approach an environmental staff member who was mopping or cleaning throughout the SCU and ask what they were doing. The staff member would happily reply back and carry on once residents had finished conversing. Alternatively, staff members also often initiated these brief verbal communications. For example, while cleaning up, one staff member (environmental staff) approaches a residents, David, and says “Hello, Mr. A, how are you today?” David responds by looking up, says “Hello” quietly followed by a few other words (mumbled) and carries on looking ahead. Similarly, care staff would often circulate throughout the dining room and briefly engage residents after or during their meals by asking a quick questions such as “Did you enjoy your dinner?” or “How is your meal [Name]?” to which a resident would reply with their response.

Care staff in both facilities also acknowledged these brief communications during interviews, despite many of their examples in terms of verbal communications emphasising interactions between staff and residents or between residents, which were more active in nature. This latter point was surprising, given the high proportion of brief verbal communications relative to active verbal communications found during observations (Figure 2). This may suggest several issues. First, care staff may put a greater emphasis or value on active verbal communications. Perhaps this is because these types of
interactions represent normalcy of verbal communications that we often strive for in the care of all residents, patients, or clients across all care settings. Alternatively, these active forms of verbal communications may be most relevant to care staff in their everyday lives (outside the care facility), hence, only the most overt forms of verbal communication were highlighted. Additionally, this finding may suggest that care staff’s definition of verbal communication does not readily include these very brief forms of communication, thus it is important to highlight these nuances during their formal training. Nevertheless, the ability to identify this discrepancy speaks to the appropriateness of the methods used, where through triangulation, actual patterns of behaviour were rigorously identified and described.

Although these examples of more active verbal communications appeared to be highlighted in interviews, staff members at both SCUs suggested that residents do engage in brief verbal communications. In all, it is evident that within the context of people with dementia, verbal communications encompass a wide range of communication types. In fact, verbal interactions which are brief in nature appear to be one of the most frequently used communication patterns among people in SCUs.

5.2.2.3 Touching

Non-verbal forms of communication accounted for approximately 49.4% of all informal social interactions observed during formal observations within this study (Figure 2). One such type of interaction, which was found to be an important behaviour within both SCUs was communication through touch. In
general, this type of interaction was characterized by one person coming into physical contact with another, where some form of response (i.e. verbal or non-verbal) was elicited from the person being contacted. In considering all formal observations taken at both SCUs, communication using touch represented 7.3% of all informal social interactions observed (Figure 2). In comparison, communication by touch accounted for 11.0% of informal social interactions in Guildwood Village, whereas it accounted for only 5.0% of all informal social interactions observed at Meadowcrest Lodge (Figure 2).

Within the context of SCUs, physical contact was expressed in a variety of forms. Most commonly, this included communications whereby a hand or finger was brought in contact with someone else such as in holding hands, tapping a shoulder, or simply shaking hands. Several examples of each of these types of behaviours were observed in both SCUs. In Meadowcrest Lodge, holding hands among female residents was the most frequently documented form of touching behaviour during informal social interactions. These interactions often occurred in the lounge area while residents were relaxing or engaged in other activities. During one example, Pauline and Olivia were seated beside each other in the lounge. Pauline was rummaging through her purse and found a notebook when the following ensued:

“Pauline takes out a notebook and begins ruffling through the pages. As she is going through it, she speaks faintly and holds out her hand to Olivia. Olivia looks over into Pauline’s eyes, takes her hand by placing her left hand on top of Pauline’s right hand, and starts nodding with a look of surprise in her face. They hold hands for a few minutes as Olivia dozes off. Pauline continues to look through the notebook.” – Field Notes, Meadowcrest Lodge
Additionally, during a separate set of observations, two other residents engaged in similar behaviours in the lounge area. Emma and Jenny were seated beside each other at a 90-degree angle, a coffee table between them. Emma is looking intently at the radio on the table when the following interaction occurs:

“Jenny is watching Emma and lets out a large smile. As Emma notices, she leans over and they grab each other’s hand. Both residents are using two hands to hold onto each other. While doing so, they pat and rub each other’s hand briefly, smile at each other, and stop. Jenny looks ahead and Emma mumbles something aloud.” – Field Notes, Meadowcrest Lodge

In both of these examples, the residents appeared to have found meaning in touching others with their hands. Evidently, these types of interactions are typically positive, quite brief, and both residents mutually agree to hold each other’s hand. This is not to say that, physical aggression during times of agitation did not occur, however these instances were quite rare and never escalated worse than a swat or light tap between residents as staff would often intervene quickly to stop the situation from escalating when they felt a further altercation may pursue.

In other cases, residents used touch to gain the attention of other individuals. This was the case in Guildwood Village, where one resident (Daniel) would occasionally approach another resident (Frank) to solicit his companionship in the lounge area. Here it is worthwhile to note that when Daniel initiated these types of interactions, they were usually only ever directed towards Frank and that they occurred in various locations throughout the facility, including in the dining room or outside of Frank’s bedroom (according to staff during
interviews). In one example of touching during an informal social interaction,

Daniel approached Frank after finishing his meal:

“After returning his plate to serving area, Daniel stops by a nearby table and taps Frank on the shoulder. Frank looks up and Daniel nods his head and points his finger towards their seat in the lounge area. Daniel responds, ‘Yeah, okay’ however remains in his seat while finishing off his food. Daniel waits a moment, walks off and sits down in the lounge area” – Field Notes, Guildwood Village

Similarly, care staff also indicated that they use touch to socialize with residents or to gain their attention during informal interactions, although this was infrequently seen during observations. Regardless, the use of touch with residents creates a different form of stimulation and consequently a different experience for people with dementia. According to one care aid, the use of touch helps elicit communicative responses, which in certain residents, would not have otherwise occurred. Such a situation was described during an interview with this care aide when asked to describe a typical interaction between herself and a resident:

“Well, Marilyn for instance, I'll say, ‘Hi Marilyn!', even though she doesn’t speak that much because I want to see if she’ll answer me. And sometimes she’ll answer, and if you touch her on the shoulder, ‘Oh, hi dear!' even though she’ll never usually say that. So in that sense I do, I like to bring out a sentence out of her because I don’t always hear it. And then…but that...her's is late stage dementia.” – Interview, Care Aide, Meadowcrest Lodge

Here, the staff member highlights the fact that Marilyn was in the later stages of dementia and that an atypical verbal response was elicited from her, when using touch to gain her attention while interacting with her. However, according to care staff, residents were not always passive in communicating through touch as in
some instances they would be the ones initiating these types of interactions with care staff. For example, during an interview with a different staff member, touching was highlighted as a frequent form of non-verbal communication, which occurred between care staff and residents. When asked to describe such an interaction it was discussed as follows:

“Oh yeah, yeah. Like hugging, and ... sometimes they hold my hand and kiss me because they feel that you’re a lovely person, close to him, they will praise you, “Oh, you’re a wonderful person”, take your hand and kiss, yeah…they can answer you simple” – Field Notes, Care Aide, Meadowcrest Lodge

This excerpt suggests that verbal communication in conjunction with touching (through hugging, holding hands, and even kissing) during informal social interaction is a by-product of developing a close relationship with residents. Interestingly, these types of behaviours are also seen between residents and their visitors, where oftentimes, visitors will hold their loved one’s hand or come in close contact with them during their visits. This was the case during one visit in Guildwood Lodge, where two family members (a wife and a son) came to visit their loved one, Samuel. Samuel was in his wheelchair in the dining room, facing the wall to the right of the nursing station. The two visitors were standing beside him, one on each side, both holding onto Samuel’s hand. His wife would speak to him in his native language, and he would open his eyes wider. Although Samuel was dozing in an out of sleep, he would also clench his hands harder, to which both his wife and son would also squeeze back. This back and forth squeezing highlights the fact that non-verbal communications and in particular, haptic communications, come in many forms and are quite important to people with
dementia in terms of providing a meaningful physical connection between individuals. Given that these forms of behaviours typically occur between residents who appeared to have close relationships, residents and their caregivers (staff, presumably a close relationship), and between residents and family members, positive interactions involving touch likely highlight the closeness of a relationship for residents.

In addition, informal social interactions involving physical contact were not limited to these above examples. Some informal interactions, particularly those between residents, included more affectionate and intimate behaviours. While this type of interaction was observed occasionally, especially within Guildwood Village, these interactions were often isolated to the same few individuals within this SCU. One of the most pronounced examples of this type of interaction occurred between a male (Jake) and female (Meghan) resident in Guildwood Village. During one instance, Jake was seated in his wheelchair by the exit, with his back to the door. This area is connected to the walking path, spacious and open, yet at the same time provides some degree of privacy given that there are two walls that extend out from the doorway, creating an alcove-like space. As Jake is seated in this space, Meghan is wandering throughout the unit, circulating in the hallways and throughout the dining room. A detailed description of these affectionate forms of touching behaviours were taken during field observations and an account is given below:

“Meghan picks up a yellow caution sign (‘Wet Floor’) from the dining room and carries it over to the exit area where she places it against the side wall. She leaves this area and continues wandering throughout the unit. Jake watches and looks at her as
she walks by. Meghan settles in the dining area for a few moments and then decides to continue walking. As she leaves the dining room, she walks straight for Jake. She puts her right hand on the left wheelchair arm, bends down, and kisses him three times on the lips. She looks at him in eyes and he looks back and mumbles something. Meghan nods and also mumbles back. She shifts her position from the front to the side of Jake’s wheelchair where she has her hand on his wheelchair back and is rolling up and down her right pant leg. After a few moments, while remaining beside him, she looks down at her nails, and shows him by placing her thumb a few inches away from his face. He focuses on the nails and raises his eye brows until she removes her hands and begins brushing his stomach up and down. Meghan is interrupted as another resident (Enzo) approaches the exit area beside the serving area in the kitchen. As Enzo moves forward, he starts yelling at Jack, flailing his hands and tells him to move [While wandering Enzo frequently bangs on the exit door, however is obstructed by Jake in this particular situation]. A Care aide comes to this area, tells Enzo to stop as ‘[Jake] is not bothering you’, and directs him away from this area. During this altercation, Meghan moves behind Jake with both hands on the wheelchair handles. The care aide returns to the exit area with a chair for Meghan, places it beside Jake, encourages Meghan to sit in it, however she does not oblige. Consequently, this care aide leaves and goes back into the dining room. Meghan continues to stand behind Jake for a few more moments and then kisses and smells Jake’s head from behind (A dietary aide who was in serving area leaves the unit by walking out past Jake, however does not acknowledge his wave). Meghan continues to rub and feel Jake’s hair and after a few more moments of this, she puts her head and cheek on top of his head. He begins speaking and looks up. Meghan bends down to hear and responds by mumbling something back to Jake, who continues to speak. While doing so, Meghan comes around to side of chair and begins picking her nails (Jake is still talking). Shortly after, she places her left arm and hand on the back of the wheelchair chair and begins to rub his chest and head with her right hand. Next Meghan moves and she sits beside Jake, to his left. He begins talking, while she seated and looking around at the ground and into main activity space. While doing so, Meghan is rubbing the top of Jake’s hands. Both are sitting up and leaning forward in their chairs (with their backs away from the back of their chairs). Jake is talking with Meghan and is holding both hands together, while facing each other. Meghan responds by nodding, rubbing his hands, and mumbling back. They continue to sit beside each other ...” – Field Notes, Guildwood Village
This lengthy interaction lasted approximately 10 minutes and depicts some of the more intimate and affectionate behaviours, which were observed during the researcher’s time at Guildwood Village. Specifically, an emotional bond between both residents is evident and expressed through such actions as kissing and caressing (e.g., rubbing hands, chest, head, etc.). According to care staff, this type of interaction between Jake and Meghan was commonplace. When asked to depict what an interaction looked like when two residents were interacting, one care staff responded as follows:

“They like sitting, and they chat [with] each other, but it doesn’t make sense. Maybe based on their past experience, they like chats. Just…but…like…Meghan and Jake, they will come together, they talk, but I don’t understand, but they can feel love each other, they can kiss each other, and [Jack] will say something to [Meghan]. She will give him a kiss … They comfort each other, they interact with each other, but it doesn’t make sense to me” – Interview, Care Aide, Guildwood Village

This excerpt highlights the uniqueness of Jake and Meghan’s relationship in comparison to other residents, and how through intimate contact, both resident’s bring comfort into each other’s lives.

Collectively, these findings indicate that touch is an important form of informal social interaction within SCUs. These interactions are expressed in a variety of ways including within actions used to solicit someone’s attention, through friendly touching, and more discreetly through intimate forms of touch. Despite this, the one commonality between most of the circumstances described is that residents engaged in social interactions involving touching appear to have an emotional connection to the person they are interacting with, much more so
than the connection one may feel when encountering an acquaintance. This implies that between residents and perhaps even between residents and staff, meaningful relationships or even friendships do develop within SCUs.

5.2.2.4 Gesture

The use of gesture was by far the most observed non-verbal form of informal social interactions observed within both SCUs. This type of behaviour was expressed in a variety of ways and was characterized by residents displaying bodily movements or actions in order to convey a message. These forms of interaction most commonly involved directed movements of the hands and arms, but also extended to other body parts including the head. In considering all formal observations taken within both SCUs, communications involving gestures accounted for 24.6% of all informal social interactions (Figure 2), however the proportion of these types of interactions differed slightly within each SCU. Within Meadowcrest Lodge, gesture was the most common form of informal social interaction accounting for 28.4% of all such observations occurring within this SCU (Figure 2). In comparison, the next most common informal social interaction within Meadowcrest lodge was brief verbal communications, which represented 26.1% of all informal social interactions observed (Figure 2). With regards to Guildwood Village, gesture was the second most common form of informal social interaction representing only 18.4% of all formal observations taken within this SCU (Figure 2). To put this into perspective, the most common form of informal social interaction, brief verbal communication, accounted for approximately 30.9% of all informal social interactions observed (Figure 2).
Gestures observed within SCUs can be grouped into two broad categories. The first of these categories describes situations where gestures alone were used in lieu of verbal communications whereas the second category included interactions where gestures were used in conjunction with verbal communications, usually in order to complement them. Informal social interactions where gestures replaced verbal communication took on many forms, however one of the most prevalent for of these interactions observed were head nods as a form of acknowledgement. For example, as lunch was wrapping up one afternoon in Guildwood Village, one of the more cognitively intact residents (non-dementia) who was seated across from Madison, makes small-talk at their table:

“Madison lifts bread and makes eye contact with Alicia as she eats. Alicia replies by asking, “is it good?”, to which Madison replies by tilting her head forward and bringing it back to its original position.”
– Field Notes, Guildwood Village

In this example, Madison interacts with Alicia by nodding her head. Although this interaction was very brief (and typical of other events involving head nods), the intent of Madison’s action was to not only to acknowledge her tablemate, but to reply “yes” to the question posed. Similarly, this type of response was also observed at Meadowcrest Lodge. For example, Victoria exits her bedroom and enters the main dining area through the kitchen-side entrance. As she continues to walk towards the lounge area, she stops at the second table where two residents are seated across from each other:

“Victoria comes to the table, looks at Julie, waits for her to look over and asks, ‘Can I sit here?’ Julie nods and helps pull out the chair."
As Victoria sits down, she turns to Julie and says “Oh, your eye looks a lot better today!” [this is in reference to a black eye that Julie had due to a fall several weeks previous]. Julie responds with a nod ...

– Field Notes, Meadowcrest Lodge

In the moments after this observation, Victoria continues to try and chat with Julie (who goes on to respond coherently and verbally), however after a few moments, Victoria stands and leaves the table. In this example, Julie nods twice in response to Victoria, both times appearing to nod in agreement. Here these nods indicate a response, which could be translated as a simple “yes” (i.e. “Yes, you can sit here” or “Yes, my eye does look better”). Thus, nodding as a form of agreement with others is one gesture often observed in dementia care settings.

However, using a head nod to indicate agreement without verbally doing so was not the only purpose of this type of gesture. More specifically, as residents moved between spaces it is not surprising that they would often encounter other individuals. During these circumstances, it was not uncommon for one resident to let out a small nod as a greeting to others. For example, early one morning at Meadowcrest Lodge, one resident (Georgia) entered the dining room and approached her usual table, a medium sized round table closest to the lounge area. As she approached, another resident (Julie) made eye contact and they both bowed their heads forward, towards one another, as to say “good morning” or “hello”. Here, both residents nod simultaneously and appear to be greeting each other. In another example at Meadowcrest Lodge, one of the residents is agitated (Kim) and is wandering throughout the hallways, repeating herself, “Hello, Hello, Hello ...” to everyone she sees. Some are receptive and others are not, however as she approaches one resident, Thomas, he tilts and
drops his head forward slightly as to nod at her and stares for a moment until they both continue on. Once again, although this interaction was very brief, Thomas’ head nod appears to gesture a simple “hello”. Thus, nodding as a form of greeting is yet another gesture exemplified within SCUs. Interestingly, gestures solely involving head nod as a form of greeting did not readily emerge from the data collected at Guildwood Village. Instead, this type of gesture was often used to supplement verbal greeting expressions. One example of this occurred one morning towards the end of breakfast. Frank was seated in the dining room at his table (second table along the nursing station wall) in the seat facing the lounge. Alicia who recently sat down to eat breakfast, has positioned herself at the next table (closest to the lounge, on the nursing station wall) and is seated with her back facing the wall. As Alicia turns slightly to her right, Frank smiles, nods and begins to speak, “hello dear, how are you doing?” Alicia looks on and replies, “I’m having breakfast – cornflakes and tea”. Frank continues to smile. Although a gesture did occur in this example, this type of informal social interaction was quite different from those mentioned previously as it was used in conjunction with verbal communication. Consequently, this expression of nodding is reflective of a second category of gesture, that is, those involving verbal communications, which will be highlighted in greater detail later in this subsection.

Additionally, head nods observed in both SCUs did not only reflect moments of agreement and greeting. On some occasions, these gestures appeared to be used as a form of thanks, that is to say “thank you” to other
individuals. One example of this type of interaction occurs while a resident in Guildwood Village is helping another pass through the sliding door threshold so they can gain access to the courtyard area:

“... Jake rises from the wheelchair, very carefully and slowly. He seems a bit unsteady. He walks up behind Stewart, who is stuck in the doorway. Jake pushes him across the threshold and out into the courtyard. Stewart looks back and nods, as to thank Jake for giving him a hand. As Stewart goes out, he tries to close the sliding doors. He motions with his hand and gestures towards Jake to close the sliding door by arching his left hand, positioning this arm across his body and moving both across the horizontal plane in front of him (i.e. closing a sliding door). Jake closes the door half way. Stewart looks at Jake and tries to close door more. Jake helps and finally shuts it all the way” – Field Notes, Guildwood Village

In this example, a gesture of thanks is visible as Stewart looks back and nods at Jake after he is helped. Likewise, in Meadowcrest Lodge, behaviours signifying gratitude through head gestures were also evident. For example, this was highlighted on several occasions, particularly one morning in the dining room where one of the residents (William) returns to his table after taking a brief walk. This is the first table in the dining room near the kitchen entrance. Two residents are seated (Rose and Julie) as William enters the room and approaches the table:

“... at one point, after William has returned from a short walk, Rose tried pulling a chair out for him. William sits down, nods at her as he sits, and then turns back to her after seated (so he is facing the rest of the room).” – Field Notes, Meadowcrest Lodge

Here, this nodding gesture appears to show thanks as Rose pulls out the chair for William to sit. Consequently, nodding as a form of thanks is yet another category of nodding gestures frequently observed in SCUs.
In all, gestures that involved nodding occurred regularly within both SCUs; however it is important to note that the meaning behind these behaviours varied significantly depending on the context in which these interactions precipitated from. However gestures also took on other forms aside from head nods. In particular, hand gestures (without verbal communication) were quite common during a wide range of informal social interactions.

In some situations, these hand gestures often indicated residents' desires such as in pointing to an object, location or person when interacting with others. Typically, these interactions involved one resident lifting their arm and either extending their index finger or in some instances all of their fingers to point. These types of hand gestures were evident both during observations and interviews with staff. For example, in Guildwood Village, residents would approach staff and use these gestures to communicate the desire to move to other locations. This was exemplified in an interview with one nursing staff member as he was discussing the behaviours of residents and the progression of dementia within the SCU:

“Now, look at [Daniel]. He can’t even say ‘What’s your name, how are you?’ This and that. just “Da-da-duh-duh”....something like that and he points to where he wants to go” – Interview, Nursing Staff, Guildwood Village

Despite not being able to articulate himself verbally, Daniel appears to gain the attention of staff members and through a simple hand gesture, communicates his determination to move to another location. This type of behaviour was observed on several occasions in the dining room. Particularly, after finishing a meal,
Daniel would usually rise, clear his plate by bringing it to a staff member and “tell” them he was going to the lounge by pointing to it using his index finger. Similar in many regards, during observations taken at Meadowcrest Lodge, gesturing by pointing was seen as being used in an attempt to be courteous to other residents:

“Pauline is looking through her purse. Erica is looking over and Pauline shifts to show her what she is doing. Erica has a quizzical look on her face. As this happens, Jenny comes behind Erica to get her walker. Erica looks over and stares at Jenny for a moment. In response to this, Jenny points to walker by extending her arm [right index finger is pointing towards the ground] and makes a circle motion towards the dining room presumably to signify ‘I’m going over there – around’. Erica nods and Jenny is on her way.” – Field Notes, Meadowcrest Lodge

Here, Jenny’s circular gesture takes the place of explaining to Erica why she has approached her and what she intends to do after interrupting her. This example has many commonalities to the observations at Guildwood Village where Daniel proceeds to inform care staff on his intentions to move to the lounge (see above). In both instances, residents felt the need to communicate their intention to others, which suggests that they do have a sense of belonging or perhaps even a sense of community within their respective SCU.

Moreover, residents also used pointing hand gestures while interacting with each other. In these interactions, the meaning behind the pointing behaviour was varied. In Meadowcrest Lodge for example, pointing could be observed as a form of greeting:

“Diana approaches Nicole while sitting down and starts mumbling something to her. Nicole does not seem to understand, but attempts to respond back. Slowly, Nicole removes herself from the
lounge area, until finally saying to Diana that she ‘has to go’. Nicole walks over to a dining room table and sits with Jessica and Jenny. Jessica points to the chair as Nicole approaches and Nicole sits down. Shortly after sitting down, Nicole sees the roses [artificial] on a table and abruptly comments on them…” – Field notes, Meadowcrest Lodge

Here, Jessica gestures towards a chair as Nicole passes by, this not only served to offer her the chair, but to also welcome Nicole to the table.

Lastly, some hand gestures observed also served to replace certain word or phrases, where residents would instead move their hands and arms to convey a message to other individuals. These messages conveyed a variety of meanings. For example, during observations made at Meadowcrest Lodge, a resident (Theresa) approached another (Diana) who is seated in the lounge area facing the kitchen:

“They make eye contact at about the edge of the carpet. As Theresa approaches, Diana lifts her right hand with all five fingers extended but slightly curved forward and begins to wave her wrist left and right very quickly as to say “stay away” [in total her hand is being displaced only a few centimetres to the left and right, her hand is only about 15 centimetres away from her chest, and only her wrist is bending causing the wave, not movement in the elbow. Diana looks at Theresa and tilts her head sideways. Theresa attempts to speak to the other woman briefly (“doors to room are locked, but my son says it’s good to get out for a while”), however in the end she ends up sitting two chairs away from Diana.” – Field Notes, Meadowcrest Lodge

In this example, the rapid hand waves by Diana appeared to replace the words “stay away”, as was indicated by the gesture itself, the lack of response to Theresa’s communication attempt, and the end distance between both residents in the lounge. Similarly, residents would also use hand gestures as a way to indicate the word “no”. For example, during dinner time at Meadowcrest Lodge,
Pauline gestures towards Melissa by putting her hand on her own stomach. Melissa replies by offering Pauline some of her dessert, however she declines by shaking her finger and head from side to side.

Yet another example where hand gestures were used to replace speech was in greeting others. Oftentimes this was characterized by a resident giving a friendly wave to others, usually a staff member or visitor. For example, in Guildwood Village, while an environmental staff member was cleaning throughout the unit, she stops by one resident (Madison) who is seated at a dining room table. As the environmental staff member passes by, she says “Hello” to Madison. Madison looks up, smiles and waves back. Here, the combination of both the smile and wave are indicative of Madison replying “Hello” back to the staff member.

Furthermore, hand gestures were not only used by residents to replace specific words (e.g. no, hello, etc.), but in some situations they replaced speech altogether. This was particularly evident in Meadowcrest Lodge during informal social interactions involving two specific residents, Jessica and Jenny, where it appeared that these two residents had developed their own language for communicating with one another through gestures. To put this into context, both of these residents were female, from similar ethnic origin, spent a great deal of time together in common areas, however these two residents did not know each other prior to admission into Meadowcrest Lodge. Additionally, it should be noted that according to care staff Jessica suffered from speech-impairment, where she was unable to articulate words, but able to produce sounds with various levels of
inflection. In contrast, Jenny did not appear to have a speech-impairment and was fluent in her native tongue. Despite these differences, both residents interacted with each other frequently. For example, during one set of observations at Meadowcrest Lodge in the mid-afternoon, both Jessica and Jenny walked together from the hallway and into the dining room from the kitchen entrance. As both approached the entrance, Jessica hesitated and waved her hand forward to let Jenny pass by. As they walked across the dining room pathway, they stopped and sat beside each other at the round table closest to the lounge area. Jenny had her back to the window, facing the rest of the room while Jessica had her back to the kitchen and was facing the lounge:

“As they are sitting, they do not talk to each other verbally [however it does appear that they have some sort of sign language system which both of them understands]. As one of the other residents walks by Jessica puts both arms and hands forward and in a circular motion in the direction of the person passing by. In seeing this, Jenny acknowledges Jessica by nodding and gesturing back with her hands [Jenny lifts her right arm, puts her thumb and index finger together and flings her wrist forward as well].” – Field Notes, Meadowcrest Lodge

In this example, the message behind these gestures was unclear to the researcher, despite the apparent meaning of this interaction between the residents. Overall, these were typical hand gestures observed between Jessica and Jenny while at the dining room table. Additionally, it appeared that these residents have developed a strong bond with each other in their time at Meadowcrest Lodge. Specifically, hand gestures were critical in developing this bond and were observed when Jessica and Jenny would frequently look for each other. On more than one occasion, Jenny would be resting in her bedroom, while
Jessica would be seated at the round table nearest to the lounge area. Jenny’s bedroom was one of two bedroom doors which was visible from the dining room via the kitchen entrance. While Jessica would be seated at the round table, she would occasionally stare at Jenny’s door and rise from her seat if she sensed Jenny’s door open. This was the case one afternoon as Jenny was getting ready to leave her room:

“Jenny pokes head outside of room. Jessica sees this from dining room chair where she is seated. She half gets up and waves Jenny over [as she rises, she holds out her hand with the palm facing the ceiling and swings her arm over her head twice]. In seeing this Jessica walks out of her room, goes back in quickly, and comes back out again with a walker and proceeds through the kitchen, eventually sitting down beside Jenny.” – Field Notes, Meadowcrest Lodge

Likewise, Jessica and Jenny have similar encounter during another day, with a slightly different outcome. In this example, Jessica is seated in the lounge in the early evening (7:00 pm) and looks back out at Jenny’s door from time to time. As Jenny pokes her head through the crack of the door, Jessica once again waves her over [similar to above - a hand gesture motioning her to come join the lounge], however Jenny waves back with her hand moving from side to side [as if saying “no, it’s alright”]. They stare at each other for a few moments. Finally Jessica flicks her right arm in the opposite direction twice, such that the palm of her hand is facing Jenny’s door. Simultaneously, she raises the back of her left hand up to her head and brings her head down slightly onto her hand. Here it appears that Jessica was gesturing Jenny to go back into her room and go to sleep. Jenny obliges by smiling, waving “goodbye” and closes the door behind her as she disappears into her room. This example highlights the complexity of
hand gestures used within SCUs, without the use of verbal communication. It is also of importance to note that the proximity between the two residents in these last two examples was quite far (approximately 15 to 20 meters away), indicating that among people with dementia informal social interactions can and do occur even when residents are not in close proximity to each other.

Gestures observed within the SCUs were not limited to those involving the hands, arms, and head. While the following examples of gesture were generally limited to particular individuals, these observations do give an appreciation for the wide variety of gestures present in SCUs, the nuances visible in gesture behaviours, and the meaningfulness of these interactions to the resident. One of the more unique forms of gesture identified was through the use of body language. Specifically, one of the residents at Meadowcrest Lodge, Jerry, would begin jerking his body back in an attempt to engage others. When asked to describe non-verbal informal social interactions, one care aide began describing Jerry’s deterioration during his time within his current facility, however highlights these body movements as his way of communicating with others around him:

“...Look at Jerry for instance ... When he first came, he could speak more fluently than he speaks now. In fact, now he can say sentences but he may not be able to. He may go a whole shift without saying a full sentence. Or he’ll just go, “D-d-d-...”, like he wants to say a sentence... but I remember when he could say sentences. But now, instead, like there’ll be someone who walks by and he will want to say hello, and he’ll go, “hhoooohhh-hhh”, but he’ll want to say, “Hi, how are you doing, I haven’t seen you in a long time”, but he can’t really say that, so his body motions will be...like, he’ll jerk, and he’ll want to interact, but can’t really follow through on...verbally, he can’t follow through verbally with what he wants to say.” – Field Notes, Guildwood Village
During observation period, this type of behaviour was evident in Jerry.

Particularly, there would be times where other residents would pass by him in the dining room walking path and he would let out a shout or would begin jerking. This was especially evident when a person would walk in close proximity to his wheelchair. During these events, Jerry would rock his upper torso back and forth, at times beginning to slouch in his wheelchair. Most of the time he was ignored by other residents, however care staff who typically cared for him would often recognize this behaviour and would approach him.

Another unique gesture observed was through mimicking or self-inflicted touch, that is, when residents touched themselves as a form of interacting with others. For example, during an early evening observation at Medowcrest Lodge, an environmental staff member was circulating around the dining room and approaches different residents. Along the way he stops by William and in a friendly voice says ‘hello buddy” followed by smacking his lips with his right hand. This makes William laugh. William rushes into the dining room near the kitchen and begins smacking his own lips with his right hand, followed by smacking his rear end repeatedly all the while laughing and saying “no, no, no, no, no...” This occurs for approximately one minute, when William stops and walks away laughing and the environmental staff member moves on to other residents to chat. This observation was interesting for several reasons. First, it appears that this was a common interaction between the environmental staff member and William as was indicated by William’s enthusiasm in approaching him. Second, over the entire observation period, William was usually very quiet and only on
very rare occasions did he overtly interact with others. Consequently, this indicates the value of familiarity during informal social interactions and highlights the variety of gestures expressed during gesturing interactions.

The use of hand or head motions in order to enhance or supplement verbal communication was observed within both SCUs and these informal interactions constitute the second category of gesture. Among this category, gestures were typically expressed in two ways, that is, through hand motions and through nods while conversing. For example, hand motions were evident in Meadowcrest Lodge during dinnertime, when two residents (Elaine and Irene) were having a very animated conversation. They were both speaking a different language from each other (non-English) and were taking turns going back and forth in their conversation. While doing so, Irene uses several gestures while speaking: she raises her hands to her face, points at other residents, and puts her hands on her eyes. In this example, Irene uses several hand gestures throughout her speech to convey the meaning behind her messages to Elaine. Another such instance where this second category of behaviour was observed comes from an interaction between two residents in Guildwood Village. In this scenario, a resident (Larry) nods and speaks in response to a question being asked by care staff after being given food. He is seated at a table between the nursing station and the serving area and two nursing staff members approach Larry as they enter the nursing station:

**Nurse** – “Oh [Larry], how is it, do you like it?”

**Larry** – “yeah” [nods head]
**Nurse** – “Oh that’s good”  
- Field Notes, Guildwood Village

In this example, Larry nods and speaks simultaneously to convey his contentment towards his food. Within this category of informal social interactions we can see that gesture is used in conjunction with words to perhaps clarify meaning.

In all, these findings indicate that gesture is a very important behaviour in the repertoire of people with dementia residing in SCUs when engaging in informal social interaction. Furthermore, these interactions are expressed in a variety of ways with and without speech, including through various hand motions, nods, and body postures.

5.2.2.5 Glancing

The use of glances or eye gazes among people with dementia was another common informal social interaction observed within both SCUs. In total, 14.8% of all informal social interactions included this type of behaviour (Figure 2). In particular, this accounted for 17.6% of informal social interactions in Guildwood Village and 13.1% in Meadowcrest Lodge (Figure 2). Within both SCUs this type of behaviour was characterized by individuals starring and making eye contact with others and was often accompanied by a smile or other facial expressions.

In the most straightforward of instances, residents would stare at each other for varying amounts of time. For example, in Meadowcrest Lodge, Norah
circulates around the unit while saying “Hello ...” repeatedly. She enters the kitchen area from the hallway and impedes the path of another resident, Ronald. Upon approaching, Ronald stopped, stared at Norah for a few seconds and then nodded after he passed by her. Similarly, in Guildwood Village, residents would also gaze at each other for a prolonged period of time. For example, Meghan was seated in the lounge and rises to go for a walk. As she is doing so, she encounters another resident, Mark, in the hallway transition area between the lounge and the dining room. They stared at each other without saying anything for several moments (approximately 20 seconds) until Meghan decided to leave and walking around the hallway corner. In both of these examples, eye contact between residents was sustained over a short period of time. Interestingly, it is also worthwhile to note that many of these interactions (as is the case in both of the examples above) occurred while residents were wandering or walking from space to space within the unit. Perhaps this provides insight into the closeness of relationships between the residents. More specifically, when residents wander they may frequently encounter others who they are unfamiliar with, whereas while at a regular dining table, they are presumably surrounded by those who they get along with, which may or may not elicit different forms of informal social interaction (e.g. touch, gesture) compared to with people they are less comfortable with.

Nevertheless, the fact that residents would cease previous activities and focus their attention to the other person when engaging in these behaviours, as well as that these gazes were reoccurring behaviours within SCUs suggest that
Some form of eye contact between residents and others do represent a very basic form of informal social interaction. However, glancing and making eye contact with others was not always void of apparent meaning. In some scenarios, eye contact and movements were able to communicate certain messages to others. For example, William, a resident at Meadowcrest Lodge, would frequently pace throughout the unit, going back and forth between the two alcoves. During one afternoon, one particular location in the hallway along his path became congested with people. With three residents on one wall and an additional three residents as well the researcher slightly behind them alongside the opposite wall (near the dining room entrance), William was unable to pass. However as he approached, he looked at the three women to his left, opened his eyes very wide. As they see this, they all immediately pulled back (through primarily the one in the middle of the group as she was positioned in slightly more in the middle of the hall. After hesitating briefly, William passed and dodged all of the other residents, while they stared at him. In this example, making eye contact and widening his eyes was a way of asking those in front of him to “move out of the way”. Likewise, William uses a similar motion while interacting with a staff member. A recreational aide is having a friendly conversation with one of the residents (Elaine) about baking and whether or not she is a good baker. William is stopped nearby and the staff member turns her attention towards him and asks, “Do you like biscuits?” William opens his eyes wide and tilts his head forward (nods). In this example, William also widens his eyes, however this time to express his agreement to the statement asked. Although these examples
focused on the behaviours of one resident, they do highlight the complexity associated with interactions of the eyes and give an appreciation for the variety of social interactions that are observed within SCUs.

Furthermore, behaviours involving eye contact or glancing were often intertwined with facial expressions. Perhaps one care aide said it best when asked to elaborate on her statement, “... he can’t really say the words, but his expressions say everything”. This person went on to explain:

“...He’ll express himself totally. You will totally understand and he won’t say a sentence. But just his eyes, his face, his body motion, he’ll moan, or groan, or try to say something” – Interview, Care Aide, Meadowcrest Lodge

This statement was reflective of many other residents within both SCUs, where through the combination of making eye contact and the use of facial expressions, communication with others was feasible and abundant. In particular, spontaneous smiling was the most frequently expressed facial expression used in conjunction with eye contact. For example, this type of interaction occurred between two resident in Guildwood Village, who very rarely interacted with anyone. They were not mobile, confined to a wheelchair, and spent most of their time in the main common space within the dining room a few meters apart (but rarely facing each other). During lunchtime one afternoon, both of these residents (Carrie and Grace) were sitting across from one another while waiting on care aides to help feed them. Grace was seated still and looked ahead as Carrie appeared to be restless and was moving her body and arms constantly. At one point, Carrie turned towards Grace and after making eye contact, let out a small
smile. Grace replies by starring back at Carrie for a few moments [Carrie stopped moving around momentarily], until Carrie finally looked away and returned to moving about in her chair. Similarly, these brief interactions were also witnessed in Meadowcrest Lodge. As Sue Ann rose and proceeded to walk across the room into the hallway (non-kitchen side), she passed by Peyton (seated at a pillar, facing the lounge), who watched her as she walked near. In noticing this, Sue Ann smiles at Peyton with a large grin on her face and bows slightly as a way of acknowledging Peyton’s reply – a quick smile back. In these examples, making eye contact and smiling were typically very brief encounters. However, in other instances, making eye contact and smiling was only the beginning of an interaction and often used as a way of initiating further socialization opportunities. For example, two residents at Meadowcrest Lodge, Pauline and Sue Ann, were seated at a table together for some time. Both were sitting quietly and neither spoke. Quite randomly, Sue Ann began to smile and look at Pauline. She appeared to be laughing and in noticing this, Pauline looked back towards Sue Ann. Sue Ann pointed and mumbled toward Pauline, who looked over and responded with a smile at first and then began mumbling back. Neither Pauline, nor Sue Ann was speaking in the same language, however from afar they appeared to be both going through the motions of a conversation while gesturing (holding out hands), smiling, nodding, and moving their lips. Collectively all of these examples demonstrate the modest interactions, which occur in SCUs, especially those which involve residents who rarely interact with others in highly noticeable ways.
5.2.2.6 Attention Seeking Behaviour

Residents also exhibited a variety of behaviours in which an attempt at informally interacting with others occurred; however in general these attempts were unsuccessful. These behaviours were grouped into a category called ‘attention seeking’ behaviours and were characterized by events in which one resident approached another individual and sought to socialize with them, but was rejected by being ignored or due to the other participant simply not wanting to interact at that particular point in time. These communication attempts included both verbal and non-verbal actions, but in general they were dominated by attempting to engage with others through speech. Furthermore, it should be noted that while these types of interactions occurred across the broad spectrum of residents, a majority of attention seeking behaviours that elicited no response, were initiated by individuals who suffered from higher levels of cognitive impairment. In total, approximately 8.4% of all formal observations included residents who attempted to engage with others but were rejected (Figure 2). In comparison, this accounted for 7.7% and 9.6% of observations taken at Meadowcrest Lodge and Guildwood Village respectively (Figure 2). Accordingly, attention seeking behaviours observed were grouped into two broad categories: “calling out to others” and “reaching out.”

In terms of “calling out to others”, this type of interaction ranged from more directed actions, where a resident focused their attention towards a single person who was in close proximity, to more repetitive behaviours, where a resident would repeat the same words or actions to everyone who they encountered or
passed by. For example, one resident (Penelope) at Meadowcrest Lodge would regularly attempt to solicit ‘help’ from those close to her, albeit care staff or the resident who sat across from her. On one occasion, Penelope was speaking to the care aide who was feeding Margaret, a resident who usually sat across from her. Penelope was quite upset and spoke in a frustrated and direct voice, “Come and help, do you hear me, hello? ... Will you give that desert to her now, please come here ...” She smacks her hand on the table and says “Please come here!” The care aide looked up a couple times and spoke quietly, however Penelope was more or less ignored as the care aide was focused on feeding Margaret. Interestingly, another care aide walked by shortly after and said, “Yes, give me a minute”. This calmed Penelope down for several minutes. In this example, Penelope tried to engage the care staff, however it is only when she was successful in connecting with another staff member that her agitation subsided.

Additionally, another example of attention seeking as expressed through calling out to others occurred as residents would wander throughout the hallways and dining room walking path. One resident in particular, Norah, would regularly circulate throughout the unit and constantly repeat “Hello, Hello, Hello ...” while looking at people to grab their attention. For example, one afternoon while William was wandering down the hallways he encountered Norah, who looked at him and repeated “Hello ... Hello ... Hello...” in approximately three second intervals, while impeding traffic in the hallway. As she was doing this, William continued to look straight past Norah, being cautious not to make eye contact with her. As he passed, Norah mumbled and continued to walk around the
hallway and into the main activity space. She said “Hello...” to everyone she saw, some were receptive but most were not. In this example, Norah attempted to speak with others but was unsuccessful.

Yet in other instances, residents who could not articulate themselves with full words or sentences, called out to others through brief verbal outbursts such as a yell or shout when someone approached or walked by. This was typical of one resident at Meadowcrest Lodge, Peyton, who would yell to get the attention of others. For example, as one care aide highlighted when describing social interactions amongst residents during an interview:

“... Oliva, she would come close to [Peyton], by the side ... and Peyton would give a reaction ‘Hey!!!!’ ...” – Interview, Care Aide, Meadowcrest Lodge

As with this example, Peyton would occasionally shout aloud when staff or residents were in eyesight. However, residents did not appear to appreciate these outbursts. During one of these interactions, a conversation between several groups of women in other sections of the dining room displayed their displeasure towards Peyton:

“Rose contorts her face, looks at Irene and says, ‘What is going on – Who is that?’ ...at another table Laura says ‘Who is that! Oh my, is that him in the wheelchair’. Beatrice replies, ‘Yes it is’, to which Laura replies by saying ‘Oh My!’ ...” – Field Notes, Meadowcrest Lodge

However, while in some instances this appeared (to the researcher) as a way of interacting with others (e.g. facial expression was neutral, and at times included a smile while yelling, or a laugh after yelling), care staff attributed some of these outbursts as a result of agitation caused by noise levels with
Meadowcrest Lodge. During an interview, a care aid familiar with Peyton indicated:

“... Norah, she'll see something and she'll see the door open and she'll start right away. And her agitation gets Peyton going. And then he'll start. And then...anyone will walk by and he'll get really angry, out of no reason, just because...his sensory overload is her just talking too much...” – Interview, Care Aide, Meadowcrest Lodge

Thus, attention seeking behaviour also appeared to be associated with agitation levels and perhaps sundowning in residents with dementia as these behaviours tended to occur with increased frequency in the late afternoons (2:30-5:00 pm). Nevertheless, in some cases these outbursts may actually reflect a desire to interact with other people. Regardless, behaviours where residents call out to other residents and staff are quite prevalent throughout SCU environments.

Furthermore, attention seeking behaviour in the form of reaching out was also observed within both SCUs. Particularly, Carrie, a resident from Guildwood Village and Marilyn, a resident from Meadowcrest Lodge would occasionally exhibit this type of behaviour. Both of these residents were in the late stages of dementia, rarely spoke (mumbled at the most), were confined to a reclining wheelchair, and spent most of the time either sleeping or self-engaged. Despite this, some instances were observed where these residents would occasionally grasp in front of them at times when another resident or staff member walked by. For example, Marilyn was seated at her dining room table prior to dinner time. Another resident was also at the table and Marilyn was facing the wall. With seemingly random movements of her hands, she would pull her shirt and rub her palm on the table. As a care aide walked from the kitchen towards the lounge...
area, Marilyn opened her eyes wider, tilted her head back, looked to her right and grasped the air in the direction of the passing care aide. Similarly, Carrie who was usually positioned between two dining tables (non-nursing station side) and facing the center of the unit, would also be self-engaged at times (pulling shirt, moving hands) and reached out in front of her as a staff member or other resident would pass by. Accordingly, these observations view these reaching behaviours as attempts at garnering attention and suggest that in certain circumstances residents may use these behaviours to indicate a desire to socialize with others.

In support of the notion that residents engage in attention seeking behaviours in an attempt to socialize with others, some care aides acknowledged these attempts and their consequences. For example, during an informal conversation with one care aide at Meadowcrest Lodge, this person talked about Norah and her tendency to seek attention from staff:

“Norah is quite the attention seeker. She will often have outbursts, but when she sees staff, sometimes she will even pretend to lose her balance. Other times she will call out, reach out, and will not stop talking once she has your attention” - Field Notes, Meadowcrest Lodge

Given the widespread presence of attention seeking behaviours, especially those involving care staff (e.g. the encounters and recollections described above between various staff members and Penelope, Peyton, and Norah), it appears that there are certain residents within SCUs who desire to interact with others however are not able to obtain adequate levels of social contact. Thus, the presence of such overt behaviours may in fact highlight that
there are unmet social care needs which exist for residents in SCUs. While staff members do recognize these attention seeking interactions, it appears as though these behaviours are primarily perceived by staff as symptoms of dementia as opposed to unmet care needs. Hence, taking this perspective appears to create a culture whereby staff members tend to shy away from responding to these individuals unless they create a disturbance among the other residents. As a result, it is of great importance for care staff to recognize these attention seeking behaviours as unmet care needs in order to satisfy the social aspects of care required for people with dementia residing in SCUs.

5.2.2.7 Other Non-Verbal Communication

As has been seen thus far, informal social interactions engaged in by residents with dementia take on many forms and expressions. While a vast majority of the behaviours which constitute these interactions have been described above, there are certain behaviours and interactions which do not easily fall into any of the categorizations defined. More specifically, approximately 2.8% of all formal observations made were comprised of unique informal social interactions (or elements thereof), which were not included in other categories (Figure 2). These accounted for 4.1% and 0.7% of all informal social interactions observed in Meadowcrest Lodge and Guildwood Village respectively (Figure 2).

Nevertheless, a unique set of specialized behaviours was identified and warrants further description. However, prior to doing so, it is important to note that some of the behaviours identified in this section (e.g. proximity) emerged as a result of ongoing observations and analysis, and consequently not consistently reflected
in the formal observation process (i.e. data derived for Figure 2). Thus, it is possible that the behaviours identified in this section likely occur at a greater frequency than indicated in Figure 2.

Informal social interaction between residents occurred through the use of objects located within the SCU environment (e.g. chairs, dolls, books, cups -- to name a few) and is an important type of interaction to be considered. In general, these types of interactions were expressed as a way of helping others without any direct physical contact between individuals. For example, in several instances residents would pull out or adjust a chair to make it easier for another resident to sit down in, pass a cup or other object to another resident without being asked and in some cases return a walker to its owner without being prompted. In one scenario, a resident from Meadowcrest Lodge (Jessica) who has a view of the dining room from her bedroom poked her head out and walked a short distance out the door. As Jessica was looking on, another resident (Julie) was trying to get up out of her wheelchair in the dining room nearest to the kitchen but was having some difficulty. Upon seeing this, Jessica walked over to Julie and began to help. Julie rises and Jessica pulls the wheelchair from under her, directs Julie into position by pointing towards a spot on the floor, and then pulls another chair over slightly so that Julie could sit. Julie finally sat down and mumbles the words ‘thank you’ towards Jessica. After Julie sat down, Jessica walked to the VIP table and seated herself. In this example, Jessica interacts with Julie, by positioning a nearby chair around her and by helping her to sit down, despite very minimal non-verbal or verbal cues between the two. Similarly,
in Guildwood Village, upon recognizing that another resident may want a drink of juice, one resident attempts to pass a cup of juice across the table. More specifically, Jake rolls himself forward to the table where Madison was seated. Once he was satisfied with his positioning, Jake started mumbling very quietly to which Madison responds by looking up and making eye contact. Jake continued to mumble to himself quietly. Madison finally reaches out (there are two glasses of orange juice in the middle of the table) and starts to tap them both forward (towards Jake) with the backs of her fingers. She is able to move it slightly forward as Jake looked down and pulled closer to table. He reached out for the glass, looked down again, and then shuts his eyes. In this example, despite not saying anything (verbally or non-verbally) directly to each other, Madison and Jake were able to interact with one another through the cup on the table. Consequently, both of these examples highlight residents helping each other (or at least trying to) and the use of objects within the environment to do so.

In addition, from ethnographic observations collected, the definition of informal social interaction in people with dementia perhaps may need to be expanded to incorporate more minute interactions, which take into account the distance between individuals as a form of social interaction in itself. More specifically, during these observations, dyads of residents would come in very close proximity (i.e. almost touching, shoulder to shoulder) without interacting in a traditional sense. For example, these individuals would frequently sit, walk, or stand beside each other, without explicitly interacting where it appeared reflect two people simply in close proximity to each other. Upon further inspection, it
became evident that it was the same individuals or dyads engaging in this type of
behaviour over time. For example, within Meadowcrest Lodge, Jessica and
Jenny, Victoria and Emma, as well as Elaine and Pauline would frequently seek
and encounter each other. Similarly, within Guildwood Village, Meghan and Jake,
as well as Frank and Alicia would find each other and stay close together for
extended periods of time. However it is also important to note that within these
dyads, most residents mentioned were quite mobile (both with and without
assistive devices), tended to suffer from less severe cognitive impairment, and
appeared to be generally more active in engaging in social activity compared to
most other residents. Aside from frequently being in very close proximity to the
person, the second defining feature of these types of interactions were small
shifts in one’s body position which minimized the distance between the two
individuals, especially when there was space available to residents to spread out.
This was most evident on couches and chairs within the lounge area of both
facilities. For example, in Meadowcrest Lodge, two residents (Jessica and Sue
Ann) were both seated in consecutive chairs in the lounge facing the kitchen
despite all other chairs in the lounge being empty during this encounter. As they
sat beside each other, both began leaning inwards on their chairs towards each
other (i.e., they each shifted – Jessica to her left, and Sue Ann to her right, both
on the insides of their chairs). This was interesting as both women were petite
and despite having space on their respective chairs to centre themselves, they
both chose to lean towards the middle while looking around. They remained like
this for more than 20 minutes, without communicating verbally or non-verbally
and appeared to find comfort in simply being close to someone. Similarly, in the lounge area of Guildwood Village, Meghan was seated beside Daniel on the couch, facing the television:

“Meghan is seated to the right of Daniel as she draws his attention by tapping him and looking at him. He responds by holding out arm. Meghan is showing him her newly painted nails – he mumbles “da, da, da, da, da, da” and points at the plates on the coffee table in front of them. She looks over and he reaches for her arm. A few seconds later, she scoots over to the middle of the couch, Daniel gets up and moves around her and sits down on the right-most portion of the couch (closest to the piano and now with Meghan on his left hand side). Both of these people are seated very close to each other. Meghan is resting and leaning towards Daniel and Daniel is seated upright watching TV (more centred by slightly to the left where Meghan is) ... they are now much closer to each other, such that their bodies are touching [this is quite the change, since both of them were on either ends of the couch a few minutes ago]. They sit here for a few minutes, Meghan adjusting herself from time to time and Daniel looks over, but doesn’t say anything. Suddenly he begins playing the piano with one hand ... Some of the residents in the dining room look up to see ... Meghan doesn’t seem to take much notice ... She doesn’t appear to look over, while Daniel does look to his right once or twice. Eventually, he stops playing and Meghan sits up, resting on her knees (elbows on knees), tilting her head forward almost over the table. Both remain like this for quite some time” – Field Notes, Guildwood Village

In this example, both residents start off on either ends of the couch and end up sitting very closely with one another. They appeared to be quite content in simply being close to another person. Both of these examples highlight the importance of being in close proximity to others and suggest that residents derive a great deal of meaning from these interactions.

5.2.3 Level of Informal Social Interaction

An element critical to defining the nature of informal social interaction across residents with dementia in SCUs is to discuss the ‘level’ of interaction
exhibited by these individuals. The current investigation goes beyond simply identifying the frequency of informal interactions and attempts to delineate the complexity of these interactions along with the circumstances through which they emerge.

5.2.3.1 Frequency of Informal Social Interaction

Results derived from the behavioural mapping instrument indicate that in over 60% of all observations made, residents spent a majority of their time alone, not interacting with anyone (Figure 1). More specifically, 68% and 62% of observations made at Guildwood Village and Meadowcrest Lodge respectively demonstrated this lack of informal social interaction. This finding is consistent with previous studies that found similar proportions of social inactivity within an SCU setting (Diaz Moore & Verhoef, 1999). Furthermore, this result does not appear to be a reflection of a bias in sampling as the observations in both SCUs were taken at various times throughout the day, including mornings, afternoons, evenings, weekdays, and weekends.

Conversely, 32% of observations made at Guildwood Village and 38% of observations made at Meadowcrest Lodge depicted residents engaging in informal social behaviours (as described in the previous section). This finding indicates that although the frequency of interactions may be low, residents are indeed able to engage in them, if and when the opportunity persists.
5.2.3.2 Negative Social interactions

Much of the previous research in the current topic area tends to have a positivistic perception of the social interaction behaviours. Very rarely, if at all, do these investigations highlight negative social interactions that may occur. Conflict and disagreement is a common interaction between humans, and does not cease to exist because a person develops a disease such as dementia or resides in long-term care. While a majority of informal social interactions within both SCUs were neutral or positive in nature, it should be noted that not all social interactions observed within SCUs in this study are positive in nature.

Not surprisingly, negative interactions became more evident during times of agitation or disarray (e.g. clutter in the hallways). In several instances, when the noise levels increased within a unit or if residents were forced to inadvertently come in close contact with each other (e.g. accidental bumping), residents would display a range of negative reactions and behaviours. More often than not, these interactions would be through verbal means, where one resident would begin to yell at another. During one example at Guildwood Village, a resident (Neil) is seated at a dining room table and got quite upset at another after he had been bumped into:

“Neil is sitting at his table, looking forward. Martin is sitting in the middle of the dining area, rolling back and forth (towards and away from nursing station). He accidentally goes too far and bumps the table Neil is at. Neil gets angry, turns and looks at Martin and says ‘Why would you do that?’ as he fixes his table, Martin moves forward. He is now about a foot further than where he was prior to this altercation. A few moments later, Martin once again bumps into the table (however he stops at the table for a few moments longer than previously) and Neil gets angry. As Martin adjusts himself, he knocks the table again. This time, Neil yells out, ‘Hey, Hey, Hey !!!’
... Martin looks back and pushes (with feet) off. Neil comes around the side of the table to adjust it and returns back to the seating position he was in. This time he sits, watching Martin for a while. Martin is much further away from the table now. As he begins to roll back slightly, Neil shouts out 'Don't think about coming closer!'. This prevent Martin from bumping the table another time” – Field Notes, Guildwood Village

These negative interactions were also physical at times. At approximately 2:45 PM one afternoon, several of the residents are walking around in the hallway. While Stacey is wheeling herself, Pauline tries to help her:

“Pauline sees Stacey and begins to follow her, walking beside her. However Stacey wants no part of it and continues wheeling by, not acknowledging Pauline at all. When Stacy gets to corner, Pauline tries to help, but Stacey gets mad. She looks at Pauline and yells “No!”, then swats at her. Pauline continues to place her hands near Stacey, who gets agitated further. Once again she shouts out “No, stop!” and punches Pauline’s hand. Pauline looks down quizzically as Stacey looks up angrily. Upon seeing this, a nursing staff member interjects and takes Pauline away to sit down (to the lounge).” – Field Notes, Meadowcrest Lodge

While negative interactions did occur, residents were often rapidly separated as care staff were quick to intervene. For example, after being in the garden area pacing around, Lily came into the main activity space from outside with a sun hat on. She did not appear to know where to put her hat and walks over to Victoria, where she tries to place the hat on her walker. Victoria gets upset and frantically points and tells Lil to put the hat “over there”. Very soon thereafter, a care aide came to interject and both residents were separated. For the most part, these interventions by care staff thwarted negative informal social interactions once they occurred. Care staff also prevented many of these
interactions as they used their expertise and knowledge of residents once they recognized the potential of agitated residents to engage in negative interactions.

Conversely, some residents were able to remove themselves from negative situations. For example, noise and agitation levels began rising on Meadowcrest Lodge one afternoon. During these times, one of the residents, Ruby, would often begin singing aloud, “do do do do da da do ...”. This would frustrate some of the residents such as Jessica, who waved her hands from side to side vigorously (negative reaction). Jessica turned to Jenny, pointed at her (nods back), and shortly after they both left the room. In this example, Jessica became upset, but removed herself from this situation prior to it escalating. However, it is important to note that this was only possible as Jessica was independently mobile and capable of removing herself from the dining area. Clearly this is not always a possibility for other residents who are immobile or in wheelchairs.

Nevertheless, the fact that negative informal social interactions exist in care facilities do not necessarily represent a detrimental impact to one’s well being. Although trying to minimize severe negative interactions (e.g. physical violence between residents or between residents and their caregiver) is important, however, it is also important to recognize that some negative interactions may bring meaning to their lives.

5.2.3.3 Typology of Residents Engaged in Informal Social Interactions

As is evident from the above discussion regarding the types and expressions of informal social interactions, there are varying levels of complexity
associated with social behaviours in SCUs. While these interactions include a broad set of behaviours ranging from coherent conversations to simple eye gazes, it is important to contextualize these within the framework of dementia and consequently recognize the heterogeneity that exists among residents within these environments. Particularly, some residents are much more willing and capable of engaging in social activities, while others may shy away from such encounters. Thus, in recognizing these similarities and differences, a resident typology highlighting the level of engagement residents endure while participating in informal social interactions may be developed. In making these distinctions, the opportunity is afforded to improve care practices, design guidelines, and the overall understanding of informal social interaction behaviours among people with dementia in SCUs. In total, residents in SCUs may be grouped into one of four categories according to the level of complexity exhibited in typical social scenarios: 1) social seekers; 2) non-initiators; 3) attention seekers; and 4) self-engagers. However, it is important to recognize that these resident categories identified are not mutually exclusive from one another. Instead they should be viewed on a continuum ranging from people who typically engage in higher level interactions (e.g. social interaction seekers) to those who minimally engage in social interactions (e.g. self-engagers).

Among these categories, ‘social interaction seekers’ consisted of people who were the most active in participating in informal social interactions with other residents and staff. More specifically, these individuals were keen on seeking out opportunities to socialize and could be frequently found engaging in prolonged
interactions or conversations with others. Within the continuum of social interaction in this category, residents who engaged in social activities on the high end of this scale were able to articulate their messages coherently. This is likely related to the level of cognitive impairment exhibited by individuals within the SCUs. For example, one care aide from Meadowcrest Lodge suggested that those residents who are less cognitively impaired are able to socially interact with others at a higher level as they are capable of verbally articulating themselves, “They are more responsive ...They can verbalize. They can say their name. They can express their feelings. They can express their wants and their needs”. Similarly, another care aide from Meadowcrest lodge described those in the earlier stages of dementia as having higher levels of interactions with care staff due to the normalcy of their conversations, albeit sustaining these conversations is somewhat challenging:

“Normally when a resident is not on a higher stage of dementia, you know, we’re talking to them normally and then their reaction is fine...the lady in the wheelchair, normally, you have to ask questions from her and she would answer exactly what she wants to answer. So there’s a smooth, you know, exchange of how’s and why’s and she would answer. But somehow, you know, the moment the conversation goes longer, she’s keeping away. It’s not on its proper track. But somehow, you know, it’s seems normal.”
– Interview, Care Aide, Meadowcrest Lodge

Both of these perspectives highlight the importance of coherent verbal communication in terms of informally interacting with residents at a high level. However, these types of high level communications don’t necessarily have to be verbal in nature. More specifically, there were several instances within Meadowcrest Lodge where residents were able to organize themselves and
articulate through gesture. This was seen in several of the examples above where Jessica and Jenny, two residents from Meadowcrest Lodge, would frequently communicate with one another via hand motions and other gesticulations. Consequently, the defining features of social seekers who engage in higher level informal social interactions would be such that communication is active (i.e. initiated by this resident), dynamic (i.e. constantly changing or some back and forth between the two parties), clearly articulated (usually verbally, but non-verbally as well), and sustained over a longer duration of time (e.g. more than a couple of seconds to a minute). Conversely, social seekers who would rank on the lower end of this spectrum, would still interact with others frequently, but in a reduced capacity such that they may initiate contact, but communication is more brief and less coherent at times.

In the next category, ‘non-initiators’ are comprised of residents who were indeed willing to socialize with others verbally but to a much greater extent, non-verbally. In terms of the complexity of social interactions engaged in, these individuals at times participated in prolonged interactions with others and were often capable of articulating the basic meaning behind their messages. However, the defining feature of these residents was that contact was very rarely initiated with others and that these interactions were usually brief including some sort of gesture and/or smile. Residents such as Oliver from Meadowcrest Lodge and Isobel at Guildwood Village may be classified as non-initiators. Both of these residents were willing to interact with anyone and in various capacities, but did not actively seek these interactions. For example, Isobel would spend much of
her time in common spaces either wandering throughout the hallways or seated in the lounge area. Particularly, while in the lounge, she would spend most of her time watching television or watching others at they passed by or engaged in some activity. However, in instances where she was approached (usually by a care staff members) she would get quite excited and spend a few moments interacting. Such was the case one afternoon prior to dinner as a care aide decides to chat with Isobel while passing by to porter other residents to their seats. The care aide stops and asks her about her jacket and tugs on it playfully. Isobel looks up at the care aide, puts on a large smile, giggles a couple of times, and bobs her head up and down a few times. Similarly, Oliver would often socialize with others if engaged by them. For example, Oliver would spend most of his time throughout the day in his bedroom, but would come into the dining room during mealtimes. While there, he would sit at the first table near the non-kitchen activity space entrance, across from another resident (Wade), who would often try talking with Oliver. More specifically, after sitting down for several minutes, Wade (social seeker) would often try to chat with Oliver, who would oblige and chat back. While the content of these interactions were unclear, Oliver would typically smile, nod, and say a few words in response to Wade, who would carry the conversation. In other instances, Oliver would socialize in a similar manner. For example, while walking throughout the unit he would smile while walking but seldom would he make eye contact with others. During one observation, Oliver crossed paths with a care aide enroute to the kitchen. As she passes, she says ‘hello’ to Oliver. Oliver stops to let her pass, makes eye contact
and replies back and then proceeds to follow the care aide into the kitchen where he waits outside. Here, Oliver gives the perception of wanting to continue to interact, however simply waits near staff. Consequently, these examples demonstrate the willingness of some resident to interact with others, particularly once engaged by these other social actors.

The third category of residents termed ‘attention seekers’ were unique as they spent a great deal of their time in public spaces trying to engage with others. However, when these individuals did so, social interactions were typically very repetitive, yet brief as other individuals would quickly remove themselves from these situations. For example, on several occasions Penelope would be seated in her wheelchair (unable to move independently) at a dining room table facing the non-kitchen side exit into the hallway. As other residents would pass by while wandering about, Penelope would lean over the table, reach out, and shout out at them for help, “Help, help ... come and help me ... do you hear me, hello?” These calls for attention would be expressed persistently until someone acknowledged her. Most residents would pass by, however in rare instances, residents would stare at her, motion to approach her, but after a few moments, continue on. Similarly, Norah would exhibit similar attention seeking behaviour where she would approach residents and staff by continually saying “Hello, hello, hello ...” and starring at them. Interestingly, in many observations involving this type of resident, it appeared as though these individuals simply wanted to be in the presence of another person. This was evidenced when they engaged with others, where they would become calmer for a brief amount of time following the
interaction. Despite becoming calmer themselves, other residents seemed to display the opposite effect, where they would actually become agitated when near these individuals. Consequently, for attention seekers, it appears that they may be overburdening other residents, thus exacerbating the problem of trying to find someone to socialize with. As a result, attention seekers would mostly engage with staff, who often intervened to limit negative encounters between residents.

Lastly, residents classified as ‘self-engagers’ were the least active in participating in informal social interactions with other residents or staff. These residents seldomly engaged in social activities with others and spent a large majority of the time alone, albeit sleeping, preoccupied with themselves or immediate surroundings, or simply people watching. However, when these individuals did interact with others, the behaviours displayed were very basic in nature. More specifically, they would be very brief and typically only consist of only a quick eye gaze or facial expression (e.g. happiness, sadness, confusion). For example, Wanda, a resident at Guildwood Village would typically be seated in her wheelchair alone in the dining room. At times while here she would be concentrating on moving her hands and arms in various directions. During one afternoon, a care aid walks over to her from the nursing station and says “Hello Wanda”. Wanda looks up, stares, and stops her arm movements momentarily as the care aide walked off. Similarly, a resident such as Marilyn may also be classified in this category. For example, she would spend most of her time in the public spaces of Meadowcrest Lodge at her dining room table, either sleeping or
self engaged. However, as one care aide suggested during an interview, Marilyn was typically unresponsive to verbal communications (i.e. when care staff would approach her to say ‘hello’), however when touched on the shoulder by care staff, she would perk up and respond verbally (“oh hi dear”) or as seen during the ethnographic observations, she would open her eyes wide and stare at nearby individuals. Accordingly, it is also important to note that within this group of residents, there were a range of individuals spanning from those who were able to interact with others and choose not to, to those who were completely unable to engage with others due to severe cognitive impairment or other health issues.

Thus, within the context of dementia it is important to recognize that no matter how small or simplistic an interaction may seem, resident derive meaning, and at the very least, a sense of comfort from these interactions.

In all, the key message within this section is that residents in SCUs are not a homogenous group in terms of how they interact with others. While social interactions within these settings range from very basic levels (starring, touch, etc...) to much more complex interactions (communication of ideas between several people), a majority of the overt displays of informal social interaction are actually displayed by a minority of residents (e.g. social seekers). Given the interview data with care staff analyzed, it is apparent that we tend to place a high value on verbal communication when interacting with others as we associate these kinds of conversations with evaluations of one’s identity and competence level. While this may simply be a reflection of human nature, within the context of people with dementia, it is important to recognize the wide range of individuals
and the levels of social interactions that do exist in SCUs in order to cater to these peoples’ socialization needs. Consequently, the typologies of residents engaged in informal social interactions identified within this section acts as a stepping stone to bring some of these issues to light and to further explore social behaviour in SCUs.

5.3 **Environmental Influences on Informal Social Interactions**

This section highlights the role of social and physical environmental features in SCUs on the characteristics of residents’ informal social interaction.

5.3.1 **The Social Environment**

Several elements of a facility’s social and organizational environment play a significant role in affording social opportunities for the residents. Among these, four key factors were identified that influence social interaction patterns of the residents: 1) Philosophy of care; 2) Role of care staff; 3) Group Size; 4) Time of day. Each of these factors is described in greater detail below.

5.3.1.1 **Philosophy of care and the Role of Care Staff**

As was previously noted, the facilities in this investigation were sister-facilities and consequently subscribed to the same philosophy of care, that is, the Gentlecare philosophy. While it was not the purpose of this investigation to assess the implementation or effectiveness of such a philosophy in relation to resident socialization within these units, the importance of staff “buy-in” to the key tenants of any such philosophy was salient and an important finding within this study. Consequently it is argued that opportunities for residents to socialize with
each other and with care staff is only realized when all levels of staff, including upper management, mid-level management, and frontline care workers internalize these values and practices outlined within a care home.

This appeared to be the case in both facilities within this study where all levels of staff (e.g. management, nursing staff, care aides, dietary aides, environmental staff, recreational staff, etc...) truly believed that their sole obligation was to the well-being of the residents. Among these obligations, care staff agreed that interacting with residents outside of their formal care practices was of utmost importance. For example, an environmental staff member discussed this when being asked about the policies and procedures in Meadowcrest Lodge during an interview. She noted, “[it] doesn’t matter what job title you do, we’re all here for the residents. We can all spend time interacting with them. So, if you’re a housekeeper, dietary nurse, doesn't matter what your job title is, we’re all here for gentle care to spend time with the residents.” Similarly, a care aid from Guildwood Village also discussed the implicit nature of informal social interactions within the context of a care aide’s role, while speaking to the policies and procedures during an interview. This care aide noted “For us, it’s also part of our job to interact with them, it’s not just basic care, to do some social interaction. I think that’s part of it, like if a resident is agitated, try to calm them down, you know, if there’s a new resident coming, you know, ask questions to make them feel welcome ...” Both of these examples highlight the culture of care within both facilities where care staff value socializing with residents and take on an active role to do so. Importantly, these perceptions were actually
translated into practice, whereby staff would frequently initiate interactions with residents throughout the day. These ranged from lengthy conversations to more brief inquiries such as asking “how are you doing today?” or “how was your meal?” to a simple “hello”. In other instances, care staff would attempt to joke with residents. For example, during lunch time one afternoon a nurse sat down beside Meghan at the dining table. A few moments later, a care aide also approached the table to help feed another resident seated near Meghan. As this care aid sat down, Meghan grabbed his hand and held on. Upon seeing this, the nurse sitting beside Meghan jokes, “Oh, you want his hand, I’m jealous” and Meghan giggles for a few moments.

Similarly, a care aide from Meadowcrest lodge admitted to joking with residents when asked to describe a typical interaction between himself and a resident “Well, when I’m not giving care, maybe sometime I’m just kind of joking around. Some of them can just like pretend like this [contorts face], and so you know [laughs], just playing around, making them happy ... That makes it easy for us to work too. You don’t want to make them miserable, then it’s hard to work [laughs]”. Additionally, even during times when care staff did not initiate these interactions, they took the time to spend a few moments to indulge residents when required. This was especially evident in this type of environment where residents would often seek care staff for assistance or other social activities.

The above examples highlight the issue of flexibility in SCUs which is a necessary component of dynamic and constantly changing environments. More specifically, these principles also extend to the facilitation of informal social
interaction, whereby the culture and philosophy of care within the two settings observed permitted staff (all levels of staff who have contact with residents) to be flexible in their daily routines such that opportunities occurred for care staff to both initiate and participate in spontaneous interactions with residents. This is not to say that care staff in both facilities spent an abundance of time informally interacting with residents. Most staff informally interacted with residents, some more so than others. Nevertheless, some improvements can be made which recognize and balance the realities of care practices (in some instances, their time consuming nature) and the relationship between informal social interactions and well-being. These results highlight that at an organizational level, implementing policies and procedures which are cognizant of flexible (i.e. non-regimented) care routines are of importance.

Additionally, care staff also appeared to be influential in facilitating informal social interactions between residents. Specifically, they routinely played a role in bringing residents together and encouraging them to interact and converse with one another. When care staff attempted to do so, informal interactions were primarily verbal. For example,

“A care aide and several of the residents are at the table after the evening snack. This staff member has decided to sit with residents while having a snack of her own and converse with them. They all enjoy it! And gravitate towards the table as the chatter increases quite a bit. Anita chirps in, Anne looks on, even Claire who is seated at another table turns and tries to engage in conversation by speaking. Several others look on... even after the staff member has left the conversation continues for a good 10 minutes afterwards” – Field Notes, Meadowcrest Lodge
In this example, the care aide played two important roles in fostering informal interactions between the small group of residents. First she acted as a facilitator by sitting beside residents and including several of them in a group conversation. Second, she helped sustain the conversation between residents by acting as a moderator at the table by asking questions and allowing several residents to share their thoughts and opinions. Thus, the care aide here played a critical role in facilitating informal social interactions amongst residents. Less successfully, one of the nurses at Meadowcrest Lodge also attempted to have two residents interact with one another as he was preparing to hand out medications. Two of the residents, Pauline and Olivia, had been following and trying to chat with him for several minutes prior to this:

“The care aide begins speaking Spanish to Pauline who replies. She starts chatting and Olivia looks interested. He then directs attention to both of them. He looks at Pauline and Olivia and suggests for them to speak with each other. They both look at him and he picks up their hands and gets them to shake/rub hands. They look at each other and exchange a smile briefly” - Field Notes, Meadowcrest Lodge

In contrast to the previous example, attempting to engage two residents was more difficult here. Regardless, this highlights that care staff on rare occasions do attempt to facilitate social interactions between residents by encouraging them together.

In some instances, staff were observed discouraging residents from interacting with others. Typically this was done to avoid negative social interactions between residents. These interventions were generally effective as care staff were experts in recognizing each of the residents and the time when
they became agitated to a point they would begin to disrupt others. However, despite the best of intentions, on some occasions, this vigilance became a barrier to positive informal social interactions when social behaviours were falsely identified as negative by care staff. For example, this was the case in Guildwood Lodge when two visitors came to visit their family member (Victoria) and another resident (Daniel) got excited and draws attention to them:

“Two visitors entered the room to visit a resident (Victoria). They go beside her (one on either side). As Daniel sees this, he shoots up, starts to stutter and points vigorously [his arm is extended and with his index finger drawn, he flicks his wrist up and down quickly] towards the hallway. A Care aide quickly comes and takes Daniel out of the way and into his room. As Daniel was doing this, the visitors say, ‘Oh no, we’re okay’, just as the care aide came by.” – Field Notes, Guildwood Village

Consequently, this example highlights how in certain instances, care staff may in fact thwart informal social interactions as they attempt to intervene by mediating interactions between visitors and residents who are not known to them. Here, the care staff intervened to allow privacy between the visitors and their loved one, not to calm the resident down. This indicates that among care staff, there is a delicate balance respecting resident’s privacy and allowing residents to freely interact with visitors, specifically family members. Care staff were also found to hinder informal interactions between residents. Such was the case one afternoon when a nurse intervened a seemingly innocent interaction between two residents at Guildwood Village:

“Neil is strolling around the unit and going from table to table and stops at a table in between nurses station and serving area. He sees Daniel sitting across at table on other side of nurses station. They make eye contact and Neil begins to speak to him, saying
‘Excuse me’ and then asking/looking for something [inadudible]. As he leaves the table and approaches Daniel, they remain in eye contact. Neil stops beside Daniel as he is standing above. Daniel doesn’t seem to know what he is saying, but extends his hand to Neil who takes it. Daniel shakes it up and down. Neil stops for a moment and starts mumbling again. A nurse comes out from nurses station and stops interaction by asking Neil what he wants and they go off into hallway” – Field Notes, Guildwood Village

In this example, it was unclear why the nursing staff member interrupted Neil and Daniel. Regardless, it highlights one instance of care staff inhibiting informal social behaviour among residents. In all, both organizational factors such as the philosophy of care and the role of care staff were found to be crucial in influencing informal social interaction behaviours in SCUs.

5.3.1.2 Group Size

As discussed previously, literature in the area of social behaviours of people with dementia in long-term care suggest that units with a smaller group of residents are generally more conducive to social interaction. Thus, on this basis alone, it was expected that among the two facilities studied in this investigation, residents in Guildwood Village would engage in more frequent social interactions than those in Meadowcrest Lodge. However, this did not appear to be the case as both the frequency and the overall number of social interaction which occurred were in fact greater in Meadowcrest Lodge (larger unit size) in comparison to Guildwood Village (smaller unit size). Setting aside the myriad of factors which may contribute to informal social interaction within SCUs (e.g. quality of SCU, SCU design, etc.), this discrepancy of social interaction in relation to group size may be due to several reasons. Firstly, having a larger number of people in a
defined space increases the probability that individuals will come into close contact with each other and consequently interact. Thus, given the larger number of residents in Meadowcrest Lodge, by diffusion of residents alone may be one possibility to explain this discrepancy in results. Additionally, unit specific factors pertaining to the health and lifestyle of residents within SCUs may provide an alternate explanation. More specifically, as was noted by the care staff, relatively higher number of residents in Guildwood Village was less mobile and in the later stages of dementia compared to the residents in Meadowcrest Lodge. The lifestyle of residents is also an important consideration. Many residents would spend a great deal of time in their bedrooms, whereas others would frequently participate in recreational activities outside the unit. Thus, it was not uncommon to have only five or six resident in the common space at any given time throughout the day. This suggests that a minimum number of residents within an SCU are required in order to maximize potential opportunities for informal social interaction in these settings.

However, in terms of group size, perhaps the most important aspect is not so much how many people are within a particular unit, but rather the group size that people within these environments congregate in and consequently how these settings support this. For example, although there were more residents in Meadowcrest Lodge, one unique feature of this unit is that people would congregate throughout the unit in smaller clusters (e.g. typically in four’s at a dining room table, pairs in the hallway). It appeared that groups between four to six residents were most conducive to social interaction between residents. This
was especially relevant in the dining room, where residents seated in such groupings were more socially active than those seated at tables with fewer than this threshold. In contrast, within Guildwood Village, group sizes in the dining area tended to be quite small, with the maximum number of people at the dining table typically being three people at any given time. Even with this number of people in a given cluster, informal social interaction was found to be minimal. Consequently, one recommendation within SCUs may be to have fewer tables with all seats filled to capacity as opposed to an overabundance of tables where only one or two residents seated at each.

5.3.1.3 Time of Day

Residents appeared to be more social during certain times of the day in comparison to others. Particularly, mealtimes generated the greatest amount of informal social interaction between residents and between residents and staff at both SCUs. Not surprisingly, this was primarily due to residents being seated at their dining room tables and being in close proximity to other residents and staff. In assessing these interactions, mealtimes were broken down into three segments: prior to meal, during the meal, and after the meal. In both facilities, residents would be seated approximately 30 minutes prior to the meal being served. During this time, most residents were brought or encouraged to sit at their respective tables in anticipation of their meal. By far, it was during these times that informal social interaction within the unit was at the peak level. The fact that residents were seated in close proximity to each other for an extended period of time helped to facilitate these interactions. In contrast, social interaction
During the actual meal was very minimal. During this time, residents tended to focus on eating their meal and only interacted with anyone after finishing a main course or in receiving their food from care staff. Lastly, residents did interact with others after meals, however not as frequently as prior to meals. While some residents would stay at their table after finishing to eat, others would quickly leave their table setting, especially those who were more mobile than others. Overall, social interaction peaked prior to meals being served, decreased while residents were eating, and then increased again in the time proceeding these meals.

Throughout other times in the day, interaction between residents and others occurred sporadically. However, aside from meal times, the only other time in the day when social interaction appeared to increase significantly among residents was between 3:00 pm and 4:00 pm. This was much more pronounced at Meadowcrest Lodge, but did occur to a lesser extent at Guildwood Village. During these times, a greater proportion of residents (than ‘normal’) would be wandering throughout the hallways and exhibit other agitated behaviours such as banging on doors. This led to some negative interactions (especially in hallway), however due to the fact that several residents would come in close contact to one another, several opportunities emerged for residents to interact with each other. Consequently, social interaction during these times may be attributed to several circumstances. First, care staff were very quick during informal conversations to identify the cause of this increased activity as being a result of sundowning. Sundowning has been described as the exacerbation of behavioural
symptoms associated with dementia and is characterized by confusion and agitation in the afternoon or early evening (Little, Satlin, Sunderland, & Volicer, 1995). While, this puts the focus on the individual with dementia, it is important to recognize the environmental influences on such behaviour. In particular, this increased level of activity coincided with changes in staff that occurred at both facilities at approximately 3:00 pm. This factor in conjunction with increased noise levels associated with this time period may help explain both the increased level of social interaction and the sundowning behaviours observed. Accordingly, in considering social interaction, it is important to take into account the time of day and the surrounding circumstances during these times to help facilitate positive informal social interactions among residents and between residents and staff.

5.3.2 The Physical Environment

The physical environment is an important consideration for this investigation as it creates the setting for informal social interaction to occur. Consequently, this term refers to elements within the SCU that surround residents and which they can touch, see or hear. Importantly, the physical environment goes beyond simply ensuring that the unit is pleasant, comfortable, and safe for residents as it also seeks to maximize the therapeutic potential on residents by, among other interventions, taking into account the strategic arrangement of furniture and design of the care unit itself. Consequently, this section attempts to delineate key features in both SCUs which impact informal social interaction, either positively and negatively. Thus, results looking at where
social interactions occurred within each SCU will be shared, followed by findings regarding key physical environmental features which hinder or support informal social interactions between residents, and between residents and others.

5.3.2.1 Location of Informal Social Interactions

Prior to identifying specific elements within the physical environment which appeared to influence informal social interaction, an overview of where these interactions occurred within each SCU is necessary. Results from this section were derived from formal observations taken using the behavioural mapping instrument and reflect all typologies of informal social interaction within each of these spaces. For each space, the percentage of informal social interactions observed relative to other spaces is given. Furthermore, the prevalence of informal social interaction within each space (Figure 3) is also given. It is important to note the difference between both of these percentages given. In terms of the total percentage of informal social interaction between spaces, this attempts to give a crude overview of where social interaction is taking place within each SCU. While these results are supported by the ethnographic observations in this study, this percentage is necessarily crude as not all spaces were occupied equally (in terms of total time) across the SCUs during formal observations. For example, the total number of observations in the dining room was greater than those made in the corridor. This is simply a reflection of where residents spend a majority of their time within these SCUs (e.g. dining room vs. corridor). In contrast, the prevalence of informal social interaction within each space attempts to contextualize informal social interactions relative to the space
residents spend their time in. Thus, this second statistic compares the number of people found interacting within a particular space, relative to the total number of people observed in this same space across all observations. This gives a better overall insight into how the spaces are used for informal social interaction.

5.3.2.2 Dining Room

Overall, the dining room was the setting which accounted for the greatest proportion of informal social interaction within both SCUs. In considering both SCUs, 67.2% of all informal social interactions observed were located in this space. However, these numbers differed slightly within each SCU. More specifically, the dining room in Guildwood Village was the location of 72.8% of the informal social interactions observed, whereas in Guildwood Village this setting only accounted for 63.7% of such observations. These findings were not surprising, especially given that residents spend a majority of their public time in this space.

In terms of the prevalence of informal social interaction found within the dining room, approximately 36.1% of all observations taken within this space were classified as social encounters (Figure 3). In comparison, this was very similar to both Meadowcrest Lodge and Guildwood Village, where respectively, this accounted for 36.5% and 35.6% of all observations within the dining room (Figure 3). Consequently, these results indicate that although most informal social interactions occur within this space, relative to the large quantity of people and time spent here, social interaction occurs less frequently here than in other
spaces. Thus, the space alone may not necessarily cause residents to socially interact, it may be more of a reflection of the amount of time spent here.

5.3.2.3 Lounge

The lounge area in both SCUs accounted for the second greatest proportion of informal social interaction, where 17.5% of all informal social interactions observed occurred here. Throughout the day, the lounge area in both SCUs would be occupied by several residents. In Guildwood Village, the lounge was located at the far end of the unit (from the entrance) with access to the garden area via a large sliding door. The main attraction within the lounge area in this unit was the television where residents would typically congregate around the perimeter in the chairs facing it. However it was typically only during times when the television was not on, that residents socialized with others more frequently. It is also noteworthy to mention that many of the interactions that did occur in this area also happened on the couch. This was one unique element within the lounge at Guildwood Village as most of the seating available was in the form of singular chairs and it provided residents the opportunity to see other parts of the unit well and to be in closer proximity to others. Conversely, the lounge in Meadowcrest Lodge was located in the middle of the main activity space and also provided access to the garden areas, although these doors were usually keypad locked (limited access for residents). Interestingly, one commonality between both units in terms of the lounge area was that there were large windows nearby, which allowed ample amount of natural light. Also in the lounge at Meadowcrest Lodge, there was no fixed television (although on a couple of
occasions one would be wheeled in on a trolley for a few hours and then removed once again) and although seating was still around the perimeter of the space, it faced the middle of the unit and provided ample opportunities for residents to watch others as they passed throughout the unit. Nevertheless, 20.2% of all informal social interactions observed at Guildwood Village and 15.9% in Meadowcrest Lodge occurred in the lounge area.

Additionally, the prevalence of informal social interactions in the lounge area of both SCUs was 33.8% (Figure 3). Thus, in 33.8% of all observations taken in the lounge area, residents were found interacting with others. Comparatively, 29.1% of observations in Guildwood Village and 38.7% of observations in Meadowcrest Lodge involved residents socializing in the lounge area (Figure 3). Collectively, these findings indicate that although social interaction occurs in moderate frequency within the lounge area overall, once in this space approximately one third of the residents interact with others. Thus, key features in this space which may contribute to informal social interaction include ample seating, availability of natural light, lack of television, and visual access to the rest of the unit.

5.3.2.4 Corridors

In considering the behaviours of people with dementia, particularly wandering behaviours, corridors or hallways provide a unique opportunity for these residents to interact with others as these spaces help facilitate this behaviour and consequently brings these individuals together for short periods of time. Accordingly, it was expected that hallways would be an important space in
terms of informal social interaction. For residents in Guildwood Village, the hallway was designed as a continuous loop with resident rooms on the outside perimeter of the hall. Despite this, very few residents used this walking path (perhaps this was a reflection of the lack of independent mobility amongst many of the residents), however when they did, residents would typically walk alone. Accordingly, only 2.6% of all informal social interactions observed in this SCU occurred in the hallways. In terms of the prevalence of such social behaviours in the corridors, 12.0% of all observations in this space included socializing (Figure 3).

In contrast, the hallways in Meadowcrest Lodge were similar to traditionally designed care facilities, where they were long, narrow, and double-loaded. Regardless, it was interesting to observe residents inadvertently modifying the walking path. Specifically, very few resident would walk to the ends of the hallways in this unit. Instead many would cut through the main activity space and loop around continuously. This was an interesting design feature of the unit, that is, having two entrances to the main activity space, as having this additional pathway afforded many residents the opportunity to interact with others in the main activity spaces while wandering about. Nevertheless, 15.4% of all informal social interactions observed, occurred in the corridors of this SCU (i.e. includes only the corridors, not the interior walking path through the main activity space). In addition, while in the hallways residents would frequently interact with others while walking. Oftentimes these would be very brief glances, gestures, or short verbal communications. This was quite different from Guildwood Village,
where residents in Meadowcrest Lodge would fill the hallways at various times throughout the day and readily interact with others. Consequently, the prevalence of informal social interaction in this space was quite high, with 62.2% of observations involving some form of social interaction with others (Figure 3). Thus, these results indicate that despite the low overall proportion of informal social interactions that occurred in the hallway (relative to all the other interactions that occurred in each facility), these spaces do indeed appear to be hubs of activity for residents to socialize with others. Thus in terms of informal social interaction, attention should be focused on improving its potential as a place for these activities. Particularly, one improvement which could be made in both SCUs would be to include adequate seating in the hallways for residents.

5.3.2.5 Living Room and Other Spaces

Both the living room and quiet room were the two settings which accounted for the least proportion of informal social interaction within both SCUs. Overall, 3.7% of all informal social interactions occurred in the living room and 1.0% of these occurred in the quiet room. The latter was not surprising as in both of the SCUs, residents who used this space were typically alone and looking for a quiet place to rest. Although care staff did indicate that residents and their families would use the quiet rooms, no such instance occurred during the multiple observation periods undertaken in this investigation. In terms of the living room, it was unexpected that minimal interaction occurred in this space. This area was used by some residents (with the assistance of care staff) to simply rest. However, in Meadowcrest Lodge this area was in the middle of the unit and
appeared somewhat appealing with three large, comfortable looking recliners and a homelike ambiance. Despite this, the fact that the space was cluttered, seating was lacking, furniture was difficult to move without assistance, and the lights over this area were usually dimmed or off completely, likely served as a barrier to informal social interaction. Unfortunately, with regards to the prevalence of social interaction within these spaces, the reliability and accuracy of the results is called into question, as very few individuals used these spaces and thus only a limited amount of data was available. As a result this statistic was excluded from the results presented here.

Collectively these results indicate that residents engage in social interactions with others across a variety of spaces. However the overall proportion of informal social interactions that occur within each of these spaces appears to be linked more so with the amount of time residents spend in these spaces rather than general attributes of the space itself. Consequently, each of the spaces was looked at individually and the number of social interactions observed within each of these spaces were compared to the total number of observations taken within these spaces. The results were expressed as a prevalence of informal social interaction within these spaces and suggest that relative to the amount of time spent within each space, corridors followed by the dining room and lounge were the spaces most actively used for informal social interactions. This differed slightly for both Meadowcrest Lodge and Guildwood Village. Within Meadowcrest Lodge, corridors followed by the lounge and dining room and within Guildwood Village, the dining room followed by the lounge and
corridors were the most used for social interaction relative to time spent in each space in the respective SCUs. Consequently, it is important to recognize these dynamics and attributes within each of these spaces in order to better facilitate informal social interaction.

5.3.2.6 Key Physical Environmental Features Influencing Informal Social Interaction

One of the key outcomes of this investigation was to pinpoint key physical environmental features within SCUs which impact informal social interaction. These factors were observed within each unit and discussed with care staff during formal and informal interviews.

Residential Character and Ambiance

Providing a homelike setting which was pleasant, intimate, and comfortable for residents appeared to be of importance in terms of facilitating informal social interactions. Along these lines, care staff tended to agree that the degree of homeliness was an important factor for socialization. For example, one care staff member at Meadowcrest Lodge likened the feeling of home to that of not feeling isolated. When asked about importance of the physical environment and the homeliness of this SCU, this care aide responded by saying, “I would say [it is]...critical...for me, personally, I like [a] more homelike [environments as they are] very important for [social] interaction, yeah. You feel more like laughing, you feel at home. You don’t feel …isolated”. Here, this care staff member placed a high values on such environments and implied that both social interaction and a sense of community is facilitated by these settings.
However while there was agreement in terms of the importance of a homelike atmosphere, care staff found it very difficult to articulate the specific features within the environment that contributed to these social interactions as they tended to focus on the environment at a more global level. Despite this, two interconnected features emerged from interview data. More specifically, spaces which were smaller and spaces that maintained some continuity to ‘home’ or residents’ past lives through decoration were identified as contributing factors to a homelike setting. For example, one care aide at Guildwood Village noted that this unit was “homelike because it’s small. And then there are enough, for me, enough stuff”. Here she is referring to both the size of the unit and objects (e.g. pictures, wall hangings, murals, knick-knacks, etc...) distributed throughout the unit which contribute to this atmosphere. Furthermore, this highlights the importance of having objects within the SCU which are familiar to residents and create some degree of interest where social interaction is stimulated from these objects. Such objects were indeed integrated within both SCUs observed.

Interestingly, it was musical instruments which generated the most interest. For example, a piano was located in Guildwood Village within the lounge area and was used at times by residents and staff, consequently spurring spontaneous interactions among these individuals. In one instance, as the dietary aides were preparing the serving area and dining room for lunch, a care aide and nurse approached some residents in the lounge, the nurse began playing the piano and singing, and the care aide began dancing. This peaked the interest of several residents who perked up, smiled at the care aide, and watched on. Similarly,
during another observation period, the piano also played a role in facilitating interaction between residents. During this scenario, Daniel and Meghan were seated beside each other on the couch in the lounge. Daniel was closest to the piano and Meghan was on his left. He looked over at Meghan a few times and then reached over to gently touch a couple of the piano keys (presumably to get Meghan’s attention). In between notes (every 3-5 seconds) he would peek over at Meghan. Although she did not explicitly take notice, this example highlights how familiar objects within an SCU environment have the potential to encourage residents to interact with one another. Additionally, such musical instruments were also located in Meadowcrest Lodge and were used to initiate interactions between residents. In particular, a small guitar was hanging beside one of the dining room tables near the kitchen. During one occasion, a resident (Rose) pointed to the guitar on the wall beside Robyn, who turned to look. Robyn turned back to Rose and mentioned that someone [a care aide who would occasionally play the guitar with residents] used to come and play the guitar, but that it was long ago and they had not been there in a while. Rose responded to her by looking at her in the eyes and nodding as the conversation ended. Consequently these examples shed light on the importance of familiar objects in creating opportunities for socialization. However it is also important to balance the number of objects within the SCU as too many may create a circumstance where some residents become over stimulated, thus inhibiting positive social interactions. This perception was indicated by several residents and was exemplified by one care aide at Meadowcrest Lodge when asked about the physical environment of this
unit, “I think ... the physical [environment is]... very important because when a specific place is very conducive without much distraction I think it helps in the well-being of a resident ... As much as possible a place should look like a home, but it should not be over done to the point where unnecessary things should be in there because it’s a contributing factor for sensory overload...”. Here the presence of clutter is highlighted as a potential deterrent to social interaction.

Another key aspect pertaining to the relationship between the character and ambiance within an SCU and informal social interaction was the noise level of the unit. Generally speaking, high levels of ambient noise, either from residents, staff, or even the radio, appeared to agitate residents and hence lead to more negative social interactions. This was primarily found to be the case in Meadowcrest Lodge. For example, as agitation levels would increase, one of the residents, Ruby, would begin singing aloud. This would contribute to the increasing noise levels where other residents would begin to vocalize their displeasure. During one observation, Jessica began waving her hand vigorously (negative reaction) and yelling. Finally, she points to Jenny, who nods and both leave the room. Similarly, during another observation period, Ruby began singing aloud once again. Several of the residents including Pauline, Olivia, Emma begin to start yelling at Ruby and frequently shush her. In contrast, Guildwood Village was typically very quiet and examples of overall high noise levels were difficult to find. This is likely a reflection of the therapeutic potential of the unit, including the smaller size and fewer numbers of residents inhabiting this unit.
Thus, limiting noise levels may decrease these negative interactions and create an environment where residents may interact freely with one another.

**Transition Spaces and Intersections**

Transition spaces and intersections such as entranceways proved to be important areas where informal social interaction occurred within SCUs. Residents would frequently occupy and congregate around these areas when moving from space to space or simply when wandering throughout the unit. These spaces were unique in both facilities as they not only connected spaces and rooms to each other, but provided an access point through which resident had visual connections to all other spaces within the facility from this locale. Interestingly, in both units observed, residents would tend to slow down or stop all together as they would pass by any transition area. For example, in Meadowcrest Lodge, William who would regularly wander throughout the hallways and would usually slow down once approaching the doorway into the dining room closest to the kitchen. Once there, he would either take a few steps in or poke his head through the entrance and take a glimpse of what was going on in the dining room, kitchen, or lounge. According to Danes (2002), this constitutes a “fringe zone” where residents may become aware of the happenings of the unit and decide whether or not and how passively or aggressively to engage with others in the nearby spaces. Accordingly, at times William would either begin wandering once again or would engage with others, such as in the previous examples given, depicting William’s socialization patterns. In one of these examples he engages with an environmental staff
person (pg. 95, gestures) in the kitchen area after being in a nearby entranceway, while in another one of these examples, rose sitting at a nearby table pulls out a chair for William to sit in which he accepts (pg. 87, gesture).

Similarly, in Guildwood Village residents would also seem to slow down and stop as they passed by the dining room entrance (on both sides of the serving area) and when passing across the hallway stretch between the lounge and the dining room. Such was the case for Meghan who while passing this transition area (between lounge and dining room) would at times continue wandering, while during others she would take a seat either in the lounge or in the dining room. Consequently, it is important to recognize that these spaces serve as important purpose for residents in terms of informal social interaction. Aside from providing a space for residents to gather and to reach other areas in the facility, these spaces also provide residents an opportunity to observe activities in these other areas and to engage with others as they see fit.

**Adequate Seating and Sightlines**

Yet another important physical environmental consideration in terms of influencing informal social interaction is the availability of adequate seating throughout the facility. Overall, both Meadowcrest Lodge and Guildwood Village did have ample seating available in all spaces except for in the corridors. This was somewhat surprising given the amount of time residents with dementia spend wandering in hallways. As a result, there was some evidence that suggests that benches or chairs in the hallways would be an asset to facilitating informal social interaction. Particularly, residents in both SCUs appear to
circumvent their respective walking paths to cut through the dining area, where they would occasionally take a seat at one of the dining room tables, sometimes alone and other times with other residents. Support for such an intervention was also indicated by some care staff, when asked about the public spaces at Guildwood Village and their influence on informal social interaction, “...only 18 residents, this is good enough. But still, if they had more space, even better ... You see, by the end of the hallway, they have no place to sit, they [should] have a couple of chairs, a bench, some flowers, a setting...” Thus, this staff member suggests that creating a social space within the hallway, by providing seating and a scenic environment would help to increase informal social interaction.

Additionally, it is important to discuss elements surrounding the arrangement of dining room tables. Particularly, one table setting in Meadowcrest Lodge may provide insight into ways of facilitating social engagement in the dining room. This table was dubbed the ‘VIP table’ by care staff and was termed as such as the residents who typically sat at this table were very adamant about sitting here (Laura, Beatrice, Jessica, Jenny, Wanda). Generally speaking, the five regular women who sat at this table were a very close knit group and the most social of all residents within Meadowcrest Lodge. Typically at this table it was not uncommon for the group to interact and converse collectively with one another as one large group. These conversations would often take the form of active verbal communications, involve a moderate amount of gesturing behaviour, and would discuss a wide variety of topics, both those related to the unit itself (i.e. talking about other residents, food, etc...) or about other life events
and circumstances (i.e. going to the doctor, growing up, childhood playmates, etc...). For example, this group often chatted about the happenings around Meadowcrest Lodge, including commenting on other residents (oftentimes those who exhibited agitation or ‘problem’ behaviours). During one instance while at the VIP table, one of the other residents walks by and begins yelling aloud. This grabs the attention of several of the women at this table and they begin commenting to each other. Jessica looks over, points and says “Ya, ya, ya, yah ....”, while Beatrice turns to Laura and asks, “What does she want? – oh my” and then proceeds to look around the unit once again. Accordingly, social engagement at this table was much higher than at others. In an attempt to delineate the reasons for this discrepancy, features unique to this table were observed. First, in comparison to most of the other tables in Meadowcrest Lodge, the VIP was the only table that was both round and accessible from all sides. However, while this did enable a greater number of residents to be seated around this table (approximately five to six residents were seated at this table at any given time in comparison to a maximum of four at any other table), this feature alone did not account for increased levels of social interaction observed. This was discovered after bringing this issue up with care staff who indicated that the table shape and size had been changed recently (from a square shape) to accommodate the large number of residents who enjoyed sitting in this area. As one care aide noted, “we put the round table there because ... it was a VIP table no matter what. It was square [before]. But you had people double seating, like this way and that way... how can you fit 2 people on one side on each side? ... it
was just beginning to be too much”. This suggested that increased social engagement at this table was a reflection of the space itself, not the table per se. In looking at this spot, the spot seemed to be ideal for several reasons. First, this table was in the middle of the main common area nearest to the lounge. Importantly, it was centred well enough that residents could see all other areas in the main common space including the lounge, kitchen, hallway entrances on both sides of the unit, and outside into the garden area. Thus, having this vast array of sightlines is crucial in terms of informal social interaction, as it attracts residents and provided them with an opportunity to interact with those in close proximity who were brought together by this location. This was also suggested by one care staff member who appeared to recognize that one of the past residents in the unit (not present during observations) sat in this space due to the ability to see all areas of Meadowcrest Lodge from this location, “I remember when Joe ...I think he made it the VIP table because everyone wanted to sit beside the guy. He was like the king of special care. And he sat right there at the head of the table kind of thing ...because he could...he sat there so that he could see everything. He didn’t want to sit any other place at the table. It had to be there so that he could see every section of [the unit]...” Furthermore, another unique feature of the VIP table was that it was located near large windows surrounding the lounge. This enabled this space to be well lit by natural light throughout the day. Thus, the popularity and effectiveness of the VIP table in terms of social engagement, appears to be due to a multitude of factors including the vast array of sightlines...
afforded by this space, a table which seats a greater number of people, and adequate natural lighting surrounding this space.

**Nursing Station Location**

The location of the nursing station relative to the main public space of the SCUs was also a factor that emerged which may influence informal social interaction, primarily those between care staff and residents. This issue came about in comparing the location of the nursing station at both SCUs and the researcher’s perception (based on ethnographic observations) of social interactions that occurred between residents and care staff (nursing staff and care aides only). Specifically, the nursing station at Meadowcrest Lodge was hidden in the hallway near the unit entrance. Visual access from this nursing station was very limited as care staff could only see down one side of the corridor from this space. As a result, care staff were forced to constantly circulate throughout the main common space of the unit to monitor residents. This translated into a much more social atmosphere between residents and care staff as they would often use this time to interact with each other on an informal basis.

In contrast, the nursing station at Guildwood Village was located in the middle of the unit, with two large cut outs to maintain visual contact with the better part of it. Accordingly, this design allowed care staff to remain inside the nursing station while ‘keeping an eye’ on residents throughout the unit. This is not to say that staff did not come out and interact with residents as they did make an effort to do so. However, there was some support to suggest that this design may in fact facilitate informal social interaction. This may be the case as care staff
(particularly nurses) are able to go in and out of the main common area more freely in between paperwork and other activities which are completed in this space. Specifically, this may shed light on results previously presented which indicate that 11.8% of observation in Guildwood Village and 6.2% of observations in Meadowcrest Lodge resulted in resident-staff social interactions (Figure 1).

Potentially, the location of the nursing station may have facilitated these interactions. Despite this contrast in design between both SCUs, some evidence was also observed that indicates that social engagement between residents and staff may be further facilitated by integrating the nursing station right into the unit. For example, on a couple of occasions, one of the care aides at Guildwood Village would complete her paper work at the dining room table with residents in close proximity, both to socialize with them and to monitor the rest of the unit. This seemed to attract residents towards her and provide an additional opportunity for residents and staff to interact with one another on an informal basis. Similarly, increased engagement was also seen between residents and staff in Meadowcrest Lodge when staff integrated themselves into the unit. This did not necessarily have to be while completing paperwork, as it could also include spending time with residents while having a snack during break time. Such an example was provided previously (pg. 126) with regards to a care aide sitting with residents while having a snack and helped in facilitating interactions between residents. As a result, these findings indicate that integrating a nursing station area into the unit (as opposed to a separate room altogether) may be one
design modification beneficial in helping to facilitate informal social interaction between staff and residents.
CHAPTER 6: DISCUSSION

This chapter highlights the key findings of this study in the context of implication for care practice and future research. Particularly, the first section focuses on the implications of this research within the context of residential care policies and practices. The second section focuses on the lessons learned, including study limitations and directions for future research.

6.1 Implications for Practice

The findings from this investigation highlight the complexity of factors which influence informal social interaction and the nuances regarding the wide range of interactions observable within dementia care settings. In addition, through taking an in-depth and comprehensive approach to analyzing informal social interaction patterns within SCUs, these results are influential in clarifying and contributing to the existing body of research literature and the conceptual framework developed. In considering the theoretical foundations for the conceptual framework presented (Gibson’s concept of affordances, Lawton and Nahemow’s competence-press model and Moos’ social ecological model of health behaviour), it is evident through this study that both individual level factors and environmental factors as well as the interaction of the two were important determinants of meaningful informal social interaction in SCUs. In particular, within both settings observed, the population consisted of a vastly heterogeneous group whereby residents exhibited a wide range of abilities in terms of cognitive
impairment and mobility levels. Accordingly, residents who were less mobile or more cognitively impaired were typically less socially active and influenced to a greater extent by their immediate surroundings. For example, these individuals would be fixed to a particular location, oftentimes in the lounge or at a dining room table which may not have always been suited for facilitating informal social interaction due to factors such as the resident’s body positioning (e.g. facing a wall limits sightlines available and the opportunity to socialize with others), noise levels within the unit (e.g. residents are not able to remove themselves from the space to socialize with others), or due to a lack of proximity to others in the environment. In contrast, residents who were more mobile or less cognitively impaired, were generally more socially active as they were able to take advantage of the social opportunities afforded by their surroundings. For example, these individuals were better able to navigate their environment such that they could relocate to amicable spaces where other individuals were present (e.g. intersections, hallways, the VIP table) and consequently had the opportunity to frequently engage in and sustain interactions with these individuals. Consequently, these findings underscore the relationship between the environment one resides in and an individual’s abilities. Hence, it is of great importance that within the heterogeneous environments of SCUs, the social needs of all residents are catered to by maintaining congruence between these individuals and their surroundings (i.e. by providing accessible spaces and environmental characteristics, as outlined in this study, which are conducive to
informal social interactions across the wide spectrum of residents SCUs are inhabited by)

Furthermore, the findings of this study demonstrate that the multitude of factors identified in the conceptual framework as influencing informal social interaction are indeed relevant in outlining the contributing factors for the various types of informal social interactions observed. However, it is important to note that these findings only reflect the influence of certain individual (e.g. cognitive impairment, level of mobility), physical environmental (e.g. space use, noise levels, sightlines, intersections and transition spaces, nursing station location, etc…), and social environmental factors (e.g. internalizing the philosophy of care, group size, time of day, etc…) within this framework. Hence, other key issues which may impact the opportunity for informal social interaction, such as organizational factors (e.g. implementation of policies, staff culture, organizational dynamics), were not explored extensively and warrant further investigation. Nevertheless, various factors are important in facilitating these interactions (as seen in the conceptual framework presented) and how they relate to the various types of informal social interactions identified within the context of this investigation will be discussed.

More specifically, in considering active verbal communications and more complex gestures (e.g. Jessica and Jenny communicating over long distances), resident level factors such as one’s level of cognitive impairment appeared to be crucial in the expression of these behaviours whereby those who were less cognitively impaired tended to engage in these types of informal social interaction
more frequently. Thus, in attempting to facilitate informal social interactions within SCUs, it is imperative to take into account these individual level differences, both in terms of delineating our expectations of which social behaviours are likely to occur and in terms of tailoring intervention to ensure that those implemented meet the needs and capabilities of the population at hand.

Moreover, situational factors and having the opportunity to engage with others also serve as the basis for informal social interaction. Hence, being in close proximity to others who are willing and capable of interacting both appeared to positively influence informal social interaction. In considering some of the more subtle forms of informal social interactions such as glancing and touching, physical environmental influences appeared to facilitate this process. Particularly, having adequate seating throughout the facility emerged as an important issue. This refers to not only the quantity of seats available, but also to their strategic positioning, that is, positioning these seats in a way which maximizes contact between individuals (i.e. having ample seating in areas where residents congregate – lounges, dining room, corridors, entrances to other spaces) and positioning seating to maximize lines of sight to other spaces (i.e. appeared to encourage residents to visit other spaces, engage with other residents, or simply discuss the happenings of the unit at a particular point in time). Thus, in terms of touching or glancing interactions, these typically only occurred between individuals when they were seated and in close proximity to another person. Thus, having close seating in areas such as the lounge or hallways (where these types of interaction generally occurred) was critical in
initiating these interactions. Additionally, these issues are also beneficial for the many other types of informal social interactions observed (e.g. brief verbal communications, active verbal communications, gesture, etc…). Thus, paying particular attention to these minute aspects of the physical environment are one element critical to understanding certain informal social interaction in SCUs.

Lastly, social environmental influences were also salient in facilitating various types of informal social interactions. Specifically, the role of care staff and their underlying perception of how they interpreted the facility philosophy of care played a role in this. Perhaps this influence was most salient in terms of intimate touching interactions observed within this study. In particular, there appeared to be a discrepancy as to how these touching behaviours (e.g. kissing, rubbing, hugging) were regarded among the various levels of staff and management within the care facilities. For example, in discussing the presence of intimate behaviours among residents with upper management, it was indicated that these types of behaviours were not encouraged. In contrast, within the unit itself, care staff appeared to be proactive in facilitating these behaviours by giving residents their space and proving seating with them (e.g. as indicated from the previous description of Jake and Meghan in Guildwood Village). Accordingly, in these interactions, although staff were not present throughout their duration, they were very influential in facilitating the behaviours. Similarly, care staff at Meadowcrest Lodge would occasionally direct discussions with groups of residents while in the dining room. In each of these examples, the guiding principles of care staff (i.e.
how they internalize the facility philosophy of care) are important contributing factor in certain informal social interactions.

As a result, it is evident that multiple factors influence informal social interaction, however how each of these influences impact the various types of informal social interactions is quite unique. In some types of interactions (e.g. active verbal communication, complex gestures), individual level factors appear to be more influential in the expression of these behaviours, whereas in other types of interactions (e.g. glancing, touching), the physical and social environments have a more significant impact.

Nevertheless, it is important to be able to apply the nuances and findings discovered in this investigation within the context and resources available in existing care facilities. As a result, various implications and recommendations are outlined and discussed below.

Perhaps the most important change supported by the results of this study is the importance of developing policies that recognize the importance of and promote informal social interaction. Within both facilities explored in this investigation, it was clear that although policies and procedures surrounding planned recreational activities (i.e. formal social engagement) did exist, those pertaining to informal social interaction were not explicitly stated. Specifically, aside from the general tenets of the Gentlecare philosophy of care, it was difficult for care staff interviewed to identify such policies. In fact, most of the staff members’ understanding of informal social interaction appeared to come from other sources than the facility itself as many stated that their educational
background (training as a nurse or care aide), attempting to make their job easier (during personal care), or simply an implicit desire to interact with residents, informed their knowledge of this topic area. Additionally, the development of organizational policy in this area is important for several other reasons. Not the least of these reasons highlights the importance of catering to the social needs of individuals who do not actively participate in recreational activities throughout the day. In one study which compared social interaction during programmed activities and those during non-programmed times, it was found that the greatest frequency of social interaction actually occurred outside of the programmed or recreational activities. This could be explained by the reality that during planned activities, the focus was on the activity itself (e.g. singing) as opposed to other residents (Danes, 2002). Thus, a policy which seeks to facilitate informal social interaction within SCUs needs to be developed. This can be brought about in several ways.

First, care facilities need to continue to focus on attending to the social aspect of care for individuals within these settings. In order to do so, the nuances of informal social interactions described within this investigation, such as nonverbal interactions including proximity to others, touching, gesturing and gazing, need to be attenuated in an attempt to foster relationships and social behaviour. Specifically, results from this investigation highlight the need to broaden our perception of what constitutes informal social interaction behaviour within a dementia care population. For example, out of all the gesture type informal social interactions observed, pointing, waving to solicit someone’s
attention, and hand gestures accompanied by speech were the only consistently highlighted (or perhaps even recognized) gestures by care staff during the interview process. Accordingly, care staff do not appear to recognize the broad range of gestures occurring in SCUs, despite the presence of gestures involving other body parts such as head nods and the unique gestures present as uncovered through ethnographic observations. This may also reflect a difficulty in articulating what a gesture actually is. For example, in most interviews when asked to depict non-verbal informal social interactions between residents or between staff and residents, staff indicated that gestures were used; however the context and expression of these gestures were rarely elaborated on.

Nevertheless, it is important to recognize that social interaction in SCUs is very broadly defined and includes behaviours (starring or making eye contact without verbalizations) that we may not typically consider as such. Thus in terms of learning experiences, it is important to train care staff on the nuances of informal social interaction such that they can recognize and facilitate these moments whether it is between themselves and residents or between residents. This should make salient the fact that interacting with people with dementia must not solely include communicating through verbal means. Instead, other forms of interaction such as gesturing, facing residents at eye level and making eye contact, and touch may be equally, if not more important to these individuals and should be used to enhance interaction between residents and staff.

Secondly, facilitating and including informal social interaction more explicitly in care practice is of great importance. For example, many care staff
appeared to value social care and stated that they did socialize with residents on a regular basis whenever they could. Despite this, results from this investigation indicate that relative to the amount of time spent with residents, the frequency of informal social interactions between staff and residents is not uniform across all staff levels as different levels of staff interact differently with residents. In contrast to care aides and nursing staff who appear to have very regimented routines within the SCU, environmental staff appear to have more flexibility in their daily routines which enables them to engage more frequently in these informal interactions with residents. Consequently, this suggests that due to time constraints, those who are in most frequent contact to residents (e.g. care aids) may be missing out on an opportunity to socialize with them. Furthermore, the interactions which care staff members do have with residents tend to focus on the clinical aspects of care with the underlying motive of social interaction during this time being to facilitate current or future care related tasks. Thus, it is important to attend to the social care needs of residents, by allowing staff the necessary time throughout the day to interact with residents on a more humanistic or informal level. This recommendation is further supported by the results of this investigation which indicates that certain social behaviours exhibited by residents, particularly attention seeking behaviours, are in fact a reflection of unmet social care needs of these individuals. Thus, the important issue here is that policies and procedures within these care facilities need to be developed and explicitly allot time for care staff to engage with residents, either one-on-one or in small groups, on an informal basis. However, in order to make
these changes most effective, both care facilities and academic intuitions must also play a role in educating care staff as to the importance of informal social interaction and provide training to these individuals with regards to facilitating informal social interaction.

Lastly, the results from this study highlight the role of the physical environment in facilitating informal social interaction. While the knowledge that is provided can perhaps best be utilized to inform the design of new facilities for people with dementia, the goal of this investigation was to also provide insight into what can be done in existing facilities within their current design and limited resources to improve social engagement for residents. As a result, the first recommendation would be to include seating areas both within the hallways and nearby transition spaces. This would allow residents who do congregate in these areas to be comfortable, defines the space as a social setting, and gives residents an opportunity to passively or actively engage with others as they pass by. Similarly, another recommendation is to arrange seating areas such that they maximize visual access to other areas of the facility. This includes seating in the dining rooms, lounges, and in all other spaces as social interaction appeared to be at its highest in existing spaces which allowed multiple lines of sight for residents. Additionally it is recommended that spaces are designed to be as homelike as possible. This means balancing public and private spaces, having homelike decorations and furniture, having adequate lighting, and attempting to reduce ambient noise. Moreover, areas within SCUs should be segregated into smaller spaces such that there are a variety of spaces which cater to residents'
individual needs and in which they can explore. For example, within the lounge area, a television is oftentimes placed here. While some residents do enjoy watching the television or appreciate the minimal stimulation it provides, others do not or are bothered by it. Accordingly, removing the television out of the lounge into another space, or even converting the lounge area into two sections with a movable wall may help facilitate informal social interaction as it provides residents with the option of another space where people can interact, relax or rest. In all, taking into consideration the issues discussed in this section and implementing the recommendations highlighted, an opportunity exists that allows residents to flourish and engage with others meaningfully and frequently during informal social interactions.

6.2 Lessons Learned and Future Research

Research focusing on informal social interaction in people with dementia is limited. As a result, it is important to outline some of the lessons learned and limitations that were encountered in this study as a way of generating and improving future research in this area.

First, from a methodological perspective, the use of the behavioural mapping instrument was difficult at times. Specifically, SCUs are dynamic environments which are always changing and social interactions, especially in this setting, occurred without notice in a split second. As a result, some difficulty was experienced in terms of documenting observations in detail in both facilities. For example, the first few sets of formal observations attempted to document the activities of all people within a large space (e.g. main common room and
hallways) within a given timeframe. This global approach was difficult as documenting the location, activities, and interactions occurring for each person throughout the unit was overwhelming. Accordingly, in subsequent observation periods, only one space was focused on and all individuals and activities within that space were documented (e.g. dining room only, lounge only, halls and transition areas only). This approach assisted in the collection of more meaningful and detailed data. Additionally, the formatting of the behavioural mapping instrument was also difficult to navigate at times. With many people in the environment, it was difficult to jot down who was interacting with whom, what each person was doing, where each person was located, and who each person was. While using pre-created maps was helpful, prerecording the identification number of each person within the unit prior to beginning an observation was not, as there was no guarantee that all residents would be within a given space during a particular time. Nevertheless, the assistance of multiple people or perhaps even technology (e.g. video cameras) may help in being more accurate in recordings.

Secondly, in terms of interviewing staff members on the issues related to this investigation, it is important to remember the environment in which they work. Specifically a long-term care setting, as in many other job settings, is a place of hierarchy, rules, policies, and procedures. The care staff in this investigation were very knowledgeable and in many cases have truly internalized these policies and procedures for the well-being of the residents. Accordingly, these policies and procedures were present in all aspects of their care routines.
In asking questions about these policies and procedures, it is important to appropriately contextualize them (i.e. policies and procedures relating to informal social interaction; policies and procedures relating to a dementia care environment) and to ask this at the appropriate time during interviews. For example, in the initial interviews of this investigation, issues surrounding the policies and procedures were asked at the very beginning. This created challenges in terms of defining what the interview was actually about (despite the interviewer’s attention to defining what it was about at the beginning of the interview). As a result, in the first two interviews respondents gave answers to subsequent questions always referring back to some policy or procedure. This created a situation where the social interactions being describing were always within a care (oftentimes, a personal care) context, which was outside the scope of this investigation. Additionally, defining terms such as the ‘physical environment’ and ‘informal social interaction’ for care staff is of utmost importance as these terms are not ones that are relevant to the job or care that they provide on a regular basis. As a result, future research in this study area which uses interviews with staff, needs to pay careful attention to how these concepts of physical environment and informal social interaction are conveyed, and importantly, perceived by care staff. This could be done via explaining what each term means at the beginning of the interview and during relevant questions (as was done in this investigation), or by paying more careful attention in providing more appropriate probes or otherwise.
In addition, given the complexity of socialization in people with dementia, the collection of certain additional pieces of information could have potentially enhanced this investigation in terms of further delineating the context of informal social interaction. In particular, information on the life history of individuals would have been beneficial in terms of assessing how social individuals were in comparison to their past lives. Moreover, length of resident stay is another type of information which would have helped to assess how familiar residents were with their environment. Lastly, the probable type of dementia and mini-mental state exam score would have also been beneficial as results suggest a wide range of variation among residents in terms of type and frequency of informal social interaction.

Throughout the process of collecting and analyzing the data for this investigation, several new avenues of research to explore became apparent. Perhaps the most glaring omission from this study was the lack of insight from residents themselves with regards to the interactions they engage in and how interpersonal relationships develop (or do not develop) within an SCU environment. While this does pose many challenges in terms of gathering this population’s perspective, it is an important point of view to consider as it is only after this viewpoint is attained that the strategies and modifications recommended can be implemented to their full potential.

Additionally, this study recognizes the complexity and numerous types of informal social interaction within a dementia care setting as well as the great deal of influence that the physical and social environments play during these
interactions. While an in depth overview of these interactions and issues was provided, it is important to connect these findings to well-being outcomes for residents. Specifically, the purpose of this research was not simply to provide insight into achieving better quality of care for residents with dementia, but importantly developing insight into how to assist these individuals in achieving a greater quality of life. Accordingly, enabling residents to engage in meaningful informal social interactions with others provides a vehicle to achieve this goal.

Furthermore, the conceptual framework presented previously, in conjunction with the results of this investigation, offer some insight into the mechanisms which contribute to resident well-being and quality of life within SCUs. More specifically, organizational level factors, social environmental factors, and physical environmental factors contribute to meaningful information social interaction in SCUs. In sustaining these interactions, residents may develop a sense of social integration and sense of community, either with other individuals or with the facility itself. Accordingly, this provides a basis for residents to potentially form and maintain social relationships with other residents in the care facility.

Interestingly, these relationships were evident in both SCUs observed and it is the viewpoint from this investigation that it is though the development of these social relationships (no mater how complex) that quality of life and well-being can be achieved by residents with dementia. Accordingly, future research should look at the relationship between specific environmental factors, meaningful informal social interaction, the development of social relationships, and well-being outcomes. While this present study attempted to look at some of these issues at
a very broad level, research which focuses on the interconnectedness of these issues is of utmost importance in order to help make a stronger case for design recommendations (such as those proposed in this study) in long-term care research.

Furthermore, various other fascinating topic areas pertaining to the phenomenon of social engagement in SCUs also emerged from this present study and should be further explored. While this investigation primarily focused and reported on social engagement in which clear examples of informal social interaction was available, many instances within both SCUs suggested that informal interactions also occur and are intertwined in formal interactions such as during personal care (resident-staff) and during recreational activities (resident-resident, resident-staff). As a result, future research should also look at teasing out the informal component on interaction during these formal interactions.

Additionally, observations within each SCU and conversations with care staff suggested that the ways in which residents interact with one another may be influenced by gender. While this study did not focus on gender differences in relation to the various types of informal social interaction, it did bring to the forefront some interesting issues in this area. In particular, the findings of this investigation suggest that gender differences may exist in terms of how touch is used to communicate. For example, touch was primarily used by female residents while socializing with one another, which ranged from hand holding to patting. In contrast, males did not exhibit these behaviours and rarely used touch as a form of communication. In several unique instances, however, touch was
also used as a form of sexual intimacy. Although these cases were rare, touch was typically initiated by female residents towards male residents, where the male resident was often the passive recipient of these advances. These observations suggest that tactile communication may be of greater importance and have an implicit meaning for female residents. Accordingly, it would be imperative for future research to further explore gender differences both within tactile communication and the other types of informal social interactions. Furthermore, the issue of sexual intimacy within a dementia care setting also warrants further investigation. Consequently, exploring the impact of gender during informal social interactions is another avenue of research to pursue.

Lastly, although both positive and negative informal social interactions were evident within this study, when thinking about the benefits of informal social interaction on well-being and quality of life, we tend to focus our attention of these positive behaviours. Perhaps then in future research it is important to also focus our attention to the negative informal social interactions that occur in SCU, after all, no environment (e.g. home, workplace, community, etc...) is devoid of conflict. Consequently, residents too may also find meaning in their lives through conflict. As such, it is important for future research to give equal consideration to both positive and negative social interactions and how they impact individuals within these settings.

6.3 Conclusions

In all, within the context of a dementia care setting, it is of utmost importance to recognize the value of informal social interactions within the day-
to-day lives of these residents. Findings from this investigation indicate that residents not only engage with others on a frequent basis, but that the behaviours expressed when interacting with others are varied. These communications range from behaviours as simple as making eye contact to brief verbalizations to complex forms of non-verbal communication such as in some gestures. As a result it is important to realize that residents in a care facility are not a homogenous group. The levels of dementia exhibited, their level of sociability, their communicative capacity both verbally and non-verbally all differ and are quite variable. This creates great difficulty in caring for this wide variety of individuals and for building environments which cater to the psycho-social needs of those living in these environments. Moreover, this study has helped highlight key features within the SCU environment which appear to be conducive to facilitating informal social interactions. These range from complex organizational solutions such as introducing a new philosophy of care or providing adequate training for staff in this area, to changes within the unit itself in terms of rearranging furniture or even the layout of the unit. Nevertheless, the key point here is that even within the context of current facilities (e.g. existing walls, furniture, and structures) there are quite a few things that we can do to help facilitate informal social interaction among residents. However, if this is to be the case, it is important that we continue to recognize the importance of these spontaneous, informal interactions on the well-being of residents by developing policies, practices and environments which maximize the potential for these interactions to occur.
APPENDICES

Appendix A: Conceptual Framework
## Appendix B: Behavioural Mapping Instrument

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Floor plan attached
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Field Notes:

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Appendix C: Social Interaction Checklist

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### Appendix D: Social Interaction Checklist - Revised

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Appendix E: Interview Guide Questions

1. What policies and procedures within your facility are you aware of that are geared towards facilitating social interaction? (Probe: please list and describe; if unaware, what practices are typically followed to ensure a positive social environment available for residents, how much choice is given to residents to participate in activities; are you given time/do you have the opportunity to interact with residents outside of your care giving duties?)

2. Aside from planned activities, describe a typical interaction between residents that one may occasionally observe. (Probe: What is the context behind the interaction? – is it purposeful, by chance, due to agitation, etc.? is it verbal or non-verbal?; what location does this takes place in?, How common is this?)

3. Describe a typical interaction between yourself and a resident outside of your formal care duties. (Probe: Where would this usually take place?; is this a common occurrence?; who is contact initiated by usually?)

4. How important of a role do you feel the physical environment plays in providing people the opportunity to interact with each other? (Probe: Why or why not?; what aspects of the environment do you feel are critical?)
5. What characteristics of the physical environment do you believe are most conducive to social interaction? (Probe: within the dining area?; activity spaces?; in corridors?)

6. In attempting to create a greater opportunity for residents casually engaging with each other, what would you recommend doing? (Probe: Is there a particular policy you would put in place?; What design features would you change?)
Appendix F: Annotated Floor Plans – Meadowcrest Lodge

Floor Plan not exactly as shown (Adapted from Chaudhury & Lyle, 2009)
Floor Plan not exactly as shown (Adapted from Chaudhury & Lyle, 2009)
FIGURES

Figure 1: Level of Informal Social Interaction and Residents' Social Partners

Who Residents are Informally Socializing With in all Public Spaces
Figure 2: Types of Informal Social Interaction Observed within SCUs

Types of Informal Social Interaction Observed Within all Public Spaces

- Active Verbal
- Brief Verbal
- Touch
- Gesture
- Glance
- Other
- Attention Seeking

Type of Informal Social Interaction

- Combined
- Guildwood Village
- Meadowcrest Lodge
Figure 3: Informal Social Interaction Across SCU Spaces

Informal Social Interaction Across Space and Facility

Percentage of Observations

Location
Lounge  Dining Room  Corridor*  Living Room*  Other*

Both SCUs  Guildwood Village  Meadowcrest Lodge
REFERENCE LIST


*Long-Term Care Homes Act*, Ontario Ministry of Health and Long Term Care. 2007, s.10.


