A place to call home?

An ethnography of the retirement village as a heterotopic place

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Abstract

People over 65 in New Zealand often enter long-term care conditional to their levels of health, family and community support. New Zealand has a growing ageing population, and people are living longer because of lifestyle choices and advances in medical technology. In response the residential care landscape has transformed, resulting in the emergence of the corporate, resort-style retirement village sector that provides several aged care living options dependent upon the older person's health, physical and economic circumstances. These villages deliver communities that aim to offer safety, reassurance, care and security. Many older people remain living at home either as they prefer to stay in their own environment or because they cannot afford other options. Most older people at the later stage of life must consider the option of either staying at home or finding a new 'home' in a facility. Often this decision is beyond their control if they are no longer safe and accessing adequate care at home, for instance, if they have a health crisis.

This study consists of an ethnographic, naturalistic observation of a retirement village as a home away from home. The methodology I employ involved close observation and reflections upon daily life in an elderly care institution. I spent 155 hours in a retirement village and was afforded access to life behind the scenes to help me understand the practices and customs of the staff, residents and relatives. This allowed me the opportunity to develop an awareness of how various spaces are deciphered, lived in or endured from the perspectives of the important retirement village stakeholders – residents, family and staff. Inevitably my own experiences of looking after my parents, and their experiences of ageing, added an autoethnographic component to this study. I employ Foucault's assertion that rest homes are heterotopias to frame, interpret and discuss my observations. I elaborate upon the feelings of dread and vulnerability that older people experience when they contemplate moving into and

settling into a retirement facility. I explore how standardised healthcare practices and customary surveillance can challenge an older person's identity and subsequently hinder an older person from finding a sense of belonging in the retirement village care.

The themes of vulnerability, dread and a sense of belonging drawn from the ethnography reinforce how essential it is for retirement village corporations, their staff and the wider community to adopt a model of caring that empowers older people. This empowerment comes from them feeling a sense of control and individuality over their existing routines and habits which have been developed in their own homes, and which give meaning to their lives. Furthermore, care needs to incorporate an understanding of lifeworld existentialism such as dread causing anxiety and vulnerability, to gain a full awareness of someone's life. I argue that institutional representatives and families need to understand the feelings associated with home as the first step in enabling an older person to feel valued and comforted in their uniqueness in a new environment such as dependent care in a retirement village. Additionally, for older people to feel central to their individual care they should be included in the decision-making process about where they live and what possessions they have around them. Thus, they are supported in a place to call their own – home.

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Preamble: My Motivation to Learn More

A fundamental part of my upbringing was understanding what it meant to be compassionate and caring about others around me. My mother's father had a significant disability, in that he was paralysed from the neck down due to a mysterious neurological disorder. The doctors believed his paralysis was possibly triggered when he was involved in an air raid bombing at work in the Second World War. As I grew up, my grandparents became my heroes; my grandfather for the way he stoically lived his life to its fullest, and my grandmother for how she devoted her life to caring for her husband at home, with limited daily nursing support to get him up and dressed. Their inspiration formulated my early life narrative, which I believe has shaped how I see my place in the world. I have always been aware of how others were feeling and experiencing the world around them. Choosing to nurse and later qualifying as a midwife came naturally and empowered me to help people at their most vulnerable.

During my mid twenties, I made a conscious choice to take a leave of absence from work, when my father was dying of cancer, to support my mother caring for him at home. Regrettably, my father's health needs required him to spend his final days in a hospice, where he died alone during the night. A nurse made the decision not to disturb our family during the night, and I still feel sad and aggrieved about not being notified so I could be with him when he died. I was devastated that my father died alone, and I promised my mother that I would not let this happen to her and that I would care for her in her old age at home.

Twenty years later, and Mum was in New Zealand living with me and my family, enjoying her lifelong dream of living near the beach. For me, the family home had become a special place for us all. For my mother, the loneliness of being a widow was replaced with busy grandchildren and being part of family life. Sadly, my mother's charming forgetfulness

gradually turned into pronounced memory loss, and life at home changed drastically. Alzheimer's had entered our home, and with it came the realisation that the time had come for me to fulfil my promise to become her safe place and person. With each stage of the illness, we adapted the spaces in our home and way of life with some practical support from the community health services for respite care and equipment. I stopped working full-time and spent my days with Mother and caring for the family. Finally, the physical cost of caring for my mother became too much. I could not be all things to all people, as my mother needed 24-hour care, my children needed their mum, and my stoic husband needed his wife. My GP's words still echo for me. She said, 'Your mother deserves a fresh nurse every eight hours rather than an exhausted daughter all the time.' Alzheimer's had defeated me.

I agreed with my GP, but this decision involving my mother needing to leave the safety of home and moving into residential care was devastating. Finding a residential facility that came anywhere near good enough to be a home from home for my mother took three attempts at different places, and the reasons she needed to keep moving were heartbreaking. The organisations were essentially unable to keep my mother safe. In the first 'home', she fell and fractured vertebrae in her neck, which resulted in a six-week stay in Auckland Hospital. However, her recuperation time allowed me to develop a checklist for the next residential home that included caring and considerate staff, a clean smell and a homely feeling. The choices were limited as I wanted my mother to be living close to our family, and beds were scarce. Finally, I chose a new place, and she moved in following an assessment as needing hospital-level care, to help with all her fundamental human needs. However, my mother fell again within a couple of weeks, knocking out her front teeth and bruising and grazing her face, resulting in another ambulance ride to the hospital. Again, I revisited the list of essentials for my mother's care. I also spent hours visiting other villages and homes, meeting staff, and asking questions about my mother's type of care and attention if she moved in with

them. I could not bear the thought of my mother hurting herself again and returning to the hospital environment, as the busy hospital ward atmosphere was so unsettling for her. Finally, my mother relocated to a new place to call home, we hoped. I spent my days visiting, decorating her room with photos and pictures of her favourite things and enjoying just being a daughter; however, my mother would want to leave with me when I left to go home. The emotional pull of our attachment and home was forever present.

The retirement village was a thirty-minute drive from my home. So I would spend many hours with my mother and soon became part of the furniture. I would chat with the staff, other residents and their family members who, like me, had a routine that involved part of the day visiting the retirement village. Over time, I offered to help feed those residents who looked for help and did not have visitors, or chatted with them when my mother was having a nap. My mother also enjoyed walking up and down the corridors with me, and while we slowly paced the halls, I would chat about the many photos and mementoes in the residents' rooms. I would get a glimpse of who each person was, a mother or father, a grandparent, a war veteran. It always surprised me when I saw residents' rooms that remained clinically bare of all personal identity. I wondered about their distance from family and home, and their inability to access those items that make them feel at home.

One of the things I found disturbing was regularly finding my mother in clothes that were not hers and certainly not what she would choose to wear. There were occasions when her fingernails would be painted shocking pink, but my mother never painted her nails. These were oversights by the carers about the unique personal details that ensured my mother's sense of self. I questioned the purpose of filling in admission forms that ask you to share personal details at a time of crisis, such as their likes and dislikes, details about their lives past and present, hobbies and favourite foods. Although my mother's pink nail polish was an

isolated incident, it remained emblematic to me about how the lack of attention to an individual's unique details can accentuate the struggle to find a place that can be called home.

My insight into the healthcare sector, coupled with a family history experiencing these caring organisations' institutional and cultural dynamics in England and New Zealand, prompts me to question how the retirement village utilises their spaces to influence the residents' feeling of home.

> To be at all, to exist in any way, is to be somewhere, and to be somewhere is to be in some kind of place. Place is as requisite as the air we breathe, the ground on which we stand, the bodies we have. We are surrounded by places. We walk over and through them. We live in places, relate to others in them, die in them. Nothing we do is unplaced. How could it be otherwise? (Casey, 1997, p. ix)

Home is our first place and a place of influence. The meaning of place is crucial throughout our lives, and day-to-day we do not give much thought to the significances or hidden meanings in the various places and spaces we pass through. The sociological, psychological and geographical paradigms converge in a place and have inspired my deeper thinking, reflected in this thesis, of the power of place.

Chapter 1: Introduction: My Journey to this Place

The preamble above provides my personal narrative that reinforces why I chose to question the notion of home in aged care. My background, life journey and desire to help others have led me to this enquiry. This introduction provides an overview of this ethnographic study exploring the notion of home by considering the notion of heterotopic space in relation to a New Zealand retirement village. I provide some key definitions, general background and a discussion of the ageing population and their care needs. I also identify the research question and explain how the method chosen to answer the question relates to the thesis structure.

Definitions of the Older Person and Institutional Care

The last thirty years have seen changes to the ageing landscape in New Zealand, resulting in the emergence of retirement village developments throughout the country, and there has been a proliferation of different types of institutional care. Several terms are used in the literature to describe elder care institutions, and here I define how they are used in this thesis.

Retirement villages are also known as continuing care retirement communities that provide various levels of personal care, housing and specific amenities that support older people's immediate needs (Yeung et al., 2017). Others use terms like rest homes, hospital care, residential care and care homes.

Another set of key terms used in this thesis are terms used to describe older people deciding upon or living in a residential care setting. The New Zealand population is growing older and living longer with advances in medical technology and lifestyle choices. The reality for numerous older people is that they may enter long-term care at some stage once they turn 65, depending on their health and social support networks. Often people now make the choice to enter retirement villages at younger ages (e.g. 55) as they can be attractive social

environments with easy access to entertainment, activities and facilities. The term older person is socially constructed, and a range of discourses are used to discuss older people, many of which limit their agency. Thus, I personally consider that how people want to refer to themselves regarding their age is their choice. However, in the interests of simplicity and clarity, this thesis defines an 'older person' as any person over 65 which is a definition commonly used in research. For instance, Broad et al. (2015) says 47% of those over 65 will require residential aged care in their lifetime, but this increases to 66% once they reach 85. There is also now a newer category used when discussing this older group which requires more speciality care, 'old-old' – people over 80 with significant health concerns (Koopman-Boyden, 2018, p. 1)

General Background

New Zealand's ageing population is a significant challenge due to the growing number of over 65s who will at some stage require care and support as they become frail and less autonomous. This means accessible quality aged care in New Zealand is a critical issue. Peace and Holland (2001) and Rowles and Chaudhury (2005) support the need to explore factors that influence the notion of home in relation to retirement villages for our ageing population, since the communities where an older person lives generate a unique sense of being for them, which is essential to their quality of life.

The trend of private-corporate retirement villages provides an alternative accommodation option for older people who are affluent and want to plan for their aged care needs. This care model is currently providing tailored independent apartments and villas, often in a gated community. At present, two-thirds of these corporate retirement villages also deliver continuity of care in co-located rest homes, hospitals and dementia support facilities. Therefore, as our population ages year by year, adequate and accessible care options increase.

Currently, aged care for the older old is already subject to the strain of supply and demand with waiting lists growing, limiting the choices of staying in the local community for many older people needing to move from home or hospital into a dependent care bed.

The purpose of this study is to explore how residential care places and spaces are interpreted in relation to ideas about home. The study brings an understanding of what it means to *be at home* and how this influences older people moving into residential care. Therefore, this thesis draws on the relevant international and New Zealand scholarship and research that is concerned with the meaning of home and relevant to understanding those living in a retirement village. It is important to stress that the scope of the study does not include the independent living commercial strategy such as options offered by corporations developing gated communities such as those described. However, ethnographic observations include observations of independent living residents going about their everyday life within the community areas of a village. Furthermore, the study does not observe those living in the dementia care environment for ethical reasons due to their vulnerability and inability to provide informed consent.

To provide a theoretical lens, I draw on the writing of post-structuralist Michel Foucault and heterotopic spaces (Foucault & Miskowliec, 1986; Gordon, 1980). Foucault's idea of heterotopia provides a lens to view established norms regarding time and space and the routines that people have that make these abstract concepts real, to make sense of the rupture that occurs when an older person moves from their home and into a retirement village. Foucault conceived the idea of heterotopia to illustrate a metaphorical mirror exposing 'the reality and unreality of heterotopias and utopias' (Sudradjat, 2012, p. 29), which are slices of time in different spaces that juxtapose and frustrate each other (Foucault & Miskowliec, 1986). Foucault specifically identified rest homes as heterotopic spaces and several other

researchers have previously used heterotopia to explain some of the dilemmas regarding rest homes and care (Sayers & Brunton, 2018). Foucault's concept of *épistémè* is also drawn upon in this thesis. Clinton and Springer (2016) use this idea to discuss the power of the nursing and healthcare regulations and institutional governance within the geography of care.

The literature on the concept of home is broad and deep and so this thesis draws on only the most relevant scholarship relating to core areas I cover on attachment to place, nursing care and dread. My background reading included reading key authors such as: Lustbader (2013) who reveals that attachment to place depends on a person's life experiences; Heidegger (1971) who took the position that humans are dwellers who instinctively create homes; Brown and Perkins (1992) and Manzo (2014) who discuss the unconscious connections that determine a sense of belonging and awareness of our environmental dynamics; and Peace and Holland (2001) who argue an older person needs a unique sense of being in a place for them to experience quality of life. From my background reading I chose to focus on literature that discusses how homes provide ontological security, dignity, privacy and individual choice where a person can feel a sense of belonging, and how these experiences might be facilitated in institutional environments.

One area of focus is relevant literature on how nursing care is related to a sense of place and wellbeing. So, to understand how we care for our older population today, I explored the historical origins of the 'care in place' practice (Carolan et al., 2006). I found that British colonial culture influences aged care institutions in New Zealand. Robertson (2019) explains that aged care policies have stemmed from the industrialised workhouses of the 1800s and policies from the British health service in the 1950s. However, the experience of elder care is not universally the same for all people in New Zealand. Allport et al. (2018) note that Māori have historically continued to care for their kaumatua within the whānau. As New Zealand is

a diverse country other cultures will also have different care practices around older persons. In this thesis I focus on institutional care and so I acknowledge that the care practices I examine predominantly relate to mainly European-originating clientele and that the elder-care issues I observe and discuss will be different in other cultural contexts. Another area of literature I chose to focus upon is the experience of dread, because this concept – dread – arises constantly in both theory and practice regarding the move from home to residential living.

The concept of dread literature provides insight into the angst generated by the desire of older people to remain independent, particularly when faced with their mortality and the probability of needing to leave their family home. The Danish philosopher Kierkegaard believes children know 'absolute freedom' as they innocently and fearlessly explore, blind to consequences or risks (Grimsley, 1956; Kierkegaard, 1957; Stone, 2017). However, over time, that fearlessness is replaced with prudence and choice as awareness of the inevitability of death becomes more apparent. Dread becomes a fundamental 'existential' mood to experience being-in-the-world.

Ageing and Care in New Zealand

Statistics from both Ministry of Health (2018) and (StatsNZ, 2020) provide evidence that the population is growing older and living longer. In 2020 the 65+ population reached 790,000; however, New Zealand will have a projected 1.5 million people over the age of 65 by 2048, and 2.2 million by 2073. Due to advances in medical technology and individual lifestyle choices, the number of the older old 85+ are forecast to increase to over 300,000 by 2048 and increase to 500,000 by 2073.

Alongside this dramatic growth in the size of the sector and the business opportunities it has provided, has been concern about the quality of care. Egan (2018) and Houlahan (2019) express concerns about the provision and quality of care in aged care facilities as families, the community and current social and health services grapple with the needs for quality elder care options (Ministry of Social Development, 2019b). The government has shown a strong historical interest in ensuring quality of care for older people in New Zealand. The Ministry of Social Development (2001) delivered a Positive Ageing Strategy to inspire communities with older individuals and ensure they can age well with a sense of dignity and belonging.

The demand for quality end-of-life care, and housing and housekeeping demands alongside social care, make it essential for providers to evolve to provide high-quality services while, at the same time, ensuring they are maintaining adaptability to the older people's individual needs in an ever-growing and ageing population (Associate Minister of Health, 2016; Nakrem, 2015). Several corporate providers have emerged on the aged care market to compete with more traditional providers.

Corporations now control 42% of the Village market and 60% of the independent living unit market in New Zealand. The dominant companies are Ryman Healthcare, Metlifecare, Summerset, BUPA, Oceania and Arvida (Jones Lang LaSalle, 2020, p. 13). They provide residential care for older people which has become a highly profitable business in New Zealand.

Corporations actively compete with homecare as they market their options to older people, who may not have the family support they will need to ensure they have quality of life as they age and inevitably lose independence. Historically, children of ageing parents have played a key role in supporting their parents in old age, either in their own homes or moving into the

family home and co-living together. However, the family structure has changed over the last 75 years and impacted how we care for our older population. White (1991, p. 23) defined family as ‘an intergenerational social group organised and governed by social norms regarding decency and affinity, reproduction, and the nurturant socialisation of the young’. Families are still considered the core of care for the needs of all generations within a family, but some family members are often not in a position to meet this social expectation for a variety of reasons including will, time, geographical distance and/or that their ageing family member’s needs are beyond their capacity to manage safely for both themselves and their ageing family member.

The pressures on contemporary families regarding care-giving are acute, as two incomes are now commonly required to support a family household. International mobility means family members are often in different countries (Froner & Dreby, 2011). In addition, the dynamics of what makes a family has altered with single parents becoming a recognised norm (White, 1991). O'Sullivan (2015) explains how stretched the baby boomer generation are feeling about being ‘sandwiched’ between their own children’s needs and their elderly parents, with the looming prospect of becoming their primary carers (p. 491). Aumann et al. (2008) and O'Sullivan (2015) also draw attention to how baby boomers are often still supporting their adult children at home. Some of this generation of people are forfeiting their own retirement to provide childcare for the grandchildren, to enable their adult children to work to provide a home for their families. All of these factors are making decisions about moving into residential care more complicated and critical.

Gillard and Higgs (2005) identified that health issues such as reduced mobility, home maintenance, financial competency and the inability to drive a car are a few other complex

considerations that influence the decision-making process for long-term care, with it being the only choice for some older people.

Government is investing considerable amounts of money into the ever-growing need for suitable care for our older people. New Zealand District Health Boards (DHB) investment is in excess of $590 million per year for residential aged care for older people who can no longer safely care for themselves in their own home (Ministry of Health, 2019). However, the process of admission to residential care is needs-based and means-tested. A large cohort of elderly residents self-fund their residential care at a baseline cost of approximately $60,000 a year (Ministry of Health, 2019). Many older people must sell their family homes to liquidate assets and fund their residential care. In 2021, residential aged care is allocated across 657 facilities throughout the country and provides 38,600 beds to both self-funded and Ministry of Health (MOH) funded care for the older person. AgedPlus (2020) also reveals that it is not unusual within the corporate retirement village model for residents to pay an additional $350 to $500 weekly fee for a premium en-suite room: $18,250 per year.

The demand for residential care is projected to increase by a minimum of 20,000 beds by 2026, with indicators predicting that most older people will require support for chronic illnesses or dementia (Ministry of Health, 2019; Te Pou, 2011). This is consistent with the findings of Jones Lang LaSalle's (2020) *White Paper*, which identifies eighty-one aged care developments in the pipeline, consisting of the expansion of existing villages and the process of land banking in preparation for new builds. There are many smaller boutique and local market care facilities throughout the country that the Ministry of Health partially funds. However, with increasing operational costs such as the higher salary thresholds for care staff and increased operational pressures, there has also been closure of several facilities (Jones Lang LaSalle, 2020; Ministry of Health, 2018). This is significant as older people have their

choice of local care in their community removed each time this happens and the pressure is then on them to move further away from their family.

There is a public perception that retirement villages isolate older people from their community; but this has often been rebutted, with several studies revealing the positive impact these living situations can have on quality of life, with worry-free environments, autonomy and security (Bohle et al., 2014; Grant, 2007; Scharlach et al., 2012). Furthermore, older people who subscribe to the retirement village's independent living philosophy and purchase a villa or apartment do so because they desire to protect their independence and retain control of assets, specifically their home, and also not burden their children with their care needs (Bowen, 2003). For a weekly fee, additional services become available providing them with the opportunity to age in place. These services include village transportation, healthcare advocacy, recreational facilities, a hairdresser and access to village meal plans for an additional cost (Commission for Financial Capability, 2021). Having an awareness of these costs and the choice to access additional support services is often comforting to older people living alone or couples who prefer the style of living being offered.

The expectations of many retirement village residents are that they will remain living within one village community and move between care levels as their individual needs change. However, the reality for many older adults is that they enter full-time care straight from home via the hospital because of a social or health crisis, which then requires them to enter rest home, hospital level or dementia level care in a retirement village. Residents who have purchased an independent living home in a retirement village also face this crossroad but they may only be admitted into their village's dependent care if there is a place available, meaning they do not necessarily get to stay in their new residential 'home' (Cheek et al., 2006). This raises the potential issue of needing to move to a different village or residence which may

prove to be socially and financially problematic for many residents, their partners and families.

In contrast, many older people choose to remain at home with the expectation of remaining at home and ageing in place, weathering all social and health crises autonomously, either self-funding or by receiving support from the Ministry of Health (MOH), Work and Income and sometimes from the Accident Compensation Corporation (ACC). The funded government support older people can access includes home help, meals on wheels and support with bathing, thus facilitating ageing in place while they remain mobile and cognitively well (Ministry of Health, 2013). However, there is evidence that declining health and mobility often force the older person to make the stressful decision to enter residential care when they do not have family or sufficient social support which imposes a loss of independence. Furthermore, the decision processes are frequently made in the hospital setting and influenced by health professional policies which creates tension, feelings of guilt and helplessness as moving into a retirement village care unit for many older people is viewed as the last stop in their ageing journey (Cheek et al., 2006; Chrisp et al., 2013; Shippee, 2012; Yeung et al., 2017). Therefore, it is essential to explore the complexities of living in the retirement village environment, both independent and dependent care, particularly when the ageing person is experiencing a personal crisis.

Research Aim and Research Question

The purpose of this study is to explore the notion of home and how places and spaces are interpreted when older people move into a retirement village.

Thus, the research question used to guide this study is:

How can a retirement village as a place of crisis become home?

Notes on Method and Structure of this Thesis

In Chapter 3 I present my research design and discuss methods. I employ a constructivist-interpretive world view and a qualitative ethnographic methodology to explore a corporate retirement village context where I observe staff, residents, relatives' interactions and the spatial dynamics in the facility. My choice of an ethnographic methodology is supported by Keeling (1999), who says more ethnographic studies of older people in retirement living communities is needed. In line with my acknowledgement of my interpretive lens, I also interweave my own experiences with my parents and as a professional carer (in the health sector) into my observational narrative. My field observations are distinguished by indented *italic* type; my personal reflections have been set as indented quotations. My own experiences have had a profound impact on the way I perceive residential care and I acknowledge this impact. I consider that these experiences both help me to see the ruptures and challenges of residential contexts, but I can also see that my personal experiences colour my interpretations. I reconsider these factors in the implications section of Chapter 5.

The themes that emerged through the analysis of literature review and my ethnographic field study are dread, vulnerability and feeling a sense of belonging. I integrate these themes in my findings chapter through my discussion of a representative day-in-the-life in a retirement village. By doing so, my aim is to communicate how the retirement village manifests as both a place of crisis (a heterotopia) and a home.

I present my observations of my empirical material using a day-in-the-life approach because it provides a useful and engaging structure to both explain the flow of life in a retirement village and organise my discussion. When I began to consider doing this study I met with several staff and relatives to gain an understanding of contemporary retirement village life. As I engaged in the formal ethnography I realised that this structure of a day-in-the-life

narrative would enable me to illustrate my key points around the dynamics of life in a retirement village, because time is a major structuring principle of care through institutional routines, and profoundly affects the personal choices of older residents, staff and visitors. This day-in-the-life approach is not a time and motion observational process but a reflective approach to understanding how the environment impacts individuals. Also, as the spaces of the retirement village are changeable, so the day-in-the-life narrative plays a role in revealing preconceived notions, realities and differences over time by drawing attention to the intimate and fragile nature of old age and living in care.

Chapter 2: Literature Review

This chapter will cover existing research, theories and evidence relating to the notion of home and how places and spaces are interpreted when older people move into a retirement village. The literature review focuses on five main areas: Foucault's notion of heterotopia, the concept of home, nursing care and a sense of place, the concept of place, and the concept of dread, which also incorporates death anxiety. Notwithstanding the literature explored also represents the ideas and concepts from various other perspectives, this study will primarily focus on their significance to the notion of home and how older people are finding a sense of place in the retirement village environment.

The literature review will begin by providing an overview of Foucault's thinking on the notion of heterotopia and how the spaces we live in are interpreted individually, depending on how a person experiences them.

Foucault's Heterotopia

Historically, heterotopia originated from the Greek words, *heteros*, meaning 'other' and *topos*, meaning 'place', together making 'other place' (Johnson, 2006, p. 77). Like heterotopia, utopia is derived from the Greek word *ou*, meaning 'no' and *topos* meaning 'place', together making 'no place' (Levitas, 2003, p. 3). Heterotopia is also a medical term describing displaced human tissue that harmlessly co-exists in its new place (Lax, 1998).

Foucault and Miskowliec (1986) suggest that heterotopias are real places, while utopias are imagined places, with a continuum between them when the heterotopic lens or mirror is used to reflect the experience in that space. The spaces we live in are individual to the way we experience them, so a happy, well-ordered home could be described as a utopia, and a home full of misery and control could be described as a dystopia. However, the reality is that life is

not always what it appears, and each person's experience is unique, which translates into the spaces in which we live and how we experience them. The heterotopia lens or mirror illustrates the space between reality and its opposites, such as the utopia or dystopia. It creates the narrative of the mixed but joint dynamics at that time in that space (Foucault & Miskowliec, 1986). Bevilacqua (2017) supports this and explains how spaces are influenced by people's disruptive and unpredictable nature, which the heterotopian lens reveals.

Johnson (2006) also explains Foucault's heterotopia with a simple analogy of a child's imaginary game when building a blanket tent under the dining table. The game effectively produces a heterotopic space of otherness that reflects the child's home environment as a reimagined space inside the tent (Johnson, 2006, 2013; Knight, 2017). Foucault has observed several other examples of heterotopic spaces throughout different cultures and at differing junctures in life. For instance, boarding schools, holiday resorts, cruise ships, prisons, hospitals and mental institutions, museums, retirement homes and cemeteries can all be described as heterotopic places (Johnson, 2013). For this reason, Foucault's notion of heterotopia provides a heuristic way of exploring the concept of retirement village as places to call home for older people by examining the 'set of relations that divide the familiar and challenge the order of things' (Featherstone & Hepworth, 1998; Sayers & Brunton, 2018, p. 20). This is achieved by being mindful of the retirement village space itself and using the heterotopic lens to understand the dynamics of the meanings and various relationships with the places. With this in mind, Carter (2019) suggests considering the retirement village as a place of transience away from the home that belongs to no one.

Foucault illustrates several different possible heterotopic categories to consider, and these descriptive types of heterotopia are helpful when considering the context of home within a retirement village (Foucault & Miskowliec, 1986).To begin with, the 'heterotopia of crisis'

described a place for those people requiring care for ill health and fragility associated with old age. The ‘heterotopia of deviation’ illustrates a place for those people experiencing a more acute crisis like dementia. The physical place that houses objects from different times and places that are not affected by time outside of it are ‘heterotopias of time’. ‘Heterotopias of ritual’ are the places that are isolated and only accessible at a particular epoch. Finally, the ‘heterotopia of compensation’ can be explained as a real space that is either consciously or unconsciously counterbalancing ‘an-other’ place, such as the older person’s ‘room’ within the retirement village becoming home.

Therefore, when considering these heterotopic possibilities, the contemporary retirement village has emerged from the historical heterotopic places of deviation and exclusion that Foucault initially portrayed (Foucault, 1966; Foucault & Miskowliec, 1986). Retirement villages today could be described as heterotopias of ritual and crisis and compensation when contemplating the notion of Foucault’s other spaces as described. This is because the villages have an elderly population cohort, often located out of view of wider society where residents are in a type of ‘crisis’ state and a place of ‘compensation’ as the older person has moved away from their home due to failing health and disability to be cared for, so home becomes ‘an-other’ place. Of interest also is how the place becomes home to those who have crossed the threshold as a distinct rite of passage (Foucault, 1966; Foucault & Miskowliec, 1986). Consequently, heterotopia is a revealing concept with which to explore the differences, meanings and indiscernible influences of retirement villages as spaces of otherness that many of our ageing population call home in New Zealand.

Understanding how people interpret space is a significant part of grasping the idea of Foucault’s heterotopia. Human experience of space begins during childhood with the lived experiences within the home. Children have the capacity to immerse themselves in their

world while also being present in a moment in time, hence they experience time differently from the more clock-bound time rituals that govern adult rituals and routines. As children become adults, the childhood sense of time becomes inhibited and interstitial spaces blur (places of childhood play and fantasy such as the aforementioned blanket-tent) as they become regulated by the homogenous passing of time dictated via clocks and linear routines of life (Reinecke, 2015). This loss of this childhood sense of imaginative freedom can be felt keenly. Levitas (2003) suggests 'interstitial spaces' of both intellectual and physical existence are places of both happiness and hope, and so adults yearn for these liminal spaces where transition and change can occur (p. 6). So, conceivably when people step outside their everyday life perceptions and begin to experience these interstitial spaces (such as a residential home) consciously, they can feel like they are returning to childhood with the associated loss of independence. Turabian (2018) agrees and proposes that the opportunities and possibilities in these in-between moments challenge perceptions and provide a different dimension due to the complex alignment of the various powers within the space. Valuing the idea of interstitial spaces exposes the fictionally perfect utopia and the heterotopic spaces of otherness as real spaces with complex and dynamic variables that have layers of meaning that intertwine while relating to each other.

It is prudent to consider the contrasting notion of utopia to comprehend Foucault's heterotopia fully and how the two constructs are interconnected. The bases of utopian ideals are uncovered in Thomas More's 1516 book, *Utopia*. More's book portrays England as the ideal country through his worldly insights and rich text as a 'good place that is not a place and is seeking to become its opposite dystopia' (Levitas, 2003, p. 3). Also, a dystopia is defined by Levitas (2003) and (Simpson & Weiner, 1989) as a society of great oppression, suffering and injustice, whereas the utopia illustrates what is good or perhaps even perfect

and offers a fair society secure and foreseeable. However, Bauman (2003) and Foucault (1970) recognised that these utopian communities would also provide specialist spaces for the internment of those who need care, treatment or punishment. Subsequently, they are often placed out of sight from day-to-day life or somewhere on the edge of the general community.

Philosophers such as Charles Fourier (1772–1837), Pierre-Joseph Proudhon (1809–1865) and Louis Blanc (1811–1882) reasoned that a desire to produce social order was the reason to pursue the utopia paradigm, and Foucault further contributes the idea that utopias are achieved through systems of power/knowledge which justify regimes. Foucault believed that we derive our identity from the connection reached through power and knowledge (Gordon, 1980). Weber (1965) says knowledge then becomes policy or doctrines such as those shaped by religions, governments and institutions worldwide. Ethics is also associated with utopias – utopias are places which we 'should' aspire to because people live their best life in them. So, societies should be shaped on the principles of virtue, reason and discipline (Bauman, 2003). Today, utopian principles are about striving for a better, more moral, and humanitarian world. This is supported by Madigan (2008) who discusses utopia philosophy as providing the 'mirror, which examines the pros and cons of the real world we live in' (p. 4). It is possible to see these philosophical origins reflecting the rationale of the utopian ideal today.

Retirement villages show how heterotopia and utopia are intertwined. Bazin and Naccache (2016) agree heterotopia is a useful way to understand organisations because it helps researchers understand how spatial dynamics can involve 'resistance, deviation, contestation, crisis and innovation' (p. 225). Following on from this insight, thinking about retirement villages as heterotopic places means the actual space of the retirement setting can be included in an analysis of the ways that older people experience the crisis of ageing when they relocate during a time of ill-health or disability, moving away from what is familiar – their homes – to

spaces that struggle to adapt into homely spaces. Foucault and Miskowliec (1986) recognise that space has opposing forces depending on existences within that place, because people have different roles in the space. For instance, besides the older person, retirement village staff also perceive the village space as their place of employment and responsibility and providing for their financial stability (Falk et al., 2012; NBCNews, 2014). Consequently, the rest home might be a heterotopic space of crisis for an older person, but not for other people that experience the space. Another significant group that engages in the rest home is the resident's relatives. These relatives may consider the retirement village as a service extension of the medical hospital as they look for a secure place of safety that provides them peace of mind, so they can go about their daily life in the knowledge that someone is keeping an eye on Mum and Dad (Falk et al., 2012; Ludlow et al., 2020). There are different meanings of place for staff, relatives and older persons who all may have differing perceptions of the space's meaning, vis-à-vis utopia and heterotopia.

So, the heterotopic lens reveals the 'sort of mixed, joint experience' that can occur in one place (Foucault & Miskowliec, 1986, p. 24). Foucault's concept of the heterotopic mirror provides a unique way to view the disruption of space. When we look into a mirror, we see ourselves and the 'virtual space that does not exist physically' but is real (Radford et al., 2015, p. 736). The mirror reflection Johnson (2013) refers to as a utopian 'placeless place' is correspondingly real and unreal, and thus illustrates a mixed and joint experience involving the actual and the imagined (Johnson, 2013, p. 80). Foucault's heterotopic lens provides a unique way to observe relationships that both divide and challenge heterotopic and utopian space simultaneously, supporting the knowledge of the different dynamics experienced by the staff, older people and their relatives in the retirement village.

An example of the relevance of these concepts is the corporate marketing of retirement villages which promotes them as utopias (Carter, 2019). The website and brochures generally provide a vision of what a problem-free life in a retirement village looks like. Staff are pictured in resort-styled uniforms with jubilant residents in attractive spaces, surrounded by manicured, well-maintained gardens. This imagery obscures the reality of the space, which is a place of crisis – not imagined, but a real heterotopic place.

The image in *Figure 1* is a generic example of retirement village marketing. The picture depicts older people living within an alternative reality of a resort lifestyle instead of the possible home truth of struggling to cope with the fundamentals of daily life. Older people viewing these images can perceive the opportunities that symbolise no longer having to concern themselves with house or garden maintenance. Furthermore, it may appeal to the older person as it offers the option of having every need met in one place: safety, support, companionship, entertainment and transport to the local mall, all with the additional knowledge of having priority access to healthcare as and when it would be needed. This identifies how utopian imagery is constructed to influence older persons to view the retirement village as a refuge from the vulnerability of ageing alone at home (Johnson, 2013; Levitas, 2003; Peters et al., 2013).

Figure 1: Retirement Village Gardens (Shutterstock, 2020b)

The institutional reality of the inner sanctum of retirement living is the muddle of mobility walkers, frail seniors, and the visibly distracted nurses wearing a tabard with *drug round in progress; please do not disturb* along with the hidden scourge of dementia behind closed doors. These influences disrupt the utopian ideal and establish the space as unreal because to be realistic, retirement villages do not liberate people from old age (LeFebvre, 1974; Levitas, 2003; Sayers & Brunton, 2018). So, it is the desire to age in comfort and safety that produces a heterotopia of illusion as it conceivably compensates for the failure of the social realities numerous older people face. Considering the anxiety older people have when they contemplate the realities of old age, Levitas (2003) discusses how utopias disclose these uncertainties because they clash with the actual heterotopic place of illusion. The stark reality of the living room existing as a waiting room between daily activities such as meals, medication and sleep illustrates the older person's vulnerability (LeFebvre, 1974). Correspondingly, Levitas (2003) suggests that the retirement village's utopian marketing appeals to the older person's yearning for happiness because unhappiness exists.

Often out of sight on the outskirts of the community, retirement villages are heterotopic spaces that reflect a life stage (Defert, 1997). Retirement villages are often seen as one step in the progression of spaces that are waiting rooms to the graveyard because most older people enter the dependent care spaces of retirement villages at times of crisis in their life. Once a person enters residential care they surrender to the institution's rules and routines, so they no longer control time, and they must make their plans around institutional norms such as mealtimes (Miller et al., 2014; Power, 2020). When in a home one must wait for moments such as meals, bathing, medication and sleep, and further, these routines come to signify the passage of time in a day (Bazin & Naccache, 2016). Foucault and Miskowliec (1986) consider retirement villages as neither homes nor hospitals, but something in-between so that they can be anything between those two poles. Conversely, the heterotopia of compensation strives to construct an actual space by compensating for another space (Foucault & Miskowliec, 1986). The idea of a heterotopia of compensation in this context can support the notion that the retirement village attempts to merge the complexities of private–public space and communal–personal space, while also mediating the influence from the institutional governance on the space.

A significant and disruptive aspect of living in a retirement village is accessibility. Securing entry to a retirement village is not a straightforward process. The older person and their family must consider a long list of conditions, some of which are unknown, such as future health status. Concerns can include current health concerns (e.g. mobility), affordability (costs vary considerably according to the type of accommodation, the nature of the facility and what extra services might be provided), availability (whether or not there are rooms available) and proximity to family and other support such as friends. But often the move to the dependent care of the retirement village or hospital space is not a planned move and the

older person is displaced from home caught in the practical and emotional tension of the bewildering range of decisions to be made about leaving their home, things they practically needs (e.g. clothes and toiletries, walking frame), and things that give them a sense of identity (e.g. family photos, books, artwork). Choosing these personal items may seem basic, but when the room in the retirement village is limited by availability, the way the space compensates for home and is thereby comprehended is important for the older person to find a sense of belonging.

Foucault's heterotopia affords a way of understanding the phenomena of the spaces that make up a retirement village and, by considering the wide-ranging examples of heterotopias, provides a context for understanding how older people can find a sense of home as they contemplate their life in another place that is not home.

The Concept of Home

Douglas (1991, p. 287) ponders the notion of home as a combination of 'nostalgia and resistance' concluding that home is more than a place for people to live and experience their associated relationships. Therefore, Douglas says that 'home is located in space, but not necessarily a fixed space … for home starts by bringing some space under control' (p. 289). Nevertheless, literature provides various observations about what makes a home homely and how these spaces can be interpreted. Moore (2000, p. 208) considers home as a spatial metaphor for 'happiness, belonging, the process of self-fulfilment, death and the end of life's journey' (p. 208). Lustbader (2013) says home instinctively makes sense to most people as a place, but on reflection home becomes a more involved concept that is not just about place, but also about feelings of being at home. Lustbader found that when people are asked what it feels like to be at home, some people had feelings of attachment, a sense of acceptance and belonging. Lustbader (2013) identifies key factors that are needed to help people feel at home: dignity, privacy and control over their everyday life choices. Additionally, he says people need to feel they can maintain and develop relationships, and it helps if they feel needed by others.

Philosophers such as Heidegger (1889–1976) and Levinas (1905–1995) say human experience in the world is inextricably linked to our notion of home, since being at home is so central to life's course (Dekkers, 2011). Heidegger (1971) believed that 'to be a human being means to be on earth as a mortal. It means to dwell' (p. 147), and because humans are 'dwellers', they can build a house and create a home (p. 148). Levinas describes the home as more than just a shelter; home is a privileged place in which people can be themselves: 'a coming to oneself, a retreat home with oneself as in a land of refuge … not a sacred place but a u-topia which has the meaning of a "non-place" … in such a utopia the human being is pre-

eminently at home' (Dekkers, 2011; Levinas, 1971, p. 156). Levinas's writing here adds to our understanding of being at home by emphasising the relationship of home to ideas about utopia as a space for refuge and retreat from the trials of everyday life.

Maslow (1943) reasoned that home provides a base of social, physiological and psychological needs essential to fulfilling human potential. This suggestion was later supported by Werner et al. (1988) who said that the physical forms of home are expressed over time through the emotional, social and physical elements experienced by the people who live there. These authors differentiate between a place as a house and a place as a home, providing more insight into the various emotional and social acts involved in creating a home. These layers incorporate terms such as family, privacy, security, control, comfort, self-expression and identity. Consequently we can see that home has a variety of meanings associated with place, feelings and actions but that common home characteristics are security, privacy, access to family, control, self-expression, the ability to express one's identity, safety and refuge. All these experiences and feelings are important when thinking about home and what it means for older people who are moving into rest homes, and those that create the spaces so that their residents can feel at home in a meaningful way (Despres, 1991; Sixsmith, 1986; Werner et al., 1988).

It is important to appreciate the unique fragilities of the older person who is thinking about moving from their own home and into a residential care setting. Much of their previous experience in their own home is unconscious and often unexpressed, as experience is intimate with a place that one knows as one knows oneself, so intimate home routines are designed to fit that space. So, when a person's life journey faces change, due to disruption such as ill-health, they experience a greater awareness of their immediate environment and the potential freedoms that might or might not be available in a new environment designed specifically for

people in their life stage with their particular needs. So, for instance, features as small as a step, the height of a sink, or access to one's own bathroom and toilet, can make a huge impact on the ways that choices are made. Research has shown that older people should be involved in the decision-making around their move if possible and not relinquish moving decisions to a relative. Older persons should engage in 'managing their relocation' (Brown & Perkins, 1992; Manzo, 2014; Merleau-Ponty, 1962, p. 290). Carboni (1990) agrees and emphasises that when considering moving, a person's life experiences and feelings should be a vital part of the process, particularly if the move is medically advised due to health and mobility concerns that require full-time care.

However, it must be acknowledged that home is not necessarily a uniformly positive concept. Some people see home as a place of conflict that holds painful memories. Marcus (1995) established the notions of 'home as a haven' and 'home as a trap' as contrasting metaphors to help explain the dichotomous feelings people might have about home. Attachment to home as a place is developed during childhood. Childhood experiences of home can be influenced by the dynamic dichotomy of negative and positive influences. External influences, say for example a divorce or abuse, can create 'a shadow side' that involves exclusion, doubt and dread (Chawla, 1992, p. 66). Consequently, personal experiences of home and feelings of belonging and not belonging, certainty and uncertainty, and confidence and lack of confidence, are all factors to consider while exploring how retirement villages, as a heterotropia, engender a feeling of home.

Maslow (1943) conveys that when home meets our physiological and psychological needs, we feel safe. The feelings of belonging and security during childhood create an internal balance that supports our ability to cope in difficult circumstances that threaten these particular basic needs (Cook et al., 2015; James et al., 2014). Likewise, Giddens (1991)

argues that when we feel that people and structures are trustworthy, we feel ontological security. This emotional security can be derived from the habits, way of life and routines that we establish to create order in our lives (James et al., 2014). Many older people live at home with their personalised routines and daily habits being either challenged or failing, for example with not being able to cook anymore, or losing a partner and thus one's social resilience, thus threatening their security both physically and emotionally (DeWitt et al., 2009). Therefore, moving into residential care may well provide them with the security and support they need, a safe place to live with others with mutual needs (Cook et al., 2015). However, Cook et al. (2015) and James et al. (2014) both highlight that this requires institutional care to ensure care is person-centred with choice, privacy and dignity which matches the older person's individual home life experiences.

Nursing Care and a Sense of Place

Retirement village residents who need nursing care have a range of requirements, from having meals prepared and cleanliness through to full hospital care. There is a considerable amount of research on nursing and elder care which has focused on how care practices can assist in the creation of a sense of place for recipients of care. Many of these studies use Foucault's notion of *épistémè* which he defines as knowledge altered by the unseen governing principles that control a place or time (Foucault, 1970). Understanding this concept uncovers the unconscious knowledge and unspoken rules that characterise the discipline of nursing care and institutional governance in the healthcare environment. According to Clinton and Springer (2016) Foucault's *épistémè* concept is valuable in understanding how time and place are enacted by care-givers in their relations with their patients. The notion of patience is especially important. Patience is important as it allows for more interaction, which then acknowledges an understanding of the older person's individual practical and emotional

needs. Moudatsou et al. (2020) found that the time carers devote to the older person allows empathy to develop and builds a relationship based on trust and respect.

Foucault's concept of *épistémè* provides a way of understanding the politics of caring in institutions like the retirement village. For instance, Clinton and Springer (2016, p. 129) argue that the discipline of nursing as a practice is full of unconscious knowledge and unspoken rules that are negotiated within healthcare institutions, and by studying the tensions in everyday nursing activity it is possible to understand more about the effects of power through examining 'discourses, practices and institutional structures' that structure what nurses know and their practices of care.

Historically, caring for older people was viewed as a domestic role carried out within homes by family (Swarbrick, 2018). In contemporary societies, practices of elder-care have cultural dimensions and so vary between cultures and regions (Barker, 1995). In the European context, during the seventeenth and eighteenth centuries, British poor houses and workhouses accommodated elderly people needing care when they could no longer work, had no income and became a financial burden on their family. The workhouse model resulted in poor conditions and quality of life for generations of older people due to the severe poverty associated with workhouses (Richardson, 2013; Robertson, 2019). The establishment of the British Ministry of Health in 1919, followed by the National Health Service (NHS) in 1948, challenged the institutional concept of the poor and infirm having no choices and started to improve state services for older people. Social housing was built for poor families, and workhouses morphed into infirmaries for the old and unwell as the policies of that era viewed ageing as a problem that adversely influenced older people's care options (Robertson, 2019).

New Zealand aged care institutional options have been influenced by the British model for older people needing care. NZ aged care models of the late 1800s were influenced by the large cohort of single immigrant men who arrived looking for work in the goldfields. When these men reached old age and could no longer work or be cared for by family, it fell to benevolent institutions such as churches, charities, hospitals and even asylums to provide the care, much like the grim British workhouses (Swarbrick, 2018). However, the New Zealand Health Act (1920) progressed aged care by introducing sweeping health and care reforms following the 1918 influenza pandemic. By the 1920s, charity and veteran homes such as the 'Ranfurly Home' were established as a recompense for their military service. Following the Second World War further church-run and private homes had also intervened, providing basic and accessible care for those who had no alternatives (Swarbrick, 2018). However, it needs to be recognised that Māori have a long-established cultural continuum of whānau caring for their kaumatua (Allport et al., 2018), although urban living is now impacting the long-term options as few Māori live interdependently with their hapu or the marae community. Consequently, more Māori are now considering institutional options, in smaller community facilities in older age (Allport et al., 2018, p. 40).

The New Zealand aged care landscape had grown significantly by the 1970s, with the highest proportion of older people in the developed world residing in residential care (Williams, 2017). This model of care perpetuates the problem-centred approach to caring for older people which had manifested due to the 1800s British model and the development of attitudes and policies that older people are a burden on the family and the economy (Robertson, 2019). This historical attitude of ageism impacts people today as they are living longer than at any other time in human history, which results from the progress of individual and family-centred wellness health initiatives today. The Ministry of Social Development (2019a) 'Better Later

Life' report articulates how negative attitudes and unconscious ageism continues, and uncovers how older people often feel marginalised with inadequate access to appropriate housing, services and transport contributing to feelings of isolation and existential vulnerability.

By the 1980s the notion of 'care in place' at home and in the community became the dominant practice and attracted Government-funded support. This focus continues today (Carolan et al., 2006). Care in place encourages the elderly to remain in their homes with practical assistance such as meals on wheels, practical help for household tasks such as cleaning and gardening and access to physical aids such as walking frames, bathing chairs and grab rails. However, while this model of care has supported ageing in place for many years, studies from van der Meide et al. (2014) and Williams (2017) discuss how the care available does not meet the health issues of vulnerable, weak and frail people over 80, who often need institutional care so that they can be safe and have some quality of life.

Health carers in the aged care sector include nurses, healthcare assistants and support staff, such as physiotherapists, occupational therapists, fluids assistants and activity coordinators. They are employed to care for and support older people 'with living; eating, drinking, standing, sitting, walking, talking, laughing, socialising, keeping clean and comfortable, administering prescribed medications, and enjoying their life' (Sayers & Brunton, 2018, p. 18). In 2018 New Zealand employed 22,000 health assistants and 5,000 qualified nurses working in the residential care sector. The residential carers are primarily female – about 91%, and over 50% are mature women aged 45–64 working part-time. Furthermore, less than 5% are qualified nurses, and less than 25% have formal aged care training (Ministry of Health, 2015). In such a labour-intensive environment, the unqualified carer to qualified

nursing ratio reflects the financial burden that paid healthcare staff has on aged care business management, resulting in the desire to keep that human cost as low as possible.

The Human Rights Commission (2012) Caring Counts Report, challenges that business strategy, stating that aged care requires increasing healthcare skills to meet a growing and ageing population's complex needs. This is further complicated by the reluctance of New Zealand-trained nurses and carers to work in retirement villages due to the low remuneration packages. In response, staff are recruited offshore from countries such as the Philippines and India. It is essential to acknowledge that these immigrant workers also face personal challenges while adjusting to the New Zealand healthcare employment systems and the accompanying bi-cultural heritage (Cookson, 2017; Gao et al., 2015; Sayers & Brunton, 2018). COVID-19 has further impacted this with the dislocation of staff from their families shut out of New Zealand through border closures.

The notion of ageing as a problem has been perpetuated since the nineteenth-century health reforms, resulting in the lingering mindset that aged care work is low-value (Sayers & Brunton, 2018). Hence, older people's care in retirement villages is considered unimportant as the work is essentially invisible, tucked away in purpose-built places on the peripheries of the community (Wolkowitz, 2002). This has led to a pay disparity of approximately $5 per hour between nurses employed in hospitals compared to those looking after our old and vulnerable in the aged care sector (Guildford, 2020; Wallace, 2019). In contrast, health carers working in hospitals and allied community services have changed their social standing. Over time, this has emerged from the original stigma of nurses as merely the doctors' 'eyes and ears' of the Victorian era to today's hospital nurses who are publicly valued and considered the caring profession's backbone. Nurses achieved this by becoming professionally educated and maintaining ongoing professional development. Therefore, the nurse–patient relationship

is progressively enhanced by implementing holistic healthcare as the patients' navigator within the political realm of institutionalised healthcare (Carolan et al., 2006; Clinton & Springer, 2016). The notion of the role of carers as a navigator is defined by Gerber (2018) as the patient's advocate providing a link to the healthcare systems, so they receive the most constructive treatment and care while safeguarding their autonomy, during which they also contribute to the decision-making process with family members when necessary.

Concept of Place

People have a need to understand their relationship with place as they are rooted in a physical context (Manzo & Perkins, 2006). Place is commonly associated with cities and geographical sites, less so with a favourite window-seat in a room at home (Creswell, 2004). Place provides a way of understanding the world through the connections and attachments they have in a particular place. This section looks at how place is discussed in health and nursing geography literature and how the institutional governance and practices of caring disrupt the sense of belonging. Foucault's lens of 'ruptured thinking' helps free us from preconceived ideas about old age and retirement village living as ideal.

Literature on the significance of place often refers to the concept of 'situatedness', or being in place, when it discusses the significance of place for both health carers and the individuals receiving care. Because situatedness is related to geography there is an area of nursing geography literature of relevance to this thesis.

Since the Victorian era of Florence Nightingale, nursing has been seen as a profession. With the advent of nursing schools and university programmes in nursing, nursing has become a discipline of study in its own right, with one key associated discipline being nursing geography (Nightingale, 1859).

Peter (2002) drew on both health and nursing geography literature to consider the implications of the human experience of institutional places to provide further understanding of the factors that impact the sense of place. Consequently, offering insights into workplace influences, healthcare culture, institutional policies and practices can disrupt the feeling of a safe and caring place for older people to live (Andrews, 2016; Carolan et al., 2006; Foucault, 1994). Understanding the influences of the power a place has, particularly in the health environment, can help carers be mindful of the older person's sense of belonging.

By exploring beyond the cultural norms of nursing care when experiencing a life-course crisis and making 'visible the social norms that control our bodies and minds' (Clinton & Springer, 2016, p. 121; Gordon, 1980), Foucault's insights can be adopted to examine the obvious and observable with a 'contrarian way of thinking' (Clinton & Springer, 2016, p. 121; Foucault, 1994). Thus, supporting Foucault, that power, however it is created, influences *épistémè*, such as personal, institutional, hidden, unconscious and gendered power-knowledge. Additionally, Foucault considers the notion of human nature as an epistemological marker, as we are influenced by society and governmentality constrained by our unique imperfections and the opportunities in the culture in which we reside (Wilkin, 1999). Hence, the power-knowledge construct suggests that we should be attentive to the influence human nature has on our way of thinking.

There is a thought-provoking counter-narrative to the critical concept of Foucault's *épistémè,* which has been proposed by Beedholm et al. (2014, p. 105), what he calls 'ruptured thought'. He argues for the significance of the idea of ruptured thought and suggests we look for what can be seen while disregarding any preconceived or biased ideas. For example, the 'unconscious knowledge within the *épistémè* of the institutional governance of nursing's geography, such as unspoken rules that creates predetermined care' (Clinton & Springer,

2016, p. 123). This means that adopting ruptured thinking facilitates the ability to interpret the caring environment from a fresh perspective that can reveal changes, differences and similarities for both carers and older people.

The reality of care in many retirement villages is that health carers work in the shadow of institutional *épistémè*, so that personal care is scheduled for 5–10 minutes each morning and is considered sufficient and compassionate (Egan, 2018). Considering that during that 5–10-minute time frame, the carer is responsible for assisting the frail older person out of bed, into the bathroom, toileting, showering, drying and applying appropriate lotions. They then find and select clothing, support the dressing process and walk or help them into the dining room for breakfast (Egan, 2018). The time frame is unforgiving considering the cognitive and physical complexities many older people live with and that they entrust their care to the compassion of skilled strangers (Egan, 2018; Johnson, 2006; Twigg et al., 2011). Consequentially, the 5–10 minute time frame can result in feelings of vulnerability for both the older person and the carer, particularly when multiple needs require patience and care for more than the allotted 5–10 minutes. Hov et al. (2009) found that the carers experienced conflicting feelings due to the high level of responsibility for the care they delivered. With no formal institutional power to act appropriately for the residents, an environment is created where care indecisively seesaws either side of the individual power dynamics between carer and resident, thereby leaving the health carers frustrated and professionally vulnerable (Stenbock-Hult & Sarvimaki, 2011). This can result in health carers being at risk of violating their professional boundaries and trusted relationship by abusing the older person physically or mentally, thus accentuating the vulnerable nature of aged care. In contrast, as discussed, the power dynamic from the older person perspective may result in damage to the relationship of trust and respect by subjecting their carers to sexism or racism that can be

associated with the subservient historical nature of the caring role (Twigg et al., 2011; Wolkowitz, 2011). Stenbock-Hult and Sarvimaki (2011) found the existential vulnerability paradox was essential to nursing practice enabling the carers to become attuned to their patients' needs creating a bond between them.

Given the historical developments for nursing and health carers over the last 100 years, the situatedness of healthcare may negatively impact health and care depending on where the person is living (Carolan et al., 2006, p. 203; Robertson, 2019). Individuals are socialised over time to become attached to others and places, making us vulnerable, and having no place of care may well be considered harmful to an older person's health (Ekman et al., 2001). Furthermore, Purkis (1996) suggested that the healthcare landscape is influenced by the sense of self of both healthcare staff and patients. Nurses as 'caring angels' is a taken-for-granted metaphor; however, Purkis (1996) has identified that nurses' sense of agency is motivated by choosing to be either respectful or neglectful of their patient. For example, a nurse's workload and patient care level can change the relationship, especially if the support from colleagues and management is poor. As a result, the nurse–patient relationship is modified by how nurses manage their feelings and actions. So, health carers who understand this as a vulnerability to their ethics can articulate their needs when they feel exposed. In contrast, the older person's care can be intimate, which engenders exposure as it incorporates touch due to the support needed with daily bodily function and mobility (Roxberg et al., 2020; Sayers & Brunton, 2018, p. 18). Subsequently, making the health carer's role distinct from the simple rudiments of personal care is imperative. They also need to be mindful of the complexities of the 'place' and protect the older person's dignity and vulnerability when their sense of being is challenged. Furthermore, Liaschenko (1994) revealed that the resolve of many older people to make a new home is challenged by the intrusion of technological paraphernalia. Twigg et

al. (2011, p. 6) highlight that aged care requires both the carer and older person to be in the same place simultaneously, therefore making the 'time and place of the personal care relatively inflexible' and causing older people to feel disempowered by their lack of control at home, including who is in their place of belonging, which impacts their personal agency and choices. Consequentially, the notion of home as a haven has changed when they are looking for a sense of belonging in care.

The Concept of Dread

The concept of dread offers an insight into the angst (in existential thinking) associated with old age, the accompanying conflict created by a loss of independence and the probability of needing to leave the family home. An inevitable part of the human life cycle is growing old, and New Zealanders are living longer (Broad et al., 2015; Ministry of Health, 2019). During the ageing process, older people learn to navigate the multitude of aches, pains and disorders while coming to terms with losing their youthfulness, friends, life partners and eventually their independence (Featherstone & Hepworth, 1998; Harvie, 2011). This foreseeable dependence on others in old age, in conjunction with facing their mortality, fills many people with a deep-seated dread.

Stone (2017) examined Kierkegaard, one of the earliest existential philosophers, and his notion of dread that revealed an involved and intellectual philosophy far deeper than anxiety and fear. Stone (2017, p. 1) revealed that Lowrie (1957) translated the word '*angst* in the title into *dread* in the translation of Kierkegaard's *The Concept of Dread*' from Danish to English.

Dread is not fear or anxiety as they are connected to situational problems such as the panic of finding a spider and the associated anxiety with its removal. Sullivan (1953) describes dread as a 'shuddery, not of this world component, a curious survival from a very emotional

experience' (Stone, 2017, p. 1), which supports Kierkegaard's depiction of the 'ominous foreboding that entangles the individual thus preventing progress in any activity' (Stone, 2017, p. 2). Dread is a constant apprehension concerning the future, often resulting in feelings of hopelessness and isolation.

Kierkegaard understands dread in two forms, as the sense of dread is a life course developmental process that begins in childhood. Primarily, dread is experienced in its 'lofty form' and distinguished by children fearlessly pursuing adventures and innocently exploring the unknown mysteries of their world without knowledge of any consequences, therefore enabling them to experience 'absolute freedom' (Kierkegaard, 1957; Stone, 2017). However, with each life experience, children begin to understand the implications of various escapades such as getting wet and dirty, falling, breaking bones and feeling disappointed. Subsequently, we learn to recognise the consequences and make knowledgeable decisions according to the varying risks or outcomes. Stone (2017, p. 7) explains Kierkegaard's second form of dread as 'total dread' causing the person to 'encapsulate themselves in shut-upness as a means of avoiding the awesomeness' of absolute freedom. As a result, the person is endlessly fearful of the future, dreading the unknown due to a fear of failure or an inability to explore new territories. Kierkegaard believes that recognising and confronting dread, despite future unknowns, is an important developmental journey that supports the freedom of choice. Thus, dread provides an illustration of conscious and unconscious human emotions and processes that are interconnected.

Humans have the unique ability to introspectively examine their existence in the world. Heidegger (1889–1976) considered the concept of dread within the phenomenology of human existence and the fundamental structures or 'existentials' that form our 'being-in-the-world' (Grimsley, 1956, p. 248). Furthermore, Heidegger explains that when people comprehend

their full potential, they can recognise the ‘sense of being there’; however, this includes the burden of understanding that humans only exist until they die.

Grimsley (1956) explains how existentials that form our being are manifested via primary ‘moods’ systemic to our existence, with one mood – dread – vital to our sense of being present. Additionally, like Kierkegaard, Heidegger distinctly separates fear from dread, stating that dread is not a response to an entity in the world, ‘dread is nothing’ (p. 249). This ‘nothing’ relates to the dread that exposes how ultimately humans are present until death occurs. Marino (2012) supports this as he believes that beyond dread there is nothing other than the experience of being, therefore we are compelled to face our mortality.

Sartre (1905–1980) supports Heidegger’s understanding of dread as ontologically associated with being and the dread of nothing. However, Sartre’s notion of ‘nothingness’ means the conscious self has an experience of reality with the ability to recreate itself through the freedom to choose, therefore revealing the unconscious self (Grimsley, 1956). To know existence in the world is to be defined by what you do and to be aware of who you are.

The Dread of Death

Old age fosters curiosity of existential moods, in particular freedom, isolation, meaninglessness and death. While young, people encounter various existential themes that influence the adult years, such as reasoning, making moral decisions and being authentic (Vitemb, 2018). Older people reflect on these past experiences that have shaped their being. Lurie (2006) explains how one’s approach to life shapes how we then give it meaning, for example, constant future apprehension, thankfulness, optimism or dread of death. Also, this impacts how we choose to enrich our lives with travel, family, friendships and work, which all influence our life experiences and bring meaning. Therefore, as people age, these feelings

and experiences influence how we manage the choices that lie ahead, losing friends, health problems, relocating from home and coping with being alone.

Hoffman (1998) says Freud insisted that death has ‘no representation in the unconscious’ and is therefore inaccessible, unimaginable and unreal (p. 36). However, we do have death anxiety which Peters et al. (2013) describe as ‘a negative emotional reaction provoked by the anticipation of a state in which the self does not exist’ (p. 14). This suggests that when humans consider their own death they are powerless to imagine the idea of it, as it has no perceptible reality in the mind, and so the feeling of dread is manifested because we can only imagine nothingness.

In the aged care environment, the feeling of existential dread will be experienced by residents, their relatives and staff. The level of dread experienced by each person would depend on their age, mindset and life experience. Individual attitudes to death are shaped by their conscious and unconscious past and present behaviours, core values, personality and a person’s unique culture. Also, a nurse or carer’s level of death anxiety is associated with their training, ability to communicate effectively and the extent of their exposure to care associated with older people that have died or are dying.

This literature review has introduced selected key concepts needed to understand this thesis and answer my research question: *How can a retirement village as a place of crisis become home?* I now turn to explaining how I answer this research question in the next chapter on research design.

Chapter 3: Research Design

This research design chapter details the research process, the study scope and methodology. The rationale for selecting an ethnographic research method is discussed, also the observations process and ethical principles underpinning the fieldwork. Details about the study information resources are given. Also discussed are the challenges of the informed consent procedure resulting in a participant-observation only ethnography, and how the study was impacted by COVID-19 in 2020 at the end of my fieldwork which restricted follow-up questions. The analysis process involved an iterative process, where I tracked back and forth between my observations, lens and literature to produce a rich day-in-the-life narrative. The analysis revealed three significant themes relevant to older people in the retirement village: dread, vulnerability (residents and staff) and a sense of place and belonging. The rationale was to write the ethnography as a narrative with a day-in-the-life structure to depict the day-to-day dynamics within the retirement village as a home for older people.

Design, Methodology and Materials

During a review of this study's literature and scope, I became mindful of the distinctive place retirement villages have in the New Zealand culture of aged care in our communities. When older people move from their home to live 'with care' in a retirement village, the dynamics of the place impact how older people find a sense of belonging. The principles of ethnography research provided a robust way of observing and understanding how retirement villages, as places of crisis, become home for the growing number of older people in New Zealand.

The study's scope is primarily concerned with observing the everyday dynamics and the connotations created within the various spaces of the retirement village. The observation

process also encompasses observing the business' cultural influences, management and administration team, healthcare staff, ancillary staff, residents and their family and visitors. I developed specific documentation that included participant information with a clear description of the study, its purpose, and the potential benefits to the residential aged care sector. The information documents also contained details about an individual's participation via interview and the time the interview would take, should that be appropriate. I also displayed details or left flyers of the research on notice boards or coffee tables within the retirement village reception, library, hospital and rest home spaces. These information resources had frequently asked questions with details of any costs, individual rights, how to communicate any questions or concerns and the contact details of myself and my university thesis supervisors. The developed documentation included a detailed consent form to ensure an informed consent process was in place and followed for any participant interviews. These resources are available in the Appendices.

In this thesis, I assure confidentiality of the retirement village and the residents and other participants in the following ways. I provide only generic information about the retirement village to ensure the organisation's anonymity. I took care to ensure all personal names of any individuals I observed during the study are either non-specific or the individual has been given an alias to protect their privacy and anonymity and ensure confidentiality. Despite the research setting being relatively public, I was constantly aware that I could not effectively obtain informed consent from every person I observed or talked to informally. Therefore, I was consistently cautious and careful about confidentiality to minimise any ethical compromise (Watts, 2011). Furthermore, I made sure I introduced myself and informally asked for permission to join any gathering or group, such as bingo or the knitting club. If a resident sat next to me, curious to see what I was doing, I would always explain that I was observing the space and studying how space was used differently from a family home. We

would most of the time chat about the weather, Christmas, village activities and what was on the menu at the next mealtime. I am therefore confident that staff and residents were aware of my study and the reason for being in the retirement village. I was very visible and could frequently be seen writing my field notes in the gardens, library or the community lounge area with a cup of tea; I would always offer details to anyone asking what I was writing about (Goodwin et al., 2003). Being mindful and reflexive throughout the research process while thinking ethically in a context-sensitive situation informed my decision-making process and conduct as a researcher (Cassell et al., 2009).

In order to understand and interpret spaces within the retirement village via Foucault's heterotopic lens, an ethnography is the most appropriate method to view behaviours, reflexive norms and their significance when studying the environment as a home for older people living there.

Freeman (2014) expresses how qualitative research makes way for a more intimate and suitable understanding of the real-life phenomena under observation. Furthermore, Marcus and Fischer (1986, p. 18) support this by stating that ethnography is a 'research process in which the anthropologist closely observes, records and engages in another culture's daily life "an experience labelled fieldwork" and then writes the account of this culture, emphasising descriptive detail.' Consequently, the ethnographic approach allowed for engagement in and observation of the multiple spaces within a retirement village; the practices, formalities and customs that occurred, whether it was the staff practices or experiences of the residents and their families. Consequently, this provided the opportunity to develop an awareness of how various spaces are deciphered, lived in or endured from each perspective.

Gathering knowledge using observation and listening skills in these personal and shared spaces enabled a critical exploration of the place (Hammersley & Atkinson, 2007; Mitra,

2010; Rosen, 1991). Alasuutari (1998) expresses that ethnography aims to ‘explore and make visible the taken for granted rules of interpretation that people use in their everyday life as well as the collectively shared assumptions on the basis of which we make sense of different interaction situations’ (p. 67). Therefore, by seeing beyond the said or seen may provide further conscious insight. Hence, illustrating the changeable and consistent facets of human behaviour and encounters such as hidden agendas, power dynamics and personal assumptions (Bland, 2003; Cameron, 1990). Geertz (1994) validates this by maintaining that ‘doing ethnography is more than just establishing rapport, selecting informants and transcribing text’ (p. 214). Ethnography also provides a methodology that illustrates how tacit knowledge is discoverable when an in-depth understanding of culture and human behaviour is undertaken; therefore, ‘we know more than we can tell’ (Kane et al., 2006; Polanyi, 1966, p. 18). For this reason, the ethnographic methodology substantiates the reliability of the study for the reader and consequently, the validity of the interpretations and any conclusions drawn from both the theoretical understanding and field note narrative.

Choosing the ethnographic methodology is validated by a knowledge gap in the aged care sector. Keeling (1999) confirms a shortfall of ethnography studies of older people within specific communities such as retirement villages. Therefore, employing the ethnographic methodological approach to study residential care villages, as other spaces, in New Zealand can contribute to policy and practice in the aged care sector. I hope that this study will add to a relevant body of research to support our elderly population in the future. Observation of the various places all over the village that hold relevance to a home from home allowed me to explore the customs, paraphernalia and moods in these spaces. Therefore, artefacts in the retirement village were vital to understanding the nature of various spaces (Madden, 2019). As a result, I sought to gather relevant knowledge from any retirement village documents

including marketing materials and other artefacts such as annual reports, social media items, press releases and website details that were freely available to the public.

Having the autonomy to choose when engaging during the field study was also important when dealing with vulnerable residents. Also, being physically present at different times of the day and on different days of the week was key to comprehending the broad picture of 'living in place' (Geertz, 1994). This facilitated my ability to move away from the field, either at the university library or home office, and afford a reflexivity to the research process and reflect on the empirical data and update learning as necessary. The reflexive process allowed me to make detailed and rigorous field notes during the fieldwork stage of the study and, as a result, provide me with thick, rich descriptions of what I was seeing and hearing in each space within the retirement village.

Ethics

The ethics approval process was rigorous due to the vulnerability of older people living in the retirement village where I carried out the fieldwork. Before commencing any fieldwork, I obtained ethical approval from the Massey University Human Ethics Northern Committee for the study; a copy of the Ethics Committee approval letter can be found in the Appendices.

A major method I employed was participant observation, which is a common method used by ethnographers to blend into an environment and undertake naturalistic and unobtrusive observations. The question of informed consent was a challenge requiring careful management throughout the study due to the many potential participants living and working within a large and diverse environment. Besides the logistics of gaining informed consent from hundreds of residents, relatives and village staff, I became concerned early in the observation process with the problem of recognising the older residents' cognitive status.

I identified that anyone with dementia would not be included in the study. I did not enter the dementia care space or observe their direct care due to the residents' vulnerability. I consider these people would be unable to fully comprehend my role as a researcher and would not be able to provide informed consent. If necessary, residents with dementia I did observe (they might be walking around the grounds for instance) would be identified in discussion with the appropriate qualified medical staff and excluded from records of observation and analysis.

I accepted that gaining informed consent from everyone I might possibly observe would not be manageable. Furthermore, I was aware of the distress that could occur if I provided repeated explanations of the research being about 'home' and relocation to the retirement village. However, having institutional consent to research as a participant-observer supported the ethical requirements. A copy of the organisation's letter of consent to research can be found in the Appendices. I also conducted participant interviews. Written consent was gained from individuals I talked directly with.

The COVID-19 pandemic reached New Zealand in February 2020, and it became necessary for me to conclude my fieldwork early. My personal life was also affected and we had no income other than the government subsidy for both lockdowns. I needed to stop studying and working. I discussed the impact of COVID-19 with my supervisors and requested an extension to complete my thesis. My supervisors and Massey University were supportive of my personal situation, and an extension was approved.

The Research Setting and Participants

I was granted permission to complete an ethnographic field study from November 2019 to March 2020. The Village Manager supported this study's ethos and was pragmatic about the benefit to the aged care community and sensitive to gaining insight into the ways of living

within the retirement village. Furthermore, the Village Manager understood the ethical rigour overseen and applied by Massey University.

The village includes several alternative dwelling spaces for residing.

- Independent living in apartments and townhouses
- Assisted living apartments
- Rest home care
- Hospital-level care
- Specialist secure dementia care

Furthermore, many retirement villages have access to several additional amenities as laid out in *Figure 2*.

Village amentities	Independent Residents	Hospital/ Rest Home residents
Reception	✓	✓
Caretaker/ Gardener	✓	✓
Gardens	✓	✓
Parking	✓	✓
Entertainment	✓	✓
Chapel	✓	✓
Hairdresser	✓	✓
Library	✓	x
Indoor Pool	✓	x
Gymnasium	✓	x
Movie Room	✓	x
Dining Room	✓	x
Bar/ Pool table	✓	x
BBQ/ Patio	✓	x
Bowls/ Croquet	✓	x

Figure 2: Retirement Village Amenities

There are over 135 funded rest home and hospital-level care beds, including dementia care, in this village with a MOH caregiver staff ratio of 3:50. The village apartments and houses are owned and inhabited by independent residents.

Between November 2019 and February 2020, I undertook 155 hours of fieldwork during a 10-week period located at a large retirement village in New Zealand. This fieldwork was completed part-time, during the Massey University summer break. This provided the opportunity to observe the village during the summertime and in the lead-up to the festive periods of Christmas and New Year, followed by the Waitangi Day commemoration and Valentine's Day celebrations, enhancing the data collection.

I had an understanding of nursing and the care older people need, and I volunteered to provide additional support by helping residents when having a drink or eating their meals. However, while I participated in various activities with the residents or staff, I continually considered the observation process' integrity as a participant-observer (Bland, 2003; Svensson, 2016). Having prolonged participation in the study environment is vital for the researcher to fully understand the ethos and behaviours present (Bland, 2003; Punch, 1993). I was aware that becoming as 'familiar as a piece of furniture' and integrating into the natural environment as a participant-observer should occur during a 'continuum of otherness between how the researcher and researched' is conceived and managed (Punch, 1993, p. 190; Ramazanoglu & Holland, 2002; Watts, 2011). This explains how limitations can be identified and processed ethically, which ensures a robust and natural observation method.

I planned fieldwork visits to be approximately 4 hours in duration, at different times of the day between 7 am and 7 pm, on weekdays and weekends. The purpose of this schedule was to afford observation of the various spaces and systems of the organisation during waking hours, while also being available to help with mealtimes when appropriate. Nevertheless, I was aware that participant observation and the nature of the researcher's engagement can be challenging, as Morse and Field (1995) noted, saying that volunteering and 'pitching in'

make it awkward to observe the environment. However, in contrast, sitting, having a coffee and watching the spatial dynamics may be seen as ‘doing nothing’ (p. 189).

Early in the participant observation, I was conscious that I engaged differently within the various spaces of the village. While helping those residents who needed support with feeding, my nurturing nursing instincts returned. However, when I was in the communal living spaces, I reverted to the student visitor while observing the place. Furthermore, I became aware that I donned my executive hat when talking to the Village Manager. Therefore, being aware of these personal characteristics was an essential part of the naturalistic observation process. It allowed the development of trusting relationships, which (Oswald et al., 2014) explain as mitigating the Hawthorne Effect phenomena when people change their behaviour while being observed. As a result, any guarded behaviour disappeared from the village community as I became a familiar face and a regular guest, which I believe relaxed any sensitivity towards being studied. Overall, the staff, residents and relatives were inquisitive and voiced their appreciation of seeing someone interested in exploring the meaning of home in aged care. Hence, allowing for an understanding of how people unconsciously inhabit spaces, and consequently, meaningful data could be collected. The following extracts from my field notes highlight these observations.

> *My presence in the village does not seem to be an issue. I seem to blend into the day to day scenery. Could I be a relative? Staff? My note scribbling from time to time gets a glance or a visit and chat as some take an interest. Perhaps my mature age helps me blend in.*

And, after a Christmas break.

> *I am pleased to see many familiar faces and find I feel more at ease in the surroundings than I did before Christmas. I know what to expect now, the familiarity*

> *of the routines, and knowing where the coffee and tea are, comforting me while studying the environment. A sense of feeling at home.*

Being in the research environment as a participant-observer, I was able to decipher the environment and become aware of the intimate moments of the residents, which highlighted the real-time life experiences that become the essence of their mental, physical and emotional identity inside the retirement village. Additionally, as a carer for my mother through her residential care journey, with a health professional background and decision-making capability in the not-for-profit social sector, I drew on my personal and professional experiences and knowledge. Thereby supporting the academic theory and ethnographic methodology to understand the meaning of home in the caring environment of the retirement village. Moreover, numerous people do not get to see inside an aged care facility until they or a relative needs the caring, sheltered environment and cannot fully understand that residential care is lived experience.

During the study, I was conscious of building rapport with the residents and staff, as they participated in the study, and gained their trust while observing the spaces within the retirement village. As the researcher, I was also experiencing the spaces and understanding the shared experience and employing the philosophical heterotopic lens to understand the distinctive spatial dynamics, particularly that of crisis and otherness (Bazin & Naccache, 2016; Rashid et al., 2015). I found I could see things I would not have otherwise been aware of, or noticed, by employing an open and reflexive approach throughout the observation period. Therefore, I determined that participant observation and time spent in the field were of greater importance than my search for interview participants, as Goffman (1961) and Hammersley and Atkinson (2007) corroborate. The rich descriptive journal field notes and observations highlighted that the questions I had initially prepared for interviews with

participants would not be helpful to the question: *How can a retirement village as a place of crisis become home?*

As previously discussed, the complex process of obtaining informed consent from the various residents, while determining a resident's ability to understand cognitively, was a challenge when considering interviews as a data collection method. The need to explain the heterotopic lens to understand how space is interpreted by those working, living or visiting the village was difficult for many people to grasp. However, I did not consider any data I would potentially collect from participant interviews would be worthless. Nevertheless, I was aware that collecting from just one or two of the trio of stakeholders (staff, residents and relatives) would become an unbalanced data. Furthermore, I was keenly aware that my decision not to include interviews could be viewed as bias, misleading or stereotyping all older people as cognitively fragile (Hammersley & Atkinson, 2007). The final decision not to include interviews as a data capture method was consequently made by the COVID-19 virus, which curtailed my ethnographic field study. The COVID-19 virus prevented me from returning to the retirement village and carrying out follow-up discussions, observations or participant interviews. Furthermore, on reflection, I consider that the impact the COVID-19 virus had in the retirement village sector has also significantly changed the dynamics and perception of home and retirement village spaces in both the short term and long term. During the initial lockdown phase of the COVID-19 outbreak in New Zealand the retirement village and aged care sector were required to place the caring environment into a high level of quarantine, isolating the residents from their families and the community. Also, the use of infection control measures such as limited movement around the facility, accessibility to activities and the use of personal protection masks, worn by the carers and staff, will all have accentuated the resident's vulnerability and institutional sense of surveillance. Thereby creating the paradox of the vulnerability of community segregation, but a feeling of protection.

Ethnographic Analysis

The analysis of evidence began unconsciously through the evolution and investigation of the concept of home for older people in retirement villages and the social context of Foucault's notion of heterotopic spaces. As the research process developed, I began to look through the heterotopic lens of 'otherness' while continuing to read and understand the significance of the alternative orders in these spaces (Foucault & Miskowliec, 1986) resulting in the correlation of data collection and analysis concurrently. Also, the iterative nature of the reflexive methodology informed the other through this contemporaneous process. The continued enquiry was both unique and iterative throughout the progression of the study; pre-fieldwork, fieldwork, journaling and the development of beliefs that are grounded in the ethnographic observations (Corbin & Strauss, 2015; Hammersley & Atkinson, 2007; Kemp et al., 2018; LeCompte & Schensul, 2013). I continued to question, how could a place of crisis for older people be called 'home'?

Ethnographic field notes analyses occurred through an iterative process entailing reading and re-reading the observation transcripts and examining the encounters and dynamics throughout the retirement village ethnography (Hammersley & Atkinson, 2007; LeCompte & Schensul, 2013). After the collation of field notes, the interpretation of the information to discover new knowledge took place, and thus the process of looking at what was happening in the transcripts became the first level of data analysis. This was the beginning of the narrative that developed the themes interpolated with the philosophical concepts and ideas underpinning the study. Initially, by utilising grounded theory to explore the phenomenon being observed, I was able to uncover knowledge of value through theoretical reasoning and social experience that is not necessarily accessible from a general everyday understanding (Davies, 2008; Glaser & Strauss, 1967).

The iterative process continued by engaging Foucault's thoughts on the notion of *épistémè* as knowledge-power and the idea of heterotopia to understand the spaces in the retirement village. Likewise, Weedon (1987, p. 113) believes that applying the discourse lens can analyse the 'control and lack of control' evident in the transcript dialogue and support the emergence of the themes as they begin to emerge. Additionally, by concurrently applying hermeneutic analysis, actively listening during the participant observation process, making contemporaneous journals and analysing each occurrence enables the researcher to 'understand the relationship between the language, social institution, subjectivity and power' (Weedon, 1987, p. 35), disclosing how the social dynamics are changeable throughout the retirement village. Also, Murchison (2020) states that through the analysis of the ethnographic data, both the unintentional and intentional significances, the action and reaction to preconceived views become apparent.

The data analysis is linked to the questions identified before and during the fieldwork process via theoretical enquiry, field notes, and document exploration as themes came to light through the collection of the rich narrative. Furthermore, my personal and professional knowledge of aged care surroundings combined with observation methodology nurtured a deeper understanding of the spaces (Murchison, 2020). In so doing, this could potentially reveal phenomena that might otherwise not have been discovered. Furthermore, comparative review and looking at the data from diverse viewpoints could uncover additional meaning and knowledge of the social setting being studied (Hammersley & Atkinson, 2007; Kolb, 2012; Rashid et al., 2015). Hence, reviewing the data through the Foucauldian heterotopic lens continued participant observation, and the accompanying field notes provided rich insights.

Therefore, I was able to identify three significant themes from my literature review and participant observation field notes that are interrelated and dynamic.

- The first theme is dread and the experiences of dependence that accompanies old age and aged care choices in New Zealand.
- The second theme is vulnerability, created by the older person's progressive frailty and the need to live within a retirement village and face the institutional culture of both the corporate and health services. The contrasting vulnerability that the healthcare staff face in their role as mediators for the residents creates a personal, cultural and political tension.
- Finally, creating a sense of place and belonging is an important theme to consider as the older person transitions to make their home within the retirement village. Likewise, reviewing the data while considering the staff, residents and relatives' perspectives, as an outsider, adds a vivid comparison of the 'otherness' experienced in the retirement village spaces, which also supports the study's trustworthiness and credibility.

By writing the ethnography as a narrative, I could interpolate the theory and academic literature with an intimate insight into an area of my academic interest. Additionally, my individual awareness as a daughter with a parent who had required residential aged care and a former health professional provided an enriched awareness of the ethnographic observation enquiry and understanding of the day-to-day dynamics in aged care. (Ricoeur, 1988) supported this, suggesting that a distinct and unique narrative transpires by jointly using the past and present as a lens to reflect on experiences and observations. Further, this supports the belief Adam (1990) has, that narrative can reflect the fundamental importance of the chronological ordering of human experience.

In my study of Foucault and heterotopic spaces, I became aware of the idea of tropological space. This is the space Foucault describes as one in which language takes an alternative route, and you discover yourself somewhere unexpected, one where one says the same thing differently, out of the blue (Foucault, 2004). Therefore, Foucault's tropological notion in the narrative space of language relates well to my reason for choosing the narrative writing method while looking at the concept of natural, utopian and heterotopic spaces. Foucault's studies take you on a linguistic and intellectual journey where you see 'things are not the same, not here but other and elsewhere' Foucault (2004, p. 18), thus highlighting it is often the mundane that illuminates the unseen.

So, by employing Foucauldian philosophy to study the residential village as a space of otherness and how they care for older people trying to make the place home at a time of crisis, I hope to contribute to the body of scholarship encompassing Michel Foucault and heterotopia. This may contribute to management theory and practice by understanding the organisation's spatial dynamics through the heterotopic lens and understanding organisations *épistémè* and how it influences both internal and external relationships. Additionally, Keeling (1999) expressed a shortfall of ethnographic studies of older people living in specific communities in New Zealand that can contribute to both policy and practice and close the gap in academic knowledge of the notion of home in a New Zealand retirement village. I am optimistic that this ethnographic study will provide additional context to the care and wellbeing that supports our elderly population in the future, and add to the body of work exploring how older people find a place to call home in retirement villages in New Zeal

Chapter 4: An Ethnography

Introduction to the Retirement Village

I had the good fortune to begin my ethnography journey with an opportunity to meet many of the relatives of residents in the dependent care spaces of the village. The retirement village was hosting a series of early evening gatherings between the staff and relatives to provide an update on care and discuss any concerns. These meetings occur every six months and are relevant to the day-to-day life in the retirement village. I have integrated them by introducing my first impressions of the ethnographic journey, meeting staff, relatives and some residents for the first time, and by including the varied emotions, the ambience of the village, and forces at work in the space that acknowledges the anthropological significance of the enquiry.

Recognising how feelings for place change over time, we tend to make generalised assumptions about places and 'the way they are and what they are' (Lewicka, 2011; Seamon, 2020, p. 7). This is particularly relevant when considering the retirement village and the feelings manifested due to personal family experiences and the unsolicited recounts of others and whether they are positive or negative. Distinguishing these 'feelings' will be subjective to the observation and could be influenced by several factors such as mood, illness, cognitive state or a physical need. Therefore, approaching the field with an open mind and implementing Foucault's 'ruptured thought' paradigm was a valuable tool for my study. Furthermore, the retirement village has a dynamic set of relations with the trilogy of human interactions between the staff, residents and families within a socio-political corporate healthcare environment that is home to many older people.

The trilogy of stakeholders with specific needs: the staff, residents and relatives all have their relationship with the institution that shapes the power relations spatially. I have illustrated the trinity of stakeholders for a clearer understanding.

- The retirement village employees provide the residents' care and maintain the environment according to its doctrine.
- The residents who are both living independently and the vulnerable and frail elderly seeking a sense of place.
- Next of kin of residents, who critique the care and facilities and provide consumer feedback externally.

All my senses were on alert and ready for anything as I drove through the open village gates on a hot and sunny November day. I did not know what to expect beyond the reception area, as when I last visited in September 2019 to discuss my study, I only ventured as far as the manager's office. Today is a mix of emotions, excitement for what lies ahead, my hopefulness that I would not look like an imposter, and at the back of my mind praying I would cope with being back in a retirement village. Apart from my initial visit with the manager, this was my first time back inside a retirement village since the heartbreaking journey I had shared with my mother a few years earlier. I am sure I am not the only person who has walked into a retirement village with mixed feelings.

> The notion of home inhabits a valuable place in people's culture, wherever we are in the world. A home is a primal place; it is the place we belong, are born, grow up, live, feel safe, have the freedom to be ourselves, raise our children and retreat to when we are vulnerable. (Carlisle, 2017)

'There is no place like home' are the final words of Dorothy in *The Wonderful Wizard of Oz* (Baum, 1900); these words resonate for many as that feeling we have about the place we miss

most when in an unfamiliar location. The place we call home is the phenomenon that affects how our identities are shaped and how we live our lives within the community. A home is a place of independence and a sanctuary for many people. However, the retirement village can be defined as a liminal space at the threshold of crisis and isolation, but also that of security and care (Carlisle, 2017). Therefore emphasising the mixed feelings of the dread of what may come to be, while acknowledging the vulnerability of the ageing residents moving their home to the retirement village environment in the anticipation of finding a sense of belonging.

It was a hot summer evening as I parked the car. The beautiful flowers and manicured gardens in the village grounds were an amazing array of vibrant colours. The tidy rows of homes and apartments stood all lined up and ready for duty. The cheerful gardener welcomed me with a big smile, and we shared a friendly moment about how vibrant and welcoming the garden beds were before I headed inside to begin my ethnography journey. I felt buoyant following that happy interaction; I wondered if the gardener understood the impact of such a simple chat.

I was delighted to see a gingerbread house the size of a children's playhouse in the village reception area. I found this an extraordinary sight, considering my research was focused on 'home' and Foucault's heterotopia. Moreover, there was a house within a home, a space within a place. This immediately reminded me of Foucault's insightful thinking of how the utopic representation of a child's imaginary game building blanket tents under the dining table essentially produces a heterotopic space of otherness that reflects the home environment as a reimagined space. As Johnson (2013) and (Knight, 2017) describe, it is the heterotopian lens that uncovers spaces and challenges their reality by breaking down the utopian paradigms. My first impression of the extent of the retirement village space, large artworks and scale of furnishings reminded me of when we first moved to New Zealand. Our furniture

from our little Victorian terrace house in England looked like dolls house furniture inside our sprawling new home in New Zealand.

The space for the family meeting was in a space customarily used as the retirement village cinema space for the residents in the independent and assisted living. The four rows of comfortable armchairs inhabiting the space and an enormous wall hung projector screen wait to entertain the many people residing there. As the relatives gather in the meeting room, it was comforting to see that the shared experience of having a frail parent was acknowledged between the many relatives as they shared their personal experiences of life with a parent or spouse in care. The meeting had familiar formality, with the last meeting minutes, an institutional update and an opportunity for feedback and questions, and the discretionary complimentary refreshments to ensure the visitors all feel valued. Remarkably, the questions and concerns raised by relatives in this meeting seemed to transpire due to the institutional nature of the village. The concerns concentrated on the day-to-day quality of housekeeping rather than the emotional care needs of their kin, providing me with an insight into the dynamics of the dichotomy engendered by the provider, staff, residents and relatives' relationships with the institutional business's landscape.

Food quality was a specific topic that was being followed up from the previous meeting.

> *'There is a new chef in place now, and a second one will be in place by the end of the year.'*

Several relatives were concerned about the noise from the alarms.

> *'The noise from the buzzers and bells through the village, can this be changed? The noise is disturbing … can you stop the noise of the alarm travelling through the village?'*

Another concern was the sparrows entering through the automated doors and finding food indoors.

'What is being done about the sparrows entering the facility?'

It was not the comments or the responses that intrigued me, but more so, the 'things' needing consideration. Who was being affected by these things? The relatives or the residents? Do residents complain about the food to their sons and daughters as something to talk about and get some attention? Did the buzzers upset the relatives more than the residents?

There are various artefacts in the village significant to the narrative in this study and the discourse they espouse. The political tension created by specific artefacts represents different things to different people within a space and how they should be responded to (Brey, 2005). Institutional and corporate artefacts are political agents that evoke their integrity, commitment and ethos. Additionally, these artefacts are employed to demonstrate their ethical appeal and character. Thus, their social and political agency impacts the sense of home in the various spaces in this place (Brey, 2005; Carter, 2019; Pfaffenberger, 1992). The buzzers and alarms are vital communication devices for the residents when they need support at their most vulnerable moments to access health care. It is their direct line of communication. Also, the buzzers and alarms are vital and essential devices in the healthcare workplace for the staff to directly communicate in an emergency when they are in a vulnerable situation and require assistance from a colleague. Therefore, the intrusion of the noise from the alarms in the retirement village community highlights the collective experience of the vulnerability of the frailty of old age, and likewise reveals the vocational exposure of the health carer as they both strive to share the space, be it their home or work.

During the meeting, the village staff use media technology to provide a visual update of the residents' experiences of recent activities. Some of the activities reminded me of my children

at kindergarten and invoked the notion of infantilisation of older people as I watched these slides illustrating scenes and social interactions. These activities included making Christmas decorations with pom-poms and cotton wool for snow and making paperchains with colourful Christmas paper. It is the dependence that old age imposes which creates vulnerability and the loss of personal agency created by the collective nature of healthcare. This correlates with Augé (1995) describing the healthcare space as reduced to a non-place that only exists in the person's mind that creates its meaning through the tangible activities that take place when employed.

Furthermore, Goffman (1961) articulates the concept of 'self-mortification' which occurs because older people are stripped of their identity when they lose control of their surroundings and access the outside world. In addition, these older people surrender personal possessions, privacy and authority of self and choices they once held at home. Salari and Rich (2001) found that these deviations from personal autonomy require the older person to adapt to a dependent lifestyle. Therefore, the retirement village activities coordinator should be mindful that the pastimes that the dependent residents engage in are to fill the time and meet their individual needs.

Meeting three of the hospital residents' husbands after the meeting was equally thought-provoking. I could see the bond they had established with each other, as I began developing an understanding of how they had created a sense of belonging in the retirement village that worked for them and their individual needs. These three husbands (Husband A, B, C) lived in the independent houses and apartments while their wives resided in the dependent hospital space. These wives had initially lived independently with their husbands in the retirement village but, over time, had developed health needs that required ongoing support of the hospital facilities and equipment due to their declining health and mobility. Over the many

hours observing village life, I developed an appreciation for how they had managed to stave off the dread of being separated from each other. This has preserved their marriage, life together, dignity and sense of individuality by giving them a sense of control and belonging which has enhanced their wellbeing and autonomy, and turned the village from a place of crisis to a place of compensation (Foucault & Miskowliec, 1986), demonstrating how the day-to-day routines they have habitually shared for years have become vital to maintaining their life together in this place.

A Day-in-the-Life of a Retirement Village

Observing the retirement village's day-to-day ambience provided an intimate insight into how life and work transect and influence each other. My first impressions of this study came from an evening gathering of the trio of stakeholders' representatives. The following ethnography builds on these initial impressions, further exploring the retirement village's lifeworld through the heterotopic lens of 'otherness' utilising the structure of a typical day to understand how a place of crisis, formed by interweaving home and institution, can become a place to call home. *How can a retirement village as a place of crisis become home?*

Early Mornings and Breakfast in Bed

The dread of the unknown and lost physical and mental ability are among the fears of older people. Grenier (2012) explains that the unpredictability of when this could happen drives older people to control what they can by creating structured days to know what is happening, with who and when, which provides them with a sense of control and security. Therefore, before entering a retirement village, many older people have worked hard to develop and adapt their routines to maintain their independence for as long as possible before the challenges of frailty and poor health rob them of their independence. This is supported by

Skilbeck et al. (2017) and Underdown (2018) when they explain how the coping strategies they developed via their personal agency are fundamental to maintaining a sense of self. Therefore, the healthcare staff that facilitate these routines, particularly in the high needs dependent care areas of the retirement village, do this to support the wellbeing and continue the older people's independence each day.

> *I arrived at 7 am in time for the nurse's handover from the night staff. The morning has started well before I arrive. The staff handover occurs around the dining room table and is attended by eight healthcare staff; one is a student nurse on a learning placement. The handover dialogue highlights the residents' individual needs that were attended to overnight. It also emphasises the 'high needs care' that is required because they can no longer physically or cognitively complete the basic tasks themselves, such as the care associated with physical comfort, bodily eliminations and pain relief; which is supported by Hospice so the individual can remain in place rather than be moved to the hospital setting.*

The well-informed competence with which healthcare staff report to each other reflects how they care about their work and those they are supporting. Listening to their exchange of thoughts, it is clear that the staff have the best interest of each resident in mind and a well-developed knowledge of their individual needs. The emotional aspect of intimate caring creates a rewarding and challenging work environment due to the mixed experiences of looking after vulnerable older people, particularly those who are dying (Wolkowitz, 2002). The health carers will feel great satisfaction and compassion as they carry out the bodywork. However, these emotions can be marred by the sometimes racist or sexist verbal abuse from the residents and relatives or the hierarchical institution's bureaucracy (Twigg et al., 2011). While diverse for the resident and the healthcare staff, these negative emotional interactions

in a place create stress for the individuals. However, it is often the simple things that cause angst for the older person when their routine is disturbed.

> *One resident has been unhappy for the past couple of days as she has had to wear a skirt and she does not like wearing them. She prefers to wear pants (trousers). Her 'pants' have gone missing in the laundry. This was discussed during the staff handover in a light-hearted and caring way. Later, in the morning, the banter continued as a pair of her trousers was finally found, and she was declared happy for the day ahead now. The staff interactions, in this unit, with each other are friendly and supportive. There is an effortless repartee between the staff and always accompanied by smiling faces; it is clear they care about what they are doing. The team spirit is delightful as they move through the morning routine of tasks getting the residents ready for the day ahead – toileting, ablutions, and dressing. There is a hardworking hum coming from the corridor of residents' rooms. It is the caring business of bathing, changing bed sheets and feeding, reminding me of the institutional function of a hospital ward, where everyone has a role, and the work gets done effectively.*

Living in the retirement home environment can become very monotonous, with the routine being homogenous due to workplace policy and meeting all the residents' needs. Adapting to living with care removes the control the older person previously had in their life and diminishes their sense of self, thus creating vulnerability and dread of each day's monotony (Stone, 2017). The healthcare routine of treating medical conditions and relieving pain is only part of the care required, and fostering individual emotional wellbeing for older people is far from simple in a large community setting (Wiles et al., 2009). Recognising that the place is a shared part of their identity as a home or workplace can become integral to reducing the

residents' dread of the intimate and exposing care generating the vulnerability of feeling dependent. This is reinforced by Seamon (2020) and Van Manen (2014) as they consider carers integral to the residents' sense of belonging and therefore understand their contribution to the residents' lifeworld.

> *The breakfast arrives on a trolley from the central kitchen. No one is in the dining rooms at 8.45 am. Are they getting breakfast in bed? There are lots of trays on another trolley. There are also tables in the dining room laid with matching crockery; maybe this is for lunch? The choice of food and drinks reminds me of a hotel buffet breakfast bar; cereals, porridge, toast, and fruit compote/fresh, yoghurt, cream and milk; the juices are orange, kiwi fruit, guava. Even the toaster is a hotel-style one that can cope with large numbers of slices. The cleaner has arrived. They are vacuuming the carpets while the residents are having breakfast in their rooms. My question about breakfast in bed has been answered.*

The helplessness of old age can be a degrading journey, particularly with the loss of ability to feed ourselves. Therefore, a breakfast tray in bed provides an opportunity for the resident and carer to spend quality time together before the day's busy schedule. The ongoing institutional intrusions often create a longing for privacy and compromise individual dignity and vulnerability to the environment, and therefore some older residents become withdrawn. However, having others' company is beneficial, but you are often surrounded by frail people and unable to share meaningful companionship in residential care. Therefore, there is a longing for the familiarity of life when all generations reside, like it was at home when you had control of the world around you (Lustbader, 2013; Manzo, 2014).

The notion of meaningful companionship resonated when I observed an interaction between a physiotherapist and nurse while they were routinely mobilising a resident.

> *By 9 am, the residents are starting to appear in the dining and living room area. One is happily walking with her carer chatting about the day ahead. Another is walking with the aid of a 'walker' and the physio. The hum of the morning routine has turned to a bustling, busy centre of various activities: Physiotherapy, medication and wheelchairs positioned in the lounge. The physiotherapist and nurse talk about their child in day-care, and the resident is listening to the conversation intensely. They talk over her, but she is smiling and enjoying listening to their dialogue. They see this and respond by including her and engaging in a positive and happy interaction. This dialogue has moved beyond day-to-day care and extended to life in the community outside the village.*

While Foucault's heterotopia contests the utopian imagery of the retirement village space as one that liberates you from your old age, it also draws people out of themselves by challenging the complex power relationships that are 'situational, unbalanced, heterogeneous and unstable in the space they are now living in' (Johnson, 2013, p. 19; Levitas, 2003). The healthcare staff have seen beyond the resident's submissive body that they are mobilising and have acknowledged her personal agency by including her in their conversation. Therefore, this simple interaction while walking with her and taking an interest in what she had to say would empower the resident to look forward to taking a walk again, even when it is difficult or painful. Thereby increasing a sense of belonging, feeling valued and less vulnerable to the institutional nature of healthcare. However, in contrast, during a morning exercise class in the lounge, I observed the following.

> *When the exercises had finished, I noted a lady wanted to return to her room as the exercises were over. She was agitated and said to the nurse that she had been brought out of her room on false pretences. The nurse deflected this and told her to remain in*

> *the lounge for lunch. She grimaced. Her husband appeared; she appealed to him to return to her room. He also dismissed her plea to return to her room. I did not know the lady's background, but observing her distress being ignored and not being asked why she did not want to stay in the lounge perplexed me. What was the harm in her being in her room? If she were mobile, she would have the freedom to choose where she spent her time. However, now she was unable to walk herself; she was at the mercy of the staff. She was moved closer to the window, which I thought was good. However, sadly, she had her back to the window and was now facing a TV that did not work as the remote control had gone missing earlier in the day.*

I pondered over this scenario for some time. Wondering what it must feel like to find yourself in care and dealing with the tension of living in a public place, being physically dependent and feeling unheard or unable to influence decisions, how is one supposed to rationalise this new way of living? Casey (1997, p. 23) shares that the power a place holds clarifies 'where I am … how I am with others and even who we shall become together'. Being in the hospital environment, I became acutely aware of homogenous care due to most residents' dependence, requiring support with feeding and personal hygiene and the need for them to be placed in expedient spaces for the staff due to their immobility and cognitive challenges. Furthermore, the subsequent need for staff to collectively feed, entertain and ensure their inclusion in daily activities inspires the living room to become the caregivers' place of choice. However, I sensed it was more of a waiting room for these older people as they mark time by the daily schedule of care, rather than feeling like it was a place for chilling out as one would at home in the lounge.

Therefore, having access to dignity, privacy and choice distinctive in day-to-day life is important. The place is undoubtedly linked as having a purpose for the human spirit to endure

(Kemp, 2010; Lustbader, 2013). Maybe accepting the situation would provide some sense of wellbeing, although Bradshaw et al. (2012) suggest it could lead to brooding anger at the loss of control.

Collectively, it is the responsibility of staff, relatives and friends to advocate and support the resident's holistic wellbeing and mediate the transition to make the retirement village home and help them find a sense of belonging (Shippee, 2009). Therefore, the importance of the village staff acknowledging the resident's prior routines, likes and aversions provides a renewal of dignity and personal control, which in turn leads to a sense of belonging and home (Cooney, 2012; Davies, 2001; Jensen & Cohen-Mansfield, 2006; Kahn, 1999; Smorenburg, 2015). The socio-political factors that ensure safety and good health within the retirement village dependent care spaces moderate the sense of belonging and create tension for both the residents and healthcare staff. However, Smorenburg (2015) states those older people should not feel vulnerable and devoid of any control over feeling emotionally safe in their space. Nor should they feel they are under constant surveillance at the convenience of those caring for them.

> *The unit coordinator gave me a tour of the hospital floor beyond the lounge and dining area and checked each bedroom; if the resident is in the room, she leaves the door ajar, 'nobody needs to be behind a closed door' – a caring statement, not considered a matter of privacy but out of genuine concern for wellbeing. However, I considered that privacy could be an issue for the residents.*

Lustbader (2013) explains that 'having your own space, own things, a lock on the door so then no one can come in when they feel like it' (p. 20). The absence of privacy I observed compounded the institutional power and therefore generated the Foucault (1977) heterotopic juxtaposition of personal space versus a place of panoptic surveillance. The perception of

surveillance in the hospital and rest home spaces in retirement villages emerges from their architectural design to flow and accommodate both the residents' fundamental needs and the ergonomic needs of the staff (Kenkmann et al., 2017).

A long corridor in the retirement village leads to the resident's bedrooms in the dependent care space. The doors are all the same, and along the corridor and cupboards are practical places for storing equipment, such as extra linen, walkers and hoists; the retirement village's space invaders. The bedrooms are functional, and each has an en-suite bathroom. These homogenous spaces are practical and spacious enough to accommodate a walker or a wheelchair, have handrails, and the obligatory alarm button should emergency attention be required. However, the bedroom is the one space where I can perceive personal space and individuality; moreover, where I had a glimpse into residents' personal history.

> *As I walk along the corridor of the residents' rooms, each bedroom has a handmade Christmas fairy on the door. Most of the doors are open as residents are now up and in the living area. I could see through and view how the rooms had been personalised. Photos, pictures, plants, books, magazines, blankets, furniture, a chair from home?*

I did not venture into any of the rooms as I viewed them as highly personal spaces that required an invitation to enter. I would just view from the open door. Probably a consequence of how my mother's journey through residential care touched my worldview.

> 'My Mum was in four different institutions and four very different bedrooms. Firstly, respite care at a private rest home resembled a bed and breakfast rather than an institutional care home. Mum then had an unexpected stay in a hospital room in Auckland hospital that was spacious and clinical. Six weeks later, Mum was transferred to a private room in a local retirement village (with no en-suite) that I could walk to from home, and finally a hospital care bed in a shared room with no en-

> suite in a large corporate retirement village in Auckland and about a 25 minute drive from home.
>
> My mother had Alzheimer's and appeared not to be too aware of her surroundings, but I believe that she deserved her own bedroom space at this stage to maintain her dignity and privacy and give us space as a family to create a space that was her own. Nevertheless, this was the fourth place in a traumatic three months that accentuated and progressed her symptoms of dementia. My mother's safety was now my priority, and the choices were sadly limited. I soothed myself by asking that if a single room became available, could she be moved. Incidentally, the lady my mother was sharing with was a sweet person, bedridden and did not appear cognisant of any intrusions we made into her space.
>
> Furthermore, my mother's reaction to sharing a bedroom was indifference, which I believe resulted from the Alzheimer's journey as her insight into having her own space had faded. She was just happy to be spending time with me as I helped her unpack her clothes, hang pictures of her garden in England, the beach in New Zealand and photos of her grandchildren both near and far. We looked for a plug socket for her loyal CD player to listen to her music, but there was not enough space for anything else. All I wanted to do was take my mother home.'

The hospital care bedroom identifies the meaning of Foucault's heterotopic space of crisis. A few photographs and objects were now the only evidence of a 'lived life' reflected within a self-styled and impersonal hospital room. King et al. (2019) highlight that many older people are consigned to retirement village hospital spaces directly from acute hospital admissions. Alternatively, they are involuntarily removed from their home when they are at their most vulnerable time of life and can no longer physically or mentally care for themselves safely.

Also, frequently in these circumstances, a family member or neighbour will select a few belongings that they consider will bring the older person comfort, not giving the older person any time to process the finality of leaving home or contemplate what would bring them the most emotional comfort in such a public place. The critical items in each resident's room that I observed are, without fail, family photographs, books, significant artwork and the customary chair that provides comfort and a sense of belonging.

Midday Moments

The morning moments have been filled with the bustling staff getting residents up, dressed, fed, mobilised and even entertained in the living room with singing songs, exercises and a game of bingo. Midday is a significant point in the day for the staff routine and includes the distribution of medication, food and personal care for those who cannot leave their beds or chairs. Grimsley (1956) explains how the existential dread and distress of leaving the family home makes them vulnerable to their new home's socio-political dynamics as they adapt to the routines and a new way of living. At the same time, they are adjusting to the communal living environment and depending on others for many of life's fundamental requirements; and perhaps that carer does not have any knowledge of their personal needs and routines (Cook et al., 2015). However, the difference it makes when a carer has personal knowledge of a resident's individuality provides an insight into individualised care in the following observation.

> *Midday, I am in the hospital lounge and about to help with lunch. I was happy to be able to support two ladies that could no longer feed themselves and was sat next to one of the nurses who is American; today is Thanksgiving. She is missing her family, who are overseas. However, she has gravitated to one of the residents sitting next to my two ladies for lunch. This resident is also American, and the nurse had made a*

> *conscious decision to feed her and talk about Thanksgiving and memories of family times with her, reminiscing about family, home and the food. The personal touch is heart-warming as I can see it is a unique and special moment for them both*.

The carer has acknowledged their shared culture and the distinctiveness of the resident's lifeworld and, by doing so, potentially created a sense of belonging. Therefore, this is a significant example of the comprehensive care that upholds the phenomenological concept that care is complex and unique to each person and encompasses 'body, space, time and things' (Van Manen, 2014, p. 302). The carer has also acknowledged her personal vulnerability by expressing that she feels homesick at a traditionally family-oriented time. Thus, removing the nutritional functionality of the resident's lunchtime experience and consciously employing personalised care and (body) language to articulate an egalitarian nurse–patient relationship. Furthermore, the conversation would be a welcome positive moment of mental interference from the dread of mealtime and being fed. Additionally, considering the Thanksgiving interaction, I found the following lunchtime observation interesting as it also highlights a contrasting sense of belonging that a resident may experience.

> *A resident I have observed regularly visiting the hospital care lounge is walking in the main hall leading to the dining room. She spends a lot of time upstairs as she enjoys the company of the staff and the structured activities. Also, this lady has previously been a patient/resident in the hospital space. However, she now lives in assisted care in a more independent setting having an apartment in the main building. Nevertheless, it appears to me that she misses the hospital care environment and perhaps gets lonely living in assisted living. I had noticed how sad she looked when she was asked to leave the hospital area at mealtimes. However, I observe that the*

> *main community dining room is lovely, vibrant and beautifully served. Also, I conclude that the walk to and from the hospital area is good for her mobility. Although perhaps the walk is something she does not enjoy, or perhaps she prefers to eat while watching TV in the hospital lounge? Eating dinner in front of the TV is not available downstairs from what I have seen.*

I get the impression that the resident has formed a bond with the hospital space and found a sense of belonging. Perhaps the planned day in this space and the previous personal experiences with the healthcare staff has created this sense of belonging and connection to the space. I reflect that she may be attracted to the hospital space due to her declining cognition, and the environment is smaller with many staff coming and going. Consequently, the structured environment and visible healthcare staff provided a great deal of comfort, creating a sense of security for her in this space (Cook et al., 2015; Foucault, 1977; Hauge & Heggen, 2008; Johnson, 2013; Martinsen, 2006; Merleau-Ponty, 1962). Furthermore, each day the staff welcomed her as she joined the activities in the living room. I observed that the staff relied heavily on the resident's compliance to leave when asked and take herself to the main community living area for her meals. Hence, she is not discouraged from visiting the hospital and therefore, a mutually respectful relationship has developed between the resident and staff that recognises the place's socio-political dynamics.

In contrast, outside of the hospital or rest home areas, the community areas of the retirement village have been designed to facilitate individual and group needs, choices and relationships for those living more independently. The independent residents have a different discourse with the retirement village's socio-political nature. They have an investment in the place and pay monthly fees to access the additional features that have created a service–customer relationship. Furthermore, a sense of belonging is generated by their conscious decision to

move into the retirement village environment. Hence, their relationship with the organisation is quite different from the nurse–patient relationship of those living in independent care. Thus highlighting how each space or place in the retirement village will hold various significance depending on an individual's history (Roxberg et al., 2020). This emphasises the idea Van Manen (1990) has about the lifeworld of care involving more than the rudimentary physical and psychological aspects of care, and needs careful consideration for the vulnerable residents in these spaces, including considering the existential needs that give their life meaning.

Considering this notion draws me to the following extract from my field notes. I regularly see the husbands I introduced earlier, and one husband, in particular, has his meals with his wife every day, organises her special wheelchair and takes her for coffee dates with other residents in the community lounge, and other times I have seen him enjoying happy hour independently in the community bar.

> *Husband B arrived at the hospital space for lunch and to help feed his wife. I am helping to feed another resident and become aware of his wife coughing. The nursing staff are attentive and think her drink is the problem, and it needs thickening to stop it from going down the wrong way. Husband B appears concerned with this new medical development, and I can see his distress. He disappears for a short time and comes back with a cushion from his wife's room to help support her head and shoulders, and she quickly settles with his reassurance.*

On another occasion, I see time shared with the pet dog.

> *Husband A was returning to the hospital space with his wife pushing her along in her big hospital chair; on her lap was their little dog. Seeing this made me and the other*

> *resident's smile. Their dog is clearly up with the play and jumps down and settled himself on the floor by her chair while lunch was happening.*

These are amongst numerous observations of these couples and caused me to think about how couples blend over the years and how the intimacy of the phrase 'in sickness and health' in wedding vows becomes such a tangible phenomenon in our twilight years. Giddens (1991) contends that when people feel that things and people are trustworthy, they feel ontological security. It is the routines, habits and way of life that provide the order leading to emotional security. Furthermore, the couple's contentment may also be supported by them making the conscious decision to move into the retirement village before either of them needed any of the assisted care that would become available to them in time. This is supported by Twigger-Ross and Uzzell (1996), who recognise the decision to stop living a particular way of life for another as conscious discontinuity. Therefore, when somebody actively engages with a place, Manzo (2014) maintains that a relationship with that space is consciously developed.

In contrast, the following reflection highlighted the existential dread and vulnerability of adjusting to a life-changing relocation into the hospital environment.

> *I walked towards the lounge as I could hear someone playing the piano. There is a lady in a wheelchair with her family; I have not seen her in the community area before. Another resident from the independent living area stops to say hello. She was talking to her about her travels through Africa as a missionary and volunteer. She wished her well and asked if she could visit her in the hospital. I then remember the lady from the hospital. I had not met her face to face before as she did not ordinarily leave her room. However, I recalled being told that her husband had recently passed away. She had lived in an independent apartment with her husband, who cared for her until that happened. After her husband passed away, she had to make a difficult*

> *decision to transition into hospital care as she could no longer look after herself independently. It struck me how difficult it must be for her as she has gone from the security of home in a lovely apartment to one room and an en-suite bathroom whilst dealing with losing her husband and being dependent on the healthcare staff.*

Drawing on the earlier discussion, the familiarity of home is central to our being. In times of vulnerability, such as the turmoil of losing a loved one, the place we call home can bring a sense of security and value as we can associate that space with the memories of the past we have shared with our family. So relocating to the hospital space and being separated from the familiarity of the many things that made up their home would impact this lady's dignity, privacy and choices, accentuating the feelings of vulnerability to life in hospital institutional care, emphasising evidence from Carboni (1990); Kenkmann et al. (2017); Lustbader (2013); Miller et al. (2014) confirming that the spaces we occupy shape our being and thus provoke an aching for life beforehand with loved ones and the comforts of home that created a sense of belonging.

Therefore, to be embodied in any space relies on how we position ourselves with others and navigate the power relations spatially (Bazin & Naccache, 2016; Foucault, 1977; Foucault & Miskowliec, 1986). Our life paths do not occur homogeneously or within empty spaces but occur in various spaces over time (Bazin & Naccache, 2016). Traditionally, this is within the family home we grow up in, followed by our first apartment with friends and then, in time, the home we create for ourselves or with our life partner. The variety of these spaces is diverse; shared, private, isolated, or connected, but all are real because they are places we have chosen to create.

Afternoon Activities and Shared Spaces

The dining room is empty, within an hour of lunch being served, and the staff are tidying up and returning the area to its pre-meal state, where it now waits in anticipation of the next mealtime. The walkers, wheelchairs and sticks have been retrieved by their owners who are now filtering back to their rooms and apartments for their after-lunch rest before afternoon activities, afternoon tea and dinner time. These are the routines of the retirement village care.

> *A resident is sitting in the corridor outside a partly open door, waiting with anticipation to see the hairdresser. She needs to organise a hair appointment. Through the door, I can hear the hairdresser talking to another resident who enjoys the in-house coiffure and hearing about all the 'outside village' local information. Another lady approaches the hairdresser and is gently reminded that she had been in the day before to have her hair set.*

These interactions with the hairdresser and her clients summed up the difference between being 'in care' and being 'cared for' (Cook et al., 2015). By utilising the Foucauldian concept of ruptured thinking to consider the caring role of the staff member as more than functional, particularly a hairdresser, and considering the space through the heterotopic lens of otherness, it provided valuable insight into the significant connections people make that enhance wellbeing (Beedholm et al., 2014). This is supported by James et al. (2014) and (Relph, 1985) as the feeling of belonging contributes to our ontological security, which is essential to our being in the world.

> *A resident from the rest home is tending to a table of pot plants outside of his room. He is unsteady on his feet and manages with the help of his walking frame to negotiate his way around the table watering and fussing over his plants.*

> ‘I am reminded of my father when he was in hospice care, and we took in his gardening paraphernalia (root powder and some potting mix), so he could take cuttings from the plants in the hospice garden as gardening was such a comfort to him in his final days.’

For residents in the retirement village, having the opportunity to retain some connectivity to items unique to their identity becomes vital to their wellbeing and sense of belonging in a strange and unfamiliar place (Featherstone & Hepworth, 1998). With the support of the healthcare staff, they acknowledged the plants were a valuable part of this gentleman’s life and therefore facilitated his time gardening.

In contrast, the experience is different for those in the hospital’s and rest home’s main living spaces. These rooms are uniformly arranged with seating around the outside of a spacious double aspect room. While this is functional and accommodates the many walkers, specialist chairs and tray tables, it feels more like a waiting room than a sitting room at home or somewhere that the residents can express their individuality. Therefore, the environment perpetuates the resident’s vulnerability to the institutional socio-political tension that manifests itself with a sense of endless waiting and suspension of time between activities organised by staff that provide the care and entertainment (Bansel, 2013). So, the residents are restricted to merely sitting by a window to watch the world go by if someone changes the furniture. Conceivably, the residents do not ask as they feel they need to conform to the way things are done, according to the staff managing the retirement village space; a stark reminder that aged care can segregate people, and the care becomes medicalised and convenient rather than holistic person-centred care (Casey, 1997; King et al., 2019). Hence, (Crampton & Elden, 2007) conclude that spaces are arranged to facilitate resident surveillance, albeit for their safety, denying any ownership of the space by the residents.

Consequently, this draws attention to the institution *épistémè* that controls the power relations spatially, particularly in the retirement village hospital's dependent care and rest home, as they are vulnerable and marginalised by their poor health and deteriorating cognition. This highlights the significance of the independent residents' relationship with the retirement village space as it is empowered by their good health and personal choice to reside in the retirement village. Furthermore, the surety afforded by the financial investment in their village apartment provides them with a sense of place and belonging that is home.

As the retirement village is a politically complicated environment, it affects the choice of whom you spend your time with and how you spend your time, because the space the residents occupy occurs communally (Cook et al., 2015; Falk et al., 2012; Wiles et al., 2009). The dilemma of the retirement village community life is supported in the following observation.

> *Six residents in a line are coming down the corridor from the rest home area. One is in a wheelchair being pushed by the activities coordinator who is happily saying 'follow the leader' and behind her like ducklings are other residents on walkers or with sticks or managing unassisted to walk alone, all dutifully following her as they take a tour of the village community. They head outside through the electric doors to get some fresh air and enjoy the gardens and watch the comings and goings of village life.*

The last time I saw a crocodile line was when my children attended primary school and headed off on a field trip to the beach with their teacher up front and a second teacher or parent at the back, so they were both accounted for and safe. Employing the Foucault and Miskowliec (1986) heterotopic mirror of otherness, I am reminded of the notion of infantilisation due to the context of the dependency of the older people in the village as we

age and become frail and more dependent on other people (Salari & Rich, 2001). In aged care, this can be accentuated by the nature of the aged care routines to the extent that 'dependence is imposed on the individual elder', which then leads to infantilisation as the older person yields to institutionalised care, and therefore their personal agency is diminished (Agich, 2003, p. 105). Furthermore, Foucault (1977) considered Bentham's panopticon as a symbol of the power an institution can apply to control behaviour in a social setting through observation. Using clumsy communication, the activities coordinator, calling *follow the leader*, highlights the power relationship between the organisation policies, staff practices and the residents (Carter, 2019). However, Agich (2003, p. 117) notes that the 'kind of choices that are meaningful or worth making' is relevant to a sense of self. Therefore, I believe that the 'follow the leader' statement made by the activities coordinator was made with the best intentions of enjoying the moment and encouraging residents to explore the village outside of the rest home environment; walking maintains autonomy, improves balance and prevents falls.

Furthermore, Hasselkus (1997) observes that aged care staff have a professional responsibility to both their employer and the residents to ensure a safe and caring environment. Therefore, sometimes they have to make decisions to practise activities that support their 'burden of keeping order' (Borell et al., 1994, p. 232). Nevertheless, the consequences can be that older people, particularly those who have cognitive changes, are stereotyped as needing simplified and childlike interactions that often occur through language and activities that are humiliating and marginalising (Salari & Rich, 2001).

The following observation offers a juxtaposition that reinforces the significant notion of living 'with care'.

> *The village van is back from a shopping trip to the local supermarket. There is a lot of hustle, bustle, chatter and laughter as the residents clamber out of the van – some need a bit of assistance to climb down the steps. In the van's boot are several reusable bags; this makes it easier to identify which bag belonged to which resident, I would imagine. But then I notice that each bag also has a name tag attached. A very organised staff member.*

Going shopping for groceries is a day-to-day activity that we take for granted when we are not physically challenged or unwell. Continuing these routine activities into old age for as long as possible with carers or relatives enhances the sense of independence and personal agency.

> 'When my mother was still living at home with me, going to the supermarket was one of the activities we continued to do for as long as we could. The household task of deciding what we would eat during the weeks and creating a list was a regular and often comforting job we could do together. Not only was it practical, but it created a chance to get out into the community. So, each week we ventured out; it would take longer than maybe it would have otherwise, but it was worth it. On other days we would go to the library, second-hand bookstore or even stroll around our local mall and get a cup of tea and watch the world go by from a local café. During summer, we would head along to the beach and get ice cream. Then, either sit and watch the boats or take a walk, even paddling in the shallows.'

Segregating older people in aged care is a powerful cultural influence that institutional practices can exert; therefore, the older person has to navigate their way through the politics of that space when seeking autonomy (Foucault, 1977). Older people dread the restrictiveness of not getting out in the community or having visitors. This restriction heightens their

dependence, and seizes their freedom and creates further vulnerability to the frailty of old age (Johnson, 2006, 2013). Therefore, Foucault's heterotopic mirror supports understanding the humble trip to the supermarket, in a retirement village, as one of living *with care* instead of existing *in care* with no autonomy (Cook et al., 2015). Having the ability to write a shopping list, book a seat in the van to visit the supermarket, choose the items, unpack and enjoy them at your leisure gives older people the ability to oversee their schedule. Likewise, this excursion encourages older people to maintain their appearance as they are in the company of other residents and out in the community. Therefore supports a sense of independence and self and consequently promotes place attachment (Falk et al., 2012). The retirement village staff are an essential factor in this context. They provide the mitigating opportunity, transport and support with the bag tags and a helping hand to support the older person remain independent.

Participant observation presented the opportunity to see many of the residents' activities in the community living areas and how the various spaces are lived in and utilised. On this particular occasion, I observed the activities coordinator busy with Christmas decorations and orientating a new staff member. I offered to help with a big box of knitting paraphernalia and was happy to sit with the ladies knitting club. These ladies were so welcoming and proudly told me how old they were and soon were happy chatting amongst themselves while we all knitted.

> *I spent the afternoon with the ladies 'knitting and natter club'. Their age range was from 85 to 97, and all very keen to share that with me. They all live in the assisted living apartments and come from very different backgrounds, and lives lived, although most of them had lived locally before moving here. They reminisced about how thrifty they were when they were raising their families, such as swapping jumper*

> *sleeves over when the elbows were worn out and reversing their husbands' shirt collars. The family was central to their conversation. Many of them were knitting items for their grandchildren or great-grandchildren. It helped them feel useful, purposeful. Some were just knitting to keep their hands, brain and memory moving.*

The ability to form an attachment to a place is supported by the opportunity to make friends. As previously discussed, socialising ensures residents consider themselves and their clothes, and maintain their appearance. Human agency gives place meaning, and continuing with activities you would have done at home closes the gap between home and a new life in a retirement village (Andrews & Shaw, 2008; Falk et al., 2012). These ladies had found comfort in reminiscing and sharing memories and continuing a craft that also empowered the bond of friendship. Furthermore, the social factor for these ladies is evident, they come from different worlds, but the commonality of ageing, knitting and their new living arrangements has created a heartening bond between them. By embracing the opportunity to spend this time together, something new has developed for these ladies that could have otherwise become a life that was lonely, isolated and prescriptive within an institutional space (Tuckett, 2007). Therefore, the heterotopic mirror reveals how delicate the threads are between the negative and positive 'orderings' within a space.

Additionally, the community spaces negate the need to invite a visitor to your 'home', whether it is a room or apartment. The heterotopia manages the space by removing the need to entertain in the privacy of your home, much like a community centre or resort (Foucault & Miskowliec, 1986; Street & Colman, 2012). Consequently, the Reinecke (2015) study of interstitial space enabled me to observe and experience how these ladies had unknowingly discovered companionship by embracing a new way of life and relationships and possibilities.

During this knitting natter, I became conscious of the 'otherness' of place that the residents experienced in the place they had chosen to be 'home'. The retirement village's institutional nature required the ladies to live with the constraints of confidentiality and employment issues while making friends with the other residents.

> *There was some chatter about a staff member leaving and how sad and disappointed they were about this. They were wary of the new person being a man, and how would they relate to him? They were sharing their first impressions with each other; was he cheerful? 'We have not seen him smile yet.' Also, they are aware of the turnover of staff and are wondering why. These ladies are sharp as tacks. They also exchange thoughts about the activity coordinator having to share their time with the independent residents as a priority and how that changed their daily routine some days.*

Foucault's heterotopian thinking proffers a lens to view the diverse and complex relationships within the retirement village. The incongruent stakeholder relationships are influenced by the institution's power and knowledge in this situation (Johnson, 2006; Mason, 2020; Street & Colman, 2012). The knitting club ladies are astute and understand they cannot interfere with the retirement village employment matters as it is not their business. However, their discontent is clearly due to the vested interest in their relationship with the activities coordinators as they have routines and lifeworld considerations that include their capital investment as village residents. Therefore, the residents see the relationships they have as more than just that of a consumer of the activities coordinator's programmes and events.

Moreover, their awareness of these matters identified that older people should not all be stereotyped as fragile and cognitively challenged (Bradshaw et al., 2012; Kemp, 2010; Salari & Rich, 2001). Perhaps a village community notice board regarding upcoming events or

changes would resolve these matters. Furthermore, being able to farewell staff and welcome the new would build a sense of inclusion for the older people. Navigating the politics of privacy and information is a very different matter when living in your own home. The community grapevine would usually activate when a friend became unwell, and the neighbours could rally around to provide support.

> *The ladies express concern for one of their fellow residents with each other. She usually sits at their dining table, and they have not seen her for a few days. Is she sick? In the hospital? Or has she passed away? When they ask after her, they cannot be told for privacy reasons.*

The heterotopic lens reveals the 'mixed but joint experience' in one place (Foucault & Miskowliec, 1986, p. 24). This heterotopian lens reveals the challenges of living in a space where institutional and professional governance constraints prevent community support that is expressed by the genuine concern these residents have towards their missing neighbour. The consequence is the inhibition of their natural agency, challenging their connection to the place they now call home (Brown & Perkins, 1992; Johnson, 2006, 2013). Furthermore, for those that previously experienced a confronting childhood and/or home life, this could be harmful, challenging their ontological security and exposing the 'shadow side' and instability of their connection to place (Chawla, 1992, p. 66; DeWitt et al., 2009; Giddens, 1991).

The Village Library

The retirement village has a library strategically placed in a high traffic area that is relatively small. It is more like a personal library in a stately home, with deep, rich mahogany shelves lining two walls wrapping around and past patio doors out into the sunshine.

This library is space within a place and highly heterotopic because it is also continuously gathering time, from the past, present and future within the books which creates a time-lag from the normal flow of time (Foucault & Miskowliec, 1986). Additionally, the library space provides a 'mixed but joint experience' of otherness in a 'space outside the everyday for engagement with other times, other histories, other cultures' (Foucault & Miskowliec, 1986; Radford et al., 2015, p. 740).

> *The books are all organised from A–Z, there are large print books, reference books, fiction, NZ history and Readers Digest volumes, they remind me of growing up when my parents must have collected them too. I remember how they often had two or three novels in one book and were hardbacks with leatherette covers and gold embossed writing down the spine offering the titles and authors of the stories of another time and place. As I peruse the shelves, a flurry of residents swoop in to collect their daily fix of puzzles and local news from the table.*

The library is a space of opportunity, where people can metaphorically step into Dr Who's Tardis and be transported to another place and feel the freedom of another lifetime if only in their imagination (Chapman, 2006). For the older people in retirement, it is the place where they can access and experience a sense of imaginary freedom from the constraints of old age.

Much like a local library, this space also has other features that offer access to information in the community and practical advice to navigate life in the retirement home.

> *A notice board is holding advertisements, upcoming events, mobility scooters for sale or an electric lazy boy armchair. Across the room was another board packed with info offering computer support in the community and other community services. Across from that was another notice board with the village policy (corporate) and the various health and disability policies and rights, and complaint procedures. Adjacent*

> *to a small desk and printer, which I believed to be for all residents to use, there is a table with folders and photo albums. A box packed full of used glasses frames waiting to go to Rotary to support others less fortunate overseas. Further investigation, I find the folders are admin files for the residents meeting notes, and there are an activities and events booking diary and another folder for outings and trips such as a fish and chips night.*

Foucault's notion of heterotopia provides a lens to observe the way this library space is different to that of one in a stately home or indeed the local community library through the provision of tailored information, publications and resources that meets the needs of its community (Radford et al., 2015). The institutional influence exerted through the display of information on the notice boards and posters are artefacts to ensure all residents receive the same communications collectively. The heterotopic lens exposes the bespoke nature of the library books being tailored to meet the interests and needs, such as large print, for those older people in the retirement village (Salzmann-Erikson, 2015; Schein, 2010).

In contrast, you would find books on a shelf or table at home and likely to be of a personal choice in various places around the home, such as the lounge, bedroom, kitchen or office. Conceivably there would be a broader range of books such as children's books, academic and recipe books. Furthermore, at home, general information is commonly found under a magnet stuck to the fridge, in the home office or more commonly these days accessed via a Google search on the phone, tablet or laptop; with the fundamental difference being the choice to keep, see or read the information.

Radford et al. (2015) draw attention to the power relations and code of conduct a library has and its expectations of those using the space. As a space of otherness, the retirement village library is different due to the mixed but joint experience because of the type of books and

resources available to the older people who access the space. The power this library space imposes is guided by the code of behaviour the retirement village has established through access to specific books, publications, games and puzzles. Furthermore, the unique power relation the retirement village exercises is via the book return system, the notice boards' content and the various folders that manage the community activities within the village. Understanding the space as one of a community resource will enable the older people to make sense of their relationship with the retirement village, library and home space (Foucault & Miskowliec, 1986; Radford et al., 2015).

Gated Gardens

When looking at the marketing of the retirement village sector the manicured gardens imagery is a strong theme. As you drive through the gated, grand entrances (see *Figure 3*), you are momentarily in a liminal space at the threshold of a place that juxtaposes the present, the past and the future while changing how time is experienced attributable to the hegemony of the institutional culture (Foucault & Miskowliec, 1986; Johnson, 2013; Reinecke, 2015).

Figure 2: Retirement Village Entrance (Shutterstock, 2020)

> *All the roads, lawns, flowerbeds and berms within the village are pristine. A positive of living in the village is not having to worry about the garden as someone is taking care of this and you get all the benefit of enjoying the outlook. Not like Auckland berms since the council stopped taking care of them and the curbs that are full of debris.*

Entrances to retirement villages are often through beautifully maintained gardens that most of us aspire to, as they attempt to create a utopian reality. As a heterotopia, the garden promotes normalising a place of crisis for the older people living there (Foucault & Miskowliec, 1986). However, the actual reality is a heterotopic representation of an idealised version of how we would like to have a garden without the effort it takes to maintain such a picture-perfect space. As considered earlier, Foucault reflects that gardens are heterotopic because of the multitude and variety of plants and trees that are gathered in landscaped spaces to be 'curated and gazed at', much like the older generation inside the retirement village (Carter, 2019, p. 2; Foucault & Miskowliec, 1986). Furthermore, gardens also hold symbolic meanings, such as the English garden that mimics nature's irregularity in its cottage garden form or the Persian garden that provides a utopian view of a sanctuary in the desert. The Persian garden was developed to depict the four world elements of water, wind, fire and earth, which are also traditionally reflected in the Persian rug; which becomes yet another heterotopic space that can move between spaces (Farahani et al., 2016; Foucault & Miskowliec, 1986). Therefore, the heterotopic, symbolic nature of gardens and the example of the heterotopic Persian rug emphasises how the heterotopia disrupts our social experience of a space.

Therefore, considering the symbolism of marigolds as artefacts of the retirement village gardens gave me further insight into the heterotopic space.

> *Marigolds feature a lot in the gardens; they are beautiful vibrant flowers that fill flower beds and patio planters. They are often an older persons' choice for a garden border.*

Understanding the culture of marigolds leads me to the knowledge held in the various meanings they possess depending on the worldview or religious beliefs that one holds. For example, Hindus and Buddhists offer marigolds to the gods as a metaphorical connection to the sun and renewed life. For Christians, the name marigold originated as Mary's Gold and therefore is attributed to the Virgin Mary. During the Victorian era, marigolds represented despair and grief, and for Mexicans, marigolds are linked to their remembrance of the dead (Porter, 2014; Samaha, 2020). The symbolism of these flowers and the cultural connotations of despair, grief, remembrance and renewed life can be reflected in the vulnerability and dread of the retirement village residents when considering the flowers as artefacts via Foucault's heterotopic mirror (Foucault & Miskowliec, 1986); therefore supporting the notion that the heterotopic lens challenges our understanding of the different meanings within a space.

While walking around the retirement village's community gardens, I am drawn to the balconies that the independent residents have with their apartments. The utopian manicured gardens now reflect in the heterotopic mirror, revealing the older people's individuality that has made their homes apartments.

> *Looking at the independent resident's apartment balconies, the eclectic décor of each one gives an insight into the personalities. For example, one balcony has two wicker chairs and a small matching table with no plants – it is plain and functional. However, the balcony below has an eclectic mix of plants in pots of all shapes and sizes. Another balcony had all white pots, with lush plants and greenery in*

> *abundance. It must provide a sense of belonging, making the balcony your own. For me, it feels much like walking along a residential street and considering people's gardens. Some people are house proud, some like gardening, some have no time and others do not care.*

The mixed and joint experience Foucault's heterotopian mirror provided while I was standing looking at the resident's balconies from the utopian gardens challenged the reality I comprehended and, therefore, provided a discerning reflection of the older person individuality (Foucault & Miskowliec, 1986). It is like the child who creates a make-believe home in a Wendy house that reconstitutes their existence where they are, in the way they know (Foucault & Miskowliec, 1986; Johnson, 2006). Therefore, these residents' balconies offer insight into the connection to the place they have chosen as home; while understanding that each person exists with the positive and negative influences that have shaped their lives (Appleyard, 1979; Chawla, 1993; Manzo, 2014; Marcus, 1995; Maslow, 1943; Merleau-Ponty, 1962). Furthermore, on these balconies, I can see the residents are free to express themselves as these areas appear immune to the institutional power of décor choice exercised throughout the village.

Afternoon Happy Hour

On a different day, each week, each care space has a happy hour. The origins of 'happy hour' have a fascinating history that can be traced back to William Shakespeare's King Henry V when King Henry says, "Therefore, my lords, omit no happy hour, that may give furtherance to our expedition" (Scene 1, Act 2). In this instance, happy hour refers to a time to enjoy rest, relaxation and some entertainment (Shakespeare, 1599, p. 22). However, further insight into the history of happy hour exposes various world events when individuals were experiencing difficult times that include the armed forces in World War One, the depression of the 1930s

and the era of American prohibition when individuals hosted cocktail parties before eating out due to the ban on alcohol. Furthermore, more recently, the licencing authorities in England banned the concept of happy hour in bars and pubs in 2010 as they believe that it encouraged binge drinking (Poppleston, 2014).

> *It is happy hour in the hospital space, and a musician has been entertaining the residents with songs from old favourites Elvis, Tony Bennett, Nat King Cole and Frank Sinatra, to name a few. There is a drinks trolley with some soft drinks, beer and bottles of wine and sherry. It appears a singalong with a beer or sherry provides a welcome social disruption from the routine and monotony of day to day life for the older people.*

Conceivably then, 'happy hour' in a retirement village can also be interpreted as a moment of relief, as it was during the war and prohibition. On this occasion, it is a relief from the crisis of old age for these older people as it temporarily liberates them from the sameness of day-to-day life by providing an opportunity for some social interaction, a live music sing-along and some refreshments. Lustbader (2013, p. 18) highlights that many older people in retirement villages have a feeling of becoming disconnected from the outside world as living in such a communal space 'feels like living on a ship that never leaves the dock', which introduces Foucault's heterotopic ship, a space, a placeless place that is independent and isolated (Rankin & Collins, 2017). However, life on the hospital floor of the retirement village is far from the independent living experience on a cruise ship for the dependent residents. Village life is far from the notion of roaming freely and choosing from a menu of cocktails on deck or enjoying a buffet breakfast, or dinner with the captain and cabaret show – the realities of each place are quite different.

I found myself thinking about why happy hour is not in the community area for all the mobile residents, where there is a bar, dance floor and pool table. I did consider and understand the dependent residents' mobility issues and subsequent practicalities for the staff being a reason for the event taking place in separated areas. Hauge and Heggen (2008) and Kenkmann et al. (2017) explain that each space's realities are quite different within retirement villages with both independent and dependent care choices. Independent residents' preference is to have separate spaces from dependent residents within their village community as it highlights the fragility of old age and how retirement villages are liminal spaces. The independent living happy hour was a somewhat different atmosphere.

> *In the community bar area, a musician sets up a stage and speaker system for the happy hour for the independent living residents. Some of the residents are behind the bar with staff getting glasses out and organising the space. A table is set up for the snacks. I can smell food cooking which smells like fish and chips. Residents start to arrive, and they have seen this as a good opportunity to get dressed up and are dressed in smart casual resort-style clothing. The bar area's age range is surprising, so I presume some people are relatives visiting for the afternoon and enjoying the opportunity to join their family for a drink. The atmosphere is a social buzz of groups in conversation.*
>
> *Husband B arrives, he looks very smart compared to the normal day-to-day casual. I can see he has found a way to balance his life and move between the independent resort life and the hospital setting to care for his wife. For him, this works for them as a couple. It might not be perfect, but they are independent and not a burden on their family. The musician starts, and some of the residents are straight up and dancing.*

> *Others are in groups talking. Some groups seem quite specific and intertwined – but much the same as in any community setting.*

The feeling of belonging and ontological security in a place comes from the routines and way of life that meets both physiological and psychological needs, and within a retirement village, this is enriched by providing a 'with care' approach (Cook et al., 2015; DeWitt et al., 2009; Giddens, 1991; James et al., 2014; Manzo, 2014; Maslow, 1943). The heterotopic mirror challenges the scenario of my initial observations as a utopian event where the older people gather in place with friends and family to enjoy a pre-dinner drink, some light refreshments and live music, much like being at a wedding or on a cruise holiday or at a resort (Foucault & Miskowliec, 1986; Rankin & Collins, 2017). However, the 'shadow side' becomes visible when looking into the heterotopic mirror and able to view the interstitial space; the choice to live in a retirement village's care can sometimes have unwelcome consequences (Chawla, 1992, 1993; Foucault & Miskowliec, 1986; Reinecke, 2015).

> *A resident is unhappily explaining to a group of friends that her husband has to move to another village as he needs specific dementia care, and there is no bed available in the village for him. 'No one tells you about this until it happens. We moved here so it would provide care all the way through whatever we needed. What did we pay for?'*

The inaccessibility of available care challenges the ontological security for this resident and her husband; that is the place they carefully chose to be their home. The vulnerability and dread materialising in this personal crisis reveal the complete illusion of the utopian retirement village. Furthermore, the heterotopian nature of this space exposes the personal dread that many older people face as the realities of old age and frailty disrupt the 'peace of mind' that the utopian retirement village constructs (Giddens, 1991; Johnson, 2006, 2013; Knight, 2017; LeFebvre, 1974; Levitas, 2003). I am sure that each resident investing in the

retirement village for long-term care has been advised that there is no certainty of continuity of care ‘in place’ as the individual health needs evolve. However, this does not invalidate the reality of the emotional impact of the realisation that your life partner or parent needs care away from ‘home’.

> ‘My mother’s experience of needing 24-hour nursing care in an aged care village was distressing for both of us. Justice (2018) confirms that the vulnerability and stress that my mother would have felt during the dreadful experience of moving from place to place several times was a significant factor that accelerated her journey into the darkness of Alzheimer’s. I felt powerless. Not being able to find the right place immediately was heartbreaking.’

Dinner Date Realities

Mealtime is a busy period for the village healthcare staff, with many residents in the hospital needing feeding. I have volunteered to support two ladies who need to be fed. Thankfully my nursing background and personal experience gave me an understanding of how time-consuming and vital mealtimes are. It is an opportunity to chat and engage one-on-one while ensuring that the resident has adequate nutrition and hydration to maintain their health. Hence, movie choice is perhaps not a priority. On this particular evening, *Mr Bean, the Movie* has been planned for those eating dinner in the living room and had been selected by a staff member. Husband B’s reaction to the movie choice emphasised the complexity of the living room’s heterotopic space as one with multiple orderings.

> *Husband B is with his wife for a meal. His interaction with the carers is about the TV and not wanting to watch Mr Bean again! ‘Please, anything but Mr Bean.’ I think to*

> *myself he is either joking or expressing real frustration at the same programme being put on day after day.*

For Husband B, this is distressing, and while he jests about the repetition of the choice of movie, I sense the disappointment in his voice and his vulnerability to the politics of place, as it is the healthcare staff who hold power over the TV remote control, which accentuates the nature of the frailty of the residents and the institutional environment. However, the dichotomy is that the movie is the go-to choice for a reason; perhaps the film has become recognised as a soothing influence for many residents who may be unsettled at this time of day due to the sundowning phenomena associated with dementia. Hence, the movie's choice reduces anxiety for the staff and residents and supports the mealtime process. Alternatively, perhaps no thought goes into the choice of the movie due to the time constraints and priorities of care.

However,

> *The volume was low, so only those closest to the television could hear the dialogue. Moreover, most of those sitting on the room's peripheries are either asleep or not cognisant enough to follow a movie. While other residents became unsettled and wanted to walk to their rooms.*

Bearing in mind, the healthcare staff have very limited time to ensure all residents are fed while the food is warm and before the next stage of care can happen, which includes medication, personal care and into bed before the night shift staff commence (Egan, 2018; Lopez, 2006). However, adapting to or considering residents' wishes or their relatives is about taking the time to consider effective communication within the caring environment, which would empower a sense of belonging and reduce the dread of mealtimes. It is the institutional constraint that affects how healthcare staff can influence their residents' care.

The protocols and rules fundamentally limit this in place, such as the ratio of staff to residents (Cristoforetti et al., 2011; Salari & Rich, 2001; Scharlach et al., 2012).

Therefore, the time constraints of residents' care can be interpreted as another illustration of the vulnerability of residents being subject to infantilisation, for example, like a mother who needs to settle a toddler and chooses to distract them with an episode of *The Wiggles*. However, from experience, this involves an element of choice or negotiation; *The Wiggles*, *Postman Pat* or *The Teletubbies*? Therefore, it is the healthcare staff's responsibility to consider the needs of all the residents and visitors in the living room and 'hear' Husband B's remarks and mediate the situation, thus creating a sense of place and belonging for residents and relatives.

Sprawling Space and their Invaders

Throughout the day, while observing the vast hall and studying the place, I became aware of the heterotopian nature of the space uncovering a range of institutional messaging. Salzmann-Erikson (2015), Carter (2019), Foucault and Miskowliec (1986) explain how institutional power relations are revealed through the building's architecture with large open spaces that communicate the corporate work-like ambience rather than a homely quality. The artefacts that indicate a space other than that of home are the contrasting furniture, fixtures and fittings.

> *The space is enormous and flows from place to place; the library, hairdresser, dining room, bar area with a full-size pool table and an impressive timber flooring that is perfect for dancing; ballroom, line dancing and group fitness. The furniture is substantial with armchairs and sofas that envelop you. Occasional tables have large ornaments; however, anything smaller in this space would look strange. There are*

> *giant urns and huge vases with large and elaborate flower arrangements on occasional tables alongside oversized bowls filled with nautical rope and glass balls resembling buoys. The colours are all neutral, neither feminine nor masculine, in design or colour scheme. The lighting is good due to safety needs, and the wall lights add a homely tone, although their size is far from homely. Finally, the luxurious full-length curtains with bold print complement the windows' size and provide a sense of warmth. I observed that several curtains had lost some of their hooks. This fascinated me as the standard of furnishings is very high-quality, like a hotel lounge. Conceivably the missing curtain hooks give the space a more lived-in and homely touch. The tell-tale signs you are in a retirement village are the emergency buttons in each space, even outside on the patio.*

On the surface, the retirement village conveys a utopian image through the manicured gardens, architecture, furnishings and leisure amenities characteristic of the sector in New Zealand. However, the heterotopian lens begins to reveal the political agency of the spaces as they are constructed and dressed to demonstrate the character of the corporate brand reducing them to non-places that are waiting to be employed through the activities that take place in them (Augé, 1995; Brey, 2005; Carter, 2019). Examples of this include bingo in the formal dining room, the staff meetings at the dining room table in the hospital area, the cinema hosting the relatives meeting. Nevertheless, when reflecting on the use of spaces at home, it is not unusual to find activities other than meals happening at the dining room table. I know mine often becomes a study hub, a place to fold the laundry and on occasion has been a table tennis table and a beer-pong table. Thus, highlighting the heterotopian discourse of space means different things to different people who are free to express themselves.

The Occupation of the Paraphernalia of Vulnerability

The retirement village marks time as a characteristic of being a heterotopian place; in the same way, a museum or garden accumulates time by the nature of the particular objects that denote time (Foucault & Miskowliec, 1986; Johnson, 2006). Consequently, these objects allow a different way of being in the space. The crisis of ill-health occurs as the body betrays older people over time, and consequently, frailty overshadows their identity, and therefore older people progressively find that their body becomes a prison. This is further compounded by the culture of old age that can be both undignified and infantilising. Subsequently, older people find that their physical body dictates the terms of their dependency on others and the paraphernalia of vulnerability.

The walking stick, mobility walker and even the wheelchair provide an escape from that dependency on others by providing a sense of freedom through movement (Featherstone & Wernick, 1995).

> *They are more than just a walking aid, providing transportation for their cups of tea and other items that they might need; their knitting, books, tissues, diaries and meaningful keepsakes such as photos of loved ones to show others.*
>
> *One lady uses hers to take a jigsaw back to the library in exchange for library books. The need for a handbag has been replaced for the ladies. I also notice the independence the walker affords as it helps one older man with Parkinson's shuffle his way around the pool table; it has also helped him stand and tend to his table of plants.*

Sayers and Brunton (2018, p. 20) explain how the 'jumbles of walkers' congregating in various spaces around the village emphasise the juxtaposition between home and institution

and reveal the heterotopian reality of compensation that is the crisis of how older people live in care. Furthermore, the frequency of walking aids through the village exposes the space as an institution, an-other heterotopic place, for the vulnerable and old in need of specialist care.

> *The walkers gather together waiting for their owners while they eat, play bingo, visit the hairdresser or join their knitting buddies. It is reminiscent of bicycles in the 'bike shed' at school. The scene is one of impending liberation to walk. Losing the ability to be independent is very real in the village.*

The 'corralled' walkers as artefacts of the heterotopian space reveal the institutional dependence, created by the staff, as they have been removed to the peripheries of the space for safety and tidiness. This orderliness of corralling the walkers is synonymous with the institutional culture of the health environment and their espoused values and assumptions (Schein, 2010). Furthermore, by moving the mobility walkers away from the older person, it is challenging their agency, reducing their autonomy, and perpetuating their dependency through the institutional power of policy and the use of space, thus prompting Foucault's 'order of things' by 'relegating the older person to an inferior position' (Foucault, 1970; Salzmann-Erikson, 2015, p. 138; Sayers & Brunton, 2018). At home, the older person would have their walker close by, next to their chair, the dining table or bed so that they have control over their ability to be mobile. These mobilisation aids provide a sense of security and control in their lives, therefore modifying their feelings of dread due to their vulnerability of falling and consequent dependence on others. Consequently, the socio-political rigidity of the institutional protocols and health and safety regulations generate a powerful message about the realities of living in a retirement village environment.

Chapter 5: Implications and Conclusion

This study has explored Michel Foucault's philosophies and ideas to understand the nature of the retirement village as a heterotopic place of crisis for the growing number of older people in New Zealand. Bazin and Naccache (2016) support the significance of heterotopia as a distinctive way to view the spatial dynamics of a place of crisis being experienced by older people, particularly those needing long-term care. Foucault's heterotopic lens illuminates the retirement village's institutional, spatial dynamics, and healthcare landscape, and confronts the individuals living and working in the space.

Reviewing the literature explored the dichotomy of the utopian/heterotopian space, which is essentially an illusion exposed by the dominant spatial, socio-political relations once inside or living in the retirement village. Moreover, this study has uncovered that 'how to feel at home' is influenced by our physiological and psychological need to feel safe, make choices and feel a sense of belonging. However, the heterotopic mirror also exposes the reality of the 'otherness' of home as it is not always viewed as a safe place. So, by applying Foucault's notion of ruptured thought informed by the use of an ethnographic methodology, I elicited three significant themes: dread, vulnerability and belonging. Furthermore, the heterotopic lens provided a unique way of considering the trilogy of stakeholders' distinctive experiences of the village spaces and how the socio-political pressure manifests and influences those places and individuals, thus illuminating how the places and spaces have diverse meanings depending on their relationship with that place.

For many, visiting an aged care residence can be distressing and an assault on the senses. The pungent smell of urine leaving you too scared to sit down, for fear of a damp seat; the vision of an unidentifiable beige and green moulied meal or the shrieks of distress from a distant

corridor. This is not very comforting for someone with no experience of caring for frail and infirm older people. However, these are undoubtedly not the only phenomena to see, smell, touch or hear. There are many positive moments to experience from personal knowledge when visiting retirement villages; the smiles that greet you; the hand that grasps yours in the delight of seeing you; the love in the arms that wrap around you; the enticing aroma of fish and chips on a Friday lunchtime and listening to so many memories of life 'way back when'.

However, the dread of old age for some people may begin to develop as they witness their parents become less physically able, and their general health begins to decline. The experience of visiting a parent in a retirement village, rest home, hospital or dementia care facility accentuates the existential dread. Indeed, you are faced with the reality of your vulnerability and mortality as you realise that you may also experience similar frailty in the future (Grimsley, 1956; Harvie, 2011; Stone, 2017).

Furthermore, the dread older people have of the dependency on retirement village care is exacerbated by horrifying media accounts of elderly abuse and neglect in New Zealand facilities. The media choose the path of presenting a salacious story to increase their readership, as the novelist William Boyd stated when discussing what sells a good story, 'if there is nothing at stake, it is not interesting' (Boyd, 2021). Therefore, it illustrates why the media choose to report understaffed facilities' caring crisis discourse and the inefficiencies of uncaring, unqualified and immigrant workers taking New Zealanders' jobs. Sadly, this can create a sensationalised illusion and spread propaganda that portrays all retirement villages as untrustworthy places. Retirement villages must be wary of these publications despite the occasional valid truth, as they collectively impact all organisation, staff, residents and relatives who continue to live and work in older people's best interest.

This study revealed how, as older people become frail, they dread the 'shadow side of life' as their 'circumference of life's experiences' reduces. Therefore, as their choices dwindle, it influences their independence, excluding them from access to family and friends, compounded by the feared decline of mental clarity due to dementia (Chawla, 1992, p. 66). Older people experience the shock and dread of retirement villages and have had a myriad of time considering their twilight years since they too looked after their parents or visited relatives and friends in care. Indeed, they have even read the media articles and listened to friends' anecdotal experiences along the way.

Therefore, the decision to leave the family home's ontological security is difficult to make when presented with the reality of life in care. Likewise, relinquishing intimate connections with the comforts of home, routines and generational community would be challenging, because at home, older people feel an unconscious sense of belonging, especially when they can access the support that reduces their vulnerability to ill-health challenges. However, DeWitt et al. (2009) advocate that the need to feel safe and have physical and emotional support will eventually outweigh any stoic desire to remain independent at home. Particularly once their unique adapted routines are challenged by failing health, the notion of being cared for provides philosophical security and support to which they reluctantly surrender.

It appears that the dread of dependence does not correlate with older people making their own decision to enter full-time care. The decision is seldom theirs as their failing health renders them powerless. However, those that remain capable of being involved in the decision-making process should be included and empowered to make decisions for themselves. Too often, they experience an un-timely hospital admission due to a fall, an infection-induced delirium, or other general health concerns that inhibit their independence. Habitually this leads to institutional interventions by health professionals and families at a time of crisis.

Consequently, the hospital admission creates feelings of dread, vulnerability, helplessness and confusion for the older person and their relatives, as this part of the ageing journey appears to often lead to the final stop in care (Chrisp et al., 2013; Shippee, 2012; Yeung et al., 2017). For some relatives, the feelings of shame often surface for not having done more, not seeing the signs of declining health or fulfilling their parent's wishes. Conversely, other relatives may feel relief that their parents are now in safe hands, with twenty-four-hour round-the-clock specialised care and liberated from the fear of finding them on the floor at home or worse, once more, highlighting the heterotopian complexity of meanings for different people and how the caring landscape is transformed by the knowledge situated in place and time. Exposing the retirement village as a heterotopia of illusion exposing the otherness of place as real spaces, generating different experiences.

A New Zealand healthcare sector phenomenon is the growing need for immigrant healthcare staff, as the need for caring staff for our older people increases year by year. Gao et al. (2015) and (Walker, 2009) outline that New Zealand has the highest proportion of non-native overseas trained nurses in the OECD. However, these are highly trained nurses and caregivers from countries where caring for the elderly is a fundamental part of their culture, and immigration policies in New Zealand are rigorous (Immigration NZ, 2021) . These vital immigrant health carers choose to confront the challenges of the caring principles in New Zealand while coping with their vulnerability to verbal and physical harm or racism from residents with cognitive decline. The Immigration NZ (2021) aged care webpage acknowledges the different caring principle with the quote, 'In Kiribati we worry less about time, but in New Zealand, I have to work quicker'. A care workforce study by Ravenswood et al. (2021) draws attention to workplace experiences of those working in the residential aged care sector. The work loads, training and development, and personal safety all present issues that significantly impacts staff retention and recruitment. The study found the most

common reason for carers ‘wanting to quit their job’(p. 52) was stress and workplace-employment conditions.

COVID-19 also impacted immigrant carers as they became stranded with work commitments and travel restrictions. Many faced a year of enforced separation from their families, which continues to affect them with the ongoing COVID immigration restrictions (O'Brien, 2021), emphasising how they integrate into a new culture, facing linguistic challenges and learning new organisational/healthcare system practices and governmental policies.

This exposes how the older person becomes more vulnerable to the intimacy of care and institutional routines as their life choices dissipate, as the institutional/organisational culture and socio-political relations generate vulnerability for the carer while managing their non-work life. Subsequently, the associated vulnerability of older persons and healthcare staff is revealed. The exposure of both the resident and the carer to the constraints of time and other peoples’ needs in the institutional workplace illuminates the ‘mixed, joint experience’ that can occur in the same place (Foucault & Miskowliec, 1986, p. 24; Sayers & Brunton, 2018).

Acknowledging their exposure to institutionalism enables the health carers to perceive that the same occurs to others around them. By doing so, they develop a comprehension of the residents, relatives and their colleagues’ individuality and thus play their part in acknowledging and mediating the culture and spatial relations that would give residents a sense of belonging and security, alleviating the feeling of dread that comes as personal agency and autonomy fade. Furthermore, when healthcare staff embrace the notion of vulnerability as a constructive attribute, they can feel empowered to express this by articulating meaningful purpose to equipment such as the buzzers (that disturb the ambience), since they reduce their exposure to injury and harm, and create a purposeful connection with the residents.

In interpreting the varying dynamics of how place and space impact older people's sense of belonging in the retirement village, the heterotopic lens reveals the power relations and spatial discourse that threatens their identity as they navigate the new spaces and relationships (Carter, 2019; Massey, 2005). Giddens (1991) and(Cook et al., 2015) explained how we develop ontological security in a place that feels safe and with people we trust. Additionally, this study has revealed the older persons' possessions offer a tangible feeling of security. For example, meaningful things like photos of family and favourite places create memories; books and artwork are imbued with deep personal meaning; a pet that has been a trusty companion is a great source of comfort; and a chair or bed provides relief from pain and insomnia. Additionally, older people develop relationships, routines and customs that provide a protective cocoon that reinforces their identity and self-determination.

This emphasises the importance for older people to be encouraged and empowered to make choices about how they are cared for, and where and when that care takes place. These choices then contribute to their unique lifeworld existentials and empower their sense of belonging (Stone, 2017; Van Manen, 2014). The healthcare staff play an essential mediating role within the dominant socio-political relations that influence the residents' quality of life and thus impact their sense of belonging.

The retirement village's homogeneous and collective institutional care routines generate a dynamic heterotopian spatial tension that disrupts the residents' lifeworld existential mood. Levitas (2003, p. 6) has illustrated how the 'interstitial spaces' are real-time spaces between heterotopic places and fictional perfection of utopias. Interstitial spaces have complex, dynamic variables and layers of meaning that intertwine and relate to each other, facilitating transition and change. This highlights how relational knowledge grows in the time and space shared between the healthcare staff and the resident. Understanding these heterotopic layers

of meaning facilitates the unpredictable and disruptive nature of human surroundings within a space. Therefore, utopias and heterotopias have a shared purpose of providing an alternative way of living and finding a sense of belonging (Bevilacqua, 2017; Foucault & Miskowliec, 1986). So, when the health carers employ the notion of ruptured thinking, it is possible to develop personalised care plans. However, this is dependent on genuine responsiveness to explore the interstitial spaces of the residents' lives, their lived body experiences, sensory reactions and emotional disclosures. Recognising the value of the bespoke routines and habits from their past and reflecting them in the present recognises the residents' exposure to the power of the place and moderates the obstacles to their personal agency, sense of security and security belonging.

In this thesis, I have from time to time interwoven my own personal reflections of caring for my parents and my professional positions, with my observations and discussion. Although I acknowledged in my introduction to this thesis that these experiences may colour my perceptions, I now also acknowledge that my personal experience has enabled me to enter the field with foreknowledge and empathy, so that my observations and powers of reflection are enhanced. I have come to a new appreciation of these environments and their complexities. My hope is that this thesis will assist others to see that retirement villages and their various spaces are not simply places where people go when they are old and infirm, but bright, contradictory places full of paradox and interesting happenings, peopled with committed professionals and real people getting on with their lives.

Conclusion

Heterotopias are not straightforward hierarchical spaces. This reveals how spaces can produce different meanings depending on the specialist knowledge, differing interests and *épistémè.* They provide a specific context for management theory and practice that is not often mentioned in management scholarship. The heterotopic lens enables us to see the unique alternative organisational culture that exists in retirement villages. Further research is needed to develop understanding about how heterotopic space allows people to explore and try alternative ways of working without the *épistémè* undermining the potential for innovations and alternatives outside of established ways of working, which is worthy of management consideration and future study.

Waring and Bishop (2018, p. 665) state that engaging Foucault's notion of heterotopia allows for a 'trialectic' understanding of 'space–knowledge–power', offering a novel way of perceiving the complexity of space. The fusion of private–public partnerships has become customary in New Zealand, with Government departments choosing to partner with both commercial and not-for-profit organisations to provide the function of their strategic direction. However, this results in a blurring of the individual organisation's politics, social structures and *épistémè* as they become amalgamated across spaces and combine differing interests. As a consequence, the heterotopic lens exposes the complex relationship between the Ministry of Health and the corporate retirement village in a private–public partnership. The *épistémè* of this partnership influences the workplace and how staff practice shapes care and affects how residents find a sense of belonging and create a home.

Pertinent to the retirement village leadership is the mediating role of the nursing and caring staff in the retirement village space who ensure the residents' wellbeing. This study leads me to conclude that encouraging further family, community connections and employing more

qualified staff would relieve the constraints on time to make the most of the various spaces outside of the typical day-to-day bedroom, dining room and living room – the waiting room. These changes in the use of the various spaces would help the residents find a sense of belonging in the retirement village community, particularly with regular opportunities to enjoy the grounds and gardens, the community areas for movies and afternoon teas or meals with family. However, I do understand this creates management and financial pressure on the organisation and funding partners to invest in the residents through increased contracts for care payments and the staff to acknowledge their worth in the aged care community with increased remuneration, training and support. However, it is also incumbent on the leadership in this sector (private and public) to recognise the social value created in improved working conditions and, therefore, performance, decreasing the risk of elder trauma and distress due to a lack of training and resources.

The number of immigrant nurses and carers in the retirement sector faces uncertain times with the Government considering a reduction in the number of carers entering New Zealand. I have seen that these people, especially those from the Pacific, India and the Philippines, have much to offer New Zealand through their instinctive cultural respect and affinity to caring for older people. Notwithstanding the wealth of Maori and Pacific culture and values in New Zealand, with the ageing population growing, we should look to the Filipino ethos of caring for family and the value they place on the notion of ‘shame’ (kahihiyan) connected with not caring for one’s elders (Estrin, 2021). Likewise, we can learn from the value Indian culture has in caring for one’s elders and how this gathers ‘good karma’ for individuals and families. Thereby offering a timely exchange of social and cultural awareness to inform policy and leadership practices in elder care and reduce ageism in health geography; there should be no shame in caring for older people in their twilight years. Catherall (2021) identified the current shortage of 300–500 aged care nurses. The growth of the 65+

population leads me to believe that this is worthy of future study to understand the sector's needs further and why so many New Zealand nurses do not see value in caring for older people. Ravenswood et al. (2021) express that with good policy aimed at a well qualified and supported workforce in the residential aged care sector the ageing population can feel secure in the knowledge that they will receive high quality care at a time of need and crisis in their life.

This ethnographic study has revealed the unseen multifaceted experiences that people have within a retirement village space contingent on their relationship within that space, staff, resident or relative. Furthermore, the study articulates how older people are confronted with old age's complex physiological and psychological turmoil, consequently impacting their lifeworld as their choices shrink amid the dread of possible surrender to long-term residential care. Employing Foucault's heterotopian philosophy provided the mirror to reflect and uncover the contesting and diverse spatial relations that create places of resistance, surrender and crisis.

Consequently, the study adds to the body of work exploring Michel Foucault's heterotopic realities and how different and dynamic forces occupy spaces. Using ruptured thinking, disregarding any preconceived ideas and habits can uncover the interstitial spaces that support understanding how older people can find a sense of belonging in retirement villages.

Returning to the research question: *How can a retirement village as a place of crisis become home?* The organisation's institutional power influences the space with dominant healthcare practices and workplace surveillance as part of its resident's 'caring regime'. To transition the caring environment from a place of crisis to a place to call home, it is incumbent on the organisation and staff to undress the dominant power and reveal the possibilities in the space. Hence, recognising the spatial influences that create dread and vulnerability, such as routines,

uniforms, furniture, décor and artefacts, by mediating them to support the resident find a sense of belonging and a feeling at home. When residents are surrounded by significant possessions that shape their identity, their past is recognised, which performs a meaningful role in their present by helping create a sense of belonging.

Furthermore, a sense of belonging can be shaped when staff include residents in the day to day decision-making and problem-solving process concerning their lifeworld and care. Therefore, it is essential to keep them informed about doctor visits, physiotherapists, blood tests, hospital visits, or any significant day-to-day changes that impact their vulnerability or belonging. Empowering the older person is critical to their ontological security and personal agency. Therefore, it is incumbent on carers to learn the rhythm and habits the older person has created and empower them to maintain control to choose their clothes, food, where to eat, shower, or spend their time. Furthermore, acknowledge the older person may have lost trust in their bodies and recognise the bond the paraphernalia creates between the carers and residents required to keep them safe, such as the buzzers and walkers.

Acute stress, such as that created by an urgent moving into dependent care in old age, evokes negative emotions such as anxiety and depression that leave the person vulnerable to their surroundings. Speer and Delgado (2017) have found that reminiscing about positive memories acts as a buffer to stress's emotional and physiological consequences by actively lowering the stress hormone cortisol. Reminiscing improves the older person's quality of life and self-esteem by connecting with the past and what gave meaning to the older person's life. When a relative, carer or member of staff takes an interest in the older person's life, they feel heard. The older person's artefacts with them in the retirement village are the objects that can trigger those conversations, the photos, books, artwork. So, asking the older person about their family traditions, such as Thanksgiving, Christmas or birthdays and developing items

such as memory boxes, life story books with a visual timeline enhances their wellbeing. The things that trigger memories such as smells, taste, food, music and movies are fundamental to a person's lifeworld.

The retirement village sector has looked to address the older person's vulnerability to place and their sense of belonging. One of the larger corporate retirement villages, Oceania (2021), is implementing an evolving care model acknowledging that homogeneous care does not suit everyone. The new Oceania model brings care to the resident's care-suite (home) and evolves in place and meets their specific needs without any disruptive moves to other spaces of care.

The Eden Alternative was established in the 1990s by geriatrician Dr Bill Thomas and Jude Thomas to enhance the wellbeing of older people requiring full-time care. This would be achieved by 'eliminating the three plagues of loneliness, helplessness, and boredom' via a model that incorporates ten principles of person-centred caring, which promotes older people to feel empowered through choice and decision-making, and therefore have an influence on their day-to-day life (Eden Alternative, 2016). Several New Zealand retirement villages and rest homes have attained complete registration to the Eden Alternative model of caring so that residents can live life with meaning. Furthermore, the model integrates plants and animals and emphasises companionship and inclusivity in their community (Eden in OZ and NZ, 1999). A study by Wilby et al. (2016) discusses the Eden Alternative Well-Being Assessment Tool (EAWBAT) as a valuable means for aged care facilities to measure the wellbeing of their employees, residents and relatives, thus offering a tangible method of organisation review. Both of these models of care offer the opportunity for further research of the wellbeing of those in the aged care sector in New Zealand.

With the growing population of older people in New Zealand, the aged care sector would be wise to gain a better understanding of how older people are experiencing the ageing journey

in New Zealand, as their unique experiences of frailty inform care practices. Having a good grasp of the older New Zealander and their life path will support their transition from home into long-term care and how they can create a sense of belonging in their new surroundings.

The heterotopic mirror exposes the dichotomy of places within the retirement village's spaces, contingent on the resident's independence or dependence on care, creating vulnerability and manifesting dread. Furthermore, the staff obligations to the *épistémè* of corporate and institutional geographies of health and nursing care reveal the utopian resort as a heterotopic space of crisis for many older residents; so, *How can a retirement village as a place of crisis become home?* The heterotopic mirror reveals the interstitial space in the place. This is where the perception of the complexity of meaning for the trio of stakeholders can be understood, thus challenging the spaces as places of otherness that expose the retirement village as a 'place of compensation', a space facilitating another place – Home.

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Appendices

Ethics Notification – NOR19/57

Date: 13 November 2019

Dear Fiona Colbert

Re: Ethics Notification - **NOR 19/57** - **There is no place like home : How the notion of home changes when moving into residential care.**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Northern Committee** at their meeting held on **Wednesday, 13 November,**

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics **Research Ethics Office, Research and Enterprise** Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973 **E** humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Organisation Information Sheet

INFORMATION SHEET

Organisation

"**There is no place like home: How the notion of home changes when moving into residential care"**

I would like to invite you to take part in this research study that is being undertaken by Fiona Colbert as part of a Master of Business Studies degree. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read this information sheet and ask any questions should you need further information using the contact details below.

You have been invited to participate because you have the experience caring for those that have left their own home and relocated to your residential village. This study will involve observing the day to day life in the village, examining organisational procedures and policy and talking with the staff, residents and their families about home and their experiences within the village community that is creating a new meaning of 'home'. If you do decide to participate, then I will ask you to sign a consent form, of which you will keep a copy. You will also have the right to:

- Decline to answer any questions.
- Withdraw from the study with the knowledge your data will be omitted from the study (within 10 days of the data collection period).
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that the organisation name will not be used.
- Be given access to a summary of the project findings when it is concluded.
- Ask for the recording device, if one is being used, to be turned off at any time during an interview.

All information collected (data) will be anonymised and will not be used in a way that would enable identification of any individual. Data will be stored securely on a password-protected computer, and any hard copy information will be kept in my primary supervisor's locked filing cabinet for a period of five years. This information will be collected through observation, conversation and sometimes through interview. This information will be used to understand different perspectives and views on what makes a 'home' and therefore inform this study.

Project Contacts

Researcher: Fiona Colbert, telephone: [redacted] email: [redacted]

Supervisor: Ralph Bathurst, telephone 094140800 x.43404 email: R.Bathurst@massey.ac.nz

Supervisor: Janet Sayers, telephone 063569099 x.84939 email: J.G.Sayers@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 19/57. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.

Residents and Relative Information

INFORMATION SHEET

Village Resident or Resident's Relative

"There is no place like home: How the notion of home changes when moving into residential care"

I would like to invite you to take part in this research study that is being undertaken by Fiona Colbert as part of a Master of Business Studies degree. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read this information sheet and ask any questions should you need further information using the contact details below.

You have been invited to participate because you have moved from your own family home and relocated to a residential village. This study will involve observing the day to day life in the village, examining organisational procedures and policy and talking with the staff, residents and their families about home and their experiences within the village community creating a new meaning of 'home'.

If you do decide to participate, then I will ask you to sign a consent form, of which you will keep a copy. You will also have the right to:

- Decline to answer any questions.
- Withdraw from the study with the knowledge your data will be omitted from the study (within 10 days of the data collection period).
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that your name will not be used.
- Be given access to a summary of the project findings when it is concluded.
- Ask for the recording device, if one is being used, be turned off at any time during an interview.

All information collected (data) will be anonymised and will not be used in a way that would enable identification of any individual. Data will be stored securely on a password-protected computer, and any hard copy information will be kept in my primary supervisor's locked filing cabinet for a period of five years. This information will be collected through observation, conversation and sometimes through interview. This information will be used to understand different perspectives and views on what makes a 'home' and therefore inform this study.

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Supervisor: Ralph Bathurst, phone 094140800 x.43404 email: R.Bathurst@massey.ac.nz

Supervisor: Janet Sayers, phone 063569099 x.84939 email: J.G.Sayers@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 19/57. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.

Staff Information Sheet

INFORMATION SHEET

Village Staff

"**There is no place like home: How the notion of home changes when moving into residential care"**

I would like to invite you to take part in this research study that is being undertaken by Fiona Colbert as part of a Master of Business Studies degree. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read this information sheet and ask any questions should you need further information using the contact details below.

You have been invited to participate because you have experience caring for those that have left their own home and relocated to a residential village. This study involves observing the day to day life in the village and talking with residents, their families about home and their experiences within the village community, creating a new meaning of 'home'. If you do decide to participate, then I ask you to sign a consent form, which you keep a copy. You also have the right to:

- Decline to answer any questions.
- Withdraw from the study with the knowledge your data will be omitted from the study (within 10 days of the data collection period).
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that your name will not be used.
- Be given access to a summary of the project findings when it is concluded.
- Ask for the recording device, if one is being used, be turned off at any time during an interview.

All information collected (data) will be anonymised and will not be used in a way that would enable identification of any individual. Data will be stored securely on a password-protected computer, and any hard copy information will be kept in my primary supervisor's locked filing cabinet for a period of five years. This information will be collected through observation, conversation or sometimes through interview. This information will be used to understand different perspectives and views on what makes a 'home' and therefore inform this study.

Project Contacts

Researcher: Fiona Colbert, phone: [redacted] email: [redacted]

Supervisor: Ralph Bathurst, phone 094140800 x.43404 email: R.Bathurst@massey.ac.nz

Supervisor: Janet Sayers, phone 063569099 x.84939 email: J.G.Sayers@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 19/57. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.

Interview Questions

"There is no place like home: How the notion of home changes when moving into residential care"

Theme – Home

- How does relocating from your home to residential care make you feel?
- What helps you feel at home here?
- What important 'things' did you bring with you from your home?
    - Does this effect how you feel 'at home' now?
- Are you still able to see your family and spend quality time with them?
- What do you miss about being in your own home?
- What do you appreciate the most about being in residential care?

Theme – Dread

- Did you dread the prospect of moving into residential care?
- Did you have control over the decision to move into residential care?
    - Does this effect how you feel 'at home' now?
- Can you describe what it was you were dreading?
- Has the feeling of dread changed as time has passed since relocating to residential care?

Project Contacts

Researcher: Fiona Colbert, telephone: [redacted] email: [redacted]

Supervisor: Ralph Bathurst, telephone 094140800 x.43404 email: R.Bathurst@massey.ac.nz

Supervisor: Janet Sayers, telephone 063569099 x.84939 email: J.G.Sayers@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application __/__ *(insert application number).* If you have any concerns about the conduct of this research, please contact A/Prof David Tappin, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43384, email humanethicsnorth@massey.ac.nz.

Research Interview Consent Form

CONSENT FORM

There is no place like home: How the notion of home changes when moving into residential care

Fiona Colbert, Researcher, telephone: [redacted], email [redacted]

Massey University, Albany Campus, Auckland

Request for informed consent:

- I have read the study information sheet provide and been given adequate time to consider it
- I have been given the opportunity to ask questions about the study and any questions have been answered to my satisfaction
- I understand that my participation is voluntary
- I understand that taking part in his study may involve being interviewed and I agree to this interview being audio recorded
- I understand that my personal details will not be revealed to people outside of this study
- I understand that my words may be quoted in publications, reports, web pages and other research outputs but data collected about me during this study will be anonymised before it is submitted
- I understand that I can withdraw from the study at any time and will not be asked any questions about why I no longer want to take part
- I understand that if I withdraw from the study my data will not be used

Name of Participant Signature Date

Name of Researcher Signature Date

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application __/__ *(insert application number).* If you have any concerns about the conduct of this research, please contact A/Prof David Tappin, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43384, email humanethicsnorth@massey.ac.nz.