Chapter 6

Resident involvement: the process and the perceived effects of the PARTNER intervention in residential care

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Abstract

Resident involvement is a new trend in care homes. The PARTNER intervention aims to involve residents through collective action to improve their community life and wellbeing. The purpose of this article is to provide insights into the process of resident involvement via the PARTNER intervention, and into its perceived effects.

A qualitative evaluation study was conducted, using participant observations, semi-structured interviews with residents, volunteers and professionals (n=16), and three focus groups. The findings demonstrate that the intervention helped residents to develop actions (gallery parties and a buddy project) to strengthen social interactions. With the help of volunteers and professionals, the residents realized their plans. We conclude that structural partnerships between residents, volunteers and staff in residential care homes need to be developed further. They lead to empowerment of residents and positive effects on volunteers, professionals, and other parties such as resident councils.

Introduction

During recent decades, health care professionals have been in the lead in residential care homes. The evidence is that professional-led care in institutional care settings tends to deactivate residents and contributes negatively to their further loss of autonomy and independency.[1-6] Such evidence is in line with the writings of sociologists like Foucault and Goffman who were critical of the humiliating and depersonalizing effects of 'total institutions'.[7] In order to counter the negative effects of hospitalization on older people, several initiatives have been started which aim to change the culture within these institutions in order to attune care better to residents' needs and to activate and involve residents in their own living environment. Notable is the development of best practice in residential care in the UK (www.myhomelife.com), and the cultural change movement in residential homes in the US.[8,9] Most of these initiatives are targeted at achieving a transition from a medical institution to a living community with a welcoming and rewarding environment for residents, families, staff, volunteers and neighbours. As part of this cultural change movement in the care of the elderly, initiatives, such as involvement in treatment decisions and care plans, have been undertaken to enhance the involvement of individual residents.[10-12]

The collective involvement of older people in residential settings has also increasingly received attention. Studies on the collective involvement of residents via resident councils show that members are concerned about their lack of influence.[13-15] System values concerning the strategic position and financial continuity of the organization tend to dominate the life-world issues of the residents.[13] Participation of the residents, apart from formal arrangements, is scarcely developed. On most occasions such involvement takes the form of gathering management information, for example on the satisfaction of clients, or information for governance and accountability purposes. These consumerist approaches hardly meet the needs of residents to use their voices and to have 'a say'. Alternative forms of involvement, such as the placement of one resident as an advisor in a team with professionals, run the risk of tokenism and pseudo-participation.[16]

In response to the reported shortcomings in resident involvement via resident councils, and based on our research on alternative forms of collective involvement, an intervention

was developed. We call this Dutch intervention the PARTNER intervention, an acronym referring to the conceptual fundaments of the intervention: Participation, Action, Relations, Trust, Negotiation, Empowerment, and Responsiveness. The aim of the intervention is to empower residents and to improve their living conditions via collective action.[17] Collective action is defined as the joint and coordinated action of a group of people based on their agenda to improve their community life and wellbeing (compare Melucci[18]). According to Barnes and Shaw[19], older people can play a role in processes of community engagement, and this involvement has benefits for the older people themselves as well as for the wellbeing of the community as a whole.

The PARTNER intervention stimulates collective action and community engagement by older people who live in residential care homes (which we see as communities of people) by the formation of a group of residents, and mobilizes sources of strength within the group. The group is dedicated to a topic that has come to the fore through the members' exchange of experiences and values. The topics are important and relevant for residents. The topics stem from, and generate solidarity with, the broader resident community in the care home. In this way, residents do not act as consumers, but as citizens who work for the shared good. In order to enhance residents' influence on issues that affect their lives and to realize improvements, the intervention fosters the development of partnership relations with professionals through dialogue.

Over the years qualitative insights have been presented about the process of resident involvement brought about by the PARTNER intervention. In a case study the process of collective action was described from the perspective of the residents, showing how a common dissatisfaction about the quality of meals led to the formation of a group identity among residents, and how storytelling and dreaming about a desired future motivated the group to develop creative solutions, which were implemented.[17,20] We are, however, still lacking insights into the process of resident involvement from the perspectives of the various stakeholders, and into how the effects of the intervention are perceived by those who live and work in residential care homes. Therefore the aim of this article is to provide insights concerning how the process and effects of the PARTNER intervention are perceived by residents, volunteers and staff members. We will present the results of an evaluation study

concerning the implementation of the PARTNER intervention in a residential care home in the Netherlands.

The PARTNER intervention

Theoretical framework of the PARTNER intervention

The PARTNER intervention is based on the hypothesis that participation leads to empowerment of residents, and that empowerment leads to quality improvements in line with residents' needs, which may ultimately result in a better quality of life. The intervention is grounded in a citizenship tradition which assumes that people are not just consumers who want to have a choice, but rather are citizens with voices, who are willing to engage in and contribute to their community beyond their own self-interest, giving feelings of solidarity with that community.[18,21] Such engagement may turn into collective action if people share a common dissatisfaction, and if there is emotional recognition, a group identity and a common goal for social betterment.[18] Examples of collective action among older people living in the community are political organizations, cultural groupings, social or leisure groups, self-help activities, voluntary action and consumer groups.[19]

Resident involvement in the PARTNER intervention is a form of action in which a group of residents consciously contributes to the residential community and the wellbeing of fellow residents. In order to deal with power asymmetries between professionals and residents, the intervention assumes that resident involvement requires, first of all, deliberation within the context of converging interests in order to empower marginalized groups (which include the older people who live in residential care homes).[21-23] The group of residents may develop empowerment as they start to recognize that personal problems are in fact more broadly experienced, and that the joining of forces may lead to a shared agenda for improvement. This process of empowerment prepares residents for negotiations with professionals.

Empowerment is a multifaceted and multidimensional concept that has become a widely used word in the social sciences across a broad range of disciplines (including community psychology, management, political theory, social work, education, women's studies, and

sociology). It refers to both process and outcomes, can be individual or collective, and is found at psychological, organizational and community levels of analysis.[24,25] Empowerment as we define it is a relational process.[26,27] This notion of relational empowerment is based on the idea that when power is given by one (powerful) party to another (less powerful) party, or taken from the powerful by the less powerful party, empowerment is imbalanced. Instead, empowerment can be seen as a dialogical learning process in which all who are involved will change. Relational empowerment is grounded in an ethics of care, and stresses that people can become more autonomous as together they develop a feeling of trust in their own opinions, are able to acknowledge criticism, and appreciate the feasibility of change.[28,29] Given the collective nature of the PARTNER intervention, this relational approach to empowerment is appropriate.

In the context of residential settings, collective action by residents does not stand on its own, but needs to be integrated with the professional practice and decision-making processes in order to be implemented.[30,31] Therefore, partnerships need to be developed, and professionals and residents have to find mutual understanding and common ground. Partnership relates to relationship, power sharing, negotiation, collaboration and co-production.[10,32] Dialogue fosters mutual understanding and partnership as a basis for negotiating the implementation of improvements.[33,34] Such dialogue is characterized by the exploration of each other's beliefs, and by listening and probing. It requires openness, respect, inclusion and engagement, and asks for participants to be willing to share power and to change in the process.[35] Thus, dialogue between residents and professionals as an approach to building partnership relations is an important element in the PARTNER intervention.

Furthermore, the PARTNER intervention takes an appreciative approach towards people and organizations, which means that negative experiences and complaints are turned into opportunities for learning.[36,37] Further, residents who are involved in the PARTNER intervention are invited to focus not only on problems and things they miss, but to broaden their view and look for best practice and good examples that already exist. During the intervention they develop a shared vision of actions that can strengthen or improve the status quo (for the topic they put on the agenda); this involves the creation and expression of a dream.

Practical steps of the PARTNER intervention

The PARTNER intervention includes five steps in an action cycle:

(1) Agenda-setting by residents: The facilitator brings together a group of 8 to 10 residents with diverse backgrounds, interests and experiences, and organizes a meaningful conversation. Values, identity and life-world experiences are shared, and an agenda for quality of life improvement is formulated.

(2) Homogeneous groups: The resident group (action group) is brought together on a regular basis by the facilitator (8 to 10 times in total) to speak about their topic of interest. In this setting, they learn about each other's perspectives and to articulate with their own voices. Creativity stimulates their conversation, and helps them to think in terms of possibilities instead of problems. At the same time the facilitator organizes homogeneous meetings (one meeting per stakeholder group) with other stakeholders who are concerned with the topic that is to be addressed. These can be healthcare workers, volunteers, family, managers, or other groups, depending on the topic. The homogeneous meetings are meant to obtain the articulation of other perspectives on the topic and to lay the foundations for partnership development, which requires other groups to work together with the action group of residents.

(3) Heterogeneous group: During the heterogeneous group meeting, residents and other stakeholders meet face-to-face to exchange ideas for practice improvements, under the guidance of the facilitator. There is a proportional balance between the number of residents (50%) and the number of members of other groups (50%) to equalize the dialogue. The facilitator guides the dialogue and makes sure that residents are heard. The facilitator brings forward the diverse ideas and plans for practice improvements that have been developed in the homogeneous meetings, and first facilitates a dialogue on the values that underlie these ideas and plans. When participants have developed a mutual understanding on the underlying values and found common ground, the residents and other stakeholders speak about possibilities for combining and implementing ideas. This way, a joint agenda for practice improvements develops.

(4) Formulating ideas and plans: The action group and other groups formulate their ideas and plans for practice improvements during the homogeneous and heterogeneous group meetings. This way, as many action agendas arise as there are stakeholder groups. However, as a result of the deliberative process in the homogeneous groups, in which other stakeholders are introduced to the client perspective and vice versa, there will be overlapping ideas. The facilitator's task is to structure all these ideas and plans systematically and use them as a way to foster a dialogue about values and the creation of mutual understanding in the final heterogeneous group meeting. The next step is that the action group of clients and the other stakeholders come to concrete agreements about 'who is going to do what and when' concerning the practice improvements. This involves negotiation between clients and professionals concerning the possibilities (in terms of money, time, personnel etc.).

(5) Action in practice: During the heterogeneous group meetings, the participants come to agreements about collaborative actions. These actions will be jointly evaluated by the residents and stakeholders after a period of time. New issues or ideas for practice improvements can develop from this collaboration, which can lead to a new PARTNER cycle.

Throughout the process the facilitator plays an important role in supporting mutual understanding. Trust is created if the facilitator deals constructively with the power dynamics and any distrust between stakeholders, and prevents subtle forms of exclusion.[38,39]

Implementation of the PARTNER intervention

The PARTNER intervention was applied in a residential care home in the south of the Netherlands from January 2010 to February 2011. The home provides care to 135 residents, most of whom still live independently but need some support (personal care and/or cleaning, or light medical care). One floor with sheltered apartments houses people with an Indonesian background. The residential care home has a restaurant which is open to residents and neighbours in the community. The management supported the idea of resident involvement and the implementation of the PARTNER intervention wholeheartedly, because it fits the vision they pursue in policy and practice ('people need people'), and they provided resources like a room to meet residents and time for the staff to be involved. The facilitator role of the

PARTNER intervention was executed by an academic researcher (the first author). After a series of conversations with residents, volunteers and staff by the facilitator, a group was formed with eight residents who wanted to be involved in improving community life and the wellbeing of residents. The residents in the Action Group (from now on abbreviated to the AG) consisted of two men and six women, aged 63-92. None of the residents had psycho-geriatric problems, and all still lived independently in their own apartments. Two of the residents, a married couple, lived on the floor for Indonesian older people.

The AG's wish to improve social interaction related to experiences with bullying and negative interactions in public areas such as the restaurant, which the AG considered to be undesirable and to have a major impact on the residents' quality of life. Furthermore, the AG felt that most residents did not even know their neighbours. At the same time, the Indonesian couple told about the strong social cohesion among Indonesian residents. The positive experiences of social cohesion of the Indonesian couple touched upon the dream of the other residents to have stronger social ties in the rest of the residential care home as well. This made the AG consider that contact between residents who lived on the same gallery (floor) might have a positive effect on their interaction and conversations. This became their agenda (step 1).

The AG met 11 times as a homogeneous group. In step 2 of the PARTNER intervention, these residents developed a plan to improve social interaction between residents by organizing 'gallery parties'. These are informal meetings with all residents who live on one floor (there are 16 apartments/rooms per floor) in a communal room of the residential care home with the aim of getting to know each other better in a pleasant atmosphere. Also, one homogeneous group was held with volunteers, and one with the middle management of the residential care home. In step 3, the AG spoke with the activity leader to see whether it would be possible to organize gallery parties. In steps 2 and 4 the care workers and the volunteers proposed that they continued a buddy project to support residents who were lonely. The buddy project had stagnated, and the agenda of the AG increased the sense of urgency among staff as well as volunteers about reviving it. Staff members of the middle management level also formulated ideas and plans concerning facilitating small-scale conversation groups for residents. Finally, all perspectives, ideas and plans were brought together during a heterogeneous meeting that was attended by fifteen people (the AG, volunteers, managers, and staff). This heterogeneous

group agreed to start organizing gallery parties and to renew the buddy project. As part of step 5, residents and volunteers started to organize gallery parties together. Also, the buddy project was revitalised by a small working group consisting of residents, volunteers and staff.

Methods

Research design and procedures

The research question for this study was: How do residents and other participants experience the process set in motion by the PARTNER intervention, and what are the perceived effects of the intervention? A qualitative evaluation study was chosen, as this is the preferred approach for gaining an understanding of people's experiences and life-world context.[40] The methodological approach was informed by responsive evaluation, as this approach is suitable for gaining an insight into the multiple perspectives of those involved in the intervention.[41,42] Participant observations of the process took place before and during the implementation of the intervention. Sixteen semi-structured interviews were held approximately one year after the intervention. At the end of the PARTNER intervention, a focus group meeting was held with the AG to evaluate the process of the intervention. After the intervention, a focus group meeting was held with the resident council, and a heterogeneous focus group consisting of residents, volunteers and staff was organized to evaluate the process (See Table 1 for an overview of these research activities). Data analysis and collection were iteratively combined; initial data were not only analysed at the end but also during the process, and this analysis steered the subsequent data collection.

The research project was completed over a period of 16 months in total (from February 2010 to February 2011, and from November 2011 to March 2012). The research team consisted of four females with different disciplinary backgrounds (cultural studies; cultural anthropology; the culture of organization and management; and ethics).

Before and during the intervention, participant observations took place. Participant observations were conducted by the researcher (the first author) before the intervention during resident and staff meetings and residents' activities (dinner time, playing games,

Table 1 Research activities

	Semi structured interviews	Participant observations	Focus group
Before the intervention		Attending resident committee's meetings, staff meetings, resident activities	
During the intervention		Continuously during the homogeneous and heterogeneous group meetings, and during the pilot gallery party	With the residents from the AG **Total: 8 participants**
After the intervention	8 residents of the AG 2 residents outside of the AG 2 staff members 2 volunteers 1 team leader 1 location manager **Total: 16 interviews**		Resident council **Total: 10 participants** 5 residents of the AG 2 team leaders 2 staff members 1 care coach 3 volunteers **Total: 13 participants**

coffee mornings, etc.), and during the AG meetings in the various intervention steps. The observations were spread over 25 days, and totalled approximately 50 hours. Observation items included group dynamics, interaction amongst residents and between residents and volunteers/staff members, involvement, leadership and communication. The researcher's role consisted of watching, listening, assisting with activities and having conversations. Observations were made on the residents, volunteers and staff in different situations (helping with preparations for meetings, taking part in actions such as the gallery parties, etc). Field notes were written immediately after each observation. These consisted of systematic notations and records of behaviour, expressions and group dynamics.

In order to be able to learn about the experiences of all those involved in the PARTNER intervention, the residents in the AG, staff members, and volunteers who actively joined in the intervention were contacted. As a small group of people was involved, the research team decided not to select candidates for interview, but to include everyone participating in the intervention. In addition, two residents who were not involved in the intervention

were interviewed. The list of topics for the interviews were based on prior insights from our research on resident involvement[13,17,20,43] The list of topics for the interviews included the perceived results of the intervention, the development of partnership and collaboration, the experience of empowerment, the perceived changes due to the intervention, and the future use of the intervention.

All interviews were completed by one researcher (the first author). The interviewer focused on the meaning of experiences, and the interviews were guided by the respondents.[44] The topic list was used to check that all topics were covered. If topics were not covered, the interviewer would bring in subjects herself depending on the flow of the conversation. The interviewer listened, probed, gave summaries and mirrored answers to invite the respondents to go into more depth. The interview setting was chosen by the respondent, and most interviews were held at residents' homes and in staff members' offices. The interviews lasted for approximately 1 to 1½ hours. All interviews were tape-recorded with the consent of the interviewee, and a short report analysing the data, including the data from the different interviews, was prepared. This report was send to each respondent to check its accuracy (member check) and was used as a guideline in the final focus group. In all instances people recognized their experiences in the summary and appreciated the interview.

Three focus groups were brought together, one with the residents that formed the AG, one with the resident council, and one heterogeneous focus group with residents, staff and volunteers (see Table 1 for details). The focus group with the AG was facilitated by the first and second authors together (with the second author taking the lead). The aim of this focus group was to evaluate how these residents experienced the interactions and collaboration with each other in the AG and with others (staff and volunteers) with regards to the PARTNER intervention. In this focus group questions were asked concerning their expectations of the project and the extent to which those expectations were met, their perception of the power and ownership of the AG, their interactions with each other in the AG, communication with staff members with regards to the project, whether there was room for addressing the topics of interest to them, the value of the appreciative approach of the PARTNER intervention, and motivating and supporting factors for their participation in the AG.

The focus group with the resident council was facilitated by the first author. The aim of this focus group was to gain insights into the experiences of the resident council of resident involvement in general and of the PARTNER intervention in particular. The heterogeneous focus group was facilitated by the first author, and its aims were to check and validate the outcomes of the interviews that were held after the intervention, and to gain insights into the perceived effects of the PARTNER intervention. The actions that followed from the intervention (gallery parties and the buddy project) were discussed, as well as the collaboration between residents and professionals, and the participants' vision of the future of resident involvement in this residential care home, based on the analysis of the interviews. Reports were made after these three focus groups, in which the outcomes were summarized. These reports were sent to the participants of the focus groups for a member check. No changes were made by the participants.

An inductive content analysis was done.[45,46] The transcripts and field notes were read line-by-line and analysed independently for repeating themes and sub-themes by three research team members (VB, FB and SW), and these analyses were subsequently brought together. We used broad definitions of partnership and empowerment, as defined in the theoretical foundations of the PARTNER intervention, as sensitizing concepts.[47,48] Sensitizing concepts do not provide prescriptions for what to see, but suggest directions along which to look, and lay the foundations for the analysis of research data. No use of computer software was made. In the research team there was discussion about the codes given to the raw data until consensus was reached, a procedure known as co-checking.[49] The team also discussed whether or not saturation was reached. Saturation occurs when there is a repetition of findings, and this was the case after this set of interviews and the focus group meetings. Triangulation of methods (interviews, focus groups, and participant observation) helped to produce a greater breadth of data, and to identify discrepancies.

This study was not considered to be invasive for residents. Residents, volunteers and staff members were approached by the researcher directly, because they had come to know each other well during the intervention. Privacy and confidentiality were respected. The researcher had no therapeutic relationship with the residents.

Findings

This evaluation study sheds light on the process and the perceived effects of resident involvement in the context of one residential care home.

Process of the PARTNER intervention

Start situation

Professionals, particularly staff members who worked at middle management level (team leaders), had an open and supportive attitude towards resident involvement. The vision of the overarching organization in which this residential care home is embedded is 'people need people'. Great attention was paid (during festivities, training and meetings) to the implications of this vision for the care services of this organization and the interactions amongst and between residents and professionals. In this residential care home, the local vision focused on dialogue as a way to bring people closer together. The PARTNER intervention was seen by the manager of this residential care home as a welcome instrument to develop resident involvement further:

The people who are involved in this home start to appreciate the value of dialogue. This is a growth process, as long as you continuously pay attention to it and try to stimulate it in diverse ways. The PARTNER intervention is part of this development.

This resulted in practical support from the local manager and team leaders towards staff members (care workers) who were asked to participate in the intervention, and thus the staff members were given time to participate. At the same time, team leaders' experience was that it was difficult to involve residents in social activities and projects. They found it hard to motivate and stimulate residents to participate, and were disappointed when only a few residents showed up. Some staff were rather sceptical about the possibilities of creating partnership relationships with residents and strengthening social interaction between residents. They tended to characterise residents as people who complained and gossiped a lot, rather than as people who were willing to be involved in problem-solving and collaboration.

Also, they felt that the residents had a lack of understanding of the organizational issues that underlay problems (e.g. lack of staff, or work pressure). A team leader stated:

They [residents, VB] seem to think 'Participation is not needed. Leave it to others.' One has to work hard to get them to be involved.

However, staff members saw the PARTNER intervention as a way to break through these disappointing experiences and to gain new insights into resident involvement.

Agenda setting

Residents, volunteers and staff all indicated that they felt urgent concern with regards to the occurrence of gossiping and exclusion amongst residents. They referred to the existence of cliques, little groups of residents who tended to sit at the same table in the communal restaurant area every day, looking at everyone who entered the room and discussing their clothes, etc. Often, these residents sent away new residents who wanted to sit down at a table. The new residents were told that the seats were taken, but usually no-one else showed up to sit there. This kind of interaction had diverse effects on residents. Some were indifferent to the issues and ignored them. Others seemed to be more affected by these confrontations, and spoke about feeling sad and lonely. This sometimes even resulted in residents staying away from the communal areas and refusing to take part in social activities. Volunteers and staff members recognized the description of these situations, and had sometimes interfered. For example, one of the volunteers in the restaurant tended to take a humorous approach, confronting residents with their actions by drawing attention to turning a chair upside down to look for an (obviously non-existent) name plate. However, a sense of powerlessness concerning the (negative) interactions between residents seemed to dominate the view of volunteers and staff. Also, residents themselves tended to feel powerless to change the existence of groups and exclusion in the residential care home, saying that this happens in every community (at work, at clubs, in a village, etc.).

In the AG, the residents spoke about these interactions. One of the residents in the group experienced exclusion herself. She shared with the group her feelings of loneliness, anger

and sadness that occurred every time she felt other residents were chatting about her when she entered the communal room. It made her feel very uncomfortable. In combination with her grief over the death of her husband and her cognitive problems caused by several TIAs, it made her feel very vulnerable and exposed in relation to other residents. Some other residents in the AG had seen similar patterns of interaction with other residents, and thus understood the feeling of this particular resident, even though they did not experience the exclusion themselves (or were indifferent towards what other residents thought of them). For the married couple who lived in the Indonesian area, the stories about exclusion were new. In their area, they experienced strong social ties and friendship between residents. However, they were touched by the stories of the other residents, and felt that it was urgent for the interactions to be improved because they wished other residents to have the same positive experience as they had themselves. From this basis of diverse experiences, the AG chose 'strengthening social interaction between residents' as their joint topic and aim for actions resulting from the PARTNER intervention.

Developing residents' collective action

The urgency of the topic of social interaction between residents, and their strong wish to improve the wellbeing of residents who felt excluded from the life of the community, became the driving forces for the AG in the PARTNER intervention. The focus on positive interactions was chosen on purpose. The AG discussed the problem and reasoned that the negative interactions were not just a matter of interpersonal conflicts, but were grounded in a lack of stimulating daily activities and personal contacts and in the slightly boring community life. Instead of preventing or prohibiting gossip and bullying, the AG wanted to focus on the roots of the problem. Moreover, the AG noticed that positive interactions like friendships and conversations were not always recognized and stimulated by the staff. Hence, the focus of the AG became the stimulation of contacts between residents. During their meetings, the AG regularly discussed this focus. They struggled with the dilemma that they did not want to force other residents to participate in social interactions. For example, they spoke about some residents they knew who, according to them, would never participate in social activities because they wanted to be left alone. These examples sometimes made the residents in the AG doubt whether their efforts to strengthen social interaction were of any use or value. This

doubt could have caused the creative process in the AG to stagnate. However, the facilitator stimulated the residents to think about what the idea would mean for other residents who actually wanted to participate in social activities, but who felt hampered in doing so. This strengthened the AG to believe in their dream and to develop a joint mission to reach those residents who would be receptive to participating in actions that would stimulate contact. They decided that residents who did not feel the need for social contacts would be respected.

The appreciative approach that is part of the PARTNER intervention stimulated the AG not only to express their negative experiences and examples of exclusion, but also to share their experiences of positive interaction between residents and examples of support and of friendships being built between residents. This also gave room for the couple from the Indonesian area to share their experiences in the AG, which became a source of inspiration for the AG.

During the process of the PARTNER intervention, we observed the development of a sense among the members of the AG of belonging to a group, and this was confirmed by the focus group meeting with the AG and by the individual interviews that were held a year after the intervention. The residents in the AG described how their interactions led to a 'family feeling' and a 'bond'. Differences between them were acknowledged and were never a barrier to their interaction. On the contrary, some of them expressed in the interviews how they thought that speaking about the differences between them had helped them to really get to know each other and to develop a joint vision. One of the residents in the AG said:

There were different opinions, but we managed to create a coherent whole out of it.

The different experiences of the residents in the AG also contributed to their mutual support. The residents who had not experienced exclusion themselves were able to stimulate the residents in the group who felt more vulnerable to have more self-confidence and to look for good contacts. The AG felt that the power of this group lay in their ability to listen closely to each other, to give room to everyone, to be friendly, to show tolerance to each other and to help each other. One of the residents in the AG was an outspoken feminist, which was not a common philosophy of life in this residential care home (or for the generation of this

resident, who was 92 at the time). Her ideas were sometimes very different from those of the other residents in the AG. However, this did not lead to conflict or misunderstandings but to respectful discussions in the AG.

Coincidentally, at the time of this project the Dutch media paid a lot of attention to the occurrence of bullying in residential care homes and nursing homes. The tenor of these media messages was that serious bullying exists in care homes for the elderly, and that an anti-bullying protocol was needed. The AG discussed these media reports and concluded that this was an unbalanced representation of community life in care homes. The residents felt that comparing older people with fighting children was stereotypical and denigrating and caused great damage to the image of this care sector. They decided they wanted to respond to these issues with their own story, thus creating their first collective action together. The researchers (VB, TA), together with the local manager and two residents from the AG, wrote a newspaper article giving a more balanced picture of the interaction between residents in residential care homes.[50,51] In the article, they protested against the suggestion of an anti-bullying protocol by stating that residential care homes are not school playgrounds and that older people are not children who need to be disciplined. The article was published in a local as well as a national newspaper and illustrates the collective action of the AG, their shared vision and their joint mission. A quote from this newspaper article:

The description of care homes where residents make each other's life a misery and where anti-bullying protocols should make sure that people show better behaviour (the way it works at schools), is incomplete (or even mistaken).

The collective action of the AG also included their efforts to organize gallery parties, with the aim of strengthening social interaction between residents. They spoke with the activity leader about the practical steps for organizing gallery parties. Together with the activity leader they developed a pilot gallery party, and they got some practical help from the facilitator of the intervention (the first author) and from some volunteers. One of the residents of the AG prepared the invitations (little cards with an invitation, hanging on a rose) and took these invitations to the residents of one floor of the residential care home. All the residents from the AG (including those who did not live on the floor that was invited) were present

at the pilot party. This pilot gallery party turned out to be very successful: all the residents came (except for two residents who were ill), the atmosphere was open and cosy, and the introduction round led to meaningful conversations between the residents who were present. Every resident was given a little card with an appreciative question (for example, 'What activity do you like most?', 'What was the best day of your life so far?', etc.). The AG had thought of this introduction 'game' in order to break the ice and to create opportunities for meaningful conversations between residents. This turned out to be a good way of starting the gallery party, because the residents answered the questions enthusiastically and interacted with each other (making jokes, and sharing their own experiences in response to those of others).

One resident answered her question ('What would you still like to be able to do?') by telling the others that she would love to go shopping, but that she was unable to do so on her own. Immediately another resident replied that she could go shopping with him, and to the surprise and pleasure of the other residents, these two agreed to go shopping together. During the introduction round, one of the residents of the AG went to every resident present, holding a microphone in front of them so that people with hearing difficulties were also able to follow the conversation. After the introduction round, the volunteers who were present gave the residents another cup of coffee or tea and treated them to some pastries. With some light classical music in the background, the residents started to chat with their neighbours, and after some time they also changed places so that they could speak to others as well. After two hours, everyone started to leave, enthusiastically thanking the volunteers and the residents from the AG for the nice evening.

The great success of the first gallery party strengthened the confidence and motivation of the AG to go into dialogue with professionals about further developing gallery parties in the residential care home. This way, their collective action would become embedded in the residential care home.

Developing partnership between residents and professionals

During the PARTNER intervention, not only residents, but also volunteers, care workers and team leaders were involved in formulating their ideas on the topic of strengthening social interaction between residents. In their homogeneous groups of volunteers, care workers, and team leaders (one meeting for each group of representatives), they were asked to reflect on a story from the perspective of a client. This story was written by the researcher (VB) and had been approved by the AG. It was based on the experiences of different residents, and presented their wish for contact with others and their disappointing and sad experiences of exclusion. The volunteers and professionals recognized this story as something they saw in their practice as well. It stimulated them to exchange their perspectives on the social interaction between residents, including loneliness and bullying, but also new friendships and mutual support. Care workers explained that they regularly worked for residents who told them that they felt lonely but who were reluctant to go 'downstairs' to the communal area and the activities room. Care workers offered support for these residents by listening to them and stimulating them to find someone to join them in going to activities or to have a coffee together. Volunteers in their homogeneous group described what they already did to influence the atmosphere between residents positively (for example using music and humour, being patient or listening to the residents). These care workers and volunteers were then asked about their ideas for actions to strengthen social interaction between residents. These ideas concerned the re-institution of the buddy project in which individual residents could get in touch with a volunteer who would accompany them to the market, to have a coffee, or on a walk.

These homogeneous meetings were experienced as valuable by the participants, giving room for their experiences and stories. The group of care workers, for example, mentioned that this way of exchanging experiences was something they missed in daily practice, because their working meetings were always full of practical issues and urgent (organizational) matters.

In the heterogeneous group meeting of the PARTNER intervention (step 3), people from diverse backgrounds participated: four residents from the AG, three staff members (middle management), three care workers, one activity leader, and four volunteers. During this

meeting, the participants spoke first about the values and experiences that lay behind the ideas and plans for action they had formulated during their homogeneous group meetings. Common ground was found in the urgency they all felt concerning the interactions between the residents. From that basis of mutual understanding, the ideas for actions to contribute positively to the social interaction between residents could be combined and decided upon. This resulted in concrete agreements about the organization of the gallery party (with active roles for residents from the AG and volunteers) and the re-institution of the buddy project (involving a small working group with two residents, two volunteers and the activity leader, who took up the task of revising the old format of the buddy project). All participants felt that this meeting was a positive experience, as it gave room to these diverse perspectives. A participating care worker formulated this as follows:

I find this very clarifying. We, as care workers, are used to talking about the residents. Like 'what can we do for them, how should we do it'. It is great to experience this today: together with the residents, so that they can have their say.

Perceived effects

Actions to improve community life and wellbeing

All respondents (residents, volunteers and staff) were equally enthusiastic about the gallery parties that were organized as a result of the PARTNER intervention. These gallery parties have become a structural part of the organization: every month residents from one gallery are invited by two residents from the AG who take the other residents a rose with an invitation card, and volunteers are present at the gallery parties to provide drinks. One year after the end of the project the gallery parties were still continuing, and were seen as a way to create a more lively and dynamic community. The gallery parties were a positive experience due to the large turnout of enthusiastic residents, the good atmosphere and the new connections that were made between residents. The gallery parties were experienced positively by residents who were not part of the AG as well, because it offered them opportunities to get to know other residents:

I thought it was very pleasant that I finally met some people. I had been living here for one year already, but I knew only a few of my neighbours.

Volunteers valued the gallery parties highly and were positively surprised by the active attitude and commitment of residents:

I think the cosiness of the gallery parties and the commitment of the residents is remarkable.

I did not expect that so many residents would show up. I was surprised and very happy to see that every time almost all residents showed up at the gallery parties.

Staff members also saw the gallery parties as a success, because of the positive experiences of the residents. A staff member:

I hear all these reactions afterwards, like 'oh, it was so very pleasant, how nice to meet each other in such a nice and relaxed atmosphere'.

A team leader even found that one of the residents wanted to move to another floor because she had heard of the gallery party that had been organized on that floor. Her floor had not yet had a gallery party, and she thought that gallery parties were exclusive to that other floor. Thus, she urged the team leader to let her move to that other floor because, over there, gallery parties were being organized.

Even though the focus of this PARTNER intervention project was on the gallery parties (because this was the action that was initiated by the AG of residents), the buddy project can also be seen as a result of the intervention. The homogeneous meetings of volunteers, care workers and team leaders provoked their sense of urgency about the loneliness of some residents they met. The need for re-instituting the buddy project was fed by the residents' stories and by the opportunity given to these volunteers and care workers by the PARTNER intervention to reflect on their own experiences and ideas for improvement actions. Since the PARTNER intervention, the buddy project has been promoted by a new slogan (invented by residents, volunteers and the activity leader, who have come together occasionally to discuss

the buddy project), which is: 'Do you feel like having a coffee or a chat? Call your buddy!' The group also developed information flyers and circulated these. The residents, volunteers and staff members who had been involved in the PARTNER intervention were convinced of the value of the buddy project for residents, and the need for making it a very accessible way for supporting residents. One of the volunteers, who is a buddy for residents, emphasizes that the buddy project is valuable for the residents as well as for herself.

It brings me a lot of satisfaction when I go to the market place with this lady. Her children do not always have time for that, and if I go to the market with her and we have a cup of coffee, well, yes, it gives me a wonderful feeling.

The residents, volunteers and staff members who were involved in re-instituting the buddy project said during the heterogeneous focus group of our evaluation that they only wished that more residents would make use of the buddy project. They had the impression that it was still a big step for residents to approach a volunteer and ask them to become a buddy. Therefore, they were going to continue to improve the buddy project. The activity leader was going to speak with a group of residents about what they thought of the buddy project and how they thought it could be made more accessible. Resident involvement and partnership thus continues.

Further, the project resulted in collective action by the AG writing a newspaper article. This was written as an expression of the collective action of the AG, and was intended to resist the negative stereotyping by society of people who live in residential care homes. For the residents in the AG, this newspaper article was meant as a contribution to building a good image and a positive vision of people who live in residential care homes, which can be considered as a source for good community life and wellbeing in residential care homes.

Resident empowerment

Residents joined the AG because of the following motives: they were looking for contact and (meaningful) conversation, they wanted to help fellow residents and they wanted to

contribute something to the residential community. The PARTNER intervention offered opportunities for them to meet these needs and motives.

This is something different: being able to talk with a group of people. Something different from sitting here on my own all day long.

I like to be involved, if only I can get in touch with others.

Some residents spoke about feeling a duty to participate and about being curious. One of the residents in the AG was a member of the resident council and felt it was his responsibility to participate in the project:

No one else from the resident council wanted to take part in the project and that made me feel embarrassed. So I decided I would become involved myself.

Some saw the PARTNER intervention as a welcome revival of their wish to be involved and to continue the values and roles of their previous life. These residents had been actively involved in club life, management jobs and/or in supporting and helping others. For them, this resident involvement was a way to continue their previous lifestyle and activities, thus promoting their wellbeing and empowerment. Another resident in the AG felt the intervention was a chance to learn and develop.

Actually, it is very good to bring people together. Because we all, except this gentleman, used to be housewives. And we were never accustomed to giving our opinions. Women in general, I mean.

Over time, residents who participated in the AG felt that they became a group (despite the differences between them), that they supported each other and that they still can count on each other. They felt proud and enthusiastic about the successful outcomes of the gallery parties. Relational empowerment became visible when the residents in the AG explicitly supported one female resident in the group. She used to be very negative about the interactions between residents, and had experienced gossiping and exclusion herself. During the meetings, the others listened to her, comforted her, and stimulated her to act differently herself. This was

of the utmost importance for her and, according to her as well as to the group, she visibly changed into a more confident and positive person.

The project exceeded the expectations of the residents who took part in the AG (they expected that only a few people would show up at the gallery parties), and they learned that they could actually achieve something. This was an empowering experience for them, since it created a sense of control and influence and it encompassed a learning process.

We were all very tense, 'will all these people actually come [to the gallery party, VB]?' They all came!

I learned how out of nothing, something can come into being. We started with nothing, and then it resulted in a gallery party.

For residents, participating in the AG of the PARTNER intervention was an empowering experience because it met their needs for meaningful conversations, and they got an opportunity to help others and to contribute something to the community, to take responsibility, to continue or develop a participating lifestyle, and to have an influence on the issues that mattered most to them.

Side effects

The PARTNER intervention has a focus on first developing the empowerment of residents, and then going into dialogue with professionals in order to create partnership. Even though the focus is thus on resident empowerment, the evaluation shed light on the positive effects of the intervention on volunteers and staff members as well.

The volunteers who were involved in the PARTNER intervention experienced the project positively and highly valued the outcomes (gallery parties). Involvement in creating improvements meant a lot for these volunteers, because it made them feel at home and valued. Further, it met their wish to have contact with residents.

I used to feel like I was 'only' a volunteer. That feeling has changed because we are asked to participate more. I gained self-confidence and I feel more comfortable to speak in a group. Being involved in projects like these has made me feel like I really matter, being a volunteer.

You can go more deeply into situations, and it makes you look at residents' backgrounds. It makes you feel that you have a bond with these people.

Feeling that one really matters, feeling at home and having meaningful contact with residents are closely connected to the wellbeing of volunteers.

The involvement of residents in the PARTNER intervention was positively experienced by staff members. In particular, the heterogeneous meeting as part of the PARTNER intervention turned out to be meaningful for raising awareness about the value of bringing diverse perspectives together. The scepticism of some of the staff members towards the possibilities for resident involvement did not vanish because of the intervention. After the intervention some staff members still expressed doubts about the extent to which they thought it possible (for themselves as well as for residents) to involve residents in projects to improve community life and wellbeing. However, the same staff members also reported a growing awareness of the benefits of resident involvement, and some had actually started to integrate it into their work.

We learned a lot from it. Lately, in one of the care improvement projects, I did not see resident involvement. That is when I thought 'We are not going to do this on our own. A resident should be involved in this project!' Well, how else will we know what the problem is and where it comes from?

I experienced that it is good to take time for people, and to bring residents together to talk about things.

For some staff members, resident involvement was seen not only as something that has an intrinsic value for residents, but also as an instrument for managing residents' discontent and for residents to gain more understanding of the complexity of managing a residential care home. As the location manager says:

I notice, with people who have participated in this intervention, that they look at problems in a more thoughtful way. They know now that it is not that easy and they have experienced that you have to weigh up the pros and cons. And that it is not like, 'We just say what we want and then something has to be done about it.' Actually, I really like that.

Thus, the PARTNER intervention was a learning experience for professionals, creating critical awareness about resident involvement and their own role in this, and making them feel more supported and understood by residents. This was an important change in their experiences and thoughts about the difficulties and barriers concerning resident involvement. These learning experiences and the positive attitude of volunteers and staff towards resident involvement contributed to making the residential care home into a more open environment where resident involvement and empowerment is fostered.

Another side effect of the intervention was that the resident council experienced the project as a source of inspiration. The resident council members discussed (in the focus group we held with the resident council) the importance of being visible for residents as their representatives. The PARTNER intervention raised the resident council's critical awareness: the council members stated that they wanted to have more contact with residents, and that it would be good if some resident council members were present at every gallery party, so that they could introduce themselves as approachable resident council members who would promote the residents' interests. Furthermore, the resident council saw this project with the PARTNER intervention as a good example of communication between the diverse groups in the residential care home. As a resident council, they were confronted with a lack of information from volunteers and staff members about developments that were taking place (in practice and in policymaking processes). They struggled to get the information they needed to formulate their advice to the local manager. Through the PARTNER intervention they were confronted once again with the importance of communication between parties, and even though they still emphasized how difficult it was for them to realize this interaction between parties, they valued the fact that the intervention showed that it was not impossible after all.

Another consequence of this PARTNER intervention project was that the intervention is now used in this residential care home for other projects as well. For example, in one of the areas, three volunteers are working together as facilitators of the intervention, with an action group of residents who are discussing the quality of the meals. Furthermore, the local manager conceived the idea of starting to recruit more volunteers for the particular function of being a facilitator for the PARTNER intervention.

Discussion

In this study we focused on the experiences of the residents, volunteers and staff members who were involved in the PARTNER intervention. The study findings revealed how a group of residents was formed around an issue of concern (social interactions), which led to meaningful actions (media coverage, gallery parties, and the buddy project). The gallery parties and buddy project have become a structural part of the organization of the residential home. The intervention led to resident empowerment, and had positive effects on volunteers, staff members and the resident council.

Critical elements in the process were the agenda-setting by residents, the formation of a cohesive group, the sharing of experiences and stories, the development of collective action, and the development of partnerships between residents and professionals and other stakeholder groups. These elements resonate with the theoretical framework of the intervention, and the previous studies in the context of residential care.[13,16,17,41] When residents are brought together and exchange their experiences of living in the residential care home, we see that topics that relate to wellbeing and community life often come to the fore. These topics can be called 'life-political' issues.[52] Life-political issues are often related to the good life and challenge the dominant system, rules and discourse, because these topics are initially not meaningful within current frameworks. In the residential care home where we conducted our evaluation study, we saw that the interaction between residents (which featured exclusion and the formation of cliques) was noticed by all (residents, volunteers and staff members) and was singled out as a vitally important matter. However, no-one felt able to do anything about it, because it was assumed to be an issue that exists everywhere and that could not be dealt with by the system (the policymaking and work routines) of the residential care home.

Nevertheless, a group of residents felt encouraged by the PARTNER intervention not to be reconciled to this status quo, and to think of actions to break through the impasse of feelings of powerlessness. The concern with regards to the social interaction between residents that was felt at the start of the intervention was transformed into the enthusiasm and optimism that were expressed in the interviews after the intervention. The PARTNER intervention thus offers tools for residents to set these important life-political issues on the agenda, and to bring about social change in the community life of residents.

Collective action is another core element of the intervention. Collective action requires three conditions: a shared dissatisfaction, group solidarity and a longed-for future.[18] The process that we studied in this evaluation showed that there was a shared dissatisfaction with the way residents interacted. This dissatisfaction was discovered and reconstructed through the sharing of experiences and stories among the group of residents. From the literature it is known that storytelling has an empowering potential: it lends itself to emotional recognition, the building of relations in fragmented communities and the discovery of new self-perceptions and communal narratives that fall outside previous 'problem saturated' or negative constructions and dominant narratives.[53,54] The storytelling helped the AG to develop a positive group identity and solidarity in the group (group feelings and a bond) as well as answering their wish to contribute to the wellbeing of other residents and to community life in the residential care home. Furthermore, the AG developed a vision of how they would like to see residents interacting with each other (their longed-for future in which residents supported each other, and were friendly and open towards each other). Empowerment and social action are closely connected: action (or mobilization) is an element of the process of empowerment.[24,55,56] Social action fosters in-group unity and mutual support,[56] and these factors can also be seen as elements of empowerment, including mutual support, helping others and a sense of collective belonging.[24,57,58]

In the PARTNER intervention, partnership between residents and professionals is seen as an important prerequisite for enlarging the influence of residents. After they have developed a strength from within and a vision on actions to improve wellbeing and community life, residents need professionals and volunteers to realize these changes. One might argue that this suggests that residents are still dependent on (and thus less powerful in relation to) the

people who work in the residential care home in order to realize the change they envisage. However, our definition of partnership between older people and professionals in residential care homes is influenced by insights into partnership as co-production,[32,59] an ethics of care perspective on relationships in the context of health care,[21,29,60] and a philosophical hermeneutical perspective.[34,61] Partnership under this definition requires a process of relational empowerment (within and between groups), mutual learning about values, the creation of common ground, dreams and inspired aspirations, and consequently the realization of collective action, shared power, shared responsibilities, and co-ownership. In this approach to partnership, residents and professionals are thus interdependent. In order to be able to work together as equal partners with professionals, residents need to develop empowerment in their own group first.[22,23] This is why the PARTNER intervention does not start with heterogeneous group meetings between residents, volunteers and professionals as a first step. In the latter construction, hierarchic relations tend to be repeated.[16]

We have seen that in the residential care home where we conducted our evaluation, staff and management were receptive to the principles of the PARTNER intervention. We reckon this open attitude of staff is helpful for an experiment with resident involvement. At the same time, staff members expressed doubts and even scepticism about the possibilities for resident involvement. However, the PARTNER intervention made staff members realize that resident involvement is actually possible, and they started to acknowledge the value of resident involvement. Ultimately, they even wanted to develop resident involvement further, in more projects in this residential care home. Thus, the engagement of volunteers and staff in the PARTNER intervention contributed to their critical awareness of the value of resident involvement and of partnership with residents. This, in turn, may create an enabling environment for residents to develop their influence and involvement in the life-political issues that have such significance for their wellbeing and community life. The lesson we draw from this is that in situations where there is scepticism towards resident involvement, an actual experience of the PARTNER intervention may lead to changes in the attitudes of those who were critical. The value of 'doing' participation, even in less favourable circumstances, in order to experiment and learn about client involvement has been reported elsewhere.[62]

Even though this project featured positive interactions in the AG as well as between the AG and other stakeholders, there were also some ups and downs in the AG. As explained in the process description, the residents in the AG struggled with the recurring dilemma that they did not want to force other residents to participate in social interactions. This sometimes made them doubt the value of their proposed gallery parties for residents who did not want to interact with others, and this doubt could have been a threat to the creative process in the AG. The facilitator played an important role in dealing with these group dynamics. Her appreciative approach proved helpful in bringing energy into the process when negatives tended to dominate. For example, she stimulated the AG to think about the positive effect the gallery parties could have on residents who actually did want to participate in social activities but who had felt hampered (for whatever reason) from doing so. This made the AG conclude time and again that they wanted to organize gallery parties for those residents who were receptive to them, and that they would respect the wish of other residents who might just want to be left alone.

The relations between the AG and other people in the residential care home (such as the activity leader, the local manager, and others who participated in the intervention) turned out to be unproblematic. In general, this might not be expected, due to power asymmetries between residents and professionals in care homes. However, we can point to several aspects that might have positively contributed to the development of an unproblematic partnership between residents in the AG and others who were involved in the intervention. First of all, the supportive vision and receptive attitude of management in this residential care home seems to have been a crucial prerequisite for the success of the resident involvement and the development of a partnership between the residents and the professionals. Another supporting factor seems to have been the gradual construction of a partnership between the residents and the professionals, embedded in the empowerment of the AG, which the PARTNER intervention provides for. Possibly residents and professionals would not have experienced such successful collaboration if they had started with a heterogeneous dialogue straight away, without paying attention to power imbalances and differences.[16,23,38] Further, we consider it to have been helpful that the facilitator was an external person who had no stake in the process or prior relationship with people in the setting. This position enabled her to be open and receptive to the proposals of the AG, and to the proposals and reactions of the

staff and volunteers. Deliberately building up rapport with all groups (a position of multiple partiality) enabled her to build bridges between the AG and other groups with an interest in the process (compare Baur et al.[38]). Whether this facilitating role can also be performed by staff inside the residential setting, and what competences are required for such a role, needs to be discovered.

The fact that the facilitator also acted as the primary researcher enabled her to gather rich, inside knowledge of the process. This resulted in a 'thick description' of the context and meanings presented here, which may provide readers with a 'vicarious experience'.[63] Such an experience may help readers to assess whether and to what extent the context-bound lessons of this case study can be transported to their own context. Yet the combination of roles also had some limitations, in terms of the evaluation of the perceived effects. Participants may have felt uncomfortable about sharing negative experiences or about disappointing the evaluator/facilitator. Although we believe that participants were honest in their responses about the perceived effects, there may be a slight bias toward positive representations. To counter this, the analysis was completed by a team of people who had no relationship with the setting and were independent.

Conclusion

We conclude that structural partnerships between residents, volunteers and staff in residential care homes need to be developed further, because this leads to an empowerment of residents and to positive effects for volunteers, professionals, and other parties, such as resident councils. Resident involvement can contribute towards a cultural change, a transformation of over-institutionalized long-term care facilities into more humane and resident-focused communities. Cultural change in this context of long-term care institutions is considered to be 'a longitudinal, systemic, holistic process, (...), a multitude of efforts aimed at transforming the psycho-social, organizational, operational and physical environment in order to enhance quality of care, quality of experience, quality of life and create a viable sustainable business (...).'[64] In order to foster a cultural change like this, more than a single intervention like the PARTNER intervention is needed. However, we argue that this intervention can be considered as contributing to the cultural change. As staff members pointed out, developing

resident involvement takes time and must be taken one step at a time, but it is a worthwhile journey.

More long-term research is needed to gain insight into the applicability of and the prerequisites for the PARTNER intervention (including insights concerning population, possible challenges of frailty, time investment of staff and volunteers, competences of the facilitator etc.) in order for organizations to use it successfully. Furthermore, there is a need for outcome measurements of the PARTNER intervention. In this study and elsewhere[17] we have gained qualitative insights into resident empowerment through the PARTNER intervention. This should be tested on a bigger scale. Quantitative research on this topic can further complement and strengthen the qualitative research. However, existing scales for measuring empowerment[65-67] are not sufficiently adapted to be able to measure this kind of collective and relational empowerment. Thus, outcome variables for measuring relational empowerment should be developed, based on existing academic knowledge (from the fields of political theory, feminist ethics and organizational and community psychology), but also including experiences of people who live and work in residential care homes themselves. Thus, we argue that the development of this instrument for measuring relational empowerment should be developed in an inclusive, participatory manner. Also, more research is needed to develop empirical and theoretical insights concerning how cultural change in long-term care facilities can be fostered.[8,64,67,68]

Resident involvement via the PARTNER intervention may function as an impulse to move from a medical, institutionalized model to a more humane and resident-focused community in care homes. Such involvement triggers residents and other groups like volunteers, family, staff and management to experiment and to develop alternative narratives of identity, relationships and values which challenge the dominant stories.

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