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Research Article

The Potential Impact of Social Prescribing on Meaningful Engagement in Collective Aged Care Settings: Perspectives From the Global South

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Background: Promoting collective care philosophies in residential aged care homes that enhances person-centred care remains a global challenge. More success is evident when an organisation's approach to care impacts the well-being of everyone who lives and works in the home. However, funding systems are seldom applied in favour of a collective approach. The uptake of social prescribing is potential yet another obstacle in eradicating the prevailing dominance of the medical model of care in aged care homes.
Objective: In the Global South, institutionalised care is becoming a more acceptable and viable option to ensure health and well-being of older adults. Introducing person-centred care philosophies, such as the Eden Alternative (EA), in settings where care approaches are not predetermined by stringent funding schemes (i.e., related to addressing 'challenging behaviours' or specifying social prescribing), provides an opportunity to explore the intricacies of collective approaches. This project specifically considered how the EA philosophy impacted the quality of collective care within state-wide organisations in South Africa.
Methods: A qualitative, descriptive research design supported the investigation of four residential aged-care settings in South Africa. Ten focus groups, guided by the nominal group technique, were conducted with 68 participants, including residents, operational staff, and management staff. Quantitative and qualitative findings were deductively analysed using the EA's domains of well-being as the guiding framework.
Results: The findings mostly indicated agreement between staff and residents on the positive contributions of the EA to support well-being associated with security, autonomy, identity, growth, connectedness, meaning and joy. Overall, security was the most prevalent theme and linked with needs for physical and emotional safety.
Conclusion: Partnerships with external bodies, such as the EA, could support cross-national learning and exchange to support stakeholders working more closely with government agencies in creating realistic and supportive operational and funding policies for collective long-term care settings.

Keywords: developing country; long-term care; nursing homes; quality of life; service delivery

1. Introduction

The need for and access to institutional long-term aged care in sub-Saharan Africa is perpetual. Despite many countries advocating for ageing-in-place [1], due to population ageing globally, the demand for long-term aged care is growing expeditiously to the extent that an estimated 165 million older adults could need long-term care by 2050 [2]. Within the African continent, South Africa has one of the largest and fastest-growing populations of aged citizens [3], and the proportion of older adults in the total population is estimated at 5.6 million people, 9.2% of the total South African population [4]. Despite the international ageing-in-place movement gaining momentum and family-orientated care at home traditionally being the most acceptable form of aged care in the Global South, it is not the most realistic care option for the vast majority of older South Africans due to rural exodus, global migration, various resource constraints and limited community support structures in the country [5].

Although institutionalised care of family members is becoming a viable care option, financial constraints [5] and emphasising a collective approach (related to the concept of Ubuntu in Africa) for older adults [6] are the predominant factors restricting the quality-of-care service provision in aged care homes in South Africa, and an understanding and commitment for long-term care systems are needed [2]. Consequently, the impact of population ageing is of great concern to developing African countries because older age often necessitates greater utilisation of health care services in an already constrained economy [7].

A global culture change movement in aged care advocates for the reform of a dominant medical care focus towards an inclusive social approach, thereby including collectivity for ageing well. The Eden Alternative (EA) is an international agency in support of organisational culture change that favours a focus on a 'life worth living' (as coined by the EA pioneer [8]) that incorporates a social approach to care. The WHO series on long-term care in sub-Saharan Africa [2] identified the EA as a philosophy that promotes a relationship-focused care approach. As an international movement, the EA proposes a care culture shift from the biomedical, hospital-like model (that often continues to flourish in aged care homes) towards a more holistic model of wellbeing [9]. The EA advocates for the creation of a human habitat where life revolves around authentic and meaningful relationships, and everyone in the community can experience a greater sense of connectedness, identity, meaning, growth, security, joy and autonomy, also known as the seven domains of well-being which serve as the EA's core framework. The seven domains of well-being [9, 10] are described in Table 1 (see Column 1).

As a human habitat, care homes should be considered as both a space and place, a complex environment with the potential to foster cobecoming [11] for all people who live and work there. The interconnectedness of people and how collective doing contributes to the well-being of communities, as both cobecoming (as a Bakaka Country concept [11]) and Ubuntu (as the African notion of belonging [12]), are supportive as foundations for understanding care and well-being. Ubuntu is essential in healthcare as it emphasises a holistic approach that considers individuals within their social and cultural contexts. This African cultural perspective highlights that a person's humanity is intertwined with their sense of being and caring for all (Nicolaides, 2023).

By adopting the EA care culture, care homes can foster a relationship-focused care approach, undergirded by promoting human dignity for Elders, as residents are referred to[1], and their care partners, the preferred reference to those who are staff, family and friends [9]. This holistic approach incorporates what is currently termed as social prescribing, a solution to complex and continuous problems [13], in complex environments. In fact, the EA domains of well-being and social prescribing share the aim of enhancing the quality of life for older adults, particularly those prone to loneliness and isolation (see Table 1 and Column 2 for more information; [14, 15]). However, where social prescribing is meant to be an additional community-based service that counteracts relational shortfalls within areas dominated by a medical approach [16], creating a more holistic, caring and personalised service is dependent on all the care partners within a collective residential setting [6]. From a culture change perspective, introducing a system approach to segregate care responsibilities counteracts a culture change process.

Despite the South African Older Person's Act 13 of 2006 delineating the human rights and quality care services that should be afforded to older persons in residential care homes, the quality and urgency afforded to institutionalised care practices in South Africa are not well-regulated [2], and a predominating biomedical care culture in South African aged care homes persists. Therefore, creating empirical evidence of the impact of a care culture shift in aged care homes, with the support of the EA as a philosophy and a culture change agent, could support an understanding of how relationship-focused care supports meaningful engagement within long-term residential aged-care settings. The objectives of this study were therefore as follows: (1) To explore and report on what the EA as an organisational culture change approach could contribute towards supporting health and wellbeing of older adults living in long-term care. (2) To explore the benefits of a holistic and integrated care approach where social prescribing is not viewed as a separate entity when providing nonmedical support in care homes but as a means to support Ubuntu experiences and cobecoming.

2. Methods

A qualitative, descriptive research design [17] directed this study. Only residential homes registered with EA settings were included. A paper-based background survey was used to capture participants' demographic information. Group discussions directed by the nominal group technique (NGT), a qualitative consensus method [18], with care partners (i.e., care partners such as managerial staff, nursing staff and caregiving staff) and Elders yielded qualitative and quantitative data. The NGT is a structured method for group

Table 1: Concepts associated with the Eden Alternative's domains of well-being and social prescribing.

	Eden Alternative domains of well-being and associated definition	**The connection between Eden Alternative domains and social prescribing**
Identity:	Being well-known, having personhood and individuality. Honouring each person's unique history	Both approaches emphasise the importance of recognising and valuing the individuality of older adults
Connectedness:	Belonging, being engaged and involved in time, place and nature	Similar to the Eden Alternative's emphasis on connectedness, social prescribing connects older adults to community resources and activities to foster engagement and involvement
Security:	Freedom from doubt, fear and anxiety. Having safety, privacy, dignity and respect	Ensuring safety, privacy, dignity and respect is a common goal, with social prescribing providing nonmedical support to enhance these aspects
Autonomy:	Having liberty, self-determination, choice and freedom	Both approaches support the independence and self-determination of older adults, encouraging them to make choices about their care and activities
Meaning:	Having and ascribing significance to daily happenings, finding purpose, value and sacredness	Both approaches aim to provide a sense of purpose and value, whether through meaningful activities or community involvement
Growth:	Opportunities for development, enriching experiences, expanding and evolving	Social prescribing often includes activities that promote personal development and enrichment
Joy:	Experiencing happiness, pleasure, delight, contentment and enjoyment	Promoting happiness, pleasure and contentment is a shared objective

decision-making and idea generation, facilitated by a single unambiguous question to elicit a wide range of responses [19]. The NGT minimises dominant voices and ensures equal participation by having participants share their ideas individually in a round-robin fashion, followed by a group discussion (qualitative) and voting on key concepts (quantitative) [18, 20]. These processes assist participants in identifying personal views and jointly prioritising areas for further investigation.

3. Research Setting

3.1. Research Population and Sampling: Aged Care Organisations. Four ($n = 4$) aged care organisations in South Africa were registered with the international EA organisation at the time of the study. Of these four organisations, two ($n = 2$) responded to the invitation to participate in the research project (see Table 2). In South Africa, a clinical approach to care dominates the aged care sector. Only a few care homes have adopted philosophies and ways-of-doing that align with social prescribing. Four care homes in urban areas, two from each organisation, were included in this research project as their adoption of the EA philosophy aligned with the study's objectives. These four homes specifically catered to institutional support for Elders, compared to other homes affiliated with the two organisations that were excluded due to a focus on catering to independent living.

3.2. Research Population and Sampling: Participants Living and Working at the Aged Care Homes. Participants included in the NGT discussion groups were recruited via purposeful, convenience and snowball sampling. Snowball sampling entailed word-of-mouth recruitment [17] of residents and staff during site visits to include a variety of participants. Specific attention ensured diversity in terms of the age range, gender, physical abilities, time period for living or working at the home, residents' accommodation type at the home and involvement with operations at the home.

3.3. Participants Represented in the Group Discussion Included

- Staff in leadership roles (e.g., administrative, nursing, catering, cleaning, maintenance, security or leisure/lifestyle coordinators; members of the governing body in leadership positions)
- Operational staff (e.g., registered nurses/physiotherapist/occupational therapist/allied health assistants/leisure or lifestyle staff and other care staff) (e.g., caregivers/cleaning, catering, security and maintenance staff)
- Elders (e.g., a range of residents permanently living at the home to represent their peers—e.g., a married couple; a resident with limited mobility, a physical disability, with good family support and with limited family support). Please note that participants with cognitive impairments did not take part in this project to ensure that Elders were comfortable to engage in the NGT discussion.

3.4. Data Collection. Data collection-entailed discussion groups were directed by the NGT. A total of 10 discussion groups ($n = 10$) were conducted. Each participant in the discussion group completed a demographic questionnaire prior to the start of the group. The NGT, initially developed by Delbecq and Van de Ven [20], is a structured brainstorming meeting that provides a systematic method for obtaining qualitative information from the participants [19–21]. The NGT's structured format limits power dynamics [19], ensuring equal participation from all participants irrespective of age, gender and personality type. The NGT was a cost- and time-effective way to direct multisite group discussions and mitigate potential power relations amongst group members by indicating priorities through voting opportunities [22]. The NGT promotes individual views to be voiced while fostering collaborative input during discussions and reaching a joint conclusion at the end of the process.

NGT discussion groups were facilitated, face-to-face, at each of the four homes, i.e. one group with residents and one with operational staff ($n = 8$). Two facilitators consistently conducted the NGT discussion groups. Available research team members supported the NGT group discussions, with a designated investigator taking field notes for each group. There was adequate assistance available for any individuals needing physical help during any part of the NGT discussion group. Venues were accessible; tables and chairs were positioned comfortably; refreshments were offered; and all Elders could move closer to the flipchart or whiteboard writings if necessary to identify their priorities.

Two additional groups ($n = 2$) were facilitated virtually via Zoom, with leadership staff from the two organisations separately, resulting in 10 discussion groups ($n = 10$). The research group discussions explored the opinions of all stakeholders on the impact of the EA at the home. Virtual discussion groups have been successfully used for research purposes [23]. For consistency, one experienced research team member facilitated both sessions, following the same procedure as prescribed by the NGT method. The additional researcher took field notes of the narrative discussions during the sessions. The sessions were recorded with consent from the leadership staff participating, and the priority statements and rankings were shared with participants during the group discussion for member checking.

The focus question posed during the NGT discussions for staff groups was 'What is the impact of the EA on the care culture of your organisation?'

The focus question posed during the NGT discussion for the Elders was 'How is this place helping you feel at home?'

3.5. Data Analysis. Qualitative thematic analysis was applied. A deductive coding analysis [17] guided by the seven domains of well-being promoted the views and opinions of all participants to be objectively conveyed. The four-step process suggested by Creswell was applied [24] to organise,

Table 2: Overview of the participating organisations.

	Organisation 1		Organisation 2	
Location	Kwa-Zulu Natal Province		Gauteng Province	
Number of care homes	6		4	
Homes	Home 1	Home 2	Care centre 1	Care centre 2
Registration as an EA home	2020	2020	2016	2016
Number of residents	76	226	136	121
Number of staff	14	22	177	102
Age range: residents	≥ 60 yrs	≥ 60 yrs	55–103 yrs	54–99 yrs
Age range: staff	≥ 45 yrs	≥ 28 yrs	22–68 yrs	25–65 yrs

Note: Yrs: years.
Abbreviation: EA = Eden Alternative.

peruse, classify and synthesise the combined qualitative data from the NGT-directed group discussion and narrative field notes. The participants' demographic details are presented as descriptive statistics in Table 3.

3.6. Research Rigour. Scientific validity, or 'truth value' [25, 26], was ensured by including all three groups of participants to form a 'system' striving for inclusive social prescribing and dignified care of the Elders, enabling internal theoretical validity of the study. Furthermore, environmental triangulation was fostered by including a range of residential care facilities ($N = 4$) and collecting data from residents and care partners at the respective sites. Investigator triangulation was applied. One of the researchers was representative of the diversity of race of the care partner-participant group and had access to the participants' vernacular language when clarification was needed. As a fourth measure for scientific validity, member checking was applied being inherently embedded in the democratic and reiterative method of the nominal group technique that enabled repeated opportunities for participants to affirm and validate their answers to the question.

3.7. Ethical Statement. This study was approved by the Health Sciences Research Ethics Committee (HSREC) from the University of the Free State (UFS-HSD2021/0653/2610). The governing committees of both organisations consented to their affiliated homes participating. The four homes consented to participation via the executive and management boards. Individual participants at each care home provided individual and informed written consent for their participation after receiving information leaflets. Since NGT groups involve face-to-face discussions, anonymity is not guaranteed. Confidentiality was ensured by protecting participant discussions and avoiding the use of identifying information in any documents. All electronic data were securely stored on a protected online platform for 5 years, only accessible by the research team.

4. Findings

The demographic profile of the participants is detailed in Table 3. A total of 68 participants from two organisations (four care homes) participated in the study. Of these, 36 (52.9%) were staff members, and 32 (47.1%) were residents. Participants comprised 55 (80.9%) females and 12 (17.6%) males, with one participant not responding. Most staff members' ($n = 34$) (94.4%) ages ranged between 26 and 55, with residents mostly being 65 years and older ($n = 28$) (87.5%).

Employment duration varied. The majority of staff (30.6%) ($n = 11$) were employed between 5 and 10 years, with 25.0% ($n = 9$) for less than three years. Five staff members (13.9%) indicated that they had worked at the respective homes for over 10 years. Only three residents (9.4%) reported a connection with the organisation of less than 1 year, while eight (25%) reported connections of less than 3 years and between 3 and 5 years, respectively. Four residents (12.5%) had a connection with these organisations for more than 10 years. While 15 (41.7%) staff reported having received training in the EA care culture, most residents ($n = 38$; 55.9%) did not. Various staff members participated, including carers, as well as cleaning and administrative staff. A few Elders indicated their role as volunteers or assisting with gardening at the homes.

Participants' perceptions of the EA, as a care culture movement, in categories ranging from not indicated, very poor, to very good, indicated that staff and residents' perceptions were mostly good ($n = 29$) (42.6%) to very good ($n = 22$) (32.4%) relating to their knowledge of EA (see Supporting Table (available here)). Staff and residents reported having overall good ($n = 33$; 48.5%) to very good ($n = 20$; 29.4%) opportunities for residents to partake in meaningful day-to-day activities. Residents' choice and involvement in activities were reported as good ($n = 37$; 54. Four percent) to very good ($n = 12$; 17.6%). Most participants perceived the incorporation of residents' life history into their care plans as good, $n = 37$ (54.4%) and very good, $n = 9$ (13.2%). Overall, in response to the EA positively impacting residents' quality of care, 340 responses from staff and residents indicated experiences that were good ($n = 156$; 45.9%) to very good ($n = 84$; 24.7%).

The findings of the 10 discussion groups ($n = 6$ staff groups; $n = 4$ elder groups) are reported in Table 4 (elders) and Table 5 (staff), respectively. Each table presents the EA domain of well-being, the combined verbatim statements from the staff and Elder discussion groups, how the statements are indicative of (either supporting or constraining) the EA domains of well-being, and their ranking of importance according to participants. Most statements indicated contentment and confidence that the domains of

Table 3: Demographic overview of participants.

Variables		Staff $n = 36$ (52.9%) n (%)			Residents $n = 32$ (47.1%) n (%)			Combined total N (68)
		Organisation 2 ($n = 16$)	Organisation 1 ($n = 20$)	Total $n = 36$	Organisation 2 ($n = 18$)	Organisation 1 ($n = 14$)	Total $n = 32$	
Gender	Female	15 (93.8)	18 (90.0)	33 (91.7)	14 (77.8)	8 (57.1)	22 (68.8)	55 (80.9)
	Male	1 (6.2)	2 (10.0)	3 (8.3)	4 (22.2)	5 (35.7)	9 (28.1)	12 (17.6)
	Not answered	0 (0)	0 (0)	0 (0)	0 (0)	1 (7.1)	1 (3.1)	1 (1.8)
Age (years)	18–25	1 (6.2)	0 (0)	1 (2.8)	0 (0)	0 (0)	0 (0)	1 (1.5)
	26–35	6 (37.5)	5 (25.0)	11 (30.6)	0 (0)	0 (0)	0 (0)	11 (16.1)
	36–45	5 (31.3)	9 (45.0)	14 (38.9)	0 (0)	0 (0)	0 (0)	14 (20.6)
	46–55	3 (18.8)	6 (30.0)	9 (25.0)	0 (0)	0 (0)	0 (0)	9 (13.2)
	56–65	1 (6.2)	0 (0)	1 (2.8)	3 (16.7)	1 (7.1)	4 (12.5)	5 (7.4)
	65 and older	0 (0)	0 (0)	0 (0)	15 (83.3)	13 (92.9)	28 (87.5)	28 (41.2)
Employment status	Employed	14 (87.5)	17 (85.0)	31 (86.1)	—	—	—	—
	Not employed	2 (12.5)	2 (10.0)	4 (11.1)	—	—	—	—
	Not answered	0 (0)	1 (5.0)	1 (2.8)	—	—	—	—
Years of employment or residency	Less than 3	5 (31.3)	4 (20.0)	9 (25.0)	4 (22.2)	4 (28.6)	8 (25.0)	17 (25.0)
	Between 3–5	2 (12.5)	6 (30.0)	8 (22.2)	5 (27.8)	3 (21.4)	8 (25.0)	16 (23.5)
	Between 5–0	5 (31.3)	6 (30.0)	11 (30.6)	5 (27.8)	2 (14.3)	7 (21.9)	18 (26.5)
	More than 10	3 (18.8)	2 (10.0)	5 (13.9)	1 (5.5)	3 (21.4)	4 (12.5)	9 (13.2)
	Not answered	1 (6.2)	2 (10.0)	3 (8.3)	3 (16.7)	2 (14.3)	5 (15.6)	8 (11.8)
Training received on PCC	Yes	8 (50.0)	7 (35.0)	15 (41.7)	7 (38.9)	1 (7.1)	8 (25.0)	23 (33.8)
	No	7 (43.8)	9 (45.0)	16 (44.4)	10 (55.6)	12 (85.7)	22 (68.7)	38 (55.9)
	Not indicated	1 (6.2)	4 (20.0)	5 (13.9)	1 (5.5)	1 (7.1)	2 (6.3)	7 (10.3)
Role in the organisation (more than one option)	Residents	0 (0)	0 (0)	0 (0)	16 (88.9)	14 (100)	—	—
	Relative/friend	1 (6.2)	1 (5.0)	2 (5.6)	0 (0)	—	—	—
	Nursing	0 (0)	4 (20.0)	4 (11.1)	0 (0)	—	—	—
	Carer	4 (25.0)	5 (25.0)	9 (25.0)	1 (5.5)	—	—	—
	Cleaning	3 (18.8)	4 (20.0)	7 (19.4)	0 (0)	—	—	—
	Catering	2 (12.5)	1 (5.0)	3 (8.3)	0 (0)	—	—	—
	Gardening	0 (0)	1 (5.0)	1 (2.8)	1 (5.5)	—	—	—
	Administrative	4 (25.0)	2 (10.0)	6 (16.7)	0 (0)	—	—	—
	Volunteers	0 (0)	0 (0)	0 (0)	4 (22.2)	—	—	—
	Others*	2 (12.5)	3 (15.0)	5 (13.9)	0 (0)	—	—	—

Abbreviation: PCC, person-centred care.

*Tuck shop; maintenance and wellness coordinator.

Table 4: Combined statements and ranking of elder discussion groups from both organisations.

	Elders ($n = 4$ groups)		
EA domain of well-being (category)	**Statement from the discussion group (code/verbatim)**	**Indicative of domain support**	**Ranking of importance according to participants**
Security	A proper screening and background evaluation before rooms are allocated	No	1
	I want to make this my home (I'm trying to save water and electricity). In contract—not to be abused. Needs more warnings and consequences and have security	No	5
	When you need something, they (the staff) are there to assist	Yes	1
	The place is kept clean and has a good smell	Yes	2
	All the tender love and care from all the angels around here. All the patience	Yes	5
Connectedness	I would like to see more visiting hours and the number of visitors/times to be revised	No	2
	Makes me feel at home. Mix of people	Yes	4
Autonomy	How to address each other without getting the management involved	No	3
Meaning/joy	It makes me forget about my loneliness	Yes	2
	Cats. To be able to have cats at the home. We have two cats	Yes	5
Growth	Residents should appreciate how hard the staff works and respect all levels of staff	Yes	2
Identity	This is a Christian centre. I am grateful for this, I feel at peace with the help of my Maker	Yes	3

Note: All statements were ranked in order of perceived importance, with a numerical score of 1 being the top priority voted for.
Abbreviation: EA = Eden Alternative.

Table 5: Combined statements and rankings from staff discussion groups of both organisations.

	Staff ($n = 6$ groups)		
EA domain of well-being (category)	**Statement from the discussion group (code/verbatim)**	**Indicative of domain support**	**Ranking of importance according to participants**
Autonomy	Good communication and respect between support staff and elders	Yes	1
	We have flipped the hierarchy from elders—management facilitates elder-centred care	Yes	4
	Involving them in the process of/and planning of activities	Yes	5
Growth	Refresh training in EA is needed	No	2
	To help them physically, emotionally and mentally	Yes	1
Identity	Terminology used when communicating to residents	Yes	3
Connectedness	Spending more time with elders (lack time)—building relationships, e.g., can provide meaningful activities	No	4
	Making them talk to us if they have a problem and need help (good communication)	Yes	3
Meaning/joy	Promoting human contact by involving external stakeholders	Yes	4
Security	Respect them and smile for them	Yes	2
	Taking care of their hygiene, grooming, eating healthy	Yes	3
	The home is very supportive, 24/7 staff available. We work as a team involving the residents	Yes	4

Note: All statements were ranked in order of perceived importance, with a numerical score of 1 being the top priority voted for.
Abbreviation: EA = Eden Alternative.

well-being were supported. However, some statements also indicated areas of discomfort and opportunities for improving the support of the domains of well-being.

Table 4 presents the amalgamated priority statements as voted on by the Elder participants during the four discussion groups. Security was the predominant domain of consideration, and while three statements indicated that Elders experienced their security as being supported, two statements also referred to opportunities for more support needed in this domain.

Table 5 provides the amalgamated priority statements as voted on by the staff participants during the six discussion groups. Similar to the resident groups, staff considered security as a domain that was supported, in addition to the domain of autonomy.

Table 6 contains the field notes made by the first author, thematically analysed to assign codes and how these related to the EA domains of well-being. This analysis creates more depth and understanding of how participants' experiences related to the domains of well-being, which formed the foundation for the statements and the ranking process of the discussion groups.

5. Discussion

This study investigated how the EA philosophy created a collective approach to support meaningful engagement in four residential aged care homes in South Africa. The findings from the discussion groups mostly indicated agreement between participants (e.g., staff and Elders) on the positive contributions of the EA to support Elders' domains of well-being, i.e., security, autonomy, growth, connectedness, meaning and joy. The findings revealed that the Ubuntu philosophy—a core concept of interconnectedness and communal well-being—was reflected by both Elders and care partners [12]. As Ubuntu highlights the collective responsibility for individual well-being, where autonomy and interdependence coexist [16], the foundation for social prescribing should be integrated in everyday doing within the home to improve the quality of life for Elders. Therefore, when considering social prescribing for older communities through the lens of Ubuntu, the social, emotional and health needs of Elders are addressed not in isolation but as part of a broader relational and communal framework [12]. These findings directly respond to the WHO long-term care series [2], as numerical and field note narrative data provided a positive step towards developing indicators that identify supporting or inhibiting factors impacting Elders and care staff. For the rest of this section, these indicators are linked to the EA domains of well-being and addressed separately.

From the seven domains, security, especially for Elders, was a prevalent theme supported by the field note narratives, as statements about security were recorded most frequently ($n = 20$). Examples from ranked priority statements varied between Elders' feelings of physical safety within the home and experiencing security in one's personhood, such as being respected and treated with patience and care. It is unsurprising that physical safety and personal security remain at the foreground of older adults' perception of health and well-being, as this is a significant concern for all South Africans, irrespective of age [27]. Supportive relationships with care partners made the Elders feel secure and valued and relates to the affective or socio-emotional component of social prescribing [28]. Without these supportive relationships, older persons, who already experience isolation and anxiety, due to the impact of crime on personal safety [29], would exponentially experience an increase in feeling anxious.

Conceptually and theoretically dovetailing with security, connectedness was highly ranked for the Elders as well as the staff. The discussion group findings and field note narratives confirmed the importance of genuine and close interaction between Elders and staff at the participating homes. In their study, Yeung et al. [30] found that caring relationships, conversations and time spent together created meaningful, positive social interaction that fostered connectedness among staff and Elders.

A field note narrative statement capturing cleaning staff being, '. . . the glue that keeps aged care homes afloat,' was mentioned during staff discussion groups and explained how cleaning staff often had more genuine relationships with the Elders whose rooms they cleaned. These opportunities for individual social interaction, combined with receiving support and/or asserting personal preferences, created meaning for both staff and Elders. For cleaners (the lowest ranking order for staff in South African aged care organisations) and Elders (being frail and vulnerable), this situation appeared to create a form of communal understanding or empathy.

Therefore, while aged care settings exhibit diverse characteristics, the notion of Ubuntu implies the presence of a cohesive cultural aspect within these collective environments, as all care partners and Elders prioritised connectedness and interpersonal engagement. Ubuntu extends this notion of belonging as an inherent human need, emphasising individual's interconnectedness and the collective contribution to community well-being [12]. Therefore, there is no separation between medical and social approaches.

When community well-being encapsulates both health and social components, it promotes the concept of care to align with both a practice and a value. Therefore, caring is not only motivated by effective practices of care but also compelled by moral salience of attending to, and meeting the needs of, the particular others for whom they take responsibility.

The intersectionality of the EA domains of well-being was evident in terms of security, which was also being subtly expressed as a basic need and foundation to good relationships that directly supported other domains such as autonomy.

Autonomy as the well-being domain was viewed as core by Elders and staff. Lima et al. [31] assert that care partners associate autonomy with the older adult's ability to do (everyday activities without the help of third parties) or with the ability to resolve (especially decision-making on a day-to-day basis). Staff seldom associated the autonomy of older adults with social integration and emotional intelligence [31]. This perception resonates with the findings of this

Table 6: Examples of narrative statements captured during the discussion groups.

EA domain of well-being (category)	Fieldnote narrative notes Verbatim	Code
Security (20 statements captured)	'Residents note that they believe there are no authoritative staff available during nights'	Negative experiences of staff at the home
	'Resident feels disrespected by junior staff'	
	'Residents experience accessibility issues in terms of ambulation'	Physical accessibility issues at the home
	'Lifts are not in working order—mentioned a few times'	
	'Residents feel safe and secure in the parameters of the home'	Residents feel physically safe at the home
	'The cats take care of the rats—cats provide companionship, but residents also experience them as pest control'	
	'Not experiencing racism—that is good'	
Organisational identity (14 statements captured)	'A senior staff member mentions that it is easier if there is one staff member to take charge of how the EA is integrated into the home'	Different perceptions about the integration and application of EA principles
	'Staff member notes that the EA is not a checklist to be completed'	
	'Senior staff experiences 'staffing challenges' as a limitation for 'doing' Eden'	
	'Staff note that it easier to manage a home from an 'institutional approach'	
Growth (14 statements captured)	'Staff encourage activity participation outside of the resident's rooms'	EA positively contributes to the growth of the homes
	'EA empowers with the knowledge to have empathy with different behaviours of elders'	
	'Staff and resource constraints make it difficult to implement EA'	
	'I have poor knowledge of the EA'	Constraints hindering growth towards EA philosophy
	'Using the language associated with the EA—however, from the discussion, it seems as if deeper understanding and application of the words might be inconsistent'	
	'Perception that the EA only applies to healthy ageing'	
Connectedness (10 statements captured)	'Staff assist with maintaining virtual contact with family members'	Staff facilitate connectedness
	'There seems to be a kinship between residents and some care staff'	
	'The resident experiences difficulty living with and accommodating other residents who are differently able to themselves'	Connectedness between residents varies
	'Accessibility of information on notice board is difficult due to vision problems'	Constraints with information dissemination

Table 6: Continued.

	Fieldnote narrative notes	
EA domain of well-being (category)	**Verbatim**	**Code**
Autonomy (10 statements captured)	'Resident experienced COVID constraints negatively—as influencing on visiting policies' 'The availability of a spaza shop is seen as overwhelmingly positive, but some residents mention that they perceive staff as not acknowledging the importance of accessing this shop'	Policies limit the experience of choice
Identity (9 statements captured)	'We all got a little devil in us—said a resident, acknowledging that in an institutional home, there will always be many personalities and preferences that need to be managed' 'There is a caring relationship irrespective of job titles' 'Inconsistencies regarding satisfaction with food, laundry services, caring services'	Challenges to support and maintain various identities
Meaning/joy (9 statements captured—meaning 3 statements captured—joy)	'The well-stocked library' 'We donate the dolls; we are a working group' 'Inconsistencies about the experience of meaningful activities available at the facilities' 'Positive experience of annual senior games day' 'Staff provide activity options over the weekend–happiness about this from residents who participate'	Meaning and joy remain highly subjective. Positive emotions experienced via participation opportunities

Abbreviation: EA = Eden Alternative.

study, wherein staff at the participating homes highly valued Elders' ability to make choices and exercise control over their decisions. In contrast, Elders emphasised autonomy in the context of social interactions, particularly in having control over visiting times and access to friends and relatives, underscoring a discrepancy of care partners' understanding and valuing autonomy within aged care settings. The COVID-19 pandemic highlighted the importance of safety and autonomy for older adults, prompting the implementation of restrictive measures to mitigate health risks. Malherbe [32] documented negative experiences of diminished autonomy and dignity among older adults during the pandemic, a sentiment echoed by Elders in this study who found visiting policies restrictive, despite no such policies being in place during the data collection timeframe.

While care partners prioritised promoting independence in daily activities, such as personal care tasks or decision-making, Elders prioritised opportunities for meaningful social engagement, valuing the freedom to connect and maintain social cohesion as paramount. Addressing this disparity necessitates a deeper appreciation of Elders' perspectives and values, reevaluating existing assumptions and norms within the aged care system. It appears that Elders accepted certain systemic rules without concern for the potential impact on their autonomy, particularly when enforced by qualified staff. This finding illuminates how power dynamics, often considered an obstacle by advocates for aged care culture change, could be perpetuated by the Elders themselves due to a generational belief in the authority of qualified individuals and a historical patriarchal modus operandi [33].

Positions of power and privilege extended to Elders expressing feelings of disconnect from fellow Elders who were differently abled than them within the same living spaces. This sentiment contradicts the ethos of Ubuntu and suggests a divergence from the ideal of communal harmony and connectedness. This reluctance to associate with fellow Elders who were less capable could stem from a discomfort with losing their sense of autonomy—being confronted by the fear of physical decline and facing similar challenges in the future. This highlights the complex interplay between the domains of autonomy and identity and how individuals want to view themselves.

Identity, within the context of the EA philosophy, revolves around the concept of personhood and the sense of 'being known' and recognised for one's individuality [9]. Personhood entails inherent dignity and having personal rights honoured [9]. While care partners prioritised the use of respectful terminology when addressing Elders as a gold standard for upholding dignity and identity, Elders underscored the significance of residing in a home affiliated with a Christian organisation. For Elders, the most crucial aspect of their identity was associated with respect and acknowledgement of their worldview. While linguistic adaptations by care partners display valued identities, it only touches on the surface of what the scope for the domain of identity entails. In-depth acknowledgement of identity that reflects the EA philosophy would be reflected by a sound grounding of guiding principles in all organisational policies and procedures.

Although care culture change is in its infancy in the Global South, it joins the Global North in search of metrics and monitoring methods to map the status of needs and services in the field of long-term care [2]. It is especially important that long-term care become (in the Global South) and remain (in the Global North) a respected and viable option for care of older adults and is 'recognized both societally and politically as a public good' [2] that ensures 'an acceptable level of well-being, not only for dependent older people but also for those who care for them' [2]. The domains of meaning and joy were important lenses for considering the well-being on a personal level.

The least number of statements are captured pertaining to the domains of meaning and joy (i.e. 12 statements in total) and are presented jointly. Experiencing meaning in one's life is crucial for fostering health and well-being, irrespective of age and ability. Human beings are 'wired' with the innate need to experience pleasure, restoration and productivity [34], and there is a direct positive correlation between the experience of pleasure and well-being during meaningful engagement [35]. Meaningful engagement is appealing due to the personal significance for the doer in terms of productive, restorative and pleasurable elements [34]. Despite its importance, the subjective nature of defining meaning and joy, due to the personal significance for the doer [34], could explain why statements reflecting these two domains were underrepresented in the voting and ranking process. Moreover, intertwining meaning and joy in the data analysis underscored these constructs' multidimensionality and subjectivity.

Insights into the preceding domains supported an understanding of how the domain of growth could be utilised to promote opportunities for development, enriching experiences and an evolving care culture that supports care partner and Elder well-being. Findings indicated that care partners perceive nonhuman resource constraints as a barrier to growth, and there was an underlying perception that the EA only applied to healthy ageing. Kilian et al. [36] found that unfavourable attitudes and dementia illiteracy contributed to passive resistance to care culture change in an organisation in South Africa. In addition, limited collectivity between care partners and Elders also negatively impacted the care culture in this organisation's homes [36]. Although governments play an essential role in building, implementing and coordinating long-term care systems, effective and well-integrated partnerships between government agencies, nongovernmental organisations, professionals, the private sector and care partners (especially families and volunteers) are essential [2]. This study, utilising both an objective measure and personal perspective from care partners, contributed to capturing and predicting long-term care needs within organisations affiliated with the EA in direct response to the WHO's suggestion for improving long-term care of older adults [2]. Findings support the next steps to address needs with training, which would ensure that culture change goes beyond the use of theoretically sound EA 'language' and supports meaningful engagement within these long-term residential aged-care settings. Moreover, findings indicate the value of a whole-

organisation approach in support of person-centred care to promote well-being—it is in the joint perseverance of care partners to engage meaningfully that collectivity is built.

The limitations of this study include a small sample size. The transferability of the findings was also negatively impacted by not involving family members as an important component within a care partner approach. Future meta-analyses could deconstruct complex factors associated with complex living environments, where social and health approaches to care are paramount for a person-centred focus. Additional data that could enable expanded recommendations are the complex historical socio-political intersectionality of race, gender and culture between the caretaker staff and residents. Although the official language of included organisations was English, the researchers did not have full access to the various first languages of the caregiving staff, which could be perceived as a potential limitation. However, in terms of strengths of this study, firstly, the themes generated by this project are universal to long-term aged care settings, and the study should be expanded to include more aged care homes across multiple organisations and countries in the Global South. Secondly, despite the limited sample, a significant degree of maximum variable sampling was obtained by including several residential care homes and three groups of various participants forming part of the facilities' purpose and operations. Thirdly, the group of researchers ensured several strategies for research rigour and constantly made use of active reflexivity during the research process.

6. Conclusion

Despite limited resources, this study indicates that partnerships with external bodies, such as the EA, support culture change and would be worth the investment. The question now is how these external bodies could support cross-national learning and exchange to ensure that government agencies create realistic and supportive policies that could tailor to the needs and services of each long-term care home as a unique entity. Careful consideration is paramount to the mounting support of social prescription, which in essence creates a medical denotation and further possible alienation for embedding and encapsulating a social approach for ageing well, within residential care settings. Only when Elders and the people who care for them are acknowledged as being part of a collective, where individuals are impacted by unique contextual factors, could care services cater to the wellbeing of everyone involved.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

One of the research team members, Dr Rayne Stroebel, is associated with the Eden Alternative Organisation in South Africa. To manage a potential conflict of interest, Dr Rayne Stroebel was only involved in the conceptualisation stage of the study and did not contribute to data collection, analysis or compilation of the findings. The other authors declare no conflicts of interest.

Author Contributions

Melissa Kilian: project coordinator—involved in data collection, data analysis, and paper writing and editing.

Tania Rauch van der Merwe: involved in conceptualisation, data collection, data analysis, and paper writing and editing.

Itumeleng Tsatsi: involved in conceptualisation, data collection, data analysis, and paper writing and editing.

Ronelle Jansen: involved in conceptualisation, data collection, data analysis, and paper writing and editing.

Marieta Visser: involved in data collection, data analysis, and paper writing and editing.

Rayne Stroebel: involved in conceptualisation of the project.

Sanetta Henrietta Johanna du Toit: chief investigator—involved in conceptualisation of the project, assembling the project team, data analysis, and paper writing and editing.

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Endnotes

[1]Note: Elders, capitalised, are the term used in this paper referring to older adults. It is a terminology associated with the Eden Alternative and reflects a wisdom and status bestowed upon the older adult. Also note that the findings and verbatim statements reflect the term 'resident' when referencing Elders, as this is the term used by participants.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. *(Supporting Information)*

The table contains participants' perception of their own knowledge about the Eden Alternative.

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