

Anna Sznajder

Care space as home, community and workplace. Reflecting upon examples from the British elderly care homes

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DOM OPIEKI JAKO MIESZKANIE, WSPÓLNOTA I MIEJSCE PRACY.
WYBRANE PRZYKŁADY Z TERENU WIELKIEJ BRYTANII

Streszczenie:

Przestrzeń opieki to ważny element godnego starzenia się. W przypadku osób znajdujących się w domach spokojnej starości umiejętność stworzenia właściwego środowiska do aktywnego przeżywania każdego dnia staje się elementem, który sprzyja podniesieniu jakości życia jednostki w grupie innych seniorów. To środowisko tworzy zarówno przestrzeń fizyczna pomieszczeń wspólnych i indywidualnych, jak i kreowana kultura organizacji, w której opiekunowie tworzą zespół działający wedle określonych zasad i reguł. W artykule ujęte zostaną doświadczenia z praktyk w dwóch niezależnych prywatnych domach opieki, które pozwolą wskazać na możliwości i ograniczenia wspomagania rozwoju człowieka starszego w analizowanych środowiskach.

To start with, community is a 'warm' place, a cosy and comfortable place. It is like a roof under which we shelter in heavy rain, like a fireplace at which we warm our hands on a frosty day. Out there, in the street, all sorts of dangers lie in ambush; we have to be alert when we go out, watch whom we are talking to and who talks to us, be on the look-out every minute. In here, in the community, we can relax – we are safe, there are no dangers looming in the dark corners (...). In a community, we all understand each

other well, we may trust what we hear, we are safe all the time and hardly ever puzzled or taken aback. We are never strangers to each other (Bauman 2001, p. 1–2).

Care spaces are an important factor in healthy aging. Space for active and purposeful being, that increase the life quality of the individual in a group of other seniors is constructed from both the physical environment – personal and communal rooms – and from an organisational culture in which carers act as a team according to rules established by a particular care home and a person-centred philosophy of care. This article reflects upon the results of participant observation in two independent private care homes, and this has allowed for the identification of the advantages and limitations constructed by organisations and care spaces. As such it should be seen as an ethnographic commentary and an in-depth view into care settings based on a one-year engagement. Viewing the space from a feminist perspective organisational culture and architecture should be seen as a masculine contribution to space arrangement, one that creates financial and emotional dependence, whilst female work within it centres on the character and personality of those who carry out the work and the relationships between them. Their work is both emotional and physical.

Culture attempts to control and transcend nature, to use it for its own purposes (Moore, 1988, p. 14). Explaining the care setting in this way supports the understanding of it in this article, particularly the words *home*, *community* and *workplace*, as a workplace where women work in a space designed by men. A masculine theory of the care setting and feminine practices within it requires a third factor – the presence of residents' families supporting the jobs of carers, and often acting as a regulating factor in the resident's well-being. The article has three parts: firstly, it reflects on care spaces in two organisations, exploring it through the concepts of home and community. The second part is a brief commentary on cultures constructed by organisations. In the last part of the article the FROC model is presented as a response to needs related to generativity, which can be briefly defined as the interconnections between residents, family members, carers and organisation in order to achieve the best standards of care.

The residential and assisted living spaces in the formation of care quality

The quality of care associated with care spaces created for individuals and groups enhances healthy aging processes. Reinforcing the positive image of the care space as a product of organisational discourses is linked with the policy on senior care in a particular country. In fact, institutional and state practices tend to construct an ideal concept, whereas entering a care space as an ethnographer participating in the daily routine allows one to explore the reality and demonstrate the complex character of care. Located in the attractive outskirts of South-East London, on the border

with Kent, the two types of residential health care facilities presented in the article represent two models of care based on British (residential care) and American (assisted living) experiences [tab. 1]. The care space is defined here as any formal setting where people live and are looked after by paid staff (Pulsford, Thompson, 2013, p. 75), and is associated with real and symbolic meanings that construct and develop the attachment of everyone involved in care homes through the architecture, organisational culture, marketing, staff selection and team training. Outcomes experienced by individuals as a result of processes happening in this space inform about the particular life quality domains of healthy aging. The role of women workers in building a home-like service is often simply forgotten and undervalued, since paid physical and emotional labour of this sort is seen as a natural predisposition if women.

Table 1. Care home I and care home II – differences between basic elderly care facilities and planning

Indicators	Care home I Network of ca. 300 homes in UK	Care home II Network of ca. 300 homes in UK, USA, Canada
Location	3-level building near busy street with easy access to shop and high street	Former mansion house located next to hospital and park
Number of residents	120	100
Number of floors	1 residential 2 nursing	3 floors with mostly independent residents, a few nursing residents dispersed among them
Facilities outside home	Garden with trees and plants	Park with fountain, walking paths, playing field
Private rooms	Room with personal toilet	Room with personal toilet and shower or shared showers (with neighbour)
Spaces of communal use	Bathroom/Shower room	Bathroom/Sauna
Community spaces	Dining room, lounge rooms	Dining space, bistro space, lounge spaces, corridors
Quality (Care Quality Commission)	Good	Good

Source:

The residential or assisted living space is designed for independent residents, those who need support in everyday routine activities (mainly related to personal care, e.g. getting up/going to bed, washing, dressing/undressing, shaving), including residents using a Zimmer frame, or in a wheelchair or assisted by a hoist. Considering the five criteria of human activity in old age proposed by Zofia Szarota (2012, p. 20) – biological, social, mental, intellectual and economic needs – by fulfilling the most of them the elderly care setting – if well organised and managed – has the potential to significantly

improve life quality in the last years of life. Studies demonstrate that deeply embedded in the Anglo-American cultural context of work are values defined in the literature as: residents' life satisfaction, longevity, freedom from disability, mastery/growth, active engagement in life, high/independent functioning and positive adaptation (Phelan, Larson 2002, 20), along with a sense of safety, security and order, physical comfort, enjoyment, meaningful activity, relationships, dignity, privacy, individuality, well-being, autonomy/choice and spiritual well-being (Kane 2001, p. 298). In the Canadian model proposed by the Centre of Health Promotion in Toronto there are three main elements of seniors' quality of life – Being, Belonging, Becoming – under which sub qualities are grouped (Baumann 2006, p. 166). All of these have influenced Anglo-American care spaces and their person-centred philosophy of care, where women's labour responds to the idea expressed by the slogan 'Our Residents do not live in our Workplace – we work in their Home'.

Among the many advantages of care spaces in co-constructing the quality of life for seniors, are also missing elements which cannot be provided even by the best care. Transmission of culturally valuable knowledge is minimalised and generativity, which Kotre argues 'creates a point of connection between or among individuals through values, knowledge, beliefs, moral values, or other cultural constructs that are partible, moving from one person to another' (Rubinstein et al. 2015, p. 550) is rarely experienced by seniors in institutional care spaces. The missing element is often regular family involvement in the care setting, the presence of which acts as a factor stimulating generational shift, knowledge exchange and the well-being of residents.

Home, community and border in the understanding of care spaces

Healthy aging is related to the role of the home in supporting or constraining the processes of getting old (Sixsmith et al. 2014, p. 4). Home can be understood as a structure arranged and organised in the form of a space, which becomes a place safe from a chaotic and unpredictable world. This private, isolated and intimate space serves as a shelter, which guarantees stability and security. It is a place where one can express oneself, a place where family relationships are established and developed over the years. This concept of home in the elderly care space is represented by the private rooms of residents and it can be extended by the engagement of individual seniors with some parts of the larger community space.

The decoration strategies of rooms highlight the inner meaning of private spaces, which serve as a connection with one's past, biography, relationships and family, interests and hobbies. A room as a private space is often represented by things that are personally significant including photos, art, collections, memorabilia, souvenirs, journals and diaries, antiques, family heirlooms, and everyday functional objects to which individuals may feel attached, e.g. armchairs, dressers, chests of drawers. Or-

ganisation of the past in relation to the present allows for preserving memories, which are part of an individual's history and unique biography. However, a room is a part of a care setting's life, thus it is organised around a series of dualisms that question its exclusively private character. The room is like an indigenous space into which enter carers or nurses, it is a gateway to understanding one's personality, beliefs and attitude to life, to start a conversation in relation to the specific object or overall atmosphere. From the perspective of residents, the room is a space where he or she can dream, rest, and suffer (if in pain) in privacy. Nevertheless, even if doors are closed residents still participate in the routine of the care space: the serving of meals or tea, the daily change of water jugs, bed making by carers, room cleaning by housekeepers and the distribution of letters and news articles by activity coordinators. Care home workers break the isolation and loneliness of seniors by engaging them in the routine, as well as providing immediate intervention in the case of falls or other accidents. Meanwhile private space remains under the control of workers and their routine, and in broader terms the corporate system of organisation. A room's private space with all its sacred memorabilia, which gives it its unique and individual character, is controlled and at risk of sudden change and intervention – all its areas are available to staff members, who might search in the wardrobe for clothes, change the order of porcelain figurines whilst cleaning, enter the room at any time, for example for a night check or medication. The last one, similarly to hospital routine, reminds residents about their dependency and disabilities.

In contrast to community spaces understood as social and with the potential to create new friendships, but also grouping together multiple numbers of people some of whom are strangers with different disabilities or illnesses, a room remains an owned space for an individual's life and becomes more than a hotel room, but less than the house or flat they possessed in the past. It is limited to four corners filled with objects and memories and is also a space for visits by relatives and friends. In the private space of the room – home creative residents sometimes write letters or postcards, involve themselves in knitting or crocheting, occasionally play instruments (mouth organs, an electric organ, flute) or eventually draw or paint (they also make caricatures of the care home staff in response to daily incidents). All of these activities attempt to break the schematic and routine life in the elderly care home. Thus, private space becomes a specific mode of the reproduction of ideas and expressions. Individual attempts at remaining mentally active include making media choices in the room, such as listening to favourite radio programmes, watching selected tv channels or using the internet – the last one practiced by a generation in their seventies or younger. These practices can be coping strategies and are rarely possible in common spaces and should be understood as alternatives to the schema offered by community life in the care home, whilst remaining under personal care and receiving assistance. The processes continuing in the care space change and empower seniors' lives through daily routine.

Community space means collective support, engagement and control over residents' lives so they can satisfy their interests as a group participating in multiple activities such as games (e.g. crosswords, bingo, quiz), exercises (e.g. valley ball, basketball, balls, wheelchair exercises), sensory involvement with music (e.g. live concerts, karaoke, dancing), arts and crafts (e.g. postcard making, drawing, painting, sculpture), plants and animals (e.g. gardening, bouquet making, pet therapy, observations of birds, or fish in an aquarium), events (visits of invited guests, occasional festivals, seasonal celebrations such as Halloween or Christmas), therapeutic workshops and classes, relaxation activities and new skills acquisition. In this context the term 'community' refers to people who are engaged in specific shared practices leading to greater participation in community life. Thus, empowerment means access to community space, which not only empowers the individual, but also motivates him or her and makes them able to empower other people.

Social well-being is linked with space as a site for social interaction and just spending time together. Community spaces might be used for conversations and information exchange. This depends upon individual resident's intellectual capacities, personal needs and interests. Space design may also support social networking, e.g. coffee tables for two or three creates a different context to the more anonymous large lounge with armchairs and sofas. Armchairs, stools and sofas in gentle and soft colours are attractive for individual and group relaxation. Other elements such as clusters, cabinets, pictures and paintings, figurines, fireplace like designs introduce to the space the flavour of the past years, as does a mini-library or a book shelf with albums representing past life. Optimising life expectancy by staying in a group of people from a similar background and communicating in the same language is an important factor in building and enhancing confidence for spending time in community spaces. Residents needing help with daily activities are known by trained staff members who offer confidential personal care without excluding residents from community enjoyment and care.

Among the community spaces gardens and parks play a distinctive role in the well-being of seniors and the carers who look after them. They inspire the observation of nature during the various seasons and the life of animals such birds or squirrels. During the warm months natural spaces and fresh air enhance rest, increase well-being and attract family members for meetings and social life within the elderly care space. As spaces imbued with meaning, symbolism and significance, gardens and parks should be designed to address the needs of seniors. They are the site of resonant objects such as a Memory Tree, or Obituary Plants commemorating residents who have passed away, as well as social activities.

The less beneficial aspect of community spaces is that they put residents at risk of conflict with each other; temperamental behaviours, disabilities and illnesses (e.g. dementia) become unavoidable elements that remind residents of the darker reality of life in a care space. The likes and dislikes of residents and occasional arguments mean that a newcomer to the care space is required to learn about the other residents

and faces a similar situation to a new pupil in the classroom. In a communal space everything is common and shared: a favourite armchair might be occupied or have been soiled by someone, a tv channel is suddenly changed by the person who has the remote control, a personal cushion is stolen, or unwelcome noises are heard. These situations are likely to generate conflicts in behaviour and interests. Sudden accidents, falls, and the deaths of neighbours reminds residents of the nature of the place, which aims to support and comfort people in their last stage of life. The rhythm of community spaces is disturbed by emergency ambulance arrivals or funeral home workers. In certain cases, poor adaptation to new circumstances can cause deterioration and the acceleration of illness: a resident with Alzheimer's will require more attention and might feel lost among others and neglected in the intensive daily routine of a residential care home. Meeting new situations, ambiguity and change may be dramatic experiences for a new resident, but for some it is the only way to improve their life quality, as at home they had remained at risk of self-neglect due to loneliness and illnesses. To meet the changing needs of individuals, care home staff must take into account the specific requirements and interrelated issues unique to each resident.

Social practices in individual and community spaces are related to time. When entering the community care space, residents start to live in the time of a particular group. Here time is measured by routine tasks, meals, and activities planned in daily, weekly and monthly calendars. A structure provided to calculate time aims to situate individual and group in the structure of past-present-future ("Think Past, Live Now, Dream Future"), so there are memories to have, the present time to enjoy, and purposeful being, such as planning for the next day's events. Time is socially constructed, and its meaning may change according to the society the individual is currently in (Bowlby 1999, p. 275), so its experience will change when family members visit. Time schedules provided by the organisation arrange one's being in private and public spaces, both restricting and stimulating it.

To eliminate barriers to adaptation to space and support identification ("This is now my home, I don't have any other") and integration (being *among* the others and *with* them) meanwhile ensuring that privacy and confidentiality is respected, *home* and *community* concepts require a *border*. The boundary between the public and private supports better spatial arrangement, respects residents' right to privacy and relates it to well-being. Borders construct places with an emphasis on difference but can also lead to conflict if the rules governing them are not respected. Physical boundaries such as doors are often symbolic and limited to a threshold when the door must remain open all day for safety reasons. Individual boundaries are created by vision and hearing impairments, by the position residents take whilst sitting in room, e.g. with backs to the doors. Boundaries are also established by residents who welcome or refuse to see neighbours or carers, ignore unwanted visitors or report them to members of staff. Room numbers and the resident's name on the door inform about the (temporary) space owner. If residents leave or pass away only staff members know what has hap-

pened within the four walls of the room: how many falls and injuries, incontinence incidents, moments of pain and agony were experienced there. This means that the border controlling a resident's privacy acted well. Real and symbolic borders, which differentiate private from public, personal from collective, and construct a distinction between home and what is outside (Bauman 2011, p. 266), are part of the three elements system. *Home*, *community* and *border* are necessary to create a care space which respects the dignity and privacy of residents while responding to their social needs and are related to security, comfort, autonomy and relationships, which makes them *spaces of empowerment* as well as *sustainable spaces* of life enhanced by the presence of women workers.

Residents breaking boundaries, such as those with Alzheimer's disease or advanced dementia are particularly 'dangerous' to a *sustainable space* that must be safe for all and is organised to that end by rules that establish acceptable boundaries. Disturbing behaviours affect not only the harmonious and peaceful existence of other residents, they also impact on staff who are required to make more interventions and give more attention to particular residents instead of spending equal time with all of them. To continue to deliver quality services organisations usually seriously consider a resident's future and takes decisions on moving him or her to a space better adjusted to the individual needs of dementia patients, which often means more care staff and less residents. In the literature there is a strong emphasis on the fact that design features assist in the long-term residential care of people with dementia: e.g. good visual access to the most important sections of the home, proper lighting for day and night, the importance of cultural, linguistic and religious aspects of space design, the necessity of single, comfortable and personalised rooms for everyone as well as recreational space outdoors (Draper 2013, p. 186), keeping noise down, avoiding mirrors, providing aromatherapy (Andrews, House 2009, p. 13), décor and furniture that is homely and in good condition, evidence of occupational tools and objects supporting everyday activity (Pulsford, Thompson 2013, p. 187) or special spaces such as multisensory stimulation rooms (Jakob, Collier, 2015), and overall highly individualised, person-centred care. Spatially adjusted care spaces provide the context for supporting dementia residents by aiming to maintain their independence and dignity.

As living in the care home supports the overcoming of physical limitations in private and public spaces, the residents may actively engage in everyday activities. Both private and community spaces are a kind of shelter from many sorts of dangers waiting outside for vulnerable adults. Empowerment in care spaces also means freedom of decision making about participation in private and public activities undertaken with the support of care workers.

Organisations, their culture and employees in workplace construction

Organisations, carers and visiting relatives' aims are to create a domestic space for residents through place arrangement, workers culture, words, behaviours and everyday gestures. As discussed above, domestication of public and private spaces happens through the residents' presence, items brought by them and their personal contribution to the overall atmosphere of the care space. Another factor is the presence of carers employed by organisations. They co-construct the safe space residents are accustomed to by their continuous presence and assistance in everyday tasks. If properly trained and motivated to work (e.g. by frequent breaks, free meals, seasonal awards, mottos on the walls and in the cosy staff room), carers better understand their role and contribute more efficiently to the space. The three dimensions of care as presented in the literature [tab. 2]: *care-as-service*, *care-as-relating*, *care-as-comfort* are linked with a resident's level of dependency, e.g. complaining residents occupy the dimension of care-as-service, those known by staff as 'more reasonable' residents, the dimension of care-as-relating, whilst care-as-comfort applies to the most dependent residents (Bowers, Fibich, Jacobson 2001, p. 541). Carers are constantly trained and reminded about residents as clients and customers of the care service and develop psychological characteristics that support them in responding quickly and effectively to the needs of seniors. Organisations provide uniforms and name badges, and a uniform dress code makes workers visible and creates a team spirit, whilst at the same time promoting equality regardless of years in service, vocational qualifications, ethnic origin and fluency in English. Women who are equalised by wearing the same uniforms (identified for example as 'ladies in pink' or 'nursies'), are easily recognised by often visually impaired residents as those who provide information, help and care. Organisations encourage workers to support each other and exchange skills and experience. Without the good will of staff and a collaborative culture dealing with disabilities and illnesses as well as the challenges of end of life care would be an exhausting and frustrating experience. Maddock argues that a supportive staff environment 'requires positive interactions with others during the course of which teambuilding, partnership and collaboration develop' (1999, p. 29). Besides carers, activity coordinators who plan activities and apply engagement techniques play an important role in the construction of a space for active and purposeful everyday life. Women in the organisation support the construction of a model of home understood traditionally as a place providing shelter, stability, rest and subsistence, relations with and between residents and a reciprocal and caring ethic.

Tab.2. Definitions of care by residents of care homes identified by Bowers, Fibich, Jacobson (2001)

Indicators	Care-as-service	Care-as-relating	Care-as-comfort
Definitions by residents	Passing food trays, making beds, assisting with bathing and personal care	Relationships with staff; their motivation to work; friendships	Physical comfort, safety, routine tasks
Interpretation in research	Technical/instrumental aspects of care; effectiveness of work; competency	The signs of individualised affection and friendship residents found in the care they received	Good relationships are necessary to receive long-term good quality care
Residents as described by staff	Complainers	More reasonable	More dependent
Typology of residents in research	Purchasers of the services	Strengthening interpersonal relationships	Maintainers of their physical comfort

Source:

The organisation and its structure, underpinned by standards and definitions, aims to design a foundation for work culture, and this determines a sustainable space for ageing as well as a successful business environment. A creative organisational culture encourages people to work effectively and engage in care provision that is best for elders. Social conversation, deep trust and rapport, and a non-judgmental attitude are specified in care home rules, as are the same Christmas presents for all, access to a relaxing staff room space, extra financial rewards for those with five, ten and fifteen years of service. The key to successful space making is to create a good team of people who support each other in achieving daily goals in care, driven by an organisational routine and residents' needs. A positive attitude and the psychological motivation to enhance team spirit is key to the smooth progress of the daily routine, particularly during difficult times: residents' illnesses, shortage of staff for rotas, and accidents. As a carer's job is low-paid and undervalued by society motivational factors minimise risk to resident's needs through negligence. The continuous rotation of workers and the regular employment of new care staff is a challenge for an organisation burdened by the mandatory requirement to train new starters within the context of ongoing recruitment. Flexibility of employment is one of the motivational elements of work in a care setting: full time, part time, or flexi-time staff, the ability to select between four, six, or twelve hour day or night shifts according to individual needs and possibilities attracts different groups of employees, such as school graduates, students, young mothers, middle-aged job seekers and those close to their retirement age. A variety of age groups brings to a care space different experiences and approaches to seniors and is one of the most valuable factors in residents' care. Strategies of instructing senior carers include purposeful guidance rather than reprimand, overall engagement and the example of their own hard work. A perception of employees as human beings with

good intentions (instead of selfish and money-oriented workers) is the first step to building trust and achieving everyday goals as a team.

From the other side organisations often place the responsibility and emotional burden of good quality care on the carers only, seeing the age-friendly arrangement of the space as their main contribution. By being involved in the organisational culture workers are complicit in its mythology, as conveyed in motivational slogans: 'Place, where people love to work', 'The best quality for all seniors', 'Longer, healthier, happier lives', 'Believe in the sacred value of human life', or newsletters and magazines for employees filled with photographs of joyful workers and residents, latest achievements, the organisation's ideas for employees in the future, such as doctor or physiotherapist telephone consultations, discounts in selected shops, vouchers for children or even loans for paying the bills or everyday items needed for work, such as shoes. This pro-workers approach aims to create a story which carers should believe, a story about the care space realm which enhances solidarity among people, equal treatment, support for the needy, and rewarding those who have decided for a career in caring which, according to the mythology, elevates them above the 'Customers, people, performance' organisational idea. In these symbolically constructed care spaces the life of residents has the highest value and is respected; as persons rather than clients they are the centre of the workers' attention. As a consequence of the myth the organisational structure has a ruthlessness to it: its rules might use the emotional engagement of workers with residents as encouragement to take low-paid overtime or work whilst short staffed (e.g. three instead of eight workers for forty residents on a nursing floor). Passion, responsibility, respect and enjoyment from performed tasks might be abused by an organisation's mythology of 'effective work', and employees' rights disrespected by the system and those managing it.

The family role in care-spaces – towards FROC model

From field observation of residents' actions and behaviours as well as their words in relation to the organisation and to family and carers, this section identifies four elements of the FROC model with the aim of suggesting a strategy for making better quality care spaces. The model is constructed around the four agents involved in a care space: Family, Resident, Organisation and Carer. The first and most important point of the FROC model is ensuring that residents' needs are fulfilled through the presence and involvement of all agents, cooperation between them and mutual trust and understanding. As one factor of sustainable elderly care the FROC model was designed to provide stability and trusting relationships between a resident's family, the resident, the organisation and carers. Its principles are safety and trust in home, community and at the borders. The role of the family is the most important factor in the organisational system and carers' work: regular visits in the care setting maintain relationships and establish a timetable in the resident's routine. Taking a resident

away from the care home for a walk, coffee or shopping in a nearby supermarket, or for Sunday lunch together improve seniors' self-esteem and everyday functioning. Additionally, regular family visits allow control over the care setting and a successful response in case of any problem on the part of the organisation or employees. The importance of family presence in softening the rule-based culture of the institution cannot be overlooked in any care model. The experience of the space through family participation includes achieving generativity – family member's involvement in the care setting allows the transmission of knowledge between generations and empowers residents. In other words, care space should be seen as an effect of the FROC discourse which aims to improve overall life satisfaction. *Home, community, border* and *workplace* help to identify the value of the care space for residents as a home-like setting with professional medical and care support, guided by frequent family presence. This makes existence in the care system purposeful and wholistic.

Conclusion

The purpose of this article was to reflect upon the residents' experience of living in selected elderly care homes in the South East suburbs of London. The accounts in this article demonstrate how identification and integration with the care setting through constructed private and public spaces improve residents' well-being and overall life satisfaction. As demonstrated, the care space includes *home, community* and *workplace* concepts, which support residents' empowerment in last stage of life. This space is functional, safe and made familiar by objects, people and their actions, preserving intimacy and dignity as well as promoting active engagement in social life. Organisational culture contributes to the life style of residents and the work of carers, highlighting the role that women play in space construction. The care spaces of two care homes organised according to the British or American models presented in this article may serve as a ground to reinterpret the care concept. Using ethnography to examine the experience of life in elderly care homes the material collected led to the proposal of the FROC idea discussed in the last part of the article, which explained how strengthening relations between family, resident, organisation and carers helps to construct a better care space and overcome the challenges of aging. This may lead to a better understanding of seniors' experiences in care spaces and the ways their empowerment and sustainable living can be constructed and supported.

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