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REVIEW

Beyond the intervention: how physical, social, and organisational contexts trigger wellbeing for minority ethnic residents with dementia: a realist synthesis

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Abstract

Background: As populations age and diversify, the need for culturally responsive dementia care in residential settings is urgent. Minority ethnic (ME) residents often face barriers to equitable care, and a ‘one-size-fits-all’ approach risks overlooking what matters most for their wellbeing. This review investigates how culturally tailored interventions improve wellbeing for ME residents with dementia.

Methods: A realist synthesis was conducted to explain *how, why, and under what conditions* interventions work. The protocol was registered with PROSPERO (CRD42024581293). Six databases were searched for studies published between 2013 and 2024. Using the Integrated Model of Place as a framework, data were analysed to develop Context-Mechanism-Outcome configurations (CMOCs). Findings were validated with stakeholders from 10 care homes.

Results: Seven studies were included. Analysis revealed that effective interventions are those aligned across three contextual domains/environments: the *physical* (culturally familiar sensory cues), the *social* (native-language communication, shared activities), and the *organisational* (supportive leadership, staff training, structured routines). When aligned, these contexts trigger mechanisms of familiarity, emotional memory, trust, and identity affirmation. This leads to outcomes of reduced agitation, improved mood, enhanced communication, and stronger family-staff relationships. On the other hand, interventions lacking this integration, such as those without language support, failed to engage residents and families.

Conclusion: Wellbeing for ME residents is not achieved by interventions alone but through care environments that are holistically culturally responsive. Culturally attuned physical, social, and organisational contexts must be synergistically aligned to activate essential wellbeing mechanisms. This synthesis provides a practical framework for designing and implementing inclusive dementia care.

Keywords: dementia residential care; minority ethnic groups; realist synthesis; sense of place; cultural competency; interventions; older people

Key Points

- Wellbeing for minority ethnic residents with dementia in care homes is place-made.
- When the physical, social and organisational environments are aligned, they trigger a sense of place.
- Interventions lacking cultural integration and organisational commitment failed to engage residents.
- The Integrated Model of Place provides a framework to understand how physical, social, organisational contexts interact.
- Our findings highlight the need for systemic changes in practice to sustainably implement culturally responsive care.

Introduction

As international migration continues and populations age, the number of minority ethnic (ME) individuals living with dementia in residential care is expected to rise in many high-income countries. This demographic shift underscores the urgent need for culturally responsive care that reflects the values and preferences of diverse communities [1, 2]. Yet dementia services remain predominantly shaped by White-majority norms, contributing to low uptake and engagement among ME families [2, 3]. Persistent barriers, such as language challenges, stigma, and a lack of culturally appropriate resources, hinder equitable access and care effectiveness for ME individuals [4]. To overcome these barriers and improve wellbeing, care models must foster a strong sense of place; a critical yet often overlooked factor. Doing so makes residential care more inclusive and relevant, fosters trust within ME communities, and prioritises holistic wellbeing.

Wellbeing and sense of place are closely linked in dementia care, particularly for ME residents in care homes. A sense of place, defined as the emotional, cultural, and psychological connection to a specific location, can enhance wellbeing by fostering familiarity, safety, and belonging [5–7]. Environmental factors such as culturally familiar surroundings, opportunities for personalisation, and meaningful social interactions are strongly associated with improved mental health, reduced agitation, and higher quality of life for people with dementia [8]. For ME residents, this association is especially important, as culturally inclusive environments affirm belonging and reduce isolation [9]. A strong sense of belonging, reflecting the attachment to place and cultural embeddedness, is a fundamental human need that predicts numerous wellbeing related outcomes [10].

The concept of wellbeing in dementia care is culturally dependent. Participatory research consistently demonstrates that wellbeing is understood differently across communities, shaped by cultural traditions, social norms, and lived experiences of ageing and illness [11]. In some cultures, wellbeing is closely related to social participation, religious observance and collective family involvement; in others, it is grounded in autonomy, identity, belonging, dignity and respect, relationships, and activities of daily living. These interpretations intersect with the physical, social, and organisational environments of care homes, therefore a one-size-fits-all approach risks overlooking what matters most to residents from diverse backgrounds. For ME residents, cultivating a culturally attuned sense of place is therefore not simply an enhancement to care; it is essential for wellbeing.

Place-based and community-based approaches have been developed to foster a sense of place while improving wellbeing for people with dementia [12–19]. As interest in these approaches is growing, significant gaps remain. First, most studies and reviews focused on community-dwelling individuals or family-based caregiving and have overlooked residential settings where structural adaptations are critical. Second, despite the increasing use of realist synthesis in dementia research, few studies have applied it to interventions for ME

populations. Third, although cultural sensitivity is frequently cited as important, the mechanisms through which culturally tailored environments influence outcomes are underexplored in residential care homes. Finally, the siloed approach adopted in previous reviews missed out crucial information on the ways the physical, social, and organisational environments interact to promote (or erode) wellbeing. The interdependence of these environments and how they jointly shape the wellbeing of ME residents have yet to be systematically explored.

To effectively address these gaps, particularly concerning the psychosocial environment for ME residents, a robust theoretical foundation is required. This foundation is found in the principles of person-centred care. Place-based and person-centred care are not opposing ideas but complementary ones. Kitwood's core principle—that personhood is nurtured through relational and psychosocial support—is directly promoted by a place-based approach. This approach recognises that interaction of the physical, social and organisational environment is a core condition through which identity, agency and belonging are experienced. Therefore, by intentionally designing spaces, routines, and cultures that affirm personhood, a place-based approach operationalised Kitwood's supportive care environment.

This review addresses these gaps by adopting the Integrated Model of Place [20] as a conceptual framework within a realist synthesis methodology. The Integrated Model of Place posits that wellbeing and care experience are shaped by the dynamic interaction of three domains:

1. The physical environment, including design features such as spatial layout, sensory cues, lighting, and materials that promote safety, orientation, and familiarity.
2. The social environment, encompassing interpersonal relationships, culturally congruent communication styles, opportunities for shared activities, and the integration of residents' cultural practices into daily life.
3. The organisational environment, comprising leadership approaches, staff training, policies, routines, and institutional values that underpin care delivery.

The IMP offers a strong overarching framework for realist reviews because it draws attention to how physical, social and organisational environments of residential care settings interact to shape outcomes. Unlike person-centred care models such as Dementia Care Mapping, VIPS Practice Model, Montessori for Dementia and Ageing, ABLE Model of Care, etc [21] focus primarily on interpersonal care processes, IMP conceptualises 'place' as a dynamic system of contexts and mechanisms, making IMP better suited to explaining how and why care practices work (or do not work) in the care homes.

Building on this, the IMP highlights that outcomes emerge not from care practices alone but from alignment of the physical, social and organisational environments. When these three environments are aligned and culturally attuned, they collectively enhance wellbeing, and fostering a sense of place

that supports identity, belonging, and emotional security in individuals with dementia [14, 22–25]. In the context of ME populations, this alignment might include access to culturally familiar foods, native-language communication, recognition of religious and cultural practices, and the presence of staff who understand and reflect residents' cultural backgrounds [2, 26–29]. These environments are not static settings, but dynamic contexts that are shaped by residents' life histories and cultural identities. When thoughtfully designed, they can activate mechanisms such as trust, familiarity, and cultural affirmation that in turn contribute to improved mood, reduced agitation, increased social engagement, and overall [23, 30, 31].

By combining the Integrated Model of Place with a realist synthesis approach, this review aims to discover *how, why, and under what conditions* culturally responsive dementia care interventions work for ME populations in residential settings. Specifically, we examine how the physical, social, and organisational environments operate as contextual factors within interventions, triggering mechanisms that leads to positive or negative or unintended outcomes. Our analysis aims to provide actionable insights for designing, implementing, and sustaining care practices that are both culturally inclusive and responsive to the complex needs of a growing, diverse dementia population.

Methods

We undertook a realist synthesis to explain how, why, and under what circumstances care home interventions promote or hinder wellbeing among ME residents with dementia, using context–mechanism–outcome configurations (CMOCs) to generate theory-informed guidance for equitable, culturally inclusive care. Contexts were conceptualised as physical, social, organisational, and dynamic features shaping implementation, mechanisms as participants' responses and shifts in motivation, beliefs, or norms triggered by intervention resources, and outcomes as intended or unintended effects arising when mechanisms operate within particular contexts [32–35]. Guided by an initial programme theory positioning care home environments as key contextual conditions, we defined interventions using the WHO definition and drew on Lasiello et al.'s wellbeing outcomes as a starting framework [36].

See *Appendix 1* in the *Supplementary Data* section for the full details of the methodology.

Results

Table 1 showed the country and types of interventions conducted in the care homes. Three groups of stimulation interventions are identified: sensory, cultural, and technological.

Majority of the interventions reported positive wellbeing outcomes. The study by Koehn and colleagues served as a salient example of how a lack of supportive context, i.e. the absence of language interpretation and culturally inclusive

practices, led to mechanisms of alienation and disengagement which resulted in negative outcomes where family and resident needs were not met [30].

Realist synthesis results

This realist synthesis revealed how culturally tailored interventions work within dementia care homes to support the wellbeing of ME residents. Drawing on the Integrated Model of Place, we identified how the alignment of physical, social, and organisational environments, which served as contexts, created meaningful experiences for residents by activating mechanisms tied to familiarity, belonging, and identity. When these environments were aligned and interventions were culturally attuned and implemented in an integrated manner, together they triggered mechanisms that supported emotional memory, trust, and engagement, thereby enabling ME residents to feel connected, valued, and affirmed.

Grouped by type of stimulation, three interlinked CMOCs were identified. Each CMOC showed how elements of place within the environments (physical, social, and organisational) interacted to influence outcomes. For examples, when familiar, multi-sensory cues—such as music, colour, cherished objects, or culturally resonant décor—were integrated into the interventions, residents' memories and sense of self can be meaningfully reawakened. Likewise, transforming everyday interactions into personalised, one-to-one engagements—through clowning, Montessori activities, cultural videos, traditional food, or native-language conversation -helped to foster positive emotions and enhance social connection. When care home managers embedded the interventions into daily routines, supported staff with training and life story resources, and cultivated a responsive culture, staff reported feeling empowered to recognise and meet individual residents' needs.

CMOC 1: sensory stimulation

Two interventions [37, 38] implemented culturally familiar sensory simulation in a physical space and supportive organisational settings delivered positive outcomes.

Context (C): Physical environments enriched with culturally familiar sensory simulation—music, colours, personal objects—implemented by staff within supportive organisational settings. Mechanism (M): Activation of emotional memory, comfort through familiarity, and sensory recognition that reinforces identity. Outcomes (O): Reduced agitation, increased engagement, enhanced emotional wellbeing, and improved communication. These CMOCs are shown in Table 2.

Stakeholder insights: Majority of the staff use music as activity in care homes. They agreed that music can easily engaged residents and families in common space. They also see music as a useful non-verbal communicative aid for residents of diverse backgrounds during group activity. Staff emphasised the importance of tailoring activities to individual preferences rather than assuming cultural background dictated interests. In terms of using colourful objects, a care

Table 1. Overview of the included studies.

Authors/year/ country	Intervention/study design	Home setting/participants/severity of dementia	Data collection	Key findings
[37]	Medical clowns, Ethnographic observational	Two nursing homes; residents with dementia, including foreign-born, 60 residents with moderate to severe dementia.	Participant observation over 10 weeks; ethnographic field notes	Used culturally responsive strategies (sensory triggers, music, personal history) to enhance social interaction and individual well-being in diverse dementia care settings.
[38]	Personalised Montessori activities, Randomised crossover trial	Nine residential facilities; 44 residents with dementia, some non-English fluent, 29 residents with severe dementia, 13 moderate dementia, two mild dementia	Observational assessments pre/during/post intervention (Montessori vs control), MMSE, CDR	Reduced agitation, increased positive affect and engagement more than control. Benefits were greater for residents who lost fluency in English.
[39]	Touchscreen technology (Sitdance), Qualitative ethnographic	Residential aged care facility; non-English speaking residents, culturally and linguistically diverse residents (67–100 years) where 36 have mild to moderate dementia.	Participant observation, informal conversations, video ethnography, semi-structured interviews (residents, family, staff)	Increased physical and social engagement, helped overcome language and cultural barriers, leadership presence increased participation, organisational barriers limited staff engagement.
[16]	Tailored TV videos, Qualitative focus groups	One long-term care home and one geriatric hospital unit; 23 healthcare providers (nurses, therapists, admin), residents from Asian cultural backgrounds. Moderate to severe dementia. No information on numbers of residents provided.	Focus groups recorded and transcribed; thematic analysis	Helped calm dementia patients, form connections, facilitate activities of daily living, and overcome cultural/linguistic barriers; staff ambivalence and organisational constraints limited uptake.
[40]	Culturally responsive companion program, Qualitative case study	U.S. nursing home; one Japanese woman with advanced dementia; staff and legal guardian interviewed (9 staff), 1 Japanese resident with severe dementia	Semi-structured interviews with staff; qualitative coding	Improved resident’s physical, emotional wellbeing, language communication, and cultural support. Staff benefited by improved care ability. Volunteers bridged language and cultural gaps enhancing resident’s quality of life.
[30]	Family council, Qualitative case study	Two publicly funded long-term residential care homes in British Columbia, Canada; nine Chinese-origin residents and 11 family carers, 295 residents: all with Chinese origins, no information was provided on severity of dementia.	In-depth semi-structured interviews, participant observation	Immigrant seniors under-represented in care homes; family councils had low participation, language barriers and cultural norms hindered advocacy; families provided substantial informal support; staff communication challenges noted.
[41]	Traditional food, Qualitative interviews	Geriatric facilities; indigenous Sami, ethnic Norwegians, and other groups Residents with severe dementia. No information on number of residents provided.	Semi-structured interviews with patients, families, nurses	Created a sense of belonging, awoke pleasant memories, boost wellbeing, encourage non-verbal residents to speak

home used have an interactive projector that projects images and games onto tables or the floor. Residents could ‘touch’ tomatoes, balloons, or frosted images that responded visually. This was described as very colourful and stimulating and highly appreciated by residents. All staff commented that life stories of residents were seen as crucial tools to provide care in general, but life stories were seldom integrated in games and activities for sensory stimulation.

CMOC2: cultural stimulation

Three interventions [30, 40, 41] applied cultural stimulation to improve wellbeing of ME residents (Table 2).

Context (C): Familiar cultural elements (traditional meals, decorations, use of native language) make the environment

more home-like. Organisational commitment through traditional food menus and cooperation with external cultural companion programs demonstrate respect for residents’ heritage. Mechanism (M): culturally and linguistically matched social interactions (native-language companions, cultural activities) build identity and belonging, while lack of language support caused breakdown. Meals, decorations and residents’ own languages trigger positive emotional memories, whereas their absence can alienate residents and families. Outcome (O): these contexts trigger mechanisms of cultural familiarity and trust, leading to improved well-being (better mood, appetite, social engagement) and stronger family–staff relationships. Conversely, when cultural needs are neglected (e.g. meetings only in English without interpretation), families disengage, and important concerns go unaddressed.

Table 2. CMOCs for sensory, cultural and technology stimulation interventions.

Context:	Mechanism	Outcome:
Physical (P), social (S), organisational (Org) environment		wellbeing outcomes
CMOC for sensory stimulation interventions		
[37] - Medical clowns intervention		
<ul style="list-style-type: none"> Common spaces designed to evoke past experiences and group activities (P) Sensory triggers (S) Colourful traditional clothing Musical instruments 	<ul style="list-style-type: none"> The clowns used sensory triggers and spaces to create an attachment and a social bond Sensory triggers (visual and auditorial) stimulate memory, comfort and identity 	<p>Increased engagement during group activities in common space.</p> <p>Enhance sense of self, increased mood, reduced social isolation improved verbal/non-verbal communication. Provided staff with strategies for better communication with residents</p>
<p>Clowns use culturally relevant music and dance as a non-verbal invitation to participate</p> <ul style="list-style-type: none"> Supportive leadership (Org) Staff provide clowns with residents' life histories beforehand (Org) Structured clown visits embedded into daily schedule (Org) 	<p>Clown-resident interactions trigger emotional responses and autobiographical memories, fostering comfort and familiarity</p> <ul style="list-style-type: none"> Life histories enable personalised interactions with residents Regular scheduling builds anticipation and routine for staff and residents 	
[38] - Montessori-based activities intervention		
<p>Familiar, tangible objects such as dry pasta, nuts, bolts, pulps, and flower arrangements to provide sensory stimulation (P)</p> <p>Individualised one-on-one interactions tailored to each resident's past experiences and abilities (S)</p> <ul style="list-style-type: none"> Staff identify residents' peak agitation times to schedule sessions (Org) Facilitators receive structured training in Montessori methods (Org) 	<p>Colourful objects provide tactile and visual prompts that provoke procedural memory</p> <p>Tailored interactions generated a deep sense of interest, and emotional connection</p> <ul style="list-style-type: none"> Timing interventions when residents were most agitated Trained facilitators adapted the activities to residents' interests 	<p>Enhanced positive emotions, reduced agitation, and increased social engagement compared to standard social interaction</p>
CMOC for cultural stimulation interventions		
[40] - Japanese culturally responsive companion program		
<p>Japanese cultural decorations and food from volunteers (P)</p> <p>Japanese-speaking companions regularly interacting with the resident to provide social companionship in their native language (S)</p> <p>Nursing home administration supported a culturally responsive companion program with structured visits integrated into daily routines (O)</p>	<p>Cultural objects and foods created a comforting, culturally familiar environment that triggered cultural and personal memories</p> <p>Shared language and cultural understanding fostered meaningful social interactions, reduced communication barriers, and alleviated social isolation</p> <p>Organisational backing facilitated effective communication between residents and the cultural companion</p>	<p>Improved physical health (e.g. better eating habits), increased emotional wellbeing, reduced loneliness, improved communication, Improved caregiving quality</p>
[30] - Family councils to support families of dementia residents with Chinese origin		
<p>Minimal provision of Chinese food and space for private family gatherings (P)</p> <p>Communication between families, residents, and staff was hindered by language barriers. Many staff did not speak Chinese, and family council meetings were held in English (S)</p> <p>Family Council meetings are held regularly for families to voice their concerns. The meetings are held in English without interpretations (Org)</p>	<p>Families and residents interpreted the environment as alienating and non-inclusive.</p> <p>Families felt they were 'chickens talking to ducks' and experienced repeated dismissal of their concerns. Over time, they viewed these spaces as unwelcoming or futile.</p> <p>Families perceived Family Councils as performative, where voices were heard but not acted upon.</p>	<p>The meetings are poorly attended by Chinese families. When families had clear concerns (e.g. food quality, toileting practices), they refrained from voicing them in formal forums</p>
[41] - cultural familiar food		
<p>Availability of cultural food familiar to residents from their childhood (P)</p> <p>Shared cultural dining experiences facilitated by family or caregivers serving culturally familiar food (S)</p> <p>Institutional provision of culturally familiar meals requiring extra planning, traditional knowledge, and creativity from staff (Org)</p>	<p>Familiar tastes, textures, and smells stimulated memory recall, evoked positive emotions, and fostered a sense of cultural identity and belonging</p> <p>Cultural familiarity facilitated social interaction, emotional bonding, and positive reminiscence among residents, staff, and families</p> <p>Organisational commitment to culturally sensitive food provision demonstrated respect and acknowledgment of residents' cultural identities</p>	<p>Familiar tastes and smells awoke pleasant memories in patients and boosted their sense of wellbeing, identity and belonging, even producing words in those who usually did not speak</p>

(continued)

Table 2. Continued.

Context:	Mechanism	Outcome:
Physical (P), social (S), organisational (Org) environment		wellbeing outcomes
CMOC for technological stimulation interventions		
[39] Touchscreen technology in care home		
Presence of touchscreen Technology and Sit-dance provided visual and auditory stimuli in shared open spaces (P)	Physical presence of a large screen made the activity visible and inviting, changing the atmosphere of the room	Increased physical activity and social engagement. Reduced boredom and social isolation, and enhanced connectedness among residents. Increased staff awareness and prioritisation of residents' psychosocial needs, enabling better quality of person-centred care
Residents' daily routine mostly involved sitting passively and 'watching' television in the common room (S)	Touchscreen activities facilitated non-verbal communication and meaningful social interaction, overcoming language barriers	
Task-oriented schedules and limited resources for social activities. Staff aware of the problems with residents' social inactivity and want to improve it (Org)	Worked best when the staff led the physical movement	
[16] Television Videos in Dementia Care		
Availability of dementia-friendly TV videos that are shorter (5 to 20 min), presented at a slower pace, and feature less complex content than regular TV videos (P)	Appropriate visual and audio stimuli of tailored videos provided familiar and calming environmental cues	Reduced agitation, enhanced memory recall, and facilitated performance of ADLs* Strengthened relationships between caregivers and residents, and more effective management of behavioural symptoms
Shared video watching among small groups of dementia patients with common interests (S)	Videos served as conversation starters and encouraged social bonding through shared memories and experiences	
Staff received information, training in using the videos (Org) Staff communication with relatives about the videos (Org)	Staff engaged in choosing videos that matched the cognitive abilities, cultural and linguistic preference of residents	

*ADL: Activity of daily living

Stakeholder Insights: all staff and managers agreed that food is central for all residents. Staff observed that residents' faces would light up when they were served cultural food that felt familiar. Families and cultural associations (e.g. Finnish, Syriac) were sometimes invited to prepare or share traditional meals. Some care homes also collaborated with ethnic-specific care homes to celebrate holidays and share cultural dishes. In terms of language, residents' own language was seen as vital for comfort and participation, but communication often relied on ad hoc solutions such as Google Translate, bilingual staff, or relatives. Staff pointed out the needs of systematic resources such as devices for correct translation, more diverse staffing, culturally adapted food and activities, stable staffing structures, and formal collaboration with cultural associations. One manager admitted that she never thought of collaboration with cultural associations.

CMOC3: technological stimulation

Two interventions [16, 39] demonstrated that accessible technology and tailored media content delivered in shared areas or physical space can effectively increase wellbeing of participants (Table 2).

Context (C): the presence of accessible technology in a physical space provides a common ground for interaction between residents (even among passive or non-verbal residents). The staff saw the opportunities of using technology to improve social inactivity among residents. Mechanism (M): staff active involvement in a large common room and

the carefully chosen videos stimulated memories. Outcomes (O): enhanced social interaction, reduced isolation, improved mood, and support in daily routines.

Stakeholder Insights: all care homes have some kind of technologies. Such as smart TVs, tablets/iPads, and translation apps, often used for music and films. Two care homes mentioned the use of VR glasses and interactive infrared sensor projector. Staff commented that some residents found it stimulating and enjoyable, while others became overwhelmed or motion sick and may be not suitable for all residents. However, all managers and staff admitted the lack of technical support, insufficient staff training, and absence of systematic routines for the use of technologies.

Convergence through the integrated model of place

Table 3 condenses the CMOCs into three broad patterns which directly aligned with the Integrated Model of Place (physical, social, organisational). Across the studies, well-being outcomes for ME residents with dementia were not achieved through the interventions alone, but through the way interventions interacted with physical, social, and organisational contexts of care homes. Familiar sensory cues in the physical environment provided comfort and reactivated emotional memory. Social contexts that supported culturally congruent interactions fostered trust, belonging, and identity affirmation. Organisational contexts were crucial in embedding these practices and sustaining staff engagement.

Table 3. Summary of contexts, mechanisms, and outcomes (CMOCs).

Context (C)	Mechanism (M)	Outcome (O)
Physical environments enriched with familiar sensory cues (music, food, décor, personal objects, touchscreen tools, TV content)	Emotional memory and recognition are triggered; residents feel comfort and familiarity	Reduced agitation, improved mood, greater engagement, enhanced communication
Social environments with culturally congruent interactions (native-language companions, personalised activities, shared meals, family involvement)	Trust and belonging are fostered; identity and cultural continuity are affirmed	Increased social participation, stronger family–staff relationships, reduced isolation
Organisational environments with leadership support, staff training, and structured routines for interventions	Staff feel empowered, confident, and supported to deliver tailored care consistently	Sustainable implementation of interventions, higher quality of care, better staff–resident interactions

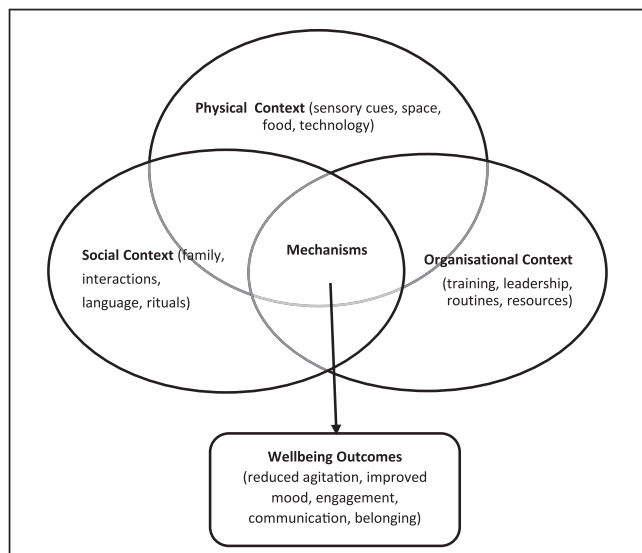


Figure 1. Integrated Model of Place in culturally responsive dementia care.

Together, the physical, social and organisation elements fostered a sense of place among ME residents, allowing them to actively participate in the interventions within the care homes. Figure 1 shows how physical, social, and organisational contexts overlap to trigger mechanisms (emotional memory, trust, belonging, identity affirmation), which then lead to wellbeing outcomes such as reduced agitation, improved mood, engagement, and a stronger sense of belonging. Importantly, when any of these contexts were absent such as lack of language support or organisational commitment, interventions risked being perceived as tokenistic and yielded limited impact.

Discussion

This realist synthesis demonstrates that the wellbeing of ME residents with dementia is not a product of interventions alone but emerges from the synergistic alignment of a care home's physical, social, and organisational environments to

activate mechanisms of familiarity, trust, and identity affirmation. By applying the Integrated Model of Place, we found that a sense of place and wellbeing arises when these three environments interact to trigger specific mechanisms. Consistent with previous research, our analysis confirms that interventions incorporating personalised cultural cues, such as food, music, or rituals, reduce agitation, foster belonging, and enhance communication by activating emotional memory and comfort [8, 37, 38]. Conversely, the failure of initiatives like the English-only family councils [30] provides a clear example of how interventions lacking cultural grounding or organisational support are perceived as tokenistic and fail to engage residents or families.

Stakeholder insights provided crucial validation for these findings. Staff consistently observed that music, food, and native languages were powerful tools to enhance comfort and participation. Technology was recognised as promising but underutilised, reflecting broader evidence that digital tools require training, organisational investment, and staff confidence to be effective [16, 39]. Most importantly, participants stressed that cultural embedding through celebrations, native-language interactions, and family partnerships, was most effective when supported by sustained organisational commitment and external networks, aligning with research that highlights the importance of co-production and culturally safe practice [15, 18].

The three identified CMOCs (sensory, cultural, and technological stimulation) function as interlinked and interdependent pathways rather than separate categories. Sensory stimulation reactivates emotional memory and comfort, but its efficacy is dependent on its alignment with residents' life histories and delivered by trained staff [37, 38]. Technological stimulation, through tools like touchscreens and tailored media, sparked autobiographical recall and social interaction, but its success was contingent on organisational support, staff skills, and resource allocation [16]. Cultural stimulation, encompassing food, rituals, and language, powerfully affirmed identity and fostered trust but was highly vulnerable to organisational neglect when interpreters, bilingual staff, or structured cultural partnerships were absent [40, 41]. Therefore, the central argument arising from this synthesis is that for interventions to be successful, they must be woven into

the routines and culture of care homes rather than delivered as episodic activities.

A substantial body of literature has demonstrated that care homes that have embedded cultural norms, routines, values and expectations in their care practices can either enable or constrain culturally responsive practice. Task-driven routines, hierarchical communication, and limited flexibility restrict staff capacity to individualise care or culturally meaningful practices into daily life [42–45]. On the other hand, care home cultures prioritising relational care, empowerment and shared decision-making are more likely to sustain interventions that support identity, belonging and personalised engagement [15, 37–39, 41]. As our CMOCs illustrate, organisational features such as leadership support, staff training, stable staffing structures, and reflective practice reflect underlying care home culture that determine whether mechanisms of familiarity, trust and cultural affirmation can be triggered. Thus, culturally responsive dementia care requires not only attention to residents' ethnic and cultural identities but also a critical engagement with the organisational and cultural norms of care homes that may facilitate or impede meaningful implementation.

Responses to environmental interventions varied notably by dementia severity. Residents with more advanced dementia were more likely to respond to music, familiar foods, native-language interaction, and culturally grounded activities while touchscreen-based Sitdance appeared most effective for those with mild to moderate dementia [16, 38, 40, 41]. While patient characteristics are often treated as confounders in experimental studies, realist studies consider them as key contextual conditions that shape how mechanisms are activated [46]. What may appear as 'confounders' are in fact integral contextual forces that ultimately determine whether an intervention succeeds within a given care environment.

Strengths and limitations

A key strength of this review is its application of a robust theoretical framework, namely the Integrated Model of Place, within a realist methodology. This combination allowed the synthesis to move beyond determining *what* works to explain *how*, *why*, and *under what conditions* interventions are effective. The model provided a critical structure for categorising contextual factors (physical, social, organisational), articulating the activation of mechanisms such as familiarity and belonging, and developing the CMOCs that illuminate actionable pathways for improving care. Stakeholder insights provided crucial validation by ensuring these theoretical findings resonated with lived practice realities. However, this synthesis has several limitations. Without residents and families' participation in the stakeholders workshop, their experience of care in care homes cannot be reported. Poor engagement of families or residents in care provision has led to unmet needs [30]. The small number of included studies limited the cultural and geographical diversity of the evidence base. Furthermore, variability in reporting detail, particularly at the organisational level, posed a challenge

for analysis. As commonly occurs in realist reviews, some CMOCs required interpretive inference since primary studies did not always clearly distinguish contexts from mechanisms [47]. We mitigated this limitation through independent dual coding and consensus building. Additionally, our focus on studies with explicit wellbeing outcomes may have excluded innovative practices not yet formally evaluated.

Implications for research

Our findings provide a theoretically informed roadmap for designing, implementing, and sustaining dementia care practices that reflect the diverse needs of residents across ethnic and cultural backgrounds. Future research should address current limitations through comparative and cross-national studies that would help illuminate how diverse cultural and systemic contexts shape mechanisms and outcomes. Such research would contribute to developing care models in residential care that are both locally relevant and globally transferable, therefore, advancing equitable dementia care for minority ethnic populations across diverse settings.

Implications for practice

Achieving wellbeing for ME residents with dementia requires a fundamental shift from isolated interventions to coherent, culturally attuned care systems. This transformation demands committed leadership, strategic investment, and collaborative partnerships to create environments that actively foster belonging, dignity, and meaningful quality of life. To realise equitable, culturally responsive dementia care, the following actions are imperative:

- Care homes must systematically integrate physical, social, and organisational contexts to activate mechanisms of familiarity, trust, and identity affirmation. This involves co-designing environments rich in culturally meaningful sensory cues (e.g. music, food, artefacts), ensuring linguistically congruent communication through trained staff or professional interpreters, and embedding cultural practices into daily routines.
- Investment in specialised staff training and resources is essential. Beyond cultural awareness, staff require practical, ongoing education in using life stories, adapting activities to cultural preferences, and applying person-centred approaches. Organisational policies must allocate protected time and support for these practices to ensure consistent implementation rather than ad-hoc efforts.
- Involved ME residents and families, community and religious organisations to co-produce cultural appropriateness practices that have a higher chance of sustaining over time. This requires establishing formal partnerships to co-design care activities, menus, and policies. Reconfigure family engagement through professionally interpreted meetings and responsive feedback mechanisms to build genuine collaboration and trust.
- Policymakers and funders must recognise culturally responsive care as a core standard and mandate enabling infrastructures. This includes funding for interpreter

services, culturally tailored resources, diverse staffing, and appropriate technology. Regulatory frameworks should require evidence of cultural alignment in care environments as a criterion for quality accreditation.

- Care homes in this review would be receiving tailored feedback reports and presentations based on the review findings, enabling staff and managers to translate insights into ongoing practice development and culturally responsive care improvements.

Conclusion

For minority-ethnic residents with dementia, wellbeing is place-made; when physical, social, and organisational contexts are aligned, familiarity, trust, and identity continuity coalesce into a strong sense of place.

Supplementary Data: Supplementary data are available at *Age and Aging* online.

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