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Mediating roles of frontline employees in transformative service processes

Abstract

Purpose – This paper aims to explore the role of frontline employees (FLEs) as mediators in transformative service processes within services targeting vulnerable users.

Design/methodology/approach – This paper is based on a case study of the development and implementation of a dementia village, and the data consist of documents, in-depth interviews, and field observations.

Findings – The analysis identifies FLEs as mediators in six different roles. These roles highlight how FLEs perform as mediators, acting in between and for vulnerable users and thus supporting their well-being. Specifically, the roles explicate the mediating role of FLEs in the design and planning of transformative changes and in daily work practices.

Practical implications – The different mediating roles of FLEs presented here should inform care providers and managers of how employees can become assets for supporting vulnerable users' well-being during the design and planning stages of transformative change and through daily service work.

Originality/value – This paper offers novel insights into the multifaceted roles of FLEs in transformative services. The findings add to the current debate on mediation in transformative services and contribute to the literature by extending and refining the established conceptual and empirical understandings of the role of transformative service mediators (TSMs) in consumers' well-being.

Keywords: Service innovation, service design, employees, co-creation, proxies, transformative service mediator, transformative service design

Introduction

Transformative service research (TSR) is defined as "the integration of consumer and service research that centres on creating uplifting changes and improvements in the well-being of individuals (consumers and employees), families, social networks, communities, cities, nations, collectives, and ecosystems" (Rosenbaum *et al.*, 2011, p. 3). TSR has been valuable in providing a framework for studying well-being from an individual, collective, and ecosystem perspective (Anderson *et al.*, 2013) in contexts with issues pertaining to poverty, equity, access to services, and vulnerability (Blocker *et al.*, 2022).

A central and emergent aspect of TSR is the concept of service inclusion, which implies that all consumers should have equal opportunities to access the resources inherent in the

marketplace exchange system (Boenigk *et al*., 2021; Fisk *et al*., 2018). Service inclusion is defined as "an egalitarian system that provides customers (e.g. consumers, clients, patrons, citizens, patients and guests) with fair access to a service, fair treatment during, and fair opportunity to exit a service" (Fisk *et al*., 2018, p. 835). Working to ensure service inclusion and well-being is highly pertinent in settings such as health and elderly care, where consumers might experience a lack of control and agency and thus rely on the opportunity to choose between services and providers (Anderson *et al*., 2013; Johns and Davey, 2019). However, in such settings, users may also be constrained from voicing their needs, ideas, and outlooks. These constraints have been linked to a lack of skills and competencies, language barriers, physical health conditions, cognitive impairments, and other associated factors (Davey and Grönroos, 2019; Dietrich *et al*., 2017; Mulvale *et al*., 2019). Hence, including the voices of consumers in the design and transformation of services, specifically by targeting vulnerable groups, depends on the ability to involve representations and representatives that effectively convey the needs and perspectives of service users (Bast *et al*., 2021; Eriksson, 2019; Røhnebæk and Bjerck, 2021). The use of representatives can be seen as a way of working around, or coping with, the diverse constraints that limit the direct involvement of vulnerable groups. However, their application in this context is not without its challenges and dilemmas. Specifically, it raises the question of whether they truly represent the service users, since their own positioning, worldviews, and agendas may influence their interpretations (Echeverri and Åkesson, 2018; Rouquet and Suquet, 2021).

The TSR literature has examined the use of representatives in relation to the concepts of mediation and coordination. More specifically, it has been argued that when consumers lack resources and the capabilities to take on resource-integrating roles, value-creating processes can be purposefully mediated by other actors serving as transformative service mediators (TSMs;

Johns and Davey, 2019) or orchestrators (Breidbach *et al*., 2016; Kelleher *et al.*, 2019). Service mediators and orchestrators (in this paper, both are termed TSMs) may take on different roles and thereby act as representatives of both service organisations (providers) and consumers (users). Thus far, the literature has illustrated the different kinds of actors that may be identified as TSMs. For instance, in care services, TSMs can be informal caregivers, such as family members and relatives, taking on different types of mediating roles between the service provider and the (end) user (Johns and Davey, 2019; Kelleher *et al*., 2019) or more formal caregivers, such as healthcare professionals (Amine *et al*., 2021; Breidbach *et al*., 2016).

In this paper, we focus on the latter and explore how healthcare professionals (i.e. frontline employees or FLEs) may act as TSMs within dementia care. Dementia care provides a highly relevant context for studying the role of TSMs because these services are customer intensive. Specifically, they involve a high degree of interpersonal interactions between users and service providers and thus position healthcare professionals as key actors in supporting consumers' or users' well-being. The literature on TSMs also suggests that FLEs can take on roles as mediators in transformative service processes by supporting or constraining vulnerable service users' value creation (Amine *et al*., 2021; Davey *et al*., 2023). Nevertheless, empirical research on TSM roles and their implications for service outcomes is relatively scant (Johns and Davey, 2019, 2021). Studies on how TSMs may affect value creation and transformation in diverse service settings are thus needed to help address the diverse roles of frontline employees in facilitating service outcomes (Bowen, 2016; Ostrom *et al*., 2015).

Therefore, the purpose of this paper is to explore how FLEs may act as mediators in transformative service processes that target vulnerable users. In particular, we aim to understand how FLEs may take on different mediating roles in various phases of transformative service processes to support users' well-being. To address this aim, we conducted an empirical study

of comprehensive transformative processes that took place in the context of dementia care in a Norwegian municipality. The study follows the lengthy and complex processes of designing new forms of dementia care through the construction of a dementia village. Based on the work of Redström (2008), we suggest that design processes can be structured into "design before use" and "design after design" phases. We understand "design before use" as the planning phase, in which the new services are envisioned, shaped, and planned for, but do not yet exist as such. Thus, the "design before use" phase precedes "design after design", in which the planned design is enacted in practice. This conceptualisation has allowed us to examine how comprehensive service transformations rely on changes in behaviour, practices, and human interactions that can be envisioned, but not *designed* as such (Vink *et al*., 2020). This further implies that FLEs may engage in different kinds of mediating roles during various phases of transformative processes. We believe that conceptualisations of these roles, based on detailed empirical studies, will generate valuable insights into how service transformation can meet vulnerable users' needs. Hence, to guide and structure our analyses, we formulated the following two research questions:

RQ1: How do FLEs enact different mediation roles during the "design before use" phase?

RQ2: How do FLEs enact different mediation roles during the "design after design" phase?

This paper builds on the conceptual framework of TSM introduced by Johns and Davey (2019) and, in doing so, contributes to the literature on service research and TSR by theoretically and empirically expanding our current understanding of TSM.

The remainder of this paper is organised as follows. In the next section, we introduce TSR and the notion of the TSM as it relates to value creation, before discussing frontline employees as TSMs in transformative service processes. We then describe the methodology, followed by

the findings and a discussion of the FLEs' roles as TSMs. Finally, limitations and future research avenues are outlined.

Theoretical framework

Transformative service mediators

In the field of TSR, a number of studies have been conducted within the healthcare domain (e.g. Anderson *et al*., 2013; Patrício *et al*., 2018). Recently, several empirical studies have attended to resource integration and value co-creation practices in healthcare service systems, particularly by exploring the role of the customer or patient (e.g. Frow *et al.*, 2016; McColl-Kennedy *et al*., 2012; Sweeney *et al*., 2015). In these studies, patients are viewed as active actors and resource integrators capable of contributing to the co-creation of value through their self-generated activities (McColl-Kennedy *et al*., 2012). However, in the healthcare context, consumers may suffer from physical and cognitive impairments that could prevent them from taking on roles as active resource integrators (Breidbach *et al*., 2016; Davey and Grönroos, 2019; Johns and Davey, 2019, 2021). The underlying assumption is that vulnerable consumers may experience a lack of agency and therefore be limited in their ability to act upon resources to create value (Anderson *et al*., 2016). In response to these considerations, the concept of the TSM is suggested as a framework for discussing the role of mediators and/or intermediaries that either directly or indirectly support vulnerable consumers during value co-creation processes, which may lead to transformative service outcomes (Johns and Davey, 2019, 2021).

Although the term mediation is commonly used across different fields, its precise meaning and relation to interconnecting concepts is not entirely clear. In this vein, Latour (2005) made a distinction between mediators and intermediaries. Intermediaries are understood as entities that transport meaning without transformations, while mediators "transform, translate, distort

and modify the meaning or the elements they are supposed to carry" (Latour, 2005, p. 39). Storbacka *et al*. (2016) drew on this distinction when studying actor engagement as the microfoundation of value co-creation, suggesting that value co-creation relies on "engagement platforms" that function as intermediaries for resource integration. Thus, they perceive engagement platforms as "neutral" facilitators of actor engagement.

Johns and Davey (2019) built on this distinction when highlighting the need for studies that address mediator roles in value creation involving vulnerable consumers. However, they also introduced the term "transformative apomediary", based on eHealth research, which refers to an actor who helps and guides consumers in accessing credible and trustworthy health information online (Eysenbach, 2008). Apomediaries are thus seen as "standing by" consumers by offering support and guidance, which may empower consumers in their quest for web-based health information. In Johns and Davey's terminology, transformative apomodiaries are seen as engaging in resource integration in ways that lead to transformative outcomes, such as enhancing (users') well-being. Similarly, intermediaries are also actors who facilitate the resources of other actors, but in contrast, their involvement does not lead to transformative outcomes. Johns and Davey (2019) suggest that these distinctions can also help us understand the nuances of TSM roles. In their framework, intermediaries refer to actors *standing between* the consumer and the provider to facilitate the exchange process initiated by the latter. Such a role differs from that of transformative apomediaries, who *stand by the side* of the vulnerable consumer and act as representatives to the service provider (see Table Ⅰ).

There are, nevertheless, few studies that empirically explore the applicability of this framework, as well as how the role of TSMs may be played out and by whom in diverse contexts and situations (Johns and Davey, 2019, 2021). An exception is the article by Amine *et al*. (2021), which draws on the distinction between intermediaries and transformative apomediaries

to study mediating roles in elderly care. In this case, they found that caregivers take on roles as intermediaries when assigning patients to a vulnerable status, rendering the patient in a passive role. In contrast, caregivers may also reduce patients' experiences of vulnerability by providing them with a more active role and placing themselves in a facilitating one (i.e. as a facilitator apomediary). Finally, caregivers may attempt to remove patients from their vulnerable status and, through this process, attempt to act along with the patient (i.e. as a transformative apomediary). Thus, this study applies and extends the conceptualisation proposed by Johns and Davey (2019) by showing how FLEs take on different TSM roles that affect value co-creation in a healthcare context.

Another exception is a recent study of Indigenous students' co-creation capabilities in Australia (Davey *et al*., 2023), which identifies a set of TSM practices performed by transformative apomediaries that support well-being in the university system from the students' perspective. In doing so, this study indicates that TSM practices can be embedded in a broad range of actors and entities within the university system, such as physical space, technologies, routines, and staff, thereby implying that the TSM may be "an actor, service provider or service system" that "facilitates a number of roles, from intermediary to transformative apomediary roles" (Davey *et al*., 2023, p. 820).

In a similar vein to TSMs, the term "orchestrators" is used in reference to actors who facilitate value co-creation processes in contexts where the user's ability to act as the primary resource integrator may be diminished and/or put under pressure (e.g. elderly care and/or hospitals; Breidbach *et al*., 2016; Kelleher *et al*., 2019). In the work of Breidbach *et al*. (2016), orchestrators are operationalised as case managers, which means that they are dedicated actors who can coordinate value co-creation processes between interdependent actors (e.g. patients and medical staff) by organising resource integration. Here, the orchestrator is seen as a

facilitator standing between the service provider and the user, although still representing the service provider. In another study, orchestration depicts the coordination of value co-creation in a service system focused on customer-centric, non-referent beneficiaries, who are here understood as family caregivers (Kelleher *et al*., 2019). These caregivers (e.g. spouses, siblings, and children) practice agency and act as resource integrators to enable value co-creation on behalf of referent beneficiaries through three identified mechanisms: assembling, performing, and brokering (Kelleher *et al*., 2019). The study shows how informal caregivers may act as mediators when coordinating and negotiating with actors, such as healthcare professionals (nurses and therapists) on behalf of the beneficiaries they represent.

These two concepts of TSMs and orchestrators both point to how users may experience a kind of vulnerability that makes it difficult to participate in value co-creation processes, therefore requiring some form of assistance and/or representation. In this article, we use the TSM concept as we understand it to include a broad set of roles that different actors may take on as mediators (Johns and Davey, 2019). The actors may be representatives of the service provider or the user. Here, we follow Amine *et al*. (2021) in exploring how FLEs in dementia care may act as TSMs in transformative service processes.

Frontline employees as transformative service mediators

In their efforts to identify service research priorities, Ostrom *et al*. (2021; 2015) highlighted the need to attend to the multifaceted and changing roles of FLEs in a world where service encounters are themselves changing in character. This approach is supported by Bowen (2016), who also discusses how FLEs act as innovators, differentiators, enablers, and coordinators in service settings (see Table Ⅰ for a more detailed description of the roles). This calls for research on how to develop the FLE competencies necessary to fulfil these changing roles, but also a

focus on more fundamental questions regarding the overall role of employees in service operations "amid the complexity of current service contexts" (Ostrom *et al*., 2015, p. 147). The literature on TSM responds to these identified knowledge gaps by developing a theoretical terminology. Specifically, these terms can help identify and specify the spectrum of roles that are played out at the intersection between service providers and customers or service users (Amine *et al*., 2021; Johns and Davey, 2019, 2021).

The literature shows that TSMs may be formally positioned within or outside the service organisation. We argue that studies exploring the role of FLEs as TSMs need to connect to existing research dialogues on the role of employees in service contexts in general (Bowen, 2016; Breidbach *et al*., 2016; Kelleher *et al*., 2019). For an overview of the existing conceptualisations of roles in the literature, see Table Ⅰ.

Please insert Table Ⅰ around here.

The mediating roles of FLEs in service transformation and innovation may seem multifaceted and constitute a complex research topic that can be approached from different angles and designs. As of now, the literature has mainly conceptualised different types of TSM roles (Johns and Davey 2019) and shown how they are enacted as a part of daily service interactions (Amine *et al*., 2021; Breidbach *et al*., 2016) to either support or hinder the well-being of users experiencing vulnerabilities (Johns and Davey, 2023; Kelleher *et al*., 2019). Therefore, TSMs are chiefly understood in terms of their role in resource integration, through which they become key actors in supporting or negating the processes of value co-creation. However, there is also a need to address the role of TSMs in supporting the inclusion of vulnerable users in the design

or redesign of service systems (i.e. transformations of the institutional contexts in which value co-creation takes place; Johns and Davey, 2021; Vink *et al*., 2020).

We address this need by exploring the role of FLEs as TSMs in the design of a new services or service systems, followed by an examination of how the new design has been enacted in practice. In the next section, we provide further details on the research design, methods, and data.

Methodology

Research design

The study is based on a single case study design and aims to illuminate how FLEs may act as mediators in transformative service processes within services targeting vulnerable users. Case studies allow researchers to explore the complexities and nuances of a phenomenon by 'closing in' on real-life situations. Eisenhardt (1989) argues that single cases are useful, especially in new research contexts or when the existing theory seems inadequate. This links to how case studies aim at providing analytical rather than statistical generalisations (Flyvbjerg, 2012; Yin, 2013). Since conceptual and empirical research on TSM is still relatively scarce, a case study approach is suitable for further developing the theoretical debates in relation to empirical research. The study is based on a single case that involves the complex design processes of creating a dementia village. This context provides a unique setting for studying the dynamics of frontline employees as TSMs because it is a site for ongoing, comprehensive service transformations in a service sector under pressure (e.g. elderly care). In this context, FLEs play a crucial role in meeting the demands of increased efficiency and effectiveness, but they also hold key positions in mediating transformations and change.

The selection of the case followed an information-oriented sampling strategy (Flyvbjerg, 2012), implying that the selected case provides an information-rich site for studying different facets of how FLEs function as TSMs. It can also be categorised as a deviant or extreme case (Flyvbjerg, 2012) because it is set in an ongoing innovation process seeking to bring about transformative change in frontline work. As such, it serves as a site in which debates around the role of FLEs as mediators of transformations may be particularly explicit and therefore easily highlighted.

Case description

Dementia villages provide an alternative environment for persons with dementia diagnoses. The dementia village concept focuses on, among other things, creating care facilities with a homelike atmosphere rather than an institutional and clinical one, with the provision of services that are more coordinated around living, rather than care. The architectural environment is just one element of the dementia village. The creation of such villages also implies the introduction of a new care philosophy that resonates with the principles of individualised and person-centred care (Chrysikou *et al*., 2018). This implies transformations in caring practices, managerial systems and structures, and organisational culture and professional hierarchies. As such, the construction of a dementia village entails efforts to transform the entire institutional context of dementia care.

The Norwegian dementia village has a gross area of 18,000 square metres, with accommodations for 136 residents divided into 17 shared apartments and a single unit for 22 residents. The village also includes a grocery store, restaurant, bar, and other services, such as a hairdresser and pedicurist, and spaces for activities and cultural meeting places, all of which surround the village's open square. These arrangements are meant to enable residents to live

active lives in a safe environment. Generally, the village concept focuses on supporting residents' well-being by creating conditions conducive to living a meaningful everyday life despite their complex diagnoses and often deteriorating health conditions.

Data collection

We used an ethnographically inspired methodology for the data collection. As shown in Table Ⅱ, we conducted multiple in-depth semi-structured interviews with key informants; we engaged in a series of participant observations of informal and formal meetings, events, and service practices in the village; and we conducted document studies of project and policy documents. Our research started after the main decisions were made regarding the architecture of the buildings and the surrounding outdoor environment. Specifically, the data were collected during the construction of the village and cover the planning and design of the new services (Phase 1: "Design before use") and after the initial opening, when management and employees were hired, and residents moved in (Phase 2: "Design after design").

The data collection focused mainly on interviews with FLEs and observations of frontline working practices. More specifically, we focused on FLEs working as healthcare professionals (e.g. nurses and healthcare workers). The informants' professional backgrounds varied to some extent, but they were all certified as skilled healthcare workers. This meant that they each had four years of training at the upper secondary level, which could be based on different combinations of school-based and workplace-based learning. However, some had gained their professional competencies merely through work experience within elderly and dementia care, and others were trained as professional nurses, which implies at least three years of education at the university level.

While the FLEs themselves were the main target group, the study also covers data that exhibit other perspectives. This meant that managers and members of the project and design team were also considered. Table Ⅱ displays the details of all the data collection activities. The interviews were semi-structured, recorded, and transcribed verbatim. There were generally two researchers present for each interview, while only one researcher was present for a few. Interviews were generally conducted face-to-face, except during the Covid-19 pandemic, when interviews were scheduled on video call via Teams. Observations were carried out as ethnographic fieldwork, during which a group of three researchers collaborated and alternated with being present in planning and designing activities for the first phase. In the second phase, the group of researchers was present in the village and conducted participant observations of daily caring practices in four different wards, which included meetings, workshops, training sessions, and onboarding sessions for new employees.

Please insert Table Ⅱ around here.

Data analysis

We deployed a combination of different strategies for the data analysis, due to the vast and eclectic empirical material of the study. To follow transformative service processes over time, we relied on process data, which can be chaotic and complex to analyse (Langley, 1999). However, different strategies are available to help make sense of and structure process data. As a structuring device, we used a temporal bracketing strategy, which creates a temporal decomposition of the flow of events in the overall process (Gehman *et al*., 2018; Langley, 1999). Regarding the two main phases of "design before use" and "design after design", we perceived the data from the two phases as having different characteristics: data from the first

phase related to how the village and the new services were designed, envisioned, and planned for, while the data collected in the second phase reflected how the village was enacted and experienced in practice. Structuring the data in this way contributed to its contextualisation. However, the aim of this paper was not to analyse the transformative processes as such, but to use the case as an empirical gateway to a further exploration of how FLEs may act as TSMs. Accordingly, we investigated the role of FLEs' mediation in relation to its impact on users' well-being indirectly in the "design before use" phase, and more directly during the "design after design" phase.

We used a thematic approach (Braun & Clarke, 2012) to identify and develop thematic categories of TSM roles, thereby extending and continuing existing work on TSM roles and practices (Amine *et al*., 2021; Davey *et al*., 2023; Johns and Davey, 2019). This required that an inductive thematic coding process be applied, in which we first elicited codes relating to TSM roles within the two phases, and then developed more general themes based on a grouping of the codes. The linkages between the codes and themes are displayed in Table Ⅲ.

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Findings

This section shows how FLEs take on roles as TSMs in different phases of transformative service processes. We start with the manifestation of TSM roles among FLEs during the planning and design of the village, before demonstrating how the FLEs enacted different TSM roles during the implementation and operation of daily care in the village.

Mediating roles during "design before use"

We identified three TSM roles based on the FLEs' activities during the design processes. These were the sensitive listener, the advocate of user needs, and the guardian of professional knowledge. While we differentiated these three as separate roles in analytical terms, we would like to underline that in practice, they are interlaced and overlapping. In the following sub-sections, we explicate the content and implications of these role categories.

Sensitive listener

Gaining access to knowledge about the needs of users with dementia during the design process is challenging. Users may find it difficult to express their ideas and thoughts due to cognitive impairments, and they may feel disoriented when they are taken out of familiar surroundings. Therefore, acquiring knowledge about their needs requires careful consideration and sensitivity to their individual challenges. In the different stages of the design process, FLEs performed the role we refer to as sensitive listeners by gathering insights into users' needs and pain points, despite their cognitive impairments. As sensitive listeners, FLEs possessed the expertise to ask the right questions and create a safe atmosphere that encouraged residents to share their thoughts and requirements.

For instance, the FLEs highlighted the importance of focusing conversations on the present tense and avoiding discussions about the future, as the latter could lead to confusion. For example, one FLE shared that instead of talking about the dementia village, she would redirect conversations with residents to their current emotions and concerns. She would avoid using language that referred to the future, such as "if you were to move" or "had to move", and instead frame the discussion around the here and now. This approach helped the residents feel more at ease and enabled them to address their needs and concerns without feeling

overwhelmed by the broader idea of the dementia village, which could have added to their stress.

Being a sensitive listener was also linked to creating a safe environment for the residents. This aspect involved personalising the interviews to meet each resident's specific state or condition. One FLE emphasised the importance of being cautious about the content of the questions they asked during interviews, as untimely questions could trigger anxiety or frustration:

> I knew that because I had tried it once before [i.e. asked about the future]. Back then, she was frustrated and really upset for many months, so we couldn't talk about that. So, I adapted it [the questions] for each individual because I knew them… [and] what was safe to ask about. (Interview with a nurse from the insight work)

These two examples demonstrate how FLEs play a crucial role in framing the information gathered from users and tailoring the service encounters to their individual needs.

Advocate of user needs

The advocate of user needs refers to how FLEs communicate user needs to the design team and decision makers. FLEs served as user representatives in workshop settings and subsequent decision making, applying their knowledge of user needs based on insights obtained from interviews and their experiences with everyday care. Hence, during the design phase, FLEs assumed a central role as advocates of user needs and played a crucial part in developing narratives that drew upon their own expertise and the perspectives of users. One of the interviewed FLEs explained this as follows:

> We always try to take the user's point of view. And we take with us our experiences and feedback that we have received from users and their next of kin. (Interview with a nurse from the design sprint)

Overall, our interviews with the FLEs during the "design before use" phase showed that through their care work, the employees gained valuable insights into the different aspects of the users' daily lives and routines. These insights can be divided into three categories that capture what is essential to the users. First, the employees brought up the importance of having a *social life* and being part of a community. They expressed that while the residents (users) enjoyed being together with other people, they needed to be able to withdraw to a more private space on occasion. They also recognised the need for users to be active and stressed that such a disposition could mean baking and/or watching someone baking, pointing to the need to adapt efforts to enhance levels of activation to individual needs.

Second, the employees highlighted the importance of meeting the users with *respect*, as demonstrated by listening and letting them make decisions when capable. Finally, the issue of *safety* was addressed. The FLEs brought up that feeling safe was imperative for users, and that they needed predictability in their lives. The FLEs' insights, interpretations, and articulations of the users' needs were central to the content that the project team used to plan the design activities. In the design sprint, the FLEs conveyed their insights and understandings of the user to provide a context to other participants with less knowledge of dementia, thereby ensuring that the development of ideas was anchored in vital contextual knowledge about the users.

Guardian of professional knowledge

Additionally, FLEs take on the role of what we term the "guardian of professional knowledge", where they must balance the inputs of what users actually appreciate and desire with their

professional knowledge of what living with dementia entails, and what it takes to provide good care when people with different dementia diagnoses are living together. This role was reflected in the way FLEs explained that "reality checks" needed to be introduced into the design process. They pointed out that in workshops and other design events, the design team placed emphasis on searching for creative solutions that focused on opportunities, meaning what the residents *could* do rather than focusing on existing diagnoses and barriers. While the healthcare employees supported this shift, they were also concerned that the discussions tended to become too unrealistic and out of touch with reality. One of the healthcare workers involved in different design events explained this as follows:

> I felt that I had to give people a reality check and say, "Do you really understand how ill they are…?" […] Most of them [the residents] are much older and with poorer health [than what is assumed by the design team], so they will not be able to participate in cooking, laundry, or anything like that. At least not without being with someone all the time. They will not be able to do things on their own, and I don't think they realise that. (Interview with a nurse from the insight work)

By bringing in their knowledge about the realities of everyday life in dementia care, healthcare professionals played an important mediating role by preventing renewal efforts from becoming irresponsible and unsound. Without this voice, there was the risk that the project team would invest in solutions that would be impractical, unsafe, or only relevant to a small group of residents. At the same time, the healthcare professionals could also be constrained by "professional blinders", meaning that they were too focused on hindrances and the residents' incapabilities. Observations from the design sprint showed that the participating FLEs would often oppose new ideas through responses such as, "No, this is not possible; this will not work", or "This is not how we do things".

Instead of exploring what residents would be able to do, despite their diagnoses, the quoted FLE claimed that "most of them" would not be able to participate in nearly anything. Through their involvement in the design events, the FLEs' perceptions based on professional knowledge and experience were challenged, which they found rewarding but also uncomfortable:

> I found that some of my presumptions were being challenged—and that is good—by someone who was totally on the outside and thus viewing things very differently. That's probably why it felt so exhausting. (Interview with a nurse from the insight work)

Hence, in their role as guardians of professional knowledge, FLEs seek to safeguard the transformative processes based on their expertise, but their professional perspectives also become exposed and explicit through this process, which gives way to self-reflections and reassessments.

The three roles represent the different types of mediation that FLEs the performed during the "design before use" phase in the dementia village. In this case, the act of mediation was primarily linked to the FLEs' knowledge and understanding of the users' daily lives and their needs. Still, we also found indications that FLEs trained as healthcare professionals could impede transformations by remaining locked into their traditional working conventions. Even so, through collaboration with other participants with diverse backgrounds, professional conventions were also challenged in design events, leading to the development of new ideas with the potential to transform dementia care.

Mediating roles during "design after design"

Based upon the work of Redström (2008), "design after design" is understood here as the process through which the village concept was further designed and shaped through actual use.

Our analysis shows that the FLEs played a crucial role in enacting and shaping the new care concept in ways that promoted users' well-being. Dilemmas and various unanticipated predicaments emerged when the new design was put into use, and these situations were continuously dealt with by the FLEs in their interactions with the residents. Although the different mediating roles in this phase could not be clearly delineated or categorised, as they were part of interconnected chains of actions, our analysis shows that three mediating roles emerged in the design in-use phase: facilitators, brokers, and bricoleurs. In the next section, we explain what these different roles consisted of and the consequences they had for the implementation of the new care concept.

Facilitator

The FLEs enacted the role of facilitators when they interpreted the visions and ideals for the new care concept and acted accordingly in their interactions with the users. In this role, the FLEs experienced limited friction or tension; they were in a position to support the users' well-being while working in alignment with the expectations of the newly designed concept. This was, for example, expressed in how the FLEs encouraged users to have meaningful and active lives by taking part in chores and other mundane everyday activities. The following quote illustrates how the FLEs took on the role of facilitator by supporting "Elsa" in being responsible for a set of chores:

> Elsa is active [in the shared houses]. She sets the table and collects the weekly activity plan every Monday. She knows this: she can go to the reception desk to get [the plan], and then read out loud, "Today there is…". We [the employees] have the activity plan on our mobile phones, but this is Elsa's task. (Interview with a healthcare worker)

The above account illustrates a typical daily activity that was foreseen as part of the village concept on the "drawing board". However, the residents were in different stages of dementia, and with varying somatic and physical conditions. Thus, living an "active life" meant different things to different residents:

> We need to plan [activities] for the residents. Some can make sandwiches for other residents [in the shared houses]. […] Some residents are not able to walk around the village, but they can still do things, like folding clothes while sitting. Others make coffee and serve it. (Interview with a healthcare worker)

By considering what the individual residents wanted and were able to do, the FLEs facilitated the residents' well-being in daily life within the options provided by the village. The designed concept was thus realised through the FLEs' ways of facilitating, and as shown in the above examples. Specifically, this involved aligning the concept to support the users' well-being.

Brokers

In other situations, we saw how the FLEs acted as brokers by being more active in interpreting the visions for the new care concept and adapting them to ensure that the users' well-being was supported. Brokers stand in between different actors, groups, or communities and attempt to align or negotiate between different interests and worldviews in "processes of translation, coordination, and alignment" (Wenger, 1998, p. 109). In the dementia village, the FLEs stood in between management and the strategic level of the organisation on the one hand, and the diverse individual needs of the residents on the other. They also stood in between the rationale of the "old" ways of working in nursing homes and the new care concept of the village. Thus, as brokers, the FLEs would sometimes act in ways that conflicted with the designed visions for

the new care concept to ensure that the various users' well-being was supported. The following quote is illustrative in this regard:

> We see a concern relating to the residents that "wander" […]. They use the whole area of the village, and they get tired at the end of the day. It becomes too much of a stimulus, and there are too many ongoing activities to be part of. I believe that many of them need to rest more, and they need peace and quiet. It all depends on the stages of their illness. (Interview with a healthcare worker)

A key offering in the village was the scheduling of different types of activities so that residents could live active lives. However, as shown in the quotation, for some residents, activities and stimuli, such as music, dance, and the gathering of people, comprised a challenge: they created noise and triggered restlessness that could propagate into the evening and negatively affect the atmosphere in the shared houses. Although the idea behind the care concept was freedom for the residents, the FLEs also needed to protect the residents, and they typically did so by accompanying them on a walk to a quieter area and/or ensuring that they were retrieved to rest in their private rooms. This kind of mediation involved the FLEs acting as brokers by taking an active role in understanding the implications of the new care concept, while also interpreting individual users' needs and assessing how the two related. As in the example above, we observed that the new concept emphasised increasing freedom for residents by enabling freedom of movement within the confines of the village, which was expected to enhance well-being among the residents, but several examples showed that the FLEs also needed to restrict this freedom to safeguard the users' well-being. To some extent, this meant that their actions conflicted with the designed concept, or that they were modifying and adapting their actions in accordance with their knowledge of the users' moods and rhythms during the course of the day(s).

Bricoleur

A third way in which the FLEs took on roles as mediators was by acting as bricoleurs. A bricoleur uses whatever is at hand and recombines resources to create something new (Levi-Strauss, 1962). Thus, a bricoleur can be understood as a craftsman who adapts, or tinkers with, materiality in various ways. In the role of bricoleurs, the FLEs negotiated or adapted the new care concept by reworking the physical environment and the materiality of the village. The physical environment prescribed the many ways in which the employees and others were expected to act on the new premises. When performing their daily work, the FLEs found themselves in situations in which these materially embedded prescriptions failed to support their own and the users' well-being. To deal with this, they tinkered with the materiality, and through such actions, they adapted the concept.

The enactments of what was considered to be a homelike atmosphere demonstrates this approach. A central premise of the village concept was that the shared houses were the residents' homes. While the residents in the village were also in need of healthcare, the village was their home, and most probably their last home. Their well-being was thus linked to whether they felt comfortable there in their everyday lives, which may have required trade-offs when it came to ensuring a working environment that the staff experienced as convenient and effective. The emphasis on creating a homelike atmosphere in the village was reflected in the use of colours, furniture, curtains, pictures, and various knick-knacks. However, in some of the houses, the FLEs had to strip the rooms and tone things down, as the environment created too many stimuli for some residents. The FLEs thus transformed the notion of homelike so that it fit with the residents' well-being.

The emphasis on a homelike atmosphere also redefined the relationship between employees and residents. Generally, the village had been designed so that there were limited options for staff to shift between "frontstage" and "backstage" (Goffman, 1965); in other words, they were expected to be "frontstage" throughout the working day. Some employees found this challenging because they were not able to draw back, take proper breaks, or relax. Several informants commented that "we have nowhere to retreat".

To deal with the lack of privacy and spaces to retreat, the FLEs started to occupy and redefine the stockrooms and a small living room as a staff room. This was justified not only based on the need for privacy, but also, they argued, because they needed spaces to retreat to discuss situations and decisions regarding the residents that could be disrespectful or violations of privacy to share when others were listening. The staff's initial improvised effort to redefine the small living room as a staff room/office was eventually sanctioned as a more permanent solution by management, which illustrates how the FLEs were reworking aspects of the concept through their roles as bricoleurs.

The three mediating roles identified in the "after design" phase all underline the crucial role of FLEs in mediating transformative change through daily care. The roles interact and overlap in many ways, yet their differentiation points to the multitude of activities and elements involved in FLE mediation, as well as the complexities at stake and the importance of researching FLEs as TSMs.

Concluding discussion

This article has explored how FLEs enact TSM roles in a transformative service context, with a specific focus on dementia care. Specifically, this study examined the mediation taking place in the design and planning of transformative changes in a service system, as well as the

subsequent mediation inherent in daily service work. As such, the research addresses the mediating roles of FLEs in a service context undergoing comprehensive transformative shifts. Hence, this article enriches the domain of service research and the TSR literature by analysing how mediation is enacted across different phases of transformative processes, and by extending and further refining the framework introduced by Johns and Davey (2019). In doing so, we also respond to broader calls for research on consumers' proactivity for well-being, identified as one of four current service research priorities (Ostrom *et al*., 2021). Our study supports extant TSM research by drawing attention to the ways in which consumers' proactive assurance of their own well-being (or value co-creation) is reliant on mediators in service contexts where they experience different forms of vulnerabilities. By identifying FLEs as TSMs in six different roles, we also illuminate the changing roles of service employees (Bowen, 2016; Ostrom, 2015). In the next section, we discuss the theoretical and practical implications of our findings and point to the limitations of the study and how they may pave the way for future research.

Theoretical implications

Our analysis of FLEs as TSMs departs from the framework of Johns and Davey (2019), which is based on an overarching distinction between transformative apomediaries and intermediaries. As outlined in our theory section, Johns and Davey (2019) developed this framework by relying on two main sources. First, the concept of the apomediary stems from eHealth research (Eysenbach, 2008) and is understood as an actor "standing by" the side of consumers, in contrast to the "intermediary", who is seen as "standing between" consumers and health information. This distinction is combined with Latour's (2005) separation between mediators and intermediaries (see also Storbacka *et al*., 2016). Following Latour, mediators can be understood as actors or entities who transform the meaning they are supposed to carry. This

means that mediators are not neutral representatives, representations, or carriers of meaning, as opposed to intermediaries. Johns and Davey (2019), on the other hand, conceptualise intermediaries and apomediaries as subcategories of mediation, which conflicts with the vocabulary of Storbacka *et al*. (2016) and Latour (2005). Moreover, "intermediaries" are used and understood differently in the eHealth literature (Eysenbach, 2008) from Latour's (2005) and Storbacka *et al*.'s (2016) definitions, making the combination of these sources and its transfer to TSM research problematic, as it leaves the meaning of the term "intermediaries" in this context unclear.

As a result, we found it difficult to apply the distinction of "standing between" (inter) and "standing by" (apo) in a meaningful way when exploring the applicability of the TSM-framework in a customer intensive service context (i.e. dementia care). To understand the nature and dynamics of this mediation and its relation to value creation and service transformations, we found it more fruitful to focus on the distinction suggested by Latour (2005) and Storbacka *et al*. (2016), that between intermediaries and mediators, and to specifically zoom in on different forms and manifestations of mediation. Furthermore, contrary to Johns and Davey (2019), our findings point to how mediators and intermediaries should be seen as existing along a continuum. This implies that TSMs are more or less actively involved in mediation, and that their involvement will have a more or less transformative impact.

Thus, we propose a TSM framework that better captures the shifting and fluid nature of mediation, which seems especially relevant for service contexts, where users may be characterised as particularly vulnerable. Specifically, our findings from dementia care reveal that, even within one service interaction, the FLEs may shift between different mediating roles. For instance, they may shift from being active and intervening agents in supporting users' well-being to being more withdrawn and distant later on, trusting the users to handle situations on

their own and thus reducing their state of vulnerability (see also Amine *et al*., 2021). In the context of dementia care, the users' capabilities and emotional states may change quickly, and the act of mediation is therefore interlinked with the FLEs' abilities to effectively interpret the situation and find the most appropriate ways to support the users. Hence, FLEs combine different roles of mediation and constantly shift between them.

Based on the above, we introduce a slightly modified overarching TSM-framework that relies on a distinction between mediators and intermediaries (instead of intermediaries and transformative apomediaries) that positions them as opposites on a continuum. This framework is illustrated in Figure 1.

Please insert Figure 1 here.

As shown in Figure 1, a set of sub-roles of mediation and mediating practices can be identified along the continuum. Accordingly, our analysis identified six TSM sub-roles that we position on the mediation side of the continuum. This does not mean that intermediaries are not relevant or present in this context, but that our main focus has been on mediation. The sub-roles of mediation identified in our analysis correspond to some extent to the five subcategories discussed by Johns and Davey (2019) and Davey *et al.* (2023). However, our analysis differs by drawing attention to how mediation occurs and changes character depending on the phase of the transformative process (in this case, "design before use" and "design after design"). This understanding introduces a new axis into the analysis and discussion of TSM roles, which brings forward new aspects of mediation. We highlight, for instance, how FLEs take on the role of the "sensitive listener" in the "design before use" phase, thereby gaining access to knowledge of user needs, which is pivotal when representing users. We also point to the material

embeddedness of mediation by identifying how FLEs act as bricoleurs, which involves the application of mediation as tinkering with the physical premises or surroundings to better support vulnerable users' wellbeing.

This broadening of the spectrum of TSM roles contributes to the still nascent TSM literature in its attempt to address how TSMs may play important roles during their efforts to transform the conditions for value co-creation, such as by transforming the surroundings, technology, or organizational structures at hand. This complements extant TSM research, which thus far has mainly focused on various forms of mediation that occur during service interactions and value co-creation (Johns and Davey, 2019; Davey *et al.*, 2023; Amine *et al.*, 2021). These earlier studies have been important for developing the foundation of TSM research. Particularly, Johns and Davey's (2019) introduction of TSM served as a timely research agenda in its focus on understanding value co-creation with vulnerable users who are limited in their ability to co-create. Based on this earlier conceptualisation, Amine *et al*. (2021) deepened our understanding of vulnerability by demonstrating how it is not an immutable state. Instead, they argue, vulnerability is constructed and thus maintained or mitigated through the practices of others, such as caregivers acting as TSMs. Here, we follow up on the call from Johns and Davey (2019) to study TSM roles and practices in diverse empirical contexts, which also entailed a test of the applicability of their framework and thus suggestions for modifications (ref. Figure 1). Moreover, our analysis supports the work of Amine *et al.* (2021) by further expanding on the crucial and dynamic role of formal care givers (FLEs) as TSMs, which underscores their crucial role in value creation and transformative processes in care contexts.

Finally, Davey *et al.* (2023) recently expanded on the notion of TSM by discussing how a range of entities (e.g. actors, service providers, or service systems) may be seen as TSMs affecting vulnerable users during the value co-creation process. With this expansion, the

discussion of TSM roles becomes increasingly connected to intersecting research on how various actors affect value co-creation with vulnerable users. We identified studies on orchestrators as one such research stream (Breidbach *et al*., 2016; Kelleher *et al*., 2019), as well as investigations into the different roles of service employees more generally (Bowen, 2016). Further explorations of these interconnections may serve to strengthen and advance future TSM and TSR research.

Practical implications

This paper identifies how FLEs take on different mediating roles in transformative service processes. Our work should provide strong motivation for managers to understand these roles and to take an active stand on how FLEs may become part of transformative processes during different phases of development in various service settings.

Conceptualising and reflecting on FLEs as mediators involve a reintroduction of FLEs' crucial role in services. Strategies and policies across public and private services have become highly user-centric, which is reflected in the proliferation of user-centred methodologies such as service design and design thinking. While this is an important shift, there is a risk that the role of FLEs will become somewhat sidelined. Our research shows that user-centrism in services targeting vulnerable users is highly reliant on the mediating roles of FLEs. Thus, user-centric strategies in services need to be pursued in conjunction with strategies that enable FLEs to enact a multifaceted set of roles as mediators. This requires that managers acknowledge and realise the potential of having FLEs working in between managers and users, and that they empower FLEs with the tools and competencies necessary for enacting these roles.

In detailing the different forms of mediation enacted by FLEs across different transformative phases, the multiple competencies and skills that FLEs (need to) apply as

mediators have been illuminated. The roles identified in the "design before use" phase, which include the sensitive listener, advocate of user needs, and guardian of professional knowledge, point to different forms of competencies. For instance, as sensitive listeners, FLEs need to apply diverse and creative methods to elicit knowledge of user needs without causing agitation or stress, while as advocates of user needs, FLEs need to use the right means and channels for communicating user needs to managers and decision makers. In the "design after design" phase, we found that FLEs mediate as facilitators, brokers, and bricoleurs, all of which require vigilance and sensitivity toward diverse user needs within a context of limited resources.

Limitations and future studies

Our study has limitations that open up pathways for future TSM research. We suggest three main avenues for future research into the roles and acts of mediation in TSR.

First, as pointed out in the discussion, we suggest that the role of TSMs can be analysed along a continuum, in which mediators and intermediaries are opposites. While our analysis identifies six sub-roles that we position on the mediation side of this continuum, it does not explore the other end of the continuum. We have indicated that this does not mean that these intermediary roles and practices do not exist, but including a review of these is beyond the scope of this article. Still, our data show examples of intermediary practices, and we suggest that these practices can be construed as a form of non-mediation. Accordingly, future research should include studies of how mediation, as well as non-mediation, may impact users' well-being.

Second, Johns and Davey (2019) initially called for research into mediation among resource-integrating actors who are neither consumers nor service providers. However, the empirical TSM research has thus far mainly studied mediation among actors and structures

within service (provider) organisations (Amine *et al*., 2021; Johns and Davey, 2023). Our study, in line with the work of Amine *et al*. (2021), serves as a continuation of this approach by focusing on the role of FLEs as TSMs. Even so, studies of external actors or third parties acting as TSMs are still pertinent. In the context of dementia care, for instance, it would be highly relevant to study how family carers and volunteers take on TSM roles. Therefore, further research should investigate how mediation evolves among multiple actors in complex systems. In this vein, future studies could also explore the connection and interplay between different actors acting as TSMs. In this study, we have only considered the roles of FLEs, yet we acknowledge that they operate within systems of multiple TSMs, including informal caregivers, such as family members. Understanding more of the networks of TSMs, how they interact, how issues of equity and power imbalances influence their roles and interactions, and whether they act in harmony or disharmony in supporting users' well-being could be interesting avenues for further research. In an attempt to effectively ground such endeavours, TSM research should draw on existing studies on the interplay between formal and informal caregivers in diverse care settings (see, e.g., Skinner *et al.,* 2021).

Finally, our research focuses solely on healthcare services, particularly dementia care. We encourage research into other service settings to develop a more comprehensive understanding of TSM roles.

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Table Ⅰ Mediation roles in transformative service research

Study	Name and short description of role	Sub-roles/categories	Type of act	Type of study
Johns and Davey, 2019	Transformative service mediators as intermediators: Actors standing between the consumer and the provider to facilitate the exchange process initiated by the service provider	Information broker	Not specified	Conceptual
		Service integrator		
		Translator of risks		
		Service provider advocate		
	Transformative service mediators as transformative apomediaries: Actors standing by the side of the vulnerable consumer and act as the representatives to the service provider	Voicing service needs		
		Co-designing services		
		Enabling benefits and managing risks		
		Advocating for vulnerable consumers		
Amine *et al*., 2021	Transformative service mediators: Employees (caregivers) whose actions and care practices impact the patient's status of vulnerability in different ways	Intermediary	Acting instead of the patient. Employees whose actions assign patients to a vulnerable status	Empirical, health care
		Facilitator apomediary	Making the patient act. Employees whose actions reduce their experience of vulnerability.	
		Transformative apomediary	Acting along with the patient. Employees whose actions remove the patients from the vulnerable status.	
Kelleher *et al*., 2020	Orchestrators (primary and co-orchestrators): Actors (e.g. nonreferent beneficiaries) who coordinate value co-creation processes on behalf of dependent actors (e.g. referent beneficiaries)	Assembling	Orchestrators who identify, assess, and configure resources in relation to referent beneficiaries by relative ties.	Empirical, health care
		Performing	Orchestrators who directly integrate resources to create value in relation to referent beneficiaries linked by relative ties.	
		Brokering	Orchestrators who coordinate, negotiate, and mediate with other nonreferent beneficiaries without relative ties or a shared history/anticipated future of value co-creation.	

Breidbach *et al*., 2016	Case managers as orchestrators: Firm-centric actors who assist others in complex health services to integrate resources	Service orchestrator	Orchestrators who act as coordinators of value co-creation on behalf of both the service/employees and the patients in service systems.	Empirical, health care
Bowen, 2015[1]	Service employees/frontline employees and their key roles in services	Innovator	Bring in user insights and ideas to innovation processes.	Conceptual
		Differentiator	The "human touch" influencing customers' experiences.	
		Enabler	Supporting the customers when acting as "partial employees" (e.g. support of self-service).	
		Coordinator	Integrating resources between customers and provider.	

1) Although Bowen discusses the role of FLEs in services generally and not specifically in transformative services, the roles suggested are relevant to TSMs and are thus included in the table.

Table Ⅱ Overview of the data collection

Data collection phases	Data (number in brackets)
Design before use (2018–2020)	*Interviews:* - Management and political leaders (17) - Healthcare professionals involved in design events (5) *Observations:* - Ideation workshop (36 participants) - Follow-up meeting of the ideation workshop (6 participants) - Design sprint workshop (5 days x 20 participants) - Evaluation and further planning related to the design activities (3) *Documents:* - Project documents (29) - "Service safari" observations (7 nursing homes) - Interviews with people with dementia, next of kin, and healthcare professionals (44) - Management and political documents (13)
Design after design (2021–2022/23)	*Interviews:* - Managers/middle managers (14) - Healthcare professionals (9) *Observations:* - On-boarding meetings on Teams (4 days) - Training/instructions meetings in the village (3) - Design workshop called "Implementation of the Care Philosophy" with department managers (12 participants) - Family carers meetings (2) - Staff meetings (3) - Observations of daily work practices in the village (16 days) - On-site observations in relation to interviews and meetings *Documents:* - Presentations and internal project documents - Workshop documents

Table Ⅲ TSM sub-roles during "design before use" and "design after design" phases

Design phases	**Themes/TSM roles**	**Codes**	**Illustrative examples**
Design before use	Sensitive listener	Framing	*[…] when we tried to phrase ourselves differently and say, "what do you like to do" or "right, don't talk so much about the dementia village" and interview about daily life, then you gained much insight into what was essential to them [persons with dementia].* (Nurse from the insight phase)
		Creating safe spaces	*I talked to user, or patients that I knew quite well. I think this is crucial when talking to these kinds of users who might not even remember why we are talking. It is ok if you are talking to someone you know […] if it was a stranger, it might not have been so reassuring and open […] it creates safety.* (Nurse from the insight phase)
	Advocate of user needs	Empathising	*[…] if you have worked for a long time, you try to see it from that person's point of view, because you have experience of what it is like for that person, who is ill.* (Nurse from the design sprint)
		Nuancing	*It's so big… they say that small is good, meaning having small units for those with dementia. Many of them become calm and safe when they are admitted to shielded units with restrictions that are only found there. To some, that's what they need; they don't need a lot of space and access to the outdoors. They are all so different. And they change, you know, relatively quickly.* (Nurse from the insight phase)
	Guardian of professional knowledge	Reality checks	*I feel like those who have been working on this, they don't know that many patients with dementia, or they haven't seen how ill they are when they are admitted to a nursing home. Because then it is not so important what you put on the wall, or which music they are playing. Because your health condition is so poor that the most important thing is to be taken care of by someone nice, who is there for you, and that you can trust. You need good food, and a nice place to stay; it's what close to them that matters, not the colours of the wall and all that.* (Nurse from the insight phase)

		Reassessing professional conventions	*First of all, I found it [the workshops] really exhausting and unfamiliar. But our group was really good – we were so different. We were two nurses, and we were probably the most rigid. So I found that some of my presumptions were being challenged – and that's good – by someone being totally on the outside and then viewing thing very differently. That's probably why it felt so exhausting – because you had to start thinking in a completely different way.* (Nurse from the design sprint)
Design after design	Facilitator	Facilitating an active life	*After breakfast, we seize the day. Some residents get mail, like newspapers, for example, so they come down and pick it up and go to the bistro and have a cup of coffee or walk around the area. You can also go shopping at the store, and some people like to go to the gym here, so we join them.* (Healthcare worker)
		Facilitating residents' independence	*[…] they ask us, "Can I do that?" and "Can I do this?" My response is, "Please, you can do that". So if I'm buttering a slice of bread and someone is sitting near me, and they can manage it, I ask, "Do you want to help me butter?" Then someone says, "Yes, we can do it".* (Healthcare worker)
		Enabling residents to be heard	*After breakfast, they sit in the living room, and then we start planning activities. We usually ask (what they want to do) while they are sitting at the table. Today it's like this, like this, or like this. Who's interested, right? Then they say I want to do this or that, and then we go. Then we have in mind, okay, who will come, who will not […]* (Care assistant)
	Broker	Balancing activation and safety	*But that garden, it slopes down like that, and it's not really suited for them […] and it's actually pretty risky. I've noticed some really tricky spots in that garden, and it's just not safe for some of our residents. We do let them go out there, but we always have to be with them.* (Care assistant)
		Balancing freedom and safety	*The main doors are not always locked, and the sensor system is not always working, but I think it is mainly the employees that feel they need to maintain that control. It's about safety, because some managed to escape from the village […] we need to maintain control of the residents, and you gain that experience when working with dementia over time. But they are supposed to have freedom here, and there are both positive negative aspects of that control, but it needs to be balanced.* *(*Healthcare worker)

	Bricoleur	Tinkering with the physical surroundings/service scape	*There were far more knick-knacks earlier; there were loads. But they were destroyed basically. Things got broken.* (Nurse)
		Tinkering with the boundaries of frontstage and backstage	*We should ideally have access to an office space […] so I guess they forgot about that (providing a room for reports or a protected space for us to talk). Because if we start talking – we have all the residents around us in a flash, because they see us, you know, because we are there in the very centre of everything.* (Healthcare worker) *What they did was to put a PC in each of the small living rooms, so the staff have the opportunity to draw back and work on a bigger screen.* (Informant from the management team)

Figure 1 Illustration of a TSM framework: Mediators and intermediaries on a continuum