THE DINING EXPERIENCE OF RESIDENTS WITH DEMENTIA IN LONG-TERM CARE FACILITIES

by

Lillian Hung
Bachelor of Nursing, University of Manitoba (1993)

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APPROVAL

Name: Lillian Hung
Degree: Master of Arts (Gerontology)
Title of Thesis: The Dining Experience Of Residents With Dementia In Long-Term Care Facilities

Examing Committee:
  Chair: Dr. Barbara Mitchell
         Associate Professor & Graduate Program Chair, Gerontology, SFU

         Dr. Habib Chaudhury
         Senior Supervisor
         Assistant Professor, Gerontology, SFU

         Dr. Loren Lovegreen
         Supervisor
         Assistant Professor, Gerontology, SFU

         Dr. Alison Phinney
         Supervisor
         Assistant Professor, School of Nursing, UBC

         Dr. Barbara Purves
         External Examiner
         Assistant Professor, School of Audiology & Speech Sciences, UBC

Date Defended: June 27, 2008
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ABSTRACT

This qualitative study aimed to explore the dining experience of residents with dementia in long-term care facilities, with a focus on the psychosocial aspect of their experiences. Data were collected by multiple methods, including participant observation and conversational interviews with residents with dementia, focus groups with staff, and examination of documents at two urban facilities in British Columbia, Canada. Data analysis revealed eight themes: (1) Outpacing/Relaxed pace, (2) Withholding/Holding, (3) Stimulation, (4) Disrespect/Respect, (5) Invalidation/Validation, (6) Distancing/Connecting, (7) Disempowerment/Empowerment, and (8) Ignoring/Inclusion. These themes provide a clear set of factors that affect the quality of residents' experiences and offer insights into the processes of how multiple factors influence the residents' experiences in complex ways. The results suggest that although staff approaches significantly impact residents' experiences, the physical environment and organizational milieu are also responsible for hindering and facilitating staff to provide care.
DEDICATION

To all of those nursing home residents who are in their journeys of living with dementia.

To my wonderful husband, Eddy, for his magnificent support and patience.

To my daughter, Rebecca, for the amazing energy she brings.

To my son, Ryan, for the joy he fills my life with.
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CHAPTER 1: INTRODUCTION

Recent research reveals approximately half of the long-term care residents in the United States and Canada have dementia (Alzheimer’s Association, 2008; Ontario Long Term Care Association & Ontario Association of Non-Profit Homes and Services for Seniors, 2001). This demographic will continue to rise with the aging of population and the resulting increased number of persons with dementia. Consequently, long-term care facilities are facing a dramatic increase of challenges associated with meeting special needs of residents with dementia. Mealtimes is one of the most stressful challenges for nursing staff (Pasman, The, Onwuteaka-Philipsen, Van Der Wal, & Ribbe, 2003). Commonly reported problems at mealtimes include residents wandering away from tables, refusal to eat, calling out, verbal outburst and physical aggression (Amella, 2002; Beattie, Algase, & Song, 2004; Pasman et al., 2003; Ragneskog, Gerdner, & Hellström, 2001). These challenges can be perplexing and frustrating for both the nursing staff and the residents.

Research evidence suggests many mealtime problems concerning residents with dementia are not merely the result of the dementia, but are related to the care routines, the social processes, and the physical environmental issues in the settings (Amella, 2008; Kayser-Jones, 1996; Moore, 1999; Pierson, 1999; Sidenvall, 1999; Zgola & Bordillon, 2001). For example, in the study by Pierson (1999), residents with dementia were fed forcefully because staff wanted residents to eat more food. Kayser-Jones (1996) studied mealtime problems in nursing homes and found residents were provided with food that
was unfamiliar, distasteful, and not to their liking; many of the residents struggled but failed to eat adequate amounts of food because there was not enough staff to provide necessary assistance at mealtimes. She also found meal delivery practice was task-oriented and many individual needs were not met. Other studies found social interaction was not always encouraged at mealtimes (Schell, 1994; Sidenvall, 1999). For instance, a recent Canadian study by Gibbs-Ward and Keller (2005) found that staff gave authoritative commands to residents such as, “I don’t want you to talk, I want you to eat!”

In my own nursing experience, many residents with advanced dementia have to eat in geriatric chairs in long-term care settings. Rather than sitting around dining tables, they are lined up along the walls and are fed in an assembly-line manner in some care units. These social and environmental issues not only impede the enjoyment of dining, but also may erode dignity and personhood in residents with dementia, making them feel incapable, devalued, disrespected, or even less human.

Kitwood (1997), among other experts in dementia care (e.g., Bond & Corner, 2001; Davis, 2004; Dewing, 2004; Lyman, 1998; Rader, 1995; Sabat, 2006; Woods, 2001), criticizes the traditional model of dementia care in that it focuses on managing biomedical problems but falls short of addressing residents’ psychosocial needs and their subjective experiences. Savishinsky (2003) described how food in nursing homes can become merely a medicalized commodity, clinicians focusing mainly in terms of what and how much goes into and out of the body, while overlooking the individual preference and emotional as well as social aspects of experience in residents. Even with great emphasis on person-centered or individualized care, many care facilities continue to fail to provide a dining environment that acknowledges residents’ psychosocial needs,
promotes individual dignity, and offers the very much needed human comfort (Allison, 2002; Amella, 2004; Berg, 2006; Kayser-Jones, 2002; Kofod & Birkemose, 2004; Manthorpe & Watson, 2003; Schell, 1994; Sidenvall, Fjellstrom, & Ek, 1994).

Given that mealtimes play an important role in the lives of nursing home residents (Castellanos, 2004; Evans, Crogan, & Shultz, 2003; Snyder, 2001), and that there is a growing interest in dementia experience, surprisingly, no studies have asked residents with dementia about their dining experiences in care facilities. Previous literature has largely focused on issues of caregivers and medical outcomes such as calorie intake, body weight, and laboratory values (Manthorpe & Watson, 2003). In the past decade, more scholars have advocated the need to address the subjective experience and the perspective of persons living with dementia (e.g., Barnett, 2000; Goldsmith, 1996; Haak, 2003; Harris, 2002; Hughes, 2001; Jonas-Simpson, 2001; Kitwood, 1997; Lyman, 1998; Woods, 2001). Conventionally, people with dementia were assumed to be incapable of contributing meaningful views to research, but growing evidence has demonstrated that many of them are capable of telling their own views and want to contribute to research (Cheston, Bender, & Byatt, 2000; Harris, 2002; Lloyd, Gatherer, & Kalsy, 2006; Mozley, Huxley, Sutcliffe, Bagley, Burns, Challis, & Cordingley, 1999; Nygard, 2006; Phinney, 1998; Proctor, 2001; Wilkinson, 2002).

At mealtimes, residents are placed physically together to eat. The three meals offer excellent opportunities to socialize, to share humor and laughs, and to enjoy good food. Food eating is not only essential for physical survival, but also important for emotional and social needs of human life. The seemingly mundane dining activities have potential to create extraordinary avenues of supporting personhood and enhancing quality
of life in residents. As Berg (2006) said, mealtimes are prime opportunities for promoting senses of community and belonging in units where residents live. The study by Evans and colleagues (2005) showed that dining experience connects with personal remembrances of home and family; even in small ways, positive dining experiences could reconnect residents with their identities as individuals. Similarly, Curch (2005) stated that dining is naturally anchored in a sense of familiarity, security, and comfort. Zgola and Bordillon (2001) urged us to view dining in long-term facilities as a meaningful activity for building relationships, supporting identities, and promoting pleasurable experiences in residents. This sentiment is echoed by Hellen (2002), who also suggested that when older people with dementia are eating in the institutional settings, it is vitally important for them to feel emotionally connected, surrounded by caring persons, and to be able to experience the sense of being included in the social world where they live.

Purpose of the Study

The purpose of this study is to seek understanding of the dining experience of residents with dementia in long-term care facilities, focusing on the psychosocial aspect of their experiences. With the increasing prevalence of dementia in long-term care facilities, it is essential that nurses, dieticians, educators, facility managers, and other decision-makers have insights into the needs and the complex experiences of residents with dementia. Such knowledge is important in order to plan and develop care that is more responsive to the needs of residents with dementia. The primary research question of this study is: What is the dining experience of the residents with dementia in long-term care facilities? Specific questions are: (a) What processes and factors impede the dining
experience of residents with dementia at mealtimes? (b) What processes and factors enhance the dining experience of residents with dementia at mealtimes? (c) What are the interrelationships among these multiple factors, and how do they influence the dining experience of residents with dementia?

**Significance**

The significance of this study is threefold. First, it is concerned with care practice. An unpleasant mealtime experience not only has negative nutritional consequences, but also may undermine a resident's dignity, self-esteem, and personhood. The majority of previous studies (e.g., Reed, Zimmerman, Sloane, Williams, & Boustani, 2005) have reported medical outcomes such as low food intake and weight loss, but these studies tell us little about the experience of residents and how to improve quality of care. The present study aims to contribute to filling this gap in knowledge. By gaining understanding of the personal accounts of residents with dementia and the complex context of mealtimes in the care settings, the study provides an opportunity for questioning current practice and pointing to specific areas for improvement in care. Findings of the study add knowledge to a range of nursing, dietetic, and gerontological literatures.

Second, the focus on the link between dining and personhood has the potential to contribute to bridging theory and practice. Although there is tremendous support for Kitwood's theory of personhood, the underpinning concept of personhood is unclear to practitioners, and, thereby, the utility of the concept in care practice remains limited (Dewing, 2004). By connecting the theory of personhood to the everyday mealtime issues in long-term care facilities, the study contributes to translating complex theory into
concepts that are more relevant and applicable to practitioners. Hence, the study is useful in helping practitioners in the field of dementia care better understand the relevance of personhood in everyday care practice.

The third significance is concerned with methodological knowledge. Few studies have examined the experience of people with dementia, particularly those who are beyond early-stage dementia (Hubbard, Downs, & Tester, 2003; Moore & Hollett, 2003). This study takes up the challenge and seeks ways to elicit the views of residents with different levels of dementia. By presenting the research process, detailing the challenges the researcher faced and strategies that were used, this study adds to the body of methodological knowledge that seeks ways to elicit the perspective of people with dementia.

**Summary**

1. Because residents with dementia constitute a large portion of population in long-term care facilities, there is a need to learn about the experience of residents with dementia.

2. Although dining is central to residents with dementia, many care facilities fail to provide an optimal dining environment and quality care for residents with dementia.

3. This study aimed to explore the dining experience of residents with dementia living in long-term care facilities, with a focus on the psychosocial aspect of their experiences.
CHAPTER 2: LITERATURE REVIEW

This chapter begins with a review of previous research, showing the major issues and interventions for mealt ime problems in nursing homes. The goal of this chapter is to provide a contextual backdrop for the study, identify knowledge gaps in the area, and build foundation for the conceptual framework.

Major Issues at Mealtimes

A review of the related literature suggests that there are three major issues at mealtimes in long-term care facilities: (a) task-oriented culture; (b) inadequate staffing and organizational support; and (c) low food intake and weight loss.

Task-oriented Culture

A task-oriented approach is a major issue at mealtimes because it does not support the individual needs of residents and neglects the psychosocial aspects of mealtime care (Kayser-Jones, 2000). Related studies have found that nursing staff are generally focused on the task of feeding as opposed to the residents at mealtimes, due to staff’s desires for control and efficiency (Amella, 1999, 2002; Gibbs-Ward & Keller, 2005; Moore, 1999; Pearson, FitzGerald, & Nay, 2003; Schell & Kayser-Jones, 1999; Sydner & Fjellström, 2005). Researchers also noted that nursing assistants forcefully fed residents when they wanted the residents to consume more food (Chang & Lin, 2005; Pierson, 1999; Schell & Kayser-Jones, 1999). Hill (2002) speculated that the reality of nursing home care being revolved around tasks rather than residents might be a protective mechanism for nursing
assistants, because it might be too difficult for them to emotionally invest in each resident. In a study, Pelletier (2005) found there were actually two types of staff: (a) "technical feeders," who believed providing adequate nutrition was the main goal; they tried to complete feeding in a timely manner and did not talk to residents; and (b) "social feeders," who believed feeding was a time to socialize with residents. Further, institutional routines may contribute to depersonalization in residents. For example, Evans and Crogan (2001) pointed out that the routine use of bibs on residents and placing a medication cart in the dining room at mealtimes not only remind residents of their limitations, but also reinforces the process of institutionalization in the setting.

**Inadequate Staffing and Organizational Support**

Inadequate staff available to assist residents with dementia is another important issue in long-term care facilities that has a significant effect on how staff care for residents at mealtimes. In a qualitative study, Kayser-Jones and Schell (1997) found that an inadequate number of staff made mealtime a hurried and unpleasant experience for residents; residents were fed too quickly, with excessively large amounts of food per bite. A staffing analysis determined that a resident on average required 38 minutes of assistance per meal, but only 9 minutes of assistance was usually provided (Simmons, Osterweil, & Schnelle, 2001). Indeed, experts recommend that at least one nursing staff is needed to assist every two or three residents who are entirely dependent in eating, and one staff to assist two to four residents who are partially dependent in eating (Harrington, Kovner, Mezey, Kayser-Jones, Burger, & Mohler, 2000). Organizational milieu also influences how nursing assistants work at mealtimes. In their study, Roberts and Durnbaugh (2002) found that staff members were not assigned to the same residents, and
they did not seem to know the residents or their eating patterns. Other organizational barriers to mealtime care in care facilities described by Crogan and Schultz (2000) included impractical staff workload, staff receiving poor support from nursing supervisors, and inadequate ongoing learning opportunities for education needs.

**Low Food Intake and Weight Loss**

Low food intake and weight loss have been frequently reported as the main problems related to nursing and nutrition issues in nursing homes. Malnourished patients have higher rates of infection, impaired immune responses, and a greater risk of developing pressure sores (Morley, 2003). Allard, Aghdassi, McArthur, McGeer, Simor, Abdolell, Stephens, and Liu (2004) gave evidence that malnutrition was associated with increased risk of mortality in the institutionalized elderly. A recent study with a sample of 400 residents with dementia showed that 54 percent had low food intake and 51 percent had low fluid intake during a single meal in assisted living facilities and nursing homes in the United States (Reed et al., 2005). Mentes, Chang, and Morris (2006) found that 31 percent of residents were dehydrated during a six-month period of study. Carrier, West, and Ouellet (2003) found that, compared to lucid residents, non-lucid residents had lower body weight, needed more assistance with meals, waited longer for assistance, had less access to snacks, and could not replace their meals as often as lucid residents. Another study showed that the decrease in food intake in residents with Alzheimer’s disease was strongly associated with the presence of behavioural symptoms, such as irritability and agitation, but not cognitive decline (Greenwood, Tam, Chan, Young, Binns, & Reekum, 2005).
Interventions for Mealtime Problems

In general, existing interventions tend to focus on increasing food intake among residents in institutional settings (Watson & Green, 2006) and reducing their agitated behaviors. Two recent Canadian studies showed that the food consumption of residents with dementia was significantly increased after introduction of the “bulk food delivery system,” which shows the food available to residents and allows them to choose what and how much to eat (Desai, Winter, Young, & Greenwood, 2007; Shatenstein & Ferland, 2000). Other studies found that, by providing better lighting and color contrast (e.g., between plate and table, table and floor), residents were able to see better and, thereby, increased their food intake (Brush, Meehan, & Calkins, 2002; Koss & Gilmore, 1998). In addition, when residents with dementia dined in a smaller dining room, positive outcomes in residents’ behaviors were found (Negley & Manley, 1990; Schwarz, Chaudhury & Tofle, 2004). Nolan and Mathews (2004) demonstrated they were able to reduce agitation in residents with dementia by adding a big clock and large-print sign below it indicating the times for meals.

Athlin and Norberg (1998) found improvement in communication at mealtimes when residents were fed by the same staff, a consistent assignment approach increased staff sensitivity to residents’ cues. In-service training or education programs provided have also demonstrated success in improving knowledge of nursing staff about mealtime care (Bonnel, 1995; Chang & Lin, 2005; Evans & Crogan, 2001; Mamhidir, Karlsson, Norberg, & Kihlgren, 2007; Remsburg, 2004). In another study, when provided verbal prompts and positive reinforcement by staff, residents were able to feed themselves better (Coyne & Hoskins, 1997). Also, a program of providing cues, including placemats, name
cards, finger food, and behavioral guidance increased independence in self-feeding of residents with dementia (Van Ort & Phillips, 1995). Studies also revealed that, when residents dined while listening to music, they were less irritable (Hicks-Moore, 2005; Rakneskog, Kilgrhen, Karlosson, & Norberg, 1996). In a few pilot studies, residents were found more engaged at mealtime activities and had positive social interactions when they were invited to participate in preparing meals (Altus, Engleman, & Mathews, 2002; Boczko, 2002).

Limitations of Current Research

Although research has examined mealtime concerns and interventions to improve mealtimes in long-term care facilities, critical issues remain unaddressed. Here, I discuss three significant gaps in the existing literature.

The Perspective of Residents with Dementia

No study could be found that specifically examined the perspective of residents with dementia about their dining experiences in long-term care facilities. Little is known about how they actually feel about their mealtime experiences, what they most value and need, as well as what they hope for. As Wilkinson (2002) argued, it is difficult to know whether the existing care services meet the needs of residents or not when the understanding of their experiences remains limited. Some scholars further argued that excluding people with dementia from participating research reinforces stereotyping of their incapacity (Barnett, 2000; Slaughter, Cole, Jennings, & Reimer, 2007). Also, recent studies have uncovered significant discrepancy on perception of experience in residents with dementia between proxies and the persons with dementia (e.g., Howorth & Saper,
2003; Kofod & Birkemose, 2004; Pearson, et al., 2003; Sands, Ferreira, Stewart, Brod, & Yaffe, 2004). These studies indicate that direct investigation of the perspective of people with dementia is necessary to truly understand their needs and experiences.

**The Quality of Dining Experience**

Studies on low food intake in nursing home residents have created tension to push for higher food intake in residents (McDonald, 2003). Though these studies make a significant contribution to identify nutrition issues in nursing home residents, a meal is more than how much is eaten. Indeed, there is a risk of encouraging force-feeding if caregivers over-emphasize the quantity of food intake but neglect the quality of residents' experiences. Researchers such as Vesperi and Henderson (1995) remind us that limiting nursing home experience to “good appetite” is a form of reduction that dehumanizes people. In the literature, less than a handful of studies (e.g., Kayser-Jones & Schell, 1997; Moore, 1999) look into the “human care”, the psychosocial aspect of care for nursing home residents at mealtimes.

**A Broader Approach**

It is the combination of factors such as the physical aspects of the dining room and the behaviors of staff and others that interweave to shape the experience of residents. In order to have a complete understanding of the experience of residents, these factors cannot be studied in isolation; instead, a broader approach should be used to investigate all the myriad factors in a systematic manner (Calkins, 2001). For example, we may be too quick to make judgment of a resident who is calling out at mealtimes as “simply confused and not knowing what she wants.” Our understanding deepens if we learn that she feels lonely and wants company because no one talks to her, even though a large
number of people are in the dining room. Perhaps the feeling of sitting in a large dining room with institutional furniture, which is unfamiliar, makes her feel even more anxious and frustrated.

**Summary**

1. The literature review suggests the three major issues at mealtimes in long-term care facilities are: (a) task-oriented culture, (b) inadequate staffing and organizational support, and (c) low food intake and weight loss.

2. Existing interventions tend to draw on the perspective of care professionals, concentrating on increasing food intake and reducing agitated behaviors in residents.

3. Three main gaps remain in nursing home mealtime research: (a) lack of perspective of residents with dementia, (b) limited research into the quality of dining experience in residents, and (c) the need to use a broader approach to capture the complexity of the mealtime phenomenon.
CHAPTER 3: CONCEPTUAL CONTEXT

In this chapter, I delineate the conceptual context of the study, beginning with a brief overview of Kitwood’s (1997) theory of personhood. Following that, I will illustrate the study’s conceptual framework, which draws upon Kitwood’s (1997) work, previous research, and my own clinical experience.

Kitwood’s Theory of Personhood

Kitwood’s (1997) theoretical framework of personhood was chosen to guide the study because it focuses on the subjective experience and the needs of persons with dementia. Personhood is defined as “a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being” (Kitwood, 1997, p. 8). He eloquently explicated how a caring relationship enables the person with dementia to retain competence while an unsupportive social environment undermines the person’s personhood and harms the person’s well-being.

Kitwood (1997) equated dementia as: “Dementia = P + H + B + NI + SP”: “P” stands for personality, “H” means physical health, “B” represents biography or life history, “NI” indicates neurological impairment, and “SP” is the social and psychological environment that surrounds the person with dementia. He advocated that a person’s experience, personality, and life history should be viewed as valuable sources of information that contribute to the understanding of what is needed to provide good care. More essentially, he elucidated that the problems of dementia are not caused solely by
neurological impairment and highlighted the necessity of looking at the person first and offering social and psychological care to sustain personhood in persons with dementia.

Kitwood and Bredin (1992) first demarcated a number of indicators of poor and good practice in dementia care. They give examples of poor care such as "ignoring," "disempowerment," and "invalidation," whereas "including," "empowerment," and "validation" are indicators of good care. They described "Malignant Social Psychology" as the social environment that tends to depersonalize, focus on disabilities, and invalidate the person with dementia. This environment is malignant in that it eats away at the personhood of those being cared for, and that it spreads from one staff to another very quickly (Brooker, 2007). A good illustration, described by Kitwood (1997), was when a nursing assistant scolded a resident for spilling food and said to another staff that if ever she got like that, she hoped someone would shoot her. Kitwood (1997) argued that frequent episodes of such negative attitude would increase ill-being of persons with dementia. On the other hand, a social environment that emphasizes the person's strength and offers compassionate care can contribute to their well-being.

**Personhood and Mealtime Experience**

Kitwood's (1997) theory of personhood is useful in understanding how the behaviors of caregivers at mealtimes may affect the experience of residents with dementia in the care settings. He illustrated that there are five fundamental psychosocial needs of persons with dementia: comfort, identity, occupation, inclusion, and attachment. The following discusses how each of these concepts may be relevant to the dining activities in the care setting and the dining experience of residents with dementia.
Comfort is about the provision of tenderness and closeness. During mealtimes, comfort can be provided through affection and kind words by staff. However, the sense of comfort can be undermined when the staff member refuses to respond to a resident’s evident need, such as a request to use the bathroom.

Identity relates to knowing the person and showing respect to the person. The identity of residents can be undermined if they are infantilized through mealtime activities. Being infantilized means the resident is treated as a small child. Using commands such as “Eat up your food or else your mother will be mad at you” is an illustration of infantilization.

Attachment is connected to bonding, trust, and relationship. It is also about recognizing the reality of a resident with dementia. Eating a meal can be a difficult activity for someone who has cognitive and functional deficits. By taking the time to talk to the person and providing proper assistance for the person at mealtimes, trust and positive relationship can be built between the staff and the resident.

Occupation means being able to involve in activities that are personally meaningful. Dining provides an opportunity for a resident with dementia to be involved in an activity that is familiar and satisfying. However, a sense of occupation is undermined when staff simply takes over and feeds the resident even though the resident is capable and wants to feed himself.

Inclusion concerns making a person feel he is a full member of the group. The sense of inclusion can be supported when residents with dementia are included in social conversations at mealtimes. However, it can be undermined if the caregivers ignore residents, talk among themselves, or talk over a resident, as if the resident is not there.
Critical Review of Kitwood's Approach

As described by Adams (1996), Kitwood's theoretical framework of personhood has provided useful insight into how the social environment of the setting has the potential to positively or negatively affect the well-being of persons with dementia. Yet Kitwood's approach does not address any connection between the physical environment and personhood in persons with dementia (O'Connor, Phinney, Smith, Small, Purves, Perry, Drance, Donnelly, Chaudhury, & Beattie, 2007). There is a fairly rich body of literature related to the important role of the physical environment in promoting functional abilities and reducing behavioural problems in residents with dementia (Brawley, 2006; Briller, Proffitt, Perez, Calkins, & Marsden, 2001; Calkins, 2003; Day, Carreon, & Stump, 2000; Schwarz, Chaudhury, & Tofle, 2004). However, there continues to be a dearth of literature examining the inter-relatedness of the physical environment and personhood in persons with dementia. This study contributes to addressing the gap by adding evidence of how different features of the physical environment in the dining setting (e.g., size of the dining room, furniture arrangement, institutional versus residential ambience) may directly or indirectly impact personhood in residents with dementia.

Conceptual Framework

The conceptual framework developed for this study was based upon Kitwood's (1997) theory of personhood, knowledge in existing literature and my professional experience. It is diagrammatically presented in Figure 3.1 on the following page. The framework was used as a guide to explore the complex relationships among variables.
that may affect the dining experience of residents with dementia in care facilities. In this study, more emphasis was given to the physical environment, staff approach, residents’ needs and the dining experience of resident with dementia as demarcated by the dashed line in Figure 3.1.

Figure 3.1: Conceptual framework presenting factors that affect the dining experience of residents with dementia in long-term care facilities.

Facility Care Philosophy and Organizational Support

The care philosophy of the facility is the common mission that the management and staff strive to achieve; therefore, it has effects on the way care is provided to residents with dementia at mealtimes (Werezak & Morgan, 2003). Relevant aspects of organizational support include polices reflecting the facility care philosophy, staffing,
training, and supervision. Supportive policies relating to mealtimes may include having flexible meal schedules, permitting residents to have access to food, and offering menu choices (Zgola & Bordillon, 2001). Staffing issues are concerned with adequate staffing and consistent assignment. Consistent staffing is assigning to staff the same group of residents, so they can get to know the residents (Athlin & Norberg, 1998). This is essential because good care at mealtimes involves providing individualized care, which requires knowledge of personal habits, preferences, and cultural needs of residents. In addition, quality care requires both continuous training and support by supervisors.

**The Physical Environment of the Dining Room**

The ambience created by interior design aspects can contribute to positive dining experiences. Studies have shown that a smaller, more intimate dining space has favourable outcomes for residents with dementia (Negley & Manley, 1990; Schwarz et al., 2004). Appropriate furniture is also important to support residents’ functional abilities (Brawley, 2006). Adequate and quality lighting and appropriate colour contrast (e.g., between plate and table) are important because many elderly residents with dementia have impaired vision and poor depth perception (Brush, Meehan, & Calkins, 2002). In addition, noise and offensive odour may have negative effects on dining experience, whereas positive stimulation such as the smell of food cooking or coffee brewing may provide sensory cues and have positive effects on the dining experience of residents (Briller et al., 2001).

**Staff Approach**

Design features that create a homelike ambience may provide staff with cues as to their care approach (Zeisel, Silverstein, Hyde, Levkoff, Lawton, & Holmes, 2003). For
example, the homelike ambience may give staff the idea that they should treat residents with a gentle manner, rather than being task-oriented and rushing through the meal. In smaller units, it is easier for staff to learn about each resident. By knowing each resident’s habits and preferences, caregivers are able to accommodate their individual needs. For instance, instead of forcing all residents to get dressed early in the morning to have breakfast, it is all right to let some residents sleep in and serve them breakfast later in the morning if that fits their personal habits. Smaller groups of residents in the dining room may offer more opportunities for staff to provide emotional comfort to residents. Positive and caring interactions not only help promote a sense of attachment in residents; they may also help residents feel included in the social world where they live.

**Family Involvement**

Research reports that families do not abandon their relatives in nursing homes, but there is little research on defining the role of family in formal care and how care facilities can help families to maintain close ties (Gaugler, 2005). Based on my work experience, some families do actively become involved at mealtimes. For instance, they provide emotional support, assist feeding, pass on important knowledge of the resident’s preferences and habits, and bring in homemade treats for residents. It is logical to think that family will be more willing to participate in mealtime activities if management and staff have a positive attitude and acknowledge the importance of their involvement. Perhaps family members would visit more often if the facility environment is more welcoming. Essentially, family involvement at mealtimes plays an important part in keeping residents feel socially connected.
Creation of Dining Experiences in Residents with Dementia

Good quality mealtime care involves providing care that meets the individual needs of residents. In order to do so, the caregivers need to learn the personal aspects of the individual residents, including food preferences, personal habits, and functional abilities, as well as cognitive challenges or health issues (Welsh, 2005; Zgola, 1999). More importantly, the caregivers need to have insight into the needs and experiences of their residents with dementia. As described previously, Kitwood’s theoretical framework of personhood suggested that the five fundamental needs in persons with dementia are comfort, identity, occupation, inclusion, and attachment. I believe these needs are central to the dining experience of residents with dementia.

Summary

1. Kitwood’s theory of personhood is useful in guiding the study because it focuses on the subjective experience and the needs of persons with dementia.

2. Kitwood stressed that many problems of dementia are not caused solely by the disease, but are related to the social environment, and, therefore, it is important to offer good social and psychological care in dementia care.

3. Kitwood’s approach does not address the role of the physical environment in supporting or inhibiting personhood in dementia. This study contributes to addressing the gap by adding evidence of how specific features of the physical environment in the dining setting may directly or indirectly impact personhood in residents with dementia.
Research Questions

This study is designed to explore the dining experience of residents with dementia in the setting of long-term care facilities. It centres on the perspective of residents with dementia and the psychosocial aspect of experience at mealtimes. Therefore, the primary research question and more specific sub-questions are as follows.

Primary Research Question

What is the dining experience of the residents with dementia in long term care facilities?

Sub-Questions

1. What processes and factors impede the dining experience of residents with dementia?

2. What processes and factors enhance the dining experience of residents with dementia?

3. What are the interrelationships among these multiple factors, and how do they influence the dining experience of residents with dementia?
CHAPTER 4: METHODS

As described in the conceptual framework, the dining experience for residents in long-term care is potentially related to a complex interplay of contextual factors, including the organizational milieu, the physical environment, and the staff approach. An ethnographic approach was used in this study, which was appropriate because of its sensitivity in capturing the complexity of the studied phenomenon in a holistic way (Hammersley & Atkinson, 1995). This chapter begins with a description of the research design, settings, and participants. Then it moves on to present the researcher’s stance, data collection procedures, and data analysis methods. The chapter closes with a discussion of ethical consideration and trustworthiness issues.

Ethnographic Inquiry

Primarily, ethnographers use methods of observation and interviews to understand how people involved in the setting view their experiences, what happens in the settings and the contexts in which social actions take place (Roper & Shapira, 2000). While interviews enable the researcher to explore the personal accounts of participants, observations provide the researcher with an opportunity to understand the context of their experiences. Experts of dementia research (e.g., Hubbard et al., 2003; Nygard, 2006) suggested that the ethnographic methods of interviews and observation are well-suited to provide information needed to explore how people with dementia perceive everyday experience. Nygard (2006) explained that because people with dementia are likely
impacted by deficits in memory and communication, by combining interviews and
observations in the natural context, the participating residents are provided an opportunity
to give immediate verbal comments and spontaneous accounts of feelings that are closely
connected to their experiences. In effect, such immediacy enables the participating
residents to express viewpoints about their everyday dining experiences that they
otherwise may not be able to articulate.

Site Selection

The study was conducted in two urban long-term care facilities in the Lower
Mainland of British Columbia, Canada. The two facilities had substantial differences in
their physical environment. The first site, River Rock Manor (pseudonym), was a
purpose-built dementia care home consisted of several small units (10-15 beds) as part of
a larger complex-level care facility. I chose this site partly because of my familiarity with
the setting through my professional nursing work there. Apart from the reason of
convenience, the facility was selected primarily because of its innovative environmental
design; I was interested to explore the effects of the physical environment on the dining
experience of residents with dementia. The general design of the units emphasized
homelike character and opportunities for personalization and social interactions. The
dining areas offered normal residential characteristics such as a baking oven, a washing
sink, cabinetry, and a small adjoining kitchen.

The second site was a mid-sized facility, Gardenview Lodge, where residents with
dementia were living and eating with residents who were cognitively intact. The facility
presented typical physical environmental features of traditional nursing homes. The
general furnishing and decor were institutional, with long identical corridors and a large cafeteria dining area. At mealtimes, the dining room served nearly 100 residents at the same time. Salient features of the two sites are summarized in Table 4.1.

Table 4.1: Salient Characteristics of the Research Sites

<table>
<thead>
<tr>
<th>Site</th>
<th>River Rock Manor</th>
<th>Gardenview Lodge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>Not-for-profit</td>
<td>Privately owned, for-profit</td>
</tr>
<tr>
<td>Type of Care Setting</td>
<td>Purpose-built dementia care</td>
<td>Traditional, integrated, multi-level care</td>
</tr>
<tr>
<td>Unit Size</td>
<td>Small (10-15)</td>
<td>Large (75-100)</td>
</tr>
<tr>
<td>Dining Room Capacity</td>
<td>Small (10-15)</td>
<td>Large (75-100)</td>
</tr>
<tr>
<td>Residents</td>
<td>Predominantly Caucasian female</td>
<td>Predominantly Caucasian female</td>
</tr>
<tr>
<td>Care Staff/Resident Ratio</td>
<td>~1:6</td>
<td>~1:12</td>
</tr>
<tr>
<td>General Impression</td>
<td>Home-like</td>
<td>Institutional</td>
</tr>
</tbody>
</table>

Participant Selection

*Resident Participants*

At the two sites, nurses who knew the residents well were asked to assist in identifying potential participants. Eligibility was only restricted to residents with dementia who were able to express themselves verbally. Residents with severe dementia were not excluded because recent evidence shows that some people with severe dementia are capable of telling their views (Bayles, Tomoeda, Cruz, & Mahendra 2000; Normann, Henriksen, Norberg, & Asplund, 2005).
Resident participants were selected by the method of theoretical sampling, an ongoing and iterative process (Sandelowski, Davis, & Harris, 1989). During the 3 months of data collection, I chose residents to represent a diverse range of experiences while I moved back and forth between the data and emerging themes. On the whole, the sampling was driven by the intention to learn in-depth about different types of dining experiences of residents. For example, residents who seemed happy and those who looked unhappy or angry were selected. Those were identified as “difficult residents” by staff or those who appeared contented were selected as well. Ideally, the sample size should be based on data saturation, which occurs when no new data can be obtained (Sandelowski et al., 1989). However, the goal of full saturation was somewhat elusive for this study because of the complex profiles of the participants. There were various experiences among the residents, and the experiences could also be changing within the same individual over time. Given the reality that the study needed to be completed within a reasonable time frame, data collection was concluded when data showed some redundancy. At that point, 20 residents were selected, with 10 at each site.

**Staff Participants**

To broaden the understanding of the mealtime situations, a focus group discussion with staff members was held at each site. Wibeck and colleagues (2007) found that participants in small groups had more opportunities to talk and their discussions were more focused. In heterogeneous groups, participants with different backgrounds and experiences can stimulate discussion and offer multiple perspectives on the topic under inquiry (Krueger, 1994). For this study, four staff members (one nurse, two care aides and a dietician) who were working on the scheduled day of focus group participated in
the focus group discussion at each site. Managers were not invited to participate in focus
groups because it was anticipated that staff might be afraid or reluctant to voice honest
opinions in front of managers.

The Researcher’s Stance

Ethnographic inquiry recognizes that the researcher is a part of the social world
being studied and her own beliefs, values, and experiences may influence the data
collection and analysis (Emerson, Fretz, & Shaw, 1995). In the following section, I will
share highlights from my personal experiences and beliefs that have shaped my interest in
this study.

Researcher’s Experiences and Beliefs

The past 12 years of nursing work in long-term care has shaped my view of
people living with the dementia and the effects of institutional care on them. Muriel was
one of the residents with dementia I had cared for. Muriel often called out at mealtimes,
“Mama...Mama...” When staff tried to feed her, she would become angry, swear at the
staff, spit on them, and sometimes even hit them. Due to her behaviors, she was given
several kinds of antipsychotic medications. In order to get Muriel to take her medications,
nurses tried different ways, such as disguising the medications in her food, which
frequently made her feel even angrier and refuse to eat her meals. Occasionally, I would
sit with her in the dining room, watching birds flying around a big pine tree outside the
windows. Muriel liked commenting on how the mother birds brought food to feed their
baby birds and how much she enjoyed her early life with her son. She always seemed to
feel happier after we had spent some special time together.
The experience of caring for residents such as Muriel caused me to question how we often assume medicine is the solution to everyday problems in dementia care. I became interested to know under what conditions a staff chooses to use a particular approach to care for residents and how each approach affects the experience of residents. I agree with Stafford (1995) that there are no clear “good guys or bad guys” in nursing homes because staff often act for benevolent, or at least benign reasons. Perhaps ritualized routines are so entrenched in daily work, and, thereby, at times, staff become unaware of how their behaviors may impact residents. I don’t believe that any staff would intentionally inflict harm or negative treatment on their residents. The negative approaches probably can be understood as being ignorant and need to be brought up for challenge. Thus, a desire to help colleagues to gain better understanding of the everyday experiences in residents attracted me to this study topic.

**Researcher’s Relationships with the Settings**

Working as a nurse in River Rock Manor for 12 years, I had a few advantages: (a) it saved time in gaining access and establishing rapport with people in the setting; (b) my presence did not stand out in the setting; and (c) familiarity with the setting, procedures, and routines allowed me to immerse myself in the setting. In terms of drawbacks for researching in one’s own culture, Koch (1994) wrote about the stress of playing the dual role of being a nurse and a researcher in the field. She was pulled to perform nursing duties that had taken away her time and energy to conduct research. Morse (2006) warned that the familiarity with the setting may also lead to overlooking implicit significant behaviors and events. Webb (2002) stated that the researcher’s position within the organization may be threatened if the organization rejects the research findings. To
minimize the potential negative effects of being an insider-researcher at River Rock Manor, I used the following strategies:

1. I met the administrator several times during the course of the fieldwork and had informal conversations with her to build a collaborative relationship. I also showed her portions of my work to make her feel informed about the research process.

2. I conducted all of my field work during off-duty hours.

3. I tried not to perform nursing care when conducting fieldwork (except a few times when I had to help residents who were in acute emotional distress).

4. I tried to maintain a position with marginal distance, stepped back and asked questions in order to identify the taken-for-granted elements (Hammersley & Atkinson, 1995). I had to admit that this was a real challenge for me as I often found myself becoming too immersed into the emotion and experience of residents. Writing a journal and debriefing with a peer friend helped me to refocus my energy and effort on the research.

5. Throughout the research process, I tried to be reflexive and critically examined my own assumptions, feelings, and actions by writing a journal and memos (Bonner & Tolhurst, 2002; Pellatt, 2003). For example, I found it helpful to write an identity memo that listed my own assumptions and beliefs. From time to time, I compared my views of the taken-for-granted issues (that I thought I knew about) with what was being said by the participating residents.

At Gardenview Lodge, I was initially viewed as an outsider because I was not an employee, a family member, or a resident. The benefits of being an outsider were that it might have enabled me to be more attuned to subtle differences (Morse, 2006) and I was
excused from the nursing obligations. The main drawback of being an outsider researcher was that staff and residents might not feel comfortable with my presence, and thus they might not express their opinions candidly. In order to establish trust and rapport with members in the setting, I employed the following strategies:

1. Before the study, I volunteered once a week at Gardenview Lodge for nine months. The volunteer experience helped me to get to know a few staff and residents, and it helped them to know me.

2. During the research process, the purpose of my study was explained several times, as appropriate, to management, individual staff, and residents in the setting. Formally, I made myself available to answer questions by having an information session. Informally, I answered questions of staff during meal breaks that I deliberately took with them in the staff room.

3. Holding back my own assumptions, using an open and nonjudgmental attitude, I tried hard to listen to the perspectives of residents and staff.

4. Field relationships took time and effort to build. I spent time to hang around with staff, residents, and families. Over different occasions, I brought them small treats such as homemade cookies and flowers from my garden.

Data Collection

Data collection consisted of a combination of methods and sources: an approach of triangulation. I used four sources of data, including the residents with dementia, staff (nurses, care aides, and the dietician), my own notes and journals, and the archival documents. To collect these data, I used the methods of participant observation,
conversational interviews, focus groups, and examination of the documents.

Triangulation is useful in revealing different dimensions of the phenomenon; it balances out weaknesses in each method and adds rigor, breadth, complexity, richness, and depth to any inquiry (Maxwell, 2005). Table 4.1 is a summary table describing the relationships between my questions, rationales, and data collection methods.

Table 4.2: Question, Rationale, and Method Matrix

<table>
<thead>
<tr>
<th>What do I need to know?</th>
<th>Why do I need to know this?</th>
<th>How will I find an answer to the question?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the care philosophy that each care facility adopts?</td>
<td>To assess the impact of care philosophy on quality of meal services, staff practice, and dining experience of residents with dementia</td>
<td>The care philosophy statement is framed on the wall near main entrances at each site</td>
</tr>
<tr>
<td>2. How does the facility ensure quality meal services for residents with dementia?</td>
<td>To assess any management support on staff practice and how that may impact dining experience of residents with dementia</td>
<td>Meal observation Focus groups Documents (e.g., policy and procedure manual)</td>
</tr>
<tr>
<td>3. What is the physical environment of the dining room like at each care facility?</td>
<td>To assess how different features of the physical environment may affect the dining experience of residents with dementia</td>
<td>Environmental observation Meal observation</td>
</tr>
<tr>
<td>4. What is dining in long-term care facilities like for residents with dementia?</td>
<td>To identify the subjective experience and perception of residents with dementia</td>
<td>Meal observation Resident interviews</td>
</tr>
<tr>
<td>5. How might the individual characteristics of participating residents affect their dining experiences?</td>
<td>To find out information about ethnicity, cultural background, gender, health problems, personal habits, and preferences</td>
<td>Documents (e.g., medical charts, Minimum Data Set) Meal observation Resident interviews Focus groups</td>
</tr>
<tr>
<td>6. What would trigger negative emotion or behaviours in residents with dementia at mealtimes?</td>
<td>To discover the factors lead to disruptive behaviours or negative experiences in residents with dementia at mealtimes</td>
<td>Meal observation Resident interviews Focus groups</td>
</tr>
<tr>
<td>7. What would enhance positive emotion or behaviours in residents with dementia at mealtimes?</td>
<td>To discover the factors enhance positive experiences in residents with dementia at mealtimes</td>
<td>Observation Resident interviews Focus groups</td>
</tr>
<tr>
<td>8. How do staff integrate knowledge of individual residents' preferences and habits into mealtime care?</td>
<td>To discover the person-centred care strategies and how they contribute to the dining experience of residents with dementia</td>
<td>Observation Focus groups</td>
</tr>
</tbody>
</table>
Data collection proceeded in three phases. By doing so, the data collected in the initial phase helped to develop further questions that could be addressed in the second and third phases. Also, this gave me opportunities to clarify any unclear information and confirm and refute ideas in the next phase of data collection. The first phase consisted of environmental observation, review of available documentation, meal observation, and interviews with resident participants. The second phase involved focus groups, meal observation, and interviews. The final phase included follow-up with focus group data, completing meal observation and interviews, and collecting additional data as needed.

Table 4.2 shows the chronology of the study process.

**Table 4.3: Chronology of Fieldwork**

<table>
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<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>-Permission by facility administrators to conduct study at facility sites</td>
<td>-Obtaining informed consents from families of resident participants</td>
<td>-Obtaining informed consents from participating staff</td>
<td>-Completing meal observation and conversational interviews with residents</td>
<td>-Writing the draft of the thesis</td>
<td>-Thesis defense</td>
</tr>
<tr>
<td></td>
<td>-Proposal presentation</td>
<td>-Environmental observation*</td>
<td>-Environmental observation</td>
<td>-Focus groups with staff at each site</td>
<td>-Reviewing with committee members, refining the draft</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Examination of available documents such as medical charts, mission statements</td>
<td>-Meal observation: approximately 4 visits/ week between two sites</td>
<td>-Data analysis, developing preliminary categories and themes</td>
<td>-Field notes, memos, &amp; journals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Conversational interviews with residents along with observation</td>
<td>-Concurrent data analysis</td>
<td>-Continuing to keep field notes, writing memos, &amp; journals</td>
<td>-Data analysis, confirming and refining categories and themes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Keeping field notes, writing memos, &amp; journals</td>
<td></td>
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</tbody>
</table>

*Informed consent was primarily completed at the outset and continued throughout the study.*


Environmental Observation

In the initial visits to the two study sites, I obtained an overall impression of the settings by beginning with general examinations of the dining environment. I used a tool, “The Environmental Characteristics in the Dining Room”, which was developed based on the Professional Environmental Assessment Protocol (PEAP), (Weisman, Lawton, Calkins, Norris-Baker, & Sloane, 1993), and current related literature (e.g., Brawley, 2006; Briller et al., 2001; Day et al., 2000; Hellen, 2002; Zgola & Bordillon, 2001). The PEAP is an instrument that measures the experiential qualities of dementia care facilities. Although PEAP focuses on the physical setting, it also addresses the social and organizational contexts.

The tool, “The Environmental Characteristics in the Dining Room” was organized to follow the eight dimensions of environmental features for people with dementia according to the PEAP. These are: functional ability, awareness or orientation, safety and security, sensory stimulation, social interaction, privacy, continuity of self, and personal control (see Appendix A). Utilizing the tool, I recorded the full range of descriptive data about the physical characteristics of the dining environment in each facility. Such information was important to understand how features of environment might impact the dining experience of residents with dementia within each setting. For example, in relation to the environmental experiential dimension of stimulation, I noted the size of the dining room and how the space was used. I paid attention to and wrote details about the quality of stimulation, including smells, sounds, colour, equipment, furniture, and decorations of the settings, as well as how people in the settings responded to these stimulations.
Participant Observation

In traditional ethnographic observation, the researcher participates in people’s daily lives, watches what happens; listens to what is said, asks questions, and collects whatever data are available to throw light on the issues that are the foci of the research (Hammersley & Atkinson, 1995). In this study, observation took place in the dining rooms of the care facilities to explore how aspects of the physical environment as well as social context impact residents’ dining experiences. Attention was paid to participants’ use of the space, routine activities occurring in the space, verbal and non-verbal interactions between residents, and interactions between staff and residents. In addition, any events at mealtimes, the process of meal serving, explicit and implicit rules, etc. were noted.

I observed during breakfast, lunch, and dinner times on different days of the week, including weekends. I observed 24 meals at Gardenview Lodge and 20 meals at River Rock Manor over a period of 3 months. Despite concentrating on observing two to three residents during each visit, careful attention was paid to any significant events that were happening to other residents as well. Each visit lasted about 2 hours. Each resident was observed two to six times depending on the context. If there were ideas or interpretations that needed to be confirmed, clarified, or expanded on, higher numbers of observations were made. I sat in different locations of the dining room to get close to the participating residents. As a participant observer, I took part in conversations, drank coffee and helped out with passing food and drink items.

I originally planned to keep participation at a low level so that I could focus my energy on observation and note taking. However, on a few occasions, I could not resist
helping residents in acute distress. I walked with residents, comforted those who were calling out, reassured some that their meals were already paid, and directed others to their seats in the dining room. Unexpectedly, these actions helped me gain a deeper understanding of the experience of residents. There was valuable data I probably could not have gained in any other way. It was only by being present with the resident when things were happening that I had the chance to observe and ask what the experience was like. For example, when a resident was angry about being ignored by the staff in the setting, I took a walk with her to calm her down. I could not have captured the emotional experience of frustrations, anger, and sadness if I was not there with the person.

In the field, I took quick notes whenever I could. Right after the field observation, I expanded my notes. Within the same week, I organized data into a computer document, the “Meal Experience Data Record” (see the print form in Appendix B). In part, the organization of the Meal Experience Data Record was based upon selected aspects of the Dementia Care Mapping Tool, which was originally developed by Kitwood and Bredin (1992). There are four columns for data entry: the positive and negative aspects of social environment, and the positive and negative aspects of physical environment. Additional space was created in the margin for more comments. For me, the Meal Observation Data Record was useful for three reasons: (a) organization of data in a systematic way helped data retrieval, (b) ongoing analysis enabled identification of areas for clarification and pointing to new areas of observation, and (c) the print version of the collected data could be brought to the field to raise sensitivity of subsequent observations.
Conversational Interviews with Residents

Multiple casual conversational interviews with the residents were conducted because they tend to be more enjoyable, are in a more relaxed pace, and allow opportunities to yield more data and confirm data (Nygard, 2006). On average, the interviews took about 10 to 15 minutes. The majority of interviews were recorded by a cellphone, which had a feature of audio-recording, and then transcribed into text. Some interviews were not recorded due to families not providing consent to the recording or residents showing signs of discomfort with the recording. In those cases, I took handwritten notes. The number of interviews varied from person to person, depending on the possibility of new data being generated. On average, three or four conversational interviews with each resident were conducted. During these conversations, I asked about their feelings and thoughts, as well as opinions about actions of others. For example, “What is important to you about eating at this place? What do you like or dislike? How do you feel about the service? What would bother you or upset you when you are eating here? Inevitably, dementia symptoms created challenges for residents to communicate their views. To facilitate eliciting views from residents with dementia, I used the following strategies:

1. A flexible approach. The residents were allowed to set the pace of the interview and given time to process and respond to questions. They decided when to start and stop the conversation, so their feeling of control could be enhanced (Aggarwal, Vass, Minardi, Ward, Garfield, & Cybyk, 2003; Clarke & Keady, 2002; Tappen, Williams, Edelstein, Touhy, & Fishman, 1997). Residents were generally happy to talk while
waiting for their meals. Sometimes, they would also initiate conversation during the meal if they had an opinion about the food.

2. **Combine conversation and observation.** It provided opportunities for residents to give immediate verbal comments and spontaneous accounts of feelings that were closely connected to their immediate experiences. The benefit of this method is that the immediacy may enable the resident with dementia to express views that they would otherwise not be able to communicate (Nygard, 2006).

3. **Apply sensitivity.** Residents’ ability to communicate varied from time to time, depending on reasons such as what had happened before, as well as their physical and emotional state. Attention was carefully paid to verbal and non-verbal signs to check resident’s willingness to participate at each time.

4. **Personalize the approach.** In order to put the participant residents at ease, I spent time with them so as to get to know them and identify the best individualized way to approach each one. For example, I looked at how the resident liked to be approached. Did the person respond well to a sense of humor? Could the person answer open-ended questions? Also, talking to staff who knew the resident well was helpful in identifying effective approaches.

5. **Allow conversational topics to arise from real actual situations** (Nygard, 2006). For example, when supper was not served after 20 minutes of wait, I asked questions such as How do you feel about the fact that you have to wait so long for your meal? Emerging issues in their responses guided following questions, and residents were allowed to lead the focus to what concerned them most at that moment in the setting.
6. *Dealing with distress.* During situations when participants became emotionally distressed, I offered time and active listening for them to talk through their distress (Pratt, 2002). I also walked with some residents when they were upset. My nursing experience suggests that validation is an effective way to deal with distress. However, in a few situations when a resident wanted to be left alone, I respected her choice.

**Focus Groups with Staff**

To gain a broader perspective of the contextual factors that may affect the dining experience of residents, I conducted a focus group with four staff members (two care aides, one nurse, and a dietician) at each facility under study. A focus group is a productive way to generate rich and diverse views about the pertinent issues within the organization (Belle-Brown, 2000). Another benefit of a focus group is its ability to generate insightful views from the interactive exchanges among members and through comparison of one’s own thoughts in the conversation of a group (Krueger, 1994). Each focus group lasted one hour and was conducted in the conference room at each facility. As outlined in the chronology in Table 4.3, the focus group was conducted in the second phase of data collection, so it gave an opportunity to ask questions about any ideas that evolved from initial data collection and identify areas for further data collection in the subsequent phases. During the focus groups, participants described their opinions about the priority issues at mealtimes within the care setting, how those issues affected the dining experience of residents and their work, as well as how they provided individualized care for residents with dementia (see Focus Group Discussion Guide in Appendix C).
Additional Sources of Data

Accessible documentations such as resident medical charts, Minimum Data Set, dietician assessment, and policy and procedure manuals were examined to obtain more information about resident participants and to broaden understanding of the mealtimes. In addition, I took advantage of opportunities to gain data that was unanticipated (e.g., informal conversation with managers, volunteers, families, and friends). These data also served to enrich my understanding of the mealtime situations within each setting.

Data Analysis

The data analysis for this study utilized the method of thematic analysis, which is an ongoing and iterative process of data analysis with data collection. The emphasis was on revealing salient characteristics and patterns of the dining experience of participating residents with dementia, and the processes of how positive and negative experiences occur in the settings under study.

Procedures

First, I began by reading and rereading the contents of transcriptions of conversational interviews with participating residents and extensive field notes made of observation to identify salient patterns and significant concepts. Salient excerpts and observations were extracted, compared, and sorted. Then, decisions were made to organize these into the Meal Experience Data Record, a computer document containing a matrix of different aspects of dining experience (e.g., positive or negative aspects relating to social or physical environment). A print form of the Meal Experience Data Record is included in Appendix B.
Then, based on the common concepts or themes identified on the Meal Experience Data Record, I went back to the field to look for more evidence to test the strength of the potential themes. For example, as I found a few residents expressed frustration with the noise in the dining room, I organized my observation and the comments of residents relating to noise under the theme of “stimulation.” Then I made connection of the potential theme with one of the needs of persons with dementia that Kitwood (1997) outlined. In this case, stimulation was categorized under the need for “comfort.” As I continued with fieldwork, I asked the participants about their views on the noise and paid attention to other aspects that might contribute or undermine the need for comfort in residents with dementia at mealtimes. A preliminary set of themes and categories identified in the early stage served as a guide pointing to areas for subsequent data collection. The identified themes were continuously checked, confirmed, rejected, and refined throughout the process to make sure data supported the themes.

The last step of data analysis involved merging and integrating all sources of data to reveal interrelationships among multiple factors that were related to the dining experience of residents with dementia. For example, some inappropriate treatments by staff identified by observation were related to the data revealed in the focus group discussion. Staff elucidated how their caregiving approaches were limited by structural and environmental constraints. Data from informal conversations with managers also uncovered the connections between the characteristics of the physical environment and staff approaches. In addition, throughout the process of analysis, memos and journals were written to record ideas, personal thoughts, questions, and decision-making. Results
of the analysis are presented in Chapter Five. Further details on the development of final themes are presented in the next chapter under the section of categories and themes.

**Trustworthiness**

*Trustworthiness* is defined as that quality which compels the reader to find that the studies are credible and worth paying attention to (Lincoln & Guba, 1985). Following the tradition of Lincoln and Guba (1985), several measures were utilized to ensure the trustworthiness of this study.

*Credibility* is the confidence that the researcher gives readers that the study findings are true. To ensure this, I followed the four ways Lincoln and Guba (1985) suggested. First, prolonged engagement allowed me to build trust with participants and better learn the culture and context in the settings. In total, I spent 44 visits over 3 months between the two facilities. Further, I have been working in River Rock Manor for 12 years and volunteered at Gardenview Lodge for 9 months. These experiences all contribute to my understanding of the people involved and the contexts in the settings. Second, persistent observation (approximately 88 hours of observation between two sites) enabled me to have opportunities to explore details and depth and clarify doubts. Third, triangulation of source and methods helped balance out any inherent weakness or bias of a single method (Hammersley & Atkinson, 1995). Fourth, I debriefed with a peer, who was helpful by probing my bias and clarifying interpretation.

*Transferability* concerns the question: Will the findings be useful to others in similar situations? Transferability of this study is strengthened by thick description of the parameters of the study, including the environmental features of the settings, sampling
rationales, the theoretical framework, as well as the process of data collection and analysis. The thick description helps readers to make judgments on what and how much they may apply findings to conditions within their settings.

*Dependability* in qualitative inquiry refers to the idea that the researcher attempts to account for changing conditions in the phenomenon chosen for study (Marshall, 1999). For dependability, I kept an audit trail, including field notes, memos, and a reflexive journal so that another researcher can be aided to follow how and why decisions were made, logistics of the study, and how potential biases were accounted for.

*Confirmability* relates to whether or not characteristics of the data confirm the findings. The audit trail provided a transparent and systematic record of my work throughout the study so that how conclusions were grounded in the data and the accuracy of data could be verified. Table 4.4 presents a summary of the strategies used to address trustworthiness of the study.

Table 4.4: Strategies to ensure trustworthiness of the study

<table>
<thead>
<tr>
<th>Criteria of Trustworthiness</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Credibility</td>
<td>Prolonged engagement</td>
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<td></td>
<td>Persistent observation</td>
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<td></td>
<td>Triangulation</td>
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<td></td>
<td>Peer debriefing</td>
</tr>
<tr>
<td>2. Transferability</td>
<td>Thick description</td>
</tr>
<tr>
<td>3. Dependability</td>
<td>Audit trail</td>
</tr>
<tr>
<td>4. Confirmability</td>
<td>Audit trail</td>
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</tbody>
</table>
Ethical Consideration

In the area of dementia research, the limitations of cognitive impairment and memory loss raise ethical concerns on the consent process. Although obtaining informed consent is difficult for this population, a diagnosis of dementia does not imply incapacity of the person with dementia to take part in decision making to participation. For this study, the consent process involved obtaining assents by participating residents, along with proxy consents.

The process of gaining assents of the participating residents with dementia involved re-informing and re-checking consents throughout data collection. This was done by explaining the purpose of the study to participating residents in appropriate terms as each visit began. For example, I said to a resident, “Mr. Perry, I am a student from Simon Fraser University. I am learning about the dining experience in care facilities. I’d like to spend some time with you, ask a few questions. Would that be alright?” To ensure their rights to refuse or withdraw from participation, I used a sensitive and flexible approach to assess the response of participants. This means paying careful attention to verbal or nonverbal signals indicating signs of distress or unwillingness to remain involved in the study. For instance, on one occasion, when I noticed a participating resident was uncomfortable with the audio recording by saying less, rigid gesture, and staring at the recording device a few times, I switched off the recording. Even though she did not show signs of objection in the beginning of the interview when I explained the process, I felt that she had changed her mind as the conversational interview unfolded. After the recording was stopped, she was more relaxed and talked much more. In the end
of the interview, she said, “Thanks for listening to my complaints. I hope they are helpful for your project.” Her comments evidently reflect that she appreciated the opportunity to be involved in the study.

I informed families of participating residents about the study by providing them a written letter and a phone call to answer questions. Each of these families was required to sign a written consent letter because the majority of residents had moderate to severe dementia, suggesting a difficulty to determine capacity to give informed consent; the local facilities also emphasized that proxy consents was a necessary procedure for engaging their residents with dementia to participate in research. A sample of the consent letter for proxies of participating residents is included in Appendix D.

Regarding the focus group participants, all staff members who participated in the focus group gave written consents (Appendix E). For the general staff working in the setting, however, it was not possible to obtain informed consents from all of them before each observation. In order to inform them, I held an information session at the outset of the study, placed a poster in the staff room and gave out handouts to explain the purpose and procedures of the study. Also, a name tag that indicated my name and my role as a researcher was worn during field work. To protect confidentiality and anonymity, names of the staff observed during mealtimes were not recorded. I used pseudonyms for all involved residents, staff, and facilities in the written documents. The specific personal descriptions of participants were avoided. Additionally, I mixed some of the comments, observations, and stories to further protect anonymity. Prior to the commencement of the study, ethical approval was obtained from the Simon Fraser University Ethics Committee and the administrators of the facilities.
CHAPTER 5: FINDINGS AND DISCUSSION

This chapter presents the findings of the study guided by the question: What was the dining experience like for the 20 residents with dementia in the two care facilities under study? The chapter is divided into several sections. First, environmental characteristics of the settings are described. Second, the general profile of the participating residents and meal activities in a typical day are provided. In the third and the most important section, I discuss the categories and themes that represent the salient aspects of dining experiences of participating residents.

The Settings

Architecturally and organizationally, the two settings under research were very different. This section describes the key features of the two dining settings. The annotated floor plans with photographs that highlight the positive and negative attributes of the dining settings are shown in Figures 5.1 and 5.2 respectively.

River Rock Manor

Each unit of the dementia care home at River Rock Manor had its own dining room and a small serving kitchen. All meals were prepared in the central kitchen and brought over to the units by a kitchen staff. The care aides on the unit were responsible for serving and assisting residents to eat. The care staff and resident ratio was about 1:6. The nurse and resident ratio was about 1:20. The philosophy of the home encouraged flexibility to meet the individual residents’ needs. The mission statement states, “We
value diversity by respecting choices, rights, privacy, and independence to maintain
dignity and self-respect in residents.” The key physical features of the dining room are as follows:

Environmental Characteristics of the Dining Room

1. Social Interaction. In the dining room, there were large windows (see Figure 5.1) providing access to views of the outside. Many participating residents in the setting reported they liked sitting around these windows as they enjoyed watching and talking about what was happening outside. Their conversation topics often included the weather, seasons, trees, and birds. This is consistent with what literature suggested that window views stimulate curiosity of residents and offer opportunity to initiate social interaction (Brawley, 2006).

2. Continuity. Adjacent to the window, a wall cabinet displayed seasonal knick-knacks, residents’ personal items, and family pictures of residents (Picture 2, Figure 5.1). Ethel, a 96-year-old resident, proudly pointed out a picture showcased on the wall, “I am in that picture, you see!” During Christmas, her son, who lived in another province, sent her a small tree with antique decorations. Instead of keeping the tree in her room, she placed it in the dining room. Ethel expressed pride as visitors, staff, and other residents gave her compliments about the tree. She enjoyed telling people stories about the tree and her earlier life. This demonstrates what the literature suggested that display of personal items in the common area contributes to continuity of self and adds to the creation of familiarity of the setting (Cohen & Weisman, 1991). In addition, Ethel’s experience indicates that displaying personal items in the dining room supports a sense of belonging, promotes socialization, and contributes to sustaining personhood of the resident.
3. **Safety.** There was sufficient space in the dining room to allow residents freedom of movement that was particularly important to those in the wheelchairs. Edges of the table were rounded with a deep-coloured soft rubber, a design intended to minimize injury in residents. The oven on the wall was wired to a secured lock.

4. **Stimulation.** The dining room was bright, which is essential for older people with dementia. Previous research showed that lighting is positively associated with food intake in people with dementia (Brush et al., 2002). The vinyl flooring with a wood-grain look gave warmth to the space. A resident pointed out that the aquarium in the dining room on her unit added life to the environment. She said, “It’s the motion that brings life here! When there is nothing going on, I like watching the fishes swimming around.” On a few occasions, I observed residents and staff discussing behaviours of the fishes. As the literature noted, natural elements contribute to a sense of richness in the setting and enhance the experiential qualities of the setting (Cohen & Weisman, 1991).

5. **Personal Control.** The serving kitchen on the unit enabled staff to accommodate personal choice of residents. Residents were allowed to sleep in while the steam table kept breakfast warm. The short serving path between the dining room and the kitchen made it easy for staff to get things residents needed (e.g., extra sauce or second helpings). I have seen staff regularly used the kitchen to warm up food, make a cup of tea, or get snacks for residents. Families also used the kitchen to store food brought from home.

6. **Orientation.** Because the dining room was visible only from one hallway and there was no other signage, a few residents did complain that they had trouble finding it, although the distance between the dining room and resident rooms was short in the small unit. Fortunately, domestic features in the dining room, such as the cabinetry and
countertops, a washing sink, a cooking oven, and small groups of dining tables, were helpful in making the space a familiar place to eat (Picture 6, Figure 5.1). At times, the aroma of baking offered sensory cues about time for meals and helped to draw people in.

7. **Privacy.** Alternative spaces (e.g., area 7 & area 8 in Figure 5.1) offered options of privacy for residents who preferred to eat in private, away from the crowd. These areas provided a sense of separation with a lower degree of stimulation. Although there was no physical closure or seat assignment, implicit personal territories were clearly defined by residents on their own. Resident Perry, for example liked to eat on a single couch in front of the fireplace, where he seemed to claim as his territory.

8. **Homeliness.** People with dementia living in nursing homes often say they want to go home. Since “home” ties to meanings of feeling secure and being loved, it is important that the environment is designed to be familiar and comfortable (Brawley, 2006). Nearly all residents I talked with in River Rock Manor said they felt the place was nice and they appreciated it. When they were asked what they liked the most, the window and the colour of the curtains were items most mentioned. A family member said, “This is like a home, I like the couch, the fireplace, everything here is nice…”

9. **Functional Abilities.** The location of the public washroom was visible and was just next to the dining room. Though the proximity was supportive to the independent functional ability of residents, the majority of residents needed staff help to use the bathroom.

In summary, the environment of River Rock Manor was thoughtfully designed. The small and residential characters brought a familiar and home-like environment for meals, making dining activities pleasant and more manageable for residents and staff.
1. **SOCIAL INTERACTION** Window views provide common topics (e.g., weather) for social conversations.

2. **CONTINUITY** Cabinet displays seasonal knickknacks, residents' personal items.

3. **SAFETY** Sufficient space for residents and staff to move food trolley and wheelchairs around.

4. **STIMULATION** Small residential scale, bright lighting, attractive décor, and calm traffic flow create a pleasant atmosphere for dining.

5. **PERSONAL CONTROL** The serving kitchen allows residents eating at flexible times; steam table keeps food warm, fridge stores drinks, food or any food items families bring from home. Families use the microwave to warm up food. Half doors and windows enhance visual access to kitchen, providing obvious cues to food eating.

6. **ORIENTATION** Cooking oven, washing sink, colourful fabrics make the dining room a familiar place to eat.

7. **PRIVACY** Alternative seating for those residents who are not ready to eat, or those prefer eating in private.

8. **HOMEYNESS** Fireplace, shelves, artifacts display offer a sense of residential character.

9. **FUNCTIONAL ABILITIES** Proximity of the washroom helps residents to avoid and reduce anxiety, and promote independence.

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Figure 5.1: Annotated Floor plan of River Rock Manor
Gardenview Lodge

Gardenview Lodge was a mid-sized facility where residents with dementia were living and eating with residents who were cognitively intact. The facility presented typical features of traditional nursing homes, including long double-loaded corridors (identical rooms on both sides) and a large cafeteria type of dining room. The dining room was an L-shape; the bigger side was called the main room, and the smaller side was called the side room (Figure 5.2). About 70 residents ate at designated seats in the main room, and another 20-25 residents with eating difficulties ate in the side room. Due to the limited space and inadequate staffing, some residents who were physically dependent ate in their beds. Meals were cooked in the kitchen behind the dining room. Two kitchen aides delivered meals to residents, and care staff were responsible for feedings. Normally, there were seven to eight care aides working day and evening shifts. Sometimes, there was added staffing (e.g., a couple of temporary care aides for a few hours) when the management felt it was needed. According to the philosophy statement, their focus was on “providing holistic and individualized care.”

Environmental Characteristics in the Dining Room

1. Over-stimulation. Almost all of the resident participants felt that noise in the dining room was problematic. Margaret, a 95-year-old resident, stated, “I lose my appetite with the noise. They really should do something about it, whatever it takes.” Because the large space consisted of a large number of tables, heavy traffic of people, several food carts, two medication carts, and talking among people, the stimulation in the dining room was indeed overwhelmingly disturbing.
2. Orientation Problem. Providing a sense of orientation within the environment is important for people with dementia because feeling lost or being disoriented are frightening experiences (Regnier, 2002). However, way-finding was particularly problematic in this dining room because the space was large and filled with many identical tables. Though numbers and name cards were placed on the tables (Picture 2, Figure 5.2), many residents said they did not know where they should go and the place was confusing for them. Meg, a resident, said, “I think we have at least a thousand people here, I don’t know why there are so many old people sitting here?” When I helped another resident to her chair, she said, “I have never been here before, have I? This is a strange place.”

3. Lack Personalization. Owing to the L-shape design of the dining room, staff working in the side room were not able to see residents sitting in the main room. In my observation, I found almost all of the care staff would stay in the side room to feed, leaving no one to attend to the needs of residents in the main room. In addition, the large size and longer serving path created higher demand on legwork for staff, which naturally discouraged accommodation of individual needs in residents (see arrow in Figure 5.2).

4. Unsupportive to Functional Abilities. Lighting quality was another concern. Uneven illumination can distort perception of height and depth, causing stumbling or tripping in older people (Marsden, 2005). On several occasions, I observed that a strong light from an uncovered window shone on a few residents’ faces, which was not only uncomfortable, but also created extra challenges for residents to see their food. Pools of glare and areas of darkness on tables are shown in Picture 4, Figure 5.2.
5. **Institutional Ambience.** Furniture with metal frames and vinyl covers, windows with metal blinds, and linoleum flooring contributed to an institutional image of the dining environment. Such ambience added confusion and disorientation for many residents with dementia. Also, during my 3-month observation, I have seen them use styrofoam cups, disposable utensils, and plastic bibs on a few occasions. A resident shook her head and told me she felt that the use of disposables indicated “poor running of the place.”

6. **Lack of Private Space.** The setting lacked alternative seating options for those who needed a quiet space to eat. There was only one single-person table, which was located right besides the busy kitchen entrance (Picture 6, Figure 5.2). The tables and chairs in both of the main and side room were crowded, and there was not enough space for family members to sit comfortably with their loved ones. The only private space offered to families to eat with residents was the library/conference room. A family member commented, “That so-called library is not a good space for eating. It’s a library. And it is not nice when you have to share the small room with several other families.”

7. **Unsupportive Social Atmosphere.** The side room, the smaller side of the dining room where they seated the residents with higher needs, looked like a waiting room in the hospital. Blank walls and institutional furniture made the space feel lifeless, not supportive for social conversation (Picture7, Figure 5.2). The lack of personal touch in the side room simply reflects the belief of staff who said, “The demented people do not know the difference anyways.” Gerontologists and designers (e.g., Berg, 2006; Brawley, 2006) have emphasized the salience of having the dining environment designed to promote social interaction because a responsive design supports nurturing human relationship at mealtimes.


8. Safety Issue. A few residents in the study commented that they disliked the dining tables and chairs being grouped too closely together, as that made it difficult for them to get in and out. Staff reported that trying to feed residents over the large rainbow table, a semi-circular table (Picture 8, Figure 5.2), strained their neck and shoulder muscles.

9. Continuity Issue. There were two rainbow tables placed against the walls in the side room. Sometimes staff would put a resident inside the rainbow so the resident could not walk away. Other times, staff would stand inside the rainbow and feed all the five residents around the table in an assembly-line manner, putting one spoonful of food into a resident’s mouth, one spoonful to the next person, and so on. On one occasion, I observed a few staff laughed at a resident as she opened her mouth waiting for the food to come. Such type of seating arrangement not only encouraged assembly-line feeding, but it also tended to discourage social interaction, probably promoted dehumanizing care, and undermined the autonomy and dignity of residents. A line up of Geri-chairs along another wall likely led to the same kind of assembly-line feeding and dehumanizing experiences as well. Although residents did not express complaints about such seating arrangement, it potentially estranged residents from their past experiences, disconnected them from their familiar way of eating, and reinforced the stigma that they were “less human,” virtually like objects with no feelings or desires.

In summary, the dining environment at Gardenview Lodge had multiple serious problematic issues that directly and indirectly caused both distress in residents and stress in staff at mealtimes.
1. **OVERSTIMULATION** High volume of people in large scale of dining lead to overwhelming and confusing experience

2. **ORIENTATION PROBLEM** Even with table number and name card, seat finding was still problematic in the big open setting

3. **LACK PERSONALIZATION** Long serving path, large scale dining make personalized service difficult

4. **UNSUPPORTIVE TO FUNCTIONAL ABILITY** Pools of light/glare and areas of darkness inhibits residents' ability to see

5. **INSTITUTIONAL AMBIENCE** Cluttered trolleys, furniture with metal frames and vinyl covers, windows with metal blinds, linoleum flooring contribute to an institutional image of the dining environment

6. **LACK PRIVACY** Alternative seating is limited for those who need a quiet place to eat

7. **UNSUPPORTIVE SOCIAL ATMOSPHERE** Blank walls and institutional furniture do not promote social conversations

8. **SAFETY ISSUE** Tight space and lots of wheelchairs make the environment hazardous

9. **CONTINUITY ISSUE** Rainbow seating encourages assembly-line feeding, not supportive to personhood of individual residents

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**Figure 5.2:** Annotated Floor plan of Gardenview Lodge
A summary of the key characteristics of the physical environment of the dining space in the two care facilities is presented in Table 5.1.

<table>
<thead>
<tr>
<th></th>
<th>River Rock Manor</th>
<th>Gardenview Lodge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conducive to social interaction</strong></td>
<td>outdoor views through large windows stimulate conversation and social interaction.</td>
<td>Unsupportive to social atmosphere. Institutional furniture, blank wall, atmosphere not supportive for social conversation.</td>
</tr>
<tr>
<td><strong>Orientation cues</strong></td>
<td>domestic features such as a cooking oven, cabinets, a washing sink and a fire place add familiarity.</td>
<td>Orientation problem. large open space, with many identical tables, seat finding difficult despite the table number and name cards display.</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>sufficient space for residents and staff to move around; details of furniture (e.g., tables had rubber edges with colour contrast) prevent injury.</td>
<td>Unsafe. tight space, table and chairs were placed too close; difficult for residents to move around, particularly for those in the wheelchair or using a walker.</td>
</tr>
<tr>
<td><strong>Stimulation</strong></td>
<td>homelike finishing and furniture, low resident density, calm traffic flow, quieter environment.</td>
<td>Overstimulation. high volume of people and traffic flow, loud, fast-paced.</td>
</tr>
<tr>
<td><strong>Personal Control</strong></td>
<td>the serving kitchen on the unit supports flexible meal schedule and routines, and individual choice.</td>
<td>Lack personalization. long serving path creates high demand on legwork, difficult to accommodate personal choice.</td>
</tr>
<tr>
<td><strong>Continuity</strong></td>
<td>cabinets filled with seasonal decorations, display of personal belongings, pictures of residents and staff help residents to maintain ties to the past.</td>
<td>Continuity issue. rainbow seating, line up of geri-chairs along wall, assembly-line feeding are not normal eating atmosphere.</td>
</tr>
<tr>
<td><strong>Privacy</strong></td>
<td>residents have options to choose eating at area that is more private.</td>
<td>Privacy. limited alternative seating, only one single seat table, lack of space that offers privacy.</td>
</tr>
<tr>
<td><strong>Homeyness</strong></td>
<td>fireplace, bright colour curtains, artefacts display enhance domestic quality and make the space inviting and pleasing for dining experience of residents.</td>
<td>Institutional ambience. linoleum flooring, gloomy furniture, lack of familiar décor, limited windows allowing view to outside, monotonous environment impede quality of dining experience.</td>
</tr>
<tr>
<td><strong>Functional Abilities</strong></td>
<td>proximity of the bathroom helps to reduce anxiety and support independence.</td>
<td>Unsupportive to residents' abilities. insufficient and uneven lighting, glare hinder capabilities of residents, increase risks of falls.</td>
</tr>
</tbody>
</table>
Participating Residents

In total, 20 residents with dementia participated in the study, 10 from each facility. The age of the residents in both settings was similar. The average age of participants at River Rock Manor was 88, with a range from 78 to 96, and the average age at Gardenview Lodge was 89.1, with a range from 81 to 95. The majority were women in both settings. The ethnicity of the participants was predominantly Caucasian in both settings.

The local nurses assessed the level of dementia of participating residents as in the mild to severe stage. According to the Global Deterioration scale (Reisberg, Ferris, deLeon, & Crook, 1982), 5 participating residents had moderate dementia (score = 5), and 5 had moderately severe dementia (score = 6) at River Rock Manor. At Gardenview Lodge, 2 people had mild dementia (scored = 4), 4 had moderate dementia, and 4 people had moderately severe dementia (score = 6).

Meal Activities in a Typical Day

The meal activities differed widely in the two settings due to the differences in their organizational policies and physical environments. Table 5.2 is a summary of the daily mealtime activities in the participated facilities.

River Rock Manor

In the morning, when residents came out of their rooms, the sound of television or soft music in the dining room often drew residents into the dining room. I witnessed some staff members who initiated greeting residents, giving them a cup of coffee or a glass of juice to welcome them for breakfast. Simple greetings such as “Good morning, Anna,
would you like to join us for breakfast?" provided cues about the time of the day and what was going to happen. Breakfast was served from 7 AM through late morning, so residents could eat when they were ready. Since care aides were consistently assigned to care for the same group of residents, they appeared to be knowledgeable about details of the residents’ habits, preferences, and routines. This was evidenced by how staff served tea and coffee to residents because they knew who preferred more sugar and who did not want sugar at all.

Lunch was served at 12 PM, and supper was served at 5 PM. Individual residents might eat their lunch and supper at different times because meals could be saved in the kitchen on the unit. For example, Kelly liked to sleep in; she normally ate breakfast at 10 AM. After a late breakfast, she was not hungry for lunch at noon. Staff often kept her lunch in the kitchen, and she was happy to eat it at 2 PM.

Residents were prepared for meals by enjoying music over a drink of juice or a cup of tea while waiting for the food. Sometimes staff would bake before lunch to create an enticing aroma, which not only stimulated appetite of residents but also provided them with cues for mealtimes. In addition, nutritious food such as bread, fruit, sandwiches, and ice cream were available 24/7 in the kitchen on the unit, and the dining room was always open. After meals, some residents might go from the dining room to their rooms. Others stayed in the dining room, having another cup of tea or spending time with staff and other residents.
Gardenview Lodge

The meal schedule at Gardenview Lodge was more restricted with the dining room only open according to a fixed schedule: 8:30 AM for breakfast, 11:30 AM for lunch, and 4:30 PM for supper. This regimented schedule for meals did not accommodate the habits and preferences of individual residents. A resident commented, “You see, we’ve just finished breakfast now [close to 10 AM], but lunch is not far away, [11:30 AM]; how can you be hungry in such a short time? There isn’t enough time to digest what you have swallowed.”

Before each meal, the residents were brought to the corridors to wait for the dining room to open. The waiting in the corridor often exacerbated confusion and disorientation in residents with dementia. Because the corridors were not very wide and those residents in the Geri-chairs and wheelchairs needed more space, I witnessed confrontations occurring when residents were fighting for space to get in line.

Residents were normally given about an hour to have their meals, which included about 20 minutes of wait time. Everyone must leave when the dining room was closed. The tight time frame created pressure for staff to work fast and made it difficult for them to accommodate any individual needs of residents. Because the care aides rotated their shifts and resident assignments, they were not always caring for the same group of residents. As a nurse in the focus group candidly expressed, “Providing individualized care is ideal, but it is impossible for us to do with what we have.” Another staff echoed, “Well, it’s all about time...some people with dementia need to take longer time to eat, some of them may have swallowing problem or behavioral problems. We just don’t have the manpower to give the individual attention.”
Table 5.2: Meal Activities in a Typical Day

<table>
<thead>
<tr>
<th>Time</th>
<th>River Rock Manor</th>
<th>Gardenview Lodge</th>
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</thead>
<tbody>
<tr>
<td>7:00</td>
<td>Residents were assisted to wash and dress, preparing for breakfast</td>
<td>Residents were assisted to wash and dress, preparing for breakfast</td>
</tr>
<tr>
<td>7:30</td>
<td>Residents who were awake were seated for juice in the dining room. While waiting for breakfast, residents might listen to music; had social conversation with staff/other residents.</td>
<td></td>
</tr>
<tr>
<td>8:00</td>
<td>Open Breakfast till 11:00</td>
<td>Residents were waiting in the corridors for the dining room to open for breakfast</td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td>Breakfast</td>
</tr>
<tr>
<td>9:30</td>
<td></td>
<td>Residents must leave the dining room when the dining room was closed</td>
</tr>
<tr>
<td>11:15</td>
<td>Residents were seated for juice and soft music, preparing for lunch</td>
<td>Residents were waiting in the corridors for the dining room to open for lunch</td>
</tr>
<tr>
<td>11:30</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:00</td>
<td>Lunch</td>
<td>Residents must leave the dining room when the dining room was closed</td>
</tr>
<tr>
<td>12:30</td>
<td>After lunch, some residents might leave the dining room and go to their rooms. Other residents might sit in the dining room, taking their time for another cup of tea, or spending time with staff and other residents.</td>
<td>Residents were waiting in the corridors for the dining room to open for supper</td>
</tr>
<tr>
<td>4:00</td>
<td></td>
<td>Residents were waiting in the corridors for the dining room to open for supper</td>
</tr>
<tr>
<td>4:30</td>
<td>Residents were seated for juice and soft music, preparing for supper</td>
<td>Supper</td>
</tr>
<tr>
<td>5:00</td>
<td>Supper</td>
<td></td>
</tr>
<tr>
<td>5:30</td>
<td>After supper, some residents might leave the dining room to their rooms or go for a walk. Other residents might sit in the dining room, taking their time for another cup of tea, or spending time with staff and other residents.</td>
<td>Residents must leave the dining room when the dining room was closed.</td>
</tr>
</tbody>
</table>

Categories and Themes

An integrated deductive-inductive approach was used to guide data analysis. While Kitwood’s (1997) theoretical work (i.e., the concepts of the five psychosocial needs, the negative and positive types of interactions between the caregiver and the
person with dementia) provided a useful means of making sense of the data deductively, his theory was critically used in the course of inquiry. Because Kitwood’s (1997) theory has not been explored in the specific care context of mealtimes in long-term care facilities and because the social processes only explain a partial picture of the residents’ experiences, an inductive approach was necessary to let interpretations emerge and to explore the essential experience of residents with dementia in the context of mealtimes. Also, beyond the social environment, an important component of the study was to explore how specific features of the physical environment may play a role in affecting the subjective experience of persons with dementia at mealtimes.

Analysis of data revealed eight key themes: (1) outpacing/relaxed pace, (2) withholding/holding, (3) stimulation, (4) disrespect/respect, (5) invalidation/validation, (6) distancing/connecting, (7) disempowerment/empowerment, and (8) ignoring/inclusion. The eight themes were grouped into categories of five needs that Kitwood (1997) outlined: comfort, identity, attachment, occupation, and inclusion. It is important to tie the themes under the categories of needs because it helps to explain how needs of residents with dementia can be supported or undermined by a range of factors and processes that occur at mealtimes. Due to the multi-faceted nature of the experience, the boundaries of these themes are blurred and overlapped. For instance, the experience of being ignored might lead to feelings of disrespect and disempowerment at the same time.

**Sensitizing Concepts**

The names of the categories and themes were drawn from two main sources. First, the five categories of needs and majority of themes came from selective concepts relating to the theory of personhood (Kitwood, 1997). Second, other themes (e.g., distancing/
connecting, stimulation) emerged directly from the data as unanticipated themes were openly pursued throughout data analysis. Strauss and Corbin (1998) warned that, although using established concepts might facilitate understanding the experience of participants, it might run a risk of preventing readers from seeing what is new. In this study, I used three safeguards to make sure that the selected themes represent the experience of the participants under study and that the implicit salient concepts are captured. First, rather than using the whole list of terms that were outlined in the Dementia Care Mapping (Kitwood & Bredin, 1992; Kitwood, 1997), I critically selected the concepts that are most evident in the specific context of this study. For example, “outpacing” (meaning the staff was talking or acting too fast for a resident to understand what was happening) was selected because it was repeatedly observed as a common pattern in the dining experience of the participants. Second, striving to remain open to learning from the participants, I repeatedly asked myself “What were the participating residents trying to tell me about their dining experiences?” and “What was the experience like for them?” Third, I carefully explored the linkage between attributes of the physical and social environment in order to gain a fuller insight into the experience of the participating residents at mealtimes.

In the next section, I discuss each of the categories and constituent themes, using illustrations from the observations and interview data. Figure 5.3 shows the 8 themes I identified in this study and their connections to the five categories of psychosocial needs that Kitwood delineated.
Figure 5.3: Themes related to dining experience of residents with dementia in care facilities.
Comfort

Comfort carries meanings of tenderness and closeness. To comfort a person is to provide a sense of security and interpersonal warmth. The need for comfort is especially great in dementia when a person is dealing with a sense of loss (Kitwood, 1997). In the two facilities under study, I found a few staff were more task-oriented; outpacing and withholding were marked in their caregiving approaches. On the other hand, a relaxed pace and expression of holding were notable qualities of other staff who were insightful. The insightful staff seemed to have a remarkable ability to understand the needs of residents and were able to provide comfort effectively. In addition, over-stimulation in the environment was a major source that undermined comfort of residents. In contrast, quality stimulation in the environment was comforting and keenly appreciated by residents. The themes that affected the need of comfort in participating residents at mealtimes were “Outpacing/Relaxed Pace,” “Withholding/Holding,” and “Stimulation.”

Theme 1: Outpacing/Relaxed Pace

Outpacing is providing information or acting at a rate too fast for the persons with dementia to understand (Kitwood, 1997). Many residents I talked with in both settings complained that they found it overwhelmingly confusing and felt lost when the staff did things too fast for them to follow. The fast-paced process seriously limited interaction between staff and residents, resulting in almost no time to attend to individual needs. An 84-year-old resident, Josephine at Gardenview Lodge, spoke of being unable to comprehend what was going on in the dining room when she saw staff rush back and forth in front of her. Josephine sat in a Geri-chair among the others along the wall. She
whispered to me, “This is so crazy here, I don’t think they [staff] know what they are
doing, I am just sitting here, I don’t know why.” Another resident, Meg, told me she was
annoyed when a staff brought her to the dining room in a hurry. “The girl just left me
here, and she ran away. I didn’t have a chance to ask her what I am waiting for. Now I
am sitting here like nuts, what for?” Their comments consistently reflect what the
literature described: task-orientation and rushed pace are major impediments to dining
experiences of residents in care units (Gibbs-Ward & Keller, 2005; Kayser-Jones, 1997;
Sydner & Fjellstrom, 2005). In Gardenview Lodge, mealtimes routinely seemed to be just
another task among others that staff wished to complete as quickly as possible. I heard
residents being told to eat up their food; meals were served rapidly, often without them
being told what food they were given to eat. The following conversation illustrates the
experience of outpacing between a staff and a resident, Sophie:

A kitchen staff was picking up dishes from tables.
She asked Sophie: Are you finished?
Staff: No, you are not. [Walked away to the next table]
here, talk to me, talk to me.
Researcher (LH): What’s happening Sophie?
Sophie: I don’t know, that girl, all of the sudden, just pop up, then she’s
gone. I don’t know what she wanna from me. I sure don’t like that. I wish
they wouldn’t wouldn’t wouldn’t do that [Put her head down, shut her
eyes for a moment]...I don’t know what to do? Um, what am I going to
do? Please help me, please. [Starting to cry and call out]
LH: Are you eating your lunch, Sophie?
Sophie: I don’t think about that in this moment. I wish they would tell me
what what to do...Please help me. [Continue to call out anxiously]
Another staff passed by but did not look at Sophie or say anything to her.
Sophie: Oh God, I hate that woman, she thinks she’s so smarty pants. Yap,
she had her nose, nose [Pointing to her own nose] [I looked at her, waiting
for her to say more, and then we both burst out laughing. I think she forgot what she wanted to say as she was distracted by my inquiring look.

LH: Sophie, what’s bothering you?
Sophie: Well, people go here, here, there, don’t care, I think I better go home.
LH: Um, people don’t care?
Sophie: Well, she here and gone, like the other one, ignore you, that’s right, thinking you are not worth.

The above case is a form of outpacing. The two staff in the above example operated in a rushed mode; they were completely absorbed by the task of collecting dishes and clearing the table. Sophie’s accounts suggest she was particularly distressed at being unacknowledged, rushed, and ignored by the staff. She felt frustrated about the staff not taking the time to help her understand what was happening. Due to dementia, Sophie needed time to produce her language, and that became impossible to accomplish when she was rushed. The staff did not have the time and patience to wait for Sophie’s response. To Sophie, the outpacing experience was confusing and frightening as well. Not knowing what to do, she reacted with behaviors of crying and calling out. Her quotes of “people don’t care” and “thinking you are not worth” indicate feelings of not being valued. This is consistent with the study that reported that nursing home residents say they feel being let down, being treated like nothing, and not respected when the nurses do not stop and listen to their concerns (Jonas-Simpson et al., 2006). According to Kitwood (1997), these feelings are psychologically hurtful and have potential to exacerbate the decline of dementia in the affected persons. He explained that people with dementia do not have strong inner stabilizers like healthy people to offset hurtful feelings, and, thereby, the social environment that surrounds the person is extremely important.
As Gibbs-Ward and Keller (2005) described, the mealtime process within long-term care facilities is complex and involves multiple factors, including the external influences such as the organizational structure and the physical environment. In the focus group discussion, a care staff in the focus group at Gardenview Lodge explained why they had to rush:

We have to rush because we have so many residents in the dining room and they all want their food at the same time... We know it can be so chaotic in that dining room, and our environment isn't ideal for people with dementia. It is too many people, too big, too noisy; some of them would wander away from the table or get agitated, we are running back and forth, trying to do the best we can...Some people need to take the time to eat, but time is an issue. We would love to have the time to do one-to-one and sit down to talk to them, but there is no time...

This excerpt provides useful insight into how factors of low staffing ratios and the restrictive physical environment were intertwined and caused the staff to rush residents in the traditional nursing home. In such situations, staff can easily be blamed for being unkind if their conditions are not considered. In Gardenview Lodge, for about a hundred residents in the dining room, there were only two kitchen aides to deliver food and clean up all the tables, while eight care aides were trying to bring residents to the dining room, keep them in, and ensure that everyone eat. Even though staff knew that residents with dementia need a slower pace and a more attentive approach, they still had to rush because of their demanding workload and lack of time for providing quality care. This finding is similar to a recent study, in which care aides reported that inadequate staffing levels put them at risk for physical assault because they had to rush residents through all aspects of care, including feeding (Morgan, Crossley, Stewart, D’Arcy, Forbes, Normand, & Camme, 2008).
Regarding the environment, residents with dementia in the dining room of Gardenview Lodge were confronted with intruding elements including excessive noise, large number of people, and many distractions. As Briller and colleagues (2001) wrote, the hurried, confusing, loud atmosphere in a large institutional dining room environment can be overwhelming for people with dementia, making them unable to function to their best ability and causing inappropriate behaviours. Hence, higher dependency and inappropriate behaviour of residents caused by the restrictive environment would add more stress and workload to the staff, creating a vicious cycle, making it even more difficult for staff to slow down the pace. This suggests any effort to eliminate the outpacing approach without taking account of staffing level and the physical environment would be in vain.

Relaxed Pace is about taking time to greet residents, not rushing the feeding, and attending to residents’ needs in a sensitive manner. In the small units of River Rock Manor, I found a few care workers were able to make good use of small opportunities, talking and providing emotional comfort to residents during mealtimes. The following field notes record an example of how an insightful staff enhanced the pleasure of dining in residents.

The nurse, Julie, demonstrated kindness, calmness, as well as respect in her caregiving approach. She showed warm and comforting ways to greet residents when they entered the dining room. Julie walked close to the resident and gave genuine eye contact. Then she opened her arms to offer a big hug and moved her head close to the resident to give an affectionate forehead touch. She addressed the residents each by name and brought them to the chair, served them a drink or something to start their breakfast. She was not preoccupied with the job of giving out medications, did not act hurried, but sincerely warmed up each resident with greetings. Her focus was clearly on the residents. Because of the authentic care that Julie provided, the residents were happy and able to enjoy the pleasure of eating a relaxed breakfast.
Here, we can see nurse Julie had her priority to work at the same pace as her residents. She patiently slowed down and provided each resident with a comforting greeting. Rather than being absorbed away in the busyness of dispensing medications, she delivered care at a calm pace and was able to create a relaxed atmosphere for the residents to enjoy the pleasure of dining. She demonstrated how to provide comfort through affective touch, kind greetings, and genuine gestures. In the focus group, Julie shared her thoughts on the importance of tending to the emotional needs of residents promptly. She emphasized the problem of how leaving one person’s emotional distress escalating could easily disrupt the atmosphere of the whole dining environment, making everyone in the space uncomfortable. Additionally, in a conversation with me, the unit manager of River Rock Manor described how the design of the physical environment contributed positively to the attitude and morale of staff. “I think the small environment helped our staff to work in a not-so-fixed, narrow manner. With fewer residents on the unit, the staff get to know the residents so well; I see they are able to do a lot more for the residents.” Her comment lends support to the literature that claimed that a small unit allows staff to have more time and flexibility to provide care that comforts residents (Briller et al., 2001).

**Theme 2: Withholding/ Holding**

*Withholding* is disregard or lack of awareness of a resident’s evident need (Brooker, 2007). In part, the physical layout of the dining room at Gardenview Lodge was responsible for the withholding experience in residents. As mentioned previously, the L shape of the dining room design and the large size (Figure 5.2) made it impossible
for those staff working in the side room to monitor residents who were sitting in the main room. The problem was aggravated by the insufficient staffing level that forced all the staff to stay in the side room to feed residents with higher needs, leaving other residents sitting in the main dining room receiving no help. The following dialogue gives a glimpse to the everyday experience of residents sitting in the main room.

Kitchen staff brought a few pieces of toast buttered, but no jam
Mavis: Is there any jam?
Yvonne: I only have some yellow [butter] on. We used to have those individual packages, but many people can’t open it, and the girls don’t have time to open it for us. Now, we don’t have them anymore, don’t ask me why!
LH: Are you going to ask the staff to get some jam?
Mavis: No, it’s okay. I don’t want to be a trouble.
Yvonne: They are busy. I don’t want to call them all the time for small things like this.

On the table there was a bowl of individual packaged pureed prune. Mavis spread that on her toast.
Mavis: Oh, this is not good, so sour.
Yvonne: I tasted it, it’s not good. I think that stuff makes you go the bathroom, you know what I mean.

The above example shows that the apparent need of jam for toast went unnoticed. The two residents did not ask for help because they did not want to be perceived as needy. Another time at supper, a resident, Martha, had to improvise when she was not given a knife to cut her meat. When I suggested to her that she should ask the staff for a knife, she responded, “No, never mind, I use my fork to cut. It’s okay.” However, since she couldn’t cut the turkey with a fork, she only ate the loose pieces and left a chunk of turkey on the plate. When residents were asked why they did not ask for help, their typical responses were that they did not want to be a bother or that the nurses were busy.
A few residents mentioned that they should not expect much because they were old. This mirrors to what other studies reported that older patients tend to avoid expressing their needs (Pearson et al., 2003; Sidenvall, 1999; Sidenvall et al., 1994). These and other findings suggest the importance of asking the residents about their needs and offering a comfortable and supportive atmosphere for them to request help. It is also worthwhile to point out that many residents with dementia I talked with were very aware of and concerned about the work conditions of the staff. They empathized with staff effort and tried their best to do things on their own in order to avoid adding burden on the staff.

To the elderly residents with cognitive frailty, sometimes asking for help is not an easy task, and it can be frustrating if the environment is not supportive. In the following case, a resident requested assistance to use the bathroom, but the staff refused to meet the need. The exchange also exemplifies the lack of autonomy facing the residents.

Resident Martha: I know I shouldn’t but I really need to go to the bathroom now. [Martha appeared to be anxious and worried; she raised her arm and tried to get attention of staff.]

LH: Let me see if I could get a staff to help you.

Martha: Good luck. The girls tend to walk the other way when you call them. Their heads were either too far up or too far down; they never see you when you need them. I am not kidding, it’s true.

A staff walked by after a little while.

Martha: I need to use the bathroom.

Staff: No, you don’t. You just went not long ago [The staff told me Martha was obsessed with her bladder, and she was toileted not long ago.]

Martha: I did not; you are making me mad [becoming angry].

Staff: Martha, it’s time to eat, you eat!

The staff ran away to the side room to help feeding. Martha did not eat her meal and wheeled herself out of the dining room. After supper, I found her crying in the hallway, asking if anyone could take her home.
In the above case, Martha experienced the complete refusal of her request for assistance to use the bathroom. Clearly, the caregiver was in a dominant role and had the power to control when the resident used the bathroom. The experience of withholding left Martha in emotional distress, feeling angry, confused, and helpless. Such a problem can be viewed as a form of invalidation as well; Martha’s point of view was being essentially discounted, rendering her a sense of social alienation. During my observation, I have seen that some staff in both settings would not take the request of residents with dementia seriously. Sometimes residents would be left alone in emotional distress for a prolonged period, and staff seemed not bothered by that. This is similar to the findings of the study by Sormunen and colleagues (2007) that looked at care practices in residential care in Finland by using Dementia Care Mapping. They reported withholding, invalidation and objectification were categories coded the most frequently among the 17 detractors, and these problems occurred mostly at mealtimes or when there was a request for help. Apart from the attitude of the staff, the physical environment could also possibly contribute to the problem of toileting, as there was no public bathroom available near the setting. Residents had to be taken to their own rooms to use the toilet, and Martha’s room was far away from the dining room. The inconvenient distance between the bathroom and dining room might explain why the staff was reluctant to do toileting during mealtimes.

Interestingly, the following case shows that the toileting issue was also problematic at River Rock Manor despite the fact that there was a washroom right next to the dining room.

Resident Tracy: I got to go to the potty. I am wet. I’m wetting. I got to go quickly. Please. I got to go fast. Please let me go. Please let me go. I got to go to the backhouse. I got to go to the toilet... [Calling out after lunch]
Staff Reese: Tracy, just let it go.

Tracy: Umm, that will make a mess? [Frowning]

Reese: No, you have a pad on!

Tracy: Oh, I do? I didn’t know I have a pad on. Thank you.

A couple minutes later.

Tracy: Please let me go to the toilet. I need to go to the toilet. [Calling out loudly]

Reese: Alright Tracy, I am waiting for my friend [Another staff] to come back, and then I will put you on the toilet.

Tracy: I don’t understand. Go to sleep? [Tracy’s hearing was quite impaired.]

On the surface, it might look like the staff was cruel as she refused to meet the evident request of the resident. By exploring the story deeper, the issue was found much more complex. The following explanation tells how staffing, organizational structure, and the complex needs of the resident might constrain how the staff provide care.

Staff Reese explained: I have no choice, my partner has to go for her lunch at 1230-1300, and I could not do Tracy on my own. [There were only two care staff on the unit.] Tracy can be aggressive because she forgets she can’t stand on her own, putting her on the mechanical lift by myself is not safe.

We can see that on this small unit with two care aides, when one staff left the unit to have her lunch break, the other one left on the unit was unable to assist residents who required two persons for care. At its worst, there were other times when both of the staff had to take a resident to the bathroom, and the rest of the residents were left with no staff in the dining room. This speaks to the importance to provide adequate staffing, a necessary condition to enable the staff to provide safe care.

*Holding* is providing safety, security, and comfort to a resident. Kitwood (1997) explained that people with dementia are in greater need of holding because they are
frequently experiencing frightening emotion due to memory loss and failing mental power in their everyday life. A good example of holding is in situations when staff and residents have interactions that are nourishing to the personhood of residents, when the staff is behaving and speaking in a manner that shows warmth and kindness. Holding is a concept closely connected to a relaxed pace, because holding can only occur when the staff are able to slow down and take the time to attend to residents’ physical and emotional needs. The following encounter between staff Ginny and resident Martha demonstrates holding.

Staff Ginny: Martha, how are you tonight? Why are you not out for a date, a pretty woman like you? Can I help you to cut up the beef? The dinner looks so good tonight. It’s roast beef.

Martha: Thank you. You are so nice. I didn’t know this is roast beef. It’s wonderful. I like roast beef. I was just having trouble to split it [Due to dementia, Martha forgot how to use the knife and fork to cut the meat.]

Ginny: No problem, the beef is quite tender, and the gravy looks so good, do you like Yorkshire pudding? [Ginny cut the food for Martha while she was talking to her.]

Martha: Yes, I do. I will eat it. Thank you, darling.

Martha was able to eat all of her food for this meal.

In the above case, staff Ginny was able to make the dining filled with pleasure for Martha to enjoy. Her courtesy and physical help clearly had positive meanings for Martha. Holding was also evident in the following case when staff Tillie attended to the emotional need of a resident, Margaret. Having no money to pay the meal, Margaret was feeling embarrassed, anxious and worried.

Margaret: Oh Gosh, I don’t have any money with me, but I ate all the food that was ordered. I don’t know how much it’s gonna cost? Did I order all that food? Am I ever in trouble?

Staff Tillie: Margaret, don’t worry. The office has your money account. You don’t need to pay cash; they charge it to your account, and you have plenty in
your account, not to worry. [Tillie put her hand on Margaret’s shoulder and offered her a reassuring smile.]

Margaret: Really, I didn’t know that. Are you sure?
Tillie: Yes, your son Ken makes all the arrangements for you.
Margaret: My son Ken. He’s so good to me. [Smiling from her heart.]

Both of the above episodes illustrate how a short moment of attentive care by staff made a big difference in the dining experience of the residents. Staff Ginny demonstrated genuine affection and a caring attitude to the resident Martha. Her warmth helped Martha feel comfortable and at ease, and her sense of humour brightened the dining experience for Martha. Similarly, staff Tillie took resident Margaret’s worry of payment seriously and provided reassurance to reduce her anxiety in a promptly manner. The empathy and respectful attitude of the two staff provided comfort and supported personhood of the residents. Treating the resident with sincere respect and courtesy clearly sent an effective message to the residents that they were seen as valued and important.

**Theme 3: Stimulation**

**Stimulation** in the physical environment emerged as an important theme in the dining experience of residents across interview, observation, and focus group data. The capability of residents to enjoy a meal can be positively enhanced or unnecessarily inhibited by the settings. For example, good lighting and colour contrast help residents to see the food; a quiet environment makes it easier to hear conversation and enticing smells offer pleasant cues about eating (Briller et al., 2001). Careful attention to the quality of stimulation is essential to minimize confusion and allows residents to function more independently at their best levels of abilities (Zgola & Bordillon, 2001). As described
previously, Gardenview Lodge had poor acoustic control in the large, open dining room; many residents complained about the noise. Several described how the noise caused irritation and affected their appetite. The mixing of residents with different levels of cognitive impairment certainly did not help the situation. The following example illustrates the anger and frustration two residents expressed towards those making the noise.

Margaret: It’s so noisy everywhere. I wish those two will just shut up. [Two residents were calling out in the side room. One called, “Where are you, Dolly?” The other one screamed at a high pitched “Ah, d dad, a dad a da…”]

Roberta: I can’t stand that woman. [Sophie was calling out, “Please, I can’t breath, please help me…”] She’s a nut. I think all she wanted was attention; she’s sick in her mind. They need to do something about her. I don’t care if they feed her outside. This crazy woman is driving us insane!

Owing to the noise in the background, residents were not always able to hear tablemates in conversation. The noise not only made residents feel overwhelmed, it affected their mood and energy as they had to struggle so hard to function in the environment. Resident Mavis described her experience:

I don’t always hear, but I laughed anyway. I don’t want people to feel I don’t like their jokes. I um, I uh, oh well. I’m tired. I’m just tired. I guess the noise is tiring me out tonight.

Glare was another major concern at Gardenview Lodge. In the late afternoon, sometimes the sun was hot and shone directly at the faces of those residents sitting by the window in the side room. When staff forgot to roll down the blinds (it happened a few times during my three months of visits), residents had to use their arms to block the sun. Resident Josephine states, “I don’t like it when it (the sun) comes to my eyes.” She
shut her eyes tightly and seemed annoyed and frustrated. However, since she was in a Geri-chair, she was at the mercy of staff to move her to another spot. Another problematic environmental stimulation was the inadequate and uneven lighting, which was not only uncomfortable for residents; it impeded the ability of residents to see. Brawley (2006) explained that people with dementia face particular visual deficits, such as depth perception and color contrast, and these deficits exacerbate aging effects in vision and increase sensitivity to glare.

At River Rock Manor, the stimulation from noise was less because the environment was small and there were fewer people. Several residents described how they valued and appreciated the quality features of the dining room. When they were asked what they liked about the dining room, nearly all the residents mentioned the windows. Apart from their interest in the weather and nature, many of them enjoyed watching the happenings in the parking lot outside — where the action is. Many visitors including volunteers and family members came in and out the parking lot around mealtimes. Residents sitting by the window frequently commented on what they saw. The outside activities provided common topics for mealtime conversation, facilitated social interaction, and decreased the boredom of waiting. Above all, the window views generally seemed to provide residents with a way to connect to the outside world and offered a sense of normalization. Resident Lucy explained this clearly in the conversational interview:

LH: Lucy, how do you like this place? What are the good things?
Lucy: The windows, we can be with the trees and fresh air. Look at all those big trees. I just love them. Even though I don’t go out much these days, I still like to be with the nature. Um, I think the nature keeps us healthy...Do you like flowers? I love watching the flowers grow in the
garden. I don’t remember the names of the flowers. But when I see them bloom, I am so happy… [Chuckles]

At River Rock Manor, staff made considerable efforts to maintain a peaceful dining atmosphere. On one occasion, a resident, Perry, was moving furniture, causing annoying noise in the dining room. Perry used to work in the lumber trading business. He had a tough life with alcohol and family problems. His manners and language had always been rough. That day, he was adamant about how the furniture should be placed. “That piece of low grade lumber should not be here,” Perry said that when he was dragging a chair. Another resident, Kelly became angry, “You bastard, stop it, I am sick of hearing you, you fat old pants, someone please give him a gun, tell him to shoot himself quick.” Perry was a tall man with a loud voice, but with his aging legs and medications, he had to struggle to drag that chair. Huffing and puffing, he shouted, “No, I can’t fucking stop, I can’t can’t, you don’t understand.” The verbal altercations between the two were like arguments between angry couples. A care aide, Kim, handled the situation skillfully. She calmly smiled at Perry and asked him to go with her. When she offered her hand quietly, Perry held it and left the dining room with her. The way Kim handled the situation protected the social integrity of the resident. By saying less and using a respectful attitude, Perry accepted the help and thereby avoided further insults by other fellow residents.

In addition, a positive quality of stimulation was a desired element in dining experience of residents. For example, staff Kim regularly baked a batch of cinnamon buns at lunch time. Residents enjoyed the taste of the bread, as well as the enticing aroma of brown sugar and cinnamon. Perry expected the cinnamon bun baking when Kim was
on duty. “Are you baking today?” he would ask. Kelly had dysphagia, a condition which affected her swallowing. Despite that she managed to enjoy a piece of fresh bun each time it was baked. Families and other visitors commented that the aroma of baking added a welcoming feel to the unit, and they often enjoyed sampling the sweet treat as well.

**Identity**

Identity involves a sense of being respected. According to Kitwood (1997), identity relates to knowing who you are and how others hold you in esteem. It is about being respected as valued individuals, not just as another patient sitting in the dining room. Because people with dementia not only confront cognitive losses but also risk being viewed as if they were less than fully human, it is particularly essential for them to maintain a sense of identity and self-worth. As Post (2006) stressed, the prime task of dementia care is to support the self-identity of the person and to use empathy to understand their experiences. Respecting the lifelong habit and preferences of residents, offering choices of where to sit, what to eat, or how much to eat are some of the ways to support the identity of the resident in the dining room. In contrast, identity can be undermined by disrespecting the person as a human with desires, feelings, and preferences. The theme influenced the sense of identity in participating residents at mealtimes was “Disrespect/ Respect.”

**Theme 4: Disrespect/ Respect**

*Disrespect* is treating residents as if they were small children or objects with no feelings. Kitwood (1997) used the term “infantilization” to describe treating the elderly
residents as children, and the term “objectification” to refer to treating the persons with dementia as if they were a lump of dead matter. Because both types of interactions undermine the dignity and diminish identity and personhood of the individual, I integrated them into the theme of disrespect. Throughout the study, disrespect is a common theme. Infantilization was manifested in staff talking in a condescending manner to residents. For example, I observed a staff refer to a resident as “a good boy.” She rewarded the resident for finishing eating so fast by giving him an extra piece of cake. Sometimes staff would habitually pat residents’ hair or grab their chins in a way like what some parents would do to their toddlers. A staff stated, “To me, they are like children or babies. I feed them, clean them, and put them to sleep.” Staff were teaching manners by using commands given to residents at times, such as “Say thank you, say hello” or “Sweetie, you shouldn’t use those bad words. You know better than that.” Although the staff did not intend to degrade the residents, treating them like children inevitably denied respect of the identity of the older residents. During a conversational interview, a resident, Irena, shared her thoughts on this:

In the background, a staff told a resident to finish her plate or she would not be given a cookie

Irena: Sometimes the girls [staff] treat the people here like a child [Turning her head].

LH: How do you feel about it?

Irena: I think it is unnecessary. I’d not like to be treated like that; it makes you feel stupid when you are told you can’t have a cookie if you don’t eat your meal. But then, uh, those people may not know.

LH: What if they do know but are unable to say they didn’t like it?

Irena: Ya, it is the best to think they know. Some older people have a lot of knowledge. Like my father, he is very smart. He was a great teacher. He would protest if people treat him like that even though he did need help. There is no reason to treat older people like a child. It makes the person
feel useless, dependent. Um, I think that is a disgrace, and I don’t want to be not respected. You know what I mean?

Irena’s comment is similar to those in the literature that maintained that the survival of personhood can be undermined by other’s patronizing attitude and stigmatizing behaviours towards the persons with dementia (Bond & Corner, 2001; Crisp, 1995; Kitwood, 1997). Irena described how infantilization makes people feel stupid, useless, dependent, and not respected. To her, that was a disgrace as the patronizing attitude meant a sense of dishonour, shame, and humiliation. At first, she felt perhaps it might not be a problem if it was done with people in late stage dementia who might not know the difference. After reflecting on the experience of her father, she spoke clearly about the importance to treat all older people with respect and dignity regardless of their mental power or age. As Kitwood (1997) warned, infantilization not only undermines the identity of the individual person, at its worst, it affirms the stigma of the wider community and society that people with dementia are less than fully human.

Beyond what and how much to eat, food in long-term care facilities carries multiple layers of meanings. For example, it is connected to meanings of nurturance, autonomy, and human relationship. In the following case, Martha told us how she seized food to displace her anger about the loss of her home, independence, and autonomy.

Martha: I eat this because I have no choice.
Tablemate: We just eat this because we don’t have anything else in the house, and we have no money.
LH: How is your soup?
Martha: I ate it. I didn’t know what it is. Ah, some kind of junk, I paid for the food, you know. I think it’s cheaper for them to cook lots of one for all everyone. [Drinking her soup] What can you do? I have no choice. I don’t have a car to go somewhere else. I have no money. I am stuck in here. My choice is eat it or starve.
LH: Martha, tell me more about the choice.
Martha: There is no choice. When I was at home, I can make what I like, the way I like it. Of course there is no place like home. Uh, now, I don’t even remember where my home was. It was in the Interior, somewhere. What name of it? Hmm, it doesn’t matter. It’s gone. I lost it. I don’t know what happened to it. I am disappointed with the government, and I will never forgive them putting me here. I haven’t seen my family for a long time. No one would come over to say hi and offer a bit of, a bit of care. The girls just dropped this junk and rushed off. I am eating it because I have no choice.

For Martha, the meals served in the institution had a disheartening quality. The fact that everyone was served the same food in a depersonalized way reflected the loss of identity of residents living in the setting. Martha talked at length about the loss of her home, car, money, family, and human care. Her narrative indicated she was unhappy not simply because of the food she was being served that night, but because of how she felt about the way she had been treated by the people and the society. Further, the impersonal service at mealtimes sent a message that the residents were homogeneous; they all could be treated the same. Such a message perpetuated a form of objectification, in which residents were seen as objects without individual needs, desires, values, and preferences. Martha’s comment is revealing as it indicates the salience of supporting the identity of older people with dementia by respecting their individuality and offering care in a personalized manner. She asks us to understand the necessities of having the human care element in the everyday care practice.

*Respect* is treating residents as valued, recognizing and accommodating personal preference and individuality. As Regnier (2002) stated, a good facility should celebrate the diversity of residents rather than adopting a one-size-fits-all attitude. Like other nursing homes, both settings studied offered residents limited choice on food. The dietician in the focus group at Gardenview Lodge said, “We don’t really have the budget
and manpower in long-term care to accommodate individual choice. Unless the particular person was allergic to the food or had a religious reason, we could not let a resident have chicken because he or she dislikes seafood but wants the chicken.” Despite the structural limitations, I observed that some staff were very good at offering small choices:

Staff Kim: Are you finished with the plate?
Resident Perry: Yeah, you can take it.
Kim: Would you like a cinnamon bun or a dish of ice-cream for dessert?
Perry: Wow, I like them both [chuckles].
Kim: Well, take them both, but don’t tell anyone else [joking].
Both started to laugh in a warm way.

On another occasion:

Nurse Jamie: Anna, good morning, how are you this morning?
Resident Anna: Fine, I think.
Jamie: Would you like a bit of salt in your porridge this morning?
Anna: Yes, thank you. You know how I like it? [Smiling in contentment]

The two residents in the above examples appreciated being asked for permission or opinion and having the small details of their preferences accommodated. These small things are critical to satisfy residents at mealtimes. By doing so, the staff help the residents feel important, valued, and respected. In the above cases, the residents clearly felt that the actions of staff respected their preferences and choices; that positive experience had great potential to enrich the relationships between the staff and the residents. During the focus group, a staff at River Rock Manor reflected:

For this group of people, it is important to know what they want, not what we think they should have. We learn their likes and dislikes mostly by working closely with them everyday. For example, when they are closing their mouth, making a face, or spitting out their food, they are saying they
don’t want that food. Then we try something else. Everyone is different, and we need to respect the desires of residents.

This excerpt tells the importance of staff using their empathetic skills to actively learn the needs of residents with dementia. This is particularly essential for those residents who may not be able to tell staff directly what they want.

In my observation, the physical environment also directly and indirectly played an important role in influencing the identity of residents. At River Rock Manor, it was evident that the serving kitchen on the unit enabled staff to respond to personal choices of individual residents, including beverage making, snack preparation, or warming up food. Staff Ursula explained:

The best thing about this unit is you can keep an eye on who eats what and find out who needs what. There is always something else in the fridge, a substitute if they didn't like the meal, like banana, sandwiches, bread, ice-cream... Residents can get up at different times, sleep in as they wish cause the kitchen here makes it easy to warm up the porridge, make fresh coffee and tea anytime the residents need it.

At River Rock Manor, the staff took pride in the care they provided. At the focus group discussion, all the staff expressed confidence that they offered high-quality care. They voiced appreciation about the physical environment, such as the small dining room and adjoining kitchen that made it easier for them to provide better care for their residents. The care director in a conversation mentioned that the homelike environment helped staff to see residents as valued and encouraged them to use a more flexible and personalized approach to provide care. Their comments lend good support to the literature that claimed that staff morale is associated with attributes of a non-institutional
environment for residents (Parker, Barnes, McKee, Morgan Torrington & Tregenza, 2004).

Attachment

Attachment relates to bonding, connection, nurture, trust, and relationship (Kitwood, 1997). It also relates to security in relationships and feeling that one has trusted others to whom one can turn in times of trouble or need. Attachment enables people to feel connected. This is especially important to residents with dementia because they are more vulnerable to a sense of insecurity. As Kitwood (1997) explained, when people are anxious, their need to feel attached to someone increases to a significant degree. Zgola (1999) alluded to this when she stated that people with dementia rely on the environment and the people around them for feedback about their security and sense of worth. The themes that influenced the sense of attachment in participating residents at mealtimes were “Invalidation/Validation” and “Distancing/Connecting.”

Theme 5: Invalidation/Validation

Invalidation is failing to acknowledge the reality of a resident in a particular situation (Feil, 2005). When examining the care plans, progress notes, and nutrition plans of residents in both settings, I found that the documents indicated only problems. The data in the Minimum Data Set were mainly focusing on problems of residents as well. Many of the goals and target interventions were generic types. These data did not help caregivers to know the residents as a whole person. As Brooker (2007) argued, the individualized care plans in traditional care culture often didn’t take into account the
resident’s perspective, which should be the centrality of care. Similarly, Parse (2004) expressed concern that the computerized systems that classify problems with designated interventions and predetermined expected outcomes might lead to “mechanization of nursing” (p. 193), in which the individual situation of patients could be easily overlooked. In both settings, many residents often were described by labels such as noncompliant, confusion, agitation, and aggression. As mentioned in the literature, placing the older person in the disease model, the labelling could lead to a loss of social worth (Downs, Clare, & Mackenzie, 2006). The following case illustrates a scenario where a staff blamed a resident being “bad and confused” as the resident was unable to put in her dentures. The staff focused on the problem of refusal of care but overlooked the emotional needs of the resident, who could have been feeling insecure, scared, and overwhelmed.

Staff Lisa: Victoria is getting really bad these days. She is so confused. She doesn’t even know how to wear her dentures anymore [staff showed frustration, raised voice tone]. Look, see what she does; she won’t open her mouth for me. [Victoria shut her eyes, closed her mouth, and put her head down]. I don’t understand why we should bother. She will end up losing them anyways.

I sat besides Victoria for a few minutes. When she lifted her head up, I greeted her and she started to talk about her family.

Victoria: My family is supposed to come to see me. I haven’t seen my father for a long time...

We talked about her childhood memory for a few minutes. When she was ready to eat, I showed her the dentures. She put them in by herself.

In the above scenario, resident Victoria was caught up in her thoughts about her family. She was struggling to hold on to the connection with her world as she probably felt insecure, worried, and being abandoned. Focusing on the job duty, Lisa insisted that Victoria should have the dentures in for breakfast. Understandably, the resident refused to
co-operate as she was busy trying to make sense of what had happened to her family. Rather than seeing her as “bad and confused,” what Victoria needed at that moment was someone to respond by being present with deep understanding and openness to validate her feelings and experience. As Brooker (2007) stated, the perspective of the resident must be acknowledged if their personhood is to be respected. Care can become mechanistic and residents can easily be blamed as noncompliant, aggressive, or agitated when care is done without reference to individual needs and perspectives. This is similar to Kitwood’s (1997) feelings about the consequence of labelling the symptoms of dementia that might lead to blaming the individual.

Validation is about using empathy skillfully to recognize the reality of the resident, trying to understand how the person feels and what the person needs (Brooker, 2007). According to Feil (2005), validation provides the person with dementia with an empathetic listener, someone who does not judge them but accepts their views of reality. When the staff is authentically attentive to the person with dementia, uses empathetic skills to understand how the person feels, the person with dementia may experience a sense of worthiness and their dignity is affirmed (Feil, 2005). The following observation demonstrates how a nurse, Alexis, helped the resident feel validated:

Anna was crying: Is Jerry coming? [Anna’s husband passed away a few months ago.] Nurse Alexis said nothing but looked into Anna’s eyes with a deep sense of empathy. Then she gave her a hug, placed her hand on her shoulder, shared a moment of silence, walked with her, and took her to the dining room for lunch. Anna got closer to the staff and returned her a tight hug. Thank you, Anna said.

The nurse Alexis expressed genuine compassion to address the emotional need of a resident. Being with the resident indicated a sense of caring. A sense of closeness,
togetherness, and connectedness became explicit when the resident felt validated with respect. Through a simple hug and the use of silence, the genuine intent of the nurse was clear in the resident’s heart. The quiet exchange fostered the relationship between the two. Feil (2005) said that empathy builds trust, reduces anxiety, and restores dignity. The same view was supported by Jonas-Simpson (2001) who stated that spending the time and being fully present with the person helps the person feel they are respected. It is an essential part of developing a connection between the carer and the person with dementia.

The following case illustrates how a care aide, Ursula, was able to recognize the urge of a resident to leave the dining room. Instead of forcing the resident to sit at the chair waiting for the meal, she validated the resident’s need to walk.

Resident Anna got up from the dining chair, looked at staff Ursula’s eyes for permission to leave the dining room?
Staff Ursula smiled at Anna and responded in a loving voice
Ursula: Yes, this time of the day, it’s too hard to sit and stay in one chair. It’s okay; you walk around. I will get your dinner later.
Anna walked out to the courtyard garden and came back to the dining room, humming a tune of her song. “Dida bum bum…” [Anna was in delighted mood on her return.]

It is important that caregivers understand that many people with dementia need and want to be able to wander freely inside and outside the building (Dewing, 2007). Regnier (2002) explained that wandering sometimes can reduce the anxiety of a resident who has an incessant need to wander. What is extraordinary in this case is the remarkable ability of Ursula in understanding the subtle request of Anna (she needed to walk). As Zgola (1999) suggested, the delivery of high quality of care depends on caregivers’
ability to understand residents’ needs. In dementia care, these needs are often expressed implicitly, and it is up to the caregivers to recognize and acknowledge it.

**Theme 6: Distancing/Connecting**

*Distancing* is about creating physical or psychological distance with residents. In Gardenview Lodge, the condition of the limited physical environment was a major factor in distancing. As mentioned before, the rainbow table and the line up of Geri-chairs encouraged assembly-line feeding and discouraged social interaction. Such seating arrangements alienated the residents’ connection to the normal way of dining. At home, meals are normally enjoyed around dining tables with social conversations. Placing the older people in a line implies a sense of disrespect and devaluation and can be seen as a form of objectification. In such physical settings, staff distanced themselves from residents. This was evidenced by staff talking among themselves and making no eye contact with residents. Lyman (1998) described the behaviour as “emotional absenteeism” (p. 79) when she saw that the caregivers in the day care centre were present but not really there. As Zgola (1999) pointed out, care can become dehumanizing and “a custodial affair” (p. 1) when the human connection is absent, when the care is delivered in a depersonalized manner.

In the face of losing connection, family ties are central to residents with dementia. In both facilities under study, residents often talked about their families at meal times. Unfortunately, at both locations, there was only a small group of family members who would come in to eat with residents. In part, this was probably related to the fact that the facilities failed to provide an optimal space to facilitate family visiting at mealtimes. As
mentioned previously, a family member described how the physical environment in Gardenview Lodge was unsupportive for such family visits. He told me that the space in the dining room was overcrowded, and there was no alternative private space to share a meal with his mother. Several family members I talked with at River Rock Manor stated that they appreciated the welcoming environment, but they also desired a private space where they could spent intimate time with their loved ones over mealtimes. A daughter of a resident said, “I know spending the time, just two of us, means a lot to my mom. It would be nice if there is a private space that I could bring a piece a cake and eat with my mom. Having that intimate time with mom, away from the others, is important to me as well.”

As in previous studies (Moore, 1999; Kofod & Birkemose, 2004), dissonance was found between the staff and residents because they seemed to have different agendas at mealtimes. While staff tended to focus on controlling the mechanical aspects, such as serving the right food to the right person, residents were more concerned about the social aspects. As a resident Chuck tells, “I watch these people all the time. Some girls are really bossy; most of the time, I just ignore them.” In the following interview, a 95-year-old resident of Gardenview Lodge, Margaret, expressed her feelings of being distanced, and she referred the facility as “an army place.”

LH: Margaret, what do you like or dislike about eating here?
Resident Margaret: I’m speaking for myself. I don’t know about the others. Uh, to me, love is very important to us, as human. I think there is something lost in today’s world. People are always in a rush. Nobody has time to care for the sick one. Look at those girls; they never have time to come over to ask how you are feeling. People need to care about people. Look what happened to me. I was left here, with no explanation or nothing. They treat me like I’m not worth, I’m nothing.
LH: It sounds like you don’t like this place?
Margaret: No, I never thought they would put me in an army place, like this. I’m filled with disgust.

LH: Hmm, an army place?

Margaret: This place is an army place, isn’t it? I don’t know. I think it is. They cook everyone the same food. You have no say. Eat it or leave it. Nobody cares.

Margaret cannot remember how and why she was placed at that facility or that she was even in a care facility. Sitting among a large number of people in a big space where no one would speak to her did not help Margaret to deal with the sense of disorientation. She was asking to be treated with respect and care. For Margaret, the distancing made her feel unsupported, isolated, and diminished. She was searching for someone to connect with in her aloneness. This case illustrates how a resident with dementia may feel socially distanced and uncared for when staff treated them in a mechanical fashion. Margaret felt that her social identity was deflated by the hardhearted approach by staff, as she described that she was literally being seen as “not worth” and “nothing.” In the old school, nursing staff were taught to “remain professional” by not disclosing personal feelings openly. Such belief seemed to promote distance between residents and staff. In contrast, Kitwood (1997) emphasized that good dementia care requires staff to have the ability to emotionally relate to the persons with dementia.

Connecting relates to gaining a sense of social togetherness. As Sabat (2001) stated, how we view the persons with dementia will affect how we treat the person, which, in turn, will affect how the person behaves. In my research, I observed some care aides who had very positive attitudes and excellent skills of reaching the persons with cognitive impairment, understanding their needs. Staff Ursula, for example, was able to demonstrate passion in connecting with the resident, seeing the persons beyond the
symptoms. She not only had an affectionate and empathetic attitude, but also had extraordinary skills in communicating with people with cognitive impairment. Beyond the language, humour, fun, and physical affection were effective tools she used to bridge people.

Resident Anna went to Staff Ursula: You got Bee, B B B B. You have the B. [Pointing to the uniform of Ursula]
Ursula: Yeah I have bumble bee on my clothes, you like it?
Anna: Yeah, did it getta getta getta?
Ursula: No, I did not get bitten. [Smiled, looked into Anna’s eyes kindly, then she poked Anna’s belly in a joking manner.]
Anna: Oh good, I love you. [Laughing, opening her arms to offer a hug.]
Ursula: I love you too. [Hugging warmly.]

In this example, staff Ursula showed the resident that she was worth listening to because she cared about her. She demonstrated patience when actively listened to language that might not easily make sense and was able to find ways to recognize and connect the emotional feelings of Anna. Through her caring attitude, she provided herself as the connection to respond to Anna as someone of value, a unique person with desires for relationships. And for Anna in that moment, it seemed what really mattered to her was that human-to-human connection. It is clear that that both of them were able to find satisfaction and joy in that moment of interconnectedness. In everyday life, since staff were often busy doing their work, mealtimes are good opportunities for staff to sit down and be together with the residents to build such connections. In the brief encounter above, one can sense a deep sense of connectedness between the staff and resident. Recently more studies are looking at the relationship between the person with dementia and the caregiver, and building a positive relationship is believed to be essential in providing quality care (e.g., Nolan et al., 2004; Zgola, 1999). All the residents I observed in this study valued care providers who listened and talked to them, were responsive to their
needs, and treated them with respect. Likewise, Hirst and Raffin (2001) stated that being heard unconditionally, even for a few moments, validates the importance and worth of an older person.

I have seen residents with dementia sometimes actively seek opportunities to connect with staff, rather than passively waiting for staff to approach. I heard resident Kelly say to one of the care aides, “Oh it’s you. I’m so glad to see you. You are always so willing to help....” Another resident, Ivy, walked up to a staff when she came back to work after a sick leave, “Oh hi, where have you been? I used to see you, but you haven’t been around, how are you doing? I miss you.” On many other occasions, I observed residents giving warm hugs and kisses to staff, sometimes imaginary gifts or real gifts; nevertheless, they were the very sincere intentions of trying to connect. As Berg (2006) stated, social connectedness gives meaning of life, and mealtimes provide the prime opportunity to experience a sense of being connected with others.

**Occupation**

*Occupation* relates to” being involved in activities in a way that is personally meaningful and which draws on a person’s abilities and power” (Kitwood, 1997, p. 83). It fulfils a deep need that individuals can have some control over the world and can make things happen (Brooker, 2007). Helping someone to overcome barriers and become able to eat an enjoyable meal is a good way to support the need of occupation. In the two facilities under study, many staff seemed to be insensitive to residents’ need of occupation, though a few staff showed compassion and patience as they persistently tried to engage residents to take part in mealtime activities. The theme that may limit or
support the need of occupation in participating residents at mealtimes was

“Disempowerment/ Empowerment.”

**Theme 7: Disempowerment/ Empowerment**

*Disempowerment* is about not allowing residents to use their remaining abilities. At both settings, the ability of the staff to recognize and respond to residents’ needs varied greatly. The following exchange illustrates how disempowerment leads to feelings of discouragement and despair in a resident:

Resident Josephine: My arm hurts. [Showing me the bruises on the arm, she had a fall a few days ago according to the nurses.]... Ya, it feels like sharp stabbing; it hurts when I move it. See, I have to do this [wrapping her arm with the bib]; I need to support it, yeah.

LH: Hmm, I am sorry to hear that. It looks very sore.

Josephine: I was supposed to sit in that chair [pointing to the Geri-chairs at the wall and trying to get up].

LH: You want that chair?

Josephine: Well, yeah, I was there before; that is my chair [continuously trying to get her out of the chair].

Staff Hilda moved her chair to block Josephine in.

Hilda: You sit, stay in the chair, you are not supposed to walk.

LH: How are you feeling, Josephine?

Josephine: Mad, I can’t get out. They have no understanding [crying].

Staff Tillie: Hilda, Josephine is supposed to sit in the Geri-chair; she is not supposed to walk. If she falls again, we will be in trouble [seemed annoyed with the fact that Hilda forgot to put Josephine in the Geri-chair].

Hilda: Josephine, you are not supposed to walk. Stay in the chair.

Josephine: I need to go, I should be there [pointing to the Geri-chair].

Hilda: No, you stay, eat your supper.

Throughout the meal, the staff spend a lot of energy trying to keep Josephine in the chair. When the staff spoon-fed Josephine, she did not open her mouth. The staff kept telling her that she had to eat. Even though Josephine could normally feed herself, she could not eat that night.
There were multiple issues in this case with Josephine. First, she was in pain and could not get comfortable by simply wrapping her arm in a bib. Not providing adequate pain management is disempowering as one cannot engage well in eating a meal when in pain. Second, invalidation can be seen as the staff did not try to acknowledge the feelings and emotional state of Josephine. Third, stopping Josephine from getting to the Geri-chair was disempowering, albeit the staff’s intention was to protect her from falling. Initially, I was struck by that request of going in the Geri-chair. But when I hold back my own assumptions and watched her when she was in the Geri chair the next day, I found that she was happy. This was partly due to the fact that her injured arm could be better supported by the attached table of the chair; in turn, she was able to feed herself the meal. More importantly, I think she was content with being in her own chair, a personal possession that she valued. When she was asked if she liked the Geri-chair, she responded cheerfully, “Yeah, I like it. This is mine. See, it’s nice and comfortable.”

Another aspect relevant to disempowerment is too much food. Several residents in the study told me they were given too much food. They said when the meal seemed too much, it took their appetite away. Meg and Roberta were able to clearly describe why they needed a smaller quantity of food.

Meg: I can’t eat all that. That’s too much. You see, I am always a small eater throughout my life. The girls kept pushing me to eat. Forcing the food in makes me feel sick. In fact, I threw up a couple days ago after lunch. They insisted that I should finish the plate. I did but then I felt so sick after.

Roberta: Wow, they gave us so much food, too much. I never eat so much when I was at home. I don’t really want to eat all these, but I hate to waste the food, so I always end up eating it all. We don’t really need so much food as we don’t move much these days. The food just stays there [pointing to her abdomen]. It doesn’t go down. I never get a chance to feel hungry.
In the above quotations, residents explained the reasons for not wanting too much food: lifelong habits and needing less due to aging effects, such as reduced physical activity, slower food digestion, and not feeling hungry. Their comments are also consistent with literature that described the eating behaviour among older adults is complex and usually dictated by lifelong practices, preferences, and cultural rituals (Amella, Grant, & Mulloy, 2008). Ironically, it seemed overly simplistic that care providers often view greater quantity of food intake as the best indicator of quality of care. As Meg described, forcing someone to eat beyond what the person could take was a nauseating experience. Seedhouse and Gallagher (2002) argued that institutions continue to focus largely on quantifiable priorities, leading to insufficient resources available to assure quality care. The findings suggest that, in order to support nutritional needs, it is essential that the practitioners consider the need of individual resident, past habits and preferences. For those who are no longer able to communicate, the family may be able to give valuable insight into mealtime history and personal preferences. Perhaps they will be better supported by smaller meals and improved access to a variety of favourite snacks (e.g., cookies and chocolate ice-cream).

*Empowerment* is letting go of control and assisting the resident to discover or employ abilities and skills (Brooker, 2007). Allowing residents to feed themselves can have important and positive implications for the sense of competence, self-esteem, and remaining strengths of the individual with dementia. During my observations, I have seen some staff who would take the extra time to reduce residents’ anxiety, giving gentle prompts and appropriate assistance to residents. Their skillful techniques made a
difference in empowering residents to use their ability to eat. The following example demonstrates how staff Ursula empowered resident Kelly to make the meal manageable:

Resident Kelly was given a pureed dinner with three colours: brown meat, white potatoes, and green vegetables.

Kelly: I can’t eat all that, I am sick. I don’t know what the hell is this? Are you sure it is for me? [Becoming angry and stressed]

Staff Ursula: Yes, you are right. This is too much. Let me change it.

Then staff Ursula went to the kitchen and brought back a small dish of mashed potatoes

Ursula: Kelly this is a small dish of mashed potatoes with gravy on the top.

Kelly: Oh thank you. I will eat it. [Looking much more relaxed and ate all the mashed potatoes]

In this example, Ursula was skillful in recognizing the need and experience of the resident. She knew Kelly had dysphagia, a condition that made swallowing difficult. She often felt overwhelmed and frightened to eat a full meal, because she sometimes choked and coughed excessively when she ate. To explain her condition, Kelly usually told people that she had a bad cold. Staff Ursula did not argue, or impose, but validated Kelly’s needs and experience. By changing the food to a single item, mashed potatoes with gravy, the food became manageable for Kelly to eat. After that, Ursula tried other parts of the meal, though Kelly did not want them except the dessert.

Inclusion

Inclusion describes the need to feel that we belong to and are part of a social group. People with dementia are at great risk of being socially isolated when no effort is made to help them be included by others (Brooker, 2007). Supporting a sense of inclusion is particularly important for people with dementia because they often suffer the powerful
discrimination and prejudice by the wide society (Downs et al., 2006). Berg (2006) stated that mealtimes are prime opportunities for promotion of the sense of community and belonging. When people are brought together to eat, staff are given the opportunity to facilitate social engagement, making the person feel accepted as a member of the group. In contrast, ignoring undermines the need for inclusion being met. The theme influenced the sense of inclusion in participating residents at mealtimes was “Ignoring/Inclusion.”

**Theme 8: Ignoring/Inclusion**

_Ignoring_ refers to situations where staff discussed about a resident with each other as if the resident was not present there. During my three-month study, on many occasions, I observed that residents were viewed as a different group as they were not invited to participate in staff conversations. I have witnessed meaningful conversation initiated by residents being dismissed or avoided by staff. Some staff members were always busy and did not have time to talk, rushing the encounter and ignoring the emotional needs of individual residents. As in the findings of another study by Moore (1999), staff in the two care facilities routinely discussed personal matters about residents in the dining area without engaging the residents. The following situation demonstrates how ignoring caused escalation of emotional distress in a resident:

LH: What happened, Lucy?

Resident Lucy: I must have been on the wrong bus. I don’t know how I got here, and I forgot the way to get home. Would you please help me? My kids are waiting for me at home, and I don’t think they are safe to be left on their own. The younger one may get hurt if I don’t hurry home. [Spoken in Chinese]

Staff Ruth: Here she goes again. Lucy is so crazy. Do you think she should be here? You know she has been so aggressive. The other day, she kept following me. I was so scared. I ran inside the kitchen and locked the
door. She kicked the door and screamed at me. I could see the demon in her eyes. When she was chasing me, she had her claws up like an animal. [Laughing]

Staff Mabel: You are right. I don’t think it’s safe to keep her here. She breaks stuff. She broke the curtain of that window, and other stuff everywhere. She is destroying the unit.

Lucy: What are you talking about? You people just hate me; no one likes me here? What have I done wrong? [Yelled in English and pushed the table in front of her]

Lucy: I need to go home. This place is not for humans to live. I should never have come here. Those girls are awful. [Spoken in Chinese]

Lucy left the dining room in distress. To comfort her, I took a walk with her.

LH: Are you okay? How are you feeling Lucy?

Lucy: I feel so useless. I can’t remember things. I am so worried about my children. I don’t know what to do. [Spoken in Chinese, starting to cry]

With increasing memory loss, Lucy struggled to make sense of the past and the present. Her brain no longer informed her of her whereabouts. According to her views, not knowing how to get home to see her children, and that they might be in danger, caused her to experience feelings of insecurity, uncertainty, anxiety, and helplessness. One can sense that the ignoring, talk-over and laughing by staff was disrespectful and could be very hurtful to Lucy. Rather than being ignored, Lucy needed to feel being accepted with non-judgemental empathy, caring support, and reassurance, particularly in that moment of emotional crisis. In addition, Lucy’s experience demonstrates the intricate inter-connections between themes. Invalidation and withholding were evident as Lucy’s emotional state was not acknowledged, and she was left alone to suffer the distress.

According to Sabat (2006), carers should avoid being too quick to interpret behaviours as being pathological, simply because the person has a diagnosis of dementia. For instance, if a person was ignored, embarrassed, or humiliated, the reacting behaviours
of the person could be viewed as a way of coping, driven by the circumstance the person was in. In the above case, since the thought about the children at home needing help was real to Lucy’s world, her worries were not unreasonable. Also, the yelling and pushing the table could be seen as natural reactions to the experience of being ignored and being laughed at by the staff.

With the decline of cognitive functions, Lucy was probably afraid of losing control. To keep herself together, she collected stuff and hid them inside her clothes. She often had a collection of cookies, spoons, and napkins in her underpants. Having worked as a nanny all her life, she needed to continue to keep herself busy on domestic chores. Breaking the curtains was probably meant to be house cleaning. Unfortunately, due to the limited understanding of Lucy’s behaviors, she was sent out to a medical unit at the local hospital for behavioral problems. During the hospitalization, she sadly had rapid decline in her health and mental condition.

**Inclusion** refers to situations when staff workers include residents in social conversation and activities, accepting residents for who they are. In large part, the way residents conversed and interacted with tablemates indicated that they worked hard to maintain socially connected. Yvonne was an example. She smiled a lot, loved to talk, and was full of fun. Staff described her as “a happily confused.” Even though Yvonne sometimes had trouble to find the right word for conversation, the interactions with her tablemates were always warm and mutually supportive. A deep sense of inclusion was clearly reflected in their mundane mealtime conversations. Another resident, Roberta, described how she actively helped others feel included, “I am lucky to have friends. I feel sorry for those they don’t have anyone to talk to, like that Chinese fella. I don’t think he
speaks any English. I started to wave at him, and now he waves back and smiles. Now we are sort of like friends in the same group.” According to Roberta, inclusion sometimes simply meant extending a warm greeting, cracking an open smile, or sending an affirming glance. Apparently, courteous social exchanges seemed to have potential to help residents with dementia cope with negative aspects of their experiences, ease some of the embarrassment at times, and more importantly, maintain social connections with people around. The following is another example:

Sophie has been regularly calling out at mealtimes. Her yelling was clearly very disturbing to other residents in the dining room. It was difficult to understand what Sophie wanted because she often had difficulty to speak clearly and coherently.

Sophie: I can’t breath. Please help me. [Calling out anxiously]
Nurse Pam: Hello, Sophie, so good to see you.
Sophie: Oh, it’s you. The one that I like. It’s good to see you.
Pam: I think we are having a beautiful day out there.
Sophie: Wonderful
The dietician: Hi, Sophie, your hair is lovely today.
Sophie: Oh, thank you. I just had it done; I think it was this morning. I like yours, too
Pam: You know, Sophie, I think you have beautiful hair....
A deliveryman passing by.
Sophie: Hello. [Waving at the man]
The deliveryman: Hello, ladies.
Sophie: I like those boots you have, a a a cowboy, right?
The delivery man laughed: Yes, you like them?...

In this example, Sophie was included in the conversation, and she enjoyed it. Her mood was transformed as soon as nurse Pam started to talk to her in a warm manner. When the nurse and the dietician were authentically attentive to her, Sophie experienced a sense of closeness, and thereby her social identity was affirmed. Despite her language
impairment, her social greeting skills remained remarkable. Similarly, a recent study also suggested that a close relationship of mutual respect may lead to more episodes of lucidity in patients with dementia (Normann et al., 2005). I found it fascinating to see the change of emotional status in Sophie from insecurity and anxiety to a socially confident person. By having a small group conversation, Sophie’s sense of self-esteem was increased and her unique social value was confirmed. Simple greetings and courteous conversation certainly enriched the inter-human togetherness among the people involved.

This study examined the negative and positive factors relating to mealtime experience of residents with dementia at the two facilities under study. It captured the processes - how multiple factors within each setting might enhance or impede the dining experience of residents, as recorded through observations, conversational interviews, focus group discussion, and other additional sources. The results support the need to enhance the dining experience of residents with dementia by paying careful attention to their psychosocial needs and affirming personhood.

Along with other frontline practitioners, I think that it is best that research has practical relevance for practitioners and a potential to effect change in practice (Barton, 2008). In the next chapter, drawing on the results of the study, I will discuss strategies and directions for possible changes in long-term care facilities in order to provide a dignified and pleasurable dining environment for residents with dementia.
CHAPTER 6: IMPLICATIONS AND CONCLUSION

This chapter discusses implications for care practice, offers suggestions for future research, and acknowledges limitations of the study. It concludes with a review of the research questions and a reflection on how this study has affected the researcher personally and professionally.

Implications for Practice

Knowledge Translation

Current evidence shows that new research knowledge in dementia care is often not developed to the point of application and quite often does not reach the hands of practitioners (Algase, 2007). Obstacles to knowledge translation include lack of time, energy, commitment, leadership, and organizational support (Estabrook, Midodzi, Cummings, & Wallin, 2007). Perhaps the biggest challenge to researchers and practice developers is to find ways to demonstrate how research knowledge can be translated to daily practice for care providers (Dewing, 2004). In everyday practice, under heavy workloads, practitioners do not always have the time to read lengthy research reports. One helpful way could be to provide practitioners with some tools that are useful and easy to use (McWilliam, 2007). Based on the study results, I designed a set of tools to remind caregivers to look beyond basic physical needs and attend to the psychosocial needs of residents with dementia. When I reported the study results to the two participated care facility, I offered the tools for them to use and discussed how they could
be incorporated in their regular practices. These tools are briefly described next and samples of the tools are included in Appendices F, G, and H.

**Useful Tools**

Drawing upon Kitwood’s (1997) theory and the findings of this study, the set of three tools are developed to bring clarity over salient concepts of personhood in the specific context of mealtimes. Educators might find them useful because they offer a language and means to improve staff practice. The first tool: “What can be done” in Appendix F provides a summary of problems and issues at mealtime in long-term care facilities, how each of those may happen, and alternative steps that staff can take to help residents with dementia to enjoy the pleasure of dining.

Second, the “Reflection practice” in Appendix G is a tool for staff to practice self-reflection on their caregiving experiences. They may also meet as a team once a month to discuss their experiences. During those meetings, the positive practices of the staff or the facility could be brought out to recognize and share. Areas that are problematic, or if there is a mismatch of experience among team members, could be discussed and worked on. My clinical experience suggests that the “how to do things” is best learned through discussion among a team, and this is particular vital in the group of care providers who have many years of experiences. Such an approach overcomes feelings of coercion and promotes openness and support. To make change requires time, energy, and commitment (Estabrooks et al., 2007). Regular team reflection is a good way to strengthen motivation and increase commitment.

The third tool is a set of two posters, in which I reorganized the eight themes, identified in the study and put them in a catchy acronym style (Appendix H). The posters
can be used as a quick reminder to show what approach works and what does not work for residents with dementia.

The Physical Environment

Results of this study affirm the literature that suggested that the physical environment is important to the dining experience of residents. Residents, families, and staff at River Rock Manor reported that they valued and appreciated the décor and features of the small and homelike dining environment in many ways. In contrast, residents, families, and staff at Gardenview Lodge expressed their frustrations with the limitations in their large and institutional dining environment. Similar results were shown in a recent study that also found that environmental issues including crowding, noise levels, mixing of residents with dementia and other residents, and lack of quiet space caused over-stimulation and residents aggression in the non-special care unit (Morgan et al., 2008). Nursing assistants in their study reported that they were often unable to provide best care because of environmental and organizational constraints. Another important finding of this study is that family members in both settings expressed a desire to have a private space where they can spend intimate time to eat with their loved ones. The following three main recommendations are based on the findings of this study and current literature (e.g., Brawley, 2006; Briller et al., 2001).

1. Create small dining clusters to avoid crowding and over-stimulation, or divide a large room by half-walls or furniture.

2. Make the dining room a familiar place to eat by providing warm and attractive décor, homelike furniture, and adequate lighting and find ways to eliminate distractions, including glare, noise, and traffic flow.
3. Offer private area for family to enjoy a meal with their loved ones.

Organizational Support

Kitwood (1997) maintained that it is the responsibility of the organization to provide an optimal work environment to continuously support the caregivers and enable them to provide good care. Zgola and Bordillon (2001) emphasized that a successful dining program requires a facility-wide commitment, culture change, and enthusiastic efforts from the whole team. In this study, staff in the focus group at Gardenview Lodge expressed discouragement, frustration, and powerlessness because they felt they were not supported in dealing with issues facing them every day at mealtimes. Similarly, a report by Seedhouse and Gallagher (2002) found that long-established traditions and cultures embedded within institutions made it impossible for staff to make change, even though they wanted to. Based on the results of the study and ideas in current literature (e.g., Zgola & Bordillon, 2001), the following three key policy interventions are recommended to support the dining experience of residents with dementia.

1. Provide adequate staffing, involve all personnel to help at mealtimes if possible, recreation staff, dietary staff, and managers all may come to sit down with residents at mealtimes, knocking down the traditional boundaries that only dietary staff deliver food, nurses give medications, and managers stay in the office.

2. Adopt flexible policies, open to innovative ideas, try open kitchen policy, leaving a variety of food, including nutritious finger food, available whenever residents need it.
3. Involve residents and frontline staff in decision-making process to ensure changes are meaningful to them. Nurture a continuous learning culture by providing adequate resources and supportive environments for regular learning.

**Transformational Leadership**

Getting staff to change practice is not always easy. A nurse in the focus group said that the mentality “If it ain’t broken, don’t fix it” made changes difficult to happen. Given the reluctance to change, improvements in practice could not be expected with few hours of in-service training alone (Pelletier, 2004). One helpful way is to provide ongoing support and supervision from a leader with expertise in dementia care (Kayser-Jones, 1997). A practice leader, such as a clinical nurse specialist, can facilitate use of research knowledge and motivate and engage care workers to improve standards. The leader also provides ongoing support, continuous monitoring, follow-up, and guidance to deal with practical issues. Many existing care facilities do not have such a leader but rely on the care director or the administrator to play this role. However, in reality, managers do not always have time to adequately deal with daily practice issues.

**Limitations**

This research has several limitations that should be acknowledged. The following addresses the key concerns.

Kitwood (1997) characterised dementia experience as a dialectical interplay between neurological impairment, physical health, biography, personality, and social psychology. Each affected person could have a unique mix of these factors, and their experiences could be in great diversity. However, in order to keep this study in a
manageable scope, I did not investigate how the individual aspects — including cognitive impairment, medical conditions, life history, and personality — might influence the dining experience of each resident. Other interacting factors that should be taken into consideration are the range of ethnic or cultural differences, gender differences, and socio-economic variations. Further, my clinical experience suggests that there is a strong connection between the person’s experience and medication use. For instance, Perry at River Rock Manor was on multiple psychotropic medications, and this could have significant effects on his dining experience. Although the connections between the factors mentioned above and the dining experience of residents are all important, generating explicit links among these factors is complicated and beyond the scope of this project. I acknowledge this as a limitation of this study. Future studies need to explore these related aspects in depth.

Since the conceptual orientation for data collection and data analysis was based upon an initial set of sensitizing concepts of Kitwood’s (1997) work, there is a potential limitation in terms of a fully qualitative interpretation. As Strauss and Corbin (1998) warned, using established concepts to sensitize data analysis might facilitate understanding the experience; yet it also risks preventing readers from seeing what is new. Although I gave my best efforts and utilized three safeguards as mentioned previously to keep myself remain open to fresh insights, it is plausible that additional issues were overlooked.

**Future Research**

Mealtimes are fundamental pleasure and an important part of all residents’ lives, including those with dementia, in long-term care facilities. More research into residents’
experiences of mealtimes in nursing homes can help develop ways to make dining a more pleasurable and dignified experience for residents with dementia. The following are suggestions for future research.

**The Perspective of Persons with Dementia**

This research adds evidence confirming that people with dementia are able to articulate their views of their everyday experiences, such as the quality of care provision and the experience of the physical environment. Even residents with significant cognitive impairment were capable of telling how they felt about the care and what they liked or disliked. The study demonstrates that many residents with dementia I talked with had meaningful insights about their situations and experiences. Future research should invest more efforts in developing effective methods to elicit information from people with dementia about their needs and experiences. In addition, although food intake and nutrition are important outcome goals, future research agendas need to extend attention to the desired goals of persons with dementia, using a more balanced approach.

**Holistic Approach**

Given the staff practice is only a partial attribute that intertwines with other factors in a complex system that influences the experience of the residents at mealtimes; it cannot be studied in isolation. For example, by simply looking at the staff approach without taking into account their organizational circumstances will not help us find effective ways to improve the situations. Without addressing the larger organizational context and the work culture, interventions are likely to be very difficult to sustain in the long term. Therefore, a deeper understanding of the complexity of the mealtime phenomenon is necessary in future research. While Dementia Care Mapping is
increasingly employed worldwide and being accepted as a good tool to investigate the experiences of persons living with dementia, it is important to continue to further develop and refine the tool. The findings of this study add evidence to others in the literature (e.g., Cohen & Weisman, 1991; Schwarz et al., 2004) that show how the physical environment is important to the experience in people with dementia. An exciting area for future research will be to find ways to expand the Care Mapping framework to include the physical environmental elements and other structural factors.

**Intervention Studies**

This study has taken the initial step to identify positive and negative approaches in care provision in the specific context of mealtimes. In addition, a set of useful tools (i.e., What Can be Done in Appendix F, Reflection Practice in Appendix G and Posters that highlight what approach works and what does not work in Appendix H) are developed based on the study findings and the guiding theory of Kitwood (1997). Additional efforts are needed to continue to explore ways to equip practitioners with the special skills needed for good dementia care. Essentially, more action research is needed to facilitate and evaluate intervention strategies that can change practice. Strategies that aim to support practitioners in exploring their own values, beliefs, and behaviours regarding the care of older people with dementia will be helpful to promote successful changes (Bezzant, 2008). Also, the interventions should focus not only on the development of the practice skills but also on the workplace culture and structural factors.
Conclusion

Drawing upon the theory of personhood (Kitwood, 1997), this study contributes to understanding the dining experience of residents with dementia by highlighting the role of social and physical environment in the psychosocial needs of residents. To conclude the study, I return to the three research questions posed in the beginning: First, What factors and processes impede the dining experience of residents with dementia? Those factors identified in this study are outlined in the eight themes: outpacing, withholding, over-stimulation, disrespect, invalidation, distancing, disempowerment and ignoring. Relating to the process, the experience of outpacing, withholding, and over-stimulation in the environment undermined the need for comfort in residents. Care delivery in a disrespectful manner weakened the identity of residents at mealtimes. The need for attachment was hindered by invalidation and distancing. Disempowerment negatively affected the need for occupation. Ignoring made the residents feel not included in the social group.

Second, what factors and processes enhance the dining experience of residents with dementia? Those factors included relaxed pace, holding, quality stimulation, respect, validation, connecting, empowerment, and inclusion. Regarding the process, the experiences of relaxed pace, holding, and quality stimulation in the environment supported the need for comfort in residents with dementia. Care delivery in a respectful manner affirmed the identity of residents at mealtimes. The need for attachment was enhanced by validation and connecting. Empowerment supported the need for occupation. Inclusion made the residents feel included in the group.
Third, what are the interrelationships among these multiple factors, and how do they influence the dining experience of residents with dementia? The relationships and their influence were complex and deeply interwoven, as discussed throughout the findings section. For instance, the physical environment directly and indirectly impacted the dining experience of residents. For direct impacts, participant residents described how they valued and appreciated the quality features such as windows and the display of personal items in the dining room. In terms of indirect effects, the large size and institutional ambience of the dining environment in Gardenview Lodge led staff to provide care in rushed, mechanical, and dehumanized ways.

Reflection

This study has been a personally and professionally enriching experience for me. Throughout the research process, I had a range of emotions, including anger, sadness, confusion, shame, guilt, self-doubt, and frustration. On some occasions, I found myself deeply immersed in the situations of residents. I felt angry when the resident Lucy was labelled as aggressive like an animal and transferred out to the hospital. I felt sad and powerless when I found out that she had a rapid decline as she was heavily sedated in the hospital, and she became weak and unable to eat. At the same time, I felt empathy for the challenges that staff faced in those situations. In the last few months, much time was spent sorting out emotions and reflecting on my practice in the past years. By examining my own practice that was similar to those of others I have observed, I realized that I have been guilty of making many of the same mistakes at some point in my own professional work.
For me, examining the practice issues that have arisen from this research in relation to my own nursing experience has sometimes been emotionally uncomfortable. Despite the challenges, this research brings invaluable benefits in enabling me to question my nursing practice and discover new meaning in my job. By speaking to the residents, I became aware of the impact that nursing staff have over the day-to-day lives of residents. What I have learned through this research experience has changed my approach in daily work and the way I interact with residents. I have learned to become more sensitive to their emotions and feelings. I have realized how important people are to one another, regardless of the level of their mental abilities. In the beginning of the project, I thought I did this study to help others. Now, as I conclude it, I have come to realize that I did it for myself as well.
REFERENCES


Ontario Long Term Care Association and Ontario Association of Non-Profit Homes and Services for Seniors. (2001). *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*.


Sandelowski, M., Davis, D. & Harris, B. (1989). Artful design: Writing the proposal for research in the naturalist paradigm. Research in Nursing and Health, 12, 77-84.


APPENDICES
Appendix A  Environmental Characteristics in the Dining Room

1. Support Functional Ability
   - Quantity of lighting
   - Quality of lighting
   - Glare from windows, floors, furniture
   - Colour contrast (e.g., between table/ floorings; plates/ table)
   - Furniture designs (e.g., table height)
   - Specialized assistive device (e.g., lip plates, special utensils)

2. Awareness and Orientation
   - Greetings/ verbal cues for residents by staff
   - A large clock, meal menu and other signage to facilitate orientation
   - Way-finding cues to the dining area
   - Visibility of the dining room from main corridors
   - Programs such as table setting/ music playing to remind residents mealtimes

3. Safety and Security
   - Residents in the dining room can be viewed by staff
   - Slipperiness of the floor
   - Design of furniture
   - Any obstacle such as food carts, or other objects located in the pathways
   - Space for staff to assist residents in the dining room
   - Potential hazards
   - Any unsecured toxic substances (e.g., detergents)
   - Readiness of staff’s to assist residents as needed

4. Sensory Stimulation
   - The size of the dining room
   - Blinds or drapes on the windows to control daylight and glare
   - Any unpleasant odours
   - Pleasant aroma (e.g., food cooking/ coffee brewing)
   - Temperature
   - Music, what type, volume, residents’ response
   - Noises (e.g., Announcement system, T.V, medication crusher)

5. Social Interaction
   - Seating arrangement (e.g., along the perimeter of walls)
   - Dining table sizes
   - Flexibility in moving of furniture to accommodate residents’ needs
   - Staff talking among themselves
   - Staff talking to residents or vice versa, tone, loudness, attitude
   - Social interactions between residents
   - Facilitation of conversation in residents
6. Privacy
   - Option of private seating arrangement
   - Option for residents to eat at alternative places
   - Space for resident and family members to eat together

7. Continuity of Self
   - Any personal items in the dining room
   - The type, appearance of furniture and furnishing
   - Personalized mealtime space (e.g., name cards or place mats)
   - Pieces of institutional equipment (e.g., medication carts)
   - Decorative items that illustrating ties to the past (e.g., pictures of local historic scenes/ symbols from earlier years of shared culture)
   - Involvement of residents in preparing the food, setting the table and clean up after meals
   - Any cleaning tools and supplies such as wash clothes, broom/ sweeper for residents use

8. Personal Control
   - Choice for residents to decide where to eat
   - Choice of time to eat (e.g., whether to eat at the regular meal times)
   - Choice of food and beverages for residents at meals
   - Choice for residents to decide how much to eat
   - Access to beverages and snacks for residents
   - Fridge and food storage for residents and family use
   - Response to residents’ opinions of temperature and lighting
   - Any type of restrain use
## Appendix B  Meal Experience Data Record

<table>
<thead>
<tr>
<th>Comment</th>
<th>Positive Aspects of Social Environment</th>
<th>Negative Aspects of Social Environment</th>
<th>Positive Aspects of Physical Environment</th>
<th>Negative Aspects of Physical Environment</th>
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</tr>
<tr>
<td>1. COMFORT</td>
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</tr>
<tr>
<td>Relaxed Pace</td>
<td>Relaxed Pace</td>
<td>Outpacing Providing information or acting at a rate too fast for a resident to understand</td>
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</tr>
<tr>
<td></td>
<td>Recognizing the importance of helping create a relaxed atmosphere for residents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holding</td>
<td>Providing safety, security, comfort to residents</td>
<td>Withholding Refusing to give asked for attention or meet an evident need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>Positive Aspects of Social Environment</td>
<td>Negative Aspects of Social Environment</td>
<td>Positive Aspects of Physical Environment</td>
<td>Negative Aspects of Physical Environment</td>
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<tr>
<td>Respect</td>
<td>Treating residents as a valued persons</td>
<td>Disrespect</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treating residents as small children or objects with no feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>Positive Aspects of Social Environment</td>
<td>Negative Aspects of Social Environment</td>
<td>Positive Aspects of Physical Environment</td>
<td>Negative Aspects of Physical Environment</td>
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<tr>
<td>Distancing</td>
<td>Connecting</td>
<td>Creating physical or psychological distance with residents</td>
<td>a sense of social togetherness</td>
<td></td>
</tr>
<tr>
<td>Validation</td>
<td>Invalidation</td>
<td>Recognizing and supporting the reality of the resident</td>
<td>Not acknowledge the reality of a resident</td>
<td></td>
</tr>
</tbody>
</table>
4. OCCUPATION

<table>
<thead>
<tr>
<th>Comment</th>
<th>Positive Aspects of Social Environment</th>
<th>Negative Aspects of Social Environment</th>
<th>Positive Aspects of Physical Environment</th>
<th>Negative Aspects of Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowerment</td>
<td>Assisting the resident to discover or employ abilities and skills</td>
<td>Disempowerment</td>
<td>Not allowing a resident to use the abilities that they do have</td>
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</tr>
<tr>
<td>Positive Aspects of Social Environment</td>
<td>Negative Aspects of Social Environment</td>
<td>Positive Aspects of Physical Environment</td>
<td>Negative Aspects of Physical Environment</td>
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</tr>
<tr>
<td>Comment</td>
<td>5. INCLUSION</td>
<td>Ignoring</td>
<td>Enabling the resident to be and feel included</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>in the presence of a resident as if the resident is not there</td>
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</table>
Appendix C  Focus Group Discussion Guide

Introduction:

Good afternoon. Thank you for taking the time to join our discussion. I am Lillian, a master’s student at Simon Fraser University. I am interested to learn about your views on the dining experience for residents with dementia in this home. There are no right or wrong answers to today’s questions. Please feel free to share your view. I am taping the session because I don’t want to miss any of your comments. It is important to stress that your name will be kept confidential in the study. It means that the opinions you express will not be identified with your name. The recorded tape will be destroyed as soon as I have reviewed the content. We have a total of an hour together today. Let’s begin.

Questions:

1. In your opinion, what are the three most important factors determine the quality of dining experience for residents with dementia and how do they affect the experience of residents? (e.g., the physical environment, care approach, family involvement…)

   Probe: Can you explain in more detail about how _____ cause a negative/positive experience in residents with dementia?

   Probe: Can you give an example?

   ..........................................................................................................................(20 minutes)

2. How does a particular factor enable or hinder you to provide the best care for residents with dementia at mealtimes?

   Probe: Can you tell me a little about one of your most challenging experiences?

   ..........................................................................................................................(20 minutes)

3. Tell me how do you gain knowledge of the individual resident’s preferences, habits and special needs and integrate such knowledge into care at mealtimes. e.g., Read the social histories in the chart, ask the residents and their family members, communicate with team members in what specific ways

   .......................................................................................................................... ... (20 minutes)

Ending:

Any other comments would you like to add?

Would it be alright if I give you a call within the next month if I have any questions?

Thank you for your participation. I appreciate all the ideas that you have shared. Let me know if you are interested in the study findings, I will send you a summary report once the research is complete.
Appendix D  Informed Consent: Substitute Decision Maker

The Dining Experience of Residents with Dementia in Long-Term Care Facilities

Master’s Student: Lillian Hung, RN, BN  Supervisor: Dr. Habib Chaudhury
Simon Fraser University

Name of Participant Resident:

Purpose of the Study:
This study explores the dining experience of residents with dementia, living in care facilities. The researcher is interested to learn what factors affect the experience of residents at mealtimes and how residents feel about their experiences.

Participation of my relative will involve:
The researcher will observe and have conversational interviews with my relative at mealtimes. The conversational interviews will be audio-taped. Broad questions will be asked relating to his/her feelings and experiences at mealtimes. Each conversational interview should normally take 10-15 minutes, but it may last longer if the participating resident wants to say more. If the participating resident shows signs of being uncomfortable with the audio-taping, the researcher will stop audio-taping immediately. The researcher may take notes during the interviews and observations. You have the option of not to consent to the audio-taping if you wish, and your relative may still participate.

☐ I agree for my relative to be tape recorded.
☐ I do not want my relative tape-recorded.

In addition, your relative’s medical and social records may be reviewed to obtain background information relevant to this study. You have the option of not to consent to the access to the medical records if you wish, and your relative may still participate.

☐ I agree for my relative’s medical records to be reviewed.
☐ I do not want my relative’s medical records to be reviewed.

Risk/ Discomforts:
There is no risk to my relative for participating in this study. If your relative may have difficulty sometimes cannot express what she/he wants or may not remember exactly what she or he wants to say, she/he will be encouraged to mention any discomfort/concerns to the researcher. She/he may stop an interview at any time and ask to change the subject or not continue further.
Confidentiality:

Only the researcher and her supervisor will have access to the notes/data to ensure the research is being conducted correctly. The name or any identifying data of participants are kept strictly confidential. Any tape recordings or written materials which identify your relative will be destroyed at the conclusion of the project. In the interim the documents will be kept in a secured area. The final dissertation will not contain any information about individuals’ identities.

What the individual says to the researcher is confidential. However, should the participating resident reveals physical, mental, emotional abuse of her/him or others, the researcher is ethically and legally bound to report that abuse to the proper authorities. The resident and you will be informed by the researcher if such reporting is necessary.

Benefits:

Your relative may not benefit directly from participating in this study. However, his/her participation will contribute to research that seeks better understanding of the dining experience of residents with dementia. This knowledge is important to developing ways to improve care of people with dementia in care facilities.

Right to Withdraw:

Your relative’s participation in this research is voluntary. You are free to withdraw your relative from the study at anytime. Your withdrawal may be in regard to a particular part of the study or may be from the entire project. In either case, this will in no way affect the care received by your relative at the facility.

Any complaints about the study may be brought to Dr. Hal Weinberg, Director, Office of Research Ethics, SFU at hal_weinberg@sfu.ca or 778-782-6593.

I may obtain copies of the results of this study, upon its completion by contacting the researcher: Lillian at nurseilly@telus.net or 604-276-0877.

Family/Substitute Decision Maker’s Signature Date

Print name and relationship to participating resident

Investigator’s Signature Date
Appendix E  Informed Consent: Facility Staff

The Dining Experience of Residents with Dementia in Long-Term Care Facilities

Master’s Student: Lillian Hung, RN, BN  Supervisor: Dr. Habib Chaudhury
Simon Fraser University

I acknowledge that I have been provided with information which explained that Lillian Hung, an MA student in Gerontology at Simon Fraser University is conducting a research study on the dining experience of nursing home residents with dementia. The research procedures have been explained to me and any questions that I have asked have been answered to my satisfaction.

- I understand that my participation in the study will involve focus group discussion of approximately an hour, and will be recorded.

- By consenting to participate in the focus group, I confirm that any information I encounter will be kept confidential and not revealed to parties outside the focus group. All discussion data will be kept confidential, only the researcher will have access to them and the final report of the study will not contain any information that could identify me in any way.

- I understand that my decision to participate in the study is not related to my work and will not interfere with my work responsibilities.

- I understand that I may withdraw from the focus group session at any time.

- I am aware that there are no direct benefits to me of participating in this study, although the results of this study may help other health care providers have a better understanding of the dining experience of residents with dementia.

- Any complaints about the study may be brought to Dr. Hal Weinberg, Director, Office of Research Ethics, SFU at hal_weinberg@sfu.ca or 778-782-6593.

- I may obtain copies of the results of this study, upon its completion by contacting the researcher: Lillian at nurselil@telus.net or 604-276-0877.

<table>
<thead>
<tr>
<th>Participant’s Signature</th>
<th>Print name</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Researcher's Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Appendix F  What Can Be Done

What can be done to improve the Dining Experience of Residents with Dementia in long-term care facilities?

<table>
<thead>
<tr>
<th>Problems/ Concerns</th>
<th>How this happens at mealtimes</th>
<th>What can be done instead?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMFORT:</strong> physical and emotional soothe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Outpacing</td>
<td>A staff walked pass a resident at the table too quickly, did not wait for the resident to finish asking a question</td>
<td>Relaxed Pace</td>
</tr>
<tr>
<td>Act at a rate too fast for residents with dementia to understand</td>
<td>Take time to greet resident, do not rush feeding, be sensitive and attend to residents’ needs</td>
<td></td>
</tr>
<tr>
<td>2. Withholding</td>
<td>A resident was not given a knife and the turkey was not cut up, causing the resident unable to eat the meat</td>
<td>Holding</td>
</tr>
<tr>
<td>Disregard or lack of awareness of a resident’s need</td>
<td>Provide security and comfort, modify routines to make mealtimes more manageable (e.g., two seating periods, staff of all departments help)</td>
<td></td>
</tr>
<tr>
<td>3. Over-Stimulation</td>
<td>At suppertime, no one noticed the resident’s eyes, making the resident unable to eat</td>
<td>Quality Stimulation</td>
</tr>
<tr>
<td>Excess noise/ busy traffic/ glare/ unpleasant odour</td>
<td>Reduce noise/ calm traffic/ quality lighting/ food cooking aroma</td>
<td></td>
</tr>
<tr>
<td><strong>IDENTITY:</strong> being respected, others hold you in esteem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Disrespect</td>
<td>After feeding, the staff grabbed the resident’s chin and told her “be a good girl now”</td>
<td>Respect</td>
</tr>
<tr>
<td>Treat residents as if they were small children, or objects with no feelings</td>
<td>Treat residents as valued persons, recognize and accommodate to personal preferences and individuality, allow access to food and food choice</td>
<td></td>
</tr>
<tr>
<td><strong>ATTACHMENT:</strong> connected to bonding, trusting relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Invalidation</td>
<td>A resident was in emotional distress, trying to make sense of why she was not with family, staff rushed in and insisted the resident should get ready for breakfast without acknowledging the resident’s emotional need</td>
<td>Validation</td>
</tr>
<tr>
<td>Failing to acknowledge the reality of a resident in a particular situation</td>
<td>Use empathetic skills to recognize the reality of the resident, try to understand how the person feels and what the person needs</td>
<td></td>
</tr>
<tr>
<td>6. Distancing</td>
<td>Placing residents in a line along the wall, a staff stood over and fed them in assembly-line manner, with no communication, no eye contact. The goal was to finish the job in an efficient way</td>
<td>Connecting</td>
</tr>
<tr>
<td>Creating physical or psychological distance with residents</td>
<td>Divide large dining space into small intimate dining areas, arrange residents in small groups, encourage conversations, finds way to communicate with residents, offer a private space for families and their loved ones to eat together</td>
<td></td>
</tr>
<tr>
<td><strong>OCCUPATION:</strong> being able to involve in activities that are personal meaningful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Disempowerment</td>
<td>Even though resident Amy was able to feed herself with fingers, a staff took away a piece of bread from Amy’s hand, broke the bread into pieces, mixed them with porridge and fed the mixture to Amy</td>
<td>Empowerment</td>
</tr>
<tr>
<td>Not allowing residents to use skills/ abilities that they have</td>
<td>Assist residents to use their abilities, allow them to choose within reasonable limits, offer familiar food and present food in recognizable manner</td>
<td></td>
</tr>
<tr>
<td><strong>INCLUSION:</strong> feeling accepted, being included as a full member of the social group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ignoring</td>
<td>In the dining room, in front of residents, two staff discussed the behaviour of a resident has declined to a total confusion, not able to do anything anymore. The resident sitting there felt discouraged and unsupported</td>
<td>Inclusion</td>
</tr>
<tr>
<td>Carrying on (in conversation or action) in the presence of a resident as if the resident is not there</td>
<td>The conversation at the meal tables must include the residents to promote a feeling of worthwhile contribution by everyone present</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G  Reflection Practice

How well did you do in meeting the needs of residents at mealtimes? Record your experience at the end of the shift, and bring it to the quality improvement meeting for discussion. Share what factors hinder or support you in meeting the needs of residents.

<table>
<thead>
<tr>
<th>Residents' needs</th>
<th>What to do</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Comfort</strong></td>
<td>- Do not rush feeding&lt;br&gt;- Attend to residents' needs&lt;br&gt;- Protect the environment, create a relaxed and enjoyable space for meals</td>
<td></td>
</tr>
<tr>
<td>Physical and emotional comfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Identity</strong></td>
<td>- Respect residents&lt;br&gt;- Treat them as adults&lt;br&gt;- Honour preference and habits</td>
<td></td>
</tr>
<tr>
<td>Having a sense of being respected, others know you well, your preferences and habits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Attachment</strong></td>
<td>- Try to understand the realities of residents&lt;br&gt;- Use non-judgmental attitude and empathy skills&lt;br&gt;- Promote social relationships</td>
<td></td>
</tr>
<tr>
<td>Connected to bonding, trusting relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Occupation</strong></td>
<td>- Encourage use of skills/abilities</td>
<td></td>
</tr>
<tr>
<td>Being able to involve in activities that are personal meaningful</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Inclusion</strong></td>
<td>- Include residents in conversations and mealt ime activities</td>
<td></td>
</tr>
<tr>
<td>Feeling accepted, being included as a full member of the group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Adapted from *Dementia Reconsidered: The Person Comes First* (pp. 46-47) by T. Kitwood, 1997, Philadelphia: Open University Press
Appendix H  Theme Posters
What Does Not Work
The following approaches make dining filled with PRESSURE to endure, not pleasure to enjoy!

P Pretend residents do not exist, talk over, ignore
R Rush the meal serving/ feeding
E Excessive stimulations, noise, glare...
S Suppress the person’s value, treat as children/ an object
S Stop residents using their abilities/ skills
U Use labels to blame, unable to empathize needs
R Refusing to meet evident needs
E Estrange relationship, distance people away
What Works
The following approaches make dining filled with PLEASURE to enjoy, not pressure to endure!

P Promote a homelike atmosphere
L Link with residents, include in conversations and activities
E Encourage social interaction
A Alleviate anxiety, attend to social and emotional needs
S Slow down
U Understand the reality of the resident, use empathy
R Respect residents, treat like adults, honor preferences
E Encourage residents to use their skills/ abilities