“PLACE” AND THE MEALTIME EXPERIENCE FOR THOSE LIVING WITH DEMENTIA: TRANSITIONS TO LONG-TERM CARE

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ABSTRACT

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This study is a secondary analysis of data collected from a six-year longitudinal qualitative study called Eating Together (ET), which sought to better understand the mealtime experience of community dwelling persons with dementia and their primary partners in care. Findings from the primary study highlighted the importance of mealtimes for these families, and as persons with dementia moved into long-term care homes it was noted that the meaning of the mealtime experience was challenged. Data from select dyads in the primary study was thematically analyzed, to understand the mealtime experience of persons with dementia and their primary partners in care, when persons with dementia relocated to a “new place”; a long-term care home. Findings revealed five themes related to the new mealtime experience in the long-term care home, including: systemizing the meal, adjusting to dining with others, holding on to “home”, evolving roles, and becoming “at home”.
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1.0 INTRODUCTION

Recent increases in life expectancy suggest that more people will be living to an older age. Because of this, many will experience dementia, as age is the primary risk factor for this syndrome (Alzheimer’s Society of Canada, 2009). As dementia progresses it impacts an individual’s ability to carry out tasks independently (Bellini, 2003) and persons with dementia are likely to become largely dependent on other people for support and care (Berg, 2006). Care within the home by a care partner is common, but often there comes a time when dementia progresses to the point where the individual can no longer be cared for at home, and must move into alternative care arrangements such as retirement homes, or more commonly, nursing homes or homes for the aged (Dash & Villemarette-Pittman, 2005).

For persons with dementia, relocating into long-term care is a common experience; over half the persons with dementia in Canada reside in some type of long-term care home (Hebert, Dubois, Wolfson, Chambers, & Cohen, 2001). The environment of the long-term care home represents a “new place” for the person to become familiar with, and as such it is often a foreign environment that is much different than their home (Groger, 1995). Although research has begun to capture the impacts of a move to long-term care on residents and family members (for example: Aminzadeh, Dalziel, Molnar, & Garcia, 2009; Davies, & Nolan, 2004; Dobbs, 2004; Dupuis, & Norris, 1997; Kahn, 1999; Reed & Payton, 1996; Weisma & Dupuis, 2010), currently there is no available literature to help us understand the experience of mealtimes after relocating to a “new place” of residence, and specifically a long-term care home.
Mealtimes are often one of those taken for granted daily activities; however, previous research has helped to highlight the importance of mealtimes for persons living with dementia (Genoe et al., 2010; Keller, Edward, & Cook, 2007; Keller et al., 2010). Therefore, a secondary analysis of selected dyads from the primary study (Genoe et al., 2010) was undertaken, in order to understand the experience of mealtimes in a “new place” for persons with dementia and to understand how relocating to long-term care changes mealtimes for persons with dementia and their primary partners in care. This project helps to extend the study of mealtimes and dementia to the long-term care context.

This research not only adds to the body of literature in this area, but it also has personal relevance. At the onset of this project, I identified and reflected on some personal experiences that impact the way that I position myself as a researcher in this study. Firstly, my grandfather was diagnosed with Alzheimer’s disease when I was in elementary school and I witnessed firsthand some of the challenges he faced as the disease progressed. It began slowly, with him simply being forgetful, but progressed to the point where he could no longer be cared for in the community and had to relocate to a long-term care home. This was my first experience being in a facility and one that I will never forget. By the time he transitioned, my grandfather was no longer able to enjoy mealtimes. It was a challenge to get him to eat and he did not get any enjoyment out of interacting with other residents at meals. I remember the experience of the dining room at mealtimes being chaotic and I found it difficult to spend quality time with my grandfather in that context. I also remember feeling uncomfortable and out of place and looked forward to the times my parents brought my grandfather to our home for meals, because
it allowed me to spend quality time with my grandfather in a more familiar environment. At home we could serve food that my grandfather was familiar with, and provide him with the individualized attention and support that he required to complete his meal.

During my undergraduate degree I was employed to work in a long-term care home and was assigned to feed persons with dementia who were no longer able to eat independently. This experience really opened my eyes to what mealtimes in long-term care can be like. They are sometimes chaotic and task oriented, but I was able to witness for the first time what mealtimes mean for some of the residents. Most residents looked forward to this time as it meant socializing with others and the enjoyment food. Once I graduated from my undergraduate degree, I worked as a dietary aid for a period of time in a long-term care home and was also able to interact with residents during meals. Through this experience I gathered a rather in-depth understanding of what mealtimes in long-term care can be like from the perspective of an employee who sees the challenges, as well as the opportunities.

My experiences have served to open my eyes to the importance of mealtimes for residents with dementia. With this project I gained a better understanding of what mealtimes mean to residents in long-term care and how mealtimes in long-term care differ from those at home. I want to be able to use this knowledge to better residents’ mealtime experiences in long-term care, as I hope to pursue a career as a Dietitian in a long-term care home.
2.0 LITERATURE REVIEW

The following chapter will provide an in-depth review of the literature relevant to this study. First, a brief overview of dementia, followed by the concept and significance of place, the impact of relocation, the nature of long-term care homes, and concluding with the significance of mealtimes and mealtimes in long-term care.

2.1 Dementia

Dementia is a widespread term used to describe a series of illnesses (Alzheimer’s Society of Canada, 2010). It is not a specific disease, it is a syndrome caused by disorders that promote deterioration of the brain, resulting in the progressive loss of intellectual abilities (Alzheimer’s Society of Canada, 2005). Symptoms of dementia may include loss of memory, judgement and reasoning, and also changes in mood, behaviour and ability to communicate (Alzheimer’s Society of Canada, 2010). There are over 100,000 new incidences of dementia in Canada per year and approximately 10% of Canadians over the age of 65 are living with dementia (Alzheimer’s Society of Canada, 2010; Alzheimer’s Society of Canada, 2009). According to the World Alzheimer Report, an estimated 35.6 million people across the globe are currently living with some form of dementia and this number is expected to double every 20 years (Alzheimer’s Disease International, 2009).

2.2 Place

2.2.1 Defining Place.

Place is everywhere (Creswell, 2004). It can be defined in a number of different ways and has been explored by many researchers in various fields of study (Creswell, 2004; Shamai, 1991). The Oxford dictionary defines place as a particular position, point, or area in space; a location. When we ask people to come to our place, this suggests
ownership and a connection between a person and a space (Creswell, 2004). When we are asked to put something back in its place, this indicates an ordering of things (Creswell, 2004). In addition, place can symbolize a geographical position, a physical state, a social status, a standard for evaluating and more (Creswell, 2004; Steele, 1981). The varied meanings for place help reflect the large role that place has played throughout human history (Steele, 1981).

Place is often considered as a formal geographical concept; however, it is more than that (Relph, 1976). Place is a way of seeing, knowing and understanding the world (Creswell, 2004) and the literature that focuses on living with dementia tells us that interpretation of place becomes increasingly perplexing for the older adult living with dementia (Orulv, 2010). Place should be viewed as a process that cannot be reduced to space or time (Chaudhury, 2008). Place often symbolizes the combination of human and physical environments (Shamai, 1991); it is part of this world that has been given meaning through personal, group or cultural processes (Low & Altman, 1992). Place is never merely an object, but it is part of a larger whole that is felt through the actual experience of meaningful events (Shamai, 1991). Places are public, they are both created and known through common experiences and involvement in them (Relph, 1976).

Relph (1976) was influential with his work on place and he identifies three components to this concept: physical setting, activities and meaning. John Agnew, a later researcher in this area, identified place as having three fundamental aspects: location, locale and sense of place (cited in Creswell, 2004). Place can therefore denote a number of things, however, the concept of place that is perhaps most significant is our interactions with the places in our lives and the meanings attached to different places.
2.2.2 Meaning of Place.

The places in a person’s world are more than material space; they are often profound centers of meaning (Godkin, 1980). The meanings associated with place are vast, as all human action and experiences occur in some place of context (Steele, 1981). Relph (1976) states that, “to be human is to live in a world that is filled with significant places” (p 1). There are many dimensions of meaning attributed to the places in a person’s life, these include: symbolic, emotional, cultural, political and biological (Buttimer, 1980). Places often have highly personal meanings, as they are repositories of memories and centers of everyday routine (Gustafson, 2001). Places where a person has lived for long periods or has returned to many times are often associated with their roots and with continuity (Gustafson, 2001). This evokes a feeling of belonging (Godkin, 1980), and the literature tells us that the feeling of belonging is both critical to wellbeing, and is an inherent human right of the person with dementia (Bell & Troxel, 1994).

Over the years, many feelings and experiences become incorporated into these places making them very meaningful (Buttimer, 1980). In particular, the places of childhood are vital reference points for many individuals and they serve to recall particular significant experiences (Relph, 1976). Often a person with dementia’s most frequent recollections as the disease progresses are of childhood times and places, as those are often the memories of who they are and how they prefer to remember themselves (Chaudhury, 2008).

Places also become meaningful because of the individuals’ relations with the people who live there or interact in the place (Gustafson, 2001). People often base their feeling of “at homesness” on the proximity to friends and family (Buttimer, 1980).
Gustafson (2001), in his study on the meaning of place, determined that its meaning is often situated in the relationships between self, others and the environment. Places are therefore repositories of memory and contexts within which interpersonal, community and cultural relationships occur (Low & Altman, 1992).

Places may also serve to foster a person’s identity. To exist in places, means to create and recreate who we are to ourselves and to others (Chaudhury, 2008). The places in our lives serve as witness to life experiences and as a record of the past (Chaudhury, 2008). The house we grew up in, the school we went to, the neighbourhood we played in, are all part of the mental landscape that help shape who we are (Chaudhury, 2008). This concept of place can be particularly important for persons with dementia as it serves to bring back memories from the past and can both protect and threaten identity depending on the place.

2.2.3 Place Attachment.

The concept of place attachment is a complex phenomenon that incorporates several aspects of people-place bonding (Cookman, 1996; Low & Altman, 1992). The word “attachment” emphasizes affect and the word “place” refers to the environmental setting to which people are emotionally attached (Cookman, 2006; Low & Altman, 1992). People can be attached to their homes, to their communities and to other places that have personal significance to them (Cookman, 1996; Brown & Perkins, 1992). Both emotion and feeling are central to this phenomenon (Low & Altman, 1992), to be attached to a place or to have profound ties to it, is often a significant human need (Relph, 1976). In fact, older persons are often attached to this sense of “place” to the
degree that they engage in “proximity keeping” behaviours, meaning trying to get home (Cookman, 2004; Weiss, 1982).

Place attachment involves the interplay of emotions, cognition and behaviour in reference to place (Ponzetti, 2003). These connections to place form as a result of the meaning given to that space, based on the feelings of comfort and reassurance created from the experiences within its walls or boundaries (Cookman, 1996; Ponzetti, 2003; Rubinstein & Parmelee, 1992). This bonding, however, depends in part on the satisfaction derived from the experiences and the identity derived from the place (Mitty & Flores, 2009). Further, the places in which people live and interact often acquire considerable emotional significance over time (Ponzetti, 2003; Marcus, 1995). Feelings about one’s place may be an important part of remembering the past and keeping the past alive (Rubinstein & Parmelee, 1992).

Often attachments to place are not to the physical structure or area alone, but are also with the shared experiences and relationships with other people that occur in that space (Low & Altman, 1992). Attachment processes involve celebrations, routines, activities, and creations of environments that serve to cultivate individual, family and personal identities (Brown & Perkins, 1992). Events such as family mealtimes are meaningful experiences that may serve to form these connections to place.

Place attachment can also relate to the extent to which the environment is supportive of the individuals’ needs and preferences (Chaudhury, 2008). Traditionally, older adults are perceived to be less mobile and are therefore less likely to change the place where they live (Gilleep, Hyde, & Higgs, 2007; Rubinstein & Parmelee, 1992). They tend to want to “age in place”; growing old in familiar surroundings, with familiar
faces and familiar routines, which can be a source of comfort in old age (Gilleyard et al., 2007). Because of this attachment to home, disruptions to place can be difficult (Wiersma, 2008). Moving or relocating to a new place holds a certain amount of risk for older adults and it can be a highly emotional experience (Gilleyard et al., 2007; Marcus, 1992).

For persons with dementia, attachment theory is being utilized in an attempt to understand their emotional world (Browne & Shlosberg, 2006). The experience of dementia can sometimes erode feelings of safety and security and this is what activates attachment behaviours (Browne & Shlosberg, 2006). Persons with dementia turn to who and what they are attached to, to feel safe and secure; for example, their care partner and their home. For most, their home provides a sense of daily and ongoing security and offers predictability (Cookman, 1996; Low & Altima, 1992). Prior to transitioning, it is likely that persons with dementia were comfortable in, and had formed emotional attachment to the dwelling in which they resided. When these feelings and attachments are disrupted upon relocation, it is possible that persons with dementia may feel uncomfortable and alone in the new environment. Place attachment can therefore help us to better understand the challenges and changes associated with relocating to a new place for persons with dementia and their primary partners in care and the potential importance of mealtime changes of this change in place.

2.2.4 Sense of Place.

Sense of place is a more abstract concept than place attachment and understanding what creates a true sense of place is a complex task (Shamai, 1991). It depends on a number of variables that are often both difficult to explain and research (Shamai, 1991).
Sense of place has been defined as consisting of knowledge, belonging, attachment, and commitment to a place or to part of it (Shamai, 1991). It is a person’s subjective perception of their environment and their conscious feelings about various environments (Steele, 1981). It involves a personal orientation towards place, in which an individual’s understanding of place and their feelings about place become fused in the context of environmental meaning (Hummon, 1992). Thus, we create our own sense of place, as it cannot exist independent of us (Steele, 1981). In other words, our sense of place is an interactional process; it is an experience that is created by the setting combined with what a person brings to it (Steele, 1981).

According to Relph (1976), to have an authentic sense of place means to belong to your place both as an individual and as a member of a community. We often have a sense of place about where we live or where we lived as children (Creswell, 2004). Persons with dementia may experience a sense of place within areas they are familiar with, such as their home (Rubinstein & Medeiros, 2005). They are also able to structure and interpret place, to create a sense of place that goes beyond the immediate experience (Wiersma, 2008). For persons with dementia living in long-term care, the ability to recall memories from the past allows them to maintain a sense of place (Wiersma, 2008). This is of particular importance, as our sense of place helps provide us with stability and identity, which is crucial for those experiencing dementia (Creswell, 2004).

Although a person’s own perspectives and feelings make a major contribution to their sense of place, the setting provides other input (Steele, 1981). Some settings have special features that make them meaningful to an individual (Steele, 1981). For example, seating around a bay window has many purposes; a place to read, an area for company to
sit, and a place to watch children playing outdoors. Similarly a large kitchen, where families take part in preparing meals together and where many celebrations occur, involves many features that imbue meaning. It is therefore not just the characteristics of the physical space that contribute to sense of place, but also the characteristics of the social environment that occur in that space.

Not all settings produce a ‘sense of place’ and some settings are more meaningful to some people than others (Steele, 1981). We tend to be indifferent to places like airports, as they are transition spaces from one place to another. Because sense of place results from a mixture of physical, personal and social factors, when the mix of these is poor we have a feeling of “being out of place” (Steele, 1981). On occasion a new place can evoke this feeling of being out of place until a person becomes accustomed to it. Other places, such as a person’s own home tend to evoke strong feelings of sense of place (Chaudhury, 2008). Persons with dementia can construct a sense of place in the long-term care home by interpreting it in a positive light and creating meaning in that setting (Wiersma, 2008).

2.2.5 The Meaning of Home.

Home is a word that captures so much in our lives (Chaudhury, 2008). A house is a physical structure, but a home is much more (Doyle, 1992). Our homes are interactive environments imprinted with individual choice, style, relationships and histories (Mitty & Flores, 2009). Home is where we belong and it carries with it a great deal of meaning and importance in our lives (Marcus, 1995; Rubinstein & Medeiros, 2005; Tamm, 1999). It is often the foundation of our identities as individuals and as members of a community (Relph, 1976). The home is a central experiential setting and our attachment to home is
often the most profound form of place attachment (Chaudhury, 2008; Relph, 1976; Rubinstein & Parmelee, 1992).

People define and experience home in a variety of ways (Annison, 2000; Dahlin-Invanoff, Haak, Fange & Iwarsson, 2007) as it is the product of individual, social and cultural experiences (Chaudhury & Rowles, 2005). Home is both an abstraction created in people’s minds and the physical structure in which they live (Groger, 1995). For many, a home is often characterized by an atmosphere of warmth and comfort (Dahlin-Invanoff et al., 2007); it embodies a sense of familiarity, independence, autonomy, continuity and cultural identity (Annison, 2000; Groger, 1995; Heliker & Scholler-Jaquish, 2006). It can be a place for self-expressions, a safe refuge where we feel nurtured, and a space in the world that belongs to us (Marcus, 1995). A home can be a point of orientation in relation to the hectic outside world (Chaudhury & Rowles, 2005) and is a place where we can let our guard down (Chaudhury, 2008; Doyle, 1992). The comfort of being in our own home is associated with the feeling of being out of the public eye and having privacy (Tamm, 1999). However, it is also important to note that home can be associated with negative feelings and experiences for some, depending on what has gone on in the home. For example, if an individual was abused as a child, their childhood home would often be associated with upsetting memories.

The significance of home changes at different stages in a person’s life (Marcus, 1995). The experience of home appears to acquire more meaning in old age, as it is the primary environment with which older adults interact (Dahlin-Invanoff et al., 2007). For many, our home is where we grow old and become comfortable (Chaudhury, 2008). Many older adults spend more time within the home as they age, due to a lack of supports
that prevent them from leaving as often as they used to (Oswald & Wahl, 2005).

Consequently, many feel most competent and secure in their own homes; it is their natural environment (O’ Bryant, 1982; Tamm, 1999). For many older adults, their home often becomes a part of themselves (Doyle, 1992) and the experience of being “at home” is associated with defining and maintaining self-identity (Russell, 2005). For those who have spent many years, sometimes decades, in the same home, it helps to shape who the older adult has become and is a reflection of their values and self-image (Cooper, 1974).

Places have the potential of anchoring, organizing and facilitating memories (Chaudhury, 2002). Because our home is often so central to our lives, memories of home are a means for sustaining our sense of self (Chaudhury, 2008). This may be particularly important for a person with dementia, as they are often struggling to hold on to their sense of self as the disease progresses (Chaudhury, 2008; Marcus, 1995). Their home and its contents are a statement about who they are as individuals (Marcus, 1995). A true sense of home is created in the older adult’s ability to personalize it, as everyone’s home is unique (Cohen & Weisman, 1991; Tamm, 1999). A home holds all of one’s life possessions and experiences (Doyle, 1992), and thus in a way, their memories. The sense of home is most intense when older adults have resided in their home for a long period of time and have created many memories within its walls (Oswald & Wahl, 2005). A home becomes a concrete place with which we can identify (Dobbs, 2004); despite the cognitive losses seen in persons with dementia, the meaning of home has been shown to remain (Frank, 2005).
2.3 Relocation

2.3.1 Relocating Place.

Living at home is related to both the older adult’s health status and sense of wellbeing and most often, remaining in the home is the most desirable option for an older adult (Groger, 1995). However, staying at home is not always an option for older adults, especially for those experiencing physical or cognitive challenges. As an older adult’s health declines, he/she might be forced to consider leaving his/her home and relocate to a long-term care home (Mace & Rabins, 1981). Often this is not a self-initiated decision, but a decision made by their family care partners (Caron, Ducharme & Griffin, 2006). As the older person’s needs escalate and their family care partners have more demands placed on them, it becomes increasingly challenging for them to keep up (Ross, Rosenthal & Dawson, 1993).

Caring for a person with dementia in the later stages of the disease can be a twenty-four hour a day job and often requires the skills of professionals trained in this area (Mace & Robins, 1981). Family care partners of persons with dementia struggle to continue care within the home, but as dementia progresses there is often a need to shift focus from community care to the acceptance of long-term care as the most suitable form of support (Cohen, et al., 1993). For persons with dementia, relocating to a long-term care home is a common experience; over half the persons with dementia in Canada reside in some form of long-term care home (Hebert et al., 2001).

Relocation involves the loss of one’s home and may be associated with initial feelings of loss, sadness and confusion upon entering the unfamiliar setting (Heliker & Scholler-Jaquish, 2006). The notion of “home” and its importance in supporting specific
cognitive-functional abilities becomes especially evident when relocated individuals demonstrate cognitive decline in the new setting (Shulz, Belle, Czaja, McGuire, Stevens, et al, 2004). Consequently, this is most often a challenging time for both the person with dementia and their family partners in care.

2.3.2 Long-term Care Homes.

Long-term care typically refers to ongoing, indefinite care for individuals who are no longer able to totally care for themselves (Banerjee, 2009). Long-term care may be required for people of any age, but it is a common need of older adults. This form of care is necessary to maintain the health and safety of older adults and others (Ministry of Health and Long-term Care, 2009).

The definition of long-term care in the Canadian context is complicated by a lack of a common language (Banerjee, 2009). Often, the formation of long-term care homes, their function and their role in relation to other care settings is location specific (Benerjee, 2009). In Ontario, long-term care homes refer to retirement homes, supportive housing, nursing homes, and homes for the aged (Benerjee, 2009).

Each type of home offers a different form of accommodations and different levels of care (Ministry of Health and Long-term Care, 2009). Retirement homes are intended for individuals requiring a minimum level of support such as meal preparation, housekeeping and low levels of personal care (Ministry of Health and Long-term Care, 2009). Supportive or assisted-living is intended for individuals who require a greater amount of care, but do not require 24-hour nursing or specialized care (Ministry of Health and Long-term Care, 2009), while, nursing homes or homes for the aged are intended for those who require specialized daily personal care and the availability of
around the clock nursing care and or supervision (Ministry of Health and Long-term Care, 2009). For this secondary analysis I am interested in all forms of long-term care, nursing homes or homes for the aged, as well as retirement facilities.

2.3.3 The Nature of Long-term Care Homes.

Life in long-term care is often very different from life at home. Relocating represents not only a move to a new environment, but also to a new way of life (Wiersma, 2008). Many routines and practices associated with living at home are disrupted and long-term care residents are forced to adapt (Aminzadeh, Dalziel, Molnar, & Garcia, 2009). This is generally very challenging for older adults and may be even more challenging for persons with dementia (Aminzadeh et al., 2009) who are already dealing with a number of other changes.

Long-term care homes are often viewed as collectively defined spaces, rather than personally meaningful places (Rubinstein & Parmelee, 1992). Living in a long-term care facility often means living in more protected, dependent, structured and communal surrounding (Aminzadeh, et al., 2009). Some people believe that to live in an institution means to be sick, dependent and under surveillance; whereas to live at home means they are healthy and independent (Caouette, 2005). Long-term care homes are often associated with routines and regimens and an emphasis on functional rehabilitation over the maintenance of all aspects of well-being (Gubrium, 1997; Rubinstein & Parmelee, 1992). Because of the emphasis on medical care, the awareness that the facility is a place where people live, a home, is sometimes lost (Rubinstein & Parmelee, 1992).

Daily life in long-term care revolves around fairly structured and predictable routines for meals, care tasks and programmed activities (Chaudhury, 2008; Cook, 2008).
Day-to-day activities occur within the building and there is a decreased use of exterior services reflecting a more restricted daily universe (Caouette, 2005). Time is generally spent participating in collective activities (e.g. tv watching in the lounge, group recreation programs), rather than personally meaningful activities (Aminzadeh et al., 2009; Caouete, 2005; Train, Nurock, Manela, Kitchen & Livingston, 2005). The regimented day in long-term care facilities often leaves residents longing for more choice and flexibility (Train et al., 2005). They wish to choose when to have meals, when to rest and when to have company. Consequently, it is difficult for older adults to establish a sense of belonging with all the rules and regulations (Caouette, 2005).

The long-term care environment can be viewed as having a lack of private rooms, of intimate places and of usable space (Caouette, 2005). The person’s room generally becomes the principle place for emotional investment (Caouette, 2005). Their room is where they welcome visitors, spend their time and rest. However, many residents have to share rooms with others and this limits their privacy. Furthermore, the structured similarities of rooms in nursing homes can sometimes make them appear as impersonal cubicles rather than personal living spaces (Rubinstein & Parmelle, 1992). Some older styled facilities do not contain storage spaces to accommodate the resident’s belongings, preventing the resident from personalizing them to their satisfaction (Fiveash, 1998). Another problem can arise from different people imbuing rooms with a different meaning. These conflicting meanings can often challenge a person’s sense of place. For example, when a resident views his or her bedroom as their space for visiting and entertaining their family and friends, and the staff on the other hand views the space as an
area where a resident can more easily be toileted, this can cause much stress and threaten the persons’ sense of place (Wiersma, 2008).

Another challenge for residents of long-term care is that their interactions are often limited primarily to those who live or work in the facility (Caouette, 2005). However, residents often find it difficult to find staff members who have time to talk with them and other residents with similar interests or level of functioning as themselves. Family involvement is sometimes decreased as the home may have restricted hours for visiting which do not always accommodate family members’ work schedules. On occasion homes even ask that relatives not visit during mealtimes (Davies & Nolan, 2004). Environmental features of the long-term care facility can therefore limit family member’s involvement (Dupuis & Norris, 1997). The meanings family members attach to the home can also influence the frequency with which they visit and the sense of place felt within the home (Davies & Nolan, 2004).

2.3.4 The Meaning of Relocation.

Relocation to a long-term care home is a major life transition, often requiring considerable adaptive efforts (Aminzaheh et al., 2009; Davies & Nolan, 2004). It represents the end of an era and the beginning of a new way of life (Aminzadeh et al., 2009). Relocating often involves risk, as persons with dementia and their families are often unprepared for what’s to come (Davies & Nolan, 2004; Gilleard, et al., 2007; Reuss, Dupuis & Whitfield, 2005). It means uprooting oneself from a familiar environment to move to a place that is not fully equipped to accommodate the various material possessions and social relations that have served to define the individual (Davies & Nolan, 2004; Groger, 1995). Relocation is therefore associated with the loss of
possessions, experiences and connections associated with being at home (Aminzadeh et al., 2009).

Adjusting to the change in environment is often difficult, as the meaning of home for older adults with dementia is not easily transferred to the long-term care setting (Groger, 1995). This new dwelling is not emotionally invested with the same memories as the previous home (Caouette, 2005, Davies & Nolan, 2004) and older adults often experience an absence of the emotional attachment to the people and things in the new environment (Dobbs, 2004). They also experience a disruption in the rituals associated with living at home (Heliker & Scholler-Jaquish, 2006). For example, an individual who was accustomed to helping with meal preparation in their own home now arrives to meals with everything already done for them. This may contribute to further discontinuity with the new environment.

Newly relocated residents often long for the experiences with family and friends, the continuity of valued roles, the special occasions celebrated, and the symbolic personal markers associated with living at home (Dobbs, 2004). Being thrown into this new environment can therefore leave persons with dementia feeling a sense of homelessness (Heliker & Scholler-Jaquish, 2006; Kellett, 1998). It is difficult for them to create a sense of place within the home initially, as this has to be co-created between all members of the community within the home, and it can take time for these relationships to develop.

During this time residents may feel vulnerable and unsure of what to expect (Dupuis-Blanchard, Neufeld and Strang, 2009). The confusion that typically occurs with the experience of dementia can often worsen for a period following the relocation, making adjustment even more challenging (Mace & Rabins, 1981). Persons with
dementia may withdraw from others, may become anxious and may have difficulties sleeping and eating (Heliker & Scholler-Jaquish, 2006). In addition, the more a person with dementia’s self-identity is threatened by losses of physical and cognitive abilities and losses of places to which they were attached, the greater the chance they may experience a loss of their sense of self (Chaudbury, 2008). Hormuth (1990) wrote about the impact of relocation on self-concept. According to him, development and change happen within the self but to understand these changes, we need to look beyond the changes happening within the individual and also examine the change in their surroundings. For some, relocation challenges self-identity and there is sometimes a need to redefine self in the setting (Hormuth, 1990). For persons with dementia they often resist the new identities imposed by staff members and attempt to find ways to reaffirm who they are in the new space (Paterniti, 2000, 2003).

In summary, relocating to a new place involves a variety of changes and it is often difficult to adjust to the new setting. The ability of a person with dementia to respond to this change is largely dependent on their stage in the disease and whether they are able to view the new setting as home (Mace & Rabins, 1981).

2.3.5 Searching for “Home” in the Long-term Care Setting.

One of the most significant challenges for older adults who have relocated to long-term care is coming to view their new place of residence as home (Dobbs, 2004). Often they have not only left behind a home, but also a part of who they are (Heliker & Scholler-Jaquish, 2006). Wiersma (2010) found that new residents in long-term care homes defined their new lives as “altered” lives, especially if things that they valued in their home environments were lost after relocating. Relocation often represents a
disruption of place and it is challenging to attempt to re-create place in the new setting; however it is possible (Brown & Perkins, 1992).

Groger (1995) examined individuals’ perceptions of long-term care facilities as home and found that the residents’ abilities to do so was related to the circumstance of their placement, the criteria they used to define home, and the degree of continuity they achieved after placement. If aspects which symbolized home for the resident were mobile and could follow them to their new residence, they were more likely to perceive that the new environment could become their home (Groger, 1995). For instance, if residents defined home as relationships, they were more likely to see the facility as a home if they developed these relationships with staff and other residents (Cutchin, Owen, & Chang, 2003; Groger, 1995). Fostering relationships in the long-term care home can, therefore, give older adults a sense of ‘at homeness’ (Cutchin et al., 2003). Family members and friends can also serve as an important link to the outside world and can help to contribute to the sense of community and continuity within the care home (Davies & Nolan, 2004).

Persons with dementia can also influence their own life in the care home (Cook, 2008). One way to become accustomed to life in long-term care is to familiarize themselves with various aspects of the home such as the staff members, other residents, activities and outings (Reed & Payton, 1996). According to Hormuth (1990), familiarizing oneself with the environment helps to stabilize a person’s self-concept and this can help them adjust. Additionally, there are many things that new residents can do to hold on to their sense of independence and to continue to do things that are important to them (Cook, 2008). A sense of continuity (Groger, 1995) can be achieved if they can
modify their rooms to make them their own space, they can initiate friendships with other residents and staff members, and they can also participate in various activities both within and outside of the home; however, supports need to be available to assist residents with this. Meaningful activities, such as mealtimes, in the new environment can also serve to create a sense of ‘at homeness’ (Cutchin et al., 2003).

Therefore, some of the experiences and meanings associated with living at home are left behind when a person with dementia relocates to a new place, but new experiences can result in positive relocation and support for identity and feeling at home. When older adults are capable of maintaining continuity with the feeling of home prior to relocating, it is often easier for them to adjust (Groger, 1995).

2.4 The Value of Mealtimes

2.4.1 The Importance of Food and Mealtimes.

For many, eating is generally viewed as a simple, rather obvious event, rendering the process of consumption relatively insignificant (Bryon et al., 2008). However, food and mealtimes have a very important role in our lives (Evans, Crogan, & Shultz, 2005; Grudzen, 2003; Kayser-Jones, 1996; Zgola, & Bordillon, 2001). Food is not simply a vehicle for ensuring physical health (Beardsworth, & Keil, 1997; Berg, 2006; Seymour, 1983); food sharing patterns, preferences and traditions are integral to family life (Beardsworth, & Keil, 1997; Crogan, Evans, Severstsen & Shultz, 2004; Seymour, 1983).

For most individuals living in the community, the food we eat, and when, where, with whom, and how much, are decisions based on individual choice and life-time habits (Kayser-Jones, 1996; Seymour, 1983). Food and eating occasions constitute a complex
phenomenon that link human biological needs to social and cultural needs and habits (Synder & Fjellstrom, 2005). People have many uses for food; it can be a way of coping with emotions, expressing feelings, celebrating triumphs, and maintaining connections with others (Evans, Crogan & Shultz, 2005).

Food is vital, but it is also associated with enjoyment (Berg, 2006). Food and mealtimes are part of our daily routine and are also associated with family traditions, social activities and special occasions (Kayser-Jones, 1996). Mealtimes place people physically together, sharing in the enjoyment of food (Berg, 2006). For persons with dementia mealtimes are a natural opportunity for meaningful interaction, socialization, reminiscing and taking part in tasks (Berg, 2006; Keller et al., 2007). Traditions surrounding food consumption are particularly meaningful, as they can provide us with a powerful link to our identity (Evans et al., 2005; Genoe et al., 2010). Because of their strong presence, food and mealtimes are often central to our lives.

2.4.2 Mealtimes at Home for Persons with Dementia.

A home is a place where people carry out every day events. It is in the home where people sleep, socialize, prepare meals, and consume them (Tamm, 1999). As daily events, meals carried out within the home help to structure the older adult’s life and help to create balance (Keller et al., 2010; Tamm, 1999). They are often familiar, distinctive patterns of family life that bring comfort and security (Evans et al., 2005). Mealtimes within the home are central to the day’s events and are meaningful to the older adult.

Mealtimes are a chance for family to gather together in the preparation of the meal. This is an opportunity for the person with dementia to get involved in various activities around mealtimes. It is a time when they can share their recipes and skills with
others. No matter how far the disease has progressed, persons with dementia are generally able to participate in some aspect of the meal preparation and these roles are often meaningful to them (Keller et al., 2010).

At home, persons with dementia often hold some control over the foods that are prepared and that they consume, which helps to foster their identity (Genoe, et al., 2010). Foods prepared within the home were also often familiar to the person with dementia, which helps bring back memories of the past (Berg, 2006; Genoe, et al., 2010). Within the home, care partners are further able to support their loved ones identity, by encouraging them to become involved with tasks they feel comfortable with (Genoe, et al., 2010). Persons with dementia can participate in all aspects of meal preparation at home, including; grocery shopping, meal planning and food preparation.

Mealtimes within the home also serve as routine social activities that provide opportunities for conversation for persons with dementia (Keller et al., 2007). In gathering together in the sharing of a meal at home, they are able to share stories and create memories with others (Keller et al., 2010; Genoe et al., 2010). This social companionship around the table can promote a sense of belonging (Berg, 2006).

2.5 Mealtimes in Long-Term Care Homes

2.5.1 Mealtimes in the Lives of Residents.

Mealtimes are not only central to a resident’s nutritional care, but are also a vital daily activity (Gibbs-Ward & Keller, 2005). Despite their challenges, mealtimes are most often the high point of the day (Keller et al., 2007). In long-term care homes, the day is structured around meals; they help to mark the time of day for the residents and help divide it into sections (Berg, 2006). Mealtimes are often one of the few motivators for
residents to leave their rooms (Kofod & Birkemose, 2004), providing a break from social isolation (Bryon et al., 2008).

Mealtimes in long-term care serve as a natural opportunity for conversation with older adults, as most have had a lifetime of experience with the traditional sit-down model of dining (Hopper, Cleary, Baumback & Fragomeni, 2007). Communication during mealtimes is essential to the resident’s mealtime experience. For many, it can be the most rewarding social interaction of the day (Gibbs-Ward & Keller, 2005). This is a time when residents can develop new relationships and share memories of home with each other (Evans et al., 2005).

Communication through language is not always easy for persons with dementia as the disease progresses. However, residents may express themselves in other ways, through facial expressions, gestures, their clothing and habits, as well as by helping others (Curle & Keller, 2010; Hopper, Clearly, Baumback et al, 2007; Li & Orleans, 2002). Staff members can aid in promoting social interaction between residents and this helps to create a pleasant dining experience for all those involved (Reimer & Keller, 2009). Family members or friends may also be present at mealtimes to join in conversation and this helps to maintain the bond between the resident and their care partner. Residents can discuss their day with their relatives and the relatives can update them on their own lives and keep them up to date with news from their community.

Family care partners can also facilitate meaningful interactions between residents (Bergland & Kirkevold, 2006; Curle & Keller, 2010). Family members often use food (bring in favourites) as a way of engaging the resident and providing a meaningful interaction.
When residents develop friendships with tablemates and staff members, this can help them to feel more comfortable and familiar with the long-term care environment (Reed & Payton, 1996). Sitting with the same people at mealtimes can also help with recognition and group identity (Berg, 2006). The connections residents form with other members of the long-term care community may assist in their adjustment to the long-term care environment and may also improve their quality of life (Bergland & Kiorkevold, 2006; Dupuis-Blanchard et al., 2009; Neufeld & Strang, 2009; Hopper et al., 2007).

Given that most practices within the institution foster dependent behaviour, mealtimes are a time when residents with dementia can embrace their independence (Altus, Engelwood, & Mathews, 2002). It is an opportunity for residents to preserve their remaining skills (Berg, 2006) and encouraging them to eat on their own and make their own food choices helps to maintain their dignity (Reimer & Keller, 2009). Making food choices is particularly meaningful to the resident, as preferences are closely linked to their traditions, religion and personal taste (Dindyal & Dindyal, 2004; Shepherd, 1999). When residents are given choice over the food they eat, this also allows them to maintain a sense of cultural continuity in the midst of the many changes and losses they have experienced since moving into a long-term care home (Kayser-Jones, 1996).

Mealtimes also offer the opportunity for residents to assist each other. Residents sometimes rely on each other for support and they can assist each other if staff members are unavailable to do so. This can help encourage relationships amongst residents (Ryvicker, 2009) as well as a caregiving role (Curle & Keller, 2010; Sandman & Norberg, 1988). For those wishing to do so, residents encourage their tablemates to eat and they can pass them their utensils, butter their bread, and pass them dishes out of their
reach. Residents can also help the dining room staff by setting the table, pouring beverages, or stacking dishes. This helps provide the individual with a role at mealtimes and gives them a sense of purpose, which can help to foster their identity (Genoe et al., 2010).

Finally, mealtimes in long-term care provide residents with a break from their previous mealtime responsibilities and duties (Wikby & Fagerskiold, 2004). Some residents see them as a much-deserved vacation from cooking; they have cooked for their whole life and now it is time for them to sit back and enjoy the food prepared by someone else (Evans, Crogan, & Shultz, 2003). They enjoy being waited on and compare it to visiting a restaurant (Evans, Crogan, & Shultz, 2003), as it takes the work out of mealtimes and is a time when they can gather together with others in the sharing of a meal.

In summary, mealtimes are a time for much more than simply ensuring that residents have adequate food and fluid intake (Bryon et al., 2008). Residents of long-term care homes can still experience a variety of meanings within meal-related activities that contribute to quality of life (Bundgaard, 2005). Mealtimes in long-term care can be a time of social interaction, staff attention and enjoyment of food (Bryon et al., 2008). They encompass the process of arriving to the dining room, the resident being acknowledged by other residents and staff, socializing, the act of eating, and various other activities that can occur during the meal (Gibbs-Ward & Keller, 2005). Mealtimes are therefore not just about the food on the plate, but rather the entire experience (Sidenvall, Fjellstrom & Elk, 1994) and can help to foster independence, support self-esteem, promote interactions with others and make the resident feel more comfortable in their surroundings (Speroff,
It is evident that mealtimes carry a lot of meaning in the lives of residents.

2.5.2 The Culture of Long-term Care and Mealtimes.

Although mealtimes can have great impact on quality of life in long-term care homes, the culture and approach within a home can greatly influence how mealtimes are experienced. In fact, providing a positive dining experience in long-term care for all residents is not easy (Speroff, et al., 2005). Mealtimes are often much different from what the older adult was accustomed to in their own home (Berg, 2006; Evans, Crogan & Shultz, 2004). In long-term care homes residents lose at least to some extent, their influence over what they eat, how much, for how long, with whom and in what surroundings (Berg, 2006). The traditional meal environment for persons with dementia residing in long-term care comprises of large dining rooms, pre-plated portions of food, staff assistance and an overall discontinuity with the mealtime standards of home (Sandman & Norberg, 1988).

At mealtimes residents sit with a group of designated individuals, usually in groupings of four or five around the table (Berg, 2006) and usually with individuals not of their choice. For those older adults who are accustomed to eating on their own or just with their spouse, this situation can be uncomfortable. In addition, they may not always feel comfortable eating with others if they have problems with choking on food, a touchy stomach, or problems watching others eat or be fed (Evans et al., 2003). Behaviours such as spitting, taking food from others’ plates and making loud noises can also make it difficult for residents to feel comfortable with their tablemates and can impede resident
interactions. Many wish that they could have a choice over whom they sit with during the meal (Crogan et al., 2004; Evans, Crogan, & Shultz, 2003; Zgola & Bordillon, 2001).

The food served to residents can also be problematic, as the quality or type is not always consistent with their personal preferences (Crogan et al., 2004). Food quality is seen as the freshness of the meal, variety of food, the presentation of dishes, and the temperature of the food (Evans et al., 2003). Often nursing homes have large-scale kitchens that simply are not equipped to offer the same quality of food provided in the home (Bryon et al., 2008). Food is often prepared in advance and some of the preparation techniques used can lead to poorer quality (Wikby & Fagerskiold, 2004). Food prepared in unfamiliar ways only amplifies the feeling of discontinuity for the resident (Evans et al., 2004).

Residents also often lack choice over what is being served. Residents have both individual and cultural food preferences and often those preferences don’t always align with what is on the menu for that day (Ducak & Keller, 2011; Kayser-Jones, 1996). Any special request made for other foods at mealtimes are generally not honoured, and may be perceived as irritating to the cook and disruptive to the meal (Dobbs, 2004). This is a cause for concern because when residents are unable to consume the food that they like their motivation to eat often decreases (Wikby & Fagerskiold, 2004). If residents choose not to consume their meal they generally have to wait for designated snack times for food, as items are not commonly accessible between meals (Bryon et al., 2008). This can lead to nutritional challenges (Wikby & Fagerskiold, 2004).

The treatment of residents by staff members can also be problematic during mealtimes. Mealtimes are times when residents and staff have the time to socialize;
however, due to pressures to serve the meal and assist residents requiring assistance, staff members often feel they have little time to acknowledge residents beyond what is needed to control behaviour or signal the resident to eat (Ryvicker, 2009). Lack of acknowledgement during meals can make residents feel like bodies that need maintenance rather than people who need to be cared for (Wiersma, 2008) and this can impact their mealtime experience (Ryvicker, 2009). Mealtimes are a busy time for staff, and because of this, discussions about care tasks often happen at mealtimes, making the conversation at the table task-oriented rather than social (Ryvicker, 2009). When staff members do engage in conversation with residents it is most often superficial, centered mainly on aspects of the meal environment (Sandman & Norberg, 1988).

Another common problem that residents experience during mealtimes is that they are infantilized (Ryvicker, 2009). Food is cut for them, assistance is provided before staff members determine if it is needed, and residents are talked to in childlike tones and given pet names. This can contribute to a loss of dignity for persons with dementia (Keller et al., 2007).

In summary, the communal nature of mealtimes in long-term care homes and the lack of choice around food, timing of meals and whom to sit with, make adjusting to mealtimes in a long-term care home a challenge. Food and mealtimes in long-term care are generally very different experiences from those at home.

2.6 Summary of Literature Review

As the Canadian population ages and incidence of dementia increases, more and more care partners are making the decision to relocate their loved one to a long-term care home (Hebert et al., 2001). Relocating into a care residence is often difficult for all
members involved and may be particularly challenging for persons with dementia who are already dealing with many changes associated with their disease. Relocating to long-term care often signifies the loss of one’s home and of one’s independence and the start of a new way of life. With the relocation comes a variety of changes that families must become accustomed to, including the disruption of family mealtimes.

The literature reviewed in this area indicated that mealtimes in long-term care homes can be chaotic and task oriented, but they often continue to remain central to the lives of residents (Gibbs-Ward & Keller, 2005; Reimer & Keller, 2009). Mealtimes are a time when persons with dementia can form connections with others and create meaningful experiences. They are also a time when they can make decisions for themselves and can assist others, which can help foster their identity. Often still, however, mealtimes in long-term care homes are much different from mealtimes within the familial home, and can be negative experiences when little choice is provided and mealtimes become routinized tasks rather than social opportunities.

In order to truly understand how mealtimes in long-term care can be improved to feel more like meals at home, it is important to understand how persons with dementia experience mealtimes after relocating to a “new place”. Currently, there is a lack of research in this area and we do not yet truly understand the importance of “place” in understanding the mealtime experience. This study helps to address this gap. The original intent of this secondary analysis was to determine how the meanings of “place” impact the mealtime experience of newly relocated residents with dementia and their primary partner in care; however throughout analysis it became evident that the data were not present to give a full sense of the ‘meaning of place’ to the mealtime experience.
Nevertheless, we were able to begin to understand how a “sense of place” influences the mealtime experience in the long-term care home. This study also helps explicate the experience of mealtimes in long-term care considering all of the changes that result from relocation and also brings clarity to the family experience of mealtime changes post relocation which is a current gap in the literature.
3.0 RESEARCH QUESTIONS AND RATIONALE

3.1 Rationale

Mealtimes are a large part of life and are an important part of social interaction for persons with dementia (Gibbs-Ward & Keller, 2005; Kofod & Birkemose, 2004). Research on mealtimes for persons with dementia living both in the community and in long-term care has taken place; however, there are no studies to date that look at the experience of mealtimes in a long-term care, considering the issue of ‘place’ and how it affects this experience.

We know that relocating a loved one into a long-term care home is difficult for all those involved and that it is associated with a variety of changes (Reed, 1996), yet we do not understand how the mealtime experience is specifically changed, from the perspective of the person with dementia and their family care partner. This study allows for an examination of the role of “place” on the experience of mealtimes for persons with dementia and their primary family partners in care who have made this transition to long-term care.

3.2 Research Questions

Due to an inability to fully examine the ‘meaning of place’ to the mealtime experience for families in this secondary data analysis, I will address only the three more detailed questions that were the original sub-questions for this study:

(1) What is it about the “new place” that contributes to the experience of mealtimes for persons with dementia and their primary partner in care?

(2) How are mealtimes experienced by the dyad after a move to long-term care and how are these experiences different from mealtimes at home?
(3) What specific strategies do persons with dementia and their family partners use to respond to the new experience of mealtimes that resulted from relocating place?
4.0 METHODOLOGY

4.1 The Eating Together Study

The Eating Together Study carried out by Dr. Heather Keller (primary investigator), Drs. Sherry Dupuis, and Lori Schindel Martin, is currently undergoing its final year of data collection in the community. The Eating Together project is a six-year longitudinal study using grounded theory methodology. The goal of this research is to better understand the experiences around food and mealtimes for persons with dementia and their primary family partners in care. Over the past five years, the researchers have been exploring how the participant’s experiences around food and mealtimes have changed as the disease progresses, how these changes impact individual and family relationships, and how families learn to cope or adapt to these changes. The focus initially was on families residing in their own homes in the community; however, since the beginning of the project several families have experienced a move into a long-term care home.

Twenty-seven families were initially recruited for the larger study from formal community agencies and health service providers located in central southern and central western Ontario. There were 26 dyads and one triad included in the study and participants were 27 persons living with dementia and 28 care partners. All persons with dementia were 55 years or older, living in the community, were in the early to middle stage of the disease and were able to communicate their experiences around mealtimes at the time of recruitment. Participants provided written consent if able on a yearly basis. If written consent was not possible, the person with dementia provided verbal consent and the
family care partner provided written consent. Ethical approval for this study was obtained from the University of Guelph, The University of Waterloo, and Ryerson University.

Data collection was in the form of active interviews (Holstein & Gubrium, 1995). Active interviews allow for an interactional process with the participant and the researcher, recognizing that all knowledge is co-constructed (Holstein & Gubrium, 1995). They are semi-structured interviews which also allow for greater breadth, which is consistent with the grounded theory methodology (Holstein & Gubrium, 1995). Eight trained researchers conducted the interviews and an interview guide was developed to facilitate this process. All researchers used the interview guide as a reference, but they had the opportunity to add or drop questions based on the direction the participants were headed. Each family was contacted to be interviewed on a yearly basis. The research team initially conducted individual and joint interviews with persons with dementia and their primary partners in care, with each interview lasting half an hour to two hours. Over time, individual or dyad-only interviews were conducted in some cases. All audio interviews were then transcribed verbatim and checked for accuracy.

Data from the larger study were collected and analyzed using constant comparative analysis consistent with grounded theory methodology (Charmaz, 2006). Constant comparative analysis is a technique whereby data collection and data analysis occur simultaneously and this allows earlier interviews to inform later interviews (Charmaz, 2006). It also allows data to be compared over time and across dyads to aid in the developing the theory (Charmaz, 2006). Several levels of coding: initial, focused, axial and theoretical, were also completed to analyze the data as per Charmaz (2006). The interviews were coded using NVivo software (version 8.0) when concepts and themes
were identified from the grounded theory analysis process. In analyzing the first two years of interview data, a theory emerged and was refined in later interviews.

Early findings of the study suggested that mealtimes were more significant than what they seemed on the surface. The first two years of data collection helped to reveal how families experiencing dementia use mealtimes as ways of being connected, honouring identity and adapting to and accepting one’s evolving life (Keller et al., 2010). This secondary analysis of the data collected for the Eating Together Study for those families that have relocated, serves to help us better understand the role of place and relocation on mealtimes, after persons with dementia move into long-term care homes.

4.2 Philosophical Underpinnings

A paradigm is a set of basic beliefs that represent how the researcher views the world (Guba & Lincoln, 1984). The paradigm with which I have aligned myself is that of social constructionism, which holds the belief that there are many interpretations possible that can help us understand social reality (Daly, 2007). It emphasizes meaning-making as an interactive process between the participant and the researcher and it also recognizes that reality can be represented in a number of different ways depending on the context in which it is constructed (Daly, 2007). Therefore, as a researcher conducting secondary analysis I realize that my results are based on both the interaction between the researcher who originally conducted the interviews and the participants, as well as my interpretation of these interviews.

Ontologically I position myself as a relativist, as I believe no external reality can exist independent of the versions created by those who experience it (Daly, 2007). Therefore, “discovered” or co-created reality arises from the interaction process between

the researcher and the participant (Charmaz, 2002). In agreement with the constructionist paradigm, I have taken the subjectivist epistemological stance, as I believe that the researcher plays a key role in shaping the direction and outcome of the inquiry (Daly, 2007).

4.3 Overview of Research Methodology

This research is a secondary data analysis of the data collected for the Eating Together study. Permission to conduct this secondary analysis was granted from the University of Guelph Research Ethics Board (REB#10AP006). This is a secondary data analysis, as the data were not originally collected for the purposes of this study, and the primary researcher conducting the secondary analysis did not participate in data collection. However, the questions being posed are sufficiently close to that of the original research, that the data set sufficiently represents the topic of secondary inquiry (Thorne, 1994). The focus of this study continues to be on the meaning and experience of food and mealtimes for persons with dementia and their primary partners in care. However, the focus here is on the mealtime experience of persons with dementia and their primary partners in care when a person with dementia has relocated to a “new place”; a long-term care home.

Qualitative data are capable of being revisited from multiple perspectives and used to answer different research questions (Kelder, 2005). This study is therefore a retrospective interpretation, as the data are being used to consider a new question that was not touched on in the original study (Thorne, 1994). This secondary analysis also allows us to extend the larger context in which the research findings of a primary study
can be useful (Thorne, 1994) and helps to identify factors related to place that might change the meaning and experience of mealtimes.

A challenge that any researcher doing secondary data analysis face is not being aware of the influence of certain features of the original data set, as he or she was likely not present to collect the data (Thorne, 1994). In order to address this issue, I met regularly with my advisor and on occasion with other members of the Eating Together Study to discuss any concerns that I was experiencing and to receive clarification when needed. During this time, they identified pertinent issues that I was overlooking in the data and also provided me with reassurance that my interpretations of the transcripts were grounded appropriately in the context of the original discourse (Kelder, 2005; Thorne, 1994).

4.3.1 Selection of Families for Secondary Study.

Eligible families for inclusion in this secondary data analysis had to have experienced a move into a long-term care home (retirement or nursing home level) during the first five years of data collection and had to have been followed for a minimum of four consecutive years. For the purposes of this study, seven out of eleven families who had gone through the relocation process, were chosen for further analysis. The families were chosen, with help from my thesis supervisor, because they represented different types of family relationships and different places in which the person with dementia had moved. The table on the following page illustrates some of the characteristics of the included families.
Table 1. Characteristics of Included Dyads

<table>
<thead>
<tr>
<th>Dyad Number</th>
<th>Care Partner’s Relationship to PWD</th>
<th>Gender of PWD</th>
<th>Year Relocated</th>
<th>Type of Placement (nursing home/retirement home)</th>
<th>Number of Interviews Prior to Relocation</th>
<th>Number of Interviews Post Relocation</th>
<th>Breakdown of Interviews (# by: PWD, CP, Dyad)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>niece</td>
<td>female</td>
<td>five</td>
<td>nursing home</td>
<td>twelve</td>
<td>Three</td>
<td>PWD-five, CP-five, DYAD-five</td>
</tr>
<tr>
<td>10</td>
<td>spouse</td>
<td>female</td>
<td>two</td>
<td>nursing home</td>
<td>three</td>
<td>Eight</td>
<td>PWD-four, CP-six, DYAD-one</td>
</tr>
<tr>
<td>11</td>
<td>Ex-spouse</td>
<td>male</td>
<td>three</td>
<td>retirement home</td>
<td>six</td>
<td>Five</td>
<td>PWD-four, CP-four, DYAD-three</td>
</tr>
<tr>
<td>12</td>
<td>spouse</td>
<td>male</td>
<td>four</td>
<td>nursing home</td>
<td>nine</td>
<td>One</td>
<td>PWD-three, CP-four, DYAD-three</td>
</tr>
<tr>
<td>19</td>
<td>spouse</td>
<td>female</td>
<td>four</td>
<td>nursing home</td>
<td>nine</td>
<td>One</td>
<td>PWD-three, CP-four, DYAD-three</td>
</tr>
<tr>
<td>21</td>
<td>spouse</td>
<td>female</td>
<td>two and five</td>
<td>retirement home, then nursing home</td>
<td>three</td>
<td>Eight</td>
<td>PWD-four, CP-three, DYAD-four</td>
</tr>
<tr>
<td>23</td>
<td>daughter</td>
<td>female</td>
<td>two</td>
<td>retirement home</td>
<td>three</td>
<td>Twelve</td>
<td>PWD-five, CP-five, DYAD-five</td>
</tr>
</tbody>
</table>
For these seven families all the transcripts from the first year of data collection through to the fifth year of data collection were examined. However, for the interviews prior to relocating, I simply read them over to understand the mealtime experience of the dyads in the community. More in depth coding of interviews was conducted in all interviews post transition. The total number of interviews included was 83 and this included: dyad interviews, interviews with the care partners on their own, and interviews with the persons with dementia on their own. The total number of interviews does not account for three interviews for each family per year, due to the progression of the disease and the persons with dementia no longer being able to be interviewed on their own. Transcripts were reviewed a number of times and excerpts that focused on location and mealtimes were the focus for coding the data.

4.4 Data Analysis and Interpretation

The data analysis methodology that was used for this study is thematic analysis. Thematic analysis is used to identify, analyze and report patterns and themes within the data (Braun & Clark, 2006; Luborsky, 1994). It serves to describe the contents of an individual’s perceptions, ideals and values (Luborsky, 1994) and is well suited for analyzing semi-structured, open-ended interviews (Burnard, 1991). Although this is not the same methodology used in the original study, it was appropriate for the purposes of this secondary data analysis. Grounded theory methodology was not appropriate for this secondary study as concurrent data collection and analysis did not occur and theoretical sampling was not used as part of the analysis, as no further data were collected (Charmaz, 2006; Daly, 2007; Webb, 2003). The purpose of the secondary analysis was not to further theory development or understand the process of relocation, but to add to our
understanding of the changed experience of mealtimes after relocating to a long-term care home (Charmaz, 2006; Daly, 2007; Webb, 2003).

In thematic analysis the researcher is positioned as active in the analysis but themes do not emerge in the same way as in grounded theory (Braun & Clark, 2006). Grounded theory analysis seeks to generate a theory of a phenomenon that is grounded in the data (Braun & Clark, 2006). In grounded theory analysis the researcher also uses theoretical sampling to generate a complete picture of the phenomenon being studied (Charmaz, 2006). In contrast, thematic analysis involves analyzing and reporting themes within the data and minimally organizing it to describe data in a rich way (Braun & Clarke, 2006).

Although this is a different methodology from the original study, it does use several of the same techniques found in grounded theory methodology. Two techniques that were utilized during the thematic analysis of the interviews were constant comparative analysis (Charmaz, 2006) and the identification of themes through coding the data (Braun & Clark, 2006). Constant comparative analysis allowed me to look for themes within and across interviews and before relocation to after relocation. For interview transcripts prior to the relocation, I concentrated on areas of the interviews that best reflected place, in order to understand what mealtimes were like for the dyad at home in the community. Line-by-line coding was conducted on all interviews post relocation in order to analyze the data in greater depth.

4.4.1 Becoming Familiar with the Data.

In order to become familiar with the data it was important for me to surround myself with the data. By immersing myself in the data, I began to become more fully
aware of my participants experiences (Burnard, 1991). I started to do this early on during my graduate program; I am one of the research assistants who has been transcribing and coding the data for the main Eating Together study for the past two years. This experience allowed me to familiarize myself with some of the families in the study as I was able to listen to their stories. This helped me create my own understanding of their experiences. I also had the opportunity to sit in on a couple of interviews with families in the study. During this time, I observed the technique that one of the researchers (HK) used to collect the data and developed a better understanding of active interviews. In being part of the data collection, I was also able to gain a more in-depth understanding of the data.

In order to ensure that I was familiar with all the families that were chosen for this relocation study, I read all the transcripts over before I began analysis. I also read over the interviewers’ reflection notes to better understand the context surrounding the interviews and any pertinent background information about the families. I then began to listen to the audiotapes of selected interviews to capture some of the context around things that were said and also to capture the emotions behind the comments. Meetings with the Eating Together team also helped me learn details about the original study that were useful to my analysis.

4.4.2 Thematic Analysis.

Thematic analysis is widely used, but there is no consensus on the best way to perform it. For example, some use the term qualitative description (Sandelowski, 2000) or qualitative content analysis (Elo & Kygas, 2007) to identify a level of analysis consistent with what has been described by others as thematic analysis (Braun, & Clark,
To date, the procedures for finding and analyzing themes have not received the same level of critical examination and development as other qualitative research techniques and methodologies (Luborsky, 1994). As a novice researcher I chose to follow the guidelines laid out by Braun and Clark (2006), as they are sufficiently detailed, while remaining easy to follow. Braun and Clark (2006) identify six phases to be undertaken during analysis.

The first phase was to familiarize myself with the data. As mentioned previously I engaged in a number of activities to familiarize myself with the stories told by families. Not only did I transcribe some of the last two years of interviews for the Eating Together project, but I also completed Nvivo coding on this data using the Life Nourishment theory framework. In addition, I reviewed all selected individual and dyad transcripts, identifying those portions that were most pertinent to my research questions and these portions were then analyzed in a more in-depth way.

Phase two is when you begin generating your preliminary codes, by creating an initial list of ideas about what was in the data and what was interesting about the data. To accomplish this, coding was performed manually and the initial codes that were generated were data-driven. First, the transcripts prior to the relocation were read over for each dyad, and then I used line-by-line coding to examine all post relocation transcripts. To identify relevant portions of the transcripts, I highlighted them with a colour that corresponded to a specific group. For example, all areas where participants mentioned their tablemates, or interactions with other residents at mealtimes, I coded green. I then revisited dyad specific data, sequentially moving through their interviews over time and post placement, to capture any codes I may have missed. I used sticky
notes to identify sections of data that I was unsure of, and also to identify coded segments that I felt could fall into more than one area. Once all the interviews were coded, I created a separate file for all the segments of data relating to one group; meaning that all of the text coded with the same colour was brought together in one file. When I had completed this, I had several separate files of data. I then went through the files and gave each segment of data an initial label; from this I generated a list of initial codes.

This process then helped me to move into phase three of analysis described by Braun and Clarke (2006), where the initial long list of the codes are sorted into potential themes. There are two basic approaches to identifying themes (Luborsky, 1994). The first is to look for statements that occur most frequently and the second is to look for statements that are marked in some way as being of greater meaning or importance to the participant, based on the way they are stated (Luborsky, 1994). The way I chose to identify themes was by focusing on areas that appeared to have great importance to the families and this remained consistent throughout my analysis (Braun & Clark, 2006). To further assist me with this latter phase, I used visual representations to see how certain codes were similar and how they could be categorized into higher order themes, seeking as parsimonious an explanation of the data as possible. I then devised a code manual in Phase three and re-examined the identified segments of data. The code manual served as a template to organize the data and to ease interpretation (Crabtree & Miller, 1999). At the completion of phase three, I had identified six themes with many subthemes.

Phase four involved the refinement of the themes that were already identified. It required me to identify codes that could be further collapsed into each other and also to consider the validity of each of the initial themes in relation to the data set. In this stage I
began seeking themes that represented most of the dyads’ experiences with relocation and mealtimes. I met with my advisor to discuss the strength of these themes and the overlap I was seeing among some of the preliminary themes. At the end of this stage I had narrowed down my list of subthemes by condensing them together and had also condensed two themes, leaving me with five remaining themes.

In Phase five, I needed to define and further refine the themes that were presented in my final write-up, writing descriptive labels and elaborating on the meaning of these themes. Here I described the essence of what each theme was about and gave the theme an appropriate name. To facilitate keeping the theme close to the data, I used active label names. In the final phase, phase six, I had all the final themes and sub-themes worked out and began to choose examples and extracts from the data to illustrate the themes. This was when I needed to go beyond the surface of the data, in order to tell a convincing and well organized story (Braun & Clark, 2006).

Constant comparative analysis was a technique used during all steps of data analysis. Thematic analysis is a method that depends on constant comparative analysis to develop ways of understanding human phenomena (Thorne, 2000). Thematic analysis required me to move back and forth within the entire data set, the coded extracts from the data, and the analysis of the data that was occurring (Braun & Clark, 2006). I compared dyads within themselves across time and location, as well as making comparison across dyads in order to develop the final themes.

4.4.3 Memo Writing.

Memo writing is the process by which a researcher begins to think about data and codes in a new way (Charmaz, 2006). Discovering and coding for themes involves
abundant and detailed memos, making memo writing an integral part of thematic analysis (Braun & Clark, 2006).

There are many types of memos: textual, observational, theoretical, operational and reflexive. They all have the purpose of helping the researcher reflect on the process of conducting or analyzing their research (Daly, 2007). Memos are a way of recording your thoughts and reflections (Charmaz, 2006). They can also serve as memory joggers throughout analysis (Burnard, 1991). Conversing with oneself through memo-writing, allows new ideas and insights about the data to arise (Charmaz, 2006). Memos may take the form of notes, diagrams or pictures that depict for me my thinking in the analysis (Charmaz, 2006).

In my analysis, I made particular use of operational and reflexive memos as the data had already been collected and my goal was to complete a thematic analysis, rather than develop a theory. Operational memos helped organize the thematic analysis and provided a documentation of my analysis process, or an audit trail; reflexive memos helped me to understand how my perspective was influencing my theme generation. In addition to these memos, thematic memos were used to help define and differentiate themes. These were mainly in the form of written text, although some basic diagrams were used (Charmaz, 2006). [Appendix C].

Furthermore, the Eating Together team was brought into the analysis in order to get their feedback on the codes and themes that were identified. Notes were recorded in these meetings in the form of memos, which were then used to assist in the analysis.
4.4.4 Reflexivity.

We do qualitative research to understand the experience of others, but we are often caught trying to fit that experience into our own schemes of relevance (Daly, 2007). It is therefore vital to be aware of this, to reflect on this, and to understand how we as researchers create our understandings of different phenomenon (Daly, 2007). Reflexivity is a strategy used to monitor how personal meaning, experiences and expectations impact our research (Kuczynski & Daly, 2003). It is a means by which we can see how the personal can affect not only the manner in which we conduct research, but also the results that we generate (Kuczynski & Daly, 2003). Maintaining reflexivity during data analysis is an ongoing process (Padgett, 1998).

In being reflexive I needed to consider my own perspective, personal experiences and biases as they related to mealtimes in different settings for persons with dementia, as I acknowledge that they became part of the data. I took reflexive notes in order to better understand how my own experiences could be impacting the way I was interpreting the data. This was done throughout the analysis and the writing of my results; a journal was used to record thoughts that arose and issues that I wished to further examine.

4.4.5 Establishing Trustworthiness.

Defining rigor in qualitative studies is much different from that of quantitative studies (Leininger, 1994). In quantitative studies researchers want to ensure that their results are replicable. However in qualitative research replication is generally not feasible as it is nearly impossible to attempt to recreate the original conditions in which the data were gathered (Padgett, 1998). Therefore, in qualitative research the key issue is trustworthiness of the data (Padgett, 1998). Trustworthiness refers to credibility of
qualitative research (Shenton, 2004). During the course of my project, I drew on four ways to establish trustworthiness of my results and these included: credibility, originality, resonance and usefulness (Charmaz, 2006).

Credibility refers to the truth-value (Leininger, 1994) and whether my research was sufficient to meet my claims and whether a credible picture of the studied phenomenon was being represented (Charmaz, 2006; Shenton, 2004). Themes can sometimes carry a researcher towards a reductionism or over simplification that can strip away some of the richness around the original expression (Luborsky, 1994). In order to maintain credibility I needed to ensure that I held on to the richness of the data. To accomplish this, I chose appropriate quotes to illustrate the themes and fully defined the themes for the reader. I also remained consistent in coding the themes within and across cases, by recording memos and reflecting on if/how each section of data fit the topic of inquiry.

Originality refers to whether this study offers new insight to the area of study (Charmaz, 2006). This study does meet the requirement of originality, as it is the first study available that looks at the role of “place” specific to long-term care homes and mealtimes for families experiencing Alzheimer’s disease and related dementias. To date little is known about how mealtimes are experienced in a “new place” by persons with dementia and their primary family partners in care. As you will see after reviewing the findings, my study contributes new understandings to the “sense of place” at mealtimes in a long-term care home.

Resonance refers to whether the study captures the fullness of the studied experience (Charmaz, 2006). This is particularly important in secondary data analysis as
there is often a concern that due to the limited relationship between the investigator and the original data source important things can be missed or small details may be overemphasized (Thorne, 1994). Resonance was insured by my participation in Eating Together team meetings and by receiving feedback from others who were cognizant of the history of the data and issues that arose either through presentations or informal discussions. Having the support of all members of the original team also helped to guard against researcher bias (Padgett, 1998).

Usefulness of the study refers to whether it contributes worthwhile knowledge to this area of research and whether it can be used to promote change (Charmaz, 2006). It is my hope that this study will be useful because it will help to raise awareness of the importance of mealtimes in long-term care. It sheds light on some of the challenges families experiencing Alzheimer’s disease face when they relocate into long-term care and how mealtimes play a role in their quality of life. It also helps to identify factors that influence the changes in mealtime experience. Finally, with an understanding of how “place” impacts mealtime routines and activities, there is the potential that interventions or modifications to place and to the relocation experience can be undertaken to make improvements; some of these ideas for future work are noted in the Discussion. This study gives participants a voice to talk about some of their challenges in the hope of making formal and informal partners in care aware of their struggles. It is hoped that this work will modify current practices in long-term care.
5.0 RESULTS

When I came to the close of my thematic analysis I had identified five themes that I feel best reflected the experience of mealtimes resulting from changes in “place” for the families in this study. The five themes include: Systemizing the Meal, Adjusting to Dining with Others, Holding on to “Home”, Evolving Roles, and Becoming “at Home”. Relocating to a new setting proved to be very challenging for both persons with dementia and their primary partners in care and the five themes identified relate not only to the experience of mealtimes in the new setting, but also the strategies they used to adjust to mealtime changes, as well as if/how they began to feel at home in the new environment.

The order in which the themes are presented relates to the order in which they were discussed across many of the dyads. Most often dyads initially focused on the experience of mealtimes in the new setting, followed by how they attempted to adapt or adjust to the new mealtime experience, and finally the outcome of adapting to the new mealtime setting, becoming “at home”. Each of the five themes, along with their corresponding sub-themes, will be discussed in detail.

5.1 Systemizing the Meal

Systemizing the meal had to do with the organization of the mealtime environment in long-term care homes and its subsequent impact on the mealtime experience. Mealtimes in long-term care were generally described as being very structured and task-oriented; compared to the more relaxed and relationship-focused mealtimes participants had grown accustomed to at home. The focus of mealtimes in the long-term care setting was commonly on the progression of the meal or ‘system’ and less on the individuals involved in the experience. Systemizing the meal embodies the routines, rules and
practices of this setting as shared by my participants. Sub-themes include: “tasking” mealtimes, over-adherence to rules and procedures, routine experience over flexibility and variety, and not living up to expectations.

5.1.1 “Tasking” Mealtimes.

Mealtimes in long-term care can be hectic times for staff and it is often difficult for them to ensure that everyone receives their food and finishes their meals in a timely manner. Mealtime tasks include: bringing all the residents to the dining room, bringing the two choices of entrees around the room, helping residents who require feeding assistance and ensuring that everyone leaves the dining room before the cleaning staff arrive. As there are a series of activities that need to often be carefully timed to ensure a smooth process, the mealtime can become more focused on ‘getting the task’ done rather than enjoying the meal. It is especially difficult for staff members to focus on other aspects of the mealtime experience beyond the tasks at hand. Often participants left mealtimes well fed, but without the social interaction and staff attention that could have enhanced this experience for them. As such, mealtimes were perceived to be a ‘task to be done’ rather than a social experience.

This is illustrated by the following quote, in which a family care partner talks about how food was presented to her partner. It was done in a respectful way, however, it lacked the added social interaction that the person with dementia could have benefited from.

*Interviewer (I1): Did she, if the food is presented to him, does anyone say something like, “Here’s chicken noodle soup. Can you smell it? It will be nice and warm. There are noodles in it. Here’s a spoon for the noodles. Why don’t you take a bite and tell me if it tastes good.” So, it’s, people don’t say these kinds of things to him?”*
Care partner (CP12): —No—
I1: —it’s not like—
CP12: —encouragement.
I1: No encouragement, no instructions, no cueing
CP12: They don’t have time. They don’t take time. Maybe they have it. I don’t know, but they don’t take it. (nursing home)

For care partners who were accustomed to providing their loved one with a great deal of support and attention at mealtimes, they feared that in this new setting their loved ones would become lost in the shuffle. When staff members did not take time to interact with the participants an opportunity to make a meaningful difference in the resident’s mealtime experience was missed.

When asked about staff attention at mealtimes, one participant (Person with dementia: PWD23) in a retirement home said the following: “There’s not too much no, because the plate comes in already and it’s set in front of you, and then they go off and they sit and talk while we eat I guess”. While staff members may perceive their actions as being respectful of the privacy of the residents; their behaviour was discouraging for some participants, as they felt that they were not being recognized by staff as individuals in need of some interaction. They sensed that they were simply part of the crowd and the task at hand. When staff members solely engaged in discussions with their colleagues, they also missed out on an opportunity to facilitate social connections between residents.

Furthermore, mealtimes were viewed by participants as a task-oriented process because it was believed that, in order for them to run smoothly and efficiently, some level of structure needed to be in place. One way this was accomplished was through assigned seating. Upon admission into the long-term care home, participants were shown to their seat in the dining room and this was where they were to sit at all meals. However, this did
not always correspond with the needs or desires of the residents. For example, one care partner who also resides in a retirement home, along with his partner, talked about the resistance to change the structure as assigned seating facilitated the task of meal and medication delivery:

This is a point [changing the seating arrangement] to take up with a place like this. For obvious reasons they don’t like changing, because everybody, all the nursing staff that administer pills and things at mealtimes and the serving staff get to know where everybody sits and consequently can handle the specifics applied to different families, so they don’t want to change. (CP21, retirement home)

Other participants required special attention that infringed upon the mealtime tasks at hand and these situations were not always perceived by participants as being dealt with appropriately. For one dyad (21) the care partner felt obligated to feed his partner at all mealtimes to ensure that she received the nutrition she required. He described her as being a slow eater and that staff did not have the patience or time to ensure that she finished her meal. In another instance, a participant (CP12) discussed her frustration with the way a situation at mealtimes was handled by staff members. Her husband was experiencing some challenges with eating and she felt that staff members too quickly jumped to a conclusion that he needed to be switched to a pureed diet, reinforcing her view of mealtimes as a task rather than a pleasurable experience.

“We’re going to put him on soft foods, or mashed foods,” or whatever [staff member describing course of action]. I said, “Why doesn’t anybody ever listen to me? He’s not choking on his food, he’s choking on mucous,” not realizing I was yelling at the nurse manager. Well, I didn’t really yell at her, I just raised my voice a wee bit, ‘cause it’s frustrating! I did it for free. I sat there and watched him eat hard cookies and drink some juice, you know, and as long as the mucous wasn’t disturbing him, he was fine, and he’s still on solid food, so they finally listened after... (CP12, nursing home)
This care partner told this story to exemplify how staff members are at times too focused on the duties that need to be performed, and they consequently lose focus on the individuals and the impacts of their actions and decisions.

It is reasonable that with a large group of people staff members are focused on the task at hand. However, a balance needs to be established between ensuring that everyone is eating and that they are receiving the care and attention that they require for mealtimes in this setting. Facility living necessitates some systemizing, however, this organized space often moves meals into task-oriented care rather than as a highlight of the day.

5.1.2 Over-adherence to Rules and Procedures.

This sub-theme reflects that part of systemizing the meal in long-term care which involves adherence to rules and procedures that are in place to ensure that mealtimes run smoothly. Some of these are formal rules such as: giving 24 hours notice for families to attend meals, signing out when leaving for meals and sitting at a designated seat at mealtimes. Others are less formal such as; residents eating in the dining room that they are assigned to and the place where guests are to be seated in the dining room. A newly relocated participant described her initial perception of the new setting in which she now lived; stating:

*There’s a lot of structure that you have to deal with, you know. It’s not like you own the place and you can do what you like with it. It’s not that way. You’ve got to adjust to the rules and the structure there. It’s not the same. (PWD 23, retirement)*

Rules and Procedures around mealtimes can have a significant impact on the mealtime experience of participants. One of the gentlemen in this study, who was newly dating a woman in his building, discussed an issue that surfaced for him at mealtimes.
The following quote helps illustrate how one of the rules around mealtime impacted on his ability to connect with his partner:

11: So you don’t eat meals together [with girlfriend]?
PWD11: No, very seldom, unless somebody is away here, and they’ll let her come over and sit here. [retirement home]

This quote highlights one of the unwritten rules in this setting that impacts the ability of this couple to share a meal together. A similar situation occurred with another dyad; the care partner wished to eat meals with his wife in the cafeteria on the main floor of the facility, where there was a greater variety of food choices. Based on his account it had proven difficult to coordinate having meals together, as it did not follow the regular procedure to eat in a different location from what was assigned to that resident. This meant that this family could only share meals together on certain days and this impacted both their ability to spontaneously decide to share a meal together and their time to connect as a dyad.

PWD’s meals are paid for over there but what she can do is she can come over here on the Wednesday - Wednesday, Friday and Sunday and as long as I tell the kitchen. CP19 (nursing home)

Mealtime rules also impacted the involvement of family members at mealtimes, which can in turn impact the connection within the dyad. The long-term care homes typically required 24 hours notice for family members to stay for meals. This was not always conducive for family members who spontaneously decided to stay for meals.

13: – then you stay for supper with PWD10. Is that right? CP10: Well I don’t usually. The problem is – that – you have to give them twenty-four hours notice. Which I think is odd. You can get away with less but – yeah, it – you don’t always know whether you’re going to be there for that – and it depends on a number of reasons. (nursing home)
The rules that are in place can also impact the residents’ ability to leave for meals. They most often needed to be signed out because the staff members needed to know whether to expect them for a meal or not. This, however, can sometimes be difficult for family members to coordinate and can put a damper on the excitement of eating out.

13: Can you maybe just talk a little more about that and how that’s affected you in terms of being a care partner, and your mom, in terms of that whole connecting that happens with eating. CP23: Well, one of the big things that we have to get used to, is the idea of signing in and out. And so, I’m really predicting how long we are going to be away. I mean, that’s not how I live my life anyway. I live alone, I’m not accountable to anybody, and I think mom’s kind of got used to that too. So if we go out and we decide to ... you know, we think we are going out for an hour and we don’t come back until late at night, that’s just the way we do things. But to actually be accountable to somebody for where you are and who you’re with and when you are going to be back, that’s one area where we’re not quite so spontaneous as we used to be. (retirement home)

The rules and procedures in long-term care also made it difficult for participants to partake in a great deal of decision-making. Often residents were told when to come to meals, where to sit and sometimes what to eat. Conversation amongst residents and staff was described as remaining light and did not involve any depth such as planning or discussing issues and making meaningful decisions. One area where participants occasionally were asked to make decisions was when it came to food choice; however, the perception was that this was also limited:

PWD11: The food? The food is...oh what’s the word I’m looking for, not so much variable, but there are a number of different kinds of food that we have. One night it might be Italian, another night it might be English, another night it might be...fish, another night it might be...pizza, it varies, but it’s usually different about 5 nights a week.

14: So you don’t have a choice. It’s this is what we’re having tonight. PWD11: No, we don’t have a choice. This is what they’re having for dinner. (retirement home)
The above example is the experience of a gentleman who resides in a retirement home where there was apparently only one option at mealtimes. In nursing homes and in some retirement homes, there are generally two options at mealtimes; however, participants discussed not always being supported to make a decision for themselves. In some instances family or staff members chose the meal for the resident based on the knowledge of the resident’s preferences, and in other situations where a participant did not fill out their choices in advance, they were given the default option.

I8: There are a few choices at each meal? CP23: Yeah I think there are two. I8: When do you make that decision? PWD23: You make that when you –ah no wait a minute. CP23: I think you’re supposed to make it the night before, but I think that there’s a default if you don’t make the decision. PWD23: Yeah you take the first choice whatever it is. CP23: So do you actually- do you ever look at that or do you just take what they give you as choice #1? PWD23: Mostly [with reference to taking the default option] (retirement home)

The limited opportunity to make decisions at mealtimes relates back to the rules and procedures that are in place to help ease the progression of mealtimes. However the lack of opportunity to make decisions impacted the participant’s mealtime experience. When participants were unable to make decisions at the point of meal service, it gave them the impression that their opinions were not valued and that they lacked control over their own care. An over-adherence to rules and regulations were not allowing them to have their individual needs, preferences, and desires met, which can lead to a sense of discontinuity in this new environment.

Care partners also noted the regimentation of the meal that influenced their interest in eating with loved ones in the facility:

I3: So it’s just really the food that is the real difference for you? It’s not so much the, um, the, the waiting staff and all that sort thing? CP23: It’s the choice, it’s
the portion size, the timing sometimes, like if you’ve got to be here right at five thirty. It’s not conducive to spontaneity. (retirement home)

Care partners discussed how it was very challenging for them to adjust to the restrictions at mealtimes and for this reason, some care partners chose to continue to consume their own meals at home. Part of this inability to adjust may have been due to the confusion and lack of clarity of the rules upon relocation. Some rules were implied or hidden and others immediately became well known. Often upon relocating to the new setting, families were unclear of all of the rules and procedures surrounding mealtimes and they became aware only when they were broken.

I don’t know what all the rules are. I don’t know which one(s) mom is aware of even. Like what the rules are around choosing your meal ahead of time. Like I think if you they would just either give you the number one choice. (CP23, retirement home)

The rules and procedures at mealtime can sometimes be challenging for participants to become accustomed to, however, they are in place to help mealtimes run smoothly and efficiently. It is important for residents and their families to not only be aware of these rules, but also to determine where there is flexibility in order for mealtimes to feel less systemized and more homelike.

5.1.3 Routine Experience over Flexibility and Variety.

Many participants commented on the predictable routine of mealtimes in this setting. Mealtimes were generally characterised as being: at set times, with a predetermined menu and a designated place for residents to sit. Although the routineness of mealtimes partially resulted from the rules and procedures in place in the setting, additional features of the mealtime environment allowed for limited variation that could spice-up the mealtime experience. There was generally little room for disruptions in the
routine and mealtimes were no longer viewed by dyads as an opportunity to be spontaneous or varied.

One care partner who resided in the long-term care home with his partner commented on how residents have come to plan their days around mealtimes. They are routine events that bring everyone together at a set time. In a sense, they begin to be the main focus of the day. However this is not always easy for everyone to adapt to, especially for those who are not accustomed to eating at a structured time. It was stated:

_It’s astounding in this place, if there are 90 people in here I bet 70 of them enter the dining room at 1 minute after 5. Now I can’t eat dinner that early, I never could, we used to eat at 6:30 at night and so on, always have done, but now we go down at about quarter to 6, and um, but it’s astounding how dinner has become the clock in this place. Breakfast, everybody is down at 8:00, everybody’s down at 12 for lunch, and everybody’s down at 5 o’clock for dinner. I can’t be that way; I’ve got to go down at 8:30 for breakfast._ (CP21, retirement home)

Having mealtimes scheduled at regular times also doesn’t always correspond with all individuals’ hunger cues. However, there tends to be an expectation that residents will come to mealtimes despite their lack of hunger. This care partner further stated:

_In here you have to abide more or less by a time schedule - which may not always relate to how hungry you are or how hungry you’re not. You know, it’s one of these silly thing(s). (CP21, retirement home)_

Some residents do however benefit from the mealtime schedule; they recognize when to arrive for meals and also feel comforted in knowing they are eating at regular time intervals. “It’s nice to know I’m getting my meds and my foods at a regular time which at home I just ate whenever” (PWD 8). However, one care partner discussed her struggle with accepting the routine events surrounding the meal:
I don’t like the routine of meals... Like, my friend said, you know...they look forward to their meals, they look forward to, like, the suppertime is five o’clock, and you’ll see them in the hall sitting and waiting in line...at four o’clock in the afternoon, or three, sometimes three thirty! Sitting there waiting to get on the elevator for five o’clock...it’s like they’re herding cattle, it’s, it’s really, really grim... (CP12, nursing home)

The events that take place during mealtimes are also rather routine. Once everyone is seated, staff members start to bring out the food and those that require assistance with feeding are helped. One person with dementia described some of the events that take place:

_We were served. We pass it to the person it is set for, and it’s always the same people that you’re sitting with. So there are no surprises there. It’s quite routine._ (PWD23, retirement home)

When asked to describe their experience of mealtimes in the long-term care home, one care partner stated, “Oh, it’s - you know, in a sense it’s the same thing” (CP10, nursing home). As voiced by the following participant, variety was craved but rarely provided in this setting:

_I3: What is it about eating out, that environment that you like, compared to this environment? PWD23: I don’t know [laughs] I guess its somebody else’s cooking is nice to try. I3: A little bit different taste and things like that? PWD23: And different surroundings. I like to get out. I don’t want to stay in the same four walls all the time. So that’s part of it._ (retirement home)

As identified in the above quotes, mealtimes are often predictable and can become repetitive for residents in long-term care homes. The routine of mealtimes leaves little to be anticipated and perhaps impacts the mealtime experience in a negative way.

Participants look forward to mealtime events that would break the established routine, such as, celebrations, holidays, eating out and guest involvement.
5.1.4 Not living up to Expectations.

The presentation and quality of food in long-term care was much different from what the participants were accustomed to at home. Food production in the long-term care setting is a complex system that often results in loss of individual preferences. Long-term care homes generally have large-scale kitchens, limited kitchen staff and tight food budgets to work with. Food is produced in large quantities to save time and often much of the food prepared is convenience products. Emphasis on food preparation lies in ensuring residents receive a meal with adequate nutrition, rather than one that suits their preferences. For participants who were accustomed to home cooked meals, the quality of food being served often did not compare. Participants discussed some of these issues and how this effect of change in place influenced the quality of their food:

*CP21:* -like it or not, feeding what, about a hundred and twenty-six people in here now. Ah, the dining room, or, or the chef, is not unable to (um) possibly satisfy everybody’s.

*I5:* Right, yeah. *CP21:* Appetites and, and tastes. And certainly not mine (retirement home)

Participants recognized how the scale of mealtime operation affected the experience and some even used this to justify why meals were not as good as meals at home:

*PWD23:* And I don’t think I would do it the way they do some of the things here, but it’s a big operation if you had too many if you have a lot of people to cook for, you can’t do the same things as you would do with a family size group (retirement home)

Furthermore, large homes often rely on a lot of prepared or commercial foods that do not taste ‘like home’. These foods were described as inferior as compared to what many participants had grown accustomed to. However, despite the difference in quality, some participants felt that they could accept the food being offered:
I8: What are your meals like here?
PWD23: They’re fine, let me see now. We get more than enough. You never go away hungry that is if you eat, if you’re not fussy, because it’s good food, very ordinary but good food. (retirement home)

While others discussed their dissatisfaction with the food provided:

I1: and you made a face when I talked about the eating of the food. You’re not impressed with it. CP12:.... But because it’s an institution, and because they’re all old people, and because they’re all ill, or they wouldn’t be there, the food is so bland, and, yeah, it just kills me to see [PWD 12] eat, ‘cause I know that he used to enjoy good food, either here, or in the restaurants that we used to go to all the time, and it just...my biggest problem is that I can’t stop feeling sorry for him...you know (nursing home)

And

It is very rarely that people say nice things about the food (CP21, retirement home)

It is evident that the relocation or change in place to facility-living resulted in a change in mealtimes, where meals were far more systemized. This resulted in a poorer mealtime experience for several participants. Furthermore, some care partners also discussed how the quality, appearance, smell, and variety of food in the long-term care home was much different than the food they served at home and this kept them away at mealtimes. They would choose to visit at other times in order to enjoy foods prepared at home.

I3: You’re moving further away from eating with [PWD10]. CP10: Well, because I don’t like the food, the food they have there [chuckles]. I get my own. (nursing home)

In addition to lack of individualization of the food and perceived blandness and poor quality, participants described the need for the quality and presentation of food to be satisfactory in order to ensure that the residents consumed their meal. As stated by a care partner who lived in the facility with his wife who had dementia:
CP21: And this sort of thing and so food is a very, very im-important p-way of life, I guess. If we didn’t have it we wouldn’t be here. Now the way meals are, are dished up - if that is the right word - and that’s quite important, I think. Especially for people our age. It’s got to look appetizing - and it’s got to be appetizing, otherwise - you haven’t got the will to eat. And so often - not necessarily here, but sometimes - you get a meal and it looks like heck. And think “Have I got to eat that!” It may taste good, but once you’ve - dug in and but. PWD21[interrupts]: Can’t bear.CP21: The look of it, you know. And in particularly for somebody like [PWD 21, I always watch your face when the meals put in front of it and I can tell right away whether you are going to like it or not. Just by what the observation of the meal is. It does become quite important in that respect. (retirement home)

Presentation of the food, especially in retirement homes where linen table cloths and formal dining settings are sometimes used, is an important aspect of quality for families. In nursing homes, the presentation of meals left much to be desired for some participants.

For other participants, however, the food quality and presentation in the long-term care home lived up to their internal standard, despite the meal being systemized. Some viewed the quality and variety of food as an improvement to what they had become accustomed to eating at home, especially when living alone (dyad 8) or struggling with the cooking role (dyad 10, 19, 21, 26). These participants had previously relied heavily on frozen entrees and sandwiches to sustain themselves. Now in this new environment the chore of preparing food was removed and they were able to once again enjoy a balanced diet. For example:

The food, wow, I’m getting fat [laughs]. The food is, is, is top notch. It is fresh, really good food, you have two choices, and you can have as much as you like.... There’s quite an assortment. And they do it I guess its routine, but to me it doesn’t seem routine, because everyday it’s a surprise. PWD8 (nursing home)

And

Oh, the food here is great! PWD 11 (retirement home)
Participants described the food and food service as feeling like they were on a vacation, or that they were eating out for every meal. After relocating one participant described being in a honeymoon period where she was accepting of all that the long-term care home had to offer her (dyad 8).

*Oh I went through the honeymoon stage for the first 2 or 3 months, not quite that, when I was in euphoria. Like everything I was just high PWD8 (nursing home)*

Therefore, how participants viewed the quality and variety of the food presented to them in this new mealtime space was dependent on what they had grown accustomed to eating at home, or their internal standard. Individuals who were consuming a wide variety of home cooked meals or eating out at restaurants were often less satisfied with mealtimes than those who were struggling with cooking prior to relocating into long-term care. For participants who were living alone prior to moving to the long-term care home, the opportunity to eat with others also appeared to impact how they felt about the meal.

**5.1.5 Summary.**

In summary, mealtimes in long-term care can be very routine and predictable, characterized by standard procedures, rules, policies and strict timelines. This was generally described as being difficult for the participants to adjust to, as they were accustomed to a more flexible mealtime schedule at home. Some strategies dyads used to combat this notion of ‘systematic meals’ was to eat out together, continue to participate in spontaneous eating occasions and also to connect outside of mealtimes. However, despite their rigidity, mealtimes in long-term care were viewed as an improvement from mealtimes at home for some participants who lived alone, or who were struggling with meal preparation, prior to relocating into long-term care.
5.2 Adjusting to Dining with Others

Adjusting to dining with others refers to how persons with dementia and their care partners adjust to eating with new companions at mealtimes. Once relocated into long-term care, mealtimes shift from an intimate time for connection between the dyad, to a shared experience with other residents. For those dyads where the person with dementia lived alone, dining with others was anticipated to be a positive effect of relocation.

Dining with others encompasses the different and new social interactions among residents, but also the impact of the individual personalities, behaviours and conduct, on the individual mealtime experience. Sub-themes include: forcing intimacy, distracting behaviours, losing privacy and fostering connections.

5.2.1 Forcing Intimacy.

Dining with others was not always an enjoyable experience for many participants. Eating with others in a facility usually required sitting with unfamiliar people. This was described as a big adjustment, especially when participants were not able to choose with whom they sat. As a result, social interactions among residents were described as sometimes unnatural and forced. Tablemates occasionally found it difficult to make conversation and often ran out of things to talk about. Consequently, they described some discomfort in interacting with these new people in their lives, making it difficult to form connections.

CP23: They’re not people you feel that close connection to or a lot in common with?
PWD23: No, not really, not at all. They’re very different personalities too. I don’t know whether to say anything and try to start a conversation or whether to just shut up and eat. I8: Has there been conflict in the past? PWD23: I wouldn’t say conflict, but there’s not a lot of response you know? I can adjust and be friendly
with anybody I think, if I have half a chance. But if I get a kind of a vibe that they
don’t want to talk, I just keep quiet. (retirement home)

Compatibility of tablemates was something that was mentioned by several
participants. Some felt that they had nothing in common with their tablemates or that
.tablemates were uninterested in what they had to say, which made it difficult for them to
feel accepted. One participant discussed how it was different eating with people that she
had not previously known and that she could not form the same connections with them as
she could with her family.

We’re not nearly. We don’t know nearly enough about each other here as a family
would. And we wouldn’t dare say the same things we’d say to family either, you
know. (Chuckles) Yeah, we can be frank and honest and, and you just don’t do
that with...13: With the tablemates. PWD23: No. (retirement home)

Other times, participants described their tablemates as having too much to say and that
there was a lot of repetition in what was discussed at mealtimes. One care partner, who
resided in a long-term care home with his spouse, discussed his experience with his
tablemates.

Yeah, yeah, I think. It becomes - not a problem, it’s just one of those things
something you’ve got to think about. We’ve heard about all this before you how,
how many times we’re going to hear it again. Um the same conclusions the same -
actions same type of - reaction and so on. You’ve just got to have a change
sometime. It sounds miserable and it’s not meant to be. It’s just inevitable That’s
the way it is. That - and um and this is what you are often confronted in a place
like this. CP21 (retirement home)

Like many others, he wished that the conversation at mealtimes was more captivating and
had more shared meaning. Some participants mentioned wanting to discuss current
events, ask for advice, or discuss future plans. However, conversation was often
described as leaning towards discussing more superficial matters, such as the food or the weather.

Part of the challenge of forced intimacy was that tablemates may not only have different interests and personalities, but also have different cognitive capacities, making it challenging for some tablemates to carry on in-depth conversations.

*I talked to the one lady and she was, it was um, she was quite quiet and uh not really forth coming. Well she’d answer your question but it wasn’t a conversation carried on. And uh, I tried to have, be, make light of some of the situation.* (CP10, nursing home)

In addition to differing characteristics and capacities of tablemates, how well a conversation was carried out depended on the willingness of tablemates to be active members in the conversation. In the case of PWD23, she attempted to make conversation, but was overpowered and discouraged by one of her fellow tablemates. She described how this impacted the types of conversations she was comfortable initiating at mealtimes:

*13: What sort of things would be the topic of conversation? PWD23: Um. Not a lot because I find that there’s an immediate response and it’s either, really sometimes quite negative. CP23: Shuts the conversation down. PWD23: Shuts it down, yeah. So I keep it to something really – CP23: - neutral – PWD23: - neutral and unimportant.* (retirement home)

One solution to dealing with the monotony and challenges of conversation at mealtimes would be to change seats. However, due to formalized or unwritten rules about ‘changing places’ participants felt hesitant to request moving tables. One care partner stated:

*But after a while you’ve talked everything out (chuckles), what else are you going to say? You know ....And yet, there is, if, if you asked to be moved - there is, in effect, a bit of a stigma, “Why do you want to move? What’s... What’s wrong with us?” So, we haven’t gone that route yet, but - I might quietly suggest it to the managers. And say, “You know, one of these days”, now people have been here*
Forcing intimacy can make mealtimes challenging for participants. Eating three meals a day at a table where residents are feeling uncomfortable or bored had a significant impact on the mealt ime experience and in some instances participants dreaded having to face tablemates. In these cases mealtimes were not something to look forward to. Compatibility of tablemates is something that needs to be assessed by staff members so that residents can be seated at a table where they feel comfortable to be themselves and where they can form meaningful connections.

5.2.2 Distracting Behaviours.

Another aspect of dining with others described as particularly challenging for participants was the behaviour of other residents at mealtimes. Most often these behaviours were unintentional, as some residents were not cognitively aware of what they were doing, such as yelling during the meal or taking other resident’s food. For others, table manners which changed with declining cognitive capacity, eyesight or dexterity were described as something to adjust to when eating with others. Whatever the case, these situations made for an unpleasant mealtime for some:

CP19: -there’s some people there that are really right out of it in a bad way. In fact there is one woman there that she cries all the time and wants help and they can’t do anything with her, and it’s not very nice to have a meal and sit and listen to that. ... I1: What’s that like? PWD19: Not very nice. (nursing home)

Some participants shared their discomfort dealing with “challenging” behaviour at mealtimes, which was sometimes perceived as childish behavior. Although they attempted to ignore this conduct, it continued to be a concern that impacted the participants’ mealtime experiences in this new place:
Well we had this one person at the table, who is inclined to be touchy. She’ll, I haven’t seen her do it, but I have heard that she is liable to snatch from other peoples plates you know that sort of thing….Well, I don’t let myself get upset about it, but if it really offended people I think they should say so, but you know I just let it go. I’m not personally affected by it. It’s usually somebody else that gets the brunt of it. Some of their table manners are kind of careless. And they don’t realize it; you know they are handling food in a strange way and that sort of thing. You just ignore it. (PWD23, retirement home)

Conflicting personalities of tablemates also created difficult situations. One care partner discussed the challenges of interacting with a fellow tablemate who aggravated him:

The other thing is … now that [PWD21] and I had our own table downstairs by the window it’s very nice and I enjoyed it. When she went because they’ve put somebody else on that table, he’s a very nice guy but he’s totally different nature to me, and I’m beginning to get sort of he’s getting under my skin let’s put it that way. For some reason he has sort of aggravating… it’s going to be a problem. (CP21, retirement home)

Distracting and “challenging” behaviours at mealtimes caused participants to withdraw from their tablemates, as a result of not knowing how to deal with the situation. It also caused them discomfort and this can consequently make dining with others in this common space unpleasant.

5.2.3 Losing of Privacy.

Family members wished to be involved at mealtimes, but they didn’t always prefer to also interact with their loved one’s tablemates and staff. Some conversations were considered private in nature and were meant to only be discussed within the dyad. Even when topics were not private, it was difficult for family members to describe to other tablemates the context behind what was being discussed. For families who wanted to share mealtimes and saw this as an intimate space for family discussion, the
CP23: I think that’s it too that I feel, yeah I feel when I’m eating in the dining room, I’m, we don’t have privacy. And it’s not really that people can hear what we’re saying. It’s really just, just the, the space, I think to see what, you know what’s on our mind without worrying that we’ll be asked to make a decision about dessert sometime in the middle - at some crucial moment. Yeah. (Both CP23 and PWD23 Laugh) (retirement home)

Lack of private space for families resulted in changes in the type of conversation that occurred for the table or reserving private conversation for their room. For example:

But nice enough people and but I don’t have the same relationship with [PWD10] – ...Well it’s like you know if you wanna talk about some situation or whatever situation that I have here and I would like to talk to her about, you just don’t do it and you’re always trying to do it before or after [the meal]. But that’s kind of the thing. (CP10, nursing home)

Loss of private space, meant that the communal mealtime became a place for being entertained by the antics of other tablemates (dyad 10) or trying to converse with and support tablemates (dyads 8, 10, 11, 23). This then lead to the mealtime conversation being about others and their needs, rather than focused on the dyad, resulting in a loss of privacy if this was the only time for the dyad to connect:

CP21: That’s one thing you do miss [chatting about personal day with PWD21], when you’re on your own, this was the table in the kitchen at home, if we sat here in the kitchen, it did give us the chance to sit down and look at each other and talk. Here you’ve got other people at the table; you don’t get that intimate with each other. You may get intimate or get along with the other people around the table. So there’s a more general conversation than a personal association. (retirement home)

AND

CP23: ... And trying to involve everyone, and... you know, it wouldn’t be the kind of natural, spontaneous thing. And I just find that there is so much that I want to talk to mom about that I don’t want to have to explain – it may not be private, but I don’t want to have to explain or bring other people up to speed on...or
necessarily listen to their input on, or whatever. I3: It would be more work, would it? CP23: Ya! It would be more work, ya. It just wouldn’t feel like a real visit to me. Ya! I’m more of a private person, I guess. Ya. (retirement home)

Mealtimes at home were an intimate time to be shared between the dyad and one participant (CP10) described it as “the special feeling of eating together and sharing”. Now in the long-term care home, participants found it more difficult to connect with one another without involving others. In order to maintain their privacy some dyads opted to eat in separate dining rooms from the other residents, or they saved their more private conversations for other times.

5.2.4 Fostering Connections.

Although eating with others did present its challenges, communal mealtimes in long-term care provided the potential for positive social interactions among participants. It is in this communal setting, that residents are brought together in the sharing of a meal. It is a time for connections to be formed and for tablemates to be recognized and appreciated. In some instances, persons with dementia were described as coming out of their shell when interacting with others. For example, PWD11 described himself as a social person and for this reason he truly looked forward to interacting with others at mealtimes. It was the connections that he formed at mealtimes that made his mealtime experience a positive one and also helped him feel more connected with the new environment.

I would like to emphasize really how important it is to be able to interact while eating, not just sit at a table and…it’s wonderful to be able to chat, and take fifteen, twenty minutes, half an hour to chat, eat, it’s just delightful, because almost everything we talk about is positive. PWD11 (retirement home)

Participants also described how mealtimes were the social focus of the day. It was a time when everyone got together to share a meal:
It’s true that, um, part of the social life of a place like this does - um, relate to the dining room, or to - to food. It’s the time when everyone sort of sits down somewhat together and the level [of] chatter goes up or not (chuckles) – depending. And, um, in that sense, for a place like this, it becomes one of the centers of – of the operation. CP21 (retirement home)

They also discussed how sharing a meal with others made eating a more pleasurable experience. It was pleasant to arrive to the dining room, be greeted, and sit down to a table of faces that had become familiar to them. This allowed them to feel more at ease in their new environment.

One care partner discussed how mealtime conversation with his spouse had improved since relocating into the long-term care facility. Connection with others had been a really positive experience for him and his wife. Conversation at the table flowed more easily than it had at home and in the new setting his wife was jumping right into conversations and becoming involved with the other members at the table.

13: Did, at that meal, I know it was only one meal, was conversation different than it was here at home with her? CP10: Yes, being the fact that there were three of us involved and uh, well I had the, this picking on me business which is fine. It was great and uh, [laughs] [PWD10], she was jumping right in. I3: She was sort of at the centre of it too. CP10: Yeah and it opened her up a bit and so on...

For this reason, this care partner preferred to eat with other tablemates than alone with his wife, which goes against the routine of the facility. Generally family members and their loved ones are provided space to eat alone in a separate dining room.

This next quote helps to illustrate how dining with others helped foster connections as meals provided the potential for residents to be recognized and accepted by others and for subsequent friendships to develop. This participant had previously lived
alone prior to relocating into long-term care and mealtimes now were much more pleasurable for her; eating was no longer a chore.

*PWD8: And I think that’s what I was missing living alone, having the company for supper. CP8: You build camaraderie over supper, the kibitzing, the joking, the talking, the moaning the groaning, the hatching over of what’s going on or who’s doing what. You grew up on that family atmosphere. I grew up on that family atmosphere. That’s what you do. That’s supper. PWD8: And that’s probably part of why I enjoy the food so much, is that I’m not eating by myself now. (nursing home)*

Another part of new connections was developing relationships that involved providing care and assistance to others. A care partner discussed how his enjoyment in participating with others at mealtimes involved taking on the new role of emotionally supporting other residents:

*I3: Okay so what do you get out of that (eating with wife and her tablemates in LTCH)? CP10: Oh I, I think it’s really interesting to hear them talk and so on and, and once you catch their names and they become free, they’re, they’re freer with their conversation and, and so on and let you know, ah, you know, and so you, if they have a little problem you try you talk to them about it or whatever. But – no, of course I enjoy people. (nursing home)*

Like many other care partners in the community, he had grown accustomed to sharing meals solely with his partner. Due to the progression of his wife’s journey with dementia, the depth of conversation at mealtimes had decreased. Mealtimes in this new environment now provided him, the care partner, with an opportunity to converse with others and receive and provide support to them, fostering new and meaningful connections.

**5.2.5 Summary.**

In summary, *adjusting to dining with others*, who were often unfamiliar, was something to which families had to adjust with the relocation to the long-term home.
Although some saw the social possibilities of eating with others, for others it was challenging, as they needed to learn to interact with tablemates who were strangers to them. They also needed to cope with different personalities and behaviours that made it difficult to form connections in this new setting.

To promote positive mealtime experiences, families needed to learn how to form connections with the tablemates, while still prioritizing the connection between the dyad. In order to adjust to these changes, some families chose to eat in another dining room, some discussed the possibility of changing tables or mingling with other residents, although most described trying to understand and accept the behaviour of others and mealtimes as just the way it was.

5.3 Holding on to “Home”

Holding on to “Home” is defined as the activities and strategies that families use to attempt to retain some of the experiences around food and mealtimes that were common prior to relocating to long-term care. *Holding on to home* fostered the connection between the dyad that had the potential of being weakened with the relocation and also helped to facilitate adjustment to the new setting. Sub-themes include: Returning Home for Meals, Retaining Personal Routines and Family Traditions, Creating New Traditions through Relocating Family Gatherings, and Remembering Home.

5.3.1 Returning Home for Meals.

Mealtimes in long-term care are much different from mealtimes at home. Some care partners in this study continued to join their loved one for meals in the long-term care home. However, they described this experience as being much different from mealtimes at home due to the meal being systemized and the communal dining space.
order to retain the mealtime experiences associated with home, care partners would often bring persons with dementia outside of the facility for meals. This allowed them to continue with their normal traditions around mealtimes prior to the relocation, as well as helped to maintain connections with home. Returning home for meals fostered the intimacy needed for connections to occur through focused attention: “Now when I go home to [CP11], we’re still eating together, we do a lot of our conversations the same as we did it in the past, over something to eat (PWD11)” (retirement home). Meals at home in the community were something to look forward to and provided reassurance that persons with dementia were supported and not abandoned by their care partners (dyad 11).

Leaving the long-term care home to have a meal with family also provided an opportunity to look forward to an event that broke the routine of institutional living. It allowed for the experience of different foods and different conversations. Participants were able to relive experiences and traditions that were familiar and comforting to them, for example:

> What was dinner like last night? Pretty darn good with Shish kabobs I’ll tell ya! I noticed when we go they try to have something that I may not have at the (nursing home) home. They’re very tuned to this and they try to BBQ or something different. (PWD8, nursing home)

This also provided the person with dementia with the opportunity to help out with the meal and this allowed them to feel part of the mealtime process at home once again. They were able to participate in tasks that they were familiar with and that they could no longer take part in at the facility.
13: does she get involved in the kitchen or what happens? CP10: she always wants to do something and [daughter] will... she’s onto this now and she’ll say “Mom, if you wanna set the table. (nursing home)

Furthermore, care partners benefitted from meals at home outside of the long-term care context. Care partner 11 talked about her positive experience with bringing both PWD11 and his new girlfriend home for a meal. Prior to PWD11 relocating into long-term care, she was experiencing a lot of frustration at mealtimes due to the constant reassurance that PWD11 required. However, now that he was only visiting on occasion, these times were something to look forward to and conversation flowed more easily with the addition of the new member at the table.

*And now, when [PWD 11] is over to my place for meals, or [PWD 11 and his girlfriend] over to my place for meals, which has happened twice recently, it’s been very pleasant, and yeah, and there is, I don’t feel the tension anymore.* (CP11, retirement home)

Participants also described benefitting from the quiet and focused time provided over a meal outside of the facility. Returning home for meals seemed to provide a balance for dyads between the sometimes chaotic mealtimes in the long-term care space and the quieter, more peaceful space of home. This allowed them to hold on to the memories and experiences of home while learning to adjust to the new setting.

### 5.3.2 Retaining Personal Routines and Family Traditions.

As a way of holding on to home dyads retained routines and traditions around food that were established prior to relocating into long-term care and were considered to be important to who they were. Some continued going out to their favourite restaurants to eat, some attended clubs and activities that involved sharing food, while others enjoyed cooking special meals (Christmas dinner) and foods together (e.g, lemon pie). The
simple act of eating together several times a week regardless of location was also a way of retaining personal routines and connections.

    PWD23: [chuckles] Well we still are eating together quite a bit. We still get together quite often. And it’s certainly been good for me because you know, all the changes don’t hit me all at once, you know. I’ve still got [daughter] so that makes a big difference. (retirement home)

This dyad also enjoyed being spontaneous and they would often go on little day trips and see where the day took them. They would stop to eat wherever was convenient and sometimes would share their meal somewhere outdoors. This was something that they continued to do after PWD 23 relocated to the long-term care home, as it helped break the routine of mealtimes in long-term care and helped keep things exciting.

    I6: I think doing things like going for that little picnic in the car helps with keeping that connection and making that special. CP23: And preserving a sense of adventure. Like I think she really does have [a] sense of an adventure and so when we do something that takes us off the beaten path. (retirement home)

Even a simple outing such as going out for coffee was something that some participants had been doing for years and this was retained (dyad 11). Such traditions provided extended focused time to discuss anything on their minds, providing comfort and security. PWD11 highlighted these times as they were very significant to him:

    I1: Is food still a fairly central piece of interacting and socializing with people for you?
    PWD11: For me it is. For me it definitely is. When [CP 11] and I go out, we - “Let’s go to Tim Horton’s for whatever, or let’s go to Timothy’s.” We always do that. It’s so much fun to be able to do that. I1: And what would you talk about when you go out to have a coffee? PWD11: Oh, gosh, it can be almost just about anything. (retirement home)

Continuing with personal routines and traditions was important for dyads, as it allowed them to hold on to experiences that reminded them of “home”. This also helped to ease
the transition into long-term care, by not having everything change all at once: “If everything had been different it would have been much more difficult” (PWD23 retirement home) Retaining these personal routines and traditions made some changes easier to accept.

5.3.3 Creating New Traditions through Relocating Family Gatherings.

To hold on to home, families adjusted the location of some meals to accommodate their family member in long-term care. Extended family and friends visited the home for meals and special occasions. Care partners also joined their loved one for holidays celebrated in the facilities as a family activity, which allowed them to continue to be together during this time and create new traditions. For one family, Easter was generally celebrated at home. However, after PWD8 relocated to the long-term care home, the extended family brought their celebrations to their loved ones’ new home. This allowed PWD 8 to be part of the celebration and also allowed the family to hold on to past memories, while creating new ones in the new setting.

I8: What was Easter like when you brought –when everyone went down to [long-term care home]? CP8: We took in.. [PWD 8’s] favourite thing, is a Kaiser Bun and meats and just piling up and making your sandwich. She was glad with that. She thought that was cool. (nursing home)

The long-term care home also became the new setting for visits from her son and grandchildren. In previous years, she would only see them on occasions when the family would eat out together. Once relocated, her family changed the location of these visits to better accommodate her. Similarly, prior to both members of dyad 21 relocating into long-term care, their daughter would visit once a week for dinner and she continued to do so in the new setting. She would cook a meal for her parents in the room on a small
hotplate that the dyad had purchased in order to be able to share more intimate family meals away from the communal dining room.

\[ CP21: \textit{she always came to dinner on Friday and um, she still does. She actually comes here one week and we go to her place the next. She likes to cook so she cooks for us every other Friday night.} \ (\textbf{retirement home}) \]

Not only was the family coming to eat with the dyad, but also cooking in their unit provided the space within the facility to have private space for visiting and cooking foods that reminded the dyad of home.

Relocating family gatherings and special meals to the long-term care home allowed persons with dementia to stay connected with the people and celebrations that were important to them prior to relocating. This allowed them to hold on to experiences from the past while also creating new ones in the facility setting. Care partner 23 talked about how in previous years she and her mother would eat out together on Christmas day. They had grown accustomed to sharing this holiday together and CP 23 thought that it would be nice to test out Christmas at the long-term care home. This had the potential to be a new tradition for this dyad.

\[ CP23: \textit{So there was that in the morning and then you might find this interesting actually, rather than go out to a restaurant I said well let’s just try Christmas dinner at [facility name] and they laid on the most amazing feast. They just, they do food so well up there. It’s just great. There were people walking around with platters of shrimp, I mean you might-} \ 16: \textit{-Oh my.} \ CP23: \textit{It was quite amazing.} \ (\textbf{retirement home}) \]

Family traditions were also modified to accommodate the changing needs of the person with dementia or care partner. For example:

\[ \textit{No, we stopped going to church last Christmas and we – she comes over here on Sunday morning and we watch ah, a sermon from ten to eleven, Schuller, and then we go to lunch here on Sundays. So we’re, we’ve been doing that every Sunday.} \ (\textbf{CP19, nursing home}) \]
Instead of going out into the community, traditions such as attending church and eating out for brunch afterwards were retained by adapting the tradition to the new place of the facility. As well, it is important to note that some families could not retain such family meal routines shortly after relocating to the long-term care home. Newly admitted participants were at times confused in their surrounding and care partners did not wish to further confuse them by bringing them home initially (dyad 10, 21).

5.3.4 Remembering Home.

Beyond retaining personal routines and traditions, remembering home refers to the ways in which participants held on to memories of home once relocated to the long-term care home. Ways that this was accomplished was by: reminiscing, holding on to objects and experiences associated with home, being informed about community news, and by retaining past relationships. These memories did not require returning home or retaining or adapting routines and mealtime gatherings to promote holding on to home. Remembering home was a way that newly relocated participants could hold on to the feelings associated with home, within the long-term care setting.

Specifically, mealtimes in the long-term care home provided opportunities for dyads and residents to reminisce about events in the past. This helped them retain memories and feelings associated with home. Some would reminisce about specific mealtimes, others about cooking occasions and others about favourite foods. This reminiscence could be between the dyad or with tablemates.

PWD8: Yeah it does happen once in a while. “Oh I remember when I used to make this.” And then we talk about it at the table and everyone says, “Well we can’t anymore so we might as well enjoy it. (nursing home)
One participant (PWD 23) would often reminisce about her past cooking experiences and she felt that that helped make it easier for her to accept that she could no longer continue to do these activities. She felt proud of her undertakings in the past and reminiscing about them helped her to hold on to the feelings associated with these accomplishments.

For some participants, holding on to objects from home allowed them to retain memories as they were components of the feeling of home. They talked about how having their furniture and some of their photographs from home, helped them feel more comfortable in the current setting and helped ease their adjustment, which would in turn impact their mealtime experience.

I3: What... helps make a change something you can live with? PWD23: Umm.. I think... trying to hold as much of the past as you can, of the things you’re comfortable with.

For care partner (CP 10), keeping his wife informed of community news was his way of helping her stay connected to home. This provided him with topics to discuss with her at mealtimes and also kept her connected with life outside of the long-term care home.

I3: And it sounds like you probably talk with her as well like bring news from outside in, is that sort of what happens. CP10: Oh yes, oh definitely yes. If I know anything about our friends or whatever, always try to do something. Sometimes I come with a list of number of things. And I told her about the chap that passed away up the street and that really struck her pretty hard. And so yeah, I feel it’s important to let her know what, you know her friends and that sort of thing. (nursing home)

There are several different ways that dyads approached remembering home. These activities helped persons with dementia hold on to memories and feelings attached to living at home. Family made the extra effort to ‘remember home’ with the person with dementia to assist with this adjustment, and sharing food at the facility often provided the opportunity for this reminiscence.
5.3.5 Summary.

In summary holding on to home was a way for persons with dementia to retain some of the feelings and experiences associated with living at home. These strategies also assisted with relocation so participants did not feel like everything was changing all at once. Care partners played a large role in facilitating this process. They would bring their loved ones home for meals, they would continue to plan special outings, would reminisce about past mealtimes and would relocate family gatherings.

5.4 Evolving Roles

Evolving roles refers to the process that persons with dementia and their care partners underwent to develop roles that better suited their new mealtime environment. This was associated with the loss of some role(s), but also the renegotiation and development of new roles. This process was sometimes viewed in a positive light and for others in a negative light, based on the resources available to the individual and their ability to adapt to the relocation. Sub-themes include: Relinquishing Past Roles, and Renegotiating and Establishing New Roles.

5.4.1 Relinquishing Past Roles

Relinquishing past roles occurred when persons with dementia could no longer continue with their previous roles at mealtimes once they had relocated into long-term care. Sometimes these roles were ones that they were already experiencing difficulty with at home, and other times they were roles that were simply not feasible to continue in the new setting. Loss of past roles was described in emotional terms, when the role was important. For example, PWD 23 tremendously enjoyed cooking, as it was a way for her to nurture others and express her creativity. Once in the long-term care home, this was
something that was no longer possible for her. Leaving this role behind was difficult for
her, because it had become part of her identity.

I8: Why is food an important part of celebration? PWD23: Isn’t it for everybody?
I8: Why is it for you? PWD23: Because it’s creative I think, and I love food and I
love working with food, and I always have. I8: Do you miss that when you’re
here?
PWD23: I do yes. I do miss that. It just kind of – suddenly I’m faced with that and
I think ah I can’t do that here (retirement home)

On the other hand, relinquishing roles at mealtimes was a positive experience for
some participants. One participant described how he was experiencing a lot of difficulty
contributing to mealtimes. He was often fatigued and had difficulty remembering how to
carry out tasks. In the long-term care home, he no longer felt the weight of the
expectations around mealtimes, he stated: “Well, at this point in time it’s a relief to have
someone doing all the things like that” (PWD11). He experienced a sense of freedom
that allowed him to help out staff at mealtimes when he was able to. Similarly, PWD 19
talked about how not having to contribute to the preparation of the meal was a positive
experience. She recognized that she had done her part in carrying out this task in the past
and was thankful that it was now time to let someone else do this for her.

I1: So, my question for you now is what’s it like to be in a place where all the food
is provided for you and you don’t touch it, you don’t make it, you don’t prepare it
in any way, what’s that like? PWD19: Well, at this point in time it’s a relief to
have someone doing all the things like that. (nursing home)

Care partner 21 who relocated into the long-term care home with his wife, experienced
mixed emotions around losing mealtime roles. He had taken over cooking when they
were still living in the community and it was something that he enjoyed. Now residing in
the long-term care home he recognized that this role was in the past. However, he did not
experience a profound sense of loss, as he had other activities to keep him busy.
I5: Do you miss cooking? CP21: Yes and no. Yes, I suppose I do because I liked cooking, but number 2 no I’m caught up in so many other things now that I don’t have time to think about it. If I had to cook it would get in the way (laughs) [retirement home]

Roles were particularly difficult to leave in the past if they were meaningful to participants and had contributed to their sense of identity. It was easier for participants to accept the loss of certain roles when they had already been struggling to maintain these roles or when they had other activities to replace these roles or take part in that now seem more meaningful.

5.4.2 Renegotiating and Establishing New Roles.

Renegotiation of roles occurred when previous mealtime roles were altered to accommodate both the changing ability of participants to engage in past roles and the potential for these roles to be continued in some way in the new setting; these roles were not lost all together, they were simply redefined. For some, this meant renegotiating the meaning of their roles around mealtimes. For others, it meant changing their approach to mealtimes. For example, for those families where eating out was common, the person with dementia altered their hosting role to offering to pay for meals in restaurants. In that sense, they could still host and nurture people at mealtimes.

PWD23: Yes, yes she does but she lets me pay for it too, if we go out together. I6: Why is that important to you [PWD23]? PWD23: Oh I like to pay my way and I know that they have a lot more.... I just have fixed expenses mostly. You know my expenses are pretty. So it’s kind of nice to have something to spend, somebody to spend money on.

...To be the hostess. [retirement home] I6: Ya rather than providing a meal in your own home, you are providing a meal- PWD23: Yes this is the alternative for that.
However, in other instances care partners and persons with dementia established new roles. Establishing new roles occurred when participants naturally fell into these roles in the long-term care setting without consciously seeking them out. It is important to note, that there was some overlap between the renegotiation of roles and the establishment of new roles. In some instances while attempting to renegotiate prior roles, participants developed new roles.

For persons with dementia who lived alone prior to the transition, mealtimes in long-term care provided them with new helping roles, for those less able than themselves at their table. They assisted tablemates in many ways and also assisted staff by providing some of the care and attention for certain residents that they did not have time to offer:

*PWD8: And just helping each other, and like [tablemate] said to me, “I don’t know what I did before you got here, but I don’t know what I’ll do without you.” It’s just the little things. The one table up, there’s a gentleman that’s got –he’s further along in his journey with dementia. I call him ‘captain’. Ever since that I’ve been able to –he relates with me. So sometimes he doesn’t want to eat, so I’ll go and sit beside him. I’ll squat down so I’m at him level. We’ll talk and I’ll say, “Well captain if you’re going to -.‖ And he’ll garble something. I say, “Well if you’re going to do that work this afternoon don’t you think you should have a good lunch?” “Yeah.” And then sometimes I can talk him into eating. It’s just helping others because that’s just me. That makes it fun. (nursing home)*

PWD8 described this new role as particularly meaningful, as it was her way of giving back. She mentioned how being helpful was her way of caring and in doing so, she was taking on the role of the “caregiver”, rather than being the one always requiring care.

Similarly, CP10 discussed how his wife took on a caring role for other residents. Once relocated, she became disoriented to time and place and thought she was a staff member. However, CP10 supported this notion by saying, “I think in a way she was”. She was
very attentive and caring towards other residents and thrived off of having this meaningful role.

Relocating place also provided the opportunity for participants to take on new social roles. For example, PWD 23 previously lived alone and had little contact with others outside of her daughter’s visits and sharing in her daughter’s social life. In the long-term care home she discovered a new role in socializing with others “Oh I try to get to know everybody at the table and talk to them and. Yeah. (PWD23).” (retirement home). She mentioned having formed strong relationships with her tablemates and also discussed often joining in on afternoon tea, where she would mingle with other residents. Similarly PWD11 developed a social role in his new home. He discussed rarely being in his room and always wanting to mingle with other residents who he could relate to. Prior to relocating into the long-term care home his social skills at mealtimes had been decreasing, but in the new environment he quickly developed a new social role.

In the new setting care partners were also able to renegotiate previous roles, as well as establish brand new roles. In this new setting, care partners found that they no longer needed to provide the same level of mealtime care for their loved one as was required at home. Their role transformed from the providers of all support to more emotional forms of support at meals. Part of renegotiating previous roles for care partners, involved realizing that formal care providers had a role to play and may have greater expertise in some areas. They also did not want to undermine the care provided by staff. For example:

I8: Do you miss being able to help her in that way to choose the foods and to make sure that she was getting food that she liked? CP21: No… I try to listen to them. I always say I don’t want to take over the helper’s jobs. They’re experts in
their field and they’re so patient. So whatever I try and do is to head to the recombination up there if you want to call it that, without changing things, without being in the way if you want to call it that. So I listen to them. If they say, “I think PWD21 would like the sandwiches.” “Oh yeah that’ll probably be nice for her.” So you listen to them and they decide. (retirement home)

Renegotiating past roles was often welcomed by family care partners, as they often struggled to keep up with the demands of care. Hands-on care shifted to a manageable level and often to emotional rather than physical support, after the move to a long-term care home.

I1: Have you noticed other reassurances that might be new in the last couple of months that [PWD 11] seeks from you? CP11: Yes, yes. It’s the safety issue, that [PWD11] thanks me every day. He telephones me at home, and that’s just fine. I look forward to the calls. And you always ask me, [PWD 11], or you tell me, “Thank you, because what you’re doing for me, just being there for me, makes me feel safe. (retirement home)

And

I4: How do you see yourself now? How would you classify you as a care partner now?
CP11: ...Oh that’s a good question because I’m really not a caregiver. Ummm – I4: -- so what would you say that you are now? What’s your new role?
CP11: I would definitely say I’m [PWD 11]’ best friend. The best friend he’s ever had. And ever will have. There’s no question about that. And I will be there for him. (retirement home)

Care partners also took on new roles at mealtimes. They began to provide support for other residents at mealtimes. For example, CP10 discussed how he provided support and reassurance to his wife’s tablemates during mealtimes. They learned to go to him with their problems and he did his best to come up with solutions for them.

CP10: Well if they, if they, I - help them out by taking the brighter side of whatever the problem is. And – hoping that you’re going to make them feel a little better about it and I think it works. (nursing home)
For one care partner who relocated into long-term care with his partner, he established a new role as the home’s ‘wine maker’, which was really significant for him. Not only did this allow him to create connections with other residents and be recognized at social functions, but it became part of his identity. Other residents referred to him as the ‘wine man’ and he took pride in this.

*I buy the makings, I make the wine, I bottle it, I serve it. It’s my entity in here and they all know me, he’s the wine man. One of those silly things ya. (CP21, retirement home)*

Both renegotiating roles and developing new roles were often viewed positively by participants. Renegotiating roles allowed participants to retain meaningful roles by simply adjusting them to suit their current circumstances. This also appeared to help them better accept and deal with some of the changes in place they were experiencing. Developing new roles that better suited the needs of the new environment appeared to assist participants in establishing their place in the new setting.

**5.4.3 Summary.**

In summary, relocating into a long-term care home required participants to leave behind some roles, while renegotiating others, and falling into new ones. Participants reacted differently to the changing roles based on what their previous roles had meant to them. Some focused on the sadness they experienced with the loss of previous roles, while others focused on how this was a time where they could get involved in new and exciting things.

**5.5 Becoming “at Home”**

*Becoming “at home”* refers to how persons with dementia and their primary partners in care began to feel “at home” in the long-term care setting. This occurred at
different points in time for dyads; for some, it occurred upon relocation, but for others it never fully happened. If it did occur, it could be a lengthy course for participants, as they needed to create new ties with this place and begin to accept it as their own. Data suggested that ‘becoming ‘at home’’ was a fluid and dynamic concept for dyads; depending on the day, their current experience and perspective they could consider the long-term care home as their ‘home’. It seemed that this concept was always be negotiated in some way by participants.

The data collected from dyad 23 helps to illustrate the struggle the person with dementia experienced in trying to accept the new setting as her “home” and how mealtimes played a role. Over the course of the four years she resided in long-term care her view of the long-term care home shifted and at times she seems described the ‘new place’ being more “homelike” than others. This first quote illustrates PWD23 first thoughts about the mealtime situation in long-term care and she distinguishes how it is different from home:

I3:  Ok. All right. One of the things that both of you talked about was when you eat here, is that it’s different in terms of hominess. And I wondered if you could comment on that for me
PWD23:  Umm. I think it’s partly not having a hand in the preparation and the serving. You know, there’s something about preparing and serving a meal to people that makes it different. As opposed to just sharing it (Year 2).

Over the next two years of data collection, PWD23 indicates her dissatisfaction with life in the retirement home. She talks about how she looks forward to leaving and misses her independence.

What is it about getting out that you like so much?
PWD23: [[Clears throat] Well this to me is not a natural life you know. I’m used to being independent. I’ve worked a lot and, and ah, and lived alone, and - well I like people. I just as soon have more space (Year 3).

However, in the same interview PWD23 discusses both how she has learned to adjust to some of the changes and how she views her tablemates as members of a family. She talks about how she enjoys eating with others at mealtimes and how her tablemates provide support for one another. To a certain extent she is learning to accept the new setting; although at this point not viewing it as home.

PWD23: Well, I’ve, I’ve just got use to - following the routine. I think you, you just sort of have or you don’t, or if you don’t adjust why I don’t think you’d be very happy here. [I3 Agrees] But, um, well you know it just came into my own mind now, it’s kind of like going to a summer camp in a way. You’re suddenly part of a much larger group and you adjust (Year 3).

And

I3: Would they just sort of be like you sit back and be entertained by Mary or.?
PWD23: Yes. I think so. Not so much entertained as - mothered. [laughs]
PWD23: Yeah. She was the, the head of the family (Year 3).

By year four PWD23 is beginning to recognize aspects of the retirement home that are more “homelike” and she has established a role in the long-term care community.

PWD23: So, but I think they have done a good job of planning. Setting up people to make them feel at home, you know. If you are ever here in the afternoon, when coffee hour, you just see people chatting all over the room in smaller bunches and couples and pairs and a larger group, so it’s quite... You can practically come into a dining room and go and sit down practically anywhere and if you think that there is an intimate conversation going on, well you probably wouldn’t. You know you sort of look twice and think well there is a group over here and I will join that group, rather than interfere in somebody’s conversation. But it’s quite; it’s quite easy to be part of it (Year 4).
However, she continued to voice some ambivalence about seeing the facility as her ‘home’ as she was continuing to find it hard to adjust to the routine of mealtimes and missing previous roles; even in Year 5 this ‘back and forth’ view of the new place as home is evident:

PWD23: Yeah um... yes sometimes when I’m not always comfortable at mealtime, I haven’t really worked out why, but –well they’re not intimate friends for one thing, and sometimes you lose out in the conversation. You don’t –maybe it’s my feeling, not anybody else’s but I think there’s a certain –if I –maybe I’m not sure this is really true but the sense that if I come in and sort of hold back on the conversation that they go on conversing together, but then not always either because we have another person in the conversation that often sort of opts out. It’s not as though everybody’s really keen to get together and talk the same (Year 5).

The data from dyad 23 illustrates how difficult it is for persons with dementia to feel “at home” in a new setting and how the perception of the new setting changes from interview to interview and even within the interview. The following identified subthemes help to further clarify this theme and they include: Comparing to Home, Belonging to a Community, Rationalizing the Move, and Calling it “Home”.

5.5.1 Comparing to Home.

Comparing to home refers to the feelings of discontinuity experienced in the new mealtime environment and making judgments of this new environment by contrasting it to mealtimes at home. This appeared to occur early on in becoming at home, as participants needed to be aware of the differences in the new setting before they could move past them and begin to accept the new environment as their home.

For mealtimes, participants discussed how the ambience within the long-term care home was something to get used to. They talked about how everything was very
controlled and that this made it difficult to feel like they could still manage their everyday life.

*Umm.. I don’t know.. [chuckles]  Umm. There’s a lot of structure that you have to deal with, you know. It’s not like you own the place and you can do what you like with it. It’s not that way. You’ve got to adjust to the rules and the structure there. It’s not the same.* PWD23 (retirement home)

Systems and taken for granted routines in the facility also made it difficult for participants to retain their independence and sense of control. One participant described it as now having to “move to the beat of someone else’s drum” (PWD23). Another expanded on this concept:

*Especially us, for all our lives we’ve been very, very independent. If anything and anybody, you know we’ve always looked after ourselves. And to suddenly come in and be looked after is rather a change. Almost seemed like an intrusion to start with. You know if you don’t go down to dinner, they ring up and say ‘Hey anything wrong, can we help, do you want to come down, what’s the problem?’ It’s the first thing that happened to me, what the heck, you don’t have to look after me you know, and then you realize this is part of what you’re involved with.* CP21 (retirement home)

For some care partners it was too difficult to accept the new reality of the mealtime space when they were ‘comparing to home’. For example:

*I1: Okay, so food played a really central role in your connection with each other, and looking after each other. And, so, what’s that like for you now? Food is not part of that central piece anymore.* CP12: *Yeah, food is just a necessity now. I’m hungry, I eat, you know. And it just tears me apart to watch him eat now, so….* (nursing home)

For those who had greater cognitive impairment, the new place of the long-term care home resulted in confusion and disorientation to time and place (PWD10, 12).

Although these residents were not always cognizant of their location, they were initially able to identify that it was not their “home”. Care partners struggled with trying to persuade their loved ones that this was their new home.
I3: Does she want to come home, why do you think? CP10: ...I guess because home’s home. You know, and uh, they, and I can’t persuade her. Well I did tell her the two or three times, I said, “[PWD10], this is your home.” But she just sort of dismisses that. (nursing home)

The feelings of discontinuity for the person with dementia were magnified with unfamiliar surroundings that did not contain the memories, visual cues and smells of home. These feelings of discontinuity were expressed by: attempting to leave the facility (PWD10), making complaints about the food (dyads 21, 23), and refusing to socialize outside of dining (dyad 21). However, as described below these feelings gradually lessened and the new place began to become more home like.

5.5.2 Belonging to a Community.

In order for a space to be meaningful to an individual, they must form connections with it. Connections can be made with the physical space itself, but also with the individuals who are associated with the space. When participants lived at home, they were attached to their home, the people in it, and the larger community. Belonging to a community is described as the formation of similar attachments with the new place, due to the presence of other residents that helped to create that sense of community. For some, making close connections naturally occurred especially as they shared their past with each other, had concern for one another and interacted on a daily basis. Their relationships became like that of a family:

CP8: just like when she went to the hospital, they [fellow residents] were concerned. They asked. I went back in and got some stuff and, “How is she? Are things ok? Is she coming back?” They were concerned. PWD8: Genuinely concerned too. CP8: Yeah like they do bond. They do make that family kind of atmosphere in there. (nursing home)

Being part of a community also meant feeling accepted and having others to lean on for
support. Mealtimes helped to define this sense of community. For example, one participant described how he felt as though he could forget about the problems associated with his disease when he was in the company of others who were dealing with similar circumstances:

_Well, this is where eating together helps a lot, because by doing that, we can share without being troubled with the dementia. When we’re talking, none of us seems to indicate, oh, we’re a little goofy, you know._ (PWD11, retirement home)

Interacting with friendly and helpful staff also added to the sense of community and made residents feel more at home. When they felt comfortable approaching staff for help or when they were acknowledged by staff in a positive way it helped them feel more connected with the new setting.

_Well, generally speaking, I’ve found them all very helpful [staff] and if I have a problem, I can’t find something, they seem to be willing to help me if [CP 19] isn’t here and if he is here he would help me._ PWD19 (nursing home)

Other participants talked about being “_totally spoiled by the staff and the kitchen staff_” (PWD8, nursing home). Some staff members went out of their way to make the participants feel accepted and that their opinions were valued:

_Often times I’m invited to sit with the staff, so they will ask me certain point of views about medical conditions or things that aren’t making them happy. ...So yeah there’s a lot of sharing and a lot of caring._ (PWD8, nursing home)

Care partners also described becoming part of the community when they visited often and formed connections with other residents and staff. They would join in on mealtimes, participate in celebrations within the home, and collaborate with staff in the care of their loved one. The long-term care home often became a new place for them to ‘belong’ and be accepted:
It's well, she knows, I would think that she knows that she's part of a community and there, you know, they'll call her by name and there's one fella, it's quite funny, [residents name]. One day I always talk to him when I go by and uh, so one day I came in he said, “Oh there’s [name of care partner].” [laughs] So you know, I’m down here, which is good, and so that, I’m sort of an illustration of you know, being part of the community and so on and I think that'll be enhanced. (CP10, nursing home)

Belonging to the community was important for some care partners. Not only did they begin to accept the new living situation of their loved one, but they were also able to consider it as their new home in which to have a relationship, typically with their spouse. Further, the communal space provided them with social interactions and connections with others that they may not have experienced otherwise. When care partners also transitioned to formal care with their spouse, this sense of belonging to a community was especially noteworthy:

*Here as soon as you go out of the front door sort of thing, this is our door here, you’re into other people. You go down and the mealtime there’s always other people there. Um, without considering these people do become really a part of a family, if you want to call it that. It’s amazing how well you get to know them and how intimate in some instances you get to know them. This just happens to be the way of life, this is the way you fall into that sort of environment.* (CP21, retirement home)

Feeling part of a larger community helped participants connect with others, feel more comfortable in their surroundings and brought them closer to becoming *at home*.

Participants began to establish connections with the new setting and it no longer felt as unfamiliar to them.

5.5.3 Rationalizing the Move.

Rationalizing the move was another way that helped bring participants closer to *becoming “at home”*. This was the manner in which both persons with dementia and their partners in care described how they came to terms with relocating into the long-term
care home and accepting it as “home”. This rationalizing involved reflecting back on their situation prior to relocating which allowed for seeing the benefits of the new place for living:

No, I think... thinking this way, makes me look back to the times when I was living alone in my house and eating meals alone a lot of the time... sometimes with [daughter]... but a lot of the time she was involved in other ways. Umm, but... I think I would rather eat with this group that I’m with now, then ... alone, yes. So I think I’m adjusting. (PWD23, retirement home)

And

And I guess the realization that it can be scary at first. Like, before mom moved to [facility name], I remember it dawning on me that this may be her home, but it’s not my home anymore. You know. But, my feelings hadn’t really materialized. Like, I come and go and nobody says, ‘What are you doing here?’ and ‘Isn’t it time you went home?’ And so, you do, adapt and it’s... OK. (CP23, retirement home)

For some, part of rationalizing the move was the realization that the move had been positive or ‘for the best’ as a result of changes that were difficult to cope with in the community. This however was most often discussed as a benefit of the relocation only after participants had come to terms with some of the other changes they were experiencing in the new environment. For example:

But as far as living at home vs. [facility name], yeah I’m glad to be there and have the regular meds because I was forgetting my meds to have them on time, and I wasn’t eating anywhere near what I should’ve been. It was, it may be a sandwich or a toast or whatever was easiest, or nothing. So having the regulated meals has been great, and then you have your juice and your snacks in between. So for the eating and diabetes end of it couldn’t be better. (PWD8, nursing home)

For a dyad that relocated to a long-term care home together, the realization that they could receive all the care that they required in their old age helped them to be more accepting of the new environment:
Well the best part is cause the - accept the fact that at this stage in life you have pretty well expert help around you if you need it, nursing and or other assistance. Second you don’t have to cook a meal every day or make your meals. You don’t have to do shopping; you don’t have to do all those other things. (CP21, retirement home)

In the community, being worried and feeling unease was stressful and caused tension among dyads. Moving into a facility could provide a sense of security and reassurance that was needed. In one case it was stated: “I think [I am] more positive. I feel safe, and I’ve got really positive relationships with the workers and almost all of the other residents.” (PWD11). This participant also commented on how knowing that it was a locked long-term care home put his mind at ease; he did not need to worry about getting lost.

It’s a locked facility and so if I go out, I go out with [ex-wife] or [son] or other people on trips, etc. And what that has done, is given me a sense of peace and a sense of...how can I put it...what’s a good word for it...a sense of peace, a sense of ...safety (PWD11)

Prior to relocating into long-term care, care partners provided most of the care and support that their loved ones required. But as the care demands increased, care partners found it too difficult to keep up. Long-term care homes were often viewed by some care partners as environments where their loved one could receive the individualized support that they require in old age. This provided some participants with reassurance that they would receive a level of safety and care that was no longer possible for them in the community. Therefore, for most care partners, the move into long-term care was viewed as being the best option for their loved one. This also helped them view the long-term care home as the new home of the person with dementia.
Um, I do feel that there’s been a big weight lifted off my shoulders, I have to say that. And I know that she’s, I’m satisfied ...that she’s getting much better care now then I could have given her. It’s best for her. (CP10, nursing home)

Feeling safe and supported by the new environment provided persons with dementia and their care partners with reassurance that they were being well taken care of. This allowed them to focus on other things, such as; familiarizing themselves with the new environment, and forming connections with residents and staff. This helped families to feel that they had made the right decision by relocating their loved one.

In addition to focusing on the benefits, participants also reflected on losses that resulted from the relocation. However, not dwelling on losses and accepting the situation was needed as part of this rationalization to become “at home”. Acceptance allowed for moving on and making the most of the current circumstances. For example:

Well, when we first moved in here you – almost feel so miserable, to - again remembering probably in a, in an obscure way what life was like before and then having to adapt to this. And in the end if you suddenly realize, this is life, you might adapt to it and get it under your belt and then go ahead. That’s my attitude, our attitude. So once you’ve accepted that, fine, make the most of it. (CP21, retirement home)

Acceptance for some meant weighing out the pros and cons of their decision. It meant recognizing the sacrifices that were made, but also how their situation improved as a result of their decision.

CP8: You can’t have your cake and eat it too. You know you’re going to have to make some compromises going in. it’s not independent living anymore. You’re going to have to march to somebody else’s drum. Yeah it’s going to take time to get used to that, but you’ve got to choose—‘by yourself and in danger’, or ‘safe and secure and following rules’. (nursing home)
Rationalizing the move was something that participants did to bring them closer to feeling at home. This was accomplished in a number of different ways, but allowed them to adapt to their current situation or to find peace in the decision that was made.

**5.5.4 Calling it “Home”**.

Calling it “home” generally occurred later on in *becoming at home* and it was evident when participants began to describe the long-term care facility as their “home”. It was the point at which they had formed personal attachments with the new setting that allowed them to feel at home. Participants who described feeling accepted in their new environment and saw the benefits outweighing the losses were able to see the facility as “home”. As stated by one person with dementia, “I am, at home. Waiting for this, this is my thing. (PWD11)” *(retirement home)*

For some participants it was the feelings of belonging and the treatment that they received from staff that made them accept their current circumstances.

*CP10: It’s home now for a change more than before, and they look after her quite well and she knows the staff, and they’re always very kind to her and joke with her and so on. So, you know, it’s quite a nice atmosphere”. (nursing home)*

For others, getting used to the communal environment, the new systems, routines and expectations, took time. As stated by a participant:

*But as far as for the Eating Study, yes when you go from independent and you go into another setting to live, there is a big adjustment. But take your time and it will gradually work out. It is a roller coaster ride. I had my honeymoon stage, I had my roller coaster ride, and now after 6 months it is my home. (PWD8, nursing home)*

These participants suggested that seeing the facility as “home” was a process with several steps, and for care partners, this meant seeing the community or family home differently as well. As stated by a daughter care partner:
I felt very sad when she left her home and moved to [facility name], because I never... I mean when she moved in I thought this will never feel like my home or like my mom’s home, but it does now you know. It’s smaller (her room) but we do feel, I do feel like this is her space. (CP23, retirement home)

Although eventually some participants began to call the long term-care home their “home” it was not always an easy process to get there. Some struggled with the term, questioning whether this place was truly their home or just a place to live. However, once time had passed and they had begun to accept their current situation, the long-term care facility appeared to feel more like home.

5.5.5 Summary.

In summary, there are many ways that persons with dementia and their care partner can began to ‘become at home’ in the long-term care facility. In order to do so, they need to not only accept the move and the resulting changes, but also begin to form attachments with the new setting. It was also important for care partners to play an active role in assisting their loved ones to become at home and to also see this new place as “home”.

5.6 Summary of Results

In summary, relocating place impacted the mealtime experience in many different ways for families experiencing dementia. Mealtimes in the new setting were generally described as being much different from mealtimes at home. The identified themes help us understand the discontinuities participants experienced at mealtimes after relocating, as well as the strategies they used to adapt to the changes and how they began to feel at home.
Systemizing the meal impacted the mealtime experience of newly relocated residents in a variety of ways. Firstly, participants felt as though staff viewed mealtimes as a task to be performed rather than an experience to be enjoyed. Participants discussed not receiving the individualized attention that they required and feeling lost in the crowd. Secondly, there were many rules and procedures with which residents and family members needed to become accustomed. Some of these included when they were to arrive for meals, where they needed to record their meal choice, and how much notice was required for a family member to stay for a meal. As a consequence of the rules and procedures, mealtimes also became routine for residents. They discussed how the events at mealtimes were very predictable and some longed for the spontaneity of mealtimes in the community. Finally, as a consequence of the meal being systemized and the scale of the individuals needing to be fed, the food offered did not live up to many participants’ expectations.

Adjusting to dining with others was sometimes challenging for residents, as in most instances they had grown accustomed to sharing intimate meals with their care partner or eating alone. Despite these challenges, for some eating with others was an opportunity to socialize and form connections with other residents. For others who felt they were not compatible with their tablemates, these connections were forced. Eating in a large dining hall with many other residents also meant dealing with distracting behaviours and losing privacy. Many participants discussed eating in a separate dining room with guests so that they did not need to engage other residents in their discussion and so that private discussions were not overheard.
Holding on to “home” included strategies that families used to adjust to the changes they were experiencing at mealtimes, while still holding on to mealtime experiences established prior to relocating. This was accomplished by returning home for meals, retaining personal routines and traditions between the dyad, relocating family gatherings to the long-term care home, and by reminiscing or remembering home.

Evolving Roles encompassed relinquishing past roles and renegotiating and establishing new roles. Relinquishing roles occurred when previous roles could no longer be performed in the new setting. The need to renegotiate roles occurred when previous roles could be modified to better suit the new environment and establishing new roles occurred when persons with dementia and their care partners found new ways of taking part at mealtimes in the new setting.

The final theme, becoming “at home”, related to the ways in which persons with dementia and their care partners began to feel at home in the long-term care home. This first involved comparing their home to the long-term care environment to establish the differences, in an attempt to be able to adjust to them. Residents also began to feel at home when they became part of the long-term care community. They formed connections with other residents and staff during mealtimes, and established their place within the home. Rationalizing the move was an additional feature that helped residents feel at home in the new setting. And finally calling it “home” demonstrated the acceptance of the long-term care home as their new home. However, it is important to remember that this did not occur in all cases.

Findings of this study indicate that there are ways that mealtimes in long-term care can be improved to bring them closer to mealtime experiences of home. This may
also aid in helping residents and families adjust to the long-term care setting sooner and will help facilitate the process of becoming “at home”.


6.0 DISCUSSION

6.1 Positioning of Research Findings within Existing Research

6.1.1 Situating the Study Findings

This study is the first of its kind to examine the mealtime experience of persons with dementia and their primary partners in care after relocating to a “new place”. The original focus of this study was to understand how the meanings associated with place impact the mealtime experience of persons with dementia and their primary partners in care after relocating to a long-term care home; however it became evident that there was not sufficient data present to address this gap. Because this was a secondary data analysis, theoretical sampling could not be used to help gather more data to assist in answering this original question. However the analysis did provide some level of understanding of “sense of place” and how this relates to mealtimes in the long-term care setting.

There are many factors that contribute to whether or not someone experiences a “sense of place” in a setting and two important dimensions were identified in this study. The first was belonging to the place as a member of the community. Newly relocated residents formed relationships with staff and with other residents and were able to feel part of the mealtime experience in the home. The second was being able to maintain some level of continuity with their previous life and this was evident in the theme of holding on to “home”. Persons with dementia retained their relationship with the care partner and were also able to hold on to memories and experiences associated with home; which helped them adjust to the new setting. This study therefore highlights the importance of the “relational” dimension of place in helping residents discover a “sense
of place” at mealtimes in a long-term care home and perhaps extends the definition by Buttmer (1980) discussed previously (pg 6).

6.1.2 Mealtimes in Long-term care.

To date, much of the existing literature on mealtimes in long-term care homes examines the nutritional status of residents; however, the importance of looking at the dining experience of residents in long-term care homes is now being recognized. Researchers have begun to examine how the organizational, social, and/or physical environment in long-term care, impact the mealtime experience of residents. However, no research has specifically examined “place” and the mealtime experience for individuals who have relocated from home into a long-term care home. Highlighted below is current research to which my results can be compared.

Evans and colleagues, (2003) investigated nursing home residents’ perspectives of quality dining in long-term care. They conducted open-ended interviews with 20 nursing home residents and their data showed that a quality dining experience involved: being able to choose their food, getting good people (desired staff characteristics), getting good service, choosing surroundings, and getting enough to eat. Out of the five themes identified, two themes overlap with the findings of the current study. The first theme was being able to exert control over the food being served, and the second related to the issue of lack of variety (Evans, Crogan, & Shultz, 2003). These same issues were identified in the current study under the theme of systemizing the meal. As a consequence of meals in long-term care being systemized, participants discussed their disappointment with the quality, presentation and variety of food served. However, participants in both studies discussed their understanding of how difficult it would be to prepare and accommodate
the food preferences of a large group. The theme of choosing surroundings, as identified by Evans and colleagues could also be compared to the theme in the current study of *adjusting to dining with others*. Participants in both studies often discussed choosing with whom to eat, some longed for more privacy at mealtimes and others longed for tablemates with whom they could carry on a meaningful conversation. Both studies help us to understand the ideal meal situation that residents in long-term care homes hope for and these findings provide staff members with strategies for addressing this situation. Strategies included; allowing the residents to provide feedback about the food served, inquiring about likes and dislikes, and giving residents some choice in where they are seated at mealtimes.

Hung (2008) looked at the dining experience of residents with dementia in two very different types of long-term care facilities. The first facility was designed to emphasize a more ‘homelike’ feel and provided residents with many opportunities for social interaction. The dining room was small, had an oven in it, and was decorated with familiar objects to help make residents feel at home. The second facility had a physical environment similar to that of traditional long-term care homes; it was more institutionalized, characterized by general furnishing and decor, long hallways, and large dining areas. Hung (2008) revealed that persons with dementia had a much more enjoyable mealtime experience in the more homelike environment. This study highlights the importance of physical characteristics of the setting in impacting the mealtime experience. Participants in the current study resided in several different types of long-term care homes; some residing in nursing homes and others in retirement homes. The size, location and funding of the homes also varied. Despite these differences many
participants’ described finding institutional elements of the mealtime setting difficult to adjust to such as: waiting for meals, having preportioned food delivered, and the general lack of choice they experienced. The current findings, supported by those of Hung, highlight the importance of considering how institutional elements can be made less apparent to promote a more ‘homelike’ mealtime environment. By making the dining rooms more intimate, decorating them with familiar objects, and encouraging social interactions and connections between residents and staff, this may be accomplished.

Kofod and Birkemoses (2004) looked at the meal situation in four non-traditional long-term care homes in Denmark to determine residents’ appreciation of the mealtime situation and their nutritional status across the four homes. These long-term care homes were unique in that, residents ate in smaller groups, they took part in the meal preparation, and had influence over the menu. This was done in an attempt to provide residents with a more ‘homelike’ meal situation. Despite these modifications, interviews with residents revealed many of the same concerns apparent in the current study. Participants discussed some of the challenges they experienced adjusting to eating with others and the lack of control they felt over the food they were served, despite their opinions being taken into consideration. Contrary to the current findings, however, when asked about their perception of the long-term care home, most participants stated that they could not consider it their home. One participant said, “This is just a nursing home. This is not what I call a home.” The results of the study by Kofod & Birkemoses (2004) help us understand the discontinuity that residents’ experience in the new environment and how for some, the meanings attached to home are not easily transferred to the long-term care environment. This study calls attention to the fact that creating a homelike
environment in long-term care can be difficult to achieve; it is more than size and activities. Results from the current study however, provide some insight into what is required to make mealtimes more homelike; such as making the routines and rules associated with mealtimes more flexible, and making the focus of mealtimes on the experience rather than the tasks at hand.

Carrier, West, and Ouellette (2009) examined whether the dining experience and food services in long-term care affects the residents’ quality of life. They conducted interviews with cognitively able residents or had care partners of persons with dementia fill out questionnaires, and they found that a number of parameters related to the mealtime experience were of importance. These included: the number of dining companions, their autonomy in relation to food, tray meal delivery service, and ratio of residents to staff. Although the outcome measure was quality of life and not the experience of mealtimes in the new setting, some results from Carrier et al were similar to the results of the current study. Carrier et al. found that the number of dining companions improved the quality of life of residents and this was attributed to the idea that social interactions increased when dining with others. In the current study, residents sometimes found it challenging to adjust to dining with others, but in other cases residents looked forward to socializing with their tablemates. They also felt a sense of belonging at their table and some discussed how each member at the table had their own role. This may have contributed to their overall sense of belonging within the home and could potentially ease their adjustment to the home. In both studies participants mentioned wanting to have a choice over dining companions; not having a choice could impact their mealtime experience. Participants in both studies also wanted control over their own
food. They wished to be able to have access to food outside of meals and to have the option of bringing in foods that were not offered in the home.

Orulv (2010) conducted an exploratory case study in a residential care unit to describe how a resident with dementia attempted to make sense of her eating environment, after experiencing disorientation upon relocation to a long-term care home. The author wished to understand how residents with dementia make sense of the situation, the place, and their part in it. Mealtime observations indicated that despite the resident being unaware of where she was and why she was there, her mealtime experiences were enhanced by her ability to maintain continuity with her previous social life, by interacting with others. This study also highlighted the need for care partner involvement to help residents make sense of the new place. Similarly, a participant (PWD10) in the current study who was also disoriented to time and place found comfort in interacting with other residents during mealtimes to maintain continuity with previous roles. In her situation the continued presence of her care partner also helped her feel comfortable in the new setting. This highlights the importance of the theme in the current study, adjusting to dining with others. For some participants being able to relate to others going through a similar situation helped them understand and accept their current situation.

The studies discussed above, highlight many of the same mealtime challenges presented in this study. The results indicate that there are improvements that can be made to mealtimes in long-term care homes, such as: family style dining, allowing residents to choose where they sit, and incorporating more of the residents choices and preferences to make the experience more enjoyable. Although there are aspects that residents look
forward to, such as socializing with other residents and staff, there are also aspects that make the mealtime experience far different than that at home. Participants long for a break in the routine of mealtimes, they wish to have more control over where they sit and what they eat, and they ultimately wish for a mealtime experience closer to that of home.

However, it is also important to mention that results from these previous studies as well as from the current study indicate that mealtimes in long-term care are now being described much more positively than they had in the past. Kitwood, (1997) in his book Dementia Reconsidered, incorporated a vignette from a care practitioner in her early days of work in 1984. The care practitioner recounted how people with dementia were often treated terribly at mealtimes. A scenario is discussed where care staff are in the residents’ rooms, feeding residents as they sit on a commode. Not only were residents forced to eat while smelling excrement, but the staff members were shovelling food in their mouths, calling them names, and discussing how if they were in the resident’s situation, they would want to be killed. She also discussed how this unfortunately was a typical scenario in the long-term care home, not an exceptional one. This goes to show just how far mealtimes in long-term care today have progressed beyond the ‘old culture of care’ (Kitwood, 1997), and how health care providers are headed in the right direction in making mealtimes more enjoyable for residents.

6.1.3 Adjusting to a New Home.

Results from this study help us better understand some of the challenges residents with dementia and their family members face after relocating to a long-term care home and the potential role that mealtimes can play in assisting residents to begin to consider the setting as their new home. Life and mealtimes as they once knew them change. There
were many aspects of mealtimes, discussed previously, that residents and their family members needed to adjust to. To date much literature exists that looks at both the relocation process and the adjustment to a new setting. Many studies also exist that examine how a nursing home can become a home to the residents, or how long-term care environments can be made more ‘homelike’. However, none of these studies focus on the mealtime experience. Discussed below is literature in this area to which the results of this study can be compared.

An early study by Brooke (1989) examined the process of adjustment for newly relocated elders and identified four major phases. They include: disorganization, reorganization, relationship building, and stabilization. Upon relocation, residents’ feel a sense of displacement and sadness in leaving their previous dwelling, but with time and by forming relationships with others, most participants in the study learned to adjust. Similarly in the current study, although many participants faced many challenges in the new environment, over time and with the help of supportive relationships they adjusted to their new place. Mealtimes both in the facility and back at home often served as a time for dyads to come together, which helped foster these important relationships. Some, in time, even were able to see the new environment as their home.

Groger (1995) published an article on when a nursing home can become a home and this article has since received a great deal of attention and been cited by many researchers in this area. Groger conducted semi-structured interviews with nursing home residents about their experiences in the long-term care setting and results revealed that their ability to consider the long-term care home as their home was related primarily to the criteria they used to define home. As discussed by Groger (1995) if residents defined
home in terms of family and social relationships, they were better able to feel at home in
the long-term care home as these factors were transferable to the new setting. However, if
they defined home in terms of independence and competence it was more difficult to
accept the long-term care home as their home. The degree of continuity achieved after the
relocation also played a part in helping them feel at home. In the current study the themes
of holding on to “home”, evolving roles, and becoming “at home” help explain how
participants began to feel at home in the new setting. Holding on to “home” involved the
strategies that families used to help their loved one maintain continuity with their life
prior to relocating. They were still able to be part of activities and traditions and were
able to retain important relationships associated with home. In addition, if participants
were able to establish new roles in the long-term care setting, they often felt included and
needed in the new setting; which helped them feel more at home.

Reed and Payton (1996) conducted a study that examined the process of adapting
to residential homes as described by newly admitted residents. One of the overarching
themes identified in their data was the idea of constructing familiarity. Constructing
familiarity related to the active searching for and constructing of knowledge of homes
and residents. In order for participants to begin accepting the home as their own they
needed to create ties with it. They formed relationships with others and became familiar
with different areas in the long-term care home. Mealtimes were mentioned as an
opportunity for residents to make contact with a vast number of other residents.
Similarly, participants in the current study became familiar with their new dwelling by
forming relationships with others within the home and also in sharing in meaningful
experiences such as mealtimes. This was a time for residents to socialize with one
another and provide support for each other. Mealtimes that were shared with family members allowed them to feel more comfortable in the setting, which ultimately made it feel more familiar.

Kahn (1999) researched how residents of a nursing home adapted to the ambivalence of the environment. The sample included 21 residents and the length of time they resided in the nursing home varied from three months to 10 years. Many participants described the setting as being their home but unlike “home”. Participants summed up their experience as “making the best of it” and this consisted of four dimensions: recognizing the ambivalence of the situation, downplaying the negative aspects, having no other options, and using volition or will to transcend the institutional environment and create home. Results of this study overlapped with results from the current study, in that participants in the current study also recognized the ambivalence of the situation, as they attempted to rationalize the move. Although they felt as though they had lost some of their roles associated with home and had lost their sense of independence they also recognized that the long-term care home was a safe place where they would receive the care that they required. The long-term care environment was, therefore, viewed by participants as being both restrictive and supportive. This was further evident in the current study through the theme of becoming “at home” in that participants discussed feeling safe and supported. These feelings of safety and being supported allowed them to weigh the pros and cons of the new environment and see the move in a more positive light.

Dobbs (2004) also explored the meaning of “home” for residents in an assisted living facility. Residents discussed how the assisted living facility was “a home” but not
“home”. For participants, home encompassed the social relations that they had formed over their lifetime, their family and life experiences, and the roles they performed. “A (nursing) home” was a public setting, where there were social rules and where strangers lived together. Mealtimes in the assisted living facility were also discussed as being much different from mealtimes at home. Similar to the current work, Dobb’s participants discussed their lack of influence over the food being served, how their choice and preferences were disregarded and how they did not have freedom to eat with whom they wanted to. The finding of this study along with the findings of the current study, highlight the need to make facilities, in particular mealtimes, more ‘homelike’. Many of the characteristics described that distinguished “a home” from “home” were also mentioned by participants in the current study; the routines of mealtimes and other areas of life within the home, the lack of privacy, and not having friends and family around at all times made the home a public setting. However, the current study also highlighted strategies (e.g. returning home for meals, retaining previous routines and traditions, eating out) that families used to adjust to the changes that they were experiencing at mealtimes in the new setting in an attempt to hold on to their past experiences of home, while still attempting to recreate a sense of home in the long-term care home.

Robinson, Reid, and Cooke, (2010) set out to better understand the ways in which care partners of persons with dementia perceived and experienced their relatives move to a new long-term care setting. The participants with dementia were relocated to specialized dementia care environments from traditional care facilities subsequent to their closure. Results of this study revealed that relationships were central to creating a truly homelike environment and this included relationships with other residents, staff, and
other family members. This study did not explicitly mention the role mealtimes serve in promoting and sustaining relationships of quality and meaning. In contrast, the current study does reveal the importance of relationships within the mealtime context and how these relationships promote a sense of “home”. Through the theme of holding on to “home”, persons with dementia were able to retain ties with their care partners. Care partners continued to visit in the new setting and they also held on to mealtime experiences such as eating out together, which helped foster the bond between them. The theme of becoming “at home” also stressed the importance of becoming part of the long-term care community. Residents formed relationships with other residents and with staff members. At mealtimes, participants described belonging to a group when they discussed their tablemates and how each member of the group had their own role. The language they used to describe this “belongingness” suggests that mealtimes are an important forum within which the older adult with dementia can transition to a sense of belonging “at home”.

In summary, results from the current study align with previous research on the relocation experience. However, what makes this study unique is that it was purposefully designed to better understand “place” and the mealtime experience. In the process, we also learned about the relocation process and how the mealtime experience is impacted when persons with dementia and their primary partners in care begin to accept the new dwelling as their home. However it is important to note that the finding of becoming “at home” may be unique to this sample, in that participants were perhaps a more resilient group of individuals, who were more willing to accept their circumstances. Participants volunteered to participate in the original study and the sample selected for the current
study was followed for five years; a significant length of time may be needed for adjustment, which was captured in this group. The sample also included residents that relocated to both retirement home and nursing home and perhaps those that relocated to retirement homes were better able to perceive the new dwelling as their home. Much of the literature examining whether a long-term care home could be a home, focused exclusively on nursing home settings. Finally, as noted, *becoming at home* is a fluid concept that appears to change and evolve over time for families. Perhaps it is the nature of mealtimes that have allowed us to discover this new finding that is not consistent with prior work.

### 6.1.4 How does this study extend the findings of the Eating Together study?

The objective of the Eating Together study was to understand the mealtime experience of families living with dementia in the community, which led to the development of the Life Nourishment Theory (Genoe et al., 2010; Keller et al., 2010). Over the course of the six years of data collection, some participants transitioned into a long-term care home. This allowed for the examination of the mealtime experience of persons with dementia and their primary partners in the new setting. The purpose of this project was, therefore, to re-examine data from these participants to understand the experience of mealtimes for families living with dementia in a “new place”.

Results from the primary study revealed that mealtimes were more significant in the lives of community dwelling persons with dementia and their partners in care than once thought (Genoe et al., 2010). Based on the results of this secondary analysis, this also appears to hold true for participants after relocating to a long-term care home. Although the mealtime experience in long-term care was reported as being much
different than those at home, most participants still looked forward to these times. Mealtimes in long-term care were also seen as a time to socialize with others, build connections with other residents and staff, and visit with loved ones. The three components of the Life Nourishment Theory also continued to be relevant to mealtimes in long-term care and they include: being connected, honouring identity, and adapting to one’s evolving life.

Most dyads in the current study continued to view mealtimes post relocation as an important time for connection. Care partners would attend meals in the long-term care home, eat out with their loved ones, or return home for meals together. Mealtimes were not only a time to visit with their loved one, but also a time to continue to nurture their connections. Relocating to the long-term care home was most often described by participants as a difficult experience, but continuing to have the consistency of mealtimes together and being able to support one another appeared to help participants cope. This was evident through the themes of holding on to “home” and becoming “at home”.

With regard to honouring identity, both persons with dementia and their care partners talked about their new mealtime roles, as well they attempted to hold on to some roles established prior to relocating that were important to personal identity. This was reflected in the sub-theme evolving roles. Care partners got their loved ones involved in the mealtime preparations back at home and encouraged them to participate in mealtime roles in the long-term care home. Mealtimes at home were also a time when care partners could prepare the favourite foods of their loved ones and offer them more choices than what was available in the long-term care home. This furthered helped to honour their identity.
Another way a care partner honoured the identity of their loved one was by providing opportunities where persons with dementia could pay for meals out. Although the person with dementia could no longer host her family for meals at her home, she was still able to be the ‘host’ by covering the cost of the meal. This is an example of how some roles evolved after relocating to the new setting. Identity was further honoured by maintaining routines and traditions that were established prior to relocating into long-term care. Some dyads continued to eat out on occasion, some participated in community events outside of the home, some continued with holiday traditions and other dyads continued to cook together. In some instances, persons with dementia were able to continue to do things that were important to them that helped to honour their identity, such as being a support for others and continuing to participate in community events.

Adapting to one’s evolving life is a component of the original theory that has great significance to the relocation process and mealtimes in the new setting. As dementia progresses and care partners are no longer able to keep up with the demands, relocating their loved one into long-term care becomes a reality. With this relocation comes a variety of changes that the dyad must face; many of these adjustments fall under the theme *systemizing the meal* and *comparing to home*. Despite these challenges, however, most dyads in the study found ways of adapting their current circumstances, transforming or adjusting to mealtime changes in the new setting, and ultimately continuing to find meaning in the mealtimes they shared together. This ultimately helped them become at “home” in the new facility.

The conclusions drawn from the secondary analysis of data collected for the Eating Together Study not only serve to broaden our understanding of “place” and the
mealtime experience of persons with dementia and their partners in care, but it also helps reaffirm the Life Nourishment Theory (LN Theory). Although the theory was not used to thematically code the data for this study, as described above, many of the themes of the current study are in alignment with the LN Theory.

6.1.5 Theoretical Considerations.

There are several theoretical frameworks that align with the study’s findings. These include gerontological theories such as Role Theory and Continuity Theory, which help to explain how older adults maintain a concept of self while trying to adapt to changes that happen in old age, such as, relocating to a long-term care home. There are also theories that pertain to the family and how they cope during changes in family life and maintain relationships. These are the Family Stress Perspective and the Attachment Theory. The results also align with theories that help in the understanding of the relocation into long-term care for older adults and these include the Place Attachment Theory and the Person-Environment Fit Theory. The results of this study will be briefly discussed in relation to these theories.

Role Theory is based on the belief that loss of significant roles in old age can lead to a decline in life satisfaction (Fry, 1992). Older adults that transition into long-term care generally experience many role changes (Atchley, 1983), which was also evidenced in the results of this study. In the long-term care setting, opportunities to participate in leisure activities, contact with the outside world and tasks that the individual previously participated in, are reduced (Atchley, 1983). During mealtimes, the person with dementia may also experience dramatic role changes, they may previously have been involved in assisting with food preparation and activities surrounding the meal. However, the theme
of evolving roles that emerged from this study, indicate that roles can be renegotiated or that new roles can be developed. For example, a participant who was accustomed to cooking for people to show that she cared for them, demonstrated this caring by assisting her tablemates. Roles are therefore not static and they are constantly changing across the lifespan and do not necessarily mean a decline in life satisfaction. An evolution of roles can help us understand adjustment in old age (Fry, 1992). This study helps us understand how roles can evolve in the new setting; some roles are lost but others are renegotiated and new roles can be established.

Continuity has been identified as a vital adaptive strategy for dealing with changes in old age (Groger, 1995), and is exhibited by desiring the situation to remain the same, to be uniform, or to be unchanging (Atchley, 1989). Although various changes are associated with aging, the concept of stability remains a core concept across the life span (Fry, 1992). Although this is not the only perspective of continuity theory, it does imply maintaining a basic structure over time and accommodating to allow for a variety of changes to occur within that structure (Atchley, 1989). This theory assumes evolution, as it allows for change to be integrated into one’s current backdrop, while attempting to maintain equilibrium with the past (Atchley, 1989). Continuity is essentially an adaptive response that older adults use to attempt to maintain familiarity with internal and external structures during periods of change (Fry, 1992). This is especially true for more vulnerable populations, such as those with cognitive impairments because the more losses they experience, the more they attempt to maintain continuity with what is still familiar (Atchley, 1983). This was evidenced in the current study through the theme of holding on to “home”. Persons with dementia were able to adjust to the changes that they faced by
still maintaining continuity with aspects from their life prior to relocating into long-term care, in particular mealtime experiences and rituals. Holding on to significant relationships, such as the one with their care partner, also helped participants maintain a sense of continuity.

The Family Stress Theory was first explained by the A, B, C, X crisis framework, created by Reuben Hill in 1947. His framework consists of two parts. The first part of the theory or framework describes the process of crisis development in family life (Mullen & Hill, 1990). The A refers to the stressor event and related hardships, which interacts with B, the resources the family has to deal with the crisis; which interacts with C, how the family defines the event and this produces X, the crisis that is experienced (Mullen & Hill, 1990). The second part of the framework theorizes how the family deals with the crisis and this includes: a period of disorganization and an angle of recovery where the family’s ability to cope drops off initially, followed by a new level of reorganization (Mullen & Hill, 1990). This theory helps to understand the findings from the current study, since the relocation into long-term care was often described as a stressful event for both persons with dementia and their partners in care. Relocation meant leaving the home to which they were attached and adjusting to a new environment where there were many unknowns. As a result of the relocation, families had to restructure their current ways of functioning in order to respond to the stressful event. They also had to rely on resources to help them get through this stressful time, and to help them adjust to unfamiliar aspects of the long-term care home, including mealtimes. Many care partners continued to be involved at mealtimes in order to continue to foster the bond between the dyad. They also maintained connections with the past through the theme of holding on “to home”, but
they also formed connections with other residents and became part of the long-term care community. This helped some participants to begin to feel at home in the new environment and helped them begin to accept their new mealtime situation; steps of accepting and rationalizing appear to be part of this adaptation process as described in becoming “at home”. Therefore, it is believed that mealtimes ultimately helped them deal with the stressful event of relocation, showing the full cycle of adaptation as described in the Family Stress Theory.

Attachment Theory can also help us understand the dynamic relationship between older adults and their family members and provide a context within which to fully understand the findings of the current study. Specifically, attachment theory explains close relationships across the life span (Browne & Shlosberg, 2006). Dementia means a long road of continuous coping and maintenance of important relationships with loved ones (Ingebretsen & Solem, 1998) and this theory helps to explain how older adults adapt to the challenges of old age, through the support of others (Cookman, 2004; Merz & Consedine, 2009). Attachment theory pertains to the relocation process and to the current study, as quality mealtimes after relocation appeared to be important in maintaining the attachment between the person with dementia and their care partner. The theme of holding on to home; the strategies that families used to both hold on to experiences associated with home, helped foster the connection between the dyad. The theme of evolving roles also pertains to the attachment between the dyad. Although in the new setting care partners no longer need to be the primary care partner to their loved one, they continued to remain involved. Their role evolved in the new setting, including during
mealtimes; they found new ways of caring for their loved ones and the bond between them continued to flourish.

Place attachment is another form of ‘attachment’ relating to connections that individuals form with surroundings based on the experiences they associate with those places (Ponzetti, 2003). Place attachment can help us better understand the meaning attached to leaving home and the challenges families experience upon relocation.

Participants in this study had different outlooks on leaving home based on the attachments they had formed with their previous residence, as well as their perception of their new residence. In order for them to be able to adjust to the new setting and begin thinking of it as their new home they needed to form attachments with the long-term care home. Participants accomplished this by connecting with other residents and staff, by involving their care partners in activities within the home and by embracing their membership in the long-term care community. These attachments often occurred at mealtimes through shared meals and family gatherings in this setting. Positive mealtime experiences also allowed dyads to feel more comfortable and begin accepting the new environment as home. This was evidenced in the theme of becoming “at home”; before participants began to feel attached to the new setting, they needed to first distinguish how the new setting was different from home and then they needed to start recreating home in the new environment.

Finally, the Person-Environment Fit model aligns well with the themes of this study. Our environment conditions us and learning to cope in the environment in which we live is an essential part of our daily routine (Atchley, 1989). Throughout life, transitions in and out of different environments can create challenges (Cutchin et al.,
The Person-Environment Fit theory is based on the premise that individuals are more likely to perceive a sense of control and positive adjustment to their environment when their needs and abilities are consistent with the environmental demands (Fry, 1992). When demands of a new environment are perceived to be high, older adults often resist the change (Fry, 1992). This can be extended to mealtimes in long-term care, as the greater the ability of the mealtime environment to be supportive of the person with dementia both physically and emotionally, the easier it will be for the person to feel comfortable and accepted in their surroundings. If there is a sense of familiarity during the meal, whether it be by the dining room decorated to reflect an “at home” feel, or the individuals preferences being taken into consideration, the environment may serve as a “good fit”. Some participants adjusted easily to the new setting, but others needed to draw on additional resources to help them cope, such as the support of family members. The theme of systemizing the meal was an example of how participants did not immediately feel how they ‘fit’ in the new setting. They experienced discontinuity at mealtimes initially, as there were many aspects of the new meal environment that were much different from home. They had to adjust to a rigid routine and become familiar with the rules and practices surrounding mealtimes. They also needed to become accustomed to food choices and presentation that they were not familiar with. The differences they experienced in the new environment, made it difficult for them to feel comfortable in the new setting early on. Dining with others was also difficult for some participants and it further reminded them that they were not eating in the familiar environment of home. No longer could they eat in privacy with only the care partner. However, for others, dining with others helped them feel part of the community in long-term care which helped them
find their place in the setting and helped them feel their ‘fit’. *Becoming “at home”* was when most participants had established their ‘fit’ in the new setting and had accepted that the new environment was supportive of their needs.

Presented in this section were a few theories that can help us understand the process of relocation and the experience of place to mealtimes. They bring clarity to why this process is so challenging for new residents and their families and how they learn to adjust. With the help of the results of this study and these theories we will hopefully be able to help promote and facilitate this process for these families.

**6.2 Making mealtimes in long-term care homes more enjoyable**

The results of the current study, in conjunction with literature in this area, highlight the need for improvements to the mealtime experience in long-term care homes. Although this study did reveal that many families in the sample adjusted to some of the mealtime changes in the new environment, too often the mealtime experience was far different from that of home. There is a need to begin to “blur the boundaries” (pg.14 Evans et al., 2003) between mealtimes in long-term care and mealtimes at home, by making mealtimes in the facility more homelike.

In order to create a more homelike environment at mealtimes, there needs to be a shift in focus away from an institutional model of care that impedes individuality and choice (Davies, Byers, Nay, & Koch, 2009), towards a more person-centered, relational, or family model of care (Kitwood, 1997; Reimer & Keller, 2009; Voelkl, Battisto, Carson, & McGuire, 2004). Person-centered care recognizes residents as individuals who have different histories, preferences, customs, expectations and needs at mealtimes (Reimer & Keller, 2009). The Family model of care provides direction for nursing homes
that wish to create a more home-like environment that helps to foster family-like bonds among residents, staff and family members (Voelkl et al., 2004). These models highlight the need to focus on the individuals that are impacted by the meal environment in long-term care and not the task at hand; meaning that mealtimes need to be less systemized and more flexible. By acknowledging the unique needs and desires of residents at mealtimes and by allowing for more flexibility, individualization of the mealtime experience can be promoted.

It is confusing for residents when LTC homes call themselves “home” and include some home routines, but then force residents to conform to institutional practices through their daily routines, policies and procedures (Weber, 2000). There is a need for staff members in long-term care homes to evaluate which procedures can be modified and what rules can be bent in order to make the mealtime experience in long-term care closer to that of home. For example, allowing a family member to stay for a meal even though they have not provided the required 24 hours notice, or offering a resident who paces during mealtimes finger foods that they can consume away from the table, will be ways to accommodate needs and make the facility less institutionalized.

Another way of making mealtimes more homelike is by removing elements from the dining room that are not reflective of home (Calkins, 2007; Cohen & Weisman 1991; Orulv, 2010). These could include the med cart, overhead paging systems, mandatory bibs, and intake binders (Calkins, 2008; Cohen & Weisman 1991). These elements can be replaced by familiar objects from the residents’ past, in order to promote a sense of familiarity and belonging in the environment (Cohen & Weisman 1991; Weber 2000; Zgola & Bordillon, 2001). For example, photographs of residents and their families,
china or special dishes, and homemade table linens, could be used. The addition of these objects also serves to bring back memories of the past and can serve as a topic of conversation for residents (Zgola & Bordillon, 2001).

The manner in which food is served can also be a source of discontinuity for residents. In several long-term care homes, steam tables are brought into the kitchen and food is plated and delivered to the resident (Altus, Engelman, & Matthews, 2002), as this is an efficient way of delivering food to residents in a timely manner. However, having preplated food delivered is similar to a restaurant atmosphere, which is a different atmosphere than the intimate homelike experience that is the goal (Zgola & Bordillon, 2001). A more homelike form of dining that can be implemented is family style dining (Altus et al., 2002; Nijs et al., 2006; Zgola & Bordillon, 2001), which is much more reminiscent of home, as food is brought to the table in large serving bowls and residents can choose which foods they would like to eat and can portion it out themselves. Family style dining enhances the residents control and independence at meals (Hotaling, 1990) and also promotes more interaction among tablemates; by passing the dishes between them and in asking for or being provided assistance (Altus et al., 2002; Zgola & Bordillon, 2001).

Although this form of dining does allow for more resident autonomy, participants also identified other aspects of mealtimes they wished to have control over. When participants resided in their own home they most often had control over the timing of meals. In many situations the spacing of mealtimes throughout the day was often a pattern they had grown accustomed to in their childhood and had maintained throughout their life. Once relocated into long-term care, participants have difficulty adjusting to the
timing of mealtimes and felt it went against their internal clock (Buckwalter, Leibrock, & Klein, 1996; Calkins & Brush, 2002). In the current study, some felt that mealtimes were served too early in the day, and that they did not feel hungry when they arrived. A more flexible schedule for mealtimes could potentially help residents feel more at home in the facility. Multiple seating at mealtimes, or offering residents who missed meals food that could be eaten outside of mealtimes (Zgola & Bordillon, 2001), can help residents retain their previous schedule from home and would provide them with more control over their own care.

Highlighted in the literature and discussed by many participants in this study was the lack of flexibility in terms of choice of tablemates (Crogan et al., 2004; Evans et al., 2003; Zgola & Bordillon, 2001). Participants often wished to be able to sit with new people at mealtimes or have more control over the selection of their tablemates. They wished to be able to eat with their friends and share a meal with individuals they felt they were compatible with and with whom they had common interests. More flexibility in seating arrangements is needed, whether it be by allowing residents to select their own seats at mealtimes, or by rotating the seating plans so that residents have the opportunity to interact with new faces. For residents who find change difficult it will also be important to allow them to remain seated at a table where they feel comfortable.

Participants also discussed wanting some control over the food being served. They discussed not having access to some of their favourite foods, or becoming tired of the options on the menu. They would like to have their input considered when developing the menu (Calkins & Brush, 2002; Evans et al., 2003). One participant who was a member of the food committee within his long-term care home discussed how the
feedback that residents provided about the food never appeared to be considered in the development of the menu. This is a significant issue that needs to be addressed as this can impact their consumption of their meal, as well as their mealtime experience and sense of value and control. Having a food committee within each home that truly listens to residents’ feedback about the food and actively involves them in the creation of the menu, may assist in making mealtimes more pleasurable.

Residents in long-term care homes also need more involvement in mealtime roles. When an individual relocates to a long-term care home, many of the major life roles disappear and are often not replaced by meaningful ones (Davies et al., 2009). This needs to change. It is important that residents be encouraged to be active participants in everyday activities rather than being passive recipients of care (Davies, et al., 2009; Zgola & Bordillon, 2001). By engaging residents in mealtime tasks, residents feel important and needed (Weber, 2000). Residents can participate with food preparation, setting the table, helping clear the table, washing dishes, folding napkins, sweeping and so forth. Not only will this help them retain roles from home, but it also helps to support their remaining abilities (Fitzsimmons & Buettner, 2003). It also encourages residents to collaborate with others and participate in a shared mealtime experience (Fitzsimmons & Buettner, 2003).

First and foremost, the focus of mealtimes in long-term care should be on making them as natural and homelike as possible; although this can be challenging as people define home in a variety of ways. Despite this however, the general qualities of home and the normalized life patterns that they imply need to be incorporated into the mealtime experience in long-term care (Cohen & Weisman 1991). Making small changes to the
current mealtime situation in long-term could dramatically improve the quality of life of those who reside there.

6.3 Assisting families with the relocation to the new place

Making the mealtime environment in long-term care more homelike will help this new place to be less foreign and more familiar for newly admitted residents and their family members. Persons with dementia would experience more continuity with their life prior to relocating and would hopefully be able to view the relocation as the beginning of a new chapter in life, rather than the beginning of the end.

The new environment could be made more welcoming for family members if their participation during meals was encouraged. This could be accomplished by having staff members personally invite families to stay for meals, making the rules more flexible around how much notice is required to stay for a meal, and hosting mealtime events within the long-term care for families to take part in. Family participation at meals would help foster the bond between residents and their family members, and would facilitate their inclusion in the long-term care community. When family members feel part of the community in the long-term care home, they likely will also be more able to accept that this is their loved one’s new home.

Family members can also help ease the relocation process for their loved one, by encouraging them to be involved in the new environment. They could assist their loved ones in choosing activities that interest them and they could also make a point of introducing them to other residents and to staff. Furthermore, family members could reassure their loved one of their continued involvement in their life and make their acceptance of the new setting as the residents’ new home known. If family members
show that they are comfortable in the new environment and choose to visit often, residents may also begin to feel more at home.

A more homelike atmosphere at mealtimes would also encourage more staff-resident interactions. Homelike atmospheres tend to break down barriers between residents and staff, which would make it easier for them to interact in positive ways (Hotaling, 1990). When staff members are more focused on the mealtime experience they may be more focused on conversing with residents and ensuring that their desires are being met. In this type of atmosphere family members and staff can collaborate in the care of the person with dementia.

Finally, when residents and family members are comfortable at mealtimes in the new setting they will hopefully be less focused on what they have left behind and more focused on the experiences they can share in the new setting. Mealtimes with family, provide a familiar structure and can help address loneliness and disconnection for the resident (Grudzen, 2003) and can promote a sense of belonging.

6.4 Study Strengths and Limitations

There are many strengths to this research, the first being that it helps fill a gap in the literature. This is the first study of its kind that examines the experience of mealtimes in a new place, after a person with dementia relocates into a long-term care home. Since this study is first in its area, it can also serve as a benchmark for future studies, as there are many strong features from which future researchers can draw. The longitudinal nature of the primary study allows for capturing of changes in mealtimes from the community to the long-term care home. This study is also unique in that, interviews were conducted
with both persons with dementia and their care partners independently and together, to help capture a complete picture of the mealtime experience.

This study was a secondary data analysis meaning I was not involved in collecting the data. However, I did have access to reflective notes where the researchers recorded both observations and reflections about the interview; which helped me visualize the interview more clearly. I was also fortunate enough to be able to participate in several interviews for the Eating Together study and for the transition sample, which allowed me to obtain a clearer understanding of the interview process, as well as the experience of some participants. It helped me reflect on the families included in my study and gave me insight into their experience. Furthermore, despite this study being a secondary data analysis, the experience of mealtimes in a “new place” was present across all dyads, regardless of the interviewer and the interview style.

Although this study does have many strengths, no research is without its limitations and it is important to disclose these. This data was not originally collected for the purpose of looking at mealtime changes specific to relocating to a new place. It was collected to understand the mealtime experience of families living with dementia over the progression of the disease. Fortunately, some dyads in the original study transitioned into long-term care homes during the course of the six years and this allowed the data to be further analyzed. Thorne (1994) states that in order to establish a fit between the data set and a new research question being posed, the questions need to be sufficiently close to the original research and that the method of analysis must also be close to that of the original study. For this study, the focus continues to be on the mealtime experience of persons with dementia and their primary partner in care, the new question simply focuses
on the significance of “place” to this experience. Although the previous study was analysed using grounded theory methodology, this analysis was thematic as theory building was not the goal of this research. However the grounded theory methodology was sufficient for identification of themes in this analysis.

Analysis was solely carried out by myself and I was not involved in the majority of the data collection, therefore there is a chance I may have been unaware of contextual factors; for example, in some instances a particular participant’s behaviour may have influenced the data collection and consequently my interpretation of the transcripts (Thorne, 1994). However, regular meetings with both my advisor and members of the Eating Together team allowed me to be reassured that the themes that were generated seemed appropriate for the data, as well as answering the research questions. In addition, I provided rich description of my themes and evidenced them with quality quotes from all dyads.

The inclusion criteria of the study also may have impacted the results that were obtained. Dyads were selected to be included in the study through advice from the Eating Together Team. In order to maximize the amount of data related to place, dyads included needed to have been in the study for a minimum of four years. Although the inclusion of only these dyads did result in five themes related to changes in mealtimes resulting from relocating to a long-term care home, this restriction may have limited the conclusions that resulted from the analysis. Perhaps dyads that discontinued with the study after relocating were experiencing more challenges than those that who continued to participate. Consequently the sample included may have been a particular resilient group of individuals who were more accepting of their circumstances.
An additional challenge that was encountered during analysis was that when the participants relocated into a long-term care home, the persons with dementia were often far along in their journey with dementia. This meant that after relocating into long-term care some persons with dementia were disoriented to time and place, or could not participate in an interview. Consequently, post relocation we are missing the voice of some persons with dementia. In those cases the mealtime changes are described solely by the care partner whose experience of mealtime likely differs from that of their loved one. Care partners are often not present at every meal and would not be able to capture all the differences that their loved one was experiencing in the new environment.

The sample used represented a variety of settings and care experiences. For example, in some instances care partners were spouses, in others the care partner was a child, or a niece. Some persons with dementia had relocated to a retirement home and others had relocated to nursing homes. In one instance, both the care partner and person with dementia relocated together. This meant that there were very diverse experiences and it was somewhat challenging to derive themes that incorporated aspects of all the dyad experiences. Also, in doing so, some important differences such as differences between the experiences of those who relocated into a retirement home versus a nursing home were not considered. However, in order to have accomplished this, a larger and more diverse sample would have been required, as well as a longer time frame for analysis.

Lastly, there would have been a benefit to having the voice of the staff included in this study. Although they could not speak to what mealtimes were like in the past for the person with dementia, they could speak to some of the challenges they felt newly
admitted residents and their family members experienced. Furthermore, they could provide some important contextual information regarding what mealtimes are like in that long-term care home and some of the challenges they face in assisting residents and family members to feel more at home in the facility. Staff members can contribute to the further development of an understanding of the constraints of the long-term care system and how these have the potential of impacting the mealtime experience for residents.

6.5 Evaluating the Empirical Groundings of the Findings

Evaluating the findings of this study provides an overall assessment of the quality and adequacy of the research, as defined by the following criteria by Charmaz (2006).

6.5.1 Credibility.

As discussed previously, credibility refers to the truth-value and to whether my research was sufficient to meet my claims (Leininger, 1994). Elliott, Fischer, & Rennie, (1999) discuss ensuring credibility of the findings, by having colleagues verify the themes who are involved in the research. Both themes and subthemes have been presented and reviewed by members of the Eating Together Team. This research was also presented at the annual Dietitians of Canada conference (2011) and positive feedback about the study findings was given. Further, a code manual was used, alongside memos to ensure that themes and subthemes were identified in a consistent way.

6.5.2 Originality.

The originality of this work is evidenced by the absence of other studies that examine the impact of place on the mealtime experience of persons with dementia and their care partners, after relocating to a long-term care home. Therefore the themes identified offer new insight into the mealtime experience resulting from a change in
place. It also helps further our understanding of the mealtime challenges residents face upon relocation and how mealtimes in the long-term care home are different from home. This also helps extend the results of Eating Together to the long-term care context.

6.5.3 Resonance.

The themes that resulted from the analysis resonate with colleagues through presentations in interdisciplinary formats including departmental seminars, Eating Together meetings and the Dietitians of Canada conference. Findings were presented to members of the Eating Together team and they confirmed that the identified themes captured the extent of mealtime changes resulting from a change in place for persons with dementia and their care partners.

6.5.4 Usefulness.

The results of this study are significant and contribute to research and practice that concerns older adults who are relocating from home, into long-term care homes. This research offers insight into how the mealtime environment in long-term care can be made more ‘homelike’. This study can be used to inform staff members of the challenges residents and family members face upon relocation to a new setting and how management and staff members can help alleviate some of the difficulties. The strategies identified can also assist other families who are experiencing a relocation.

6.6 Implications of the Research

The results of this study are pertinent to families living with dementia, researchers, and health professionals who work with older adults who have relocated into a long-term care home. It will help them understand some of the initial challenges and discontinuity that newly relocated residents and their family members experience in the
new environment and how this impacts their mealtime experience. Several implications at the family, staff and policy level have been identified.

6.6.1 Residents

Results of this study suggest that for newly relocated residents it is important to:

- Retain significant relationships to help ease adjustment to the new setting.
- Attempt to hold on to memories and food-related experiences associated with home to maintain continuity with their previous life.
- Become involved in the long-term care community; form relationships with other residents and with staff members, establish mealtime roles, participate in activities and invite loved ones to events within the home; such as mealtimes.

6.6.2 Families.

Results from this study suggest for families that:

- Continued family involvement at mealtimes is important in helping newly relocated residents adjust. Family members need to inquire about options that allow for family involvement, such as; sitting with the resident, eating in a separate private dining area, or being able to take the resident’s meal to a cafeteria in the building etc.
- Family members need to form connections with the long-term care community to help them feel included and to move towards acceptance that this is their loved one’s new home. This can be accomplished by making friends with their loved ones’ tablemates, forming relationships with staff, participating in special events at the facility, etc.
➢ It is important for families to develop strategies to retain experiences associated with home, as it may further help ease adjustment into the new setting. Examples include; returning home for celebratory or traditional meals, bringing in special food items and continuing to eat out at restaurants if this was the habit.

6.6.3 Staff.

There are also several learnings that can be taken from this study to help educate staff members in regard to ways that they can assist in making mealtimes in long-term care less about the task at hand and more about the mealtime experience.

➢ Staff members need to be taught how to enhance the homelike qualities of mealtimes in the care homes to make them feel more at home. They should inquire about resident likes, dislikes, and food-related practices, provide individualized attention to residents, seat residents with tablemates with whom they are comfortable with, and inquire about what mealtimes were like for them at home in an effort to try to re-create this feeling for them.

➢ Staff members also need to be instructed on how to include family members at mealtimes, as family relationships are vital in helping newly admitted residents feel at home in the new setting and maintaining family attachments as the disease progresses. Staff members can make care partners feel welcome to stay for a meal, rearrange seating to provide the opportunity for them to sit together and consider processes that allow for spontaneous meal sharing.
6.6.4 Policy and Facility Design.

This study can also help inform the direction of health care policy and ministry standards for meal delivery in long-term care and provides suggestions for management and design of facilities: Results suggest:

- Organizational and communal space of mealtimes in long-term care leads to barriers that make it hard for residents to “feel at home”; dining rooms need to be smaller and more intimate, seating sections and room dividers could be used; provide kitchenettes where residents can help with meal preparation, or cook for their own enjoyment, and include personal touches that remind residents of home such as pictures on the wall.

- Residents’ desire to have more control over their own care; provide opportunities to choose when they eat, with whom they eat, and have some control over the menu.

- Facilities need to consider where current routines, rules and other organizational structures can be made flexible to promote personalization of mealtimes and hopefully a more positive transition for families living with dementia. They need to consider talking with each family about their mealtimes at home and routines that were followed and how these can be replicated in the home.

- Ministry standards need to be re-evaluated to determine where changes can be made to make mealtimes more enjoyable for residents and promote flexibility. For example, allowing residents to have access to a refrigerator so they can consume
food outside of meals, offering flexible timing for meals, and providing more opportunities where they can prepare food.

**6.7 Future Research**

This study highlights the importance of more research in this area to help improve mealtimes in long-term care and make them more comparable to mealtimes at home. This study was a secondary data analysis of data that were not collected for the purpose of looking at the mealtime experience after relocation to a new place, therefore future work should be primary studies that have this as a purpose. Future studies should also attempt to understand the impact of “place” on the mealtime experience as this question could not be answered in this study.

Future studies should be longitudinal in design in order to understand mealtime changes shortly after relocating into a long-term care home, followed by how families learn to adapt to the relocation and what helps them begin to feel more at home. Researchers should also focus on understanding the differences families experience in different long-term care homes; possibly having a separate study for retirement homes and nursing homes, and then comparing the two, to identify which environments are described by participants as producing more pleasant mealtime experiences and the reasons for this difference.

It would also be beneficial to obtain the staff members’ perspectives. Focus groups could be conducted with all staff members who are present at mealtimes to obtain their perception on the challenges newly admitted residents face and also to receive feedback on how they feel mealtimes can be improved for the residents. It would be beneficial to obtain information about what staff members feel is their role in this process.
and what more they would be able to do to make mealtimes in long-term care more ‘homelike’. Conducting interviews with managers in long-term care homes prior to the research study may also be beneficial, to determine where they feel barriers to change at mealtimes exist and how/if they feel these barriers can be overcome.

Future research with persons with dementia should capture dyads shortly after relocating to the long-term care home so that persons with dementia can reflect on their mealtime experiences from home and their current mealtime experience in the new setting. Inclusion criteria should comprise persons with dementia who are still able to share their experiences if at all possible, or researchers need to use more creative ways to capture the experiences of persons with dementia. Because care partners commonly attempt to care for their loved ones in the community for as long as possible, recruitment of persons with dementia who are able to share their experiences may be a challenge. However, having their perspectives can impact the outcomes of the study and could have important implication for practice that may not have been mentioned by the care partners.

Finally, future research should also examine the impact of relocation to long-term care on mealtimes in different cultural groups. Some cultures really value family time at meals and have unique customs and practices that may be disrupted when relocating into a long-term care home.
7.0 CONCLUSION

In conclusion, this research is significant in that it advances our knowledge of the experience of mealtimes in a new “place” for families living with dementia, and specifically the relocation from home to facility living. To date there is no existing research on this topic, and this study provides insight for future research directions. This research also helps us understand the significance people attribute to home, especially in the mealtime context, and the challenges residents experience in trying to recreate home and home-like mealtimes in a new setting. Furthermore, this study highlights the discontinuity that participants experience at mealtimes after relocating and discusses strategies that families employ to adapt to these changes in order to bring them closer to feeling “at home” in the long-term care home. It places emphasis on the continued importance of the bond between the dyad, as well as the importance of forming attachments to the new setting. This was accomplished when participants formed relationships with other residents and staff and began to establish their place in the long-term care community. Mealtimes were an important venue for this to take place.
8.0 References


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9.0 Appendices

Appendix A
Certification of Ethical Acceptability of Research Involving Human Participants

RESEARCH ETHICS BOARD
Certification of Ethical Acceptability of Research Involving Human Participants

APPROVAL PERIOD: May 11, 2010 to May 11, 2012
REB NUMBER: 10AP006
TYPE OF REVIEW: Delegated Type 1
RESPONSIBLE FACULTY: HEATHER KELLER
DEPARTMENT: Family Relations & Applied Nutrition
SPONSOR: SSHRC STANDARD RESEARCH GRANT
TITLE OF PROJECT: Eating Together 2: Transitions in Care for Families with Dementia - Long Term Care Home Sample
CHANGES: 7 Jul 10: B.13 Recruitment

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human subjects in the above-named research project and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement.

The REB requires that you adhere to the protocol as last reviewed and approved by the REB. The REB must approve any modifications before they can be implemented. If you wish to modify your research project, please complete the Change Request Form. If there is a change in your source of funding, or a previously unfunded project receives funding, you must report this as a change to the protocol.

Adverse or unexpected events must be reported to the REB as soon as possible with an indication of how these events affect, in the view of the Responsible Faculty, the safety of the participants, and the continuation of the protocol.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research protocols.

The Tri-council Policy Statement requires that ongoing research be monitored by, at a minimum, a final report and, if the approval period is longer than one year, annual reports. Continued approval is contingent on timely submission of reports.

Membership of the Research Ethics Board: M. Bowring, CME; F. Caldwell, Physician (alt); J. Clark, PolSci (alt); J. Dwyer, FRAN; M. Dwyer, Legal; D. Dyck, CBS; D. Emile, Physician; M. Fairburn, Ext.; J. Hacker-Wright, Ethics; G. Holloway, CBS (alt); V. Kanetkar, CME (alt); L. Kuczyinski, FRAN (alt); S. Lachapelle, COA; L. Mann, Ext.; J. Minogue, EHS; P. Saunders, Alter. Health Care; S. Singer, COA (alt); L. Son Hing, Psychology; V. Shalla, SOAN (alt); L. Sprat, CBS; L Trick, Chair; T. Turner, SOAN; L. Valls; CBS (alt).
Appendix B
Interview Guide for Primary Study

Eating Together 2 Study: Interview Guide

**Before visiting family:**
Review composite portraits and key themes for ET1 and ET2-1 to refresh

**First interview:**
Review focus of interview and purpose of project; complete consent forms

I’d like to know what mealtimes are like for you now, *just as if I were with you* in your home for a meal. Think of recent mealt ime and tell me about it like a story or movie – pretend you took a video of your mealt ime right from preparation to cleanup and describe it for me scene-by-scene (or if you prefer, describe it like a hockey game – play-by-play). Help me to vividly imagine your mealt ime. I want to see, hear, taste, and smell what you experience at mealtimes. I want to picture in my mind what you do and say and think about at meals.

If necessary, prompt to describe:
- Deciding what to eat
- Preparing the food
- Preparing the table
- The food and how the food is served
- Conversation happening during prep/eating/cleanup
- Cleanup from the meal

1. How are mealtimes working now, compared to last year: *describe previous year*
(work together with participants to further understand how things have changed based on their mealt ime description – i.e. it seems that...has changed, is that right? Can you tell me a little more about how this change came about? What else has changed?)

   - What has changed now in terms of meal preparation?
   - What has changed in the mealt ime experience?
   - What changes are happening as a result of dementia (e.g., using objects inappropriately, not following through, change in roles)
   - What changes are happening as a result of caring (e.g., less time for cooking)?
   - What changes have occurred outside of dementia or caring (e.g., change in physical health of either member of dyad)?

**Follow-up on changes noted in previous year (e.g., conversation) how has this changed?**

*Diet:***
• Meaning of food choices in the dementia context, i.e., for care partners [CP], e.g., “how has what you eat and choose to eat, changed for you?”

• What influences the food you choose to prepare/serve/eat?

2. Evolving Life

*Mealtimes are an example of how changes happen in a family.*

• How have worked through these mealtime changes in the past year?
• What strategies have they used?
• Probe on the process of change —
• How do you recognize that a change is happening or could happen?
• How do you adjust to this change (learn, negotiate, access abilities/resources, identify gaps)?
• What affects adjusting/adaptation/coping?
• What changes are difficult to adjust to and why?
• Are there differences in the process of adapting to change for CP and PWD? (e.g. no longer telling PWD about the change to avoid upset)
• Any new strategies to help with adaptation (e.g. presenting a short list of options for PWD to help them with decision making; changing diet behind the scenes without communicating to PWD)

3. Being Connected: *Mealtimes seem to mean more to families than eating food.*

How has the **physical presence** changed at mealtimes?

• Taking time
• Sharing/taking part in tasks
• Focusing attention
• What affects these?

How has **cognitive participation** changed at mealtimes?

• Sharing activities
• Making plans/decisions
• Learning from others
• What affects these?

How has **getting/giving support** changed at mealtimes?

• Physical, psychological, emotional support- shifts in dyad?
• Others outside of dyad? Where go for support and why?
• Reciprocity?
• Perception of adequacy of support?
• What affects support?

Probe on consequences of being connected: How do you feel?
4. Honouring Identity  *Mealtimes can say something about who we are as people.*

- What have you let go of or what has become more important to control?
- How is autonomy balanced now? Is there a feeling of autonomy?
- What shifts in autonomy have happened? How do members of dyad feel about these changes?

Protecting Dignity

- Changes in being/showing accepted?
- Changes in being acknowledged/valued as an individual (own preferences etc.)
- Values that influence dignity changing?
- What is being veiled?
- What affects dignity now?

Having meaningful roles

- Changes in competence? What roles are being clung to? Why?
- How does enablement happen or not?
- How is capacity negotiated within dyad?
- What affects these roles now?

Reaffirming self in the world

- Reminiscing/Keeping informed/Sharing and creating stories
- How are mealtime decisions made? (preferences, roles)
- Have rituals/routines changed? Why?

5. Overarching Theme: Mealtimes are the Way We Are

1. What makes you happy? What makes you sad?
2. What one word/phrase describes your life right now?
3. How do mealtimes tie into the way you live your life? What parts of meals make you happy? What parts of meals make you sad? What place do mealtimes have in terms of celebration - particular pleasure - what made that experience positive?
4. What do you see happening in the next year? What are you hopes and dreams over the next couple of years? How do you see things changing in the future?

Check: demographics - change in living situation, income if CP working?
Appendix C
Memo Depicting Relationship amongst Themes

Becoming “at home”

- Adjusting to Dining with Others
- Systemizing the Meal
- Holding on to Home
- Evolving Roles


### Appendix D

**FAST Record and Living Situation**

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