Providing Person-Centred Mealtime Care for Long Term Care Residents with Dementia

by

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ABSTRACT

PROVIDING PERSON-CENTRED MEALTIME CARE FOR LONG TERM CARE RESIDENTS WITH DEMENTIA

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Person-centred care is a holistic care approach that aims to build up and support the personhood of residents with dementia, and thereby enhance quality of life. Through a review of the literature on mealtimes in long term care homes, four main aspects of person-centred mealtime care were identified: providing food choices and preferences, supporting residents’ independence, promoting the social side of eating, and showing respect. Using a critical realist lens, this descriptive qualitative study examined current implementation of person-centred mealtime care, the influences on its implementation, and steps to more fully adopt a person-centred approach. Semi-structured interviews were conducted with 52 staff from four diverse long term care homes in southern Ontario. Participants included frontline workers, registered health care professionals, and managers. Interviews were transcribed and analysed for themes. A conceptual framework was developed through analysis of the interview data, identifying five key ways to support staff to provide person-centred care: forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care. Specific strengths and areas for improvement in implementation of person-centred mealtime care were identified and explained using this conceptual framework. Elements of the framework were also applied to explain important considerations for hiring staff, educating and training staff, developing a culture of good teamwork, and involving family members and volunteers in mealtime care.
ACKNOWLEDGEMENTS

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TABLE OF CONTENTS

Chapter 1: INTRODUCTION ........................................................................................................ 1

Chapter 2: LITERATURE REVIEW ........................................................................................... 4
  2.1 Person-centred care ......................................................................................................... 4
  2.2 Conceptualizing person-centred mealtime care ............................................................ 11
      2.2.1 Providing choices and preferences ........................................................................ 13
      2.2.2 Supporting independence ...................................................................................... 17
      2.2.3 Promoting the social side of eating ....................................................................... 20
      2.2.4 Showing respect .................................................................................................... 23
      2.2.5 Research gaps in providing person-centred mealtime care .................................. 28
  2.3 Staff influences on person-centred mealtime care ............................................................ 29
      2.3.1 Seeing the mealtime experience from the resident’s perspective .......................... 31
      2.3.2 Knowing how to meet residents’ needs for assistance and social interaction ........ 35
  2.4 Contextual influences on person-centred mealtime care .................................................... 38
      2.4.1 Leading culture change and putting knowledge into action .................................. 40
      2.4.2 Government regulations and related policies and procedures ............................... 46
      2.4.3 Staff workload ....................................................................................................... 50
      2.4.4 Education and training for direct care providers .................................................... 55

Chapter 3: STUDY PURPOSE AND POSITIONING FOR QUALITATIVE INQUIRY ................. 59
  3.1 Study purpose and objectives ......................................................................................... 59
  3.2 Ontology and epistemology ........................................................................................... 60
  3.3 Theoretical sensitivity ...................................................................................................... 62
  3.4 Reflexivity ........................................................................................................................ 64

Chapter 4: METHODS .............................................................................................................. 67
  4.1 Selection of long term care homes .................................................................................. 67
  4.2 Recruitment of interview participants .......................................................................... 69
  4.3 Interview procedures ...................................................................................................... 72
  4.4 Transcription .................................................................................................................. 74
  4.5 Data analysis .................................................................................................................... 76

Chapter 5: STUDY FINDINGS .................................................................................................. 79
  5.1 Introduction ...................................................................................................................... 79
      5.1.1 Conceptual framework ............................................................................................ 79
      5.1.2 Overview of the study findings to be presented ....................................................... 84
  5.2 Selected examples of strengths and areas for improvement .............................................. 87
      5.2.1 Providing choices and preferences ......................................................................... 88
      5.2.2 Supporting independence ....................................................................................... 96
      5.2.3 Promoting the social side of eating ....................................................................... 104
      5.2.4 Showing respect .................................................................................................... 112
      5.2.5 Summary ................................................................................................................ 120
  5.3 Influences on implementation of person-centred mealtime care and steps for improvement .........................................................................................................................121
      5.3.1 Hiring point of care staff ......................................................................................... 126
      5.3.2 Educating and training staff .................................................................................. 132
      5.3.3 Developing a culture of good teamwork ................................................................. 139
      5.3.4 Involving family members and volunteers ............................................................. 149
      5.3.5 Summary ................................................................................................................ 157

Chapter 6: DISCUSSION .......................................................................................................... 158
  6.1 Forming a strong team .................................................................................................... 160
      6.1.1 Personal attributes of team members ....................................................................... 160
      6.1.2 Involving family members ...................................................................................... 164
TABLES

TABLE 2.1 Personal detractors ................................................................. 9
TABLE 2.2 Personal enhancers ................................................................. 10
TABLE 3.1 Potential influences on mealtime care based on review of the literature ........................................ 62
TABLE 3.2 Potential influences on mealtime care based on personal reflections on practice ....................... 66
TABLE 4.1 Background information on the participating long term care homes ........................................ 68
TABLE 4.2 Study participant summary ....................................................... 71
TABLE 4.3 Potential influences on mealtime care practices ........................................................................... 73
TABLE 4.4 Transcription protocol ...................................................................... 75
TABLE 4.5 Data analysis steps ........................................................................ 76
TABLE 5.1 Elements of supporting staff to provide person-centred care and supporting data ...................... 80
TABLE 5.2 Elements of supporting staff to provide person-centred care: theorized effects of one element upon another in the conceptual framework .................................................................................. 82
TABLE 5.3 Influences on person-centred mealtime care: similarities and differences among participating long term care homes ........................................................................................................ 124
TABLE 5.4 Relationships between key points on hiring point of care staff and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010) ........................................................................ 131
TABLE 5.5 Relationships between key points on educating and training staff and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010) ........................................................................ 138
TABLE 5.6 Relationships between key points on developing a culture of good teamwork and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010) ........................................................................ 148
TABLE 5.7 Relationships between key points on involving family members and volunteers and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010) ........................................................................ 156

FIGURES

FIGURE 2.1 Four main aspects of person-centred mealtime care ................................................................. 11
FIGURE 2.2 Person-centred care is found within the context of standard quality care ......................................... 41
FIGURE 5.1 Elements of supporting staff to provide person-centred mealtime care ........................................ 79
FIGURE 5.2 Individual, team, and organizational/leadership level influences .................................................... 122
FIGURE 6.1 Six main aspects of person-centred mealtime care ........................................................................ 187

ABBREVIATIONS

MOHLTC Ministry of Health and Long Term Care
OLTCAG Ontario Long Term Care Action Group – Dietitians of Canada
PSW Personal Support Worker
FSW Food Service Worker
1. INTRODUCTION

In 2008, almost half a million Canadians were living with dementia and the prevalence is expected to more than double in the next thirty years as the population of older adults expands (Alzheimer Society of Canada, 2010). Dementia refers to symptoms of loss of memory, impaired judgment and reasoning, and changes in mood, behaviour, and ability to communicate. In Canada, Alzheimer’s disease accounts for 63% of cases of dementia, and 20% of cases are attributed to vascular disease (Alzheimer Society of Canada, 2010). Almost three-quarters of residents living in long term care homes in Ontario have Alzheimer’s disease or related dementias (Ministry of Health and Long Term Care, 2008). As the prevalence of dementia increases in the Canadian population over the next few decades, the demands for long term care are also expected to grow.

As a dietitian, I am interested in preventing unintentional weight loss and malnutrition in long term care residents, particularly those living with dementia. This is challenging because a variety of risk factors related to aging and illness can contribute to low food intakes in this population. Declining appetite, taste changes, chewing and swallowing difficulties, and decreasing motor dexterity are common problems that can make it difficult for older people to eat well (Elsner, 2002; Keller, Gibbs-Ward, Randall-Simpson, Bocock, & Dimou, 2006). In addition to these risk factors, residents with dementia may have low intakes due to an inability to express hunger, fear of food (due to choking or confusion), and tendency to become distracted while eating (Aziz et al., 2008). With advancing dementia comes greater dependency on others to provide eating assistance, and challenging eating behaviours may develop such as pushing food away, closing the mouth, and spitting food out (Gillette-Guyonnet et al., 2007).
In 2010, data collected from over 125 long term care homes in Ontario revealed that seven percent of residents experienced significant to severe unintended weight loss, as evidenced by a decrease of five percent or more in body weight over a 30-day period, or ten percent or more over a six-month period (Ontario Health Quality Council, 2011). A study of eleven long term care homes in Toronto found evidence of widespread subclinical malnutrition; over half of the residents had low intakes of key micronutrients and 30% had low intakes of protein (Aghdassi et al., 2007). Likewise, a study that included five long term care homes in Saskatchewan found that over 70% of residents consuming regular diets had inadequate intakes of several key micronutrients (Lengyel, Whiting, & Zello, 2008). Decreasing the prevalence of weight loss and malnutrition in long term care homes is a challenging but important goal given the potential health consequences. Nutritional inadequacies are associated with increased infections (High, 2001), slower wound healing (Harris & Fraser, 2004), falls and fractures (Dawson-Hughs, 2008), and lower health-related quality of life (Kuikka et al., 2009).

Typical interventions include providing snacks, using flavour enhancers, increasing the energy density of foods, and providing micronutrient or oral liquid nutrition supplements (Dunne & Dahl, 2007; Padala, Keller, & Potter, 2007; Silver, 2009). Studies conducted in long term care homes in Ontario and Saskatchewan identified that even if residents ate all the food they were served daily, those on regular and pureed diets would fail to meet the current Dietary Reference Intakes for several nutrients (Wendland, Greenwood, Weinberg, & Young, 2003; Dahl, Whiting, & Tyler, 2007). Thus, there is an iatrogenic component to the problems of weight loss and
malnutrition in long term care homes. This needs to be addressed through good menu planning and the development of palatable foods extra-rich in nutrients.

An equally important approach to addressing the problem of poor food intakes is to look at mealtimes holistically and work to improve residents’ dining experiences. There have been widespread efforts to promote pleasurable dining and make mealtimes more homelike in long term care homes (Pioneer Network, 2012a; Dietitians of Canada, 2007; Zgola & Bordilon, 2002). However, to my knowledge there have been no studies to date on mealtimes that explicitly look at applying a person-centred philosophy of care for residents with dementia. Person-centred care is a holistic approach which aims to enhance well-being, particularly for people living with dementia (Kitwood & Bredin, 1992; Kitwood, 1997; Brooker, 2007).

The purpose of this study is to determine what types of practical and educational support are needed to help direct care providers in Ontario long term care homes to make mealtime care more person-centred for residents with dementia. I will describe current implementation of person-centred mealtime care practices in long term care homes in Ontario. I will also explain what influences implementation of person-centred mealtime care and identify steps needed to more fully adopt this holistic care approach. To set the stage, in the next chapter I will review the literature on the following topics: the meaning of person-centred care, how I have conceptualized person-centred mealtime care, and staff and contextual influences on mealtime care practices.
2. LITERATURE REVIEW

2.1 PERSON-CENTRED CARE

The goal of person-centred care is to build up and support residents’ personhood, and thereby enhance quality of life. Kitwood (1997) defined personhood as “a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect, and trust” (p. 8). Kitwood’s conceptualization of personhood did not depend on an individual’s autonomy, abilities, or attributes; rather, he asserted that social relationships are necessary to create personhood early in life and sustain personhood in those living with dementia (Kitwood & Bredin, 1992). Kitwood drew upon the work of Buber (1937) to explain the meaning of personhood (Kitwood, 1994, Kitwood, 1997). Buber identified and contrasted two basic ways of relating to others, which he referred to as “I-Thou” and “I-It” modes of relating. The word “Thou” is no longer very common in our language, but to address someone as “Thou” implies extending grace – something that need not be earned or deserved. Personally connecting with someone by addressing him or her by name, making eye contact, and sharing a smile are simple ways of relating to a person as “Thou”. In contrast, “I-It” relating is characterized as cool, detached, or instrumental. Person-centred care means relating to a person with dementia as “Thou”, regardless of his or her abilities and personal attributes.

Yet, people with Alzheimer’s disease or related dementias tend to be treated in ways that do not uphold their personhood (Kitwood, 1990; Kitwood, 1993; Kitwood, 1997). They may be excluded from conversations or not given the opportunity to use abilities they still have. Kitwood theorized that it is not simply neuropathic changes in
the brain that cause a person to develop more advanced dementia. Rather, he asserted that processes and interactions that depersonalize a person with dementia impact the state of the brain, leading to further neurological impairment. He referred to these depersonalizing interactions as “malignant social psychology”. Kitwood clearly emphasized that these sorts of interactions are rarely if ever done with harmful intent, but are passed on inadvertently as one picks up the habits of others. He used the term “malignant” to convey their damaging effects and the way they tend to be spread without awareness within society. Moreover, without training and vigilance they can easily become part of the culture of care providers in long term care homes.

Kitwood’s hypothesis that malignant social psychology actually contributes to progression of the neurological impairment in the brain cannot be fully tested. Yet, it brings to our attention how the actions of society, and care providers in particular, strongly influence the well-being of people with dementia. The task is not merely to manage the disease and accompanying behaviours, but to uphold the person with dementia as a relational being with a personal identity. Kitwood advocated that personhood needs continual replenishing. He stated:

In dementia the inner self of stability and security, held in place through memory and judgement, is vanishing to nothing. Now personhood can only be guaranteed, replenished and sustained through what others can provide. And as the neuropathology advances, reducing individual capacity, the need for that ‘person-work’ will grow more, not less. This is the fundamental challenge of good dementia care (Kitwood, 1997, p. 71-72).

The aim is not only to eliminate the depersonalizing interactions of malignant social psychology, but to replace them with “positive person-work”. Examples of positive person-work include asking a resident about his or her preferences and working together
to give the person opportunities to use his or her abilities. Such actions that build up personhood characterize person-centred care.

Others have built upon Kitwood’s work to further conceptualize what it means to provide person-centred care. For example, Edvardsson, Winblad, & Sandman (2008) outlined the following characteristics of person-centred care: personhood is thought of as being concealed rather than lost as dementia progresses, personhood is acknowledged in all aspects of care, care provision and the surroundings are personalized, decision-making is shared, behaviour is interpreted from the person’s point of view, and relationship building and physical care tasks are given equal priority.

Likewise, McCormack & McCane (2006) further conceptualized what it means to provide person-centred care. They identified five key care processes in their Framework for Person-Centred Nursing: working with the person’s beliefs and values, engagement (connecting with the resident), shared decision-making, having sympathetic presence (giving undivided attention), and providing for physical needs. In a more recent version of the framework, ‘providing for physical needs’ was revised to ‘providing holistic care’ (McCormack & McCane, 2010). This framework was developed to be applied in all health care settings, and not just with people living with dementia.

Variations of the basic ideas of person-centred care have also emerged over time, referred to as client-centred, patient-centred, resident-centred, family-centred, or relationship-centred care. There is a lot of overlap in the meaning of these terms, and sometimes they are used interchangeably in practice. Hughes, Bamford, & May (2008) identified ten common themes among the various types of “centred” care. All encompass showing respect, accepting the perspective of the individual, being non-judgmental,
recognizing interdependence, thinking holistically, using lay knowledge, sharing responsibility, communicating well, and supporting autonomy. While care recipients are the focus, there is also an emphasis on valuing care providers. Furthermore, Hughes, et al. (2008) concluded that different types of centredness do not have discrete essences to separate them, and the term chosen depends mainly on context (i.e. resident-centred or person-centred are most appropriate in long term care settings).

Brooker (2007) contended that as use of the term “person-centred” has become commonplace and is sometimes freely exchanged with other terms, it has come to mean different things to different people. Often it is thought of synonymously with an individualized approach to care. She cautioned:

There is a danger that, by just focusing on individualised care, the person with dementia stays firmly hidden behind their disease label and person-centred care still does not occur. Although it is not possible to do person-centred care without taking an individualised approach, it is possible to do individualised care that is not person-centred (Brooker, 2007, p. 47).

A person can be given an accurate assessment and individualized care plan without being related to as “Thou” (Kitwood, 1997). For example, a resident’s food preferences and level of assistance required at meals may be carefully documented in a care plan, but the application of this information at mealtimes may still be task-oriented in nature.

Drawing upon the work of Kitwood and others, Brooker (2007) arrived at the following four-part definition of person-centred care, which forms the acronym VIPS and can be remembered as Very Important Persons:

V – A value base that asserts the absolute value of all human lives regardless of age or cognitive ability; I – An individualized approach, recognizing uniqueness; P – Understanding the world from the perspective of the service user; S – Providing a social environment that supports psychological needs (p. 13).
Implementing this definition of person-centred care places the emphasis back upon the need to eliminate malignant social psychology and uphold personhood through positive person-work. Brooker built upon the ideas of Kitwood, providing a more extensive list of types of malignant social psychology and positive person-work; she termed them “personal detractors” and “personal enhancers” respectively. Examples of personal detractors and personal enhancers outlined by Brooker are found in Tables 2.1 and 2.2. Brooker’s conceptualization of person-centred care is particularly well defined with practical examples, and was developed specifically for the care of those living with dementia. Therefore, it has largely influenced my understanding of what it means to provide person-centred mealtime care for long term care residents with dementia, as described in the next section.
<table>
<thead>
<tr>
<th>Table 2.1 Personal detractors (from Brooker, 2007, p. 86-89)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intimidation</strong></td>
</tr>
<tr>
<td><strong>Withholding</strong></td>
</tr>
<tr>
<td><strong>Outpacing</strong></td>
</tr>
<tr>
<td><strong>Infantalisation</strong></td>
</tr>
<tr>
<td><strong>Labelling</strong></td>
</tr>
<tr>
<td><strong>Disparagement</strong></td>
</tr>
<tr>
<td><strong>Accusation</strong></td>
</tr>
<tr>
<td><strong>Treachery</strong></td>
</tr>
<tr>
<td><strong>Invalidation</strong></td>
</tr>
<tr>
<td><strong>Disempowerment</strong></td>
</tr>
<tr>
<td><strong>Imposition</strong></td>
</tr>
<tr>
<td><strong>Disruption</strong></td>
</tr>
<tr>
<td><strong>Objectification</strong></td>
</tr>
<tr>
<td><strong>Stigmatisation</strong></td>
</tr>
<tr>
<td><strong>Ignoring</strong></td>
</tr>
<tr>
<td><strong>Banishment</strong></td>
</tr>
<tr>
<td><strong>Mockery</strong></td>
</tr>
</tbody>
</table>
Table 2.2 Personal enhancers (from Brooker, 2007, p. 90-95)

<table>
<thead>
<tr>
<th>Personal Enhancers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warmth</td>
<td>Demonstrating genuine affection, care and concern for the resident.</td>
</tr>
<tr>
<td>Holding</td>
<td>Providing safety, security and comfort to a resident.</td>
</tr>
<tr>
<td>Relaxed pace</td>
<td>Recognizing the importance of helping to create a relaxed atmosphere.</td>
</tr>
<tr>
<td>Respect</td>
<td>Treating the resident as a valued member of society and recognising their experience and age.</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Entering into a relationship based on an attitude of acceptance or positive regard for the resident.</td>
</tr>
<tr>
<td>Celebration</td>
<td>Recognizing, supporting, and taking delight in the skills and achievements of the resident.</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>Recognizing, accepting and supporting the participant as unique, and valuing them as an individual.</td>
</tr>
<tr>
<td>Genuineness</td>
<td>Being honest and open with the resident in a way that is sensitive to their needs and feelings.</td>
</tr>
<tr>
<td>Validation</td>
<td>Recognizing and supporting the reality of the resident. Sensitivity to feeling and emotion take priority.</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Letting go of control and assisting the resident to discover or employ abilities and skills.</td>
</tr>
<tr>
<td>Facilitation</td>
<td>Assessing the level of support required and providing it.</td>
</tr>
<tr>
<td>Enabling</td>
<td>Recognizing and encouraging a resident’s level of engagement within a frame of reference.</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Treating the resident as a full and equal partner in what is happening, consulting and working with them.</td>
</tr>
<tr>
<td>Recognition</td>
<td>Meeting the resident in his or her own uniqueness, bringing an open and unprejudiced attitude.</td>
</tr>
<tr>
<td>Including</td>
<td>Enabling and encouraging the resident to be and feel included, physically and psychologically.</td>
</tr>
<tr>
<td>Belonging</td>
<td>Providing a sense of acceptance in a particular setting regardless of abilities and disabilities.</td>
</tr>
<tr>
<td>Fun</td>
<td>Accessing a free, creative way of being and using and responding to the use of fun and humour.</td>
</tr>
</tbody>
</table>
2.2 CONCEPTUALIZING PERSON-CENTRED MEALTIME CARE

Studies on mealtimes in long term care homes have not, to my knowledge, specifically looked at application of a person-centred philosophy of care. However, as I reviewed the literature on the subject of mealtimes in long term care homes, I identified four main aspects of mealtime care practices that are consistent with the VIPS definition of person-centred care developed by Brooker (2007). These four aspects of person-centred mealtime care are providing food choices and preferences, supporting residents’ independence, promoting the social side of eating, and showing respect (Figure 2.1) (Reimer & Keller, 2009).

![Figure 2.1 Four main aspects of person-centred mealtime care](image)

This section will describe each of these aspects in more detail, specifically drawing out applications of the Ontario Ministry of Health and Long Term Care (MOHLTC) regulations (MOHLTC, 2010) and best practices for dining identified by registered dietitians of the Ontario Long Term Care Action Group (OLTCAG) (Dietitians of Canada, 2007). I will also identify selected personal detractors and personal enhancers outlined by Brooker (2007) that potentially apply to the four aspects of person-centred
mealtime care. Some of the personal detractors and personal enhancers listed in Tables 2.1 and 2.2 theoretically seem to apply to certain aspects of person-centred mealtime care better than others. I have chosen to discuss ones that I assume to be most relevant.
2.2.1 Providing food choices and preferences

From the perspective of long term care residents, having variety and choice, proper portions, and opportunities for second helpings are important aspects of a quality dining experience (Evans, Crogan, & Shultz, 2003). Residents also appreciate the ability to try new foods, return foods that are not liked, order alternatives to what is on the menu, and bring foods in such as home cooked items from family members (Shultz, Crogan, & Evans, 2005). Residents’ stories about food and mealtimes indicate that meals are significant to remembering their roots, including their traditions, religion, and personal tastes (Evans, Crogan, & Shultz, 2005). Having one’s food preferences acknowledged and being able to continue making food choices are important aspects of honouring the identity of people living with dementia (Genoe et al., 2010).

Providing food choices and preferences begins with careful menu planning. The MOHLTC regulations require that long term care homes provide alternative choices of entrees, vegetables and desserts at lunch and dinner. Residents also must receive alternative beverage choices at meals and snacks. The menu needs to be reviewed and updated at least annually, and part of this process is having a Residents’ Council in the home provide their input. Long term care homes also need to ensure that appropriate foods and beverages are accessible to staff to serve to residents at any time of day or night. Best practices for dining identified by the OLTCAG indicate that menu planning should be based on assessments of residents’ preferences and appetites, use of residents’ satisfaction questionnaires, resident food committee comments, dining audits, feedback from point of care staff, and plate waste records.

Providing food choices and preferences is also an important issue to consider when planning processes of meal service. The MOHLTC regulations require a process to
ensure that food service workers and other staff who assist residents are aware of the residents’ diets, special needs, and preferences. The OLTCAG best practices recommend that staff be assigned to regular tables so that they become familiar with the residents’ personal needs and preferences. They advise that staff offer beverage choices as residents arrive for meals. They also guide long term care homes to offer food choices visually on sample plates unless a resident’s care plan indicates an alternate method is more appropriate. For example, rather than showing sample plates, it may be better for staff to choose foods for some residents according to a list of likes and dislikes or refer to a family marked menu. The OLTCAG recommends displaying the regular texture choice to residents receiving altered texture diets, likely because it may be difficult to tell what pureed foods are from their appearance. To ensure that meals are portioned according to each resident’s recorded needs, it is advised that staff relay residents’ choices to dietary workers by table and by name. Dietary staff who plate residents’ food should be trained on portion control and to recognize that receiving the correct food items enhances residents’ feelings of control and self-worth.

In the past, long term care homes commonly adopted highly institutionalized food service systems similar to those found in hospitals. Meals were traditionally assembled onto individualized trays in a central kitchen and then transported and served to residents in large dining rooms. Residents could select what they wanted to eat from menus in advance of mealtimes, but not at the point of care. Using individualized trays based on preselected menus has been described as giving “token choice”, not “true choice” (Bump, 2010). In accordance with the OLTCAG best practices, long term care homes in Ontario have moved away from using a tray system of food delivery. Instead, meals are served
one course at a time with menu choices shown to residents on sample plates at the table. A study conducted at a long term care home in Ontario found that residents who had their food served onto dishes in the dining room (n = 26) had significantly greater food intakes than residents who received individualized trays (n = 23) (Desai, Winter, Young, & Greenwood, 2007). Notably, improvements in intake were greatest among cognitively impaired residents with low body mass index.

**Personal Detractors and Personal Enhancers: Providing choices and preferences**

Long term care homes in Ontario have set in place good processes for menu planning and meal service in accordance with the MOHLTC regulations and OLTCAG best practices. Yet, following these processes does not fully ensure that mealtime care will be person-centred. Below, I will identify several personal detractors and personal enhancers from the work of Brooker (2007) that may apply to the provision of food choices and preferences at mealtimes.

In terms of personal detractors, it is possible that outpacing may occur if staff don’t give residents enough time to make food choices when going around with the sample plates. Disempowerment may happen if staff do not give a resident the opportunity to choose when he or she still has that ability. There also may be cases of imposition, where staff override the resident’s desires and deny choice, particularly if the resident wants something that is not allowed according to his or her diet order.

Creating a relaxed pace where residents have sufficient time to make their choices is a personal enhancing action. Other personal enhancing actions include enabling residents by encouraging their engagement in making food choices, and facilitating their involvement by assessing and providing the level of support needed to make these
decisions. For example, a staff member may gently prompt the resident by suggesting items he or she usually likes. Processes of collaboration should also be evident, where the resident is treated as an equal partner in decision making as long as he or she is able, especially regarding special diets. Whether or not residents are able to select what they want from the menu choices at mealtimes or make decisions about their diet, personal recognition should be given; this means meeting residents in their uniqueness by finding out and remembering what they like and taking the time to provide it.
2.2.2 Supporting independence

The second main aspect of making mealtimes person-centred is supporting residents’ independence. As cognitive impairment advances, residents have an increasing need for support in activities of daily living including feeding themselves. Providing the appropriate level of verbal prompting and assistance can help residents significantly improve their food intakes (Simmons et al., 2008). Enabling people who are living with dementia to continue using their current abilities also honours their identity (Genoe et al., 2010). Supporting independence means offering the level of assistance needed to continue self-feeding as long as possible and also means creating ways for residents to carry on roles in food preparation and other meal-related activities if desired.

Slaughter, Eliaziw, Morgan, & Drummond (2011) found that three main predictors of residents’ inability to feed themselves were advancing dementia, comorbidities, and less supportive environments. Physical and social dimensions were considered in their measure of how supportive the environment was for residents with dementia. Moreover, supporting independence at mealtimes involves aspects of the dining room environment as well as the interactions between staff and residents.

Regarding the dining room environment, the MOHLTC regulations require that the chairs and tables be at an appropriate height so the residents can sit comfortably and reach their food easily. Eating aids and assistive devices also must be provided as needed. The OLTCAG best practices recommend that all residents be assessed by the registered dietitian and interdisciplinary care team to determine appropriate seating, positioning, and needs for assistive devices. It is advised to seat residents at tables of
four, where a staff person can sit between two residents who need full eating assistance and help them while encouraging and assisting two other residents to eat independently.

Staff interactions with residents, such as providing verbal, visual, or physical cueing and assistance, are essential to supporting residents’ independence at mealtimes. The MOHLTC regulations require a process to ensure that food service workers and other staff who are helping residents are aware of each person’s special needs for assistance at mealtimes. Residents must be provided with the personal assistance and encouragement they need, and sufficient time must also be given for each resident to eat at his or her own pace. The OLTCAG best practices recommend that all residents be assessed by the registered dietitian and interdisciplinary care team to determine the level of support, supervision, encouragement and assistance needed at mealtimes. Staff also need to be aware of sensory aids residents need such as hearing aids, eyeglasses, and dentures, and make sure the residents are wearing them before bringing them to the dining room. Residents should also be assessed to determine the need for participation in a Restorative Dining Program, where they can be trained and supported by restorative care staff to maximize their level of independence. The OLTCAG also recommend training staff to monitor for signs that a resident’s needs for assistance are changing, and continually updating residents’ care plans as needed.

Supporting residents’ independence at mealtimes takes time and effort. Osborn & Marshall (1992) stated, “Maximizing independence is not the same as giving the least amount of assistance possible. Types of assistance that support self-feeding are more, not less, effortful than spoon-feeding” (p. 254). To ensure that enough workers are present to provide the assistance needed by each resident, the OLTCAG advises long term care
homes to view mealtimes as a priority where all interdisciplinary care team members are available to help.

**Personal Detractors and Personal Enhancers: Supporting independence**

Even with processes in place according to the MOHLTC regulations and OLTCAG best practices, it is possible that efforts to support independence at mealtimes may not be fully person-centred. Potential personal detractors outlined by Brooker (2007) might be seen, especially if staff feel rushed at mealtimes. In particular, there may be instances of outpacing, where residents are not given enough time to complete their meals independently. In this case, staff may take over feeding, which is also an example of disempowerment. Infantilization may occur, without staff even being aware of it, if they pick up habits of treating residents as if they were young children through their tone of voice, words, or actions as they give assistance. Disparagement might even occur if staff are not careful and make remarks that residents are incompetent, useless, or incapable of feeding themselves.

Residents’ independence should be supported through personal enhancing actions, like creating a relaxed pace where residents have ample time to feed themselves. Staff need to engage in facilitation, where they assess and provide the level of support needed for each resident to maximize independence at eating. They need to see opportunities for empowerment, where they let go of control and assist residents to use their remaining abilities to feed themselves. Ideally, staff will also encourage residents through celebration at mealtimes, where they recognize the residents’ achievements with words of praise.
2.2.3 Promoting the social side of eating

The social side of eating is the third main aspect of person-centred mealtime care. Long term care residents’ descriptions of enjoyable mealtimes experienced throughout their lives revealed that meals were times when relationships were developed and maintained (Evans et al., 2005). The social side of eating should continue to be promoted in long term care settings to maintain social connections. Meals regularly bring people face-to-face, involve giving and receiving various types of support, and are an opportunity for communication, making them a good time for people with dementia to connect with others (Keller et al., 2010). There is also research to suggest that promoting the social side of eating can help improve residents’ food consumption. Paquet et al. (2008) observed 32 patients in a geriatric hospital and found a positive association between the total number of interactions at the table and energy intakes, which was only partially explained by meal duration.

Part of promoting the social side of eating is having good interactions regularly take place between staff and the residents. Another important part to consider is residents’ interactions with each other at the table. Observational research on social interactions among tablemates in a retirement home setting found not only positive interactions, but also instances where residents ignored or excluded others at their table (Curle & Keller, 2010). Factors influencing interactions among tablemates included personal characteristics. Some residents were leaders, whereas others took on more of a spectator role in social interactions. Having common interests and backgrounds helped residents connect, whereas health challenges such as hearing or vision problems or cognitive impairment placed limits on social interactions at the table. Furthermore, staff
need to be attentive to residents’ personalities and needs, and how well residents get along with each other, and work to develop a good seating plan for all.

Government regulations and best practices pertaining to the social side of eating are limited and rather vague. The MOHLTC regulations require that long term care homes provide meal service in a congregate setting unless a resident’s assessed needs indicate another setting is more suitable. The OLTCAG best practices likewise recommend that meals be served in the dining room setting, with accommodations for other types of service under special circumstances. These guidelines also advise seating residents with suitable tablemates and having the seating plan accessible to staff in the dining room.

**Personal Detractors and Personal Enhancers: Promoting the social side of eating**

Although meals are a time when residents and staff regularly come together and socialization may be verbally acknowledged as an important aspect of dining, there is potential for malignant social psychology to unconsciously pervade mealtime practices. Several personal detractors outlined by Brooker (2007) might obstruct the social side of eating. For example, there is a danger of staff ignoring residents, particularly by carrying on conversations with co-workers without including the residents. **Objectification** might also occur, where workers sit down and begin feeding residents without saying anything or making eye contact. **Mockery** might happen, where staff tease residents or joke with one another at a resident’s expense. As staff assist and chat with residents at mealtimes, they may fail to acknowledge the resident’s reality, **invalidating** their fears or concerns about various things such as the food, family members, or responsibilities they think they must attend to. If residents are particularly anxious and concerned about something, and
staff are busy, there may be instances of withholding, where staff do not give the
attention that anxious residents seek or fail to meet an evident need for contact.

Banishment is a personal detractor that may occur if a resident is sent away from the
dining room or kept in a separate room without efforts to maintain a sense of connection
with staff members or other residents. In relation to this, stigmatization may occur,
where the resident is treated like an outcast by staff or other residents.

In contrast, giving careful attention to the social side of eating can be a catalyst
for personal enhancing actions. Including residents by enabling and encouraging them to
be a part of conversation at the table is one of these personal enhancers. Likewise,
residents can be built up personally by creating a sense of belonging, where residents are
accepted regardless of their abilities. Part of the social side of eating can also include
sharing in good fun and humour, with attention to the residents’ wellbeing. When staff
chat with residents and hear their stories and concerns and they enter the resident’s reality
to respond appropriately, they are validating the resident. If a resident is upset or
anxious, staff may respond by holding, which means staying with the resident to provide
safety, security, and comfort.
2.2.4 Showing respect

Showing respect is the fourth major aspect of providing person-centred mealtime care. Showing respect is a relatively open concept, encompassing many potential actions intended to create pleasant mealtime experiences for residents. The concept of showing respect undergirds efforts to provide food choices and preferences, support independence, and promote the social side of eating, but also goes beyond these aspects of mealtime care. Respect for residents is behind the efforts of staff to provide a homelike mealtime environment and serve and assist residents in a courteous manner. Long term care residents appreciate courteous, truthful, caring, and responsive staff (Evans et al., 2003). In the eyes of long term care residents, these qualities are major contributors to good dining experiences.

Examples of showing respect through attentiveness to the mealtime environment and quality of service are illustrated well in a mealtime intervention study conducted by Nijs et al. (2006). They implemented a multifaceted protocol to create a pleasant mealtime ambience at mealtimes. Family-style meal service was initiated, where residents had the opportunity to serve themselves from common platters or bowls at the table. A number of other changes also took effect at mealtimes: tables were nicely prepared with a table cloth and flower arrangements; at least one staff person was assigned to sit at each table to chat with the residents and assist them; there were no staff switches during meals; medications were given out before meals started; meals began after everyone was seated, after a moment for reflection or prayer; distractions were minimized by closing the dining room to visitors and other health care providers; carts for food, medications, and files were kept out of sight; and cleaning began after everyone
was finished eating. Six months after baseline, those receiving the intervention (n = 94) showed significant improvements in energy and macronutrient intakes compared to a control group (n = 84) who received regular tray service.

The findings reported by Nijs et al. (2006) cannot be attributed to any particular aspect of the multifaceted mealtime protocol. It is unclear, for example, how much the increase in food intake can be explained by serving food family-style in bowls or platters and having staff at each table to support residents’ independence and enhance the social side of eating. The whole mealtime ambiance was improved through efforts to make the dining environment more homelike, reduce distractions, and improve the quality of service. All of these actions, which may have in some way contributed to the results, can be conceptualized together as ways of showing respect for residents at mealtimes.

The MOHLTC regulations do not provide much specific guidance on creating a pleasant mealtime environment. Very simply, they require long term care homes to have appropriate furnishings in their dining rooms, with comfortable chairs and tables at the right height for the residents. The OLTCAG best practices advise long term care homes to create a pleasant, homelike environment for residents to eat in by keeping the dining room clean, well lit, peaceful, and cheerful. Seasonal décor is encouraged along with tablecloths and place mats. They recommend efforts to minimize noise and interruptions in the dining room. They advise giving meds to residents as they arrive and leave the dining room so the meal is not interrupted. In fact, they recommend that meds should not be given in the dining room at all unless indicated on the resident’s care plan, and they should not be disguised in foods served as part of the meal.
The MOHLTC regulations do provide some clear instructions on the timing of meals and procedures to be followed to ensure good quality service. Breakfast is to be served at least until 8:30 am, and supper is not to be served before 5:00 pm to make sure that meals are well spaced throughout the day. Scheduled meal and snack times are to be reviewed by the Residents’ Council, respecting their wishes. The regulations also require that meals be served one course at a time unless otherwise indicated by the resident or the resident’s assessed needs. To make meal service fair and orderly, the OLTCAG best practices make a further recommendation to follow a table rotation order, so that all residents have an opportunity to be served first. They emphasize providing meal service in a relaxed, unhurried manner, allowing enough time for residents to complete one course before the next is offered. Keeping a relaxed pace also means taking time to portion and garnish meals so they are visually appealing to residents. The best practices recommend serving hot beverages and dessert after the main course. To prevent residents from feeling rushed at the end of the meal, the OLTCAG recommends waiting to clear the tables and wash them until all residents have finished eating and left the dining room. They advise using a team approach to make sure that meal service is well paced and flows smoothly.

The MOHLTC regulations specify several requirements to ensure good quality care for residents who need full eating assistance at mealtimes. Staff need to use proper techniques when feeding residents, including safe positioning, and they are not to help more than two residents who need total assistance with eating or drinking at the same time. Also, residents who require assistance with eating or drinking are not to be served their meal until someone is available to provide the assistance needed. The OLTCAG
best practices further advise staff to sit down while assisting residents and make eye contact, inform them of the food they are about to eat, and involve them in conversation. Other recommendations to enhance the quality of care are to make sure residents are properly dressed and groomed before they are brought to the dining room, and they are not brought to the table more than 20 minutes prior to meals. Also, in preparation for mealtime, many residents may need to be given protective coverings for their clothing; it is advised in the OLTCAG best practices not to call these coverings “bibs” to protect the residents’ dignity. Alternative recommended terms are aprons or clothing protectors (Alzheimer Society of Canada, 2012).

**Personal Detractors and Personal Enhancers: Showing respect**

Between the government regulations and the best practice guidelines available, long term care homes have helpful instructions on how to create a pleasant dining environment, and organize the timing and mealtime procedures for quality service and eating assistance. However, there is still potential for long term care staff to fail to show respect for residents because of personal detractors described by Brooker (2007) that creep into daily care practices. For example, **labelling** may occur, such as use of the term “feeders” to refer to residents needing full assistance at mealtimes. **Accusation** may also occur, for example, if residents are blamed for making a mess at the table. **Intimidation** might take place in the form of spoken threats that residents won’t get dessert if they do not finish their meal or that a family member will be upset if they don’t eat. **Treachery**, which is the use of trickery or deception, may be seen in staff tactics to get residents to come to the dining room and eat more. **Disruption** might include waking residents to eat
or bringing them to mealtime before they are ready, interrupting them from eating to give medication, or taking away utensils or dishes before they are done or prepared to let go.

In contrast there are many personal enhancing actions that staff may engage in at mealtimes which show respect. Waiting to serve each course when the residents are ready, not starting clean up too soon, and being careful not to spoon feed residents too quickly are examples of maintaining a relaxed pace. Acceptance is shown by having unconditional positive regard for residents, regardless of what they do or do not do at mealtimes. Acknowledging residents at mealtimes means valuing them as unique individuals, and this may entail honouring their choice to eat at a different time or location. This goes along with genuineness, which means being sensitive to the resident’s feelings at mealtimes and trying to see things from his or her perspective. Warmth can be demonstrated through genuine affection, care, and concern, particularly if a resident isn’t eating much or not feeling well.
2.2.5 Research gaps in providing person-centred mealtime care

Research is needed to describe how staff in Ontario long term care homes provide food choices and preferences, support residents’ independence, promote the social side of eating, and show respect at mealtimes. In their implementation of the relevant government regulations and best practices described in this section, what things do staff do well and how could mealtime care be improved? What personal enhancers and detractors are evident in the way staff interact with residents at mealtimes? Further study is also needed to identify what influences care providers’ abilities to provide person-centred care. Potential influences on implementation of person-centred mealtime care will be reviewed in the next two sections.
2.3 STAFF INFLUENCES ON PERSON-CENTRED MEALTIME CARE

According to the Framework for Person-Centred Nursing developed by McCormack & McCance (2006), implementation of person-centred care depends on the attributes of individual care providers and aspects of the care environment in which they work. This section will focus on attributes of staff that influence mealtime care practices, while the following section (2.4) will focus on contextual influences. This section reviews some connections made in the literature between mealtime care practices and the personal qualities and knowledge that staff possess. Two main topics will be addressed: 1) Seeing the mealtime experience from the resident’s perspective; and 2) Knowing how to meet residents’ needs for assistance and social interaction at mealtimes.

I will endeavor to draw some links in this section to the Framework for Person-Centred Nursing (McCormack & McCance, 2006; McCormack & McCance, 2010). In this framework, five main personal attributes of staff are identified as prerequisites for person-centred care: professional competence, interpersonal skills, commitment to the job, clarity of beliefs and values, and knowing self. The original publication on the development of this framework in 2006 gave limited detail on the meaning of each of these prerequisites. More recently, a book was published about the framework which brings more clarity to the concepts (McCormack & McCance, 2010). Professional competence encompasses the knowledge and skills to make decisions and set priorities, and includes competence in the physical and technical aspects of care. Interpersonal skills include verbal and non-verbal communication skills as well as emotional intelligence (i.e. self-awareness and empathy). Commitment to the job means going beyond the call of duty, intentionally doing what is thought to be best for the resident,
and commitment to team participation. Clarity of beliefs and values helps staff work toward a shared vision. Beliefs are what staff think is true, and values are what they think ought to be done. Knowing one’s self is closely connected to having clarity of beliefs and values, but it focuses on personal insight into how one functions or puts those beliefs and values into action.
2.3.1 Seeing the mealtime experience from the resident’s perspective

One of the main individual level influences on mealtime care that is discussed in the literature is the ability of staff to see things from the resident’s perspective. Long term care residents with advanced cognitive impairment often have difficulty verbally communicating their needs and desires. Even those who could verbally express what they need and want without much difficulty may refrain from doing so because they do not want to complain or make special requests (Pearson, Fitzgerald, & Nay, 2003; Sidenvall, 1999; Wu & Barker, 2008). Therefore, care providers need to be reflective and empathetic, taking a critical look at mealtimes as best they can from the resident’s point of view.

Schell and Kayser-Jones (1999) conducted an ethnographic study in which ten residents who needed complete eating assistance were each observed for six meals. Findings of these observations were interpreted through a lens of symbolic interactionism, where role-taking (the ability to put oneself in another’s shoes) explained differences in how mealtime care was provided. Care was marked with compassion when staff seemed to understand and see the meal from the resident’s perspective. Nursing assistants with good role-taking abilities addressed the residents by name, found meaning in residents’ patterns of behaviour, sometimes ate together with the residents, and were attentive to the social side of eating. In contrast, when the staff did not exhibit good role-taking abilities, their manner of caregiving was routine and mechanistic. They began feeding without saying anything except for giving cues to eat, and did not help the residents by identifying foods on their plates or giving choices about what to be fed.

Similarly, Pierson (1999) observed that nursing assistants sometimes did not give choices to residents needing full eating assistance. Instead, they started feeding the
residents whatever they perceived to be the most nutritious part of the meal. For some this meant the main protein source, while for others it was the soup or oral liquid nutrition supplements. Chang & Roberts (2008) had similar findings. Pearson et al. (2003), also conducted mealtime observations and interviews with long term care workers and found that some of the staff seemed to be more attuned to the residents’ feelings and their needs for social interaction than others. While some care providers felt it was important to sit down and be at eye level while assisting residents, others were indifferent about whether to stand or sit while providing eating assistance. These studies show that staff may fail to seek understanding of the residents’ perspectives, and be more inclined to follow personal and cultural patterns of thinking and acting.

Sidenvall (1999) provided a theoretical explanation for the quality of mealtime care, giving particular attention to similarities and differences between the cultural beliefs, values, and habitus of nursing staff and older patients. Data were collected at a rehabilitation and long term care hospital, where 60 patients and the nursing staff providing their care were observed and interviewed. Some cultural beliefs were similar for both groups, particularly regarding what was considered acceptable table conduct. Nursing staff were influenced by the organizational culture in which they worked; they considered it important to provide a home-like environment to aid rehabilitation, to ensure that fair methods were used when serving food, and to be responsible by keeping order in the dining room. It was theorized that problems arose in mealtime care because the nursing staff were relatively inflexible with their organizational ways of doing things (habitus), and this hindered their ability to meet the needs of patients whose mealtime habitus had been abruptly altered. Patients were in a new setting and often had new
physical or cognitive challenges that made it difficult to eat the way they used to. Yet, patients tended to hold on to their cultural values of being quiet and not complaining. Therefore, sometimes their needs went unexpressed and unnoticed by staff. Mealtime care was described as “defective” when usual mealtime work routines were carried out automatically with little reflection regarding the patients’ experiences.

Byron et al. (2008) found that nursing staff did think about mealtimes from the residents’ perspectives, but struggled to create a balance between patient-oriented care and the need for a functional or organizational approach. For example, they understood the importance of mealtimes for social interaction and taking time for relaxation and enjoyment, but also needed to make sure that policies and procedures were followed to make sure things went smoothly and efficiently. Thus, care providers’ beliefs and values regarding their responsibilities at mealtimes are likely to ultimately influence their priority setting. Pelletier (2005) studied the attitudes and beliefs of 20 nursing assistants and categorized them in two main groups – those who saw feeding as a social time, and those whose top priority was to see that residents ate enough. Some of the nursing assistants did not fit well into either category, perhaps trying hard to keep a balance between these two priorities.

The Framework for Person-Centred Nursing developed by McCormack & McCance (2006, 2010) indicates that clarity of one’s beliefs and values and knowing self are key personal prerequisites for person-centred practice. This would involve introspection on beliefs and values regarding nutrition, eating behaviour, social interaction at the table, and mealtime routines. Another prerequisite is commitment to the job; this would mean endeavoring to see mealtime experiences from the resident’s
perspective in order to provide the best possible care. The prerequisite attribute of interpersonal skills includes the ability to empathize, or see from the point of view of another.

Further research and theorizing is needed to expand our knowledge of how individual attributes of staff influence mealtime care practices. The current study will identify individual qualities that care providers in Ontario long term care homes think are important for providing person-centred mealtime care. This study will not obtain information directly from residents about their perspectives; however, as staff reflect on mealtime care, they may identify strengths or areas for improvement based on what they know the residents need and want.


2.3.2 Knowing how to meet residents’ needs for assistance and social interaction

Researchers have also identified the need for more education on mealtime care for point of care staff in long term care homes. One specific area that more training would be helpful in is knowing how much assistance or what forms of assistance to give residents at mealtimes. Pearson et al. (2003) observed forty residents from ten nursing homes who needed eating assistance, and also observed and briefly interviewed the staff who provided their mealtime care. The staff knew the importance of promoting independence at mealtimes, but they did not all judge residents’ abilities in the same way and some provided more assistance than others. This highlights a need not only for more detailed assessments and care planning regarding residents’ needs, but also training for point of care staff to recognize when needs are changing and specific ways to facilitate independence.

Staff are also likely to benefit from more training on how to handle resident behaviours such as wandering from the table and difficulties with eating. In a case study involving three long term care residents with dementia, providing verbal cues and encouragement at least every two minutes, with non-verbal cues in between significantly reduced instances of wandering away from the table, and two of the three residents had significantly improved food intakes (Beattie, Algase, & Song, 2004). Teaching staff techniques like this would equip them to better meet residents’ needs. Pelletier (2004) observed and interviewed nursing assistants in four long term care homes and found that they needed more training on how to manage difficult eating behaviours. Having received little training, the nursing assistants picked up poor strategies from their coworkers like mixing all of a resident’s food together to speed up the eating process. Pearson et al. (2003) learned in interviews with nursing assistants that they disliked feeding the same
residents all the time and felt it was unfair to do so, especially when assigned to residents with eating difficulties. Potentially with more training, they would feel better equipped and more positive about working with residents who are challenging to assist.

A need for further training on promoting the social side of eating has also been identified. Observational studies have found that point of care staff tend to use more imperative task-oriented statements when assisting residents with advanced cognitive impairment (Carpiac-Claver & Levy-Storms, 2007; Pelletier, 2004). In interviews with nursing assistants, Pelletier (2004) learned that they were not comfortable communicating with residents who could no long carry on conversation verbally. Likewise, Pearson (2003) reported that staff felt the amount of conversation they had with residents depended on how responsive they were. In observations, Pearson (2003) also found that conversation seemed to be limited between staff and the residents who were most independent, likely because most of their time was spent with those who needed the highest levels of assistance.

Overall, the amount of social interaction at mealtimes may be extremely low. Stabell et al. (2004) conducted systematic mealtime observations involving six residents, where each was observed for three minutes per meal twice a day for ten days. Only 6.8% of residents’ behaviours showed independent social engagement such as taking initiative to talk to others or pass food. Only 5.7% of staff behaviours were considered supportive of social engagement by showing awareness of and responding to residents’ social needs. This provides further evidence that more training on promoting the social side of eating would be helpful for staff to make care more person-centred.
The Framework for Person-Centred Nursing developed by McCormack & McCance (2006, 2010) indicates that professional competence and interpersonal skills are prerequisites for person-centred practice. At mealtimes in long term care homes, part of professional competence is knowing how to meet residents’ individual needs for assistance and social interaction. Providing assistance and promoting the social side of eating also require the development of strong interpersonal skills for connecting with residents who cannot verbally engage in conversation. Moreover, staff need to continually embrace new knowledge and skill development, and this dedication relates to the prerequisite attribute of commitment to the job. Further research is needed to identify specific learning needs for direct care providers in Ontario long term care homes to more fully adopt a person-centred approach to mealtime care.
2.4 CONTEXTUAL INFLUENCES ON PERSON-CENTRED MEALTIME CARE

Implementation of person-centred mealtime care is not just dependent upon the personal attributes and knowledge of individual staff members. It is important to also carefully look at influences of the context in which they work. This section will examine the care context regarding the following four topics: 1) Leading culture change and putting knowledge into practice, 2) Government regulations and related policies and procedures in Ontario long term care homes, 3) Staff workload, and 4) Staff education and training programs.

The Framework for Person-Centred Nursing identifies several key aspects of the care environment: appropriate skill mix within the team, shared decision-making, effective staff relationships, supportive organizational systems, power sharing, and potential for risk-taking (McCormack & McCance, 2006). In an updated version of the framework, the physical environment was added to these identified contextual influences (McCormack & McCance, 2010). Appropriate skill mix refers to staffing levels, with particular emphasis on the mix of registered and non-regulated staff depending on the complexity and acuity of care. Shared decision-making has to do with development of a learning culture which has ongoing commitment to team relationships and processes and maximizing individual potential. Effective staff relationships are also essential to the care environment; group oppression and clique formation are counter-productive to person-centred care. Supportive organizational systems are also identified as an essential aspect of the care environment. This part of the framework has not been well defined, perhaps to keep it wide open for interpretation. Power sharing is another loosely defined concept in the framework which seems to overlap greatly with shared decision-making and effective staff relationships; it refers to the philosophy of exercising shared power.
versus domination and exploitation of staff. Potential for innovation and risk taking is also an essential aspect of the care environment in the framework. This involves staff empowerment and being able to balance risks with patient or resident preferences to negotiate a course of action.

While the Framework for Person-Centred Nursing provides a good general picture of what the care environment should be like to provide person-centred care, more detailed definitions and examples would help to clarify some of the concepts, especially those which seem to overlap. In this section, I will endeavour to make applications and draw connections between aspects of the care environment outlined in the Framework for Person-Centred Nursing and contextual influences on care practices identified elsewhere in the literature.
2.4.1 Leading culture change and putting knowledge into action

Kitwood (1997) discussed the necessity of transforming organizational cultures to implement a person-centred approach. This means looking carefully at the structures and relationships within an organization and the shared values of its members. He described some common characteristics of organizations that hold a person-centred philosophy of care. For example, leaders of these organizations enable and facilitate others in decision-making rather than using a top down approach. Divisions and power differences are minimized, and the focus is turned to improving communication and discussing feelings and issues openly in a supportive environment. The concepts of shared decision-making, effective staff relationships, and power sharing in the Framework for Person-Centred Nursing resonate with Kitwood’s guidance (McCormack & McCance, 2010).

Kitwood (1997) also emphasized that staff should be valued by the organization by receiving a proper level of pay for their work, adequate training, and regular supervision and feedback. They should be given opportunities to develop their personal abilities and interests, increase their qualifications, and take on new responsibilities. Staff need to be empowered to make care decisions as they work with residents. Likewise, in the Framework for Person-Centred Nursing, maximizing individual potential in staff is emphasized under the concept of shared decision-making, and empowerment is highlighted under the concept of potential for innovation and risk taking (McCormack & McCance, 2010). Brooker (2007) also advocated that organizations should have systems in place to ensure that staff feel valued and empowered and that their skills will continue to be developed.

Differences have been identified in leadership approaches among long term care homes endeavoring to implement person-centred care initiatives (Crandall, White,
Person-centred care was core to the mission of organizations that made significant changes. They were open to doing things differently and had previous experience in making practice changes. The leaders were committed to person-centred care and encouraged and supported staff to be creative. Staff were involved in teams committed to promoting person-centred care. Job descriptions, policies, procedures, and training materials were changed to reflect a person-centred approach, demonstrating systemic change. Such changes may be considered examples of what McCormack & McCance (2010) referred to as supportive organizational systems for person-centred care.

Crandall et al. (2007) found that in organizations that made moderate progress in implementing person-centred care, there was interest in a particular project, but using a person-centred approach did not become part of the organization’s mission or values. Decision making tended to remain hierarchical, and staff involvement on teams was variable. Most of the changes focused on the environment, while the culture was not deeply changed. Long term care homes that showed minimal implementation of person-centred care likewise did not experience systemic change. These organizations also experienced considerable turnover in administration and staff, and changes became viewed as extra work.

Theories developed in the field of implementation science can also help explain how the context of care and approaches taken by organizational leaders influence practice change. There is a growing body of literature on the theory and practice of putting knowledge into action in health care settings (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006). Often the focus is on implementing specific practice guidelines, but
implementing person-centred care is a broader aim encompassing a philosophy of care that shapes practice in many ways. One conceptual framework for knowledge implementation that is particularly amenable to this broader aim of practice change is the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Kitson et al., 2008; Rycroft-Malone, 2004). According to the PARIHS framework, knowledge implementation is a product of the nature of the evidence, qualities of the context, and the way the process of implementation is facilitated. Concept analyses of these elements of the framework have been published, and I will briefly describe some of their potential applications to the implementation of person-centred mealtime care.

The first element of the PARIHS framework is the evidence upon which care practices are implemented, and this may include information from four main sources: research evidence, clinical experience, information from care recipients, and locally collected data (Rycroft-Malone et al., 2004). According to the PARIHS framework, knowledge implementation depends upon the value that organizations place on the source of the information and what they judge as relevant. With respect to mealtime care practices, research in the form of clinical trials is very sparse. Knowledge from observational studies and clinical experience is more widely available. Rycroft-Malone et al. (2004) emphasize that knowledge from clinical experience should be purposefully discussed, evaluated, and made more explicit to increase its credibility. The best practices for dining developed by the OLTCAG are a good example of knowledge derived through this type of process. Long term care homes may be influenced to varying degrees by information from residents about their dining experiences and their expressed needs and preferences. The extent to which long term care homes give attention to the results of
mealtime audits and performance information may also vary. These are influences to consider regarding the implementation of person-centred mealtime care. Use of various sources of knowledge or evidence is not addressed clearly within the key aspects of the care environment identified in the Framework for Person-Centred Nursing, but it may fit under the concept of supportive organizational systems (McCormack & McCance, 2010).

The second element of the PARIHS framework is the organizational context, and this has three main sub-elements: culture, leadership, and evaluation. McCormack et al. (2002) provided a concept analysis of these sub-elements, drawing upon the literature to discuss the best conditions for knowledge implementation. Culture was described as more than the systems, processes, or structures within an organizational context. The culture of an organization refers to underlying beliefs, values, and assumptions shared by its members. Moreover, it is possible for different groups within an organization to have different cultures. This may be relevant to mealtime care where staff of different departments need to function as a team. If dietary and nursing staff have differing sets of beliefs and values, this may impact their ability to work together to make mealtime care person-centred for the residents. In the Framework for Person-Centred Nursing, clarity of beliefs and values is considered a personal prerequisite for staff (McCormack & McCance, 2010).

McCormack et al. (2002) indicated that organizations with learning cultures are best positioned for knowledge implementation. In such organizations, the contributions of all staff are valued, and staff are encouraged and equipped to fulfill their potential. This is supported by transformational leadership, where the focus of organizational leaders is to enable and empower everyone to be a leader of something. Effective
teamwork is developed as transformational leaders spread their vision and include staff of all levels in decision-making processes. Transformational leadership and development of a learning culture are captured under the concept of shared decision-making in the Framework for Person-Centred Nursing (McCormack & McCance, 2010). The extent to which transformational leadership is found in Ontario long term care homes and how this influences mealtimes is unknown.

Another aspect of the organizational context examined by McCormack et al. (2002) was measurement or evaluation of effectiveness and quality of care in health care settings. This should include not only measured outcome data, but also perspectives of care providers and recipients. Evaluation of mealtime care in most long term care settings is expected to primarily be based on food intakes, changes in residents’ weight, minimizing waste and controlling food costs, and making sure that the government regulations are followed. The Framework for Person-Centred Nursing outlines four major types of outcomes that should be evaluated: satisfaction with care, involvement with care, feeling of wellbeing, and creation of a therapeutic culture (McCormack & McCance, 2006; McCormack & McCance, 2010). A therapeutic culture refers to having shared decision-making, collaborative staff relationships, transformational leadership, and support for innovation.

Harvey et al. (2002) provided a concept analysis of the third element of the PARIHS framework – facilitating knowledge implementation. Facilitators are people who help others achieve goals and enable effective teamwork in order to move evidence into practice. Facilitators may be external or internal to the organization. External facilitators tend to focus on helping organizations achieve specific tasks or goals. Internal
facilitators, on the other hand, tend to have a broader focus; they identify learning needs, guide group processes, encourage critical thinking, and assess achievement of learning goals. Facilitators can assess the organization’s needs and the most appropriate strategies for knowledge implementation based on the other two main elements of the PARIHS framework: how the organization values and uses different types of evidence, and aspects of the organizational context. The qualities of facilitators may best be represented under the personal prerequisites of professional competence and interpersonal skills in the Framework for Person-Centred Nursing (McCormack & McCance, 2010). With respect to mealtimes, registered health professionals and managers actively train and help staff implement the MOHLTC regulations and many of the best practices advocated by the OLTCAG, but it is unclear to what extent they may truly be considered facilitators of person-centred mealtime care.

Gibbs-Ward & Keller (2005) found that direct care providers in Ontario long term care homes felt powerless to make changes to improve the quality of mealtime care. The context in which they worked was highly influenced by the activities of others at various levels of leadership including registered health professionals and managers, the long term care home administrator, and government officials. Further research is needed to understand the relationship between organizational or leadership level influences and the abilities of staff to make mealtime care more person-centred in Ontario long term care facilities.
2.4.2 Government regulations and related policies and procedures

Policies and procedures set in place in Ontario long term care homes are largely guided by the current MOHLTC regulations (MOHLTC, 2010), as described in section 2.2 of this chapter. Long term care homes receive unannounced inspections by government agents to make sure they are meeting these regulations, so compliance is a high priority. Prior to the current regulations which came into effect in 2010, mealtime policies and procedures were based upon the ministry standards of care for dietary services and an accompanying set of guidelines found in the Long Term Care Homes Program Manual (MOHLTC, 2006). Best practices for mealtimes outlined by registered dietitians of the OLTCAG closely reflected these standards and guidelines, in some cases adding helpful details on how to implement them (Dietitians of Canada, 2007). For example, the previous standards (and current regulations) require long term care homes to offer alternative choices of entrees, vegetables, and desserts, whereas the OLTCAG best practices further advocate providing these choices visually.

The revised regulations currently in place are very similar to the previous standards for dietary services. They aim to ensure that residents’ nutritional requirements are met, food choices and special diet needs including appropriate textures are provided, food safety procedures are followed, and that residents are safe, comfortable, and receive the assistance they need. There were some small changes in the wording of some regulations. For example, the current ministry regulations require course by course meal service “unless otherwise indicated by the resident or by the resident’s assessed needs”. This is slightly different from previous regulations which indicated that meals were to be served one course at a time “unless individual residents request otherwise”. The new
wording seems to allow for more flexibility; staff can apply their discretion as they assess how to best meet the resident’s needs. One notable difference that long term care homes have needed to adjust to with the new regulations is that a resident who needs eating assistance is not to be served until someone is available to provide that assistance. In the past, residents were not to receive their food more than five minutes before having someone available to help them.

Overall, the regulations set in place pertaining to mealtimes ensure that a standard level of quality care will be met by accredited long term care homes. However, as indicated in section 2.2 of this literature review, there are many ways that mealtime care can fall short of truly being person-centred, even when the MOHLTC regulations are followed. Personal detracting actions can still be present and need to be identified and replaced by personal enhancing actions. I contend, as shown in Figure 2.2, that long term care homes cannot have person-centred care without regulations in place to ensure a standard level of quality care. However, standard quality care does not ensure that mealtimes will be person-centred – staff need to be able to see mealtime experiences from the residents’ perspective and individualize care to meet specific personal needs.

Figure 2.2 Person-centred care is found within the context of standard quality care
Ontario long term care homes are required to assess each resident’s specific needs and update their care plans at least quarterly using an interdisciplinary approach. Currently, the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) 2.0 is the primary tool for assessment and monitoring in Ontario long term care homes (interRAI, 2000; MOHLTC Performance Improvement and Compliance Branch, 2007).

There are two sections within the MDS that pertain to mealtimes and nutrition. Section G, which covers a number of activities of daily living, includes an assessment of the resident’s level of independence in eating and the appropriate support required. Section K is also related to mealtimes, but it is more focused on specific nutrition needs and outcomes. It includes oral problems, height and weight, weight changes, nutritional problems such as low food intake, nutritional interventions, and parenteral or enteral intake. Beyond identifying the level of assistance a resident needs at mealtimes, it is not a useful tool for promoting person-centred care.

Government funding and associated budgetary regulations may also impact the extent to which person-centred care is implemented at mealtimes. Accommodating the preferences of a diverse population of residents on a limited budget is a great challenge regardless of a long term care home’s size, location, or status as a for-profit or not for-profit facility (Ducak & Keller, 2011). Funding may also limit the purchase of new equipment, furnishings, dinnerware, décor, and other supplies for pleasurable dining. In keeping with the current regulations, long term care homes also need to carefully track the number of meals prepared for non-residents along with any revenue or internal recoveries from the sale of foods and beverages prepared by the home. This may deter
some long term care homes from giving family members the opportunity to purchase a meal, and may be a reason for not allowing staff to eat with the residents.

The influence of government regulations and related policies and procedures is not clearly addressed within the Framework for Person-Centred Nursing (McCormack & McCance, 2010). Theoretically, I think they fit best under the concepts of supportive organizational systems and potential for innovation and risk taking. Appropriate standards need to be in place, but organizational policies and procedures also need to keep the door open for each resident to receive individualized care. The level of freedom that point of care staff have to individualize care for residents in Ontario long term care homes needs further study.
2.4.3 Staff workload

In their seminal ethnographic study, Kayser-Jones & Schell (1997a) conducted extensive mealtime observations in special care units in two American nursing homes and reported on the effects of inadequate staffing. This research provides the most detailed account of how limited staffing affects mealtimes for residents. Without enough nursing assistants on shift, residents were brought to the dining room without first receiving enough help to get properly dressed and ready and meals were more often served in bed where they did not have the necessary assistance to eat well. Meals in the dining room tended to be an unpleasant experience where residents were fed quickly and forcefully, and often all the solid food was mixed together with the liquids to speed up the process. Other consequences were that dysphagia went unrecognized, residents sometimes did not receive assistance, and there was greater reliance on oral liquid nutrition supplements and interventions by family members.

Kayser-Jones & Schell (1997b) provided a more in-depth analysis of staffing issues on one of the special care units, contrasting care on the day and evening shifts. At lunch time, one nursing assistant fed two residents and assisted one to two others. There was extra supervision and help at lunch from other staff. At supper, however, each nursing assistant was responsible for five to seven residents. While lunch times were very pleasant, mealtime care at supper was mechanistic and resembled an assembly-line. Communication with residents was minimized, and less attention was given to keeping them clean and giving them time to chew and swallow. In agreement with these findings regarding the impact of staffing levels, Kitwood (1997) advocated a ratio of one staff person to four residents. When physical dependency is high, he recommended a ratio of
one staff person to two or three residents. He advised that having too high of a workload can hinder staff from truly being present and giving free attention to the residents.

Low staffing levels have a serious impact on the abilities of staff to provide the verbal encouragement and cueing and physical assistance needed to support residents’ independence in eating. In a study involving mealtime observations of 302 residents sampled from ten nursing homes, 56% of the residents who ate less than half of their meal received less than or equal to one minute of assistance (Simmons, Babineau, Garcia, & Schnelle, 2002). Of those residents who were identified as needing eating assistance based on Minimum Data Set (MDS) assessment records, 56% received less than five minutes of assistance. Also, 35% of residents who received physical assistance were not given any verbal prompts during the meal. Of further concern is that these observations were conducted during breakfast and lunch when staff-resident ratios tend to be higher, whereas at supper, the amount and quality of assistance is expected to be lower.

It takes a fair bit of time and effort on the part of staff to support residents’ independence and provide adequate eating assistance. Several studies focusing on residents with low food intakes have given indications of just how much time is indeed required. Simmons, Osterweil, & Schnelle (2001) tested a one-on-one intervention that involved social interaction and prompting to encourage residents’ self-feeding abilities. Of the 74 residents who received the intervention, 39% improved their intakes by over 15%, and 11% had improvements of 10-15%. The staff time required for the intervention was about 40 minutes per resident. To make things more efficient, assistance may be provided in small groups. In a second part of this study, 18 of the residents who had
improved their intakes by more than 15% in the one-on-one trial were fed in groups of three, and 14 had even better intakes when assistance was provided this way.

Simmons & Schnelle (2006) also tested the responsiveness of 91 residents to graduated levels of eating assistance and the staff time needed to carry out the protocol. Levels of assistance began with social stimulation and encouragement, followed by nonverbal cueing, then verbal cueing, physical guidance, and finally full physical assistance. The most appropriate level was determined for each resident, and it was found that 35-40 minutes were required to improve the residents’ intakes by at least 15%, regardless of the level of assistance given. An important point to note was that residents who were more cognitively impaired and physically dependent were most responsive to the eating assistance intervention.

Simmons et al. (2008) also evaluated the effectiveness of providing snacks with eating assistance compared to the graduated eating assistance protocol. Among the 69 residents with a 15% increase in intake or greater, 75% were more responsive to snacks. Again, more time was required for the snack intervention. The eating assistance time increased from one minute under usual care to fourteen minutes per resident per snack.

These studies point to the need to find the best strategy (graduated assistance at meals or provision of snacks) for each resident to provide efficient and effective care, and clearly demonstrate that more staff time is needed to provide assistance during meals and snacks.

The Framework for Person-Centred Nursing identifies appropriate skill mix as one of the essential aspects of the care environment; this has to do with the staffing level and the mix of registered and non-regulated staff depending on the complexity and acuity of care required (McCormack & McCance, 2010). The studies described above provide
further insight into the consequences of inadequate staffing at mealtimes, the time
required for providing eating assistance, and the need to pay careful attention to staff
workload. The particular mix of registered to non-regulated staff at mealtimes and
assistance provided by volunteers are issues not well addressed in the literature.

In Ontario, Personal Support Workers (PSWs) are primarily responsible for
assisting residents at mealtimes. PSWs are non-regulated care providers supervised by
registered practical nurses and registered nurses. Staffing levels for PSWs in Ontario
long term care homes have been reported to average around one PSW to 11 to 13
residents (Health Professionals Regulatory Advisory Council, 2006). According to this
report there are no fixed ratios or minimum staffing levels for PSWs. Employers oppose
having minimum staffing levels for PSWs, as they argue it is more important to have
minimum care levels set and allow for flexibility in staffing. The average ratio of PSWs
to residents is much higher than the one to four ratio advocated by Kitwood (1997) for
person-centred care.

Food Service Workers (FSWs) assist cooks with some aspects of food
preparation, set tables, portion food, clear tables, and wash dishes. They are referred to
as FSWs in the MOHLTC regulations, but often in long term care homes they are called
dietary aides or nutritional aides. In some long term care homes, FSWs take residents’
orders and serve them at the table, but often PSWs have this responsibility. Specific
requirements are set out by the government regulations regarding the minimum staffing
level for FSWs. The minimum number of staffing hours per week is to be A x 7 x .45,
where A is the licenced bed capacity for the home. If occupancy of the home is less than
97 percent, then A is to be the number of residents residing in the home for that week.
An increase in the minimum staffing level from .42 to .64 hours per resident meal day was advocated by the OLTCAG (Dietitians of Canada, 2009), but the increase made in the current regulations was only to .45 hours per resident meal day. One key reason for this recommendation was the increasing complexity of care since residents in long term care homes tend to be older and frailer than a decade ago. Also, having smaller dining rooms where food is transported in bulk and portioned at mealtimes, rather than being pre-plated in the central kitchen, has increased the workload for dietary staff. It is expected that workload has an important influence on the abilities of staff to make mealtime care person-centred, but this needs to be examined further.
2.4.4 Education and training for direct care providers

PSWs and FSWs provide much of the direct resident care during mealtimes in Ontario long term care homes. In Canada, PSWs are almost exclusively women, many of whom are immigrants (Church, Diamond, & Voronka, 2004). Many colleges in southern Ontario offer the required PSW certificate training program. Standards for this program have been set by the Ontario government to direct vocation-specific learning outcomes, as well as generic skills and education requirements (Ontario Ministry of Training, Colleges and Universities, 2004). Although there is some variation in the structure of these programs, all of them include course work and clinical placements, and generally involve one year of full-time study (Conestoga College, 2012a; Centennial College, 2012a). FSWs require certification through a recognized college program which can be completed within one semester. The focus on the FSW training program is on food preparation and service, sanitation, and safety. Some basic instruction on nutrition and health and special diets is also provided (Conestoga College, 2012b; Centennial College, 2012b). The Long Term Care Homes Act of 2007 requires that regular training be provided to staff involved in direct resident care on all the regulations and policies of the long term care home that they need to follow (MOHLTC, 2007). In addition, they are to receive training on mental health, including the care of residents with dementia and behaviour management.

Moreover, both the formal certificate training and government-required orientation and in-service training seem to be limited in scope to the basics of providing quality mealtime care without fully and directly addressing what it means to use a person-centred approach. Even in the peer-reviewed literature on mealtimes in long term care, education for staff has never been directly identified as “person-centred” to my
knowledge; however, there are a few examples in the literature of educational programs to improve dining services which can help provide some general guidance on how to structure in-service training on mealtime care.

One example of a mealtime enhancement program, Bon Appetit!, combined staff training with environmental adaptations to improve mealtime experiences for residents (Zgola & Bordilon, 2002). Emphasis was placed on supporting residents’ dignity and identity and encouraging social engagement. Detailed educational materials were developed and used in training to change the culture in long term care homes regarding mealtime care. Staff received training on how to interact socially with residents, assess needs for assistance, and use proper feeding techniques. The program included many details involving quality of the food, the physical environment of the dining room, mealtime procedures, and encouragement of self-feeding abilities. Although the program itself appears comprehensive, its evaluation had significant limitations. Based on retrospective evaluation by 45 staff in one Canadian long term care home, there were reported improvements in meal service and residents’ behaviour. Positive comments were made about outcomes of the program, including how it made residents more calm and sociable and how the meal experience had improved (Zgola & Bordilon, 2002). What is not known from this evaluation is the effect of the training on staff knowledge and behaviour, as well as residents’ food intakes.

Other studies have evaluated training programs on specific aspects of mealtime care. A study conducted in two long term care homes in Taiwan tested a feeding skills training program that involved three hours of class time and one hour of hands on training (Chang & Lin, 2005). This research found significant improvements in the
knowledge, attitudes, and behaviours of staff who received the training. However, the sample size was small and validity and reliability of some of the questionnaires had not been established. Another training program was designed to improve mealtime assistance in a group dining environment where residents were able to eat independently (Bonnel, 1995). This program centred on a metaphor describing eating as “work”; staff were taught that the right tools and supervision make the job of eating easier for residents. The training involved an hour-long session that focused on simplifying the task of eating, making use of resources, creating a good eating environment, and being available and responsive while supervising the meal. Participant satisfaction with the program was high and their comments indicated increased awareness of mealtime challenges residents experience. However, neither mealtime outcomes nor staff knowledge and behaviour were evaluated.

Education programs to improve nursing assistants’ communication with residents are more common than training programs specific to mealtimes. Pietro (2002) reviewed such programs, particularly for residents with Alzheimer’s disease and made several recommendations. Lectures should be minimized, and a variety of active learning experiences should be used, particularly role playing. Nursing assistants should be given a chance to suggest topics of importance to them. Training should be provided on-site, and it is best delivered in one hour sessions over several weeks or months by someone who can monitor performance. And finally, ongoing emotional support for nursing assistants, in addition to training, was suggested to help reduce turnover and absenteeism.

In summary, studies evaluating training programs for staff to improve mealtime care are sparse and there have been huge limitations in study design. Larger sample sizes
and a greater variety of outcome measures are needed. Ongoing training and mentoring as opposed to one-time educational sessions are likely needed to significantly increase care providers’ long-term knowledge of what it means to provide person-centred mealtime care and to put this knowledge into action.

Staff education and training is a contextual influence that is not covered particularly well in the Framework for Person-Centred Nursing (McCormack & McCance, 2010). The types of knowledge that staff need for person-centred mealtime care would fit within the concept of professional competence in the framework. Programs and methods for educating and training staff on mealtime care would likely fit best under the general concept of supportive organizational systems or shared decision-making because of the emphasis on developing a learning culture and maximizing individual potential.

In order to develop highly relevant training programs and resources for direct care providers in Ontario long term care homes, current strengths and areas for improvement in mealtime care practices need to be examined first. Research is also needed to gain a better understanding of what influences implementation of a person-centred approach at mealtimes. This knowledge can be used to tailor the structure of training programs and identify other ways to help staff more fully adopt a person-centred approach.
3. STUDY PURPOSE AND POSITIONING FOR QUALITATIVE INQUIRY

3.1 STUDY PURPOSE AND OBJECTIVES

In long term care homes, making mealtimes person-centred means providing residents with food choices and preferences, supporting independence, promoting the social side of eating, and showing respect. Implementation of person-centred care may be influenced by the attributes and knowledge of individual care providers and also by aspects of the context in which they work. The purpose of this study is to understand what types of practical and educational support are needed to help direct care providers in Ontario long term care homes make mealtime care more person-centred for residents with dementia.

The specific objectives of this study were to:

- Describe current implementation of person-centered mealtime care.
- Explain what influences implementation of person-centered mealtime care practices.
- Identify practical steps to improve implementation of these practices.

Three main research questions were addressed:

- In what ways are person-centered mealtime care practices being implemented well and what are some areas for improvement?
- What factors at the individual, team, and organizational levels enable and hinder implementation of person-centered mealtime care practices?
- How can current barriers to providing person-centered mealtime care be overcome?

The findings from this study will be used to guide future development of staff education and training resources. The findings will also be used to form recommendations for long term care educators and practice development leaders, dietitians and food service managers, administrators and directors of care, and policy makers to promote person-centered mealtime care.
3.2 ONTOLOGY AND EPISTEMOLOGY

I chose to conduct this study through a critical realist lens, where my process of inquiry was anchored in the assumption that society enables or constrains the behaviour of individuals, but individuals also have the ability to change or shape society (Bhaskar, 1998b). In other words, understanding what types of practical and educational supports are needed to help staff make mealtimes more person-centred requires examination of relationships between individuals and the context in which they work. This begins with exploring personal attributes and knowledge of staff and organizational aspects of long term care homes that influence implementation of person-centred care. Coming from a critical realist perspective, I believe there are real, or at least relatively enduring, structures and relationships to uncover in the social world where people live and work that influence their behaviour.

What sets critical realism apart from other philosophical perspectives is a stratified view of ontology. Bhaskar (1998a) delineates three levels of reality: the empirical (what is directly experienced and can be measured or described), the actual (events or patterns which occur but may not be recognized without careful study), and the real (underlying mechanisms or conditions that generate events or patterns). In the natural sciences, the domain of the real consists of generative mechanisms or causal laws that are assumed to operate continually, independent of our knowledge of them. Even though these laws of nature are continually at work, their effects may not occur in readily perceivable patterns because of the open systems in which they naturally function. In the social sciences, the domain of the real is understood as the underlying social structures or relationships that produce effects in society (Bhaskar, 1998b). These structures and relationships are assumed to be relatively enduring.
A critical realist philosophy of science supports both quantitative and qualitative methods. In fact, triangulation (through use of various methods) is encouraged in order to counteract potential biases, create a more comprehensive understanding, and promote abductive reasoning (use of metaphors, analogies, or models) to explain findings (McEvoy & Richards, 2006). Moreover, critical realism embraces the view that all beliefs are socially produced (epistemic relativism), but it does not accept that all beliefs are equally valid (judgmental relativism) (Bhaskar, 1998b). Given that the underlying conditions or social structures and relations affecting human activities may not be readily intuitive, research participants may not be able to fully grasp or explain what influences their experiences or behaviours (Bhaskar, 1998b). Therefore, various perspectives and forms of information are needed to deepen understanding of conditions or influences that lie beneath the surface. Ideally, multiple methods such as interviews, observations, and surveys would be helpful to address my research objectives. However, some pragmatic boundaries were set to keep the project manageable in size. Data collection was limited to semi-structured interviews with staff, but efforts were made to include the perspectives of those working in a variety of positions across four diverse long term care homes.

Another pragmatic boundary for this study was to focus attention on influences at the individual, team, and organizational levels without delving into detailed examination of macro-level influences such as the government policy and funding context of long term care homes. Likewise, I did not seek to examine the broader influences of the surrounding community and beliefs and values staff hold related to their cultural backgrounds. While these macro-level influences are recognized as important considerations within a critical realist lens, they were beyond the scope of this study.
### 3.3 THEORETICAL SENSITIVITY

Theoretical sensitivity guides qualitative researchers, influencing what they deem to be pertinent in the data and enabling them to understand and give meaning to it (Strauss & Corbin, 1990). Based on my review of the literature, I was sensitized to a number of potentially important influences on implementation of person-centred mealtime care. These influences are outlined in Table 3.1 below.

Table 3.1 Potential influences on mealtime care based on review of the literature

<table>
<thead>
<tr>
<th>Potential Influences on Mealtime Care</th>
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<tr>
<td><strong>Resident personalities and needs</strong>: Residents with advanced dementia may not be able to verbally express what they want, and those who are able might refrain from doing so because they do not want to complain or make special requests (Pearson, Fitzgerald, &amp; Nay, 2003; Sidenvall, 1999; Wu &amp; Barker, 2008).</td>
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<tr>
<td><strong>Personalities/attributes of staff</strong>: Staff need to be able to see mealtime experiences from the perspective of the residents (Schell &amp; Kayser-Jones, 1999; Sidenvall, 1999). They need to be professionally competent, have good interpersonal skills, be committed to the job, and have clarity of personal beliefs and values and knowledge of self (McCormack &amp; McCance, 2006).</td>
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<td><strong>Beliefs and values</strong>: Individually and collectively held beliefs and values guide the actions of staff in organizations (McCormack et al., 2002).</td>
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<td><strong>Co-worker influences</strong>: Malignant social psychology (personal detractors) may be spread unconsciously among coworkers (Kitwood, 1997; Brooker, 2007).</td>
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<td><strong>Leadership influences</strong>: For knowledge implementation, transformational leadership is desirable (McCormack et al., 2002) and facilitators are needed who can help staff achieve goals and enable effective teamwork (Harvey et al., 2002).</td>
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<td><strong>Power to make decisions</strong>: Shared decision-making systems and empowerment are needed for person-centred care (Kitwood, 1997; Brooker, 2007; McCormack &amp; McCance, 2006), and knowledge implementation (McCormack et al., 2002).</td>
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<td><strong>Supervision and feedback</strong>: Organizations that adopt a person-centred philosophy of care value their staff. Staff are shown they are valued by leaders who provide supervision and feedback to help them develop their abilities and interests (Kitwood, 1997; Brooker, 2007).</td>
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<td><strong>Teamwork and communication</strong>: Effective, collaborative staff relationships and good communication are needed for person-centred care (McCormack &amp; McCance, 2006), and knowledge implementation (McCormack et al., 2002).</td>
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<td><strong>Evidence that it works (evidence for using particular approaches)</strong>: Sources of evidence may include research, clinical experience, information from care recipients, and locally collected data (Rycroft-Malone et al., 2004).</td>
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<td><strong>How mealtime care is evaluated (i.e. mealtime audits)</strong>: Care should be evaluated not only based on specific quantitative outcome measures, but also by the perspectives of care providers and recipients (McCormack et al., 2002; McCormack &amp; McCance, 2006).</td>
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<td><strong>Policies and procedures:</strong> Policies and procedures in Ontario long term care homes are guided by government regulations (MOHLTC, 2010). The previous government standards and guidelines (MOHLTC, 2006) and best practices developed by dietitians (OLTCAG, 2007) have also shaped the policies and procedures currently in place in many facilities.</td>
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<td><strong>Workload:</strong> Inadequate staffing can lead to a mechanized, assembly-line approach at mealtimes and residents may be fed too quickly (Kayser-Jones &amp; Schell, 1997a, b). Inadequate staffing also limits the amount of encouragement and cueing residents receive to support their independence (Simmons et al., 2002).</td>
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<tr>
<td><strong>Formal education and training (certificate programs):</strong> Required college programs for PSWs and FSWs who work in Ontario long term care homes appear to provide basic training on quality mealtime care without fully and directly addressing what it means to use a person-centred approach (Conestoga College, 2012a,b; Centennial College, 2012a,b).</td>
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<tr>
<td><strong>In-service education and training:</strong> Specifically, staff may need more training on how to support residents’ independence, handle difficult feeding behaviours, and communicate with residents with cognitive impairment (Pearson et al., 2003; Pelletier, 2004; Carpiac-Claver &amp; Levy-Storms, 2007).</td>
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3.4 REFLEXIVITY

Reflexivity means engaging in self-introspection throughout the whole research project, beginning in the planning stages (Dupuis, 1999). It means asking yourself about how your emotions and experiences influence your research. Reflexivity involves thinking about your role as the researcher in the co-creation of knowledge through your interactions with study participants.

I entered this research project with a lot of past experience as a care provider. Before and during my undergraduate training in dietetics, I worked in two small family-operated personal care homes in Saskatchewan (about nine years in total). I typically worked full-time in the summers and on evenings and weekends throughout the rest of the year. The home I worked in most often had fourteen residents, and the other home had five residents. All residents in the homes were women. Typically those who came to live in the larger home had mid-stage Alzheimer’s disease or related dementias and required assistance with activities of daily living including bathing, dressing, and eating. I held a wide range of responsibilities including assisting residents with personal care in the morning, cooking and serving meals, feeding residents who needed full assistance, administering medications, house cleaning and laundry, and leading recreational activities.

I had minimal education when I started working as a care provider in these homes; all that was required for the job was a food safety certificate and a first aid/CPR course. A home care nurse taught me how to administer insulin and eye drops. Otherwise, I learned from my initial on-the-job training, my personal experiences, and by watching other staff. In the large home, the ratio of staff to residents was one to seven from about 6am-2pm, and one to fourteen for the remainder of the day. Having staff with
little training maintaining high workloads for low wages led to high staff turnover. Although the owners’ vision was for the residents to receive high quality care in a homelike environment, I think we often fell short of this due to lack of staff education and efforts to minimize costs.

Working in the smaller home with five residents was a very different experience. The workload and time pressures were not nearly as high and the residents were more independent and able to engage in conversation. I enjoyed having the time and flexibility to make and serve special items for lunch like homemade soups and fresh biscuits, which the residents appreciated. I often had the opportunity to sit down and eat with them, and I also did more recreational activities with them such as playing card games in the afternoons. Thus, it was easier to develop meaningful connections with the residents in this setting and provide care which I would consider to be more person-centred.

I did not come to this research with much experience from a dietitian’s perspective on mealtime care practices in long term care homes. During my dietetic internship in Saskatchewan, I had a one-week clinical rotation in a long term care / rehabilitation setting, and a ten week rotation in food service management which included projects in two long term care facilities. One of the projects I worked on was a waste audit of thickened beverages for residents with dysphagia, and I found that a very large volume was being returned to the kitchen. It was evident that the residents either did not like them or were not being provided the assistance and encouragement needed to consume them; I suspect that both were contributing factors.

The main take-away points from my experiences as a caregiver and dietetic intern that help inform my inquiry are summarized below in Table 3.2:
Table 3.2 Potential influences on mealtime care based on personal reflections on practice

- **Resident personalities and needs:** From my experience, some residents were much easier to connect with than others, depending on their mood and ability to carry on conversation.

- **Personalities/attributes of staff:** Although I wanted to provide good care for the residents, I did not know much at all about dementia except through experience and this made it hard to know how to respond to residents’ behaviours at times. It was important to be patient, and well organized to remember everyone’s needs and meet them in a timely manner.

- **Beliefs and values:** Long term care homes can espouse particular beliefs and values, but without staff having knowledge of how to care for people living with dementia, it is hard to fulfill them.

- **Co-worker influences:** Without having formal training and minimal in-service training, my coworkers at the personal care homes had a dominant influence on how I learned to provide care.

- **Workload:** My work experience at the two privately owned personal care homes differed substantially. Having an integrated role (i.e. personal care, cooking, housekeeping, etc.) worked well in the home with five relatively independent residents. Providing care for more residents with higher needs at the other home was challenging. A heavy workload makes it hard to provide person-centred care.

- **How mealtime care is evaluated (i.e. mealtime audits):** From my experience as a dietetic intern, my attention was directed more to food intake records, food temperature records, and waste audits than social interaction and level of assistance provided at mealtimes.
4. METHODS

This chapter will provide details on the methods used for this descriptive qualitative study, including the selection of long term care homes, recruitment of interview participants, interview procedures, transcription, and data analysis. Ethics clearance for this study was obtained from the University of Guelph.

4.1 SELECTION OF LONG TERM CARE HOMES

Four long term care homes in southern Ontario were purposively sampled for maximum variation in order to identify common patterns and differences in organizational influences on mealtime care practices (Miles & Huberman, 1994). The aim was to include homes of different sizes from urban and rural settings, as well as representation of homes with for-profit and not for-profit status. An external advisory group was formed in the early planning stages of the study to provide some practical guidance on the research methods, and discuss potential avenues for future knowledge translation initiatives. They were able to provide some initial contacts for long term care homes that might be interested in participating. A letter explaining the study was sent to three prospective long term care homes, and one of these homes came on board. Contact information for two more homes was obtained through online resources from the local Community Care Access Centre. Information letters were sent and they agreed to participate. Midway through data collection, I was contacted by a representative of a fourth home that was interested in getting involved in mealtime research. Recruitment of interview participants had been going slowly at two of the previously selected homes so having a fourth home involved would help increase the number and diversity of participants. Including this home would also add the unique dimension of serving a large
Chinese population. Thus, the fourth home was invited to join the study. Table 4.1 outlines background information on each of the participating long term care homes.

Table 4.1 Background information on the participating long term care homes

<table>
<thead>
<tr>
<th>Home</th>
<th>Characteristics</th>
<th>Focal points of mission/vision/values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home A</td>
<td>Rural location &gt;150 residents Municipally owned and operated, not for-profit Includes two special care units for residents with dementia</td>
<td>Love, comfort, and growth Innovative leadership in long term care</td>
</tr>
<tr>
<td>Home B</td>
<td>Rural location &lt;75 residents Privately owned and operated, for-profit Residents with and without dementia live and dine together</td>
<td>Excellence in health care</td>
</tr>
<tr>
<td>Home C</td>
<td>Urban location &gt;150 residents Corporately owned and operated, for-profit Includes two special care units for residents with dementia</td>
<td>Lifestyle and quality of life that exceeds residents’ expectations Respect, empathy, service excellence, performance, education, commitment, trust</td>
</tr>
<tr>
<td>Home D</td>
<td>Urban location &gt;150 residents Corporately owned and operated, for-profit Residents with and without dementia live and dine together</td>
<td>Culturally sensitive care Mutual respect, excellence, effective communication, teamwork, resident safety</td>
</tr>
</tbody>
</table>
4.2 RECRUITMENT OF INTERVIEW PARTICIPANTS

Recruitment flyers that provided a short description of the study and researcher contact information were given to the administrators or directors of care for each participating long term care home to be distributed to all eligible staff. Specifically, PSWs, FSWs, cooks, restorative care workers, recreation staff, and private companions hired by family members were invited to participate. In Homes A and C, where there were special dementia care units, only those who worked regularly in these units were invited to take part in the study. Invitations were also extended through recruitment flyers to registered health professionals and supervisors or managers in the long term care homes who oversaw mealtime care. To help protect the identity of participants, those who directly served or assisted residents in the dining room are collectively referred to as direct care providers (or point of care staff) in this study. Registered health professionals, supervisors, and managers are referred to as indirect care providers.

In preparation for the interviews to be conducted, I did informal observations of two to three mealtimes in each participating long term care home. These observations just helped me familiarize myself with the mealtime environment and processes used. This was a chance for me to introduce myself to staff members and tell them about the study in person. At Home A, staff in each of the dementia care units had a weekly team meeting, and I was able to personally deliver recruitment flyers and briefly explain the study to staff at these meetings. Extra flyers were provided for distribution to those who were not able to attend.

Participation was voluntary and staff members contacted me by phone or email if they desired to participate. They had a choice of being interviewed in a private location at the long term care home where they worked, or at their home, or another agreed upon
location. Almost all of the interviews took place at the participating long term care homes, and a few staff chose to be interviewed at their houses. Participants received $50 compensation for their time if the interviews took place outside of work hours; all interviews with direct care providers were outside of work time.

Table 4.2 shows how many direct care providers and indirect care providers participated from each long term care home; a total of 52 staff took part in interviews. Out of all participants, 96% were women, 81% were between the ages of 30-59, and 60% worked full-time. Forty percent of participants had worked at the present facility for more than 10 years, and eight percent had been at their current workplace for less than one year. Sixty-three percent of participants had worked a total of more than ten years in long term care.
Table 4.2 Study participant summary

<table>
<thead>
<tr>
<th>Participants</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct care providers</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Personal support workers, food service workers, cooks, restorative care workers, recreation staff, and private companions</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td><strong>Indirect care providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered nurses, registered practical nurses, registered dietitians, food service supervisors and managers, restorative care or recreation managers, and directors of care</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>7</td>
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<td>18-29</td>
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<td>1</td>
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<td>3</td>
<td>6</td>
</tr>
<tr>
<td>30-39</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>14</td>
<td>27</td>
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<tr>
<td>40-49</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>15</td>
<td>29</td>
</tr>
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<td>50-59</td>
<td>7</td>
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<td>13</td>
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<tr>
<td>60+</td>
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<td>1</td>
<td>3</td>
<td>-</td>
<td>7</td>
<td>13</td>
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<td><strong>Full or part-time status</strong></td>
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<td>5</td>
<td>12</td>
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<tr>
<td>Part-time</td>
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<td>7</td>
<td>3</td>
<td>5</td>
<td>21</td>
<td>40</td>
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<tr>
<td><strong>Years working in the present facility</strong></td>
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<td>1</td>
<td>1</td>
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<td>10</td>
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<td>3-4</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>7</td>
<td>12</td>
<td>23</td>
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<td>5-10</td>
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<td>3</td>
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<td>19</td>
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<td>10+</td>
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<td>5</td>
<td>-</td>
<td>5</td>
<td>21</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total years working in long term care</strong></td>
<td></td>
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<tr>
<td>&lt; 1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>3</td>
<td>6</td>
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<tr>
<td>1-2</td>
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<td>2</td>
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<td>19</td>
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<td>10+</td>
<td>16</td>
<td>6</td>
<td>1</td>
<td>10</td>
<td>33</td>
<td>63</td>
</tr>
</tbody>
</table>
4.3 INTERVIEW PROCEDURES

Semi-structured face-to-face interviews were conducted with the study participants, and these interviews averaged about an hour in length. The interviews were structured in three parts, following the basic pattern of a look-think-act approach to facilitate critical reflection on mealtime care (Koch & Kralik, 2006). The aim of the first segment of the interview was to look at current implementation of person-centred mealtime care. Specifically, participants were asked to describe how workers at their long term care home regularly do the following: provide choices and preferences, support independence, promote the social side of eating, and show respect. I prompted them to tell me about what they thought was being done well and to identify areas for improvement in each of these aspects of person-centred mealtime care. The next step was to think about what influences mealtime care. I brought a stack of index cards to the interviews with potential influences written on them to help guide this discussion. These influences are listed in Table 4.3. I asked participants to look through these cards and identify influences that they felt were particularly important and comment on them. Some participants felt they were all important and spoke briefly about each one, while others chose to talk more in-depth about particular influences. In several interviews, participants had already spoken about many of the influences at length as they described practice in the first part of the interview, so this part was condensed or omitted. The third part of the interview focused on how to act in response to the areas for improvement and related influences on mealtime care that they identified. In other words, we talked about practical steps that could be taken to help staff to more fully adopt a person-centred approach at mealtimes.
Table 4.3 Potential influences on mealtime care practices

- resident personalities and needs
- personalities of staff
- beliefs and values
- co-worker influences
- leadership influences
- power to make decisions
- supervision and feedback
- teamwork and communication
- evidence that it works (evidence for using particular approaches)
- how mealtime care is evaluated (i.e. mealtime audits)
- policies and procedures
- workload
- formal education and training (certificate programs)
- in-service education and training
- other influences
4.4 TRANSCRIPTION

Audio recordings of the interviews were transcribed by undergraduate research assistants. Poland (2003) warned of a number of problems that can occur in transcription. For example, it can be difficult to make judgement calls about where to put punctuation when people talk in run-on sentences. Sometimes transcriptionists fail to indicate when speakers are paraphrasing or mimicking others. Words can also be mistaken for other words that sound similar. Poor quality recordings with background noise and transcriptionist fatigue can also make it challenging to accurately capture what has been said. Thus, it is recognized that to produce a truly verbatim transcript is likely an unattainable goal. To ensure that the transcripts were as accurate as possible, the transcriptionists followed the protocol shown in Table 4.4. When each transcript was complete, I also reviewed it for accuracy while listening to the audio recordings. This step also helped me further familiarize myself with the data for analysis. The greatest challenge for the transcriptionists was accurately capturing what was said by participants from Home D, where English was a second language for many staff and some of them spoke with strong oriental accents. Interestingly, it was easier to follow along with their conversation in person than it was to listen and capture it from the audio recordings. In many cases, the transcriptionists and I edited the grammar substantially to make it easier to read and understand the written transcripts.
Table 4.4 Transcription protocol

- Capture intended meaning through appropriate punctuation
- Indicate sounds or feelings in square brackets (i.e. [chuckling], [laughing], [crying], [phone rings])
- Identify crosstalk if conversation overlaps and it cannot be understood (i.e. [crosstalk])
- Use dashes to indicate interruptions (i.e. Someone cuts off the sentence of someone else. Dash at the end of first person, then dash at start of next person, then dash at end of that person’s talking if interruption continues. If interruption doesn’t continue, use a period.)
- Use dashes also if a participant doesn’t complete a thought (i.e. He did – well I thought he did)
- Use ??? where words are unclear
- No need to type – um, ah. Do at the beginning (first 10 minutes) and then just occasionally to provide flavour of the person’s speech patterns. Can also use “…“ to indicate when a person is saying “um, uh and pausing”
- Pauses: use “…“ for pauses <5 seconds, but time the pause if >5 seconds (i.e. [pause – 12 seconds])
- Don’t type interviewer’s acknowledgements such as “uh-huh, yes” BUT, do type participants’ agreement when it occurs (i.e. [participant agrees])
- When you finish an interview, carefully listen to the audio file again and make any necessary edits (data cleaning)
4.5 DATA ANALYSIS

Data analysis for this project was a journey involving a complex non-linear path. I loosely endeavored to follow the steps of thematic analysis detailed by Braun & Clark (2006), as outlined in Table 4.5. They emphasized that the process should be expected to be non-linear with movement back and forth between different phases.

Table 4.5 Data analysis steps (from Braun & Clark, 2006)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Familiarizing myself with the data through reading and re-reading the transcripts and noting initial thoughts.</td>
</tr>
<tr>
<td>2.</td>
<td>Generating initial codes using a systematic process across the whole data set.</td>
</tr>
<tr>
<td>3.</td>
<td>Searching for themes by grouping related data.</td>
</tr>
<tr>
<td>4.</td>
<td>Reviewing themes by checking that coded data fit the themes well across the dataset.</td>
</tr>
<tr>
<td>5.</td>
<td>Refining the specifics of each theme, generating clear definitions and names for themes.</td>
</tr>
<tr>
<td>6.</td>
<td>Reporting the themes with vivid examples, relating them back to the research questions and literature.</td>
</tr>
</tbody>
</table>

I began the journey by going line by line through each transcript and jotting brief summary notes in the margins. Basically, this step helped me familiarize myself with the data. I also made notes on the interviews, sectioning them according to the three main parts of the interviews: 1) describing mealtime care practices; 2) influences on mealtime care practices; and 3) what can support staff to make mealtimes more person-centred.

From my notes, I began generating some initial codes and searching for themes.

I did a lot of concept mapping as opposed to writing memos as I worked on identifying these initial themes. What I found was that there appeared to be some clear themes that prevailed across the three main sections of my interviews, tying all the data together. At that point, I decided to work on developing those themes further using NVivo9 software. I began the coding process with fifteen interviews that I perceived to be rich in content, and I felt I had reached a point of saturation with all data segments in
these interviews fitting in one or more of five major interrelated themes. I went on to code the remaining interviews in this framework.

I encountered several difficulties along the way. One was the sheer volume of data coded within each of these five themes. At this relatively early stage of analysis, I did not want to let go of the richness of an abundance of strategies staff shared for making mealtime care person-centred. They also talked in detail about challenges and areas for improvement that they saw. To focus my presentation of the results on key findings from each of the five major themes, I felt like I was merely skimming the surface of the data and not able to adequately address each of my research objectives.

Therefore, I decided to once again separate out the strengths and strategies staff described for person-centred care, and I coded and developed themes with these data using the basic a priori framework of providing choices and preferences, supporting independence, promoting the social side of eating, and showing respect. Likewise, I separated out data on the challenges and areas for improvement and developed themes related to these four main aspects of person-centred mealtime care. I wrote a very long descriptive presentation of the findings of these thematic analyses, weaving in some references to the five original major themes I had developed using NVivo. This document functioned as a detailed descriptive memo of the study findings. In consultation with my thesis committee, I realized that what was needed for this dissertation was a relatively short, clear, more interpretive summary.

I had difficulties writing about the original five major themes individually because of their interrelated nature. From my perspective, it was far more clear and practical to select some examples of strengths and areas for improvement and provide my
interpretation by using the original five themes as an explanatory conceptual framework. I also identified several practical issues that long term care homes could focus on to improve implementation of person-centred mealtime care, and I explained these in terms of the conceptual framework I had developed. Thus, my presentation of the findings in this dissertation does not follow the traditional format of a thematic analysis, but I believe it is the best approach to address my research objectives in a clear interpretive manner.

Although the analysis was conducted independently, my thesis committee provided guidance along the way that ultimately helped shape my focus in data analysis and the presentation of the findings. I was advised to provide less description and more interpretation by explaining what the findings meant in terms of person-centred care. To do this, I related findings of strengths and areas for improvement to specific personal enhancers and personal detractors outlined by Brooker (2007). I was also encouraged to make explicit connections between the elements of the conceptual framework I developed through this study. Thus, I moved beyond stating that the elements were interrelated and worked to clearly outline the relationships I saw. My committee members also impressed upon me to view person-centred care as something staff do with thoughtful intent; in other words, it is not simply a “happy accident” when it occurs. Furthermore, members of my committee have a vision for development of staff education programs and future research in this area. Thus, strategies for person-centred care and findings regarding the education and training of staff were emphasized in my data analysis and presentation of the findings. My committee also directed me to clearly recognize the government funding and regulatory context of long term care homes, while acknowledging that they were not the focus of the study.
5. STUDY FINDINGS

5.1 INTRODUCTION

5.1.1 Conceptual framework

The purpose of this study was to understand what kinds of practical and educational support are needed to help direct care providers in Ontario long term care homes make mealtime care more person-centred for residents with dementia. Analysis of the interview data revealed that long term care homes can support staff to provide person-centred care by focusing on five elements: forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care (Figure 5.1). These elements are highly interrelated, and it is most practical to discuss them with an applied focus. Therefore, they will not be examined individually as themes, but used as a conceptual framework to help explain the study findings.

![Figure 5.1 Elements of supporting staff to provide person-centred mealtime care](image-url)
Meanings of the elements of the conceptual framework will become clearer as the findings are presented throughout this chapter. As an introduction, Table 5.1 briefly summarizes what each element entails and provides supporting quotes. Table 5.2 further outlines theorized relationships between these elements. Identifying information has been removed from all quotes presented in this thesis. Names appearing in quotes are pseudonyms, and the source of each quote will be indicated by participant number (i.e. C7 = participant #7 from Home C).

Table 5.1 Elements of supporting staff to provide person-centred care and supporting data

<table>
<thead>
<tr>
<th>Five Key Elements</th>
<th>Supporting Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forming a strong team</strong> means thinking about who comprises the team in the dining room. This means hiring staff with important personal attributes, and it also means involving family members and volunteers as part of the team.</td>
<td>[What specific qualities would you look for in hiring somebody for the unit?] Somebody that was cheerful and, you know, like a pleasant personality – Somebody that you could tell loved the residents and loved their job, rather than, ‘It’s just something to do.’ And you could be feeding the chairs as much as you’re feeding a person (C7). …sometimes we have volunteers, and sometimes family comes in and help feed. Because there’s a lot of people in there that need feeding (C7).</td>
</tr>
</tbody>
</table>

| Working together to provide care | I do work with an amazing team. I’ve known them for a long time, so our teamwork is great and we communicate really well. At mealtime with this certain resident that we have, it can be pretty exhausting if you’ve dealt with this resident for a half an hour through mealtime. And you’re just feeling really like, ‘I’m pretty tapped out, I don’t know what else I can do.’ And I have a team that the next person will come and say, ‘You know what? I’m going to try’” (B3). |
**Knowing the resident** means knowing each resident’s preferences, needs, personality, and biography. It also means knowing what they believe and value at mealtimes. Staff learn about the residents by communicating with them and their families, observing them over time, sharing information with coworkers, and using documentation systems.

“…Because you work with that resident so often, you know the choice over time that the person likes, so you relay back to him and say, ‘George, it’s barbeque chicken today. That’s your favourite!’” (D1)

**Having a toolbox of strategies** refers to knowledge of a variety of specific approaches or actions that staff can use to help meet individual needs. Approaches used should aim to help residents be happy and peaceful at mealtimes, and eat until satisfied.

…what works for one [resident] isn’t going to work for another, and almost always what worked yesterday or even this morning is not, or may not work for lunch…you always have to be thinking to the next step, so you always have to foresee worst-case scenario, best-case scenario, and kind of have a quick situation for anything (A1).

**Creating flexibility to optimize care** means keeping options open by having foods and resources available at all times to meet each resident’s individual needs. This also includes having the ability to bend usual rules and routines as needed for the benefit of the resident.

…we don’t have a cookie cutter [approach], like, this is the way it is, you know? We don’t have that. There’s guidelines, even as far as rotating the tables, you know, with the ministry standards…today this table starts, tomorrow that table starts…that’s all very well and good. We still do try, but…if this resident is in the dining room and is upset and anxious, and we only have this little window of opportunity, then if she’s not table one today, that doesn’t matter. We will be feeding her right then and there, so that we’ll get that nourishment into her. I say, we feed anybody, anywhere, anytime (A14).
Table 5.2 Elements of supporting staff to provide person-centred care: Theorized effects of one element upon another in the conceptual framework

**Forming a strong team**
- Personal attributes of good communication skills and being a team player help staff *work together*.
- Personal attributes such as empathy and good communication skills can help staff and volunteers on the team *know the residents’* needs and preferences.
- Personal attributes of enjoying dementia care and desiring to learn can help staff and volunteers to build up their mental *toolbox of strategies*.
- Personal attributes of being calm and able to adjust one’s routine based on the resident’s needs provides *flexibility to optimize care*.
- Involving family members and volunteers in mealtimes helps free up more time for staff to spend with other residents. Decreasing time constraints creates more *flexibility to optimize care*.

**Working together to provide care**
- To help *form a strong team*, dietary and nursing staff may need to work with a volunteer coordinator from another department to recruit and train volunteers to help at mealtimes. Long term care homes also may need to work with community organizations to actively recruit mealtimes. They also need to work with family members to encourage and equip them to take part and help at mealtimes.
- As care providers share information and problem-solve with one another regarding residents’ needs and preferences, it helps them come to *know the residents* better.
- As care providers share information and problem-solve with one another about how to respond to residents’ needs and behaviour, it helps expand their mental *toolbox of strategies*.
- Lending a hand (i.e. helping a co-worker, or having staff from other departments come to assist at mealtimes), helps decrease time constraints and creates more *flexibility to optimize care*.

**Enabling staff to know the residents better**
- Knowing what works to address the needs of one resident might be useful to address the needs of other residents. Thus, what care providers learn about the residents can help expand their mental *toolbox of strategies*.

**Equipping staff with a toolbox of strategies**
- Care providers often learn about the residents through experience, using a trial and error approach. Thus, having a good mental toolbox of strategies to draw upon can help staff get to *know the residents* better.
- Strategies used to help a resident one day may not work the next day, or even from meal to meal. Knowing many possible strategies to try helps create *flexibility to optimize care* because staff are better prepared to tailor their approach to residents’ changing needs and preferences.
Creating flexibility to optimize care

- Having flexibility within one’s job description and work routine enables staff to work together better, lending a hand as needed and taking time to share information and problem-solve together.

- Care providers need to expect change over time in residents’ needs and preferences, especially as cognitive impairment advances. Keeping care plans and food preference lists flexible through continual monitoring and updating helps staff stay informed and know the residents better.

- Keeping options open (i.e. having a variety of foods accessible to staff for the residents, and the ability to bend rules and routines as needed) helps expand the number of feasible ideas to try within one’s toolbox of strategies.

As Table 5.2 shows, there are many relationships between the elements of the conceptual framework developed through this study. At this point, I hesitate to claim that certain elements are more important than others; I think that all are equally necessary for person-centred mealtime care. As will be shown in the next section, all five elements are needed to help staff avoid personal detractors and use personal enhancing actions described by Brooker (2007).

Table 5.2 reveals that forming a strong team, working together to provide care, and having flexibility to optimize care seem to have the most direct influence upon the other elements of the framework. These three elements are all needed in order for staff to know the residents and be equipped with a toolbox of strategies; thus, they may be considered top priorities to pursue from an organizational or leadership perspective. For example, if the organization’s primary goal is for staff to work more closely together (by sharing information and ideas), this is conducive to helping staff know the residents better and increasing their mental toolbox of strategies.

There are some similarities between the five elements I have identified and concepts found in the Framework for Person-Centred Nursing developed by McCormack & McCance (2006). The prerequisite attributes of staff identified in their framework are
akin to desired qualities of staff identified in the element of *forming a strong team*.

*Working together to provide care* has similarities to the concepts of shared decision-making, effective staff relationships, and power sharing, which are considered essential aspects of the care environment in the Framework for Person-Centred Nursing. *Flexibility to optimize care* is somewhat similar to the potential for innovation and risk taking, which is another essential aspect of the care environment in their framework.

*Enabling staff to know the residents better* and *equipping staff with a toolbox of strategies* are not represented as clearly within the Framework for Person-Centred Nursing. The types of knowledge needed in one’s mental toolbox may fit best under the prerequisite attribute of professional competence in this framework. Working with the patient’s (or resident’s) beliefs and values and providing holistic care are two of the person-centred care processes identified in the Framework for Person-Centred Nursing. Theoretically, these processes seem dependent upon the elements of *knowing the residents* and having a *toolbox of strategies* found in the current study.

### 5.1.2 Overview of the study findings to be presented

Section 5.2 of the findings will primarily address my first study objective – to describe current implementation of person-centred mealtime care. For each home, a selected example of one strength and one area for improvement in each of the following areas will be examined: providing choices and preferences, supporting independence, promoting the social side of eating, and showing respect. The selected examples of strengths and areas for improvement will be linked back to specific personal enhancers and personal detractors outlined by Brooker (2007) to help explain what the findings mean in terms of providing person-centred care. Reasons for the identified strengths and
areas for improvement will be further explained in terms of the elements of the conceptual framework for supporting staff to provide person-centred mealtime care shown in Figure 5.1.

Section 5.3 of the findings will more fully address the second and third study objectives – to explain what influences implementation of person-centred mealtime care and identify practical steps for improvement. The study set out to determine influences at the individual, team, and organizational levels. My focus in the presentation of the findings will be on the organizational (leadership) level influences of hiring point of care staff, educating and training staff, developing a culture of good teamwork, and involving family members and volunteers at mealtimes. Elements of the conceptual framework shown in Figure 5.1 will be integral to my explanation of these findings. I will also draw connections to aspects of the Framework for Person-Centred Nursing in this section.

My decision to frame the findings from an organizational or leadership level perspective was purely pragmatic. It seemed to be a more succinct and practical approach for examining influences on mealtime care than addressing these influences separately at the individual, team, and organizational levels. For example, important personal attributes clearly appeared in the data but rather than presenting them as individual level influences and referring to them again at the organizational level from the perspective of hiring staff, they will simply be covered under the topic of hiring. Team level influences also were clearly seen in the data, but what happens at the team level is strongly driven by personal attributes of staff at the individual level, and team processes structured at the organizational or leadership level. Thus, I think it is most practical to address them from the perspective of what leaders can do at the
organizational level, particularly regarding development of a culture of good teamwork. Team level influences will also appear in relation to educating and training staff, and involving family members and volunteers at mealtimes.
5.2 SELECTED EXAMPLES OF STRENGTHS AND AREAS FOR IMPROVEMENT

This study revealed numerous strengths and areas for improvement in implementation of person-centred mealtime care; the aim of this section is to describe and explain selected examples from each participating home. In this section, one strength and one area for improvement from each long term care home will be examined for each aspect of person-centred mealtime care identified prior to the study: providing choices and preferences, supporting independence, promoting the social side of eating, and showing respect. To help explain what each strength and area for improvement means in terms of providing person-centred care, specific personal enhancing and personal detracting actions based on the work of Brooker (2007) will be identified and underlined (i.e. enabling or disempowerment) (see Tables 2.1 and 2.2, p. 8-9). To better understand what contributed to these strengths and areas for improvement, elements of the conceptual framework I developed through this study will be identified and italicized (i.e. forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care).

Selecting the examples to present in this section was a subjective process based on two key considerations: 1) I aimed to select strengths or areas for improvement that uniquely stood out to me about each particular long term care home. 2) In some cases, I chose to highlight a particularly good quote from one of the long term care homes about a strength or area for improvement that was common to other facilities. Having been well immersed in the data for a long period, I was quite familiar with the interviews, and that helped me greatly with this highly subjective process.
5.2.1 Providing choices and preferences

Home A – Providing choices and preferences

A notable strength among the participating point of care staff at Home A was their ability to clearly articulate strategies that they used at mealtimes to provide residents with choices and preferences. For example, a direct care provider said:

...when I go around with the tea and coffee, I know what everyone takes. Margaret – I know she likes tea with cream and two sugar, but I will approach her. I always address her by her name. And look – you know, you look directly at a person. You have that interaction with them. ‘Would you like a cup of tea today, Margaret?’ ‘Yes I’d love a cup of tea.’ ‘Do you like cream and sugar in your tea?’ And that prompts them...they’re thinking, ‘Do I like cream and sugar?’ Or a lot of times residents – you can tell when you’re asking them – they’re not quite sure, ‘Is this lunch or breakfast?’ [So I say], ‘You usually like a cup of tea at lunch time, Margaret. Would you like one today?’ ‘Ah, yes I would.’ (A6)

This care provider’s description of her interaction with the resident demonstrates that her words and actions were carried out with thoughtful intent to involve the resident in making choices. The personal enhancing action of enabling the resident to express her choice is an example of person-centred care. To explain the intentionality behind her actions, the first point to note is that she knew the residents well. She was familiar with their preferences because she worked consistently on the same unit, and a list of each resident’s food likes and dislikes was readily available in the servery for her reference. Second, she was well equipped with strategies to help residents with cognitive impairment to participate in decision-making. She skillfully prompted the resident with her gentle guiding questions to indicate what she would like to drink. Other point of care staff at Home A were similarly able to share many specific ways they helped the residents to make choices.
A common challenge that participants at Home A described, with regard to providing choices and preferences, was offering choices to residents on pureed diets. Regardless of a resident’s diet texture, the staff used sample plates of the regular texture menu options to help residents make their food choices. Thus, some residents on pureed diets felt disappointed when they received their food; as one point of care worker explained, “They get a little upset, because it doesn’t look like what you’ve shown them” (A7). When asked how she handled this, the staff member said:

Just explain to them this is what they [need]…because of their chewing ability or their swallowing. Like, ‘Henry, you really can’t chew that, so this is much easier for you to swallow.’ And he’ll agree. The one thing he really dislikes is pureed bread. He says, ‘Could you just give me bread?’ ‘No I’m sorry Henry. We don’t want you to choke on us.’ So they’re trying – I noticed yesterday, they’re trying with the pureed bread to maybe put Cheez Whiz on top of it, or a jam or something just to give it a little bit more flavor (A7).

This worker’s response showed she probably did the best she could in a difficult situation. She showed some warmth toward the resident as she recognized his feelings and took time to explain why his food was pureed. If residents were upset and cognitively unable to understand such an explanation, she had the flexibility to offer the choices verbally instead of using the show plates. As a point of care worker, she had no power to provide a regular slice of bread for the resident as requested; this was not acceptable for a resident on a pureed diet. She and her team handled it to the best of their ability with some creativity in the servery to improve the flavor of the bland puree.

Although the staff did what they could, this example brings to light a form of imposition where the resident has been denied choice, which is a personal detractor. This is a delicate issue because it involves resident safety and liability due to the risk of choking; yet the risk of offering a slice of bread may be relatively small. Making special
provisions like this was possible, but first the resident would need to be reassessed by the dietitian and the care plan updated giving approval for these exceptions. While this process allows for flexibility in special diets, it’s important to evaluate how quickly staff are able to bring this flexibility into effect. Important questions to consider are whether or not point of care staff immediately put in a request for the dietitian to look into these issues as they arise, and how long it takes until the dietitian can do so. In many long term care homes, dietitians are not full-time employees.

Processes are needed to ensure careful initial assessments take place to know the residents’ individual needs and honour their informed choices. Mealtimes could be made more person-centred by increasing collaboration with residents in decision-making about their diet as long as they are cognitively able to do so. Policies are needed that allow for staff to give residents foods not on their diet list when they are requested, detailing how to inform the resident of the risks and manage these risks. When a resident can no longer make these decisions, ongoing consultation and collaboration with his or her substitute decision-maker and point of care staff who know the resident well are essential to maintain person-centred mealtime care.

Home B – Providing choices and preferences

A particular strength at Home B, with respect to providing choices and preferences, was the opportunity for the cook to regularly interact with the more cognitively able residents at mealtimes while portioning food at the servery and cleaning up afterward. Residents would come by and tell her what they liked or didn’t like about the meal, and sometimes they made suggestions for the menu:

…they’ll say, ‘Oh we haven’t had muffins in a couple of days and I’d really like to have muffins tomorrow morning for breakfast,’ or that sort of thing. Usually
we’ll try to do that the best that we can. If we have the time we’ll bake them the muffins or we’ll do that sort of thing. It’s nice that we do have a little bit of leeway there with the menu, because a lot times you’ll go to get something out of the freezer and it’s not there anyways, so we have to improvise. So we’ll just improvise with something we know they like, like bran muffins or something like that and make them something special (B8).

Including residents by listening and responding to their menu requests is a personal enhancing action. In Home B, having the cook be present at mealtime and empowering her to make small menu changes based on requests and known preferences gave the necessary flexibility for care to be more person-centred. In accordance with ministry standards, each home had a resident food committee to provide feedback on the menu and make special requests, but having regular opportunities for the cook to interact with residents at mealtimes could be more effective. It enabled the cook at Home B to know the residents better, and more residents could have their opinions and suggestions heard directly.

An area for improvement at Home B was hearing from residents with more advanced cognitive impairment. When asked to describe how they provide choices and preferences, point of care staff at Home B had few specific strategies to share. Rather, they tended to make comments such as:

So we have two choices [at mealtimes] – there’s always the main and the alternate. We tend to only ask people that actually can respond to it. We’re supposed to ask everybody, but you know… [a shy laugh]. So we have a couple of tables where we ask, because those are the people that can respond in any way that makes sense (B3).

Certainly there are times when residents need the staff to make food choices for them, particularly if they tend to become more confused or agitated when shown their options. Since I did not conduct formal observations in this study, I cannot say with clarity whether residents who could indicate their choice did not have this opportunity, but there
may have been such cases of disempowerment. What was apparent is that staff at Homes B and D shared few strategies for helping residents to make choices in comparison to staff at Homes A and C. Participating point of care staff at Homes A and C worked in special dementia care units where they developed a large repertoire of strategies by experience, sharing ideas with coworkers, and receiving special in-service training on dementia care. Staff at Homes B and D provided care for residents with a much wider range of cognitive and physical abilities. Care providers in all long term care homes need a good toolbox of strategies to draw upon because the more strategies they possess within their consciousness, the more intentional and person-centred their approach can be for the residents.

**Home C – Providing choices and preferences**

In the following excerpt from an interview with a direct care provider from Home C, the participant described how she provided choices and preferences for the residents in her care:

> So we always ask them, and…some of them are not always able to tell us what they want. But if you hold the [sample] plates in front of them long enough and you talk to them about it, they kind of look at one longer than the other, so you sort of know what’s catching their eye…then if you start to feed them, and you see that they’re not liking it, we always go and get the second choice. And then as—as full-timers, we try to keep an eye on that. So maybe John didn’t like the fish the last time – we might try it again if he’s telling us that he wants it. But if he goes to eat it and he’s showing us the face of ‘I don’t like that,’ then we kind of know and make notes of stuff like that, right? So that people don’t try to force him to eat this fish. (I: So making mental notes? Or do you write those things down?) No, we write a lot of the stuff down. We talk to our co-workers about it as much as we can so that everybody’s on the same page (C3).

Acknowledging each resident’s preferences and enabling them to take part in making food choices as long as possible are personal enhancing actions. Looking carefully at this example, the first key to this worker’s person-centred approach was that she knew
strategies to figure out what the resident would like. Even if he couldn’t verbalize his choice, she knew to watch the resident’s eyes and body language. Having flexibility to meet his needs was the second key – she could easily go and offer the second menu option if needed. The third key was that she and the other staff gave attention to the resident’s eating patterns so they could learn his food likes and dislikes and know the resident better. She wisely recognized it takes time to see a pattern because a resident’s food preferences can change. Just because John didn’t like fish one day didn’t mean it should never be offered again. Finally, a closely related key was that the staff worked together well, making notes for each other because they had a common goal of learning as much as they could about the residents.

An area for improvement at Home C was ensuring that residents received what they wanted each time, in spite of time pressures faced by staff. Even when workers tried their best, there were times when the demands were so high that they left some things undone:

I know some residents who love coffee, but some days, I don’t have time to give them their coffee. I try my hardest—like I get 80%...I work fulltime…I’m ten days every two weeks. Maybe eight days I’ll give coffee, two days I won’t. So I try but it’s just—it’s hard. ‘Cause you get residents getting up, leaving, and you’re calling them to come back to sit down, and you get ones yelling, and the other ones are getting aggravated because—it’s like a chain reaction—once one starts, [whispers] they all start. That’s what I find challenging, not enough hands (C4). Participants said that some staff were so stressed and anxious to get all the work done that sometimes they ignored residents’ desires such as having their dinner roll heated or adding mustard to a sandwich. Ignoring residents’ requests or known preferences is not just a sign of poor service, but is a personal detractor. To address such problems, long term care homes need to work at forming a strong team with staff who are able to be
calm and *flexible* with their routine even under pressure, and encourage family members and volunteers to help so more time can be spent with individual residents.

**Home D – Providing choices and preferences**

Home D had the challenge of planning and preparing meals to suit the preferences of a very culturally diverse resident population. Most residents were Chinese, but there were also residents who had immigrated from other countries and some who had lived in Canada for a long time. To accommodate varied food preferences, Home D went beyond the MOHLTC regulations of providing two menu choices; they regularly offered three menu options, one always being a Chinese meal. Having three options available at each meal (and sandwiches as a fourth option) helped create *flexibility* for point of care staff to offer foods that the residents liked.

Point of care staff were also careful not to make assumptions about the residents’ food preferences based on their ethnicity. For example, a direct care provider said:

So by working with these residents every day, you sort of have an idea what their likes and dislikes are. So sometimes we know that, like Mrs. C, she don’t, even though she’s Chinese – sometimes, not all Chinese [residents] like the congee (savory rice porridge) – so we know that she don’t like congee, she likes soup. It’s just like rice, you know – we know the residents who would prefer mashed potatoes even though they’re Chinese (D2).

Staff at Home D **acknowledged** individual differences in preferences, which is a personal enhancing action. The key was that they *knew the residents* because they worked with them consistently. Also, as staff went from table to table with the menu options, they could quickly and easily refer to a basic list of each resident’s food preferences; it was included on the sheet that they used to write down the orders.

The most common difficulty that staff at Home D reported regarding providing choices and preferences was serving beverages that the residents would like to drink. In
accordance with MOHLTC regulations to meet fluid needs and the menu planning
requirements of Canada’s Food Guide, the residents were regularly served milk, fruit
juice, and water at mealtimes. However, cold beverages were not culturally appropriate
for the Chinese residents:

…it’s a waste, like you can see. You can see in all the tables almost all the juice
are there [untouched] because they think it’s very cold for them and they don’t
like to get sick. They say, “No, I gonna get sick with that cold juice” (D12).

The food service department provided tea, hot water, and hot milk, which were
acceptable beverages for the Chinese residents. Yet, the residents were also
automatically still served the cold beverages at the start of the meal. An indirect care
provider explained, “But we insist because it’s a ministry standard that you need to
provide – you need to push the fluids so that they won’t be dehydrated. But then, it’s also
a waste” (D10). Many staff considered this to be a waste of time and money. Moreover,
constantly providing beverages that the residents don’t want is a form of imposition,
where residents are denied choice. Another problem that some point of care staff noted
was that sometimes the hot milk was not available, so they improvised by adding a little
hot water to the residents’ cold milk. There was clear room for improvement on this
issue in the eyes of participating staff; having more flexibility in the menu planning
policies and available options would help make mealtimes more person-centred.
5.2.2 Supporting independence

Home A – Supporting independence

Staff at Home A were good at finding ways to keep residents as involved and independent as possible in feeding themselves at mealtimes. For example, a direct care provider said:

We have one lady…I set her up with the utensil to eat. But I also offer bites in between, because she has a lot of difficulty getting the food on the fork, or, she’ll pick it up with her hands. But she likes to do it herself. So, if I help give her alternate bites, at least, you know she’s getting some food, because she often doesn’t eat. So, it’s sort of a teamwork thing (A5).

This care provider’s teamwork approach with the resident demonstrates the personal enhancing action of collaboration because she treated the resident as an equal partner in her care. One key to her person-centred approach was that she knew the resident well by working with her consistently, listening to her, and carefully observing her patterns of behaviour at mealtimes. She facilitated the resident’s independence by assessing and providing the level of assistance that the resident needed and wanted. Staff at Home A were very attuned to the fact that residents’ abilities at mealtimes can change from day to day and even from meal to meal. They were equipped with a toolbox of strategies to make eating a little easier for residents, and they knew how to provide verbal, visual, and physical cueing and assistance as needed.

Interestingly, one thing at Home A that sometimes limited the extent to which staff supported residents’ independence was differences among staff in their personal views on eating etiquette. Participating point of care staff at Home A made comments like:

My thing is – even if the resident uses their hands to pick up their potato and bite it and put it back down, that’s cool with me. They’re doing it themselves…Does it matter? No one else notices. She’s enjoying her meal. Leave her be, you
...But I can see it’s driving [other staff] nuts. You know, I can see that it’s like, ‘[Teeth clenched] If it was my mother I wouldn’t let her do that!’ Well, it’s not your mother, and let her do it (A11).

If a resident wants to eat with his or her hands, denying that opportunity because it creates a mess or is considered improper is an example of disempowerment, which is a personal detractor. On the other hand, if the resident prefers to be fed by someone because he or she would feel embarrassed or uncomfortable about making a mess and not using a proper utensil, then it is important to provide the desired level of assistance. The main point is to be flexible, responding according to the resident’s point of view, rather than imposing one’s own idea of what is acceptable eating behaviour. Viewpoints of the resident’s tablemates also need to be kept in mind; staff need to ensure that residents are seated with others who accept them regardless of how they eat. It is important to know the residents well, so that each one will receive an appropriate level of assistance and feel comfortable around his or her tablemates.

**Home B – Supporting independence**

Enabling is the personal enhancing action of giving residents the opportunity to do what they can for themselves. Facilitation is another personal enhancing action where staff carefully assess residents’ needs and provide the necessary level of assistance to maintain as much independence as possible. Enabling and facilitation were the focus of restorative care staff in all the participating long term care homes. One strength of the restorative care worker at Home B was that she regularly used a collaborative approach with the point of care staff to assess residents’ needs and develop individualized care plans. A direct care provider commented:

[The restorative care worker] is back and forth with us as far as “What have you guys noticed that’s not working?” and, “This is what I’m doing when I’m with her
one-on-one,” and, “What do you think of this and that?” So it’s constant all the time (B2).

She and the other point of care staff regularly worked closely together, consulting one another and sharing information and ideas so they would mutually know the residents better and build up their toolbox of strategies to respond to the residents’ needs for assistance.

The main challenge, however, was that time pressures made it difficult for staff to maintain interventions to support residents’ independence. This was a problem not only in Home B, but also in the other participating homes. A direct care provider commented:

…if they’re dawdling, we have to help them. Do you know what I mean? Hurry them up just a little bit. So…we do try and do what we can to make sure they’re eating [by] themselves and that kind of thing. But if we’re running low on time then we have to take over (B3).

Taking over and starting to feed residents who would be capable of doing more for themselves is a personal detractor. This action disempowers residents from using their abilities, specifically by outpacing them; they can’t keep up to the expectations of the schedule that the staff feel obligated to keep at mealtimes. What is required is more flexibility in the mealtime routine, where residents can take extra time as needed to complete their meal at their own pace. The difficulty was that staff felt the weight of having many other responsibilities to complete after the meal before their shift ended.

Working together by lending a hand to one’s coworkers as needed is a partial solution. Staff also need to be assured that certain responsibilities which are lower priority can be completed later in the day or by those coming on to work the next shift if necessary. Leaders have an important role in critically examining staff responsibilities and schedules and reassigning tasks as needed to make sure that a relaxed pace is
maintained for residents at mealtimes. What also is deeply needed is to form a strong team by encouraging family members and volunteers to take part and assist at mealtimes, increasing one-on-one time that can be spent with residents.

**Home C – Supporting independence**

A particular strength of the restorative care program at Home C was that staff assessed and worked with residents at their usual seat in the dining room. In contrast, restorative care workers at Homes A and B took a small group of residents to another quiet room at mealtimes to assess their needs and work with them. Keeping residents with their usual tablemates may help maintain a sense of belonging, in which case this could be considered a personal enhancing approach. Certainly, a close sense of belonging could also be established in the relative intimacy of a small group eating in a separate room with the restorative care worker. However, this arrangement is only temporary and not for all meals, so it may end up being more disruptive from the perspective of some residents with dementia.

A direct care provider at Home C explained another aspect of the rationale for keeping residents at their usual table when the restorative care worker is with them:

> We do [restorative care] right in the dining room…So every variable is there. ‘Cause sometimes, people that are on a restorative dining program – sometimes the intervention only consists of having that person face the opposite direction, right? So you’d never catch that if you took that person out of that element, and then just try to figure it out (C8).

Sometimes problems with residents’ self-feeding abilities were related to distractions in their eating environment. At Home C, keeping residents in the dining room was helpful for restorative care workers to make an accurate assessment of needs for assistance versus issues that could be addressed in other ways. With regards to person-centred care,
keeping residents with their usual table mates helped staff with the personal enhancing action of facilitation; it positioned them well to make an accurate assessment of needs and appropriate strategies to support independence. It helped restorative care staff to know the residents better, giving a more complete picture of their needs in their everyday environment. At the same time, they were able to mention tips to the other staff and model how to help the residents. Thus, by working together closely with restorative care staff on a daily basis, point of care workers also grew in their knowledge of the residents and were equipped with strategies to support independence to make care more person-centred.

Like all other participating long term care homes, however, Home C was not always successful in continuing to implement strategies that were initiated by restorative care staff at mealtimes. One potential reason for this was that staff had a hard time remembering what each resident needed because they assisted many different residents when they worked. A direct care provider explained:

…we have found that a lot of times, the restorative programming, when it gets handed over to the PSWs, kind of falls off the wayside, because there isn’t a consistency, right? …So what we are proposing at this time is to assign staff to particular tables, ‘cause it does promote consistency. The resident gets comfortable with that person. They don’t have a different person with them every day. And the staff grow in their ability to do restorative dining programs, if they’re doing it consistently with that person. That’s something that we’re looking into (C8).

Without a good knowledge of what types of cueing, encouragement, and assistance are needed for each resident, there is a greater likelihood of disempowering residents, which is a personal detractor. Having staff work consistently with the same residents would help them know the residents better. When asked what would make it challenging to implement more consistency, the participant said, “Well, what would make it challenging
is we don’t have enough staff, because you can’t just stay at one table. Yeah…I’m not too sure about the challenges yet, because we haven’t actually done it” (C8).

In situations with limited staffing, it is important that assignments to help residents at particular tables do not become too strict. Residents’ needs are best met when the staff help each other, working together to monitor and assist all residents in the unit. PSWs in all the participating long term care homes needed to spend most of their time assisting residents who required full assistance. To the credit of staff at Home C, they often managed to keep an eye on the residents who were more independent and provide some cueing and assistance as needed by taking some responsibility to help any resident in need. Long term care homes need to retain this flexibility to optimize care, especially when needs are high and staff are few. The best solution is to form a strong team with family members and volunteers present so that more time and attention can be given to all residents at mealtimes.

**Home D – Supporting independence**

In all four participating homes, restorative care programs were integral to supporting the residents’ independence at mealtimes. Home D was different from the other homes in that whenever residents were referred to restorative care, an occupational therapist always conducted the resident assessment and care planning rather than the restorative care workers. The occupational therapist directed the restorative care staff regarding the goals and interventions to implement for each resident. Residents stayed at their usual seats in the dining room, similar to Home C, to help maintain a sense of belonging with their tablemates. Restorative care staff each typically worked closely with four residents at any given mealtime. However, since they were always in the
dining room at mealtimes, they also helped out by looking table to table and giving some encouragement and cueing to other residents as needed. An indirect care provider explained, “They help beyond the four people. If there’s those residents they know that just need that simple cue, they’ll go around, because they float the dining room, right” (D4). In this way, they were able to lend a hand to the PSWs who needed to focus more of their attention on assisting residents who needed full assistance. Furthermore, as they worked together with the point of care staff in the dining room, restorative care workers had an ongoing role in the personal enhancing actions of enabling and facilitating self-feeding.

If aspects of the care plan weren’t working very well for a resident, the restorative care staff would consult the occupational therapist. An indirect care provider explained:

…if they need to adjust something equipment-wise, or how they’re maybe training or teaching [a resident] something, or whether or not the goal’s realistic. Maybe we need to change the goal a bit, you know... And then they’ll talk to the occupational therapist and get a little bit more information (D4).

In the other participating homes where the restorative care worker had a greater role in assessing residents’ needs and care planning, discussions like this about goals and trying different strategies would more often take place with the PSWs and dietary staff. An interesting finding was that the point of care staff at Home D did not seem to be quite as well informed and on board with restorative dining interventions, and it might be because there was less direct consultation and information sharing between them and the restorative care workers. There was also an expressed need for more in-service training for point of care staff on supporting residents’ independence.

In-service training and more regular discussions between the restorative care workers and other point of care staff would help them get on the same page as they
worked together. A direct care provider said, “First of all we have to be aware, and then we have to be on the same ground – where we should aim. [I: What’s the goal?] What the goal is. So is it to improve their independence? Or to…get…[enough] nutritious food?” (D3) PSWs were concerned about maximizing the amount of food residents consumed whereas restorative care staff focused on maximizing independence. As staff mutually grow in knowledge of each resident’s needs and develop their toolbox of strategies, they can better enable and facilitate independence while promoting good food intake.
5.2.3 Promoting the social side of eating

Home A – Promoting the social side of eating

Staff at Home A tried their very best to make sure that each resident had a place to sit in the dining room that well suited his or her social capabilities, needs, and preferences. They recognized that some residents desired to sit at a table without others and made accommodations for this, while also making sure that those residents did not feel isolated. For example, a direct care provider said:

Another lady just really doesn’t like to socialize with anybody, and when you put her at a table she won’t eat with anybody. She doesn’t want anything to do with them. But you put her at a table by herself, close to where the staff are that she’s familiar with, and she just eats away. She sits just in front of the servery, and she always does this – she always looks behind to see and make sure that the staff are back there keeping an eye on her, and she’s quite content. Yeah, so even though they sit by themselves, they’re not by themselves. There’s always somebody that goes by and chats with them or they can observe what’s going on around them (A4).

Acknowledging this resident’s preference to eat at her own table is an example of a personal enhancing action; the staff recognized, accepted, and supported her uniqueness. They also seated her strategically by the servery near familiar staff, where she felt a sense of belonging.

This person-centred approach stemmed from knowing the resident well – the staff understood what made her happiest because they carefully observed her behaviour and worked together, regularly sharing what they learned with each other. The staff at Home A were particularly flexible with the seating arrangement. Although they tried to keep it fairly consistent, when necessary they tried out different ideas of where to seat residents so they would be more content and enjoy their meals better. It may be helpful to think of residents’ social needs and ways of meeting them on a continuum; there are always ways
to promote the social side of eating, but it does not always mean seating residents
together for social interaction. Staff at Home A were well attuned to the differences
among residents in their social needs and had creative ways of meeting them.

The greatest ongoing challenge that staff at Home A described regarding the
social side of eating was the tendency to talk to each other at the table, leaving residents
out of the conversation. For example, a direct care provider said:

...really, it is better when staff don’t, you know, within the table talk to each
other—or say if I’m sitting here, and there’s another table [nearby], that happens,
that talking...Because you know when [the registered nurse] walks in the door, it
stops. And it’s funny, like, sometimes, depending on the [RPN] that’s on – like,
the nurse giving meds – depends when that [talking] happens or not. And
sometimes one nurse will say something about it, and then sometimes she won’t; I
think it just depends what mood she’s in, or how she’s feeling. It’s hard not to do
it, but…it’s better not to, obviously (A17).

Ignoring or leaving residents out of conversation while talking to fellow staff members is
a personal detractor. It’s not that point of care workers should avoid talking with each
other while assisting residents. In fact, talking with other staff at the table can be a way
of promoting the social side of eating if residents are enjoying listening to the
conversation. Workers just need to make sure that the topic is of interest to the residents
(i.e. stories about their pets) and make efforts to involve the residents in the conversation
by asking simple questions like, “Mary, you used to have a dog too, didn’t you?”

Supervisors have an important ongoing role in coaching and reminding staff to
include residents in conversation. Thus, part of the solution is working together through
regular supervision in the dining room by effective leaders. Not including residents in
conversation was a problem in all participating homes, and point of care staff were well
aware that they should avoid this. However, they acknowledged that it was a continual
challenge and regular reminders were helpful.
Home B – Promoting the social side of eating

Staff at Home B shared many topics of conversation that they often had with residents as they assisted them at the table. For example a direct care provider said:

I say for instance, ‘Oh pasta is my favourite. Did you always like to have pasta?’ …Like especially Italians – we have a fair share of Italians. And when I see pasta, I always think Italian right? So…I’ll say, ‘Did you used to make your own pasta?’ And then it revolves into, ‘My husband and I use to make this sauce,’ and then it would relate to… ‘we made our own pasta,’ and then it would come to their husbands and we’d be talking about the husbands (B1).

Having pleasant conversation with residents while serving and providing assistance at mealtimes promotes a sense of belonging, which is a personal enhancer. Staff at Home B also talked about using gentle humour as they interacted with residents at mealtimes, and having fun together in this way is also personally enhancing for residents. Knowing each resident’s interests and personality helped the staff connect with the residents at mealtimes, especially when residents had limited abilities to carry on conversation verbally. Staff knew a good repertoire of strategies to make conversation, even when it was primarily one-sided.

A big challenge that staff at Home B faced in promoting the social side of eating was the time pressure that they felt at mealtimes. For example, when asked if she chatted with the residents while serving them their food and beverages, a point of care worker responded:

A little bit, yeah, but I can do it just for supper time…because lunch time is really busy, oh dear! Yeah. [I: How come there’s a difference? What makes supper time different for you compared to lunch?] Maybe because it’s – we come in at ten o’clock, and then it’s just bam, bam, bam. It’s, it’s the lack of time. Maybe if we start a little bit early, you know? But…we start at ten, we serve the snack, we do some other stuff, and then we serve lunch, and it’s just rush, rush (B6).
She thought that coming in to work even a half hour earlier would be helpful. When staff are rushing to serve residents at mealtimes, there is potential for more personal detracting actions including outpacing by talking too fast or objectification where residents are served rather robotically without personal acknowledgment.

To prevent this, it is vital to form a strong team with staff who are calm and flexible with their schedule in the face of time pressures, and include family members and volunteers who are available to help. Working together by involving staff of other departments such as recreation, or having those in leadership positions take turns helping in the dining room can also help meet this need. Leaders also need to coach staff to reprioritize aspects of their work routine as needed to increase flexibility in the schedule and take time to promote the social side of eating.

**Home C – Promoting the social side of eating**

One strength at Home C was that point of care staff were involved in discussions about the dining room seating arrangement when changes seemed necessary. An indirect care provider explained:

*Usually, it’s the PSWs are complaining that somebody isn’t getting along with someone else [at the table]. And then they talk to the RN, and then they have a discussion: …Who do you think that they would get along with… You know, do these two people sit together in the living room? Are they friends? Maybe we should put those two people together and *these* two people really are very reactive to each other and these people are sort of neutral. We could put them with them. So there’s a discussion, and then they pass on their discussion – or their decision – to the food service manager. And she puts it onto the…dining room seating plan (C6).*

Thinking carefully about who would be good tablemates is a personal enhancing action because the aim is to create a sense of belonging for each resident and avoid discord. This requires knowing the residents well, including their personalities, their abilities to
participate in conversation, their table etiquette, and their needs for assistance. It also requires the flexibility to make changes in the dining room seating arrangement based on such knowledge, even having opportunity to trial suggested changes to see if they work well for the residents. Working together is also key; through discussion, point of care staff are empowered to make care more person-centred by sharing their knowledge of the residents with each other and having direct input to create the best seating arrangement for the residents that they can.

An area for improvement in promoting the social side of eating at Home C was making conversation with residents with dementia. Experienced staff who took part in interviews for this study were able to share many examples of types of conversations they had with the residents at mealtimes. However, some point of care workers were likely less experienced or not as naturally adept at this. An indirect care provider commented, “You can do a lot of socializing through reminiscing. And [residents] feel very comfortable and very normalized. But I have to admit – I think that’s probably our weakest area of care” (C6). When pleasant verbal or nonverbal interactions are missing at mealtimes, residents are served or fed rather robotically and objectified. They also may be ignored as staff are tempted to talk with each other rather than including the residents. Such actions are personal detractors which can be prevented by having a good mental toolbox of strategies for conversing or interacting with residents with dementia. Knowing the residents, including some of their life history and interests also helps to make conversation. Education and training on socializing with residents with cognitive impairment is important, but it is also helpful for leaders to form a strong team by hiring
staff for dementia care units who genuinely enjoy interacting with the residents regardless of their cognitive ability.

**Home D – Promoting the social side of eating**

At Home D, a barrier to the social side of mealtimes was that not all staff spoke the residents’ language. In light of this, it was a strength to have residents’ family members present at mealtimes because they not only assisted their loved ones and talked with them but also translated to help the staff and residents communicate. Likewise, staff who spoke the residents’ language were always willing to help translate for their coworkers as needed. Another strength is that when point of care staff did not speak the same language as the residents they were assisting, they recognized the significance of just being there and communicating through facial expressions. A direct care provider said, “We all smile the same way. We all smile…we understand that language, right” (D12). Some staff even learned a few simple words and phrases in Cantonese such as how to say, “Time to eat!” Showing **warmth** through facial expressions and learning some of the resident’s language is a personal enhancer. Whether it is a language barrier, hearing impairment, or advanced cognitive impairment that makes mealtime conversation difficult, the key is for staff to know **strategies** to still make meaningful connections. Just being there and being attentive, with kind and understanding facial expressions while serving and assisting residents makes mealtime care more person-centred.

An area for improvement at Home D was that development of the dining room seating plan was more rule-centred than person-centred, and point of care staff had relatively little input on it. The seating was arranged by the dietary manager, following the general rule that when a resident passed away or moved to another part of the home,
the next new resident filled the vacated seat. Practical seat switches were sometimes made so that those who needed more assistance and those who used wheelchairs were not positioned next to the wall. A perceived benefit of following the general rule for the seating plan was that residents with dementia were mixed in with those who were more cognitively able to carry on conversation. Idealistically, this would create a sense of belonging and inclusion which are personal enhancers for residents with dementia. However, sometimes this approach led to situations where residents with advanced cognitive impairment would spill their juice or kick others under the table, making mealtimes less pleasant for their tablemates who did not have dementia. Furthermore, the desired sense of belonging was not well achieved, and could even have resulted in stigmatization, a personal detractor. If the point of care staff had concerns about the seating they could talk to the charge nurse who would talk to the dietary manager to see if a change could be made. Occasionally residents were moved to another table if there were behavioural concerns, but other considerations or exceptions to the rule were relatively rare.

Not only was there limited input from point of care staff, but requests made by family members about seating were often turned down:

…visitors – they would say, ‘Oh there is an empty spot. I want my mom to be there.’ So we try to refuse those requests because all of them have rights. All of them have equal rights. Because they say, ‘Oh we’re paying.’ All of them are paying. So…we want the families to understand that even those who doesn’t have visitors, even those who are not able to express themselves, they have equal rights as them (D10).

Although this approach prevents showing favouritism and certainly simplifies decision making on the seating arrangement, it is much more rule-centred than person-centred.

Using a person-centred approach means listening and carefully considering input from
residents and their families and also seeking input from the point of care staff, especially for residents who cannot express themselves and don’t have family visiting. When each resident’s personality, needs, and preferences are thought about carefully in this manner when making seating decisions, residents are treated with equal consideration and mealtime care becomes person-centred. To create a good seating arrangement for promoting the social side of eating, staff need to know the residents, understand strategies for identifying appropriate tablemates, work together with each other and with families to make seating decisions, and have the flexibility to make changes as needed.
5.2.4 Showing respect

Home A – Showing respect

One aspect of showing respect is being able to make necessary accommodations to individualize care for residents. The policies and procedures that structure how things are generally done at mealtimes are supported by good rationale as they are all intended to ensure high quality care. Yet providing person-centred care requires an extra degree of flexibility. Home A appeared to be the strongest of the participating homes at recognizing when exceptions to the rule were appropriate. An indirect care provider explained:

…we don’t have a cookie cutter [approach], like, this is the way it is, you know? We don’t have that. There’s guidelines, even as far as rotating the tables [regarding who gets served first] – with the ministry standards…this table starts, tomorrow that table starts, tomorrow that – and so… that’s all very well and good. We still do try, but, we very much, down here, this is what my expectation is and what the dietary staff are good with – if this resident is in the dining room and is upset and anxious, and we only have this little window of opportunity [to feed her], then if she’s not table one today, that doesn’t matter. We will be feeding her right then and there, so that we’ll get that nourishment into her. I say, we feed anybody, anywhere, anytime (A14)

Making exceptions to the rule like this as needed is a personal enhancing action, where individual needs are recognized and met. Withholding an immediate response in order to comply with the policy of serving all residents according to a table rotation plan is not person-centred. In this situation, point of care staff had the flexibility to optimize care because they knew that their leaders would support them in bending the rules when they felt it was in the resident’s best interest.

One area for improvement noted at Home A, as well as the other participating homes, would be to train staff to abandon the term “feeders”. For example, a care provider said, “I have a feeder that I have to feed on this side, and a lady I have to
supervise on the other side” (A9). Why not say, “I have a lady to assist on this side and a lady to supervise on the other side”? Referring to residents who need full eating assistance as “feeders” is an example of labelling, which is a personal detractor. Use of the term “feeders” was commonplace among both the frontline and indirect care staff – it is presently embedded in long term care home culture. Not one participant made any comment about discomfort with use of the term. By comparison, staff at all homes were typically very conscientious about protecting the residents’ dignity by using terms such as “aprons” or “clothing protectors” in place of the word “bib”. Although it takes longer to say “residents who need full eating assistance” versus “feeders”, it shows respect, and helps remind us all of each resident’s personhood. It would also be just as easy to use the residents’ names. Making a change like this begins with bringing it to one’s attention. Such habits are unlikely to change overnight; staff need to work together, reminding one another to avoid labelling, and leaders have an important role in this.

**Home B – Showing respect**

Staff at all participating homes knew it was important not to rush the residents at mealtimes and felt it was disrespectful to do so, yet they faced constant time pressures. To the credit of staff at Home B, even though they rarely received any extra help from other staff in the facility or from family or volunteers, they tried very hard not to rush the residents. A point of care worker said:

…when it comes to feeding and anything else in the whole [mealtime] – I just wish there was time… I try to feed the residents to the best of my ability, and if they want to eat they eat. If they need more time I do give the time, but I find sometimes that’s been taken away somewhere else that I need to be. Do you what I mean? (B1)

Keeping a relaxed pace at mealtimes is personal enhancer for residents. Staff at Home B
were not always successful in maintaining a relaxed pace during meals, but they did what they could to achieve this goal. Their priority was to spend one-on-one time with residents as needed. The key was they were personally flexible to the extent that they could be with their schedule so that residents were not fed too quickly. Sometimes this meant a domino-effect occurred where they were late or unable to complete other tasks following the meal.

Although staff at Home B made it a priority to spend adequate time with residents who needed assistance, to compensate under the time pressure they tended to cut some corners which potentially resulted in cold food. For example, a point of care staff member commented:

> We’re technically supposed to have only one [course at a time] – like the porridge is on the table, they eat the porridge, then you go get them their second [course]. But that’s not actually...like their toast and egg is sitting on the table before they’re done their porridge. Because we don’t – you know, getting one thing at a time is not going to work, right (B3).

Certainly, cutting corners with the mealtime procedures like this decreases the quality of service. With respect to person-centred care, bringing residents’ food to the table before they are ready for it is a form of outpacing, which is a personal detractor. The root of the problem is the lack of time and lack of help to meet the demands of care. Furthermore, an important part of the solution would be to have staff from other departments ready to lend a hand and work together with the nursing and dietary staff as needed. There also needs to be a more concerted effort to encourage involvement of family members and volunteers to form a strong team with more help present in the dining room.
Another aspect of showing respect is knowing how to respond well to residents who are upset or anxious at mealtimes. A direct care provider at Home C shared the approach the staff commonly used in the dementia care units:

We have one resident that’s constantly crying, saying, “Why am I here? Where’s my family?” Like she’s very upset—it’s not her fault, it’s just her disease, obviously. But the other residents get upset with that. So if she gets too upset and is bothering too many, we bring her maybe out to the family room and sit with her and try to spend some one-on-one time with her. Our RPNs are usually okay with that because they’ll actually help us if they’re done their medications—they’ll help by going and sitting with her one-on-one or going in the dining room to help. So again, that’s a little—to me, that’s being respectful. It’s—we’re not trying to take her away from everybody else—as such; it’s just trying to give her some time alone with us and hopefully make the other residents happy as well (C3).

Holding is a term in person-centred care that refers to staying near a resident who is experiencing intense emotions, calming them in much the same way as a parent holds and calms a young child. In the example above, spending one-on-one time with this resident was a personal enhancing action; staff were “holding” her through her distress, and also maintaining a sense of belonging by staying with her. One key to their person-centred approach was that point of care staff had flexibility to optimize care, knowing that they had the option of taking the resident to another room to eat. What also contributed to this flexibility was that the RPN was willing to work together with the PSWs, lending a hand as needed. They also sometimes had extra help from recreation and restorative care staff, which made it easier to respond to needs for more one-on-one attention.

Unfortunately, the morning rush to get to breakfast on time tended to only increase anxious and agitated behaviours among the residents. This was a problem in all participating homes, but it was particularly stressful for the staff and residents at Home C. Interestingly, one of the main issues contributing to the problem was the lower staffing
level of foodservice workers at breakfast time. Only one person served both dementia
care units at breakfast, whereas each unit had their own food service worker to serve
lunch and supper. In each dementia care unit, there were three PSWs to get up
approximately twenty-five residents and bring them to the dining room. Thus, there was
a lot of work to do in a short period of time. A direct care provider explained:

We’ll have a dietary staff over on the one side. She will serve at 8:00, and then
she will come rushing over to [the other unit] to serve at 8:30. Well, the residents
that have to be in the dining room at 8:00, it’s kind of tough – certainly for
the staff. You know, when you talk about how [residents] are going to react in the
dining room and things like that. It’s certainly a little bit more of a rush than the
other side who has an extra half an hour to get people ready. That is a money
issue. That comes down to that. It would be nice if everybody had breakfast at
8:30. It gives the staff a lot more time, makes the residents feel better. Sometimes
you have those behavioural problems because that resident felt rushed in the
morning. Maybe they were rushed. And so now they’re gonna be uptight in the
dining room. They’re gonna be ticked off, and they’re gonna throw some of their
food. Now we have that happen. Sometimes that can be associated because of
how fast they had to get up and rise and shine, right? (C8)

Outpacing residents by rushing them to get ready in the morning is a personal detractor.
If they don’t wish to get up, it’s also an imposition.

This participant attributed the low staffing of foodservice workers in the morning
to cost savings. Certainly, part of the solution would be to increase spending on labor if
at all possible and form a stronger team by having one more dietary worker on shift so
the timing of breakfast would not have to be so tight. They could also try to encourage
more family members and volunteers to come help, but it’s unlikely many would come so
early in the morning. Recreation and restorative care staff at Home C often worked
together with the PSWs at mealtimes to help assist residents; perhaps they could also help
before breakfast by walking or wheeling residents to the dining room and helping them to
be seated. This would relieve some of the time pressure. Another potential solution
would be to increase the *flexibility* in when residents could have breakfast by introducing a continental breakfast option as they did at Home A.

**Home D – Showing respect**

Part of showing respect to residents is striving to create a peaceful and pleasant dining environment. Staff in all four participating homes wished that their dining rooms would be less noisy. Some residents with dementia tend to be quite loud at mealtimes and need extra one-on-one attention. The noise level also may be high due to dishes clanging, music playing, people coming and going in nearby hallways, and the voices of staff, residents, family members, and volunteers talking throughout the meal. It was especially challenging to keep noise down in the dining rooms at Home D because they were very large; one dining room, for example, seated 130 residents. An indirect care provider said:

> You don’t want it to seem like it’s a—you’re in a market. You know, and sometimes it can—it can feel like that when everybody is talking at once and trying to communicate. ‘Cause you have the residents communicating with each other and with the family members...Then you have the servers that are asking for the food also. So—and the dining room is so large that it just echoes...at times. So we got to try and...encourage the staff and...families and residents just to keep it to a minimum at mealtimes. We don’t want to discourage conversation between the residents because that’s when they get to socialize with each other and so forth, but just to keep it at a minimum so that it’s a pleasurable place to dine (D5).

Staff did their best to minimize the noise level by choosing not to play background music during mealtimes and trying not to speak too loudly to one another. To help control noise and also maintain adequate seating space, Home D also made a rule that each resident could only have one family member visiting or assisting in the dining room at mealtimes. If more than one family member wanted to come and visit during a meal, they were welcome to take the resident to the lounge or recreation room to eat instead.
Keeping the noise level down at mealtimes is an aspect of creating a relaxed pace for residents. Having too much stimulation in one’s surroundings only tends to increase anxiety and agitation, especially for residents with advanced dementia. Thus, efforts to keep the dining room peaceful and pleasant are personal enhancing actions. Two keys at Home D to making the dining room a pleasant place to eat were that staff had figured out strategies to minimize noise and were working together with each other and with family members to accomplish this.

One area for improvement in showing respect that staff at Home D pointed out was that some of the point of care workers seemed to push residents to eat more than they wanted. An indirect care provider attributed this to the cultural background and knowledge level of the staff:

…[with] these girls, you know the benchmark to measure anything is food…They think when a resident eats a whole lot of food, they good. Not necessarily. You know and this is why they have this…they force the resident sometimes…And you know, ‘Oh you must, you must.’ ‘Oh if you don’t [eat], you’re going to get sick’ – this kind of stuff (D7).

It seems that these care providers did not feel they were doing a good job unless the residents ate well. Yet, pushing residents to eat when they are not hungry is an example of imposition, a personal detractor. To simply stop assisting a resident when he or she refuses food or beverages is not the solution either, particularly if the resident has cognitive impairment. It is the care provider’s responsibility to first figure out any underlying reasons why the resident does not want to eat or drink. Perhaps the resident doesn’t like the food or is physically uncomfortable. Maybe the resident is too tired now but will eat later. Maybe the resident just needs a rest from eating for a few minutes. Perhaps the resident is full because he or she ate a lot at the previous meal. There are a
lot of things for staff to consider. Furthermore, direct care providers need to be trained to
do this detective work. One key is knowing the resident’s usual eating patterns and
another is having a mental toolbox of strategies to figure out why a resident may be
refusing food or fluids.
5.2.5 Summary

This section of the study findings has highlighted and explained selected examples of strengths and areas for improvement in the implementation of person-centred mealtime care in each of the participating long term care homes. Many personal enhancing actions were identified, but at the same time, there was also evidence of personal detractors. These findings were interpreted in relation to the conceptual framework of ways to support staff to provide person-centred care. It is evident that long term care homes need to focus on forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care. This section only skimmed the surface of the data regarding what staff can do to provide food choices and preferences, support independence, promote the social side of eating, and show respect at mealtimes. A compiled list of strategies or ways of making mealtime care more person-centred is found in Appendix B.
5.3 INFLUENCES ON IMPLEMENTATION OF PERSON-CENTRED MEALTIME CARE AND STEPS FOR IMPROVEMENT

This section of the study findings will address the research objectives of explaining what influences implementation of person-centred mealtime care and identifying practical steps for improvement. Although influences at the individual, team, and organizational levels have been identified, individual and team level influences will be reframed in terms of what needs to be considered at the organizational or leadership level. Specifically, this section will examine lessons from the data regarding hiring point of care staff, educating and training staff, developing a culture of good teamwork, and involving family members and volunteers at mealtimes.

As explained in the introduction to the study findings chapter, my reason for presenting these findings with the focus on organizational or leadership level influences was to be practical and avoid repetition. Figure 5.2 on the following page helps illustrate and explain how I have conceptualized influences at the individual, team, and organizational levels and the ways they are connected, based on my interpretation of the data. Individual influences include the personal attributes and knowledge and skills of point of care staff (particularly, their knowledge of the residents and mental toolbox of strategies). Team level influences include sharing information, problem-solving together, and lending a hand. Organizational or leadership influences include hiring staff, educating and training staff, developing a culture of good teamwork, and involving family members and volunteers at mealtimes. It is recognized that all of these influences are set within the broader context of government regulations and funding for long term care homes in Ontario.
Figure 5.2 Individual, team, and organizational/leadership level influences

In the diagram, team level influences are surrounded by a dotted circle with arrows to represent action. Critical action takes place at the team level which influences the ability of individual staff members to make care more person-centred (i.e. sharing information and problem-solving together helps staff learn more about the residents and increase their toolbox of strategies). What happens at the team level is influenced by the personal attributes (i.e. empathy, patience), knowledge, and skills that individual staff members bring to the team. Action at the team level is also highly influenced by organizational or leadership factors (i.e. educating and training staff, developing a culture of good teamwork, and involving family members and volunteers at mealtimes). Team level action (sharing information, problem-solving together, and lending a hand) within and across departments and levels of authority has potential to affect structures and relationships at the organizational or leadership level that guide day to day practice.

Direct links between the individual and organizational or leadership levels are less clear. Coming from a critical realist perspective, my interpretation of the data is anchored in the assumption that social (organizational) structures and relationships enable
or constrain the behaviour of individuals, but individuals also have the ability to change or shape these structures and relationships. While I think that organizational or leadership influences (particularly hiring, and educating and training staff) can affect care providers directly at the individual level without being mediated by team processes, I think that the power for individuals to produce change in the organization is through their influence as a team.

Given the interrelated nature of the individual, team, and organizational level influences, I have chosen to address them all from the standpoint of what should be considered at the organizational or leadership level. Thus, this section covers four main topics: hiring point of care staff, educating and training staff, developing a culture of good teamwork, and involving family members and volunteers. Unlike the previous section of findings, I will not discuss each long term care home separately. Instead, I have written about each topic in this section with examples from various participating homes.

My aim when writing this section was to select examples that demonstrate how to apply each element of the conceptual framework for supporting staff to provide person-centred mealtime care (Figure 5.1). For example, on the topic of hiring point of care staff, I will explain applications of forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care. These elements will be identified and italicized for emphasis as in the previous section. At the end of each subsection, I have provided a table that summarizes applications of these elements. In these tables, I will also draw connections to concepts from the Framework for Person-Centred Nursing
This will demonstrate an alternative way of conceptualizing the data and also show how concepts within the Framework for Person-Centred Nursing could be clarified and expanded upon through this study.

I will be drawing more heavily upon quotes from Homes A and C in order to present examples of valuable applications of each element of the conceptual framework.

For interest and background information, Table 5.3 provides a basic summary of some of the similarities among the participating long term care homes and unique points about particular homes regarding each of the topics to be covered.

Table 5.3 Influences on person-centred mealtime care: similarities and differences among participating long term care homes

<table>
<thead>
<tr>
<th>Hiring staff</th>
<th>Similarities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants from all the long term care homes tended to talk about good interpersonal skills and personal attributes such as empathy, desire to learn, being a good team player, and having a positive or cheerful outlook.</td>
</tr>
<tr>
<td></td>
<td><strong>Unique points:</strong></td>
</tr>
<tr>
<td></td>
<td>• Homes A and C had special dementia care units, and the staff who worked there more strongly emphasized the need to be flexible, calm, and patient in these settings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educating and training staff</th>
<th>Similarities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• At all participating homes, staff talked about learning by experience and from each other while providing care.</td>
</tr>
<tr>
<td></td>
<td>• In-service education primarily seemed to focus on implementation of government regulations.</td>
</tr>
<tr>
<td></td>
<td><strong>Unique points:</strong></td>
</tr>
<tr>
<td></td>
<td>• At Home A, the nurse who oversaw the dementia care units was very good at coaching staff to be skilled problem-solvers. Also, some of the experienced point of care workers were passionate about mentoring new staff.</td>
</tr>
<tr>
<td></td>
<td>• At Home B, in-service education was generally carried out by providing printed information and workers would sign a form when they had read it.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing a culture of good teamwork</th>
<th>Similarities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Information was shared among coworkers at mealtimes and shift change, and through documentation systems.</td>
</tr>
</tbody>
</table>
**Unique points:**
- Home A had a strong interdisciplinary focus. Point of care nursing, dietary, and housekeeping staff attended weekly unit team meetings together. Staff were empowered through opportunities to discuss and solve problems together at these meetings.
- Point of care workers at Home A felt that their leaders actively showed appreciation and were responsive to their input and ideas.
- Homes A and C regularly had recreation staff assisting residents at mealtimes, using an all-hands-on-deck approach.
- Staff at Home D tended to keep to their job descriptions and responsibilities more strictly than in other long term care homes.

<table>
<thead>
<tr>
<th>Involving family members and volunteers</th>
<th><strong>Similarities:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff at all participating homes thought that more help was needed in the dining room. They felt it would be helpful to have more family members and volunteers assisting residents at mealtimes.</td>
</tr>
</tbody>
</table>

**Unique points:**
- Homes A and C had some volunteers from the community who assisted at mealtimes but they wished there were more. These volunteers received some training from the long term care homes.
- Homes B and D had no mealtime volunteers, and lack of training for them was a key barrier.
- Homes B and D also did not allow family members to purchase a meal, but they could bring food in if they wanted to eat with the residents.
- At Home D, where many residents were Asian, more family members or privately hired care providers regularly came to help at mealtimes than in the other homes.
5.3.1 Hiring point of care staff

Making careful hiring decisions is an important aspect of *forming a strong team*. Participating staff identified personal qualities that made some frontline personnel better suited to work with residents with dementia than others. These individual level influences not only affect mealtime care, but also other aspects of residents’ daily living. Several essential personal attributes will be examined below, in relation to elements of the conceptual framework for supporting staff to provide person-centred mealtime care.

In the eyes of participating care providers, *knowing the residents* was essential. New staff are able to learn about the residents to some extent through reading care plans and other documentation. But to excel in person-centred care, staff need to have a genuine interest in the residents and the interpersonal skills to build good rapport with them, their families, and other staff so that they can learn as much as possible about the residents. Participating staff also highlighted how important empathy is to anticipating and knowing the residents’ individual needs and preferences, especially when residents cannot verbalize what they want. Without the ability to see things from the resident’s perspective, needs may go unnoticed. An indirect care provider who stressed the importance of having empathy explained:

> When you have good staff, that encompasses everything because they see the environment. They see maybe so and so is not happy sitting there. Or maybe they see that table’s too high for that resident (A15).

The ability to carefully observe and see how to make care more person-centred comes not just from awareness through education and training, but also from the personal ability to empathize.
As staff gain experience and receive training they can gradually increase their mental toolbox of strategies to make mealtime care more person-centred. Yet, participants recognized that staff need to have the internal motivation to build up their knowledge and try new approaches. As one point of care worker said, “…[staff] can quickly learn if they have that attitude of wanting to learn” (C8). Workers in all departments who help provide care for residents with dementia need to have the interest and motivation to keep learning. An indirect care provider said, “…you need even to have dietary staff who are very much on board with dementia care too. It’s not just about the nurses, it’s about the whole team” (A14).

Staff also need to have the flexibility to optimize care. Flexibility is commonly constrained by the organizational structures of schedules, assigned responsibilities, and policies. Yet, these constraints can be balanced to some extent by staff who personally keep a flexible approach to their everyday routine in order to meet residents’ individual needs. When asked about what she looks for when hiring staff for the dementia care units at Home C, an indirect care provider said, “Compassion and flexibility is what’s needed – a slow, patient, flexible person that can adapt for persons with dementia” (C6). Likewise, an indirect care provider at Home A said:

…other people [in other units], you know, I value them for maybe being very fast at what they do, but that’s not a quality in…that particular area [dementia care] that I would necessarily look for. It’s maybe that calmness and ability to prioritize their work, and really establish what’s important for me to get done here and then not to…but be overwhelmed if you can’t (A13).

Point of care staff who worked in the dementia care units in Homes A and C talked about the importance of being flexible because residents’ needs and preferences can change from day to day and even from meal to meal. As one direct care provider said, “…you
have to always be…willing to know that your schedule is not going to be, you know, set in stone every day. As a matter of fact, it’s never, ever, ever the same any day” (A1).

Keeping a flexible attitude toward one’s work routine and responsibilities also leads to better teamwork, and *working together* is a key to person-centred care. If staff only pay attention to the residents they are assigned to on the unit, cooperation can break down and residents’ needs will not be met in a timely manner or may even go unnoticed. In a well-functioning team, staff take responsibility to help monitor all the residents on the unit and lend a hand to their coworkers when they have the ability to do so. A direct care provider described the problem of becoming too narrowly focussed on the residents one is assigned to assist at mealtimes:

…tunnel vision – sometimes in dementia care you really have to be able to multitask and have a very good view of what’s going on around your area the whole time. You can’t just center on one person. You have to – you always have to be looking out to see what’s going on, and I find with some people they can’t do that (A4).

Moreover, not all staff may have the same willingness to help monitor the residents or lend a hand as needed. A direct care provider commented, “I would take every and any [resident] out of the dining room [after the meal]. But some of the workers, no, they leave them” (D13). Some staff were only willing to look after their assigned residents, while others were ready to help out for the benefit of all.

Participants also commonly talked about the importance of being positive and having a cheerful personality. They tried to avoid bringing frustrations or personal problems to work, and if others did so, they tried to tune them out so they would not have a negative influence. Getting along well with one’s coworkers and even having some fun
together had a positive influence on the whole team and upon the residents. An indirect care provider said:

…there’s one [PSW] in particular who’s just so charismatic. She can bring a smile to the grumpiest old lady’s face. And I think that that’s a real value when you’re hiring and when you’re ensuring that you’re picking the right people for the job. That’s one of the things you’re looking for, is that somebody who has the spark and who has the charisma, and can be in the face of a little bit of sadness every day and still maintain that really cheerful mentality (B7).

Staff who are well-suited to work with residents with dementia genuinely enjoy being with and helping the residents and their coworkers.

The social side of eating may especially be impacted by the personalities of staff, and specifically the particular mix of personalities on a team. A direct care provider reflected:

…the one team is…louder but happy and jokes around, and they get a better response I think from the residents than the other team that’s not – like they’re just more to their job, to their routine. And it’s like, ‘We got to do this.’ And I think the residents feel that too (B4).

There’s a possibility that changing the dynamics within the team by strategically including one or more staff with an outgoing, cheery personality might be what it takes to positively influence the interactions team members have with each other and with the residents at mealtimes. Education and training alone may not have as much impact on the social side of eating, particularly if a team is made up of staff who are naturally more task-oriented.

When new staff are hired, it is common for them to start with a casual or part-time position, and they are scheduled to work in different units throughout the home as needed. While leaders should aim to make staffing as consistent as possible on the units so that staff will get to know the residents well, having new staff work in different
settings provides a good opportunity to discover the best fit for them within the long term care home. Some workers may feel comfortable interacting with residents with advanced dementia whereas others may not and their strengths may be more effective elsewhere. Staff who eventually obtain full time positions in dementia care units should be carefully selected. If they express that they truly enjoy working in this setting and have demonstrated the desired personal qualities discussed above, they will help form a strong team to make care more person-centred.
Table 5.4 Relationships between key points on hiring point of care staff and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010)

<table>
<thead>
<tr>
<th>Key Points from the Dataset</th>
<th>Relationship to concepts within the Framework for Person-Centred Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>To know the residents well, staff need the ability to build rapport with residents and their families, and have empathy to see from the residents’ perspectives.</td>
<td>Ability to build rapport and having empathy fit within the prerequisite attribute of having <strong>interpersonal skills</strong>.</td>
</tr>
<tr>
<td>To develop a good <strong>toolbox of strategies</strong>, staff need motivation to keep on learning new approaches.</td>
<td>Motivation to learn would best be represented under the prerequisite attribute of <strong>commitment to the job</strong>. Commitment refers to intentionality and desire to do what is best for the resident.</td>
</tr>
<tr>
<td>To have <strong>flexibility to optimize care</strong>, staff need to be willing and ready to alter their routine. They need to be calm, patient, and able to prioritize their work.</td>
<td>Ability to set priorities fits under the prerequisite attribute of <strong>professional competence</strong>. The qualities of being calm, patient, and flexible are not represented well in the framework, but may be considered part of having <strong>interpersonal skills</strong>. Personal awareness of how one works (i.e. being flexible with one’s routine to meet residents’ needs) would be considered part of the prerequisite attribute of <strong>knowing self</strong>.</td>
</tr>
<tr>
<td>To <strong>work together</strong> well, staff need to be willing to lend a hand to coworkers. They need to get along well with others, having a positive, cheerful personality.</td>
<td>Having a positive, cheerful personality fits best under having <strong>interpersonal skills</strong> in the framework. Willingness to lend a hand and be a team player falls under <strong>commitment to the job</strong>, which includes commitment to team-level participation.</td>
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5.3.2 Educating and training staff

Participating staff talked about the importance of education and training in relation to providing person-centred mealtime care. *Knowing the residents* is necessary for person-centred care, so one of the first objectives in training new staff should be for them to learn as much as possible about each resident’s needs and preferences. An indirect care provider at Home A described how experienced staff often gently guided new workers with tips at mealtimes: “They’ll just say, *oh, why don’t you try it this way,* and they’ll show them how to do it… Or, *you know, if she’s not eating that dinner, give her an egg salad sandwich. She’ll just eat that up*” (A11). Some point of care staff were particularly passionate about mentoring new workers:

If you’re a new staff…coming into the unit, it is so incredible. I’ve seen the girls…they’re going home, they don’t get paid overtime, but I’ve seen them go and with that new staff member… say, ‘Okay, this is so-and-so. This is what you need to do, or don’t do,’ and go through the whole list and write it down for them. And, I’ve even had some of them turn around and say to new staff members, ‘Well, I’m not going out anywhere tonight, so if you run into trouble, phone me, and I can talk you through it’ (A11).

The efforts of experienced point of care staff to pass on their expertise of what each resident needs and likes or dislikes should be recognized and highly valued. Supporting staff to provide person-centred mealtime care involves training experienced staff to be good mentors and adequate time should be created in the schedule for them to share their knowledge about the residents one-on-one with new staff.

Staff also need to be *equipped with a toolbox of strategies* for providing person-centred mealtime care. Participants often talked about having to figure out what “works” for a resident. What works to help them make choices? What works to support their independence? Where does it work best to seat them? What works well when they say they don’t want to eat or come in the dining room? Staff said they knew things were
working well if residents were happy, peaceful, and eating until satisfied. Understanding that much had to be learned through experience to find out what works, an indirect care provider at Home A recognized the importance of being prepared with strategies:

I talk with the staff about having their own little toolkits with interventions, you know… imaginary toolkits full of interventions. So…every resident probably needs – today, this will work for them, to get them to drink or eat—but tomorrow, we’re going to need another intervention, or at supper, we’re going to need another intervention because what you just did at noon isn’t working. So, what else works, you know? There has to be a bunch of things that will work (A14).

Furthermore, a second important objective in educating and training staff is to continually expand their repertoire of strategies – particularly strategies that uphold residents’ personhood. The goal should not simply be to manage behaviour and get residents to do what the staff want them to do, but to have mealtimes where residents are happy, peaceful, and eat until satisfied – basic evidence of person-centred care that staff recognize.

In-service education to teach staff person-centred strategies needs to be practical and considerate of the real-world environment of long term care settings. A common critique of the formal training participants had received in the past was the apparent disconnect from reality:

…a lot of what we learned is what you do in an ideal situation, where everything –where you have lots of time and you have lots of staff and you have residents that…do what you want them to. There’s your perfect world that’s not actually ever going to happen (B3).

Moreover, training is best delivered by someone the staff respect who has first-hand experience. In fact, one of the best possible modes of in-service education may be facilitated discussion among staff on selected issues they encounter in practice. A direct care provider commented:
In-services would help for sure. We just had one on customer service…but I found that it was just kind of repetitive, like in-the-textbook stuff. Like you need to know – and you need to know from talking to your other…employees…like how to do things, and their experiences and knowledge. Like you can’t just hire somebody to come in and tell you how to do something when you…disagree with half of it cause you know it doesn’t work (C5).

Making time for staff to discuss strategies as part of in-service training keeps learning very practical and empowers staff as they have the opportunity to problem-solve together regarding real issues.

The registered nurse overseeing the dementia care units at Home A was a particularly good leader-educator. She empowered staff by training them to be good problem-solvers. A direct care provider commented:

Leadership influences I think is really big. We have a great leader – our charge nurse, she’s wonderful. She allows you as a team to work together, to make decisions. It’s not what she thinks is the best decision, it’s like how as a group do we feel this will be the best. And she educates us and teaches us how to be good thinkers, and how to be good problem solvers – I really do believe that. (I: Tell me just a little more about that. How does she do that?) How does she do that? I think she values our opinion. She always brings it back to what the question was, what the problem was, you know. What could we have done better? What could we do next time to make it better? Really listens, really listens, values what we say, and she really listens! She’s not formulating in her mind the answers she’s seeking for, she actually listens. And she teaches us how to be good, good workers by… I’m trying to think how she does it, because she just – after a while you’re just used to going to her, and she kind of helps you to figure out how to solve it. You know, what happened at the time, what did you do and how did – why did you do it that way? Do you think you could do something different the next time? And she tries to get you to figure it out for yourself instead of just giving you the answer. Sometimes people are just looking for a quick answer, but she kind of – and she’ll give you that if you need it, but she tries to teach you how to, you know, how to! (A4)

These problem-solving discussions often took place in weekly interdisciplinary meetings that this leader held with the point of care staff. Having time to work together in these meetings to share ideas and information made them good educational opportunities for staff. Regular mealtime observation and feedback from registered health care providers
also helped staff learn ways to improve care. The ability of participating staff from this home to so clearly articulate the various strategies they used in providing mealtime care is evidence of the success of the on-the-job education and training they received at this home through working together.

Another objective in educating and training staff should be to increase flexibility to optimize care. The inflexibility of rule-centred care tends to dominate unless staff are empowered through education about making care more person-centred and know when it is appropriate to bend the rules for the benefit of the residents. Ministry regulations and related policies and procedures of the home are vital, and it is important for staff to understand them and aim to follow them as a general rule. They are intended to protect both the residents and the staff, and ensure high quality provision of care. Yet there are sometimes situations in which bending the rules and breaking with routine is in the best interest of the residents. This tends to happen covertly in practice as point of care staff intuitively sense that bending the rules would allow for care to be better tailored to a resident’s needs. Opening up discussion between point of care workers and registered health professionals and management staff about these issues would help clarify gray areas and increase flexibility to bend the rules when appropriate without the fear of being caught.

Take the following issue for example: A direct care provider at Home A shared a story about a resident who had not eaten anything solid for three days. The resident was awake late one evening so she brought her to the dining room and tried giving her a peanut butter sandwich. Even though the resident normally loved peanut butter sandwiches, she still wouldn’t eat. Knowing it was against policy for her to eat with the
resident while on duty, she decided to try doing so anyway because she thought it might help encourage the resident to eat something. The worker went ahead and picked up half of the sandwich, and as soon as she took a bite the resident picked up the other half and began to eat as well. In fact, she said the resident ate a whole sandwich and a half that evening. Reflecting on the policy, she commented:

I don’t think I should sit beside you and have a full meal—you as the resident, me as the worker…I do think that, if by me taking a bite of something it is going to get you to eat, then, I don’t see the harm in it (A1).

She was pretty sure her supervisor would be supportive of her actions, but she also recognized the risk. She explained, “I’m sure she would [understand]; however, there would be nothing she could do if the ministry [inspectors] happened to see you do it, so…you always have to be real mindful” (A1).

Rule breaking for the benefit of the resident, as seen in this example with eating together, needs to be clearly distinguished from rule breaking that poses a significant safety risk and/or reduces quality of life for the residents. Staff need to have a good toolbox of person-centred strategies to draw upon when residents do not eat very well. Some strategies may need to be more carefully examined and discussed with point of care staff so they develop a good understanding of what is acceptable to try and what is not, and under what conditions, and why. It is important to get everyone on the same page on these matters and for staff to be assured that they will be supported in taking appropriate actions that go against the normal rules and routines. An indirect care provider at Home A spoke of advocating for staff to bend the rules and do things differently when the benefits were clear:

I’m certainly an advocate for abandoning those processes if something works for us. I’d be quite willing to and have in the past talked to the ministry people and
said, ‘That’s fine and that’s your standard, but here’s why we’re doing it [this way]. This is why it works for us and for this resident’ (A12).

This care provider also happily anticipated that with the movement of the ministry to a more outcomes-based approach to inspecting homes and evaluating care, there would be less emphasis on whether the standards were followed exactly as written and more attention would be given to results from the residents’ perspectives.

One more objective in educating and training staff is to form a stronger team by helping develop desired interpersonal skills and attributes in staff. In particular, experiential learning activities and watching video clips may be powerful methods of cultivating empathy – the ability to see things from the resident’s perspective. For example, some participants recalled training experiences of being fed by a co-worker. A direct care provider said, “It reminds you of what it’s like, and reminds you of not doing the bad things that we slip into like chatting amongst ourselves” (A5). Some staff also had a chance to taste different minced or pureed foods and found that helpful. Video clips of common care scenarios were good tools to get staff reflecting on the care they provide and the experiences of the residents:

…you’re rushing every day, right? So you don’t really see what you’re doing. Sometimes you may do something and you might think…You know that what you just did was not what [the resident] wanted, but, you know what, I only have five minutes…But when you sit back and you look at it on a clip, it really hits home (C3).

Making educational messages memorable means bringing them to life, and experiential learning and videos are ways to do this. They serve as good reminders and promote empathy, leading to more person-centred care.
Table 5.5 Relationships between key points on educating and training staff and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010)

<table>
<thead>
<tr>
<th>Key Points from the Dataset</th>
<th>Relationship to concepts within the Framework for Person-Centred Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced workers need to mentor new staff to help them <em>know the residents</em> better by sharing what they have learned about the residents’ needs and preferences.</td>
<td>Sharing knowledge and tips with new staff is related to having effective staff relationships in the care environment. Going beyond the call of duty to mentor new workers by sharing knowledge about the residents fits under the prerequisite attribute of commitment to the job.</td>
</tr>
<tr>
<td>Staff need to be taught and encouraged to build up their personal mental <em>toolbox of strategies</em>. Point of care workers prefer to receive in-service education led by respected staff who have plenty of first-hand knowledge and experience. Registered health professionals (i.e. the Registered Nurse in charge of the unit) can train staff to be good problem-solvers. Staff can also learn many strategies from each other through facilitated discussion.</td>
<td>Equipping staff with a toolbox of strategies is not represented clearly within this framework. Having knowledge of strategies would best fit within the prerequisite attribute of professional competence. Learning from respected, well-experienced staff is loosely related to having effective staff relationships in the care environment. Being trained to be good problem-solvers and learning from facilitated discussion best fit with the concept of shared decision-making, which emphasizes developing a learning culture and using team processes.</td>
</tr>
<tr>
<td><em>Working together</em> by sharing information and potential strategies provides a good opportunity for education and training on person-centred mealtime care.</td>
<td>As described above, sharing information and strategies with coworkers is related to the concepts of having effective staff relationships and shared decision-making.</td>
</tr>
<tr>
<td>To have <em>flexibility to optimize care</em>, there needs to be open dialogue about when it is appropriate to bend rules and routines.</td>
<td>Educating staff on when it is appropriate to bend rules and routines is related to having potential for innovation and risk taking.</td>
</tr>
<tr>
<td>To <em>form a strong team</em>, help staff grow in empathy through experiential learning and video clips.</td>
<td>Empathy fits best in the framework under the prerequisite attribute of having interpersonal skills.</td>
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</table>
5.3.3 Developing a culture of good teamwork

Developing a culture of good teamwork leads to better implementation of person-centred care. To some extent good teamwork stems from the personal attributes of staff, especially their willingness to be good team players. However, there are also many aspects of the organization itself that impact teamwork. A culture of good teamwork is developed by the processes and expectations set in place by those in leadership.

When teams are working well, staff learn a lot about the residents from each other. As they get to know the residents and build their up their own toolbox of strategies through experience, it is important for staff to share what they have learned with the rest of the team. Written documentation is the most basic way to ensure that information gets passed on to everyone. Staff at the participating homes relied highly on their daily report book or communication book to share information and ideas regarding mealtimes and other aspects of care. For example, a direct care provider said:

…you can write in the report book, and under that person’s name document, ‘Very resistive at mealtime, suggested this, offered this, and resident ate full meal.’ So then they’re like, ‘Oh okay, well we’ll try that for dinner.’ And if it works, you know, you write it there again. And because you get to read the report book from the day before, and I mean, it’s like a week of reports in there before they get filed away. So you know, there’s always that resource there (C5).

When long term care homes have a culture of good teamwork, staff are regularly educated about the importance of writing down tips for the rest of the team and are given adequate time to do so. Expectations about the amount of documentation required should be well balanced. Having to spend too much time on documentation takes away time spent with the residents.

Documentation alone is limited in its ability to help staff learn about the residents and about various strategies that may be useful. Participating staff were appreciative.
when their coworkers shared tips at mealtimes about what residents liked to eat.
Likewise, shift change was often a good time for sharing information as well as ideas to try. What set Home A apart from the other participating homes was the opportunity for staff to discuss strategies in their weekly interdisciplinary unit team meeting. A direct care provider said, “I guess the big thing is if we’re having a problem with someone – if they’re not eating, or they’re disruptive in the meal – we take it to our team meeting, and then everybody shares what works and what doesn’t” (A5). Point of care staff need to be given the space and time to communicate and problem-solve together.

Home A had an exceptionally strong interdisciplinary focus which was supported by the leadership of the home through the time they created in the schedule for point of care staff to come together to meet each week. The weekly interdisciplinary team meetings in the dementia care units were attended by point of care nursing, dietary and housekeeping staff, and facilitated by the registered nurse responsible for the units. Participating staff recognized the value of hearing the observations and input of staff from other departments and saw themselves as a unit team. A direct care provider said:

…quite often when we have a team meeting, it’s always interesting because [dietary staff] will actually give [nursing] information that maybe they hadn’t seen before. Because sometimes when you’re trying to assist three or four people at a time, it’s pretty hard to see really what’s going on at a table that – you know – they are the more independent table, so you’re not observing that. But [dietary staff] kind of look table to table to see how things are going, especially in dementia care (A4).

Having regularly scheduled unit team meetings created an opportunity for direct care staff to consult one another and share information, leading to better knowledge of each resident and understanding of how to make mealtime care more person-centred.
Leadership at Home A increased the *flexibility of staff to optimize care* by encouraging and empowering them to discuss and solve problems as an interdisciplinary unit team. For example, an indirect care provider said:

I must say that the staff...in the dementia care area are very in-tuned with...you know, sort of shaking up the menu in a way that is appropriate to the residents in dementia care. For example, a few weeks ago we had our first barbecue of the season...The recreation staff planned the event, which is fine, but our girls serving it said, you know, they had way too many fixings on the hamburgers; the residents didn’t know what to do with them, they couldn’t eat them—plus all these salads. It was just very overwhelming. So I said, ‘Okay, well, take it back to your [unit] team and talk about what...is appropriate’...Then that whole thing evolved into...now we’re going to have a picnic with nice sandwiches and some salads, and, you know, make it a little bit more...in line with what they’re capable [of eating] (A13).

The interdisciplinary team meetings were also times when staff discussed potential changes to improve the seating arrangement in the dining room. Empowering staff and providing space and time in the weekly schedule to have these discussions and make changes together led to more person-centred care.

Yet, interdisciplinary team meetings for point of care workers were uncommon in the other participating long term care homes. A direct care provider at Home D described having occasional in-services with the dietary and nursing staff together. For example, she said they had recently met to discuss what to do when the nursing staff were late bringing residents to the dining room. Likewise, at Home B, a direct care provider commented, “...maybe once a year we’d have a mixed meeting, maybe. And then it’s always about timing and who’s doing what” (B3). When asked if more interdisciplinary meetings would be helpful, this participant thought it might be beneficial but she worried that it would just be a time of raising complaints. Another point of care worker felt that the information shared by nursing staff would not pertain to the dietary staff and vice
versa. They did not recognize the value of consulting one another and sharing information to the same degree as staff at Home A did. The cultural attitude and approach to interdisciplinary teamwork differed between Home A and the other participating long term care homes. Using Home A as a model, leaders can develop a culture of better interdisciplinary teamwork by creating regular times for point of care staff from different departments to meet, and encourage them to share observations and ideas, and problem-solve together on issues. Leaders also need to spread a vision of interdisciplinary teamwork, and help staff see how this can help them make care more person-centred.

The qualities of those in leadership and how they involve themselves as part of the team also affect the development of a culture of good teamwork. For example, an indirect care provider said:

The RPNs are typically the team leaders of the shift in the neighborhoods. Some are better at the leadership roles than others in terms of gauging what’s going on in their neighborhood, and developing a plan and communicating the plan – developing the plan with input from the rest of the team… Some see that yeah, that’s what their job is. Others, if they’ve been in other environments where that wasn’t the case, that they really just did their work individually, cared for their own patients or residents or clients, then it’s a tougher learn I’m noting (A18).

Part of forming a strong team is hiring leaders who have experience at encouraging and facilitating collaborative group efforts, and providing training opportunities to further develop these skills.

Furthermore, leaders at all levels need to be approachable, inviting the input of direct and indirect care providers, and showing by their actions that they truly value their input. It’s not enough to simply receive and thank staff for their feedback and ideas – there needs to be some follow-up. This applies to formal evaluations of dining service as
well. An indirect care provider recalled doing a week of audits in the dining room and said, “…you’ve given me a tool to use to evaluate but then you don’t do anything about it. I keep writing the same thing day after day after day – what have they done about it? (D7). In some cases, it may not be possible to act upon input and ideas received from staff, but at minimum it helps to talk about the issues together. For example, at Home A, where point of care staff were empowered to a greater degree than other homes, an indirect care provider said, “…we do discuss [their ideas]… Sometimes when they hear why this isn’t occurring this way, you know, that’s…good. I mean, discussion is good and that’s how people do learn, and I’m all about that” (A14). Moreover, such discussions with members of the team could lead to further ideas that would be better solutions to issues raised.

For leaders, choosing to empower staff requires letting go of some control over decision-making and taking on more of a coaching role. Point of care staff are better prepared to make decisions when they understand the philosophy of resident care shared and demonstrated by their leaders and know how to apply relevant policies and procedures within the home. An indirect care provider said:

I hope that I empower them to be able to work independently and to come to me with decisions that they’re struggling with. But I try very hard to support them in decisions that they make, because I think the worst thing I can do is…ask them to make a decision and then say I’m not happy with their decision. You know, if they—they have to know me well enough to know how I feel about certain things and the way I would want them to do it, and also what—the way they should do it from a, you know, a standards-based decision. And I feel that that does happen quite a bit because they will often come to me and say, ‘You know, I think this is what you would want us to do, right?’ And I’d say, ‘Yes, that’s exactly what I want you to do’ (A13).

In-service training and teaching simple mottos or catchy phrases such as “we work in the residents’ home, they don’t live in our workplace” were common ways to spread a
philosophy of care and get staff on the same page with each other and with leadership on appropriate care approaches and strategies. Yet, nothing can replace actually coming to the dining room on a regular basis to observe, provide constructive feedback, and role model person-centred care.

Too often, however, management staff were not present at mealtimes. Other responsibilities and having multiple dining rooms within the facility to go to limited the time they spent observing meals. Supervision was especially limited at Home B because it was such a small home that the dietary manager was only a part-time employee and the dietitian only worked one day per week. Not only is it important for management and registered staff to supervise and provide feedback at mealtimes, but there also may be meals where their hands-on help is needed. This is a good chance for them to role-model strategies for person-centred care and teach staff to work together to meet needs.

Part of developing a culture of good teamwork is encouraging staff of all departments and levels of leadership to see themselves as part of the team, ready to lend a hand at mealtimes. Home A appeared to have the highest amount of help available in the dining room among the four participating homes. They routinely had extra help at mealtimes from recreation staff, bed-makers, and sometimes community volunteers and family members. The registered nurse overseeing the dementia care units also was available sometimes to assist with feeding residents, and periodically they also had nursing students. Each of the dementia care units had 30 residents, and at minimum, the team in each unit had three PSWs to assist the residents, and a registered practical nurse to oversee the dining room and distribute meds. A cook and two food service workers served residents on one dementia care unit and then the next. Generally at lunch and
supper each unit also had the help of an additional PSW whose shift entailed monitoring those at high risk for falls and spending one-on-one time with residents to help prevent or decrease anxious or agitated behaviour.

Yet, even in this relatively well-staffed environment, there were times when more help was needed – particularly on weekends when extra help from other staff in the long term care home was scarce. What also cannot be overlooked is that the number of residents requiring full eating assistance can vary greatly as abilities change and different residents move in and out of particular units. For example, staff working in one of the dementia care units at Home A said that although they only had six residents who currently needed full eating assistance, there was a time in the past year when 16 residents in the unit needed this level of care. As residents’ needs increase in a unit, this can also greatly affect dietary staff. For example, an indirect care provider explained:

In some of our home areas we have some particularly high nutritional risk residents. So, obviously then, supplementation during mealtime and during snack time is a pretty big part of their nutritional care. All of a sudden, in a home area [unit], they could be preparing eighty labeled snacks in a day, you know, and another area might be preparing twenty. And it’s that lack of appreciation maybe that, all of a sudden, I’ve got this huge complement of high risk people, and it is affecting how long mealtimes take because they typically take longer to eat, there’s more texturizing of food and there’s a lot more labeling and care of supplements. So there can be these imbalances in workload due to that, so we try to be sensitive to that and try to kind of find ways that we can meet that demand as it happens (A13).

Leaders have a particularly important role in recognizing and anticipating these changes in workload. Creative approaches may be needed, including reassigning staff and calling upon other departments for assistance.

The general ratio of 8-10 residents per PSW was common across all four participating homes, but this is clearly inadequate at mealtimes when the demands of care
are extra high. A more meaningful ratio that continually needs to be reassessed is the number of residents requiring full assistance to the number of PSWs. In the participating homes, a PSW would sometimes have three or four residents to provide full assistance to, and this meant that residents had to wait for their meal. For example a care provider said:

You can only feed two at a time, and then you got two over here waiting to be fed, and you can’t feed them because you got to concentrate on these two. And I usually try and, like, give these two their soups, and then I tell them to wait for their meal, and then I go over and feed these two their soup so that…but you just don’t have enough staff to do it all at once (A9).

It would be ideal if each PSW was responsible to provide full assistance to no more than two residents. There should also be at least one other staff member, either a dietary worker or PSW, who is able to focus on serving the residents and providing some cueing and assistance as needed for those who are more independent. The PSWs responsible for providing eating assistance to residents would also be able to attend better to the needs of those who are more independent at their tables if they only had two residents to assist fully. When care needs are high, an all-hands-on-deck approach should be used, with all staff in the home willing to work together when necessary to achieve a two to one ratio for residents who need full assistance.

Morale grows when staff work in a culture of good teamwork where everyone lends a hand and those on the frontline are empowered to help solve problems and making decisions. Morale in turn is an ingredient for perpetuating good teamwork. As one direct care provider said, “Once you got morale up, then people want to help and people start thinking, and great ideas come up” (C8). When leaders show appreciation by recognizing efforts and thanking staff, holding social events, or even delivering
occasional free coffees, this also helps increase morale. A culture of good teamwork is seen on the faces of staff. An indirect care provider said:

I think, when you see at the end of your shift that the staff are going out with smiles on their face and joking and that, and they’re not stressed, I think that’s evidence it’s working…I know our main focus is the resident and then the family, but I think when you see it all coming together like that, then it completes the picture (A11).

*Working together* with enjoyment completes a picture of person-centred care.

Developing a culture of good teamwork is a goal to be pursued by all long term care homes.
Table 5.6 Relationships between key points on developing a culture of good teamwork and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010)

<table>
<thead>
<tr>
<th>Key Points from the Dataset</th>
<th>Relationship to concepts within the Framework for Person-Centred Nursing</th>
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<tbody>
<tr>
<td>Sharing information and tips with coworkers in the dining room, at team meetings, and through documentation help staff <em>know the residents better</em> and develop their <em>toolbox of strategies</em>.</td>
<td>Sharing information and strategies with fellow workers is related to having effective staff relationships. It is also related to shared decision-making, which focuses on development of a learning culture and using team processes.</td>
</tr>
<tr>
<td>Empowering staff by providing ongoing opportunities to problem-solve together helps <em>create flexibility to optimize care</em>.</td>
<td>Empowering staff pertains to the concept of potential for innovation and risk-taking. Problem-solving as a team also is related to having effective staff relationships and shared decision-making.</td>
</tr>
<tr>
<td>Part of <em>forming a strong team</em> is hiring and training registered health professionals and management staff to be approachable, have good facilitation and coaching skills, and have ability to communicate and model the philosophy of care in the home.</td>
<td>Being approachable and having good facilitation and coaching skills may be considered aspects of having interpersonal skills. Ability to communicate and model the philosophy of care starts with the prerequisite attribute of clarity of beliefs and values. Being a good facilitator and coaching staff is also related to having effective staff relationships and commitment to power sharing.</td>
</tr>
<tr>
<td><em>Working together</em> involves lending a hand as needed. Registered health professionals and management staff need to work with point of care staff by regularly supervising and role modeling mealtime care, showing appreciation, and recognizing and responding to changes in workload.</td>
<td>When staff lend a hand to one another, and when leaders regularly take time to supervise mealtimes, act as role models, and show appreciation they demonstrate commitment to the job and effective staff relationships. Recognizing and responding to changes in workload may best fit with the concepts of appropriate skill mix, which focuses on staffing levels, and having supportive organizational systems.</td>
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5.3.4 Involving family members and volunteers

Even with the very best staff hired to look after the residents, their time and ability to make care person-centred is limited at mealtimes if care needs are high and if the number of other staff in the facility able to help is inadequate. *Forming a strong team* to provide person-centred care means involving family members and volunteers at mealtimes. At all four participating homes, when staff were asked about what could support them to provide person-centred mealtime care the most common response was more help in the dining room.

Home D, which had a large Chinese population, seemed to have the most family members coming regularly at mealtimes. Some families also privately hired care providers to come and spend time with their loved ones throughout the day and to assist at meals. Even so, estimating roughly from participants’ comments and my own observations, only about 5-10 percent of the residents had a family member or private care provider present at mealtimes. Staff at Home D were greatly appreciative of the family members and private helpers who assisted residents because it gave them more time to help others, and also helped with the language barrier because not all staff spoke Cantonese.

Besides a few family members, Homes A and C had some volunteers from the community to help at mealtimes. Yet they wished there were more volunteers. A direct care provider said, “We do have some volunteers – volunteers are pretty scarce. They are *very* well-appreciated” (C8). Homes B and D did not have any volunteers to help, and the main barrier at both of these homes was concern about who would take responsibility
if there was a choking incident or if anything bad happened. An indirect care provider explained:

I remember [a coworker] and I talk about having volunteers helping... to feed the residents, ‘cause in other homes I see a lot of volunteers coming in and—‘cause a lot of students they would like to come, a lot of retired people they would like to come and help... But we also talk about the liability and the safety, that it would mean that they have to get formal training... about how to feed the resident. Or maybe even with people with—residents with dementia, how they can deal with it when... the resident get restless or agitated and stuff like that. You should know how to deal with it. Liability issue would be if the resident choke or aspirate. Who is going to take the—I think that issue we haven’t been able to deal with that yet (D9).

This issue of needing to train volunteers was a clear barrier, but it is a relatively easy one to overcome.

At Homes A and C, volunteers received some basic training by video on how to position and feed residents to ensure safety. They were trained to recognize signs of swallowing difficulties and what to do if a resident began to choke. Participants at Home A said that volunteers received more hands on training in the dining room where they first watched one of the staff assist a resident, and then the staff member observed the volunteer assist the resident. Staff always gave volunteers residents who were considered quite easy to assist and at least risk for choking. Further work could be done to educate volunteers on what challenges to expect in the dining room and how to respond with person-centred approaches. A direct care provider said:

...before they go in there, you know…[educate them about] the behaviours that they might see. Let them know what could potentially happen and what potentially does happen every day so that they’re not just like oh my gosh, like after the first day I’m not going back there because this is way too much…And just, you know…the knowledge, and have the staff really try to, almost take a little bit extra time with them and give them all that information that they wouldn’t normally have (C5).

Certainly such training would also be valuable for any family members who wanted to
help at mealtimes. Just like staff, volunteers and family members would benefit from the opportunity to build up their *toolbox of strategies* to deal with different situations they may encounter to make care more person-centred.

Staff highly acknowledged the importance of helping volunteers get to *know the residents* who they come to assist. For example, a direct care provider said:

...you would give the volunteer one person, and that would be their person every time they came, unless something happened to that resident. There you could build a trust between the resident and the volunteer. They would get to know how that resident ate, and every time they [had difficulty swallowing] they would be familiar with what they coughed like, or that they like their food with gravy on it at all times, or if they didn’t like anything salty, and the best way to feed that resident whether it be small sips of fluids between each bite, or they like all their drinks at the end. It’s just a better meal experience for both (A4).

Of course, generally family members know the residents’ needs and preferences as well as or better than the staff, but volunteers who come in need experienced care providers to share the little details that they know about what the residents need and like or dislike.

Not all family members or volunteers may be comfortable with providing one-on-one eating assistance at mealtimes, but there are other ways they may enjoy helping. For example, some participants thought it would be great to have volunteers help bring residents to the dining room. Others suggested they might help with welcoming residents in the dining room, serving beverages throughout the meal, and cutting food. The difficulty with this is that the volunteer would need to be someone able to come quite often so he or she would become familiar to the residents and get to know them all, including where they sit and what they like and dislike. An indirect care provider recalled a time when a volunteer came once a week with her three children to help greet residents and socialize with them as they came to the dining room. Though it sounded like a good idea, it didn’t work the best in the dementia care unit. She said, “That doesn’t
help, because it creates more noise, more distraction, more [residents thinking], I don’t know those people. Am I supposed to know those people?” (A15) She could feel the confusion rising in the dining room. Having volunteers greet and socialize with residents might work very well in units where residents have less cognitive impairment. In any case, it is best if volunteers are able to come on a frequent basis to build and maintain familiarity and rapport with the residents.

To form a strong team, long term care homes need to see family members as part of the team and be proactive in encouraging them to be involved at mealtimes. Of course, some family members cannot help at mealtimes for a variety of reasons, or they do not want to assist and this must be respected. Yet there are others who may be open to helping but need to be eased into it so they will feel more comfortable in the environment, or they may simply not realize how much their help is needed and welcomed. As one point of care worker said, “I don’t think they understand that the help is needed, but maybe more encouraging on that would be good” (A3). Recognizing that residents were paying to live in the long term care home and knowing that it was their job to feed and care for the residents, participating staff felt hesitant to ask families for help. If a resident was quite anxious or agitated or not eating well and staff knew that the resident would respond better to a family member, they were more likely to ask the family member to come and assist at mealtimes.

Making family members feel comfortable about helping at mealtimes begins with a clear welcome and invitation to be involved from the very start. An indirect care provider said:

…we welcome families. I am always clear, as are my colleagues, that when we provide tours prior to a resident coming to live with us, I’ll always say, ‘There
was a time when we said to you, you just leave your resident here. We’ll provide all the care this older adult needs. Now we’re saying: *You are part of this, we will include you*’ (A18).

Such invitations to take part in providing the resident’s daily care need to be extended not only at the start from leadership, but also from point of care staff on an ongoing basis as they get to know family members when they visit. A simple casual invitation to stay for a meal, either to eat with the resident or watch and visit while sipping on a cup of coffee or tea is potentially a way to make both the resident and the family feel more at home in the dining room. As the family member’s comfort level increases in staying at mealtime, the invitation may turn into, “Would you like to help feed your mom today?”

Providing meals at a reasonably low cost for family members who would like to stay and visit may help them feel more welcome. An important consideration is how much extra work this might entail for staff. For this reason, Homes B and D chose not to provide the option of purchasing a meal but encouraged family members to bring in food to eat or share with the resident at mealtime. Offering a complimentary beverage and perhaps a dessert would be a good compromise. Moreover, if a family member is helping a resident who needs a high degree of assistance at mealtime, his or her focus needs to be on the resident and it would be challenging to eat and enjoy a meal at the same time.

To really *form a strong team*, long term care homes cannot only rely on staff and family members to provide assistance at mealtimes, but need to make a concentrated effort to recruit, train, and schedule volunteers from the community who want to help. *Working together* with local organizations to spread awareness of the need for volunteers is a path for the future. High schools, colleges, churches, seniors’ centres, and volunteer
centres may be good partners for reaching out to bring aboard more people to help. An indirect care provider said:

…it is making the community aware that this is a vital place to be, and…as I think about it out loud, the bigger your volunteer base is, the more likelihood you have then of developing a number that will consider doing the dining [assistance] (A18).

Some volunteers, like family members, may develop a greater comfort level in communicating with and assisting residents with dementia over time. They do not necessarily have to start volunteering in the dining room, but might enjoy reading to residents or doing other activities for a while and then be approached to see if they would like to try helping at meals. Home A, for example, had a full time volunteer coordinator who got to know each of the volunteers and would ask them what they thought of helping in different areas that she felt they were prepared and well suited for.

The assistance provided by family members and volunteers gives staff greater flexibility to optimize care because it frees up more time to spend with other residents who need their help. Long term care homes need to be more intentional about creating this flexibility by carefully assessing the demands of care in the dining room on an ongoing basis and scheduling adequate numbers of volunteers accordingly. Just like recreation departments need to ensure that they have enough volunteers to carry out various activities successfully, each unit needs to figure out how much extra help is required to make mealtime care more person-centred. A direct care provider at Home A said, “Some days we have all kinds [of help], and then other days we have none. So I think they need to start balancing that out” (A3). She found that less help was available on the weekends, and as a result residents were being rushed to eat and drink. Also, with the number of residents needing full assistance going up and down over time, the number
of required volunteers can frequently change. Being prepared with volunteers who are trained and ready to be called upon would increase the *flexibility* with which homes could respond to these needs.

Making sure that the recruitment, training, and scheduling of mealtime volunteers meets demands may also require *working together* more closely as an interdisciplinary team. At Home C, for example, mealtime volunteers were overseen by the recreation department rather than nursing or dietary, so sometimes unit staff were unaware of when they would be receiving extra help. Making sure there is enough help in the dining room needs to be a priority that staff of all departments are prepared to work together carefully to obtain. By involving adequate numbers of volunteers as well as family members, staff will be supported to provide person-centred mealtime care.
Table 5.7 Relationships between key points on involving family members and volunteers and concepts within the Framework for Person-Centred Nursing (McCormack & McCance, 2010)

<table>
<thead>
<tr>
<th>Key Points from the Dataset</th>
<th>Relationship to concepts within the Framework for Person-Centred Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcoming and encouraging family members and recruiting mealtime volunteers is part of <em>forming a strong team</em>.</td>
<td>Involving family members and volunteers is not represented in the framework. It seems to fit best under the concept of having <em>supportive organizational systems</em>. It may also loosely be related to having appropriate skill mix, which focuses on staffing levels.</td>
</tr>
<tr>
<td>Family members and mealtime volunteers need a mental <em>toolbox of strategies</em> to draw upon just like staff. They need to be taught about person-centred care along with how to provide safe eating assistance.</td>
<td>Providing training for family members and volunteers would best fit with the concept of having <em>supportive organizational systems</em>.</td>
</tr>
<tr>
<td>It is best when volunteers can come regularly and work with the same resident in order to <em>know the resident</em> well. It is also important for staff to share with volunteers and family information and tips about the resident’s needs and preferences.</td>
<td>Having volunteers work consistently with the same residents also seems to relate best to the concept of <em>supportive organizational systems</em>. Taking time to share helpful information with volunteers and family members fits with the prerequisite attribute of commitment to the job.</td>
</tr>
<tr>
<td>Long term care homes need to <em>work together</em> with organizations in their community to actively recruit volunteers. Staff need to work as an interdisciplinary team, communicating needs for volunteers with the volunteer coordinator.</td>
<td>Working with other organizations to recruit volunteers would best fit under having <em>supportive organizational systems</em>. Working with the volunteer coordinator in another department of the long term care home is related to the concept of <em>shared decision-making</em>, which focuses on team processes.</td>
</tr>
<tr>
<td>Proactively recruiting, training, and scheduling volunteers helps give staff the time and <em>flexibility to optimize care</em> when many residents have high needs.</td>
<td>Again, the recruitment, training, and scheduling of volunteers would fit best under having <em>supportive organizational systems</em>.</td>
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5.3.5 Summary

This section has examined four main organizational or leadership influences on implementation of person-centred mealtime care: hiring point of care staff, educating and training staff, developing a culture of good team work, and involving family members and volunteers. Through examination of these four influences, the importance of action at the team level (i.e. sharing information, problem-solving together, and lending a hand), and personal attributes, knowledge, and skills at the individual level were also addressed. This section has also drawn attention to and demonstrated applications of each element of the conceptual framework for supporting staff to provide person-centred mealtime care: forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care. Connections were also drawn between the study findings and concepts from the Framework for Person-Centred Nursing (McCormack & McCance, 2010). This has provided an alternative way of conceptualizing the data and shows how concepts within the Framework for Person-Centred Nursing could be clarified and expanded upon.
6. DISCUSSION

The findings of this study help us understand what kinds of practical and educational support are needed to help direct care providers in Ontario long term care homes make mealtime care more person-centred for residents with dementia. Objectives of this study were to describe the current implementation of person-centred mealtime care, explain what influences implementation of these care practices, and identify steps to more fully adopt a person-centred approach. More specifically, the research questions addressed were as follows: 1) In what ways are person-centred mealtime care practices being implemented well and what are some areas for improvement? 2) What factors at the individual, team, and organizational levels enable and hinder implementation of person-centred mealtime care practices? 3) How can current barriers to providing person-centred mealtime care be overcome?

A conceptual framework was developed through analysis of the interview data, identifying five key ways to support staff to provide person-centred care: forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care. In section 5.2 of the study findings, I applied the elements of this conceptual framework to explain reasons for strengths and areas for improvement in implementation of person-centred mealtime care. In section 5.3 of the study findings, I identified individual, team, and organizational influences, but particularly focused on four mealtime care influences at the organizational or leadership level: hiring point of care staff, educating and training staff, developing a culture of good teamwork, and involving family members and volunteers. The five elements of the conceptual framework I developed were used to
help explain important considerations regarding each of these influences on mealtime care. Some practical steps for improving implementation of a person-centred approach were identified throughout the findings and will continue to be discussed in this chapter.

The five elements of the conceptual framework will be discussed in relation to pertinent literature on these topics. I will discuss how to form a strong team based on important personal attributes to seek and develop in staff, and guidance from the literature on involving family members and volunteers in mealtime care. Lessons will also be drawn from the literature on working together to provide care, particularly with reference to empowering point of care staff through shared decision-making processes, the related role of facilitators, and applying a person-centred approach with staff through recognition and inclusion as part of an interdisciplinary team. Enabling staff to know the residents better will be discussed in terms of how staff learn about the residents, what is important for them to know, and the need to recognize and respond to changes in the residents’ needs and preferences. I will also discuss why a toolbox of strategies is needed, what kinds of strategies should be part of the toolbox, and related implications for staff education and the evaluation of person-centred care. Creating flexibility to optimize care will be discussed in terms of scheduling and assigning staff responsibilities, maintaining standards and smooth operations, and advocating for residents and managing associated risks.
6.1 FORMING A STRONG TEAM

Making mealtimes person-centred requires a strong team of people to serve and assist residents in the dining room. Part of forming a strong team is considering the personal attributes desired in team members and seeking these qualities when hiring staff. Desired attributes should also continue to be encouraged and developed over time through staff education. Findings of this study also emphasize that family members and volunteers need to be considered an integral part of the team at mealtimes. Forming a strong team means making every effort to invite family members to take part, and offering them the guidance and encouragement they need to feel comfortable and confident to provide assistance. It likewise means proactively recruiting and training volunteers who would like to assist residents at mealtimes.

6.1.1 Personal attributes of team members

Study participants identified individual level characteristics that they felt were important for providing person-centred care. Not surprisingly, one of these qualities was having empathy. In the Framework for Person-Centred Nursing, having empathy is identified as an interpersonal skill needed for person-centred care (McCormack & McCance, 2010). Schell & Kayser-Jones (1999) had found that without empathy, staff were more likely to have a task-oriented approach at mealtimes. Point of care workers in the current study talked about treating residents the way they would treat a family member in their care or how they would like to be treated personally. Similarly, Kontos, Miller, & Mitchell (2009) conducted interviews with PSWs and found that their care practices were influenced by their imaginary kinship ties with residents and by thinking about shared experiences such as what makes them feel comfortable.
This type of reflection can be very helpful when providing care, as it guides staff to act with patience and compassion. Yet, what participants described in terms of having “empathy” may in some cases fall short of the real goal in person-centred care, which is to see situations from the resident’s perspective. What the resident wants may be different from what the staff member would want personally or how she thinks a family member would want to be treated. Seeing things from the resident’s perspective is one of the main elements of Brooker’s definition of person-centred care (Brooker, 2007). Similarly, in the Framework for Person-Centred Nursing, working with the patient’s (or resident’s) beliefs and values is considered one of the characteristic processes of providing person-centred care (McCormack & McCance, 2010). To see from the resident’s perspective means knowing the resident adequately to understand what he or she wants. Moreover, it’s important for staff to be able to distinguish potential differences between themselves and the residents in their desires or ways of thinking.

Knowing self and clarifying personal beliefs and values are two of the personal attributes identified as prerequisites for person-centred care in the Framework for Person-Centred Nursing (McCormack & McCance, 2010). In my interviews with staff, when beliefs and values were mentioned, participants tended to think immediately of rather easily identifiable issues. For example, they understood and respected a resident’s desire to pray before eating or to follow a vegetarian diet if desired. Knowing a resident’s religious and cultural beliefs and values and distinguishing them from one’s own is part of being person-centred, but long term care staff need to go beyond such issues. They need to understand themselves better regarding potentially taken-for-granted matters. What do they believe is the most important part of the meal for the resident to eat? Do
they believe the residents will get sick if they don’t finish everything on their plates? Do they value keeping residents clean and well-mannered at mealtimes more than letting residents feed themselves if it is messy? How do such beliefs and values influence their care practices? More work could be done with direct care providers in long term care settings to clarify their beliefs and values and know ‘self’, particularly regarding these more subtle issues of mealtime care.

Flexibility was another important personal quality that participants highlighted in this study. The notion of flexibility went hand-in-hand with having a calm nature and the ability to go with the flow. It meant being able to adjust one’s routine depending on the residents’ needs each day. Janes et al. (2008) also found that PSWs talked about the importance of being flexible in their job, coupled with being persistent. Often when working with residents with advanced dementia it takes several attempts to provide the personal care they need. Waiting, returning, and trying again requires flexibility, calmness, and persistence. These qualities are not well represented in the Framework for Person-Centred Nursing; it would be helpful to add them as types of interpersonal skills needed particularly in dementia care settings (McCormack & McCance, 2010).

Direct care providers commonly talked about the importance of being cheerful and keeping a positive attitude in their work. Having an understanding of dementia and responsive behaviours helped staff to not take things personally when residents refused their attempts to provide assistance or acted with aggression. Janes et al. (2008) found that PSWs endeavored to maintain composure in such situations, keeping a positive frame of mind and staying calm. In fact, some were able to reframe difficult behaviours in a positive light as challenges to embrace, and enjoyed the work of figuring out how to
solve problems. These characteristics could be added to the concept of commitment to the job within the Framework for Person-Centred Nursing (McCormack & McCance, 2010). The desire to continue learning in order to improve practice was another characteristic that participants in the current study thought was essential for person-centred care. In the Framework for Person-Centred Nursing, desire to learn is represented best under the prerequisite attribute of commitment to the job, and the types of knowledge needed are captured under the attribute of professional competence (McCormack & McCance, 2010).

A study which focused on the experiences of facilitators who helped long term care nursing staff implement evidence-based practices found that the feelings, motivations, and attitudes of staff impacted the extent to which they embraced new knowledge (Janes et al., 2009). Burnout and stress were thought to underlie the negative emotions some staff exhibited toward learning and making changes in practice. Motivation was highest when staff saw a clear need for change. Moreover, the desire to learn and implement changes is not simply an intrinsic characteristic, but may grow or be stifled depending on conditions of the work environment and the influence of others. Findings of the present study suggest that empowering staff through opportunities for team problem-solving and being responsive to staff input can foster motivation to keep learning and improving practice. The concept of shared decision-making in the Framework for Person-Centred Nursing focuses on maximizing individual potential through creation of a learning culture (McCormack & McCance, 2010). Findings of the current study further support that shared decision-making is an essential aspect of the care environment because of its potential to stimulate desire to learn.
Study participants highlighted the importance of communicating well with others and being a good team player. Making an effort to always share tips and strategies for working with the residents, and offering to lend a hand as needed are important aspects of working with a team in long term care. Helping each other out to understand and meet residents’ care needs augments personal flexibility, persistence, and ability to maintain emotional composure in challenging situations (Janes et al., 2008). In the Framework for Person-Centred Nursing, good communication with coworkers is captured under the prerequisite attribute of having interpersonal skills, and commitment to working with the team is considered an important aspect of commitment to the job (McCormack & McCance, 2010).

6.1.2 Involving family members

When family members choose to assist at mealtimes, it is a big help to staff and it can benefit the family members and residents at the same time. Mealtimes are a good opportunity for family to connect with residents with dementia (Keller et al., 2010). Skemp Kelley, Swanson, Maas, & Tripp-Reimer (1999) studied the meanings families make of visiting residents in special care units, and three main reasons for visiting were to be faithful, to be their eyes and ears regarding care quality, and to be family. Continuation of “being family” was primarily achieved through communication and by providing food or sharing in mealtimes.

Yet, as participants in the current study indicated, relatively few family members visit or assist their relatives at mealtimes. Reasons for not coming at mealtimes are likely associated with factors that tend to deter family members from visiting in general. Gladstone, Dupuis, and Wexler (2006) found that family members did not visit as often if
they found visits emotionally difficult, if the resident seemed unaware or unresponsive to their visits, or if they had difficulty carrying on conversation. Visits also declined when there were competing demands for their time, when they felt more comfortable with the resident’s transition to the home and the care they were receiving, and when other family members also went regularly to visit.

Family members’ reasons for visiting and what dissuades them from coming should be taken into account when encouraging them to stay and assist at mealtimes. Varied levels of emotional support and education may be needed to help them feel more comfortable with visiting and assisting their relative in care. When family members help with aspects of direct care, it is important that they are made to feel appreciated and included as part of the care team and not merely there to help make up for deficiencies in care (Boise & White, 2004). Communicating well with family members helps prevent an “us versus them” chasm (Austin et al., 2009). To cultivate identity as part of the team, Boise & White (2004) recommended that family members who help with direct care be included in problem-solving discussions to resolve care issues as they arise. As part of a person-centred philosophy of care, residents’ family members should be included as part of the team through information sharing regarding the resident, participation in care at the level they desire, and collaboration on organizational-level decisions in the long term care home, including policy and program development (Alzheimer Society of Canada, 2011). Involvement of family members in care is not addressed in the Framework for Person-Centred Nursing, but seems to fit best under the concept of having supportive organizational systems (McCormack & McCance, 2010). Leaders have an important role in promoting family involvement in care, making it part of the organizational culture.
6.1.3 Involving volunteers

Having volunteers on board who regularly help in the dining room also strengthens the team. Peer-reviewed literature on involving volunteers in mealtime care is sparse. A systematic review on use of volunteers at mealtimes in hospitals and long term care homes located only ten articles on this topic (Green, Martin, Roberts, & Sayer, 2011). Three papers included in the review reported increased intakes in residents who received eating assistance from volunteers, but the methods of measuring intake were not robust. Satisfaction among residents, family members, staff, and volunteers were common findings reported across the articles, but the methods used for evaluation were typically unclear because the reports were brief and focused on description of the volunteer programs. Three papers on mealtime volunteer programs in long term care facilities provided helpful details to consider regarding recruitment, training, supervision, scheduling, documentation, and volunteer appreciation (Lipner, Bosler, & Giles, 1990; Musson, Frye, & Nash, 1997; Marken, 2004).

Recruitment of mealtime volunteers was a challenge according to participants in the current study. Marken (2004) recruited university students and volunteers from the community to take part in the Dining with Dignity program. Students received course credit for their volunteer work with the long term care home. Volunteers were also recruited through appeal to community groups and churches, and through newspaper and television advertisements. Lipner et al. (1990) recruited volunteers from the community by sending public relations staff to visit schools, colleges, and seniors centres. Posters and internal mailings were also sent to all departments in the facility to recruit staff who were interested in volunteering at mealtimes. Staff were given up to 2.5 hours of release
time per week to provide mealtime assistance. Similarly, in the Silver Spoons program described by Musson et al. (1997), staff were recruited to volunteer at mealtimes and they received special volunteer recognition. In particular, staff from the administrative services department and community volunteers who regularly helped with administrative duties were recruited to help at mealtimes if they wished to have more contact with residents. Ideas from these volunteer programs could be applied to facilities to help increase recruitment.

Recruitment of volunteers seems to be easiest for the noon hour meal. Lipner et al. (1990) indicated that most volunteer assistance was provided at lunch time; few volunteers were able to help in the evenings or on weekends. Musson et al. (1997) noted that most volunteers were available at lunch or supper time. Participants in the current study commented that few volunteers were available on weekends. Special recruitment efforts and careful scheduling are needed to make sure that volunteer help is consistently available.

Comprehensive training was provided for volunteers in all three programs. Much of the training focused on how to safely provide eating assistance, with emphasis on proper positioning and preventing aspiration. Each program touched on how to interact with residents, but the Dining with Dignity program described by Marken (2004) placed special emphasis on providing social support through interaction at mealtimes. In the current study, lack of training was a barrier to including volunteers in two of the participating homes. Training resources designed for mealtime volunteers that emphasize how to implement a person-centred philosophy of care need to be made widely available to long term care homes. Tips and examples of how to make mealtimes more person-
centred for residents with dementia can be drawn from the findings of this study. Content on using a person-centred approach when communicating and socially interacting with residents with dementia may also be drawn from other available training materials. A good example is a training program developed by Damianakis, Wagner, Bernstein, & Marziali (2007) for volunteers involved in a Friendly Visitor program.

Lipner et al. (1990) emphasized the importance of matching volunteers with residents who needed more time and encouragement to eat, enabling staff to focus more of their attention on residents who are at higher risk for choking or malnutrition, or have challenging behaviours at mealtimes. Likewise, participants of the current study explained that volunteers were generally assigned to residents who were considered to be easier to assist. In the Silver Spoons and Dining with Dignity Programs, described by Musson et al. (1997) and Marken (2004) respectively, volunteers regularly assisted the same residents in order to promote relationship building. Musson et al. (1997) cautioned that it was difficult for volunteers when their mealtime “buddy” became ill or passed away because of the attachments that grew over time, and advised that volunteers should be assigned to more than one resident and receive support from a social worker in the facility during times of transition.

Marken (2004) and Lipner et al. (1990) indicated that professional staff provided ongoing supervision of volunteers who helped with mealtime care. Regular supervision and good communication are needed to make sure that volunteers feel well supported and residents are receiving the best quality care. Musson et al. (1997) indicated that volunteers were encouraged to pass on residents’ requests and concerns to staff by making notes in a suggestion log. Lipner et al. (1990) reported that volunteers were
asked to fill out a quick log after each meal indicating the type of eating assistance provided, how much the resident ate, and whether any difficulties were encountered. However, they found that these logs were not consistently completed.

Long term care homes are at a great advantage if they have a staff member whose role is to coordinate volunteers in the facility. A volunteer coordinator can manage recruitment of volunteers, make sure they are well equipped and educated for the role they will take on, clarify boundaries in their responsibilities, and act as a liaison between the volunteers and staff (Neno & Neno, 2007). As a liaison, the volunteer coordinator should endeavor to minimize concerns and extra work that involving volunteers may entail for unit staff (Damianakis et al., 2007). Lipner et al. (1990) and Musson et al. (1997) reported that a volunteer coordinator had a key role in ongoing communication and supervision of mealtime volunteers.

Volunteers in the programs described by Lipner et al. (1990) and Musson et al. (1997) wore identification badges or buttons that helped create recognition as part of the team. After 200 hours of service in the Silver Spoons program, volunteers received a special silver-plated pin for recognition (Musson et al., 1997). Lipner et al. (1990) indicated that volunteers received a certificate of completion after going through the training program, and were formally recognized at annual awards ceremonies. Incentives and recognition for volunteers is a topic that did not come up in interviews in the current study, but this is another important aspect to consider when developing a mealtime volunteer program.
6.2 WORKING TOGETHER TO PROVIDE CARE

Care providers need to work together to provide person-centred mealtime care, and three main ways they can do this are by lending a hand, sharing information, and problem-solving together. In this section of the discussion, I’d like to focus attention on information sharing and problem-solving as a team. There are some key points to draw from the literature on empowering point of care staff through shared decision-making processes and the related role of facilitators. The importance of applying a person-centred approach with point of care staff through recognition and inclusion as part of an interdisciplinary team will also be discussed. Working together by lending a hand will be addressed later in the section on flexibility to optimize care (6.5) where I will discuss the need for flexibility in schedules and assigned responsibilities in order for staff to freely assist their coworkers or volunteer their time to provide eating assistance.

6.2.1 Empowering point of care staff through shared decision-making processes

Shared decision-making is one of the essential aspects of the care environment identified in the Framework for Person-Centred Nursing (McCormack & McCance, 2010). The weekly interdisciplinary team meetings for point of care staff that took place at Home A in this study seem to be a promising model of how to operationalize shared decision-making. They were an effective way to promote team information sharing and problem-solving. Researchers have studied similar models intended to empower point of care staff. Some informative comparisons can be made between two of these studies conducted in long term care facilities.

The first study, reported by Yeatts & Cready (2007), established empowered work teams comprised of certified nursing assistants (similar to PSWs) in five long term care facilities.
homes in the United States. These teams reviewed residents’ health conditions and made recommendations, addressed specific issues as requested by nurse managers, and dealt with other issues concerning certified nursing assistants. They had weekly half-hour meetings, and minutes were recorded and submitted to nurse managers. The nurse managers read the minutes and provided written feedback. Sometimes the proposed decisions and recommendations of the team were immediately approved and other times they needed to be revised and resubmitted.

The second study implemented a practice model that involved highly structured weekly staff meetings for auxiliary nurses (similar to PSWs) in two European long term care homes (Røsvik, Kirkevold, Engedal, Brooker, & Kirkevold, 2011). These weekly meetings, which lasted 45-60 minutes, were specifically designed to help care providers apply the VIPS definition of person-centred care developed by Brooker (2007). Recall that VIPS stands for Valuing the resident, using an Individualized approach, seeing things from the resident’s Perspective, and providing a Social environment that meets psychological needs. The agenda at each meeting was to use the VIPS framework to analyze a specific situation arising in daily care for a particular resident and come to a consensus on an appropriate person-centred course of action. Some of the teams were led by an auxiliary nurse and some were led by a registered nurse. An expertise group of four experienced senior staff in each long term care home were available to provide guidance for the team leaders upon request.

An auxiliary nurse who regularly provided the resident’s care was designated as the spokesperson for the resident in the meeting. This nurse presented the situation, the group analyzed it according to the VIPS framework and shared relevant knowledge and
experiences, and an intervention was planned by consensus. The nurse acting as the resident’s spokesperson scrutinized the plan from the perspective of the resident, and if found to be fitting, documented the intervention and a date was set for evaluating its outcomes.

The structured practice model described by Røsvik et al. (2011), with its clear focus on making care more person-centred, appears to be a more effective approach for empowering point of care staff to work together, share information, and problem-solve. Using the less structured approach, Yeatts & Cready (2007) found that only about 60% of participants agreed or strongly agreed that they learned from each other through the meetings, discussed how the work should be done, and learned more about what the residents liked and disliked. Although this shows a measure of success, about 20% disagreed or strongly disagreed and 20% said they were neutral regarding each of these outcomes. Qualitative findings revealed that energy and enthusiasm were high when there were particular issues to address, but if there were no burning issues then there was less interest in meeting and less was accomplished. Further, sometimes the nurse managers delegated specific issues for them to discuss, and sometimes they simply forgot or found it faster to make the decisions themselves.

There were no similar quantitative data from the study by Røsvik et al. (2011) to compare, but qualitative evaluation of this practice model indicated that the structure of the consensus meetings strengthened legitimacy of the decisions made and helped staff to coordinate their efforts to provide person-centred care. Support and supervision was needed for the auxiliary nurses who led consensus meetings for their team. Seeking guidance from members of the expertise group who did not work on the unit felt strange
to them; they more highly valued the expertise of senior staff with direct experience on their unit who knew the residents.

Registered nurses who managed participating units thought they were in the best position to lead the consensus meetings. These findings suggest that if regular team meetings were to be initiated in Ontario long term care homes and led by PSWs or even registered practical nurses, registered nurses who manage the units would need to play a key role in training and supporting these leaders. Alternatively, they might choose to lead the meetings themselves, in which case they would need to clearly see their role as a facilitator or coach, guiding staff to provide their input and come to consensus on how to make care more person-centred.

6.2.2 The role of facilitators

The role of facilitators in helping teams work together to achieve goals and put knowledge into action is well documented (Harvey et al., 2002). Janes et al. (2009) studied experiences of 34 facilitators who worked with nursing staff on best practice knowledge utilization in long term care homes in Ontario. These facilitators were external to the organizations, working with multiple long term care homes. Through interviews and written accounts, facilitators reflected on critical incidents – times that were particularly satisfying in their work and times when things did not go so well. The facilitators identified factors that influenced their efforts. Facilitators found that they needed to frame best practice knowledge so it would be highly relevant to point of care staff, and they did this through case-based learning regarding care challenges they faced with particular residents. Facilitators needed to bring knowledge from a conceptual level into more concrete terms, particularly for point of care workers. Facilitators also found it
helpful to engage staff in knowledge utilization though brainstorming sessions, team consultation, sharing experiences, doing surveys, and small group work.

Practice development initiatives in the United Kingdom seek to transform individual and team practice and change the culture and context in health care settings to be more person-centred (McCormack & Garbett, 2003; McCormack et al., 2009). Cornerstones of these initiatives are engaging nurses in active learning with their colleagues and developing their facilitation skills (McCormack et al., 2009). Boomer & McCormack (2010) evaluated a three-year practice development program for nurse leaders that focused on building a shared vision, changing the context of care delivery, and maximizing leadership potential. Nurse leaders became more reflexive and proactive, valued teamwork more, increased their availability to staff, and took on a more facilitative leadership role. This is a promising model for helping nurse leaders in long term care homes to develop their skills for facilitating team information sharing and problem-solving to make care more person-centred.

Janes et al. (2009) found that external facilitators wished they had more time for follow-up with staff in the various long term care homes they were responsible to work with. They thought that a train-the-trainer model could have been used more often, where they focused on training leaders within each facility to be internal facilitators of knowledge implementation. One of the main criteria for being a good facilitator that they noted was having some real-world experience, which gives credibility in the eyes of point of care staff. This was expressed by participants in the current study as well regarding in-service education leaders. Recall that Røsvik et al. (2011) similarly noted that nurse managers believed they were in the best position to lead team consensus meetings for
person-centred care; their expertise and knowledge of the residents made them good facilitators. Moreover, development of facilitative nurse leadership skills needs to be an objective of college nursing programs. Practice development initiatives, as described by Boomer & McCormack (2010) would be helpful to initiate in long term care settings for nurses presently in the field.

6.2.3 Applying a person-centred approach with staff

Kitwood (1997) and Brooker (2007) both emphasized the importance of using person-centred management approaches, valuing all staff members’ contributions to the team. PSWs and dietary staff provide most of the direct care for residents at mealtimes, and they are among the least educated and lowest paid workers in long term care homes (Daly & Szebehely, 2012). They have challenging work with few tangible rewards and often little recognition. Recognition from leaders, coworkers, and family members are a source of motivation to PSWs, but often PSWs feel that their efforts are overlooked (Janes et al., 2008). Emotional exhaustion, low sense of personal accomplishment, and weak work group relationships have been associated with intent to leave the job in long term care settings (Tourangeau, Cranley, Laschinger, & Pachis, 2010).

In the present study, almost 60% of participants had been employed at their current workplace for at least five years, and their comments suggested that there were relatively low levels of turnover among point of care staff. However, only point of care staff at Home A seemed to be very satisfied with the level of recognition they regularly received. Certainly more work could be done in long term care settings to increase tangible and intangible ways that direct care providers are shown they are valued as part of the team. A recent report outlining an action plan to address abuse and neglect in long
term care homes recommended establishing collaborative employee-management groups to examine quality of work life for staff and to implement solutions (Long-Term Care Task Force on Resident Care and Safety, 2012). Valuing point of care workers by carefully listening to their input on work life issues is an important first step in applying a person-centred management approach.

Endeavoring to see things from the perspective of point of care staff and involving them in decision-making are person-centred approaches that should become part of the organizational culture (Brooker, 2007; McCormack & McCance, 2010). Janes et al. (2008) found that PSWs felt honoured to be asked for their input on decisions. The personal enhancing actions of inclusion and belonging advocated by Brooker (2007) for residents are important to apply in working relationships with staff as well. McCormack & McCance (2010) identified effective staff relationships as an essential aspect of the care environment for person-centred care. Findings of the present study indicate that this means developing effective relationships across hierarchies, and also working to create a cohesive interdisciplinary team, without a silo-mentality.

There has been a strong movement for health professionals to work collaboratively with members of other disciplines. However, interdisciplinary work at the frontlines in long term care is relatively uncharted territory in the literature. Interestingly, Cott (1997) described how the structure in long term care teams had shifted from “I decide, you carry it out” (I being the physician, and you being the other health professionals), to “We decide, you carry it out” (We being the interdisciplinary team of health professionals, and you being unregulated care providers). It is time to increase inclusion of point of care staff in care decisions, and do so in an interdisciplinary manner.
Inclusion in interdisciplinary information sharing and problem-solving as a unit team is needed to bridge potential existing silos of dietary and nursing staff. Enabling direct care providers to meet regularly for discussion and decision-making involves time commitments that are not easy to uphold (Yeatts & Cready, 2007; Røsvik et al., 2011; Janes et al., 2009). In the current study, it took some creative scheduling at Home A where staff from one unit helped out in their sister unit releasing staff to go to their team meeting. This shows that where there is a will there is a way. Financial resources are needed so staff can be paid to stay for a team meeting after their shift or come in early to meet, or extra staff can be scheduled to help while such meetings take place. Otherwise staff will have a divided focus, worrying about things like not getting a resident to the toilet on time. It would be strategic to put financial resources for staff education toward regular team meetings because working together this way has great potential to enable staff to know the residents better and equip them with a greater toolbox of strategies for person-centred care. Making this type of commitment and putting financial resources behind it shows staff that their input and personal development are important to the organization.

The Framework for Person-Centred Nursing identifies supportive organizational systems, effective staff relationships, and shared decision-making as several of the essential aspects of the care environment (McCormack & McCance, 2010). When the structure is set in place for staff to work collaboratively as an interdisciplinary team, more effective relationships develop, and individual potential is maximized as each person’s voice is included in team problem-solving and decision-making. Valuing the input and contributions of staff in this way will benefit the residents too in the end.
6.3 ENABLING STAFF TO KNOW THE RESIDENTS BETTER

Workers in long term care homes need to know the residents well in order to truly make mealtime care person-centred. The following subsection will discuss how staff learn about the residents, what staff need to know about the residents, and the importance of recognizing and responding to changes in the residents’ needs and preferences.

6.3.1 How do staff learn about the residents?

Ontario long term care homes have ministry-driven processes in place which are essential to developing individualized care plans for all residents (MOHLTC, 2010). Staff can refer to information that is collected and documented right from the time of admission regarding the resident’s basic care needs and preferences. Upon admission, residents are interviewed with their family members and a list of food preferences is generated as part of this process. Residents’ needs are assessed and monitored through a standardized tool, the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) 2.0. Residents are reassessed quarterly using the RAI-MDS and the care plan is updated accordingly. An interdisciplinary care planning conference is held with the resident and his or her family within six weeks of admission and at least annually thereafter.

This process is meant to develop a good foundation for learning about the residents and generating individualized care plans. Yet, this foundation is not a guarantee that the type of information point of care staff need to truly make care person-centred will be available for them. For example, lists of residents’ food likes and dislikes tended to be very basic in the view of study participants, and point of care staff did not talk about gleaning valuable information from the RAI-MDS data. Residents’ care plans were informative to a point, but the ways staff said they learned the most about the residents
were through experience and sharing what they learned with their coworkers. Much of this sharing took place either verbally or through their daily communication book.

Likewise, Kontos, Miller, & Mitchell (2009) found that PSWs learned what they could about the residents by working with them, talking to the residents’ family members, and sharing knowledge with one another. They found the RAI-MDS data to be of limited use because it focused largely on clinical concerns and lacked the biographical information that they found useful for daily practice.

The importance of information sharing among point of care workers cannot be overlooked. In a study on PSWs’ experiences of bathing residents with dementia, participants reported learning a lot from their coworkers (D’Hondt, Kaasalainen, Prentice, & Schindel Martin, 2011). Part-time and casual staff found it especially helpful to ask other PSWs for advice and information before bathing residents who they didn’t know very well. Knowing the residents enabled them to build trust and tailor their approach. Janes et al. (2008) also found that one of the main sources of information that PSWs used to help make care person-centred was talking with coworkers. Much of this sharing among direct care providers happens informally, as they typically don’t have scheduled opportunities to pass on information and problem-solve together like nurses and allied health care professionals do (Kontos et al., 2009). Participants in the current study passed on helpful tips to coworkers in the dining room as issues arose, and shift change was another regular time for information sharing. Only one of the four long term care homes held weekly interdisciplinary meetings for point of care staff where ideas and information could be passed on to others. Designating time in the schedule for direct care
providers to share what they observe and know about the residents with one another on a regular basis needs to be a priority to make care more person-centred.

This does not mean that less emphasis should be placed on documentation. A good example of a practical way to help staff learn more about the residents through documentation is found in work done by McGilton et al. (2011). They evaluated an intervention for patient-centred communication with stroke survivors in a complex continuing care facility. As part of the intervention, a speech-language pathologist developed an individualized communication plan for each patient; it included very practical information and strategies for nursing staff regarding how to communicate with the patient, how the patient communicates, what the patient likes to talk about, and other special tips to know about the patient to avoid communication problems. In focus groups, staff said that the individualized care plans increased their awareness of different strategies to use, especially if they were ‘stuck’, not knowing what else to try. It was helpful to have this information conveniently documented for each resident. Likewise, point of care staff in the current study made comments that more detailed easily accessible written information on residents’ needs and preferences would be beneficial.

Brooker (2007) warned that care will not be person-centred if too much attention and emphasis is placed on documenting a detailed care plan without also focusing on valuing the resident, seeing things from the resident’s perspective, and creating a social environment to meet psychological needs. Detailed practical information that is accessible to point of care workers has great potential benefits. The important thing to remember is that documentation itself is not person-centred care – learning from it and using it alongside principles of person-centred care is what is required.
6.3.2 What is important to know about the residents?

With respect to mealtimes, any information that will help staff make meals more peaceful and pleasant for the residents and help them eat until satisfied should be sought out. More specifically, staff need an ever-growing understanding of how to help residents make food choices, how best to assist them to maximize independence, how to enhance the social side of eating for them, and ways to show respect. One important aspect of showing respect is understanding and responding appropriately to residents’ behaviour, including issues like refusing to come to the dining room, pushing food away, yelling, or wandering from the table. Understanding dementia and other physical or mental health challenges residents face is part of what it means to “know the residents” because it helps staff see things from the residents’ perspectives and figure out the meaning of their behaviour. Likewise, drawing upon knowledge of each resident’s life history can sometimes provide important clues to help staff to make meaning of their actions (Kontos et al., 2009).

In the recent guidelines developed by the Alzheimer Society of Canada, “dignity and respect” is one of the core concepts of the philosophy of person-centred care (Alzheimer Society of Canada, 2011). They emphasize that the values, beliefs, and cultural and spiritual background of each resident need to be considered as care is planned and delivered. Likewise, working with the patient’s (or resident’s) beliefs and values is one of the main processes of person-centred care conceptualized in the Framework for Person-Centred Nursing (McCormack & McCance, 2006). Furthermore, care can be made more person-centred by learning as much as possible about each
resident’s biography or “life plan”, including their life priorities, goals, ambitions, dreams, and desires of the past and present (McCormack & McCance, 2010).

In the participating homes, efforts were made to gather and use information about each resident’s culture and spiritual background, and related beliefs, values, and preferences. Yet from my interviews with staff, it seems that this was generally being done at a basic level, with information that was relatively easy to glean from residents and their family members. For example, staff would quite likely know that “Mary”, an aphasic resident who needs full eating assistance, is Italian and is a devout Catholic who likes to pray before meals, and one of her favorite foods is pasta. Staff may even know that she used to cook all her food from scratch including her own pasta and reminisce with her about this as she eats. What they may not know about Mary is that the pasta dishes at the long term care home are quite bland to her palate and if she could, she would sprinkle on some extra salt and pepper and parmesan cheese. They also may not know that she would rather clean her own mouth with a damp cloth than have a staff member regularly wipe her chin with the spoon or napkin as she eats. Moreover, “knowing the residents” needs to be viewed as a quest to discover things that may not be readily apparent, but would make residents’ mealtimes more peaceful and pleasant and help them eat until satisfied. It is time to look deeper and more broadly, always aiming to know the residents better.

6.3.3 Recognizing and responding to changes

With all the emphasis placed on learning about each resident’s past and the foods they have enjoyed throughout their lives, it is important for staff to stay open to the possibility that residents’ preferences can change. A resident may suddenly begin to refuse certain foods he or she previously liked or begin asking or reaching for something
that was previously known to be a dislike. Bump (2010) described a situation where a long term care resident simply mentioned to a staff member that she was tired of having eggs at breakfast, so eggs were put on her dislike list and she was never served eggs again. Time passed, and the facility switched from using a tray delivery system to restaurant style meals where residents were asked which choice they would like when seated at the table. Staff panicked when the resident asked for eggs because it was on her dislike list. Participants in the current study described similar scenarios, where there was great hesitation to provide foods that were recorded as dislikes, even if the resident asked for them. So long as the resident does not have a known allergy or intolerance to a particular food, there should be no reason for withholding the chance to have it if that desire is expressed. Furthermore, food preference lists ought to be seen as workable documents at all times.

Likewise, residents’ self-feeding abilities and desire for social interaction may change from day to day or even from one meal to the next, depending on their health, alertness, and mood. Thus, it is important for staff to be attentive and sensitive to the level of assistance each resident needs and where and when residents want to eat. For example, there may be times when a resident wants to eat with others, and times when he or she would feel more relaxed at a separate table. It is also possible that particular aspects of person-centred mealtime care may become more salient than others to a resident. For example, being able to eat independently with one’s hands may be more important than maintaining eating etiquette and participating in the social side of eating with tablemates. Knowing the resident and being able to respond with flexibility to his or her changing needs and preferences is integral to person-centred mealtime care.
6.4 EQUIPPING STAFF WITH A TOOLBOX OF STRATEGIES

If person-centred care is equated with building relationships with residents and treating them with compassion, it may be viewed as something that good care providers just do naturally from the heart. Findings of this study indicate that person-centred care involves conscious thought and decision-making about how to best meet each resident’s needs and preferences. It requires a great deal of knowledge about the residents and also about clear ways to make care more person-centred. This sub-section will discuss further why a toolbox of strategies is needed, what kinds of strategies should be part of the toolbox, and implications for staff education and the evaluation of person-centred mealtime care.

6.4.1 Why is a toolbox of strategies needed?

Nurses are commonly described by the public as caring, compassionate people – sometimes even as angels. Gordon & Nelson (2006) examined the discourse of members of the nursing profession and identified how they collectively uphold the image of nursing as a virtuous practice by the way they describe their work to others. They tend to talk about what they do in terms of building relationships and addressing the psychosocial needs of those in their care. The medical and technical aspects of their work are largely absent from their portrayals of what they do and are even devalued in their discourse. Lack of recognition and appreciation for the vast medical and technical expertise nurses possess and use is not the only negative consequence of the way nurses tend to view and talk about their work. I think that there is also a danger of overly attributing the relational and social aspects of what nurses do to the ‘caring’ personal qualities and ethics of a good nurse, while the specialized knowledge base for attending
to these psychosocial needs remains tacit and underdeveloped. Moreover, nurses have a vital role in making this knowledge explicit and passing it on to direct care providers who have less formal training. Making care person-centred cannot be taken for granted as something that good people naturally do.

Providing person-centred care is not simply a matter of having your heart in the right place, being a compassionate and empathetic person, and loving the residents – it requires special knowledge and skills. This is especially true in dementia care where good interpersonal skills are not enough to respond with expertise to the unique challenges staff face in upholding residents’ personhood. Registered and non-registered care providers who work with residents with dementia need to know a large repertoire of concrete ways to apply person-centred care in daily practice. In the current study, point of care staff commonly described the trial and error nature of their work, where the approach that they used with a resident today might not work tomorrow. They needed to be prepared with other ideas that might work, as they strove to make mealtimes peaceful and pleasant and ensure that the residents ate until satisfied.

Similarly, Janes et al. (2008) found that PSWs described their work in a dementia care unit as a “game of chance”. They figured things out in the moment because of the unpredictability of residents’ moods and behaviours. The process of figuring things out began with “melding” their knowledge of person-centred approaches with their knowledge of the resident to decide upon a course of action to try. Staff need a mental toolbox of person-centred strategies to draw upon in the moment, at the point of care. Development of this toolbox may be considered part of attaining professional
competence and serve to enhance the potential for innovation needed for person-centred care (McCormack & McCance, 2010).

6.4.2 What kinds of strategies should be part of the toolbox?

The kinds of strategies deemed important to include in one’s toolbox depends on how person-centred care is conceptualized. For the purpose of this study, I had conceptualized person-centred mealtime care as providing choices and preferences, supporting independence, promoting the social side of eating, and showing respect. These four aspects of mealtime care were identified a priori as I applied the definition of person-centred care developed by Brooker (2007) to the available peer-reviewed literature on mealtimes in long term care homes (Reimer & Keller, 2009). My conceptualization of person-centred mealtime care was used to help structure the interviews I conducted with staff. As we talked about strengths and areas for improvement at mealtimes, participants shared many of the specific ways they made care person-centred in these four aspects of mealtimes.

In comparison to the first three aspects of person-centred mealtime care, the construct of “showing respect” was somewhat ambiguous and reflected a higher order principle. In fact, before the study even began I recognized that the idea of showing respect seemed to undergird each of the other elements. Providing choices and preferences, for example, is a way of showing respect. I explained this to the interview participants, and they agreed. Yet, they were able to identify many ways that they showed respect at mealtimes beyond providing choices and preferences, supporting independence and promoting the social side of eating. Broadly categorized, these additional ways of showing respect included creating a peaceful and pleasant dining
environment, providing unrushed courteous service and assistance, and understanding residents’ behaviour and how to respond. With this knowledge, I would now expand my conceptualization of key aspects of person-centred mealtime care as shown in Figure 6.1. An important outcome of this study is that a good repertoire of practical strategies was articulated by participants to help develop a clear picture of what each of these aspects of mealtime care looks like. Thus the findings could provide a good starter toolkit for person-centred mealtime care to augment existing best practices, and I hope that registered health professionals and point of care staff would continue to add more person-centred strategies over time.

![Person-centred mealtime care table]

Figure 6.1 Six main aspects of person-centred mealtime care

Existing best practice guidelines for dining developed by dietitians of the Ontario Long Term Care Action Group (Dietitians of Canada, 2007) provide an excellent foundation, but specific strategies to make care more person-centred for residents with dementia could be added. There is a need to continue making tacit knowledge explicit and share this knowledge as a best practice evidence base for person-centred care. The caveat is to see this knowledge base of strategies as a toolbox to draw from and “meld” with knowledge of the resident, as described by Janes et al. (2008). The other important
point to emphasize regarding development and use of a toolbox of strategies is to always reinforce the link back to the philosophy of person-centred care. At the end of the day, staff should be able to articulate what person-centred strategies they have used and understand the connection between their approach and the central aim of upholding residents’ personhood. In presenting the findings of this study, I endeavored to reinforce the link between the specific mealtime care practices of staff and the philosophy of person-centred care by referring to personal enhancing and personal detracting actions outlined by Brooker (2007).

While Brooker’s descriptions of personal enhancers and detractors helped clarify the meaning of care practices with respect to person-centred care, I also experienced some challenges and limitations in trying to apply them. For example, seemingly subtle differences between the meanings of ‘enabling’ versus ‘facilitation’ or between ‘accepting’ and ‘recognizing’ left me puzzling over how to categorize some actions and I found it rather trivial to discern the difference. On one hand, I think it is helpful for staff to learn about person-centred care through vivid examples of personal enhancers and detractors. The language used to depict common personal detractors such as ‘mockery’ or ‘treachery’ help expose the serious nature of malignant social psychology. Yet, to advance a knowledge base for how to provide person-centred care, a more pragmatic framework such as the six aspects of mealtime care shown in Figure 6.1 is useful.

Person-centred care has been conceptualized in other ways, sometimes at a more philosophical level. For example, the Framework for Person-Centred Nursing identifies five main care processes as person-centred: working with the patient’s beliefs and values, engagement, shared decision-making, having sympathetic presence, and
providing for physical needs (McCormack & McCance, 2006). More recently, providing for physical needs was revised to providing holistic care in the framework (McCormack & McCance, 2010). Using this framework, staff need to develop an increasingly clear picture of what these care processes look like in daily practice. In other words, they need concrete ideas of how to practice principle processes like engagement or shared decision-making with residents with dementia. Further work could be done to detail what these processes look like in different aspects of care such as mealtimes. Potentially, person-centred strategies identified in the current study could be re-conceptualized within this more widely adopted framework, forming a stronger bridge between the philosophy of care and mealtime care practices.

At the other end of the spectrum, the Pioneer Network in the United States has amassed a huge body of practical guidance to transform dining in long term care from traditional institutional approaches to processes recognized to be more “person-directed”, upholding values of choice, dignity, respect, self-determination, and purposeful living (Pioneer Network, 2012a,b). This body of work is oriented primarily toward the organizational aspects of delivering food services. To date, specific mealtime strategies for staff working with residents with dementia are not highly developed in tools and resources available through the Pioneer Network, and this addition could certainly strengthen their efforts to transform the culture of long term care. I also think that as long term care homes continue to come onboard with the culture change movement and implement changes that the Pioneer Network advocates for mealtimes, it will be important to make sure staff understand the link between the changes and the philosophy of care they are established upon.
In our nation, the Alzheimer’s Society of Canada (2011) set out guidelines for providing person-centred care for people with dementia living in care homes. After outlining the meaning of a person-centred philosophy of care, these practical guidelines go on to describe “What person-centred care looks like.” They descriptively provide a picture of what can and should be done to help residents enjoy every day, feel safe and independent, participate in meaningful activities, and have changes in mood and behaviour skillfully addressed. Practical guidelines on how to make mealtimes person-centred are provided in the section on enjoying every day. Yet these guidelines are very basic; they emphasize, for example, to create a homelike environment and consider residents’ preferences, nutritional needs, and independence when offering food choices, but give few details on how to do this. Findings of the current study could help expand upon these guidelines, more fully developing a toolbox of strategies for person-centred mealtime care.

6.4.3 Implications for staff education and evaluation of person-centred care

Equipping long term care home staff with a mental toolbox of person-centred strategies involves education and training. Although experience and role-modelling are important modes of learning, it cannot be assumed that training on person-centred approaches will happen automatically – it needs to be intentional and given priority. Skaalvik, Normann, & Henriksen (2010) studied the experiences of nursing students working with long term care residents with dementia, and they recognized that they needed more knowledge about how to respond to residents with challenging behaviours, but it wasn’t discussed in their training and they questioned whether staff indeed knew how to handle these situations. As upper-year students, they were exposed to limited
role-modelling by their supervisors as most of their work was done independently or with other students. This reinforces the message that education and training to equip staff and students with a toolbox of person-centred strategies requires a deliberate plan of action.

Equipping staff for person-centred care should be considered an ongoing process, where creative new strategies are added to their toolboxes and relevant but old, forgotten ones are brought back to remembrance. Providing point of care staff with a detailed manual that describes strategies is not likely to be an effective way to help them develop their mental toolbox. Røsvik et al. (2011) gave staff a manual that described many practical ways to apply the VIPS definition of person-centred care developed by Brooker (2007), and staff simply didn’t have the time to read and refer to it. Several short handouts, posters, or pocket docks (pocket-sized information cards) identifying some key strategies that stimulate thinking about different approaches to try may be more useful. Short video clips or vignettes on common mealtime scenarios that staff can discuss in education sessions may also be helpful tools. Findings of the current study indicate that learning with and from coworkers is an important way to promote the ongoing development of a good toolbox of strategies.

Another vital part of equipping staff with strategies is helping them to clearly make the connection between these strategies and the philosophy of person-centred care. As discussed above, care providers should be able to articulate what specific approaches they have used with residents and why these approaches are considered to be person-centred. Mottos, catchy phrases, and acronyms that become part of the cultural discourse can be helpful in linking the philosophy and practice of person-centred care. The “VIPS”
definition of person-centred care developed by Brooker (2007) is a good example of a memorable acronym that can help staff make this connection.

Many tools have been developed over the years to evaluate the implementation and outcomes of person-centred care, each having different conceptual foundations which are not always well explained (Edvardsson & Innes, 2010). The Framework for Person-Centred Nursing provides a good theoretical foundation for practice and research, and it identifies the need to evaluate the following four outcomes: satisfaction with care, involvement with care, feeling of well-being, and creation of a therapeutic culture (McCormack & McCance, 2006). Dementia Care Mapping involves a much different approach, where person-centred practice is evaluated by trained observers who carefully document the personal enhancing and detracting actions of staff along with effects on the resident’s mood and level of engagement (Brooker & Surr, 2006). More research on education to equip staff with practical person-centred strategies and related outcomes would be a strong addition to current efforts to evaluate person-centred practice.

Providing educational support for staff on person-centred strategies opens the door for intervention research measuring changes in attitudes, knowledge, observed staff behaviours, and related resident outcomes. Theoretically, there should be a link between implementation of person-centred mealtime care practices and resident responses, including reduced agitation and increased food intakes. When it comes to observing staff behaviour to evaluate the application of strategies, I think it is quite important to augment these observations with reflective commentary by staff members on their approach. Since knowledge of the residents is central to the application of strategies in practice, it may not always be apparent to an outside observer how well care is being tailored or
individualized for each resident. For example, the rationale for seating residents in particular spots may be highly person-centred, taking into account their capacity and desire for social interaction, their needs for assistance, and other factors. On the other hand, the seating arrangement might be determined by rote with little taken into consideration at all. Without talking to staff, it would be hard to really determine how intentionally person-centred their mealtime care practices are. Much further research could be done on equipping staff with person-centred strategies.
6.5 CREATING FLEXIBILITY TO OPTIMIZE CARE

Another key element of supporting direct care providers to implement a person-centred approach at mealtimes is creating flexibility to optimize care. Staff need the flexibility to bend rules and routines to meet residents’ individual needs. This subsection will discuss the issue of flexibility to optimize care in relation to three key topics found in the literature: scheduling staff and assigning responsibilities, maintaining standards and smooth operations, and advocating for residents and managing risks.

6.5.1 Scheduling staff and assigning responsibilities

Cohen-Mansfield & Bester (2006) described a long term care home in Australia where flexibility had been adopted as a management principle in several ways, including how they scheduled staff and assigned responsibilities. The long term care home had only 36 residents, with nine residents living in each of four attached homelike units. Flexibility in scheduling was achieved by creating shifts that varied in length (i.e. eight, seven, six, and four hours long). This enabled managers to tailor staffing to the needs of the residents, with more help being available at mealtimes; staffing was highest from 8am-1pm and 4:30-8:30pm. Many of the staff worked part-time, with a mean of 22 hours per week. Flexibility in scheduling was also created by giving staff the opportunity to work with and get to know all the residents in the long term care home; this made it easier for staff to switch their shifts with others as desired. The flexibility that staff experienced with their work schedule made it easier to maintain work-life balance, especially for those with young families.

Flexibility was also a management principle in the assignment of staff responsibilities. Direct care providers had a wide variety of roles including cleaning,
cooking, laundry, and personal care, and the schedule to complete these responsibilities seemed to be held loosely. For example, quality of care was not determined by how early the beds were made in the morning. Rather, the director of nursing knew that things were going well if the staff were eating breakfast with the residents and enjoying time with them. Moreover, it appears that a philosophy of person-centred care was the vision underlying the flexible approach taken by management.

Adopting flexibility as a management principle for scheduling staff and assigning responsibilities, as described above, seems to enable implementation of person-centred care. However, other research has shown that staff who work in similar environments still have difficulty finding time to attend to residents’ social and physical needs the way they wish they could. For example, direct care providers in Sweden (n = 292) were responsible for personal care, meal preparation, cleaning, and leading recreational or social activities, and many of them wished that they could do less cleaning and spend more time on other aspects of resident care (Daly & Szebehely, 2012). These staff members reported working with 8.8 residents on average. Their cleaning responsibilities added to their workload and reduced the flexibility they had to provide the quality of care they desired to give.

Daly & Szebehely (2012) compared the situation in Sweden to that in Canada and found some notable differences in the way work was structured for staff. In Canada, staff roles were highly differentiated (as in the present study), where PSWs provided much of the hands-on resident care while dietary, housekeeping, restorative care, and recreation staff had distinct supportive roles. They found that PSWs in Canada (n = 415) reported helping 15.2 residents on average, which is almost double the ratio of residents to staff in
Sweden. Although Canadian care providers had tighter boundaries around their responsibilities, PSWs reported that more tasks were being given to them due to cutbacks in other areas. For example, they were taking on roles in serving food, putting away laundry, and cleaning that they felt should be the job of staff in other departments. Some alarming findings from the Canadian data were that 60% of PSWs felt they had too much to do all or most of the time, and 46% said they worked short-staffed almost every day due to sickness, vacation, or vacancy. Heavy workloads leave little to no room for the level of flexibility needed in daily work routines to provide person-centred care.

Whether the model of care is like that in Sweden (having staff with integrated roles) or like that in Canada (staff with differentiated roles), the complexity of residents’ needs and related demands upon staff time need to be carefully considered. From personal past work experience, having integrated roles worked well with five residents who were relatively independent, but it was very challenging when looking after more residents with higher needs. Findings of the present study suggest that care can be made person-centred where staff have differentiated roles, but there needs to be enough flexibility that workers within and between departments can step in and lend a hand to others or volunteer their time as needed. Working together reduces the workload, and so does forming a strong team with the help of family members and volunteers. Having an appropriate workload creates flexibility to optimize care. Flexibility is also created by loosening the schedule and empowering staff to shift responsibilities to a later time or the next shift if necessary in order to fully adopt a person-centred approach.
6.5.2 Maintaining standards and smooth operations

Government regulations and organizational policies are set in place to achieve and maintain a standard level of quality care. By loosening the rules, there may be a fear of losing care quality. However, a beautiful relationship can exist between flexibility and control. Think of the sport of gymnastics as an analogy; exercising flexibility with muscular control and stability prevents injury and enables gymnasts to carry out very difficult skills with poise. Exercising flexibility in the realm of long term care with the control and stability of a foundation of guiding rules and regulations enables staff to move beyond standard quality care to person-centred care.

Long term care homes have many policies and procedures, and in some cases there may be confusion among staff over which ones are required according to government regulations and which ones are based on guidelines, best practices, or other reasoning. For example, participating staff referred to the policy of rotating the order in which tables are served as a ministry standard or regulation, but upon taking a second look at the regulations, I realized that this was not listed among them. It was part of the ministry guidelines which accompanied the old set of standards in the Long Term Care Homes Programs Manual (MOHLTC, 2006), and it is also included in the OLTCAG best practices (Dietitians of Canada, 2007). Likewise, there is nothing in the current regulations that says staff cannot eat with the residents; however, this was perceived as something that government inspectors would criticize. Moreover, long term care home staff may have potential for much more flexibility with current policies and procedures than realized. It would be helpful for registered health professionals and managers in long term care homes to identify and review the reasoning behind written and unwritten
policies and procedures in their facility that are not related to the current regulations. Point of care staff need to be taught the reasons for policies and procedures they are asked to follow and learn under what circumstances it is appropriate to bend the rules for residents.

Person-centred care may require making exceptions to the rules from time to time to uphold residents’ autonomy and wellbeing. I prefer to think of it as bending the rules as opposed to breaking the rules. Like a material that can stretch and bend but always go back in shape, the overall integrity of the rules needs to be maintained. Kontos, Miller, Mitchell, & Cott (2010) studied the point of care decisions made by PSWs in Ontario long term care homes and found that violations of the rules were contextualized rather than routinized. In other words, direct care providers broke (or bent) the rules when they thought it was in the best interest of the residents. Supervisors tended to be complicit about rule violations if they felt the action was consistent with the resident’s needs and preferences. However, rule breaking was not allowed to be routinized on account of surprise government inspections and the need to keep operations running smoothly in the long term care home.

6.5.3 Advocating for residents and managing risks

Point of care staff may frequently need to act as advocates for residents with dementia, and sometimes what the resident needs and wants or what the staff member thinks is best for the resident goes against usual policies and procedures of the home. An example encountered in the current study was when a resident on a pureed diet requested regular bread with his meal. This puts the staff member in the position of potential conflict – although she wants to provide what the resident wants, she also has the duty to
follow the resident’s diet order. Moland (2006) discussed a similar situation that happens often in the work lives of registered nurses in hospitals. Sometimes there is discordance between the desires and expressed or perceived needs of the patient in their care and the physician’s orders they are expected to follow. Nurses could choose to handle the conflict by simply doing what the doctor orders while sympathizing and commiserating with the patient. Alternatively, they could choose to routinely disobey orders and do what they believe is in the patient’s best interest. In the first case, they fail to act as the patient’s advocate, and in the second case, they deny their responsibility of working with the physician and may put the patient at risk. Moland’s argument was that nurses maintain their integrity in these situations by acting with appropriate deliberation and compromise. There needs to be open dialogue to resolve such issues. Similarly, point of care workers in long term care need to be trained to handle potential conflicts as they act as advocates for the residents in their care while endeavoring to follow policies and procedures.

Risks may be involved when staff advocate for residents to make changes to their diet order. The Pioneer Network recently developed standards for long term care homes regarding individualized special diets which state, “When a [resident] makes ‘risky’ decisions, the plan of care will be adjusted to honor informed choice and provide supports available to mitigate the risks” (Pioneer Network Food and Dining Clinical Standards Task Force, 2011). Risks and benefits need to be explained not only to the resident but also to the interdisciplinary care team, and the team should be trained on how to manage the risks involved. For a resident on a pureed diet wanting to eat regular
texture food, this may simply mean watching the resident as he or she eats and knowing how to recognize and respond to signs of choking.

Problem-solving together through open dialogue is the key ingredient to resident advocacy and managing risks that may be associated with bending the rules. In some cases, there may be good reason to break (or change) the rules; there may be policies or procedures that care providers frequently encounter conflict with and wish could be changed to improve resident care. Applying a critical realist lens, Kontos et al. (2010) found that care providers were unable to bring about change in the regulations and related policies because these issues were never openly addressed between point of care staff and supervisors. Supervisors spoke up if they believed PSW rule violations compromised the quality of care, but they basically turned a blind eye if they felt that the rule violations were justified. There is no power to change the rules or how they are enforced unless staff at all levels begin opening dialogue about them. Policies and procedures that routinely reduce flexibility need to be revisited. Providing person-centred care requires potential for innovation and risk-taking (McCormack & McCance, 2010). Engaging in resident advocacy by problem-solving together has potential to generate revisions to policies and procedures which create this potential and the give the flexibility to optimize care.
6.6 STUDY STRENGTHS AND LIMITATIONS

Credibility, transferability, dependability, and confirmability are well established criteria for evaluating qualitative research (Lincoln & Guba, 1999). Credibility refers to how well the author’s data representations and interpretations reflect the truth, and therefore could be confidently applied by others as a basis for action. Two limitations pertaining to data collection affect the findings in this regard. One is that some participating staff tended to focus their interview responses on strengths in current practice and seemed somewhat reticent to share about areas for improvement. However, in all four long term care homes, there were some participants who were quite open and reflective about what could be improved in mealtime care. A good future study to check and enhance credibility of the findings would be to carry out more in-depth research in one long term care home, involving a variety of data collection methods including observations of mealtimes and a close examination of how teams function. The other main limitation of the current study is that when participants identified and commented on influences on implementation of person-centred mealtime care, these influences were often not directly related back to concrete examples of care practices. This was due to how the interviews were structured. Thus, I think that a good method for another possible future study would be to use critical incident technique, where staff describe strategies used with particular residents (perhaps those with low intakes or responsive behaviours in the dining room) and critically reflect on what influenced their care approaches.

Lincoln & Guba (1999) advocated using triangulation of data sources for enhancing study credibility. One strength of this study was the inclusion of interviews with staff of various positions from four diverse long term care homes. Member
checking has also been advocated; this has not been conducted, but follow-up education sessions with the participating homes will present an opportunity to share the findings and see how they resonate with the staff.

Transferability refers to how well the information gathered and presented enables others to make judgments about their applicability to other contexts (Lincoln & Guba, 1999). One of the great challenges for me as a researcher in this study was managing the scope and depth of data collection. The level of understanding I attained about the context and culture of each of each participating long term care home and my ability to provide thick description about them was limited due to the wide scope of the study. Had the focus been on one or two long term care homes and the inquiry narrowed down to a particular aspect of mealtime care such as providing choices and preferences or the influence of teamwork on mealtimes, more details of the context and culture would have been examined. However, I aimed to describe strengths and areas for improvement in four major aspects of mealtime care: providing choices and preferences, supporting independence, promoting the social side of eating, and showing respect. I was also seeking to identify influences at the individual, team, and organizational levels. Further, this study included voices of direct and indirect care providers from four long term care homes. Therefore, the scope of the study was very large and limited the depth attained. I also needed to find a balance between providing enough description about each home and the participants without making them easily identifiable. Although thick description of each long term care home was somewhat limited, knowing that the findings were based on four diverse long term care homes can increase confidence in their applicability to other long term care facilities, particularly in Ontario.
Dependability is akin to the concept of reliability and has to do with consistency in the process of inquiry (Lincoln & Guba, 1999). In other words, if the same process was followed, would you end up with similar findings? Confirmability is a related criterion, having to do with the relative neutrality of the process of inquiry (Lincoln & Guba, 1999). Evaluating confirmability means questioning how well the product of the study (the interpretations and conclusions) are supported by the data and how they were influenced by the researcher’s assumptions and values. The criteria of dependability and confirmability are both best addressed by keeping an audit trail of the methods used in data collection and analysis and practicing reflexivity. My audit trail includes the raw data, summaries of the data, concept maps, descriptive memos of themes, and this final report – my dissertation. In chapter three, I described my ontological and epistemological position, potential influences on mealtime care that I had been sensitized to through the literature, and reflections from personal experience which particularly influenced the focus of my interviews with participants. I could have been more reflexive throughout the data analysis process by journaling about my assumptions and values and their influence on my interpretations. I think one thing that helped me achieve a relatively neutral stance during data analysis was stepping away from the literature and immersing myself in what participants were saying by becoming very familiar with the interview transcripts. I invite you as a reader to review the process of inquiry described in the methods chapter and critically evaluate how well my interpretations fit the data as presented in the findings chapter of this dissertation.
6.7 DIRECTIONS FOR FUTURE RESEARCH

As described in the previous section, two directions for future research would be:

1) To conduct a more in-depth, ethnographic examination within one long term care home using a variety of methods including observations of mealtimes and team processes, and 2) To use critical incident analysis regarding influences on approaches used at mealtimes with residents with poor intake or responsive behaviours. These studies would be helpful to extend and confirm the current findings. In particular, I think it is important to further examine relationships I have interpreted from the data regarding how action at the team level influences the implementation of person-centred mealtime care. Regarding theory development, I think it would also be helpful to do a secondary analysis of the current data specifically in relation to concepts identified in the Framework for Person-Centred Nursing (McCormack & McCance, 2010). Doing so could extend and refine our understanding of how this framework applies to mealtimes in long term care settings.

The conceptual framework developed through this study is potentially a good tool for long term care home staff to use to guide their reflections on how to improve implementation of person-centred care in their unique setting. Furthermore, I think a participatory action research approach could be used to engage a long term care home in this process of reflection and then study the process and outcomes of changes they decide to implement. These changes may focus specifically on forming a stronger team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, or creating flexibility to optimize care.

Another area for future research is how to recruit and train mealtime volunteers and how to encourage and support family members to come and assist with feeding.
Perhaps a good first step would be to conduct a province-wide survey-based study on current volunteer recruitment and training processes and the level of involvement of volunteers and family members at mealtimes. Current resources used by long term care homes to train volunteers on feeding and communicating with residents with dementia should be identified and reviewed. Development and evaluation of programs to increase involvement of volunteers and family members could follow.

There is also plenty of research that could be done on educating and training staff to develop their toolbox of strategies for person-centred care. Ongoing education and training through team problem-solving facilitated by a registered nurse could be compared to other forms of in-service training (i.e. presentations, use of print materials, or online learning) in terms of knowledge and behaviour change. Ideally, it would be good to measure effects on residents’ mealtime satisfaction, food intake, and behaviour that may result from such changes. Research is also needed on the process of engaging frontline nursing and dietary staff in ongoing information sharing and problem-solving as an interdisciplinary team to mutually increase their knowledge of the residents and their toolbox of strategies.

This study included the perspectives of direct and indirect care providers in a wide range of roles in order to gain a more comprehensive understanding of mealtime care practices, what influences these practices, and how to help staff make care more person-centred. It was not the intent of this study to directly compare the perspectives of different groups of participants. Reflectively, I did not notice great differences between the viewpoints of direct and indirect care providers. As could be expected, the direct care providers were able to share more detailed examples of how they served and assisted
residents, and indirect care providers were able to describe further detail on the kinds of things they looked for when supervising in the dining room. I do not think it would be a high priority to do further study on differences in points of view between staff of various departments or levels of leadership. What I do think would be useful is further research on the knowledge of strategies for person-centred care that different groups possess (i.e. How does the knowledge of personal support workers compare to that of food service workers, recreation staff, and private companions who help provide mealtime service and assistance?). Any gaps in knowledge identified could then be addressed through more targeted educational interventions.

This study included long term care homes that differed in size, location, and for-profit and not for-profit status. It was not the intent of the study to directly compare and contrast perspectives of staff from each home to understand the effects of these specific organizational characteristics. Selecting long term care homes for maximum variation provided a broad set of interview data to more comprehensively answer my research questions. Future research could look at organizational factors such as size, location, and profit status in more detail, but I would encourage researchers to focus their attention on factors that have greater potential to be modified. Organizational factors that I think would be more beneficial to study in further detail would be the size and physical aspects of dining rooms (i.e. space, noise, and distractions), mealtime staffing levels, and organization of workflow at mealtimes. Considering the breadth of the current study, these issues were touched upon but could certainly be examined in greater depth.

Another organizational factor that would be good to study is whether working in a special dementia care unit is associated with greater knowledge of strategies for person-
centred mealtime care. In this study I noticed that staff who regularly worked in special units for residents with dementia seemed to able to articulate more strategies that they used to provide person-centred mealtime care. This reflective observation needs further study; if confirmed, it would mean there is a need for more intensive training on person-centred approaches for staff in long term care homes without special dementia care units.

Macro-level influences on mealtime care practices were not the focus of this study. Yet, from a critical realist perspective, the relationship between staff practices and broader societal influences cannot be neglected. In particular, it would be helpful to conduct a more detailed examination of how government funding, regulations, and the inspection process affect mealtime care. Findings of this study revealed that there is a need to improve staff understandings of the regulations and their knowledge of when it is acceptable to bend the rules. It would be prudent to follow-up with a larger survey-based study on staff knowledge of the regulations, points of confusion, and also the views of compliance inspectors who enforce the regulations.

Another avenue of future research at the macro-level is to look into the broader influences of the community in which staff live and work and personal beliefs and values related to their cultural backgrounds. Several comments were made by participants in this study about how personal cultural and religious beliefs may influence staff care practices. Yet, considering the scope of the study, these relationships were not discussed in detail. Given there are large numbers of immigrant workers in some long term care homes, it would be interesting and useful to more deeply examine differences among the beliefs and values of staff and how these are associated with their current community and culture of origin. It would also be helpful to examine education to raise cultural
awareness that staff have received formally and through in-service training. The effect of such training could be evaluated through study of staff knowledge and how this knowledge is put into practice as they care for the residents and work as a team with others of different cultures.
7. CONCLUSIONS

The purpose of this study was to understand what types of practical and educational support are needed to help direct care providers in Ontario long term care homes to make mealtime care more person-centred for residents with dementia.

The specific objectives of this study were to:

- Describe current implementation of person-centered mealtime care.
- Explain what influences implementation of person-centered mealtime care practices.
- Identify practical steps to improve implementation of these practices.

Three main research questions were addressed:

- In what ways are person-centered mealtime care practices being implemented well and what are some areas for improvement?
- What factors at the individual, team, and organizational levels enable and hinder implementation of person-centered mealtime care practices?
- How can current barriers to providing person-centered mealtime care be overcome?

The intended outcomes of this study were to use the findings to help guide future development of staff education and training resources and to develop recommendations for decision makers. In this final chapter, implications of this study will be summarized for several groups: educators and practice development leaders, dietitians and foodservice managers, long term care home administrators and directors of care, and policy makers.
Descriptions from point of care staff about the education they received through college programs, on-the-job training, and in-service workshops indicated that their training tended to focus on the basics of mealtime care without always clearly addressing the philosophy of person-centred care and how it applies to mealtimes. As expected, the emphasis in their training was on the MOHLTC regulations and implementing best practices for dining identified by the OLTCAG. This training has helped to ensure that a good standard level of quality care is attained, but there is a need for further training in college programs and long term care homes on strategies staff can use to make mealtimes more person-centred, particularly for residents with dementia. Staff would benefit from further training on six aspects of person-centred mealtime care: providing choices and preferences, supporting independence, promoting the social side of eating, creating a peaceful and pleasant dining environment, providing unrushed courteous service and assistance, and understanding residents’ behaviour and how to respond.

Understanding the behaviour of residents with dementia and knowing how to respond with person-centred approaches is particularly important for staff. Point of care workers indicated that they desired more training on real-world challenges they faced in practice such as what to do when a resident has low food or fluid intake, or how to recognize and address responsive behaviours. Recently a report on long term care in Ontario recommended that staff training on responsive behaviours should be a priority to prevent instances of abuse and neglect (Long-Term Care Task Force on Resident Care and Safety, 2012). Future staff education initiatives on dementia and responsive behaviours that are implemented in reaction to this recommendation could purposefully
incorporate more examples of challenging situations staff may encounter at mealtimes and how to respond using a person-centred philosophy of care. Such education needs to be provided not just for PSWs, but also for FSWs and others who serve and assist residents at mealtimes. Registered practical nurses who supervise the dining room while administering medications before and during mealtimes also need to be well educated on person-centred strategies that they can encourage staff to implement.

Currently available best practice guidelines on mealtime care (including those developed by the OLTCAG, the Pioneer Network, and the Alzheimer Society of Canada) could be updated with more specific strategies for residents with advanced dementia that participants described. As an example, the current OLTCAG best practices advise using sample plates to help residents make their food choices; this guideline could be extended by instructing staff to watch the residents’ eyes when using sample plates. If residents cannot express their choices verbally, their eyes may be drawn to the choice they would prefer. It is also important for best practices to indicate that flexibility may be needed in their application in order to meet residents’ individual needs and preferences. For example, the OLTCAG best practices currently advise staff to show residents their choices in the regular texture, regardless of the type of diet the residents are on. Point of care staff participating in this study described how residents with dementia on pureed diets tended to be upset and confused when they were shown the regular texture sample plates but received their food in pureed form. It would be helpful to amend such guidelines to reflect the need for flexibility in how they are implemented.

This study draws attention to the importance of opportunities for point of care staff to learn from each other by sharing information and problem-solving together as an
interdisciplinary team. Registered nurses who oversee units in long term care facilities are in a good position to facilitate team meetings and enhance their learning outcomes. Development of strong group facilitation skills needs to be an objective of college training programs for registered nurses and practice development initiatives in long term care homes. This focus is in-line with the PARIHS framework (Rycroft-Malone, 2004) and the Framework for Person-Centred Nursing (McCormack & McCance, 2010); both frameworks indicate that development of a learning culture through shared decision-making processes is needed to successfully implement changes in practice.
7.2 IMPLICATIONS FOR DIETITIANS AND FOOD SERVICE MANAGERS

As described in the introduction to this thesis, residents with dementia are a population who are particularly at risk for unintentional weight loss and malnutrition. This issue is what sparked my interest as a dietitian in studying mealtimes in long term care homes. Moreover, the findings of this study have implications for dietitians as well as food service managers who are seeking ways to improve mealtime care and thereby promote good food intakes.

Dietitians at all four participating long term care homes understood the importance of working closely with point of care staff; they sought the input of PSWs and FSWs who regularly work with the residents in order to learn more about each resident’s needs and food preferences. This practice of working closely together needs to continually be modelled and encouraged as new dietitians are trained, and the conceptual framework developed through this study could be used to explain the rationale for developing strong working relationships with point of care staff to make care more person-centred. Food service managers and supervisors in training likewise need to be taught and reminded of the importance of working together with point of care staff in order to tailor the menu, plan seating arrangements, and organize meal service to meet residents’ needs and preferences.

Knowing the residents is essential for providing person-centred mealtime care, and an important aspect of this is developing food preference lists and using them to their full potential. Participants commonly indicated that food preference lists tended to be basic, with only a few foods listed as likes and dislikes. Dietitians and food service managers could help set in motion plans to create more detailed food preference lists,
especially for residents who cannot indicate their own food choices to staff at mealtimes. Further, more could be done to provide residents’ favorite foods and cultural preferences, with special attention given to desserts, snacks, and beverages. The quality and variety of pureed options on the menu is also important for dietitians and food service managers to regularly review.

An issue that point of care staff said they often struggled with was what to do when residents had low food or fluid intakes. Dietitians in long term care homes have a vital role in equipping staff with strategies to use in these challenging situations. It is important for dietitians to remember that what works one day may not work the next day or even at the next mealtine, so staff need to be prepared with knowledge of a variety of strategies consistent with a person-centred philosophy of care. They also need to have a clear understanding of each resident’s nutritional needs. Part of knowing the resident means knowing how much food and fluid he or she needs each day. Without clearly knowing how much a resident needs to eat or drink to stay healthy, staff may push residents to consume more than they want to. Dietitians can help point of care staff learn to be good problem-solvers, understanding reasons why residents may refuse food or fluids, and knowing how to respond with person-centred approaches.

Dietitians are called upon to assess residents’ needs for special diets, including texture modifications for chewing or swallowing problems. Dietitians endeavor to carefully involve the resident and/or the resident’s family in decisions regarding special diets of any kind. Yet, findings of this study indicate that when decisions are made to start residents on a special diet, more flexibility is sometimes needed to provide requested foods that are not normally allowed. Making care more person-centred would involve
proactively having more conversations with the resident and/or family about foods they may desire from time to time that are not accepted on the resident’s new diet. Care plans and protocols need to clearly indicate how staff can respond with a collaborative person-centred approach when special requests are made, ensuring that residents and family are making informed decisions and taking steps to minimize risks. This will help create flexibility to respond to requests as they arise at the point of care.

Dietitians and food service managers participating in this study were aware that caring for many residents with high needs makes it challenging for staff to provide person-centred care at mealtimes. In order to meet the demands of care, a strong team is needed, including the help of family members and volunteers. Dietitians and food service managers need to be active advocates for the recruitment of mealtime volunteers and help plan and provide the training they need to provide mealtime assistance. As dietitians speak with family members about residents’ nutrition care plans, they can also invite and encourage their involvement at mealtimes.
7.3 IMPLICATIONS FOR LONG TERM CARE HOME ADMINISTRATORS AND DIRECTORS OF CARE

This study has shown that the abilities of staff to provide person-centred care are impacted by organizational or leadership level influences, and this reveals some important lessons for organizational development. Leaders need to not only form a strong team by hiring staff with key personal attributes, but also continually apply a person-centred approach that empowers workers at all levels to maximize their potential. An important way of promoting this growth is developing a culture of good teamwork. Leaders can enhance the training of their staff and improve the quality of teamwork simultaneously by creating space and time for point of care staff to take part in interdisciplinary meetings where they can share information and problem-solve together.

Part of problem-solving together is opening up communication between point of care staff and supervisors and managers about situations where more flexibility is needed. Such conversations are essential to clarify appropriate times for bending rules and routines, and identifying circumstances where more options are required to meet residents’ individual needs and preferences. Intentionally opening discussion on these issues also helps to get all staff on the same page with a shared vision of what it looks like in practical terms to implement a person-centred philosophy of care.

Leaders also need to be proactive in recognizing and responding to changes in workload that point of care staff experience as residents’ functional and cognitive abilities decline and new residents enter the unit. Long term care homes need to establish a cultural expectation that staff within and across departments and hierarchies will step in to lend a hand as needed at mealtimes. Likewise, lending a hand outside of mealtimes, by helping bring residents to the dining room or assisting with cleanup and other duties
after meals, increases the flexibility staff have to serve and assist residents at a relaxed pace. Enabling staff to pass duties on to the next shift if needed can also help create flexibility to optimize care.

Time pressures may be especially high at breakfast and supper, and on weekends when fewer people are available to help provide assistance. Long term care homes need to proactively encourage family members to come and help at mealtimes, and recruit, train, and schedule volunteers to provide eating assistance. This not only gives staff time to make mealtime care more person-centred for residents, but also improves their working conditions. Improving workload and acknowledging staff for the challenging work they do are important aspects of applying a person-centred management approach.
7.4 IMPLICATIONS FOR POLICY MAKERS

One of the most important things that can be done to improve implementation of person-centred care is to ensure that there is adequate staffing at mealtimes. Current regulations require that no staff person assists more than two residents at the same time who need total assistance with eating and drinking (MOHLTC, 2010). Based on the study findings, it would be advisable to encourage long term care homes to assign each PSW to no more than two residents who need full eating assistance, period, at any given mealtime. Assigning staff to more than two residents who need full assistance creates a situation in which outpacing and other personal detractors are more likely to occur. Thus, more funding is needed to increase staffing at mealtimes, especially in dementia care units where needs for assistance are typically quite high. Until the necessary government funding is available, I do not think it is reasonable to amend the regulations to enforce higher staffing levels at mealtimes. However, long term care homes should be encouraged to make this their goal.

In light of current funding and staffing limitations, part of forming a strong team to provide person-centred mealtime care is encouraging residents’ family members to become involved and help provide eating assistance. Some family members may wish to help at mealtimes but cannot due to their work schedule. Given the accelerating growth in our population of older adults in Canada, it would be prudent government policy to encourage employers to provide flexible work hours so that family members can assist with elder care. The supportive role that family members play when their relative is in a long term care facility cannot be taken for granted; they are a vital part of the care team.

Accreditation bodies help ensure that long term care homes achieve a high level of quality care. The standards that Accreditation Canada outlines for long term care
services include sections on engaging prepared and proactive staff and enhancing quality of life (Accreditation Canada, 2012). Ongoing training for staff on person-centred care and the quality of teamwork to enhance care need to be covered in these standards.

Compliance inspectors from the MOHLTC have a vital role in making sure that long term care homes achieve and maintain a high standard level of quality care by complying with the current regulations. The regulations provide a good foundation for person-centred care by setting in place processes for staff to know the residents’ needs and preferences and deliver care accordingly. There is a need for more staff education on ministry regulations and what compliance inspectors are looking for when they observe at mealtimes. Confusion between what is actually a regulation and what is a best practice guideline can hinder the flexibility with which staff respond to residents’ individual needs. For example, following a table rotation order was referred to by some participants as a ministry standard, but it is really a best practice guideline and it could be carried out with more flexibility than staff may realize.

As it stands, a conservative measure of flexibility is encouraged by the ministry regulations; making exceptions to the rule in order to individualize care is supported, so long as these exceptions are documented in the resident’s care plan to be applied consistently by staff. However, when working with residents with dementia, there is a greater need for flexibility to be applied in the moment, as the situation calls for it. As participants often indicated in this study, what works for a resident one day may not work the next day or even at the next mealt ime. Point of care staff have the constant challenge of figuring things out in the moment by trial and error (Janes et al., 2008). Thus, when compliance inspectors from the MOHLTC observe mealtimes and conduct interviews,
careful judgment needs to be applied regarding the flexibility staff exercise to meet residents’ needs and preferences. Shortcuts that compromise quality of care need to be clearly distinguished from actions done with the best interest of the resident in mind. The intentionality of staff in applying a person-centred approach and steps taken to address any related risks ought to be clear when they describe how they provide care for each resident. Education for compliance inspectors should emphasize the need for such flexibility, especially in dementia care.
7.5 KEY TAKE-AWAY POINTS FROM THIS STUDY

This study identified five key ways to support staff to provide person-centred mealtime care: *forming a strong team, working together to provide care, enabling staff to know the residents better, equipping staff with a toolbox of strategies, and creating flexibility to optimize care.* Every long term care home is a unique practice setting, and some of these elements will be more pertinent than others to focus on depending on what they see as their strengths and areas for improvement. It would be a helpful exercise for long term care homes to critically reflect on each of the above elements and identify goals and appropriate courses of action to more fully adopt person-centred care practices at mealtimes.

In general, based on the findings of this study, some recommended priorities for action would be the following:

1. *Forming a strong team:* Increase recruitment and training of mealtime volunteers and encourage family members to be involved in mealtime care.

2. *Working together to provide care:* Establish a culture of good teamwork where staff within and across departments and hierarchies lend a hand as needed, share information, and problem-solve together.

3. *Enabling staff to know the residents better:* Assess what kinds of information point of care staff feel they need better access to and improve opportunities for information sharing.

4. *Equipping staff with a toolbox of strategies:* Create times in the work schedule for staff to regularly share ideas and problem-solve together so they learn more from each other as a team.

5. *Creating flexibility to optimize care:* Open dialogue with point of care staff about appropriate circumstances for bending the rules to individualize residents’ care and problem-solve on issues that decrease flexibility.
REFERENCES


Cott, C. (1997). “We decide, you carry it out”: a social network analysis of multidisciplinary long term care teams. *Social Science and Medicine, 45*(9), 1411-1421.


Appendix A
Recruitment Materials
INVITATION TO PARTICIPATE IN RESEARCH  
Research Ethics Board # 10MR021  

Providing person-centered mealtime care  
for long term care residents with dementia  

Person-centered mealtime care means:  
Providing residents with choices and food preferences  
   Supporting independence  
   Showing respect  
   Promoting the social side of eating  

We would like to interview Personal Support Workers and Food Service Workers who serve or assist residents with Alzheimer disease or dementia at mealtimes.  

Interviews will be about:  
   • Your experiences of serving or assisting residents with dementia at mealtimes  
   • Your thoughts about what affects workers’ abilities to provide person-centered mealtime care  
   • Your ideas about what actions can be taken to better support staff to provide person-centered mealtime care  

Interviews will take place outside of work hours. Participants will receive $50 cash as a thank-you for contributing to this research.  

Participants can be interviewed at their home, at their workplace, or another agreed upon location if desired.  

If you would like to participate or receive further information, please call or email:  

Holly Reimer, RD, MSc  
(519) 831-2246  
hreimer@uoguelph.ca
INVITATION TO PARTICIPATE IN RESEARCH
Research Ethics Board # 10MR021

Providing person-centered mealtime care for long term care residents with dementia

Person-centered mealtime care means:
Providing residents with choices and food preferences
Supporting independence
Showing respect
Promoting the social side of eating

We would like to interview food service managers/supervisors, nurses (RN’s and RPN’s), allied health professionals, and recreation staff about mealtime care for residents with Alzheimer disease or dementia.

Interviews will be about:
• Your experiences and observations at mealtimes in the dining room
• Your thoughts about what affects workers’ abilities to provide person-centered mealtime care
• Your ideas about what actions can be taken to better support workers to provide person-centered mealtime care

Interviews may take place outside of work time if desired, with $50 compensation for your time.

Participants can be interviewed at their home, at the long term care home, or another agreed upon location if desired.

If you would like to participate or receive further information, please call or email:
Holly Reimer, RD, MSc
(519) 831-2246
hreimer@uoguelph.ca
Providing person-centered mealtime care for long term care residents with dementia

Person-centered mealtime care means:
Providing residents with choices and food preferences
Supporting independence
Showing respect
Promoting the social side of eating

We would like to interview private companions of residents who regularly eat with or assist residents with Alzheimer disease or dementia in the dining room.

Interviews will be about:
• Your experiences and observations at mealtimes in the dining room
• Your thoughts about what affects workers’ abilities to provide person-centered mealtime care
• Your ideas about what actions can be taken to better support workers to provide person-centered mealtime care

Participants will receive $50 cash as a thank-you for contributing to this research.

Participants can be interviewed at their home, at the long term care home, or another agreed upon location if desired.

If you would like to participate or receive further information, please call or email:

Holly Reimer, RD, MSc
(519) 831-2246
hreimer@uoguelph.ca
Information Letter and Consent Form
CONSENT TO PARTICIPATE IN RESEARCH

Providing person-centered mealtime care for long term care residents with dementia

Consent for Individual Interviews

You are asked to participate in a research study conducted by:

Holly Reimer, RD, MSc (Graduate Student), Family Relations and Applied Nutrition, University of Guelph
Heather Keller, RD, PhD, FDC (Faculty), Family Relations and Applied Nutrition, University of Guelph
Donna Lero, PhD (Faculty), Family Relations and Applied Nutrition, University of Guelph
Lori Schindel Martin, RN, PhD (Faculty), Daphne Cockwell School of Nursing, Ryerson University.

The results of this study will contribute to the dissertation of Holly Reimer, PhD student.

If you have any questions or concerns about the research, please feel free to contact:

Dr. Heather Keller
Ph. (519) 824-4120 x52544

PURPOSE OF THE STUDY

This study will examine experiences and insights of long term care home staff about mealtime care practices for residents with Alzheimer disease or dementia. Person-centered mealtime care means providing residents with choices and food preferences, supporting independence, showing respect, and promoting the social side of eating. The purpose of this study is to learn how to better support staff to provide person-centered mealtime care.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Participate in a face-to-face interview to talk about:
Your experiences of serving and assisting residents at mealtimes
Your thoughts about what affects workers’ abilities to provide person-centered mealtime care
Your ideas about what actions can be taken to better support staff to provide person-centered care
The interview will be about one hour long. If more time is needed, we may request a second interview with you. The interview will be audio recorded and transcribed.

A day after the interview, the interviewer will make a brief follow-up phone call or email to see if there is anything else you thought of that you would like to add to the comments you gave.

Interview participants will be mailed a summary of the findings from their personal interview to review. We ask that you will read the summary and allow the researcher to follow-up by phone or email regarding any changes you would like to be made.

A summary of the findings from the whole study will be mailed to participants when the research is completed.

POTENTIAL RISKS AND DISCOMFORTS

In the interview, we would like to learn about strengths and areas for improvement in mealtime care. One potential risk of participating in an interview is you may feel uncomfortable about sharing any negative experiences you have had or observations you have made about low quality care. Workers in the long term care home may feel concerned about their jobs if information they share is passed on to others. All information you provide will be confidential. When quotes are used in reports of the study findings, names will be changed and any identifying information will be removed. Interview participants have the option of having the interview away from the long term care home. You may be interviewed in your own home or other agreed upon location. Correspondence and follow-up phone calls will be made to the participants’ homes to protect confidentiality.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Findings of this study will be used to develop education and training tools for long term care home staff to promote person-centered mealtime care. Recommendations will be given to long term care home administrators and policy makers to help address challenges workers experience in providing person-centered care. This research is intended to improve the quality of life of residents.

Staff of participating long term care homes will receive an education session on person-centered mealtime care at the end of the study.

PAYMENT FOR PARTICIPATION

Interviews will take place outside of work hours for personal support workers and food service workers. All participants who are interviewed outside of work hours will receive $50 as a thank-you for giving their time to this study.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study.
Only the research team will have access to information you provide. Information will be kept in locked storage at the University. Your audio recording, the transcript of your interview, and written summary will be identified with an assigned participant number. This consent form and your contact information will be kept separate from the audio recording, transcript, and summary of your interview. You have the right to review or edit your interview audio recording, transcript, and summary if desired. Final disposal of audio recordings will occur at the end of the study, approximately one year after the interview. Written results will include direct quotations from the interviews, but they will have no reference to individual participants.

Only four long term care homes will be taking part in this study, so there is potential that participants in certain positions (i.e. administrators or dietitians) will be identifiable by their occupation. The results will indicate the numbers of participants who took part in the study based on their position (i.e. how many personal support workers, food service workers, family members, administrators, dietitians, nurses, etc. participated). However, quotes from participants will be reported as quotes from “personal support workers”, “food service workers” or “indirect care providers” to protect confidentiality of what was said by certain participants who might otherwise be identified by their position.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don’t want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Coordinator
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236
SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I have read the information provided for the study “Providing person-centered mealtime care for long term care residents with dementia” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

____________________________________
Name of Participant (please print)

____________________________________
Signature of Participant

______________________________
Date

SIGNATURE OF WITNESS

____________________________________
Name of Witness (please print)

____________________________________
Signature of Witness

______________________________
Date
Appendix B
Strategies for person-centred mealtime care

Providing choices and preferences

Knowing each resident’s dietary needs and preferences
- When new residents come, ask them and/or their family members what foods and beverages they like and dislike. Make sure this information is readily available for all staff and helpers on the unit who provide mealtime care. The more information collected and recorded the better, especially when residents have difficulty communicating what they want at mealtimes.
- Check with residents to see if they like what they were served. For example, after preparing a cup of coffee, ask: Was that too sweet? Did you like that?
- Carefully observe what residents eat and what they leave on the plate. Realize that a resident’s preferences can change from day to day, so look for patterns. If a certain item is always left on the plate, figure out why. Do they not like it? Is it too hard to eat?
- When anyone learns something new about a resident’s likes and dislikes, it is important to pass this information on to the rest of the care team – document it and tell others verbally.

Planning the menu and having extra options available
- Plan menus to include foods that the residents recognize and enjoy. If using standard menus from a food distributor, replace items that would be unfamiliar to the residents with foods that are more culturally appropriate. Consider not only the entrees, but also the types of beverages, desserts, and snack foods served.
- Regularly include theme meals and special snacks and desserts in the menu that are suitable for residents on all types of diets. Work to expand appropriate dessert options for residents on diabetic or pureed diets.
- Find ways to increase the favour and appeal of pureed foods. For example, add jam or cinnamon to pureed bread, and serve it warm if the resident prefers.
- Regularly include natural finger foods such as sandwiches or chicken fingers in the menu because they are easier for residents to eat independently. Also consider adapting the way items are served to make them easier for residents to eat. For example, a tuna melt could be served with the bread or bun on the side – then it can be picked up with the hand and the tuna can be eaten with a spoon.
- Special considerations about the appearance of food may be necessary for residents with cognitive impairment. If a resident leaves an item on the plate or picks away bits of food, find out why. For instance, the resident might think that something bad has gotten into the food when he or she sees green specs of parsley.
- Have alternatives to the menu choices, such as sandwiches, fruit, and ice cream prepared and easily accessible in case residents don’t want the regular menu options.
- Encourage family members to bring favorite foods from home for the resident to eat. Have a fridge that family members and/or nursing staff can easily access. Advise families to bring in quantities that can be consumed at one sitting or at least within one week to avoid the possibility of food spoiling. Implement a system to make sure that staff are aware of food brought in by family and offer it at meals or snack times.
**Using show plates and helping residents make choices**

- Make sample plates and show the residents their choices at mealtimes. Hold them at an angle where the residents can see them well. Give the residents time to choose and say or point to what they want to eat.

- When showing the choices, identify what is on each plate. For example, say: “John, this is chicken with mashed potatoes and carrots, and this is meatloaf with rice and green beans. Which would you like for lunch today?”

- Sometimes it is less confusing for residents with advanced dementia when staff just name the entrée rather than identifying each item on the plate. Simply say: “John, we have chicken or meat loaf for lunch today. Which would you like?”

- Staff can help residents with dementia to make their own choices with some gentle prompting. For example:
  - If a resident’s favorite item is on the menu, bring it to his or her attention. (i.e. George, it’s barbeque chicken today – that’s your favorite!)
  - Suggest what the resident usually likes (i.e. Margaret, you usually like a cup of tea at lunch time. Would you like one today?)

- The regular size portions can look quite large and overwhelming to some residents. If they think the portions are too big, some residents may automatically refuse the choices shown. If residents will be receiving smaller portions based on their care plan, consider making the sample plates also show smaller portions.

- Residents who are on a pureed diet are usually presented their choices using the regular menu sample plates. It may be necessary to explain to them why their food looks different when served. If the resident tends to be upset that the food appears different, give his or her choices verbally rather than using the sample plates.

- After choosing from the sample plates, some residents with dementia may reach for the plate they want, not understanding why the staff member is walking away with it. Be sure to explain you are going to get a plate of food for them that is hot and fresh.

- If language is a barrier, try using picture symbols to indicate the type of entrée on each plate (i.e. attach a small picture of a cow to a sample plate containing beef).

- Maximize choices by allowing residents mix and match items they see on the sample plates. For example, let them have rice instead of potato if desired.

- Ask residents what toppings or sauces they would like such as butter or gravy.

- Respect a resident’s choice not to have particular standard items such as vegetables, milk, or juice. If a resident regularly refuses foods from a particular food group, consult the dietitian and discuss alternatives to ensure that the resident’s nutritional needs will be met.

- When using sample plates, some residents with advanced dementia will not be able to verbalize or point to their choice. In this case, watch their eyes – residents may look longer at the choice they want, so use this as a clue. Keep in mind, however, that their eyes may be drawn to foods that look more colorful on the plate rather than the choice they would like most.

- Sometimes presenting two choices is too overwhelming for residents with advanced dementia and they don’t respond in any way to indicate their choice. Instead, bring them one option based on known preferences and if they don’t eat that bring the other choice. If they don’t eat that either, then try bringing a sandwich.

- If no clear preference is known, consider what choice is easier to eat independently, which is most visually appealing, or which would give the resident more variety.
Supporting independence

Knowing each resident’s needs for assistance

- Be attentive and watch to see when help is needed. Recognize that residents’ needs at mealtimes can change from day to day and even from meal to meal. Monitor them carefully and assist as needed.

Setting residents up to be more independent at mealtimes

- Make sure the resident is sitting upright and positioned well to eat, not too high or too low or too far away from the table. If the resident uses a wheelchair, transfer to a regular dining room chair if possible.
- Keep the eating environment and table setting as similar as possible from meal to meal.
- Provide appropriate adaptive utensils and dishes to help residents feed themselves.
- Provide finger foods.
- If the resident’s eye sight is better on one side than the other, place the resident’s food where he or she can see it best and point out where each food item is on the plate.
- Avoid putting too much in front of the residents at once. For residents with advanced dementia, it is often best to give one item at a time to focus on. For example, give one beverage at a time and only the utensil needed for the course they are eating.
- Help residents by cutting food or opening packages as needed.

Encouraging, cuing, and assisting residents as they eat

- Orient residents to the meal, making sure they know whether it is breakfast, lunch, or supper.
- Sometimes residents need some assistance and prompting just to get started and then they can carry on eating independently.
- Provide gentle verbal reminders and encouragement. Rather than saying, “I need you to drink this water,” say, “Would you like a drink of water, Martha?”
- Provide step-by-step prompts such as “pick up your spoon”.
- Give encouragement and praise for eating or drinking well.
- Remember that too much verbal cuing may be annoying to residents and cause agitation.
- Prompt residents with visual cues such as the motion of bringing the spoon to the mouth.
- Provide physical cues such as putting the food, utensil, or cup in the resident’s hand, or gently touching the resident’s hand or shoulder.
- Provide hand-over-hand assistance as needed. Sometimes just an occasional hand-over-hand prompt may be needed to get residents started in the rhythm of eating.
- Let residents eat part of the meal independently if they are able. Residents may start out well on their own and get tired and need more help toward the end. Others may find more strength toward the end of the meal to eat their dessert independently. Some residents may have the strength to feed themselves every other bite.
- Provide cueing and encouragement before providing further assistance, especially when residents’ abilities tend to change from day to day or from meal to meal. Give residents time and opportunity to try feeding themselves.
Promoting the social side of eating

Knowing each resident’s personality, interests, and history
- Knowing about each resident’s personality, interests, and history helps staff connect with the residents. Ensure that staff have opportunities to learn about each resident through recorded information and discussions with other staff and family members.

Making seating arrangements
- Seat residents together who have similar ability and desire to participate in conversation.
- Consider each resident’s needs for assistance. Usually those who are most cognitively able to participate in conversation are also most independent in eating.
- Seat residents who need full assistance together so staff can help two at the same time.
- Consider residents’ table etiquette and who they will be most comfortable sitting with.
- Take note of who gets along well together throughout the day and find out things that residents have in common with each other from the past.
- Women may prefer to eat with other women, and men with other men. Some residents may prefer to eat with members of the opposite sex.
- Consider seating residents together who are on similar types of diets. For example, residents on minced or pureed diets may feel upset if they see others at their table eating regular texture foods.
- Consider the layout and space available in the dining room. Carefully think about where to seat residents in wheelchairs so they are comfortable.
- Consider the input of family members if they want their loved one to sit with certain residents.
- Some residents are overwhelmed by being around other people in the dining room, and are not happy to eat at a table with others. Try placing them at a separate table in the dining room. Make sure that staff regularly interact with residents who are seated at separate tables.
- If a resident is very anxious, it may help to seat him or her at a separate table facing away from others to decrease stimulation.
- Some residents may need more personal space at mealtimes, but still want to sit with others. Try joining tables together to create more room for the residents as they eat.
- Some trial and error may be needed to find out what seating arrangement works best for the resident. Recognize that what works one day may not work every day. Carefully monitor how well residents are getting along with their tablemates. Trial a new spot to see how well it works.
- Be cautious about making too many changes in the dining room. Try to keep things consistent so residents have familiar people to sit with.
Having pleasant conversation and companionship at mealtime

- An important part of the social side of eating happens naturally while providing choices and serving the residents. Speak with a kind and friendly tone of voice, and be attentive to the residents’ needs.
- Whether or not residents can speak back to you, initiate some pleasant conversation.
  - Ask how their day was.
  - Ask if they’re hungry and talk about favorite foods or reminisce about cooking.
  - Talk about the weather or what you see out the window.
  - Talk about program activities happening that day.
  - Talk about what their family or your family members are doing.
- Acknowledge the resident’s reality – if he or she speaks as if living in a time of the past, enter and follow the conversation naturally without trying to orient the resident to the present.
- Residents with advanced dementia may say things that do not make sense, but continue to show that you are listening and care about what they are saying. If you see that they are smiling and enjoying talking to you, it doesn’t matter that you didn’t understand the conversation.
- Recognize that residents may not engage in conversation at the table because of poor hearing. Speak into the ear that they hear better with. It may be necessary to repeat things so that the residents hear and understand what others are saying at the table.
- Watch the residents’ body language carefully, especially when they cannot verbalize what they want very well. Pay attention to facial expressions.
- Keep residents in a calm, peaceful state of mind. Avoid talking about things that would upset them (i.e. mentioning that someone is sick in your family or that you hurt yourself while doing something).
- Some residents enjoy when staff joke around with them at the table and make them laugh. Yet, be aware that some residents may not be in the right mood for humor.
- Although it is important not to treat residents as though they are young children, some residents may genuinely enjoy children's songs and nursery rhymes.
- Residents may enjoy listening as staff talk with each other at the table. Always make sure the subject is of interest to the residents and try to draw the residents into the conversation.
- For residents who need eating assistance, the social side of eating often simply means being there for them, helping them eat, and watching and listening carefully to respond to what they want.
- Residents with advanced dementia often need to focus on their food and eating at mealtimes, so talking may be minimal. Engage in pleasant conversation, but also enjoy companionable silence.
- Welcome family members to take part in mealtimes, eating with or assisting residents in the dining room or in a more private setting if desired.
Showing respect

Creating a peaceful and pleasant dining environment

- Having soft, relaxing music playing in the background may or may not be helpful. Sometimes it just contributes to the noise level in the dining room. Therefore, it may be best to let the music play before and after the meal, but turn it off during mealtime to create a quieter environment and promote communication at the table.
- Avoid raising your voice as much as possible. If you need to speak to someone across the room, walk over to the person first rather than speaking loudly.
- If a resident is loud and the noise disrupts others, lead the resident to another quiet room to eat, with one-on-one attention and assistance.
- Aim to keep noise from nearby hallways and entrances to a minimum during meals.
- Minimize the noise of dishes clanging and keep the dirty dish cart away from residents during meals.
- Use simple décor such as tablecloths and flowers to provide a homelike ambiance. Choose flowers or centrepieces that do not block one’s view of others across the table.
- Don’t rush residents to leave the dining room, but allow them to linger at the table after meals if desired.

Providing unrushed courteous service and assistance

- Speak to residents as adults, not as young children.
- Address new residents as Mr. or Mrs. Ask what name they prefer to go by. Avoid endearing terms such as ‘dear’ or ‘honey’ unless special rapport has been built with the resident and it makes him or her feel closely connected to staff.
- Ask residents before you do anything. Say, “Would you like me to help you?”
- Honor residents’ personal space. Ask them if they would like a hug or a back rub. Remember, residents may respond differently to different staff.
- Prevent long waiting times at the table before and after meals. When residents arrive in the dining room, provide warm wash cloths for them to clean their hands and serve beverages from a cart. Likewise, after meals, help residents clean up as needed and leave the dining room when they are ready.
- Make sure dishes and cutlery are clean and that food is presented nicely.
- Double check to ensure that residents receive the menu choice they asked for.
- Monitor the residents and respond promptly to requests. Watch for signs like reaching for another person’s juice that may indicate what a resident wants.
- Never stand while providing eating assistance – sit and make eye contact.
- Assist residents to eat at the pace they are comfortable with, using a teaspoon.
- When assisting residents with eating, ask what they would like to eat next or tell them what you are putting on the spoon.
- Learn how residents like to be fed (i.e. from the right side or the left; sips of fluid between bites or more fluids toward the end of the meal).
- Watch the resident’s facial expressions and body language while providing eating assistance to better understand what the resident wants.
- Record food and fluid intakes discreetly. Avoid asking other staff how much certain residents ate or drank while the residents are there listening.
Understanding each resident’s behaviour and how to respond

- Understand that every behaviour has meaning.
- Give residents time to settle in when they are new. Expect their behaviour and appetite to change over the first few days or weeks until they adjust to living in their new home.
- If a resident’s behaviour changes dramatically, first check to see if the resident is uncomfortable or unwell. For example, changes in behaviour are commonly associated with a urinary tract infection.
- Aim to prevent mealtime difficulties by making sure residents are comfortable, relaxed, and prepared for the meal:
  - Make sure residents are dressed appropriately for mealtimes in clothes they are comfortable wearing in the dining room. Make sure they are not too hot or too cold.
  - Offer clothing protectors and ask before assisting residents to put them on.
  - Make sure residents are wearing their hearing aids, glasses, and dentures as needed.
  - Take residents to the bathroom before mealtimes.
  - Give residents an opportunity to clean their hands before and after the meal.
  - Avoid rushing the residents – extend mealtime if necessary.
  - If residents are not ready to wake up in the morning, let them continue sleeping. Provide a continental breakfast later when they get up.
- If a resident refuses to eat, encourage the resident but don’t push – instead:
  - First, try to figure out why the resident might not be eating (i.e. something stuck in their dentures, needing to go to the bathroom, etc.). Make sure the resident is comfortable.
  - Offer something the resident is known to enjoy such as dessert. If the resident eats this, then try offering the main course again.
  - It may help to leave for a few minutes and then come back to encourage or assist the resident again. Try this three to four times if needed.
  - If the resident still does not want to eat, encourage good intake of fluids and offer a snack between meals.
- If a resident gets up from the table before finishing his or her meal:
  - Check to see if the resident needs to go to the bathroom.
  - Ask if he or she would like to eat and if so bring the resident back to the table.
  - Try taking the resident for a little walk or to look out the window and then bring him or her back to the table.
  - If the resident continues to get up from the table, lead him or her to another room to eat with one-on-one attention and assistance.
- If a resident refuses to come into the dining room to eat, don’t push – instead:
  - Wait a few minutes and try again.
  - If possible, lead the resident to a table near the dining room entrance facing away from others to minimize visual stimulation.
  - If necessary, serve and assist the resident in another room where he or she is comfortable.