Dining exp presentation CAG 09

Notes to accompany slides

2 - Modifications to the dining experience have the potential to improve both nutritional status and quality of life, but the need for *flexibility* is underscored by the American Dietetic Association's recognition that therapeutic dietary interventions should be liberalized to permit more choice for frail older adults in order to maintain quality of life. Only then is the risk for weight loss and undernutrition reduced [1].

3 - Changes to the food itself (quality/suitability, serving sizes, frequency, variety, and sensitivity to residents' preferences, including culturally appropriate foods) [2-5, 5-13];
Presentation and food delivery (e.g. without trays, with placemats/tablecloths, restaurant-style with waitress service, family style, buffet style etc.) [14-22]
Associated physical environment features that sometimes coincide with a philosophy of care, such as the Green House model (e.g. location of dining – communal versus private, size of the dining room, home-like features of the room, levels and quality of noise and lighting etc.) [16, 23-28];
The level and quality of residents' interactions with others present [13, 29, 30] and ways in which those interactions can be facilitated or inhibited (e.g. orchestrating who sits next to whom; one seating per meal or more) [16, 31];

4 - Engagement of residents in "therapeutic kitchen" initiatives that involve them in the preparation of food, meal set-up and so on [32].
The organization and training of staff (ratio of staff to residents; level and type of meal assistance; involvement of different types of staff, such as physiotherapists as per a 'restorative care approach,' the use of paid trained "feeding assistants," training of staff in person-centred care versus a task-oriented approach, etc.) [7, 12, 16, 22, 33-38].
Establishing organizational policies and procedures that support a positive dining experience and promote optimal nutrition intake (e.g. by establishing a philosophy of care focused on residents, ensuring clear communications between different levels of staff, implementing regular nutrition screening procedures and quality controls, etc.) [25, 39].

5 - Such studies tend to have weak or inconclusive findings. In screening out a large number of potentially meaningful variables, little can be concluded about the practical applicability of the intervention. For example, a study by Altus *et al.* [17] examined the effect on resident communication and participation in mealtime tasks of changing the mode of meal delivery to "family style" (*i.e.* residents were served with bowls of food and empty plates versus prepared plates). Only modest improvements were observed as a result (e.g. a shift from 5% to 10% of appropriate communication among residents following the intervention). The addition of another variable, a nursing assistant trained in prompting and praising appropriate behaviour, boosted appropriate resident interaction to 65%, begging the question, **What other variables may *combine* to influence that behaviour**?

Studies that focus on nutritional intake typically rely on the measurement of food remaining on a plate at the end of the meal (e.g. [14]. Important contextual factors that will be discussed in this paper seriously compromise the validity of such measures.

Little if any effort is made to distinguish the components of quality of life from its determinants (e.g., health) [40, 41] For example, having argued that social interaction among residents is an important component of quality of life for institutionalized elders with dementia, Diaz-Moore and Verhoef [29] then make the leap of collapsing the two concepts such that presence of social interaction is taken to be evidence of quality of life.

Altus et al.'s [17] sample size was 6.

6 - It is more than twenty years since Scheper-Hughes and Lock [42] challenged us to understand the "body as simultaneously a physical and symbolic artefact, as both naturally and culturally produced, and as securely anchored in a particular historical moment." Researchers are thus entreated to eschew Cartesian dualisms that analytically separate minds from bodies, individuals from societies, and to move beyond disciplinary and paradigmatic positions that limit the breadth of our inquiry. Phenomenological, constructivist and critical perspectives are all necessary if we are to appreciate interrelations between the 'existential immediacy' of the body [43-45], and the ways in which the body reflects and reproduces the social order [46-48]. Also important is the recognition that bodies are socially constructed and controlled by sources of power at specific moments in time.

7 - Our observations of direct experience provided an important balance to the dialogue recorded in the focus groups and personal interviews [49].

8 - All interviews, both collective and individual, were audio-taped and transcribed. Participant observations were recorded as field notes and periodically as activity charts that provided snapshots of resident activity and interaction within a ten-minute period. This data was imported into the computer-assisted qualitative data analysis program, Altas.ti version 5.2.0, which permitted the systematic exploration of inductive themes, their co-occurrence with one another, and their clustering into core categories. The program also facilitated comparison of themes across groups (staff, family and residents). Here we report only on the themes and relationships central to this case study.
While the themes emerged from the data, the coding also reflected the researchers' critical-interpretive perspective that explores how it is that people construct their worlds while at the same time remaining cognizant of the relations of power which constrain their choices [50]. Goffman's interpretive interactionist theory was critiqued by Bourdieu for its over emphasis on individual agents; in his structuralist theory of practice, he emphasized instead the economic, cultural and symbolic *capital* available to people in different social spaces. Critical interpretive researchers [51-53] nonetheless maintain that the two theories share a concern with the issues of rules, (symbolic) power and practice, and that each is necessary to account for and link the micro, meso and macro levels of analysis and provide a holistic picture of society.

12 - Diaz Moore's [29] multi-method, intrinsic case study of social interaction in a special care unit (SCU) for cognitively impaired older persons found that residents are capable of developing a range of social bonds even though the SCU in question was found to have several organizational and physical factors that unwittingly thwarted its therapeutic potential.

14 - Other research has found that prompting and praising appropriate mealtime behaviors by a nursing staff member, in combination with family style meals increased resident participation to 65% of tasks and appropriate communication to 18% [17].

15 - These findings are nonetheless relatively weak – in McDaniel et al.'s [23] study, residents in the room without lighting enhancement and higher noise were actually eating better! ("Noise was significantly lower in the EC ($p <$ or $= .02$). Lighting was significantly higher in the EC ($p <$ or $= .001$). Intake of calories and protein was slightly higher, with some days significantly higher, in the AU.")

"Over-stimulation was a main concern in the dining environment of the traditional facility, Gardenview Lodge. In the large dining room, there were many tables, heavy traffic, food carts, medication carts, talking among people, etc. Residents described the noise caused irritation, tired them out and affected their appetite. Many residents complained that they did not know where they should go because there were so many identical tables. In addition, their furniture and finishing gave an institutional ambience (e.g., furniture were mainly made of metal frames and vinyl covers, linoleum flooring), that added confusion and disorientation for residents with dementia." [31]

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