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Caregiver-Resident Interaction at Mealtime in an American Nursing Home

by

Ellen S. Schell, RN, M.S.

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

In

NURSING

In the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco



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by
Ellen S. Schell, RN, Ph.D.

Abstract

CAREGIVER-RESIDENT INTERACTION AT MEALTIME IN AN AMERICAN NURSING HOME

Ellen S. Schell, RN, Ph.D.

University of California, San Francisco, 1994

This study proceeded in two phases: a *general observation phase*, in which data for an ethnographic description of a nursing home were collected; and a *focused observation phase*, in which ten physically and cognitively impaired resident subjects were observed during six individual meals over a two-week period. At each meal, the researcher studied the caregiver-resident interaction, recording in her field notes detailed descriptions of significant verbal and non-verbal behavior. These *qualitative* data were later analyzed using symbolic interaction as a theoretical framework. In addition, three *quantitative* measures were used: an observational checklist of key caregiver behaviors; a calculation of the percentage of food consumed by a resident at each meal; and a determination of each resident's moods as assessed by the Clark and Bowling (1989) Mood Scale. The observational checklist scores were correlated with the percentage of food consumed and with the Mood Scale scores.

The results showed that the caregivers tended to be task-oriented in mealtime interactions, often omitting important elements of psychosocial care such as greeting or speaking to the residents before feeding them. The most skillful and empathetic caregivers used their detailed, intimate knowledge of the residents to provide individualized care, making meals pleasant and nourishing experiences. These caregivers were guided by residents' subtle cues. Nevertheless, the expected

positive correlation between the observational checklist scores and the amount of food eaten by residents was not found. The observational period may have been too short to determine a trend. There was, however, a moderate positive correlation between the observational checklist scores and some Mood Scale scores.

The organizational environment placed important constraints on the caregivers by limiting the amount of time they could spend with the residents and by failing to provide an adequate system for transmitting and using the caregivers' valuable knowledge about residents. The study's findings have important implications for the training of caregivers and for the organization and delivery of mealtime care.

Jeanie Kayser-Jones, R.N., Ph.D.
Jeanie Kayser-Jones, RN, Ph.D., Chairperson

THE

The Old Man and His Grandson

There was once a very old man who was almost blind and deaf and whose knees trembled. When he sat at the table, he could hardly hold his spoon; he spilled soup on the tablecloth, and when he'd taken a spoonful some of it ran out of his mouth. His son and his son's wife thought it was disgusting and finally made the old man sit in a corner behind the stove. They brought him his food in an earthenware bowl and, worst of all, they didn't even give him enough. He looked sadly in the direction of the table, and his eyes filled with tears. One day his hands trembled so much that he dropped his bowl and it fell to the floor and broke. The young woman scolded him, but he said nothing and only sighed. She bought him a wooden bowl for a few kreuzers, and from then on he had to eat out of it. As they were sitting there one day, the little four-year-old grandson was on the floor playing with some pieces of wood. "What are you doing?" his father asked. The child replied: "I'm making a trough for father and mother to eat out of when I'm big." Husband and wife looked at each other for a while and burst into tears. After that they brought the old grandfather back to the table. He ate with them from then on, and even when he spilled a little something they said nothing.

—From Jakob and Wilhelm Grimm (1977, p. 274).

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I also thank each of my children, Joshua, Peter, Maria, and Sasha, for staying interested in the project throughout the years and especially for their physical contribution to and spiritual participation in the family dinnertime. Whenever I returned from a particularly dreary experience at the nursing home to join them for a delicious meal brightened by laughter and conversation, I

resolved to make things better for elderly people in nursing homes.

To all my friends who have expressed their interest and encouragement, I give my heartfelt thanks. I am especially appreciative of the generous concern of Mark Lodico, who was laboring on his own dissertation at the same time.

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TABLE OF CONTENTS

Abstract.....	iii
Acknowledgments	vii
List of Tables.....	x
Chapter 1: Study Problem.....	1
Chapter 2: Review of the Literature.....	6
Chapter 3: Methods	12
Chapter 4: A General Ethnographic Description of Central City Nursing Home	26
Chapter 5: Structural and Organizational Factors that Affect the Mealtime Interaction.....	57
Chapter 6: Caregiver-Resident Interaction at Mealtime.....	79
Chapter 7: Caregivers' Responses to Common Mealtime Problems	116
Chapter 8: Limitations and Implications.....	129
References.....	139
Appendix A: Mealtime Observational Checklist.....	145
Appendix B: Mood Scale.....	147

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LIST OF TABLES

Table 1: Subject Profile.....15

Table 2: Caregiver Demographics.....16

Table 3: Resident Demographics37

Table 4: Diet Texture Type38

Table 5: Ethnic Breakdown of Nursing Staff48

Table 6: Length of Employment of Nursing Staff49

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CHAPTER 1:

STUDY PROBLEM

Elderly people come to live in nursing homes because their health problems have overwhelmed their ability to care for themselves. Upon entering the nursing home, they give up much: the security of familiar surroundings, control over daily routine, and long-established patterns of relating to friends and family who may have also acted as caregivers. Suddenly, they must depend on strangers for help with their most intimate functions: using the toilet, bathing, dressing, and even eating. Half of all nursing home residents have problems feeding themselves and require the assistance of a caregiver to obtain nourishment. They are, in Siebens's term, "eating disabled" (Siebens et al., 1986). Many with such problems eat poorly enough to be at nutritional risk.

Eating problems present themselves in a host of ways, from difficulty manipulating and using implements, to problems swallowing, to lack of appetite or loss of interest in food. Many residents with eating problems also have cognitive impairment severe enough to limit their ability to express their needs and desires or to explain why they have difficulty eating (Siebens et al., 1986).

While some physiological mechanisms affecting eating behavior are understood, little is known about the social factors affecting elderly people's eating behavior. One factor may be the way in which caregivers (nursing home staff and/or family members) interact with the residents they assist at mealtime. If residents are satisfied with this interaction and feel that their physical, psychological, and social needs and desires are met, they may eat better. A

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rewarding interaction may also satisfy psychosocial needs.

Purpose of the Research and Specific Aims

The purpose of this study is to provide an ethnographic description and analysis of nursing home residents' mealtime interaction with caregivers. The study examines the verbal and non-verbal behavior of both residents and caregivers as it occurs during mealtime periods. The caregivers studied are directly involved in the care of the residents they help, either providing extensive assistance or actually feeding them.

The specific aims of the study are to:

1. Identify and analyze the environmental (organizational and physical) constraints on the mealtime interaction.
2. Identify and classify the verbal and non-verbal behavior occurring during this interaction.
3. Show how caregiver behaviors affect residents' food consumption and psychosocial state.
4. Measure the effect of selected caregiver behaviors on the quantity of food consumed and the residents' mood state.
5. Identify and analyze the effect of caregiver strategies when dealing with common eating problems.

Significance

The significance of this research is twofold. First, eating problems among elderly nursing home residents often lead to serious clinical consequences. Malnutrition and dehydration resulting from eating problems can lead to skin breakdown, delayed healing, increased susceptibility to infection, and even death.

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When malnutrition is severe, residents may require tube feeding, which is not without risks. Complications include infection, aspiration, incorrect tube placement, irritation of the nasal mucosa, and discomfort (Herrmann, Liehr, Tanhoefer, Emdi, & Riecken, 1988; Metheny, Spies, & Eisenberg, 1988; Pingleton, Hinthorn, & Lui, 1986). Additionally, self-extubation and agitation often occur (Ciocon, Silverstone, Graver, & Foley, 1988), sometimes resulting in the use of restraints, which can lead to additional problems such as immobility and psychological stress.

The present study provides data on how caregivers' behaviors affect residents' nutritional intake. Such knowledge can be used to develop interventions to improve mealtime care. If residents eat well, they can avoid the problems of malnutrition and the risks of tube feeding, maintaining better physical health.

Eating, however, is not only a physiological function but also a complex behavioral phenomenon, with myriad psychological, social, and cultural aspects. Mealtime, the context for eating, serves a variety of functions in society, providing a setting for conversation, information exchange, and the renewal of personal relationships. Outside of the nursing home, mealtime is often at the center of such events as business deals, awards ceremonies, rites of passage, and religious and national holiday celebrations. That we humans have raised food preparation to an art—that we set our tables with an array of complicated instruments and decorations, and that we have developed complex cultural rituals around the serving and eating of food—is a testimony to the importance of mealtime in human social life. As Visser (1991) put it, mealtime raises eating to “a medium for social relationships: satisfaction of the most individual of needs becomes a means of creating community” (p. ix).

Yet, in the nursing home, mealtime is often reduced to a time during which

the caregivers simply perform another nursing task. How a caregiver handles the mealtime interaction can make a difference in the resident's experience. If, for example, the caregiver creates a pleasant physical environment, sits down with the resident, takes the time to talk with him or her, and provides an affectionate, gentle touch, the resident may experience mealtime more positively than if the caregiver stands while feeding the resident, rushes through the meal, and never talks to or touches the person.

This research provides a detailed description, categorization, and analysis of caregiver and resident behaviors, showing how caregivers interact with the residents while assisting them and how residents respond. In addition, this study illustrates how environmental factors affect the context of the interaction, sometimes placing constraints on what the caregiver can accomplish.

Dissertation Overview

Following a review of the literature (Chapter 2) and a description of the methods (Chapter 3), the results and discussion are presented in four chapters. Chapter 4 provides a detailed ethnographic description of the research site, Central City Nursing Home.¹ Chapter 5 identifies and analyzes environmental factors that affect and circumscribe the caregiver-resident interaction. Chapter 6 describes and analyzes caregivers' and residents' behaviors occurring in the interaction. Chapter 7 discusses caregivers' management of problematic eating behaviors. Chapter 8 discusses the implications and limitations of the study.

Symbolic interaction (SI) is the theoretical framework used to present the

¹"Central City Nursing Home" is a pseudonym, as is any personal name used in this study to denote a resident, staff member, or visitor to the home.

results and to guide the analysis of the data. This framework was chosen because of its focus on face-to-face human interaction. It explains human behavior through the mediating effects of the socially formed mind of the individual and through the individual's interactions with others. The context in which an interaction occurs has a profound influence on the interaction itself, shaping much of the participants' behavior.

Other frameworks might well have been used for the analysis. Structuralism, for example, would have explained the caregivers' and residents' behaviors in terms of the actions that established and maintained the social order of the nursing home. Symbolic interaction, however, stresses the role of face-to-face interchanges in shaping behavior, and therefore seemed especially appropriate for a detailed analysis of the intimate, *one-on-one* interactions observed. For example, the SI concept of role-taking, central to the analysis of the present data, explains how one person takes the role of another, seeing that individual's world from his or her perspective. Role-taking, based on people's commonly held symbolic meanings, helps to explain why some aides give such compassionate, empathetic, imaginative care, while others attend to residents in a more task-oriented, uninventive, mechanical way.

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CHAPTER 2: REVIEW OF THE LITERATURE

Although eating problems are common among institutionalized elderly, and feeding is one of the most basic nursing functions, there has been little research in this area of nursing care. Related literature has examined the nutritional needs of the elderly (Asplund, Normark, & Pettersson, 1981; Blumberg, 1986; Chernoff, 1987; Drugay, 1986; Morley, 1986; Morley, Glick, & Rubenstein, 1990; Munro, 1984; Welch, 1989). Some investigators have addressed the ethical issues involved in feeding the elderly, focusing on feeding tube placement and on forcing a person to take food orally (Akerlund & Norberg, 1985; Fry, 1988; Knox, 1989; Norberg & Hirschfeld, 1987; Norberg, Asplund, & Waxman, 1987; Norberg, Norberg, Gippert, & Bexell, 1980). Less studied are the nature and prevalence of eating problems, the process of feeding and the effectiveness of nursing interventions, and the mealtime interaction between caregiver and resident. This chapter briefly reviews previous research, beginning with a clarification of terms.

Definitions

There is no consensus about whether people's difficulties should be called eating or feeding problems. By definition, eating is the act of consuming food; eating describes the action taken by the person needing nutrition—in this case, the patient or resident of an institution (*Oxford English Dictionary*, 1971). In contrast, feeding is defined as the act of giving food or supplying nourishment (*Oxford English Dictionary*, 1971). This is the action taken by the caregiver. The caregiver

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feeds the resident; the resident *eats* the food. Yet, nursing home residents are typically characterized as having “feeding problems” and are often described as “feeders.” For the purpose of this research, the terms are defined as above: *eating* describes the act of taking food into the body; *feeding* describes the act of assisting a person with eating.

The Nature and Prevalence of Eating Problems

Some researchers have investigated the types of eating problems of elderly people with common disorders such as stroke (cardiovascular accident, or CVA), Parkinson’s disease, and dementia. Axelsson, Norberg, and Asplund (1984) studied 104 stroke victims to investigate the prevalence and characteristics of eating problems. They found that 50 percent of the subjects had one or more eating difficulties, such as hoarding food in the mouth, dysphagia (swallowing difficulties), or chewing problems.

Using video recordings, Athlin, Norberg, Axelsson, Moller, and Nordstrom (1989) catalogued the aberrant eating behaviors of 24 patients with Parkinson’s disease. Ten of the patients also were demented. The investigators found that the motor impairments associated with Parkinson’s disease caused considerable difficulty in manipulating and transporting food. Both demented and non-demented patients had difficulty with communication and concentration.

Residents with Alzheimer’s disease show special problems in eating. Decreased or increased intake, preference for sweet foods, poor food choices, pica (eating non-food items), and inability to recognize and use eating implements have been noted in people with dementia (Fairburn & Hope, 1988; Morris, Hope, & Fairburn, 1989; Watson, 1993). One study of people with severe end-stage

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dementia found problems such as “refuse-like” behavior (turning the head away, shutting the mouth, or spitting food out), primitive reflexes (sucking or biting the spoon), inability or unwillingness to close the mouth, and difficulty swallowing (Michaelsson, Norberg, & Norberg, 1987).

Some authors have suggested that the memory impairment associated with Alzheimer’s is responsible for the oft-seen declining intake; they speculated that people with Alzheimer’s disease simply forget to eat (Fairburn & Hope, 1988; Morley, 1986). Such speculation is based on the assumption that cognitive impairment overpowers physiological drives; there appears to be no research to prove or disprove this assumption. Nonetheless, anecdotal evidence has suggested that some patients respond positively to reminders to eat (Finn, 1989; Morris, Hope, & Fairburn, 1989).

Nursing Interventions for Eating Problems

A few studies have examined the effects of nursing interventions on eating problems. In one study, investigators supplemented Heimlich’s (1983) swallowing retraining program with cognitive strategies to help a tube-fed stroke patient get over his fear of eating (Axelsson, Norberg, & Asplund, 1986). Baltes and Zerbe (1976) used operant conditioning in the treatment of a 67-year-old nursing home resident to re-establish self-feeding skills. In another study, Nageroni & Pierce (1985) found that soft-textured foods that could easily be eaten with the fingers improved self-feeding and self-esteem in a group of 22 psychogeriatric patients. Finally, in a randomized control study, researchers tested the effect of caregivers’ touch on the nutritional intake of 42 dementia patients who were capable of feeding themselves (Eaton, Mitchell-Bonair, & Friedmann, 1986). The treatment group

($n=21$) consumed significantly more calories and protein than the control group ($n=21$).

The success of the interventions in these studies has demonstrated therapeutic potential in the interaction between the caregiver and the patient or resident. These studies point to the need for deeper understanding of the caregiver-resident interaction.

The Effects of the Organizational Environment

How care is organized and delivered can have an effect on caregiver-resident interaction at mealtime. In a large descriptive study conducted in Sweden, investigators found that some nursing home residents had as many as 30 different caregivers assisting them with meals in the course of a single month (Backstrom, Norberg, & Norberg, 1987). They also found that staff took very little time in feeding residents. The median time for breakfast was 6–10 minutes; for lunch and dinner, 10–15 minutes. The investigators concluded that staff viewed feeding residents primarily as a nursing task to be accomplished as quickly as possible. The organizational environment did not support the development of caregiver-resident relationships nor did it encourage staff to focus on the psychosocial aspects of mealtime care.

A task-oriented approach to feeding sometimes encourages residents' dependency. Osborn and Marshall (1993) found that nursing staff tended to take an "all or nothing approach," either spoon-feeding the resident the entire meal or not helping the resident at all. This approach meant that some residents did not get enough help, while others got more than they needed. Sandman, Norberg, and Adolfsson (1988) uncovered similar behavior in their study of five institutionalized

patients with Alzheimer's disease. When the five patients were permitted to eat together without the assistance of nursing staff, the two least demented patients took on a caregiving role and helped the more demented patients eat. This caregiving behavior stopped when two nurses joined the group. The researchers concluded that staff members sometimes inadvertently discourage independent behavior.

The previous two studies indicate that staff may not always know the best way to support and assist residents needing help with eating. Kayser-Jones's (1990b) findings support this conjecture. In interviewing nursing home residents' relatives, she found that some family members believed their relatives would have eaten better if adequate and properly trained staff had been available.

In an intervention study, investigators tested the effects of a consistent care assignment system (Athlin & Norberg, 1987). Using six resident subjects, the researchers arranged for the same caregiver to feed the same subject during fourteen meals. Interviews and videotape analysis showed that caregivers became more confident in interpreting the eating behavior over time. At the end of the intervention, the caregivers expressed increased satisfaction in their work and indicated that they held a more positive attitude toward the patients.

Effects of the Physical Environment

A few studies have examined the effect of the physical environment on eating behavior. In her nursing home ethnography, Kayser-Jones (1989b, 1990a) found that factors such as the unpleasant features of dining rooms, the poor quality of food, the manner in which it was served, and the lack of choice of food profoundly affected the residents' ability to eat.

Two studies found that simple changes, such as grouping residents around the tables and allowing them to serve themselves food, resulted in increased social interaction among residents (Davies & Snaith, 1980; Melin & Gotestam, 1981). Swedish investigators found that changing the decor in a nursing home dining room to 1940s style (reminiscent of their youth) and allowing residents to serve themselves food improved nutritional intake (Elmstahl, Blabolil, Fex, Kuller, & Steen, 1987).

Nurse Attitudes Toward Residents with Eating Problems

Two studies have examined nurse attitudes toward patients with eating difficulties. Barnes (1990) found that patients who were easy to feed were more positively regarded than those who exhibited refuse-like behavior or those who spilled their food. In an interview study of Swedish enrolled nurses (comparable to American licensed vocational nurses) and nurses' aides, investigators found that caregivers find "food refusal" a vague term and are uncertain about how to interpret and respond to refuse-like behaviors (Norberg, Backstrom, Athlin, & Norberg, 1988). This uncertainty was a source of anxiety for caregivers.

In sum, research on eating and feeding problems of the institutionalized elderly is at a seminal stage. The studies described here point to the importance of the caregiver-resident relationship in providing a quality mealtime experience for residents with eating disabilities. There are no ethnographic studies that provide detailed description and analysis of caregiver-resident interaction.

CHAPTER 3: METHODS

The context-sensitive method, ethnography, was selected for use in this study. The study of mealtime behaviors cannot be divorced from the circumstances in which they occur. Mealtime in a nursing home is very different from mealtime at a family dinner table or in a restaurant. The physical environment, the organizational milieu, and the mission of the institution dictate particular features of the setting and define and circumscribe mealtime activities. The ethnographic approach is especially well-suited to identifying and describing such factors.

Ethnography's roots in anthropology make it particularly appropriate for the study of a culture-bound phenomenon like mealtime. Ethnographers set out to discover and describe the meaning and impact of rituals and symbols that shape the culture (Fetterman, 1989). Rituals and symbols constitute a form of cultural shorthand that contains complex meanings in a condensed form. Eating is a highly ritualistic, symbolic, and culturally embedded human behavior (Tannahill, 1973).

Ethnography's focus on both verbal and non-verbal activities is particularly suited to the study of populations in which much of the communication is non-verbal. Ethnographers have a long tradition of observing non-verbal behavior (Jorgensen, 1989). An anthropologist studying an obscure non-literate society may have to collect data about it while knowing little if any of its language (Edgerton & Langness, 1974). While learning the language may be desirable, most anthropologists are limited by time and money, making thorough mastery impossible. The realities of fieldwork mean that anthropologists must rely on strong

observational and descriptive skills to document the non-verbal aspects of the culture that will enlighten their understanding of it. These same skills apply in the study of the interactions between caregivers and dependent, cognitively impaired elderly at mealtime.

Participant-observation is a key data-collection technique for the ethnographer and was the primary method used in this study. Informal interviews supplemented and supported data gathered through observation. Data collection proceeded in two phases: (1) general observation of the nursing home setting; and (2) focused observation of the mealtime interaction.

General Observation Phase

The first phase involved a six-month period of general observation. In the initial stage of work, following the methods described by Schatzman and Strauss (1973), I regarded all experiences as worthy of attention and interest, and kept voluminous field notes. I immersed myself in the setting and observed a range of activities in the nursing home during the daytime and evening hours. Although I paid particular attention to mealtime activities, I also observed the staff performing other nursing duties, such as maintaining the residents' hygiene, assisting with their mobility, and giving them medications. I went to activity periods and social events, sometimes participating in them, performing such tasks as passing out cookies or taking over the leadership of a game when the activities director was called to the telephone. But in general I kept to the observer end of the participant-observer spectrum described by Hammersley and Atkinson (1983).

During this phase, I conducted informal interviews with key personnel in the nursing home, including the administrator, the director and assistant director of

nursing, the staff development director, the dietitian, the chief of maintenance, members of the nursing staff, family members, and other visitors. I also examined certain key documents such as menu plans, charting forms, and company newsletters.

I recorded data from this phase in handwritten notes taken while I was in the field. At the end of the day, I reviewed the notes and entered them into a computer word-processing program in narrative form. Periodically, I organized newsletters and other documents and filed them for analysis.

Focused Mealtime Observation Phase

The second phase of data collection consisted of focused mealtime observation of ten resident subjects.¹ Using theoretical sampling (Morse, 1986), I chose subjects to represent the range of difficulties commonly seen in eating-disabled elders, such as agitation, reluctance to eat, and trouble swallowing. All subjects required extensive assistance with eating at least 50 percent of the time. As we can see in Table 1, they exhibited impaired mental status, as measured by the Kahn, Goldfarb, Pollack, and Peck (1960) Mental Status Questionnaire (MSQ), and high levels of dependency in activities of daily living, as measured by the Katz Index of Activities of Daily Living (Katz, Ford, Moskowitz, Jackson, & Jaffee, 1963). Impaired mental status and dependency in activities of daily living are typical of eating-disabled elders (Siebens et al., 1986).

¹Anthropologists typically call their information sources “informants” rather than “subjects.” Informants are key members of the culture who are articulate and knowledgeable and will provide an accurate descriptive picture of the culture’s main features (Spradley, 1979). In the present study, I have used the term “subjects” because most of the residents had such severe cognitive impairment that they were unable to be informants in the sense typically used by anthropologists. I learned from the subjects by observation and made inferences about their behaviors. My analysis of these behaviors was supplemented and confirmed by the comments supplied by the caregivers.

Table 1
Subject Profile (N=10)

Name	Sex	Age	Ethnicity	Primary Diagnoses	MSQ	Katz	Diet Texture
John Merchant	M	79	African-American	Alzheimer's Disease, CVA	4	F	purée
Deborah Schmidt	F	98	Caucasian	Degenerative Joint Disease, Dementia	0	G	purée
Sally Marshall	F	77	Caucasian	Diabetes, Dementia	0	G	purée
Violet Iannotta	F	92	Caucasian	Atrial Fibrillation, Dementia	1	F	regular
Sarah Washington	F	89	African-American	CVA, Diabetes, Dementia	0	G	purée
Walter Chan	M	69	Chinese-American	CVA, Multi-Infarct Dementia	1	G	mechanical soft
Li Bing	F	98	Chinese-American	CVA, Diabetes, Hypertension	0	G	purée
Bill Green	M	85	Caucasian	CVA	0	G	mechanical soft
Lucy Manford	F	84	Caucasian	Parkinson's Disease	0	G	mechanical soft
Hiroko Ishibashi	F	93	Japanese-American	CVA, Dementia	3	F	regular

NOTE: Subjects are listed in the order in which they were inducted into the study. The MSQ scores have a possible range of 0–10. A score of 0–2 indicates severe cognitive impairment; 3–8 indicates moderate impairment; 9–10 indicates mild to no impairment. The Katz Index measures dependency in six functions: bathing, dressing, toileting, transferring, continence, and feeding. Scores range from A (no dependency) to G (dependency in all six functions).

Because the present study focused on the interaction between residents and caregivers, caregiver behaviors were also of interest and therefore became part of the study.² Caregivers were chosen for observation by convenience. That is, the caregivers observed were those who happened to be responsible for feeding a

²Although the caregivers were, in effect, subjects in the study, the use of the term “subjects” in this dissertation refers only to the ten residents studied.

particular subject at the time selected for observation. Demographic information about the 32 caregivers observed is presented in Table 2.

Table 2
Caregiver Demographics (N=32)

<u>Staff (CNA) Caregivers (n=29)</u>		
	<i>n</i>	%
<i>Ethnicity</i>		
Filipino	21	72.4
African-American	3	10.9
Latino	2	6.9
Chinese	1	3.4
Hawaiian	1	3.4
Caucasian	1	3.4
<i>Sex</i>		
Female	27	93.1
Male	2	6.9
<i>Age</i>		
20–29	15	51.7
30–39	9	31.0
40–49	1	3.4
50–59	4	13.7

<u>Family Caregivers (n=3)</u>		
	<i>n</i>	%
<i>Ethnicity</i>		
Japanese	3	100
<i>Sex</i>		
Female	3	100
<i>Age</i>		
60+	3	100

Human Subjects Assurance

Because all resident subjects were cognitively impaired, each subject's responsible party was contacted to obtain consent for participation in the study. The purposes and procedures of the study were described to the responsible parties, and permission was obtained and documented on the form approved by the University of California Committee on Human Research. Responsible parties who seldom or never visited were contacted by phone or mail. Responsible parties of fourteen potential subjects were contacted. Ten parties consented; two (one public guardian, one relative) explicitly refused. Two parties never responded to mailed requests.

The purposes of the research were also explained to the subjects in simple terms as each observation began. For example, I would say to a resident, "Mr. Merchant, I am a nurse from the University of California. I'm learning about mealtimes in nursing homes. I'd like to watch Lena help you with your meal today. Would that be all right?" In no case did a resident deny me permission to observe.

Nursing home staff caregivers were informed about the study in a series of in-services. They were observed at their work in the public areas of the home under the Committee on Human Research's general rubric permitting observation of human behavior in public places. Family caregivers learned about the study when asked for permission to observe their relative. When observing one-on-one mealtime interaction in more private areas of the nursing home, such as residents' rooms, I always asked caregivers for permission to observe. No caregiver ever denied permission.

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Data Collection

Qualitative data: After I obtained consent, I observed each of the subjects during a series of six meals over a two-week period. Again, as a participant-observer, I chose to keep on the observer end of the spectrum. While I worked to put both the resident and the caregiver at ease with my presence as an observer, I did not interfere with the interactions between them by giving advice or making suggestions. In particular, I never fed the subjects.

Each subject was observed during breakfast, lunch, and dinner. One observation took place during a weekend meal. Observations began with the delivery of the tray to the resident and ended when the tray was removed. All verbal and non-verbal interaction between the resident and the caregiver was recorded during the mealtime in the form of brief handwritten field notes. Caregivers frequently chatted with me during the meal, revealing much about what they were doing and why. Sometimes I asked them about their actions, conducting a kind of informal interview as the mealtime progressed.

After the observation period, I retreated to a quiet corner of the nursing home to refine and expand the notes taken during the interaction. Then, at the end of the day, I entered my notes into a computer word-processing program in narrative form. This three-step method enhanced my recall of the events I had witnessed.

Quantitative data: The use of quantification techniques to determine the frequency of a behavior constitutes a type of methodological triangulation and can expand the insights gained through the qualitative approach (Duffy, 1987; Jick, 1979; Murphy, 1989). In the present study, three quantitative tools were used.

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First was the mealtime observational checklist (see Appendix A). This instrument, which was developed specifically for this study, was directed at measuring the presence or absence of certain key caregiver behaviors noted in the first phase of data collection. It was used to examine such things as whether the caregiver employed touch during the mealtime or threatened the resident in any way. Positive interactional behaviors (those assumed to be beneficial to the resident) were scored as a +1 if they occurred during the mealtime and as a 0 if they did not. Negative interactional behaviors (those assumed to be detrimental to the resident) were scored as a -1 if they occurred during the mealtime and as a 0 if they did not. Thus, the higher the score, the more beneficial the style of interaction. The possible range of scores ran from -7 to +22. The actual scores ranged from +2 to +16. The instrument was also used to calculate the frequency of the selected listed behaviors. The reliability and validity of the instrument were not established.

The second tool was the Clark and Bowling Mood Scale (Clark & Bowling, 1989; see Appendix B). This scale, which was developed as an observational measure of subject mood, was designed especially to measure mood in cognitively impaired residents who are unable to report their own feelings. The scale measures each of eight moods—"happiness," "contentment," "interest," "neutrality," "discontentment," "unhappiness," "distress," and "aggression"—on a Likert scale ranging from 1 to 5. Validity of the scale is not established, but Clark and Bowling reported 100 percent agreement on interrater reliability. In the present study, following the Clark and Bowling protocol, two readings were taken during each mealtime observation, at 15-minute intervals.

The third tool was a calculation of the percentage of food eaten at each meal. The total amount of food on the tray at the beginning of the meal represented 100

percent, with the main course representing 75 percent, the dessert 15 percent, and the beverage 10 percent of the total. At breakfast, the entrée represented 40 percent of the meal, cereal and toast 40 percent, juice 10 percent, and milk 10 percent. Coffee, tea, and water were not counted as part of the total, since they do not have nutritional value. The percentages were adjusted for differences between individual trays. For example, if the resident did not get milk on the tray at breakfast, the percentage was redivided among the items actually on the tray.

Percentage figures are customarily used to calculate the amount eaten by hospital and nursing home residents. While imprecise, these figures do give a general picture of how much a resident eats at a particular meal and also suggest the relative success of the caregiver in providing nutrition to the resident.

Interrater reliability was not established for the observational checklist or the measurement of food eaten. The study was conducted by a sole investigator, as is often the case with ethnographic research, and introducing an additional researcher would have been disruptive to the rapport so carefully established between the investigator and the subjects. In a future study, interrater reliability could be established by having two researchers working together from the very beginning.

Analytic Procedures

Qualitative Analysis

In ethnography, analysis proceeds simultaneously with collection of data. Descriptions of human behaviors and culture are inherently theoretical (Pelto & Pelto, 1978). The task of the researcher is to make the theory explicit as it emerges from the descriptive data.

Ethnographers typically use coding techniques to identify themes and

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features of the culture under study. The “open coding” technique developed by Strauss and Corbin (1990) begins with a line-by-line reading of field notes. Using this technique, I reviewed the field notes and jotted down codes in the margins. Then I assigned names to categories and themes as they recurred in the data. I paid particular attention to terms used by the members of the culture, especially the staff. For example, aides often described residents as “full assists” or “partial assists.”³ These terms indicate that the level of help needed by a resident was an important way that aides categorized residents, reflecting their task orientation. Paying attention to these *in vivo* terms often points to theoretically important concepts (Hammersley & Atkinson, 1983).

The conceptual categories generated in this process were then reduced by selection, clustering, and ordering. Categories were then linked to show relationships between concepts, and theories about these relationships were elaborated.

The following example shows how the analysis was done. In the course of my observations, I noted that the caregivers often encouraged residents to eat. Sometimes the caregivers offered positive reinforcement, using terms such as “very good” when people ate. At other times, the caregivers encouraged residents to try particular foods. One type of encouragement, which was quite distinctive, occurred even before the meal arrived and was used exclusively in interactions with residents who were having difficulty eating. In this particular type of encouragement, the caregivers appeared to be trying to put residents in the right frame of mind to eat.

³The term “aide” in this dissertation refers to Certified Nursing Assistant (CNA), a category of nursing personnel. This kind of employee must complete a six-week training course in basic nursing personal-care techniques and must pass a state certification exam. She or he is officially called a “CNA,” but “aide” is the term commonly used in nursing homes.

Because the caregivers' actions resembled the behavior of sports coaches addressing athletes before games, I called the caregivers' behavior "coaching." Since the coaching always occurred before the meals, I added the modifier "pre-meal." Naming this new category provided insights into how caregivers encourage the residents they help.

Typically, analysis in ethnography does not progress in the orderly sequence suggested by the analytic procedure described above. Indeed, as Hammersley and Atkinson (1983) argue, the reflexive nature of ethnographic work is one of its key features and strengths. For this study, theoretical insights were recorded as they occurred to me. Labeling these "theoretical notes," following Schatzman and Strauss (1973), I entered them as part of the field note narrative. As I read and reread the field notes, I developed theoretical ideas, refined them into schemes, and tested them against new data being collected. As schemes broke down with the collection of new data, I revised or discarded them (Agar, 1986).

Quantitative Analysis

I calculated the scores for the three quantitative instruments and the frequencies of selected behaviors from the observational checklist. Using the CRUNCH statistical package, I determined for each subject the Pearson correlations between the observational checklist score and the percentage consumed, and between the mood scales scores and the percentage consumed.

Reliability and Validity

Establishing reliability and validity in qualitative research poses special problems. Critics have accused qualitative research of being too subjective and

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artistic to be deemed scientific (Miles & Huberman, 1984). Proponents of qualitative research have recently addressed this problem at length.

Reliability concerns the replicability of scientific findings. The observations made in qualitative research should be replicable by an independent investigator observing the same phenomena. One way of establishing reliability is to keep fieldwork descriptions concrete and precise and to avoid use of interpretive terms (LeCompte & Goetz, 1982). In my own observational notes, I described what I saw and heard as accurately as possible, recording only data received through the senses. I recorded theoretical hunches, interpretive comments, or emotional responses separately and labelled them as “theoretical notes.” In this way, I maintained a division between data collection and analytical tasks.

To further ensure reliability, I confirmed the accuracy of my observations with the people I observed. For example, one subject, “Walter,” did not seem to open his mouth very well, and I concluded that the aides often had difficulty getting a spoon into his mouth. One day an aide who was feeding him said to me, “See how little he opens his mouth?” Her comment confirmed my interpretation.

Validity concerns the issues of how well data and analysis actually represent reality. Internal validity is concerned with the question of whether scientists are actually measuring what they purport to measure. External validity concerns the applicability of research findings to the larger population or to similar groups.

Internal validity is commonly thought of as ethnography’s strength (LeCompte & Goetz, 1982). Ethnography’s contextual and developmental focus counteracts the threats to internal validity posed by history and maturation. For example, when I first arrived to begin the phase of generalized observation, the nursing home was preparing for the annual visit from the state evaluators. The staff

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members were tense and became more so as the date of the evaluation approached. Everyone feared that the evaluators might find a violation of the regulations. (My interviews with directors of other nursing homes suggest that this fear is by no means unique to Central City and may be pervasive when state evaluators are coming.) Many of the aides seemed especially tentative and quiet as they delivered their nursing care. If I had only observed the home during this period, I would have obtained a much different impression from the one I got by observing for more than a year.

Similarly, the anthropological tradition of staying in the field for lengthy periods of time can counteract observer effects. Subjects may initially “put on an act” for the researcher, but over time the effort to maintain the performance becomes exhausting, and the subjects revert to their accustomed behavior. In the course of this study, I noticed that the longer I stayed in the field, the more the staff came to trust me. At first, many of them thought that I was “from the state,” and believed I was there to evaluate them. As they came to understand that I was a student and a researcher, many began to trust me and tell me what they thought about their work, the residents, and the institutional leadership. One staff member said, “You are part of the family now.” Another stated that when I sat observing in the dining room, “We sort of forget that you are here.”

Validity was also enhanced by the subject selection criteria. I chose subjects to represent the diversity of eating disabilities present in the population in this nursing home. The use of theoretical sampling helped to guard against selection threats.

Finally, the cycle of collecting, coding, and analyzing data, developing theoretical insights, and returning to the field to test the insights against new data

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provided a “constant validity check” (Bernard, 1988, p. 320). As new data challenged a developing theoretical scheme, I modified the scheme to represent more accurately the phenomena under study.

External validity is more difficult for the ethnographer to establish (LeCompte & Goetz, 1982). Because the ethnographer’s interest is in portraying the distinct and unique features of a particular culture, it can be difficult to generalize results to other cultures. Yet, at the same time, anthropological methods require researchers to look for universal patterns and to seek commonalities between cultures and research settings.

External validity may be somewhat easier to achieve when studying the organizational culture common to institutions in modern industrial societies. Health-care institutions such as nursing homes may have common cultural features that are present across settings. In the United States, for example, nursing homes serve predominantly white females in collective living situations. Central City Nursing Home fits this profile, with a population that is 67 percent female and 67 percent Caucasian. As in most other nursing homes, Central City’s residents are dependent on nursing staff for nearly all of their basic survival and health needs. And in this home, as in others, the majority of the nursing staff (62 percent) is comprised of the lowest paid and least educated class of health-care workers: nurses’ aides. As a for-profit facility, Central City, which is part of a large corporate chain, is typical in its institutional type.

The similarities between the research site and the majority of American nursing homes enhances the external validity of the study. Because this home includes many of the features of other homes, the findings of this study may well generalize to the population of elderly residents in other similar homes.

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CHAPTER 4: A GENERAL ETHNOGRAPHIC DESCRIPTION OF CENTRAL CITY NURSING HOME

This chapter presents the results of the first phase of data collection. The goal of this phase was to gain a general understanding of Central City Nursing Home. The specific objective was to describe (1) the layout, appearance, and functions of the physical facility; (2) the characteristics of the resident population; (3) the daily routine with a particular focus on mealtime; and (4) the roles and duties of personnel in the various departments.

Neighborhood and Exterior

Central City Nursing Home is a 90-bed facility located on a major artery in a rapidly gentrifying, urban neighborhood of a large West Coast city. The neighborhood includes single- and multiple-family townhouse dwellings, many from the Victorian era. Two major commercial zones (one consisting of about 10 blocks of small shops and restaurants, the other a mall facility) and a 200-bed private hospital are located nearby.

From the street, Central City looks like an innocuous modern building with a long wheelchair ramp across its front. The building exterior is painted and in good repair. Some fairly large trees shade the street.

The Main Level

Entryway and Hall

Most people, including visitors, staff, and residents, enter the nursing home by coming up the wheelchair ramp that leads to the central entrance on the main floor. The large front double-doors open to a small foyer that serves as a waiting room. It is furnished with a love seat near the door. Across from the love seat is an elevator that goes down to the lower level of the home. Straight ahead is a high reception counter that resembles the check-in desk of a Victorian hotel, wooden and trimmed with brass railings. The counter is lit by three attractive billiard table type lamps suspended from the ceiling. As one enters the foyer, one can see the receptionist's face over the counter. Near the counter is the administrator's office, a small but pretty, light-filled room. The administrator has given it a homey feeling by situating two comfortable chairs across from her desk and by decorating the room with plants and a few appealing stuffed animals. Because of its location, the office is easily accessible to visitors and residents, and the administrator often comes out to visit with residents.

This main floor also includes all the residents' rooms. Two small patios are located in the center of the building. Each one has a table with an umbrella, surrounded by six chairs. Infrequently, a resident or two may sit with a visitor on one of the patios. When I first began my research, these patios contained some rather scraggly looking plants. Over the course of the study, the plants benefitted from some careful tending by one of the housekeepers and a resident's son.

The Lounge

An attractive lounge about 30 feet by 10 feet lies along the street side of the

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building. Windows run the length of the room, offering a view of the street with its trees and the Victorian houses opposite. During the study, I often found residents sitting in this room looking out the window. One resident enjoyed looking at the houses across the street. She pointed out that two of them were matched in design and commented on the pretty way they were painted.

The lounge contains high-quality furniture upholstered with a waterproof print fabric, which makes the chairs easy to clean should a resident be incontinent. There is an appealing sky-blue and mauve color scheme in the lounge, which is repeated throughout the home. The chairs are upholstered in coordinated prints and solids in this same color scheme. Some of the chairs are winged armchairs; others are love seats. The room contains several small end tables. Especially appropriate for elderly people who are unsteady on their feet are several straight-backed chairs with firm wooden arms. A pretty clock, a wooden bookcase filled with large-print books, and a carved marble fireplace grace the room. There is also a piano, on which an activity aide leads a sing-along one afternoon a week.

A room divider between the lounge area and the hall holds many house plants. Some potted plants are arranged around the fireplace. One of the laundry workers keeps these plants healthy and green. This room does not have a television set, but there are some mounted on the wall in each dining room and a big-screen TV downstairs.

The lounge is a relatively quiet area of the home. Family members seem to enjoy using it as a place to visit with residents. Ambulatory residents come here to read the newspaper, especially in the late morning or mid-afternoon. The lounge is also used by residents who wait for aides to take them to meals.

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Dining Rooms

The two architecturally identical dining rooms, each measuring about 15 by 14 feet, are located opposite the lounge. They have sliding glass doors that open to the patios. Each dining room seats 16 people at four tables of four. Dining Room One serves the residents who are able to feed themselves. Dining Room Two serves the residents who need considerable assistance with eating. Because most residents are wheelchair bound and are pushed to the tables, there are few chairs in either dining room.

Tablecloths are used in both dining rooms. In Dining Room One, meals are served on place mats. Each resident's plate and drinks are removed from the tray and placed directly on the mat. In Dining Room Two, meals are served on the tray placed on the table. Only Dining Room One has small silk flower arrangements on the tables. This differential treatment seems to reflect institutional attitudes about impaired residents. Residents with eating difficulties (who tend to be cognitively impaired) are assigned to the less decorated dining room. Flower vases and place mats are reserved for the alert, cognitively intact, independent residents.

The assistant director of nursing confirmed the conscious decision in this distinction, commenting that the administrator likes to maintain a "restaurant atmosphere" in Dining Room One. She added that residents who are able to feed themselves but cannot eat neatly are seated in Dining Room Two because they detract from the restaurant atmosphere. Her comments suggested that no one has considered the aesthetic experience of the more impaired residents who eat in Dining Room Two.

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Hallways

The hallways are clean and well-lit by overhead skylights. The floors are kept sparkling and polished. The janitor works hard to keep them in this condition. One resident's wife commented: "They keep this place *so* clean. They are always doing something when I come in. And if you spill something, you just ring the bell and they are right here to clean it up." The hallways are wallpapered, have railings all around, and are decorated with prints of French Impressionist art. Empty of permanent furniture, the hallways are used primarily for transit or as places for residents to sit in wheelchairs or geri-chairs.

Certain movable items are found in the halls at various times. Wheeled laundry bins appear in the morning, when beds are changed and baths given. Nurses use carts for medicine rounds, at 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. These carts are returned to the nurses' stations between times. In the morning, when residents are assisted with grooming, a staff member delivers carts carrying plastic "care baskets" to the halls. Each aide takes one of these baskets, which contain personal grooming and hygiene products, such as body lotions, combs, hair tonics, and shavers. The items in the basket are personalized to meet the needs of the residents served by the aide. At mealtimes, tall tray carts are brought up from the kitchen downstairs. Several times a week, a wheeled garment rack is brought from the laundry room with residents' clothing. The clothing is returned to the appropriate rooms.

Resident Rooms

There are 34 resident rooms, numbered 1–12 and 14–35. There is no room number 13. Every two rooms share a lavatory that contains a toilet and sink.

Twenty-two of the rooms have three beds each, and twelve of the rooms have two beds each, for a total of 90 beds. At the time of the study, however, one of the residents was paying to have a single room, so one of the usually two-bedded rooms had only one bed in it, making the actual bed capacity of the facility at the time 89.

Fourteen of the beds are assigned to residents whose payor source is Medicare. These Medicare-designated beds are clustered in six rooms around one corner of the facility. Residents of this area are generally in the facility for shorter periods, a few weeks or months, because Medicare only pays for one hundred days of nursing home care. Most of these residents require rehabilitative care and are destined to return to their homes.

Outer rooms are arranged along the outside walls of the building, and inner rooms partially ring the two inner patios. The rooms are tidy and clean with pleasant decor in the same color scheme as the lounge. The wallpaper, curtains, and bedspreads are all color coordinated. The beds have a hand-crank mechanism that allows staff to raise both the heads and the knees of the beds. Beside each bed, an 18-inch by 18-inch lucite wall panel enables residents to tape cards or photos to the wall. Each resident's name is written on the panel along with the name of the attending physician. There is a bedside stand by each bed that holds personal belongings and a water pitcher.

The resident rooms are very small. The three-bedded rooms measure about 9 feet by 18 feet, and the two-bedded rooms measure about 9 feet by 12 feet. There is no space for additional furniture besides the beds and nightstands for each resident. Clothing is hung in built-in closets and dressers. In a past state facility evaluation, the inspectors commented that there was nowhere for visitors to sit in

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the residents' rooms. In response to this criticism, the nursing home provided one folding wooden chair for each room. These chairs do indeed provide seating, but some visitors might find them uncomfortable, especially during a prolonged visit. Unfortunately, these chairs are not always returned to the assigned rooms; I frequently saw visitors searching for them.

Because the rooms are small, there is little space for objects that might personalize the rooms. Staff, however, do make an effort to display family photos and cards prominently. Also, many of the residents' beds have colorful afghans folded at the end. These are often used as lap blankets when residents are up in the wheelchairs.

Nursing Stations

There are two nursing stations, numbered 1 and 2, at opposite corners of the central core of the building. The nurses' stations have a conventional hospital configuration. Behind a high counter runs a desk-height writing surface. The residents' charts are kept on this counter. The station also contains a sink, some cabinets, and a locked medicine room behind the desk where controlled medications and other supplies are kept. The licensed nurses spend much of their time at the station working on charts, preparing medications, making phone calls, and planning and organizing care.

Offices

The office of the director of nursing (DON), which is adjacent to Station 2, is a long narrow office with two desks and a computer station. One licensed vocational nurse (LVN) works full-time at the computer, inputting data. She

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updates resident profiles, enters changes in physicians' orders, and prepares information for the multidisciplinary admission assessments.

Two other offices are located on this floor. The staff development coordinator has a small office on the central hallway. Behind the receptionist's desk is the business office, a narrow room where the business manager and the admissions coordinator work.

Other Rooms

The main floor of the home also contains shower rooms, a bathtub room with a specially designed tub for geriatric patients called a "century tub," and supply and maintenance closets.

The Lower Level

The lower level of the facility is a partially submerged basement. The indoor space on this level is about half the size of the main level. The remaining area under the main floor is a 20-space underground garage that provides parking for staff and visitors.

The Living Center

The largest room on the lower level is called the "living center." It is a large room about 12 feet by 25 feet that serves several purposes. The main pieces of stationary furniture in the room include a big-screen TV and an upright piano. The room houses activities, exercise classes, and the restorative eating program that serves twelve residents. Chairs and three collapsible round tables are stored in the hallway nearby. This furniture is brought in for activities and for lunchtime meals.

Laundry

The laundry room contains industrial washers and dryers, since all linens are washed on the premises. For a laundry service charge of fifteen dollars per month, residents' clothing is washed here, too. Many residents take advantage of this service, although one resident's guardian complained that clothes frequently "disappeared" in the laundry. When she spoke to the administration about the issue, she was told, "This is a problem we have." Other residents elect to have their families wash personal laundry. If this is the case, a sign indicating "family will do laundry" is posted at the bedside.

Kitchen

A large, modern, industrial kitchen is next to the laundry. Tiled in terracotta, it is filled with steam tables, refrigerators, freezers, and a large stove. Food is stored in the adjacent pantry.

Maintenance/In-Service Area

A large unfinished room is used by maintenance staff for supplies, tools, and temporary storage of items needing repair. Part of this room had been roughly walled off to make a space for staff in-service classes. The staff development coordinator commented that she felt embarrassed about the space because it is so cluttered and haphazardly planned. It is furnished with a small round table, about eight chairs, and a blackboard. A video cassette recorder and a TV set are available for in-service instruction. During the course of this study, the recorder was stolen. The staff development coordinator (SDC) used funds that were slated to purchase a slide projector and an overhead projector to replace the VCR.

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There is an incongruity between the SDC's talent and the workspace she is given in which to conduct her work. The condition of the in-service room suggests that education does not carry a high priority in the mission of the home. Yet, the SDC is a well-qualified, hard-working woman, who provides classes weekly for the nursing staff.

Physical Therapy Room

At the end of the hall on the lower level is the physical therapy room. This is about 12 feet by 15 feet and contains parallel walking bars, weights, and other physical therapy equipment.

Staff Facilities

Near the kitchen is a small staff lounge containing three tables, a dozen chairs, a vending machine, a microwave, a coffee maker, and the employee bulletin board. A restroom and small locker room for employees are located across the hall.

Other Rooms and Facilities

A small beauty shop is located next to the locker room. It has a shampoo basin and hood hair dryer and is staffed by a nun who volunteers her services every Wednesday. Next to the beauty shop is a toilet room for residents, which is large enough to allow an aide to accompany a resident if needed.

This level also houses an office shared by the social worker and activities director.

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Pets

Pets are permitted to visit residents. One resident's family member told me about bringing her pet teacup poodle to visit her husband. She told me how much the other residents enjoyed seeing and playing with the animal. Another resident kept her two caged parakeets at her bedside.

A goldfish lives in a bowl at Station 2. One of the nurses takes care of it, keeping the water in the bowl crystal clean.

Level of Care Provided

Designated as a skilled nursing facility, the home provides care for dependent, disabled adults. It does not provide sub-acute care such as intravenous therapy. A few residents need oxygen, which is supplied from portable tanks. There is no bedside wall oxygen system. The home can manage tube feedings, which are given by the continuous pump method. There are usually between four and six residents on feeding tubes.

Resident Population

Demographic data for residents is presented in Table 3.

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Table 3
Resident Demographics (N=87)

		<i>n</i>	%
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<i>Sex</i>			
	Male	32	36.8
	Female	55	63.2
<i>Ethnicity</i>			
	Caucasian	58	66.6
	Chinese	15	17.2
	African-American	10	11.5
	Hispanic	3	3.4
	Filipino	1	1.1
<i>Payor Source</i>			
	Medi-Cal	41	47.1
	Private	18	20.7
	Veteran's Administration	10	11.5
	Other (HMOs, Hospice)	18	20.6
<i>Age</i>			
	Mean	81.13	
	Range	59–102	
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The majority of residents at Central City are severely impaired both mentally and physically. Thirty-eight percent of the residents have a diagnosis of dementia on their charts, others show milder memory impairment, suffer from aphasia, or have sensory deficits that impair communication. Less than a half-dozen residents are fully ambulatory. A dozen more can walk with the assistance of another person. Most get about by using wheelchairs. Over a third of the residents have enough difficulty swallowing or chewing that they require foods of modified texture (see Table 4).

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Table 4
Diet Texture Type

<i>Texture</i>	<i>Number of Residents</i>	<i>%</i>
Regular	58	66.7
Mechanical Soft	11	12.6
Purée	12	13.7
Tube Feeding	6	6.9

Daily Routine

Residents are awakened and served breakfast in their bedrooms at 7:00 A.M. Residents requiring assistance with eating are helped by the day-shift aides and by four night-shift aides who stay over to help until 7:30. After breakfast, morning care begins. All residents are helped to wash their hands and faces, brush their teeth, insert dentures, and get dressed. When finished with these early-morning tasks, about 40 of them are brought downstairs to the living center for an activities period. The people who come to the center are the ones who function best cognitively. The activities director (or an aide) reads the paper to the group, leads them in a short exercise period, and plays Trivial Pursuits with them, using questions geared toward the 1930s and 1940s, the period of their youth. (Most of these residents have short-term memory loss, but do well remembering events from long ago.) The activities personnel work hard to get discussions going during this period, and generally have some success in doing so. Coffee and cookies are also served during this period.

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Residents who are not taken down to the living center remain in their rooms, sit in the hallways or lounge, attend physical therapy, or are taken to a dining room, where a staff member turns on the TV. Some residents are taken to Dining Room Two as early as 10:30 and remain seated in the same spot at one of the tables until lunch is over at 1:00 P.M. The TV in Dining Room Two is on throughout much of the day. One can usually find a half-dozen residents in this room at any time of day. It is unusual to see a resident attending to the TV. The set is on, but the residents do not appear to be watching it. They stare vacantly into space or doze off.

Residents who are receiving physical therapy either go down to the physical therapy room or, in some cases, receive therapy upstairs. A speech therapist or occupational therapist may schedule appointments to meet with residents during the morning. A few residents are completely bedridden and never leave their rooms.

About 11:40 A.M., residents are moved from their rooms or are brought from the living center to the dining rooms for lunch. There are two seatings of lunch in Dining Room One, the first at 11:45 A.M., the second at 12:30 P.M. Residents who are scheduled for the second seating wait in the lounge. Residents who require assistance with eating are taken to Dining Room Two, where a full hour is allotted to lunch. About 12 residents have lunch in the living center, where they are part of the restorative eating program, in which self-feeding skills are encouraged. Individuals who are particularly difficult to feed are also sent here to receive special assistance. Some residents eat in their rooms, mostly by choice.

After eating, residents are returned to their rooms for rest, or they go to afternoon activities. The latter include dramatic and documentary movies (shown on the big-screen TV), discussion groups, and art classes led by an art therapist. The

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residents' art is displayed in the downstairs hall and is available for purchase; all proceeds go to the resident artist. Sometimes, entertainers come to the home. Physical and other therapy appointments continue throughout the afternoon. Cookies and juice are always served at 2:00 P.M.

At 5:00 P.M., dinner is served. There is one seating for dinner in each dining room. No residents eat dinner in the living center. In fact, most residents eat in their rooms. On a typical evening, I observed 15 residents in Dining Room One, ten in Dining Room Two, and one in the hallway. All other residents had dinner in their rooms. After dinner, the nursing home becomes very quiet. By 8:00 P.M., when visiting hours end, the one or two evening visitors have left, and most residents are already in bed for the night. Nourishments (usually milk and graham crackers) are served in the rooms shortly after 8:00 P.M., lights are dimmed, and the residents go to sleep.

Staff

A total of 85 people are employed by the facility, some in part-time positions. Many of the employees have worked at the home for a long time (many for ten or more years). The administrator has a tenure of eight years; the director of nursing, four years. This longevity of leadership is atypical of long-term care facilities, which often have a high turnover in key positions (Kayser-Jones, 1990a; Tellis-Nayak, 1988).

A description of the key personnel in administration, nursing, and other departments follows. In addition, a description and demographic profile of the entire nursing staff—the largest group of workers, and the employees directly responsible for assisting residents at mealtime—is presented.

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Administration

Administrator: The administrator, Emily Warren, is a small, friendly, well-dressed Caucasian woman with ramrod posture. She is a registered nurse (RN), with a diploma from a hospital school, and has a Bachelor's degree in psychology. She has been an administrator in long-term care since 1965, has worked for the parent company for 22 years, and has been at Central City for eight. She likes this facility because it is "lower key" than her last post, and the residents are not as ill or disabled.

Ms. Warren knows the names of and much personal data about the long-term residents, but is less familiar with those who stay for a few weeks. Much of her time is spent in her office, but she regularly finds time to talk with residents in the lounge or hallways. When I arrived at Central City one day, a new resident, who had been in the home just a few days, was sitting in a wheelchair propelling herself randomly about the front hall and mumbling. Her hair was uncombed, and she was dressed only in a hospital gown with a sweater over it. Ms. Warren, coming out of her office, spotted the woman and asked her who she was and who was caring for her. The resident did not reply, but stared at Ms. Warren confusedly. Ms. Warren then turned to me and said, "Who is this person?" I answered that I didn't know; she must have come since my last visit. Ms. Warren said, "She doesn't look like one of ours, she looks like a lost waif." Then she asked an aide to dress and groom the resident. Ms. Warren's remarks suggested that the staff had not met her standard of appearance with this resident. She remedied the situation by getting an aide to groom and dress the resident properly.

Ms. Warren was happy to have research in the facility and welcomed my

project, asking me to share the findings with her. She believes that residents enjoy talking to researchers and noted, "It gives them something to do."

Twice in the 17-month data-collection period, state regulators made their annual visit. During these times, Ms. Warren shared her frustration with me concerning the regulatory process. She sees it as somewhat arbitrary and bent on fault-finding.

When asked about the unusual longevity of her staff's tenure, she talked about the importance of stability, noting that a stable staff allows for consistency in caregiving and the opportunity to build relationships with residents. If given the choice, she would rather have mediocre staff who stay for a long time than exceptional staff who stay briefly.

The location of Ms. Warren's office right near the entrance to the home makes her readily available to families; she is at hub of life in this small, busy facility.

Business Manager: The business office is managed by a motherly African-American woman, Mary McKenzie, who has been at the facility for many years. Her own mother-in-law is a resident, and at lunchtime Ms. McKenzie often helps feed her. Ms. McKenzie is assisted by a young Filipino woman who also serves as the receptionist.

Admissions Coordinator: Alma Brooks, a friendly, engaging, Caucasian woman, works with residents, families, and physicians to complete the admissions forms and does all the intake work for new residents.

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Nursing

Director of Nursing: The DON, Theresa Garcia, is a quiet, unflappable, well-organized Filipino woman in her thirties. She generally wears an attractive dress or skirt under her laboratory coat, distinguishing herself from the other nursing staff, who wear uniforms. She completed a Bachelor's degree in nursing in the Philippines and then came to the United States in 1986. She worked in a small chain of nursing homes in New Jersey owned by some relatives and obtained RN licensure there. She moved to the West Coast in 1988 and first applied for work in acute-care settings, but because she did not have a California nursing license, she was not hired. Ms. Warren, however, was willing to hire her while she awaited licensure. Ms. Garcia worked first as a charge nurse and then became co-director of nursing in 1989, job-sharing the position. In 1990, the other co-director resigned, and Ms. Garcia took the position full-time. Like the other leadership staff in the home, Ms. Garcia has been there for an unusually long time. Her five years have given her time to build management skills, forge relationships, and develop rapport with both staff and residents.

At first, Ms. Garcia found the American system of geriatric care strange. She commented: "It's so different. We don't have them [nursing homes] in the Philippines. The old people are taken care of by family there." She has come to like working in the nursing home and feels very comfortable in her position. She still thinks about entering acute care, in which she could earn more, but is concerned that she does not have the necessary skills.

Ms. Garcia knows her staff well. When I asked about the ethnicity of the staff, she remarked that she did not have that information recorded anywhere, but

she could easily tell me. She pulled out a staff list and quickly went through it, designating the ethnicity of each staff member. Ms. Garcia works hard to keep the facility running smoothly. Although she works mostly during the day, she frequently stays into the evening to finish work, and sometimes comes in on her days off, Sunday and Monday, to check on special cases.

She was somewhat evasive about her relationship with the physicians, especially the medical director, saying that “he’s okay, but he could be better.” At Central City, the physicians visit regularly, unlike at many other facilities, undoubtedly because the admissions coordinator will not admit residents whose doctors refuse to visit.

The administrative structure of the home appears to have clearly delineated lines of authority as the following incident revealed. One day as I was talking to the staff development coordinator, Ms. Jefferson, in her office, Ms. Garcia came in. She asked Ms. Jefferson to observe a newly hired aide, who, she said, was leaving linens on the floor and had left a resident’s room untidy. Ms. Garcia also gave some other examples of the aide’s poor work. After Ms. Jefferson said she would watch the aide, Ms. Garcia left. Ms. Jefferson explained that newly hired aides are under her supervision during their monthlong orientation. After that, the aides come under the supervision of the regular nursing staff. Then, if there are problems with the quality of work, the DON or the charge nurse is responsible for supervision and correction.

Assistant Director of Nursing: Dorothy Keeling, the assistant director of nursing (ADON), a Caucasian woman in her forties, is an RN with a diploma from a hospital school. She has been at the facility for five years. Ms. Keeling

assists the DON in her administrative duties and does much direct supervision of the aides. She is in charge when the DON is out of the facility. Ms. Keeling takes Friday and Saturday off so that either the DON or the ADON is in the facility every day.

Ms. Keeling appears to know the residents well. I often found her interacting directly with them. She talks with them in a caring manner and often uses touch, patting their arms and rubbing their backs, as part of her mode of communication. She also has a gentle sense of humor in her interactions with residents and staff.

Staff Development Coordinator: Emma Jefferson, the staff development coordinator, is a Caucasian woman in her sixties. She holds a Bachelor's degree in nursing, and brings a long and varied career in long-term care to her job. She has been with Central City for only one year, but with the parent company much longer. She likes her job at Central City, enjoying teaching and the process of developing programs. She communicates well with the administrator, who takes an interest in her work. She made the importance of this last point clear to me when she described her experience in another facility run by the parent company, to which she had been sent to give the staff in-service on blood-borne disease. The in-service was required by the state. If it were not completed by a certain date, the facility faced a hefty fine. The parent company sent Ms. Jefferson to teach the in-service because the facility's own staff development coordinator had quit her position suddenly. Ms. Jefferson told me that she was glad not to work in that facility because the administrator there had shown no interest in her work, telling her to "just do your thing." Ms. Jefferson prefers to discuss her plans with

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the administrator and to get input and direction so as to serve the facility's needs in the best possible way.

Much of Ms. Jefferson's work is directed at fulfilling state-mandated requirements for education. Recently, legislation was enacted that requires aides to take a written test for certification. This has been a very difficult requirement for the aides. Many of them have little education, many speak English as a second language, and, according to Ms. Jefferson, "they are scared to death of the test." Ms. Jefferson has a great deal of empathy for the aides. She feels that they work hard, get paid poorly, and have a "dead-end job." Yet, she is amazed how many of the aides really enjoy their work. She said that she recently heard two aides, who had been at Central City for many years, discussing the work with a newly certified associate: "They said to her, 'This is a great job, there is always work,' and they told her she would like working here."

Ms. Jefferson is more frustrated with the licensed personnel, who rarely come to the in-services that she presents every Tuesday. She recently led a series on Alzheimer's disease that ran over several sessions, covering such topics as etiology, managing behavioral problems and catastrophic reactions, and working with family members. The series included two guest speakers. The aides came to all the sessions, but the licensed staff only came to the session they were required to attend (on families). Ms. Jefferson says she doesn't understand why she can't get the licensed staff to attend. "I guess they think they know it all," she says.

Ms. Jefferson also runs the employee injury prevention program. The parent company is working hard to reduce the number of staff injuries in order to lower its costs for providing care to workers hurt on the job. Ms. Jefferson had no staff injuries to report since she took over the program a year before. She showed

MAINTENANCE
JAN 1981

me a bulletin that listed the injury records of all the regional facilities belonging to the company, and Central City had the best record. The facility with the worst record had over \$100,000 in costs for worker-related injuries.

Ms. Jefferson started a program to reward workers for giving good care, for preventing injuries to themselves, and for perfect attendance at work. Workers can nominate one another for the “care excellence” award each month. One name is randomly selected from the pool of nominees, and that person receives a \$75 bonus. Similarly, one name is randomly selected each month from the list of all employees with perfect attendance, and that winner is also given a \$75 bonus. If there are no worker injuries at all, a name is randomly selected from the whole facility staff to receive a third \$75 award. These awards are given at a small party held for the staff each month at which cake and lemonade are served. The party and the bonuses appear to boost staff morale.

Ms. Jefferson works well with the administrator, whom she likes and respects. She values the administrator’s RN credential and told me that “the best administrators are nurses—they understand the work.”

Nursing Staff: The nursing staff is divided into two categories, licensed staff (LVNs and RNs) and aides (CNAs). Almost all of them are female; out of a total of 53, there are only three male licensed staff and three male CNAs. The ethnic breakdown is presented in Table 5, and length of employment in Table 6.

Table 5 shows a staff composed overwhelmingly of people from ethnic minorities. The majority of the resident population, however, is Caucasian (see Table 3). This discrepancy between the ethnicity of the staff and that of the residents is common in American nursing homes (Diamond, 1992; Tellis-Nayak &

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Tellis-Nayak, 1989). While beyond the limits of this research, the implications of the differing ethnic backgrounds of staff and residents bear further study.

The three RNs include the DON and the ADON and one other RN. This RN works as a supervisor from 1:00 P.M. until 9:00 P.M., so with the DON and ADON, there is at least one RN in the facility from 7:00 A.M. until 9:00 P.M. each day. LVNs serve as charge nurses for the two nursing stations, each serving 45 residents. There is an LVN on duty at each station for 24 hours a day. The LVNs dispense medications, maintain charts, give treatments, and directly supervise the aides. Two other LVNs serve in special capacities: one inputs computer data and keeps records current; the other works as a treatment nurse for the Medicare patients, who generally require more complex medical care.

Table 5
Ethnic Breakdown of Nursing Staff

	<i>n</i>	%
20 Licensed Staff		
RNs (all full-time)		
Caucasian	2	66.7
Filipino	1	33.3
LVNs (8 part-time)		
Filipino	11	64.7
Caucasian	2	11.8
Korean	2	11.8
Chinese	2	11.8
33 CNAs (1 part-time)		
Filipino	22	66.7
African-American	5	15.2
Caucasian	2	6.1
Latino	2	6.1
Chinese	1	3.0
Vietnamese-American	1	3.0

Table 6
Length of Employment of Nursing Staff

	Range	Mean	Median
<i>Licensed Staff</i>	1 mo.–14 yrs.	4.76 yrs.	3.7 yrs.
<i>CNAs</i>	1 mo.–25 yrs.	5.86 yrs.	2.79 yrs.

The aides perform most of the hands-on care in the facility. They are responsible for assisting residents with daily personal care, including bathing, dressing, and getting to the toilet. Their duties also include helping residents to walk and exercise as well as transporting them to activities, meals, and various therapies. They also help residents at mealtime and feed those who need assistance.

On the day shift, each aide has an assignment of eight residents. The aides work in teams of two and help each another with their assignments. On the evening shift, each aide has sixteen residents. At night, when only four aides cover the entire facility, they do not have specific assignments, but answer calls as needed or as directed by the LVNs. The big discrepancy in staffing ratios between day and evening shifts is explained by the differing workloads during the two periods. The day shift must help with two meals, assist with daily hygiene, and transport residents to activities and therapies, whereas the evening shift must help with only one meal and assist with fewer and simpler activities.

While there is a core of aides who have been at the facility for several years, there is still a fairly high turnover rate among the others. However, the economic recession that occurred during the study apparently had reduced turnover

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somewhat, for during the study the staff development coordinator held CNA orientation for several individuals once a month or less, whereas prior to the recession she had had to do so every week.

A few private-duty aides, hired by families to work with a specific patient, work in the facility. If these aides are in the facility for several weeks or months, they tend to integrate themselves into the staff community. During the study, for example, one private-duty aide worked for a resident who enjoyed attending group activities. The resident did not need constant attention, so when not occupied with her care, the aide helped the nursing home staff by assisting with transfers, bringing trays, and helping with coffee or snacks.

The facility also serves as a clinical site for a private CNA training program run by master's-prepared RN. The instructor brings groups of seven or eight students several times each week during the six-week training period to learn and practice care. Ms. Jefferson, the staff development coordinator, likes this program. It allows her to observe the students and see the work of prospective employees. She likes to hire graduates of this program and feels they have been well-trained.

The nursing staff works in three shifts: days, 7:00 A.M.–3:00 P.M.; evenings, 3:00 P.M.–11:00 P.M.; and nights, 11:00 P.M.–7:00 A.M. Most of the nursing staff work during these hours, although a few have special shifts, coming in late morning and staying through early evening to provide additional help with the evening meal and with activities.

Wages for the unionized CNAs are a little over five dollars per hour, which is comparable to what similar facilities pay. Compensation also includes medical and dental benefits and eligibility for membership in a credit union. After one year, employees may join the retirement plan. They may also buy stock in the parent

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company through a stock-option plan.

Because wages are low, many of the aides work a second part-time job in addition to their work at Central City. Most work at other long-term facilities or as private-duty aides.

Activities Department

Activities Director: The activities director, Al Ritter, is a friendly Caucasian man in his late twenties, who has a bachelor's degree. He plans and organizes activities for the residents and conducts many activities himself. In addition, he supervises meals in Dining Room One. Although most residents in this dining room can eat independently, he helps by cutting food, opening packages, and getting condiments for those who need them.

Shortly before the start of the study, the dietitian began to provide cognitively intact residents with menus offering two entrée choices for each meal. Mr. Ritter was made responsible for making sure that these residents got what they ordered from this menu. He added this duty to his other responsibilities in Dining Room One.

Mr. Ritter wants to become a nursing home administrator. He is working toward that goal, gaining the required education and training.

Activities Aides: The activity director has one full-time assistant and one part-time assistant. The full-time assistant is a young Caucasian woman in her early twenties, enthusiastic and lively in personality.

The part-time (50%) assistant, Max Boxer, is in his sixties, Caucasian, and a retired schoolteacher. He graduated from Pomona College and has a master's

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degree in education from Stanford. He is employed full-time by the nursing home, his other job being to maintain the central supply closet. In that capacity, he inventories and orders supplies. Mr. Boxer mentioned that he had himself once been a resident at Central City for nine months. Following surgery, he had been sent to the home to convalesce. When he recovered, he sought employment at the facility. He is currently taking a course at a community college to become certified as an activities director. The nursing home is paying his tuition and transportation costs to complete the course.

Mr. Boxer is very sensitive to and interested in the residents. In addition to planning and conducting entertainment and activities, he helps to seat and assist residents at meals. He also passes coffee and cookies to the residents who come to morning activity sessions. He expressed much interest in my research and conveyed several fascinating observations about the eating and drinking habits of the residents—for example, the way some of them take their coffee, the best method to give it to them, and how they react to various approaches.

Social Work

A full-time social worker is employed by the facility: Frances Oxford, a Caucasian woman in her mid-forties. She assists families with financial arrangements, advises them about benefits and resources, runs a support group for families of residents, and assists family and residents with psychosocial needs. A consultant from the parent company is available to help with especially complex cases.

Dietary Staff

Dietitian: The facility employs a full-time dietitian: Grace Havel, a lively Caucasian woman in her early twenties who recently graduated from a program in dietetics. She is completing the necessary prerequisites to apply to medical school, which she plans to do in a few years.

Her job is divided between clinical and management responsibilities. In her clinical role, she evaluates residents' physical condition and selects appropriate diets for them. If she deems a therapeutic diet necessary, she presents her recommendations to the appropriate physician.

In her management role, Ms. Havel oversees the monthly food budget, develops recipes, plans the menu cycle, orders food and dietary supplies, and supervises the kitchen help. She works closely with the head cook, a Filipino woman who has been at the home for many years.

Ms. Havel has access to a regional dietitian from the parent company and to a consultant chef, both of whom she has found very helpful in her work.

Kitchen Staff: In addition to the head cook, the kitchen help consist of six Filipino women, one German woman, and one Filipino man who works part-time. Kitchen helpers stand in for the head cook on the weekends, when she has her days off. The absence of the cook appeared to adversely affect weekend meal offerings. Twice, family members of residents reported that the quality of food declined on weekends.

Physical Therapy

Director of Physical Therapy: Karen Jordan, the director of physical

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therapy, is a Caucasian woman in her thirties. She has a gentle but firm rehabilitative approach. One resident, recovering from a fracture of the femur, said: "She really pushes you. She makes you work hard, but it's good." Ms. Jordan spends most of her time in the physical therapy room working with residents.

Physical Therapy Aide: Jean O'Brien, a physical therapy aide who works with Ms. Jordan, is a Caucasian woman in her early twenties. She is energetic and friendly. During the study, I frequently found her assisting residents to walk or exercise. She also helped some residents with eating, especially when the facility was short-staffed.

Other Professional Services

Because Central City is part of a large national nursing home chain, many services are provided by people who work for the parent company. One example is the consultant who is available to the social worker. Services such as speech therapy and occupational therapy are contracted out to a professional by the parent company.

This system of providing special therapies has both advantages and disadvantages. On the one hand, it means that a small facility such as this one can avail itself of therapeutic services that are required by residents on an occasional basis. It would be too expensive for the home to hire many specialized therapists, but this system makes them available when needed. On the other hand, this system means that therapy is not always as intensive as might be ideal. During the study, for example, the parent company's occupational therapist was visiting a stroke patient who suffered from dysphagia. The woman had a feeding tube, but the

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therapist was helping her learn to swallow again. She saw the resident five days a week for one meal each day. The therapist felt certain the resident would regain her ability to eat normally, but added that the resident's progress would be faster if she could see her several times each day.

Occupational therapy and speech therapy are only available to residents by a physician's order. In practice, these therapies are prescribed on the basis of rehabilitative potential, particularly the potential to return home. However, residents with no possibility of returning home might benefit from these services. For such residents, these therapies might improve quality of life. It seems unjust to deny such residents these services.

Housekeeping, Laundry, and Maintenance

The housekeeping and laundry departments are merged under the direction of Ricardo Marquez, a Latino man in his late twenties. There are three full-time laundry workers and three full-time housekeepers. One part-time worker helps with housekeeping or laundry as needed. A janitor takes care of heavy cleaning, including washing and waxing floors, and a maintenance man repairs and maintains all equipment.

Medical Care

The facility has a Caucasian medical director off-site, Dr. Gerald Woolf, an internist in his forties, who has been associated with the facility for about five years. He supervises medical care, providing on-call consultation, formulating and reviewing standing orders and protocols, and serving as attending physician for many residents. He also reviews and approves employee physicals performed by

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the parent company's nurse practitioner.

Each resident, regardless of payor source, is permitted to choose his or her own doctor. These doctors serve as attending physicians and visit their patients once each month. Although the doctors do visit as required by law, their presence is not a defining characteristic of the home. Doctors are consulted about residents and called in to visit as necessary, but as one nurse said to me, “This is a *nursing* facility.” She added that nursing was the primary activity carried out in the facility, and that doctors were needed mostly in a consulting capacity.

CHAPTER 5: STRUCTURAL AND ORGANIZATIONAL FACTORS THAT AFFECT THE MEALTIME INTERACTION

This chapter identifies the structural and organizational factors that affect the mealtime interaction between caregivers and residents. These factors determine many aspects of the interaction, such as the physical location in which it occurs, its duration, and even which caregiver will participate. In symbolic interactional terms, these factors determine the *context* of the interaction.

The factors discussed in this chapter often limit the possibilities for mealtime to serve the rich range of functions it serves outside nursing homes. Because of these constraints, instead of being a time for refreshment, relaxation, and renewal of social ties, mealtime often becomes a rushed period in which staff focus on accomplishing one specific task: feeding residents.

Government Regulation, Safety Issues, and Mealtime Care

Like other long-term care institutions, Central City is very concerned with meeting government regulations whose violation can result in hefty fines. These regulations play a major role in shaping the nursing approach to mealtime care. State regulations dictate that a physician must be notified when a resident sustains a weight gain or loss of more than five pounds in one month (State of California, 1990). Central City's policy dictates that aides must report to the charge nurse any resident who consumes less than 75 percent of the meal. The desire to avoid

government sanctions prejudices supervisory staff to focus on weight changes and/or insufficient intake rather than asking larger questions about the purposes of mealtime and eating in social life.

Safety concerns are another important determinant of the nursing approach to mealtime care. Residents positioned improperly are at risk for choking or developing aspiration pneumonia. The licensed nursing staff are aware of the importance of correct positioning. In the dining rooms, the nurses often direct aides to reposition patients who slip into unsafe positions. Many times, the nurses themselves help with the task of repositioning.

For supervisory staff, then, the chief goals are ensuring adequate food intake and safely feeding residents (as defined by company policy) and maintaining satisfactory weight (as defined by the state). These pragmatic and technical concerns govern the supervisory approach to mealtime care. There is little attempt to understand individual residents' eating difficulties or to determine effective strategies for nursing intervention. Psychosocial and aesthetic issues, so important to making pleasant mealtimes outside nursing homes, receive scant attention even in rudimentary form. Such issues as the length of time that the caregiver spends with the resident at meals, the care and kindness with which the caregiver treats the resident, the attractiveness of the table setting, and the appeal of food receive little regard.

The consequences of this narrowly focused approach to mealtime care were made plain during the study. Supervisory staff, for example, while assuring correct positioning for *safe* feeding, seldom positioned residents to promote *self*-feeding. Especially when eating in bed, many residents capable of feeding themselves were positioned too far from the over-bed table that held the tray. Others were close

enough but positioned too low, and these residents were forced to reach up to obtain food they could barely see. For people whose hands tremble with arthritis or who have vision problems, poor positioning poses unnecessary challenges, making spills more likely. Spilling food is embarrassing and can adversely affect the self-esteem of a person struggling to remain independent.

The Categorization of Residents by Level of Eating Dependency

At Central City, the admitting nurse assesses residents for eating dependence when they enter the facility. She records this information on the Minimum Data Set (MDS),¹ classifying each resident as: (a) independent; (b) requiring minimal assistance; or (c) requiring extensive assistance. This assessment is then reflected in the nursing care plan, which is developed at a care conference that includes one or more members of the supervisory nursing staff, the social worker, the aide who cares for the resident, and the LVN responsible for maintaining the care planning chart forms. Residents, families, and physicians are welcomed, but rarely choose to come. At this conference, a resident's ability to feed herself (or himself) is determined, and she is categorized as "independent," "partial assist," or "total assist." These categories determine how much help is given at meals. This schema, however, is extremely gross and does not reflect the day-to-day variation found among residents. Mrs. Manford, for example, often made no attempt to feed herself breakfast, even if the aides coached her and put utensils in her hands. But she generally fed herself lunch. Several demented residents were

¹The MDS is the basic physical, psychological, and social assessment information required by government regulations.

able to feed themselves at one meal, but if left to their own devices at the next, would not eat anything. Because the MDS and the care plan fail to reflect this variability, they do not provide caregivers with information that would help them know when and how to intervene with particular individuals. Such information could help the caregivers to support the residents' independence.

The categorization of residents' dependency also determines dining-room placement. "Independent" residents and those requiring only assistance with tray set-up are assigned to Dining Room One. Dependent residents requiring "partial assist[ance]" or "full assist[ance]" are assigned to Dining Room Two. Dependent residents with a high potential for rehabilitation to independent eating status or those with special eating problems such as dysphagia are assigned to the living center at lunchtime.

Dining-room placement affects the caregiver-resident interaction by determining the physical environment in which the interaction will occur and by determining the type and extent of contact with staff and other residents.

Placement in Dining Room One means that the resident eats in a relatively quiet place and has the nicety of a small vase with silk flowers on the table. In this dining room, the resident is seated with the least impaired residents, who are the most capable of conversation. Contact with staff is limited to the activities personnel (generally the director and one assistant), who help the residents as waiters would in a restaurant, bringing food and condiments to the tables and assuring that the residents get what they ordered. Some of these residents are dependent on staff to do such things as open packages, cut meat, or butter bread, but all are capable of putting food on the utensil and getting the utensil to their mouths without help. In addition, residents who eat in this dining room do not need to be reminded or

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encouraged to eat.

Placement in Dining Room Two means the resident eats in a busier environment. Three to four aides are generally in the room, moving about from one resident to another, assisting or feeding them. The aides' activities give the residents plenty of opportunities to interact closely with staff. However, the staff assigned to Dining Room Two vary from day to day because of work assignments and schedules. In addition, each staff member simply helps out where he or she is needed, rather than working with particular residents. So although residents have lots of opportunity to interact with the aides in Dining Room Two, it is difficult for them to build relationships with specific aides. Furthermore, residents are even less likely to interact with *one another*, because their high levels of cognitive impairment reduce their ability to converse.

Placement in the living center means that the resident eats lunch in an attractive but windowless room, a quieter place than either of the dining rooms. The living center provides greater continuity in caregiving because the same two aides are regularly assigned to work there.

As noted, residents assigned to the living center have a high potential for progressing to independent eating or have special eating problems. Ms. Garcia, the DON, referred to "the restorative eating program" of the living center as though this were the purpose for placing residents there. However, when I questioned the living center aides about the specific goals of the restorative eating program, they answered, "We just help them eat."

Despite the aides' attitude about the mission of the restorative eating program, the living center seems to have a beneficial effect on the residents who eat there. During the study, one living-center resident regained his ability to swallow

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The Effect of Caregiver Assignment Procedures

As in many other institutions, the DON and the ADON assign aides to residents on a room-by-room basis. This has the advantage of efficiency but the disadvantage of being somewhat impersonal. On the day shift, an aide may be assigned to the residents in rooms 1, 2, and 3. On that shift, each aide cares for eight residents, working in partnership with another aide also caring for eight. On the evening shift, each aide is assigned sixteen residents. Aides are permanently assigned to the same rooms in an effort to maintain continuity in care. Staff shortages, turnover, vacations, and sick leave, however, often disrupt these efforts.

In assigning residents, supervisory staff do not consider how many of the residents in any particular assignment need to be fed. Thus, when mealtime comes, one aide on the evening shift may have three residents to feed among her sixteen assigned residents, while another may have six or seven. Clearly, the number of residents an aide must feed determines the amount of time she may spend with each. At dinner, for example, trays are available for a maximum of one and a half hours. An aide who has six residents to feed will have about ten minutes to feed each one after she has delivered and set up the trays for her other assigned residents. But an aide with only three residents to feed may be able to spend as

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much as twenty minutes with each one.

Several factors can extend the amount of time aides have to spend feeding residents. A day-shift aide may rely on the help of her team partner if she has an especially high number of residents to feed. Her partner may feed one or two of her assigned residents, allowing the aide to spend more time with the others. Such work sharing is dependent on how well the aides cooperate in general. Aides reported that they liked or didn't like working with certain partners. Aides who do not get along may offer each other little help.

Although aides are not required to work as partners on the evening shift, I sometimes observed one aide helping another by feeding some of her co-worker's assigned residents. The two living-center aides also help to feed residents. The DON arranged their special working hours, 10:00 A.M. to 6:30 P.M., specifically so they can help with dinner. Despite this extra help, especially in the evening, the press of finishing the task of feeding had the effect of shortening and rushing the interaction between caregivers and residents. The aides seemed hurried and eager to see the residents finish so they could move on to the next person.

Supervisory Support of Resident-Caregiver Relationships

Central City has a policy of supporting caregiver-resident relationships. The home, for example, has implemented the "adopt a resident" program designed by the parent company. This program encourages staff to build personal relationships with residents. Staff members who volunteer to participate make an effort to spend time with the residents they adopt and pay them special attention, such as bringing them cards or small gifts. A certificate of "adoption" is hung at the resident's

bedside.

Supervisory staff recognize the importance of caregiver-resident bonds. The permanent assignment staffing plan reflects an attempt to support these bonds and acknowledge their impact on the quality of care. The following example shows how the ADON recognized and supported the therapeutic nature of the bond between one caregiver and the resident she helped during meals.

Lena Hernandez, a young Filipino aide who worked in the living center, developed a fondness for Mr. Merchant, a tall dignified African-American man who had had a stroke. The resulting dysphagia made swallowing very difficult for him. At first, he ate almost nothing, holding food in his mouth and then spitting it out before he could swallow it. Although his stroke and underlying dementia had affected his ability to describe his experience, it appeared that he feared swallowing. Mr. Merchant's weight loss was severe enough that the nurses, the dietitian, and the speech therapist considered tube feeding.

A thorough dysphagia evaluation conducted at an outside clinic, however, indicated that with proper coaching, Mr. Merchant was capable of swallowing food. Knowing the results of the evaluation, the physician and nurses decided to postpone placing a feeding tube. Each day, Lena worked patiently with Mr. Merchant, helping him overcome his fear and tirelessly coaching him as he tried to eat. He began swallowing with more ease and took enough food to stabilize his weight. Ms. Keeling, the ADON, recognized the pivotal role of Lena's relationship with him and commented, "She is the one he really likes." Ms. Keeling supported this relationship by regularly assigning Lena to care for Mr. Merchant.

Yet, despite the intention to support such therapeutic relationships, supervisory staff were inconsistent in doing so, as the following example shows.

Suzanne Miller, a middle-aged Caucasian aide, had grown particularly fond of an older Chinese gentleman, Walter Chan, whom she had cared for over many months. This resident was frequently agitated, and he groaned loudly. His behavior was frustrating and exasperating to staff and residents alike. Suzanne, however, had a remarkable ability to calm him down. She was able to coax Mr. Chan to eat even when he was most agitated.

Suzanne spoke of her fondness for Mr. Chan and explained how she had “adopted” him. She added that she looked for little ways to please him. When she discovered, for example, that he liked chocolates, she started bringing him one every day after lunch. Suzanne’s concern extended to her off-duty hours. Once, when Mr. Chan was going through a particularly agitated period, Suzanne called Central City from her home to inquire about him. She asked the nurses to let him know she had called. Mr. Chan returned her affection. Although he remembered few people, he often asked for Suzanne by name.

Yet, despite the clear benefit Mr. Chan obtained through his relationship with Suzanne, because his crying out disturbed his roommates, he was moved to another room that was not part of Suzanne’s assignment. Then Mr. Chan was cared for by aides he did not know or trust. The change had no effect on his nutritional status, for although he continued to be difficult to feed—often restless and agitated during meals—his new caregivers managed to give him enough food to maintain his weight. Yet, the psychosocial effects of the change were noticeable. Mr. Chan cried out frequently, asking for Suzanne. His agitation intensified and began to alternate with periods of withdrawal.

Incidentally, Suzanne herself mourned the change in assignment, saying sadly, “I would have liked to have taken care of him until the end.” Although she

Walter Chan

no longer provided his day-to-day care, she continued to visit him daily and bring him a chocolate after lunch. The effects of such disruption of established caregiver-resident relationships on staff and resident morale bear further study.

Assignment of Residents to Mealtime Locations

Effects of Location

The physical location in which a meal is served affects the caregiver-resident interaction in three ways. First, the location determines the length of the interaction between caregivers and residents. Residents who take their meals in congregate settings—the dining rooms or the living center—have the opportunity for prolonged interaction with the caregivers. In these spaces, a caregiver may sit between two residents, both of whom need assistance. The caregiver can help one and then turn to help the other while still being present to the first person. If the resident is eating slowly or needs to rest for a moment, the caregiver can leave to help someone else in the dining room, keeping an eye on the first resident and returning when she sees some indication that the person is ready to resume eating. In this setting, caregivers can help several people at once and sustain the interaction over a period of time.

When the residents eat in their rooms, however, caregivers typically move from one room to another and finish working with one resident before moving on to the next. The flexibility of moving back and forth between residents or returning to the slower residents is not possible. This work pattern, together with the problems of occasional short staffing, limits the amount of time that staff can spend with those residents who eat in their rooms.

Second, the location of the meal determines aspects of the physical environment that affect caregiver-resident interaction. Some dining areas are more

stimulating and louder than others. For an easily distracted resident, Dining Room Two, with its bustling activity, may prove a problem, taking the resident's attention away from the meal. Conversely, a sleepy or listless resident may respond to and enjoy the stimulation, which may help the person to stay involved in the interaction.

Third, the location of the meal usually determines the physical posture that a caregiver takes for the meal. If the resident is fed while in bed, the caregiver almost invariably stands at the bedside to assist with the meal. In the standing position, the caregiver's face is much higher than the resident's, limiting the amount of eye contact that can occur. Furthermore, in standing over the resident, the caregiver symbolically emphasizes the weak and dependent status of the resident. In the dining room, caregivers customarily sit with the residents in an egalitarian face-to-face relationship, facilitating eye contact.

Institutional Policy and the Assignment of Meal Locations

Central City policy calls for the socialization of residents. To some extent, the institutional culture supports this. In order to encourage social interaction, the home serves lunch to as many residents as possible in congregate settings. Toward this end, the home instigated the two seatings in Dining Room One, the dining room that serves residents who are able to feed themselves. This scheduling change, undertaken during the course of the study, allowed 32 residents to be accommodated in Dining Room One at lunchtime. Prior to this change, only 16 residents could be served there, leaving many high-functioning residents to eat lunch in their rooms.

Residents responded positively to the opportunity to eat lunch in Dining Room One, filling nearly all the available spaces of the new second seating. The

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administration achieved its goal of increasing opportunities for social interaction among residents through this scheduling change. The activities director, who supervises Dining Room One, commented that the residents assigned to the second seating quickly formed groups of preferred tablemates who liked to converse with one another, just as their predecessors in the first seating had done.

Especially for the more impaired residents, however, the actual location where any particular individual eats is determined less by the socialization policy than by a consideration of (1) the fit with other care routines; (2) the level of the resident's physical and cognitive impairment; (3) staffing levels; (4) aesthetics; and (5) resident and family preferences. These five factors form a complex calculus.

Fit with Other Care Routines: The location of a resident's breakfast, lunch, or dinner is determined in part by the nursing home's schedules and routines. All residents eat breakfast in their rooms, and all but a few have it in bed. The remainder, whom supervisory staff have determined require a sitting position in order to eat safely, are placed in their nightclothes in wheelchairs at the bedside.

Aides do not dress the residents until after the meal. Only one resident, Mrs. Manford, was ever dressed at breakfast. When Jennifer Kalani, a Hawaiian aide, cared for Mrs. Manford, she dressed her and took her to the dining room for breakfast. Jennifer noted that this resident ate better after getting the stimulation and attention of being dressed. This observation was not part of the resident's general care plan, so it was only when this particular aide cared for Mrs. Manford that she was dressed before breakfast. Other residents might have similarly benefitted from getting up for breakfast, but the rigidity of the nursing home schedule prohibited all but the most self-directed aides from trying different routines.

Only lunch includes all the possible mealtime locations. Both dining rooms and the living center are open. Nevertheless, some cognitively intact residents elect to eat in their rooms.

At dinner, both dining rooms are open, but not the living center because the evening staff is smaller than the day staff. Ten to 15 residents eat dinner in Dining Room One, and about ten eat in Dining Room Two. There is no second seating in Dining Room One. About 70 percent of the residents are put to bed at the end of the day shift and stay there for dinner. Thus, dinnertime provides fewer opportunities for congregate dining, compromising the home's claimed goal of socialization at mealtime.

Level of Resident Dependency: As described above, the supervisory nursing staff determine where a resident will take a meal on the basis of the eating-dependency level determined at admission and updated in the care plan.

Staffing Levels: It is possible to serve lunch in several locations because the greatest number of staff are available to help during this time of day. At dinner, when half the number of staff are available for the same number of residents, there is less choice in mealtime location. In the interests of efficiency, most residents are put to bed at the end of the day shift, when there are the maximum number of staff on duty to help with the task. Thus, at dinner, the evening staff's time is completely taken up with moving from one room to the next, feeding the residents who are unable to feed themselves. Only one or two staff members are available to help people in the dining rooms.

Unexpected staffing shortages can also reduce the number of options for

11/10/11 10:11 AM

congregate dining. When the facility is short-staffed, the living center closes down and is not available to the residents. This happens especially on weekends. During the seven weekend lunch periods I observed, the living center was closed twice.

Aesthetics: I noted in Chapter 4 that Central City tries to maintain a “restaurant atmosphere” in Dining Room One. The supervisory staff assign residents who might detract from that atmosphere to eat elsewhere. Mrs. Taylor, for example, spilled much food as she slowly but proudly fed herself with painfully arthritic hands. Although clearly “independent” in her ability to feed herself, she was assigned to Dining Room Two because she did not fit the picture of a “restaurant” diner.

Mrs. Taylor presented a poignant picture as she struggled to maintain her independence. Yet, in spite of her efforts, she was assigned to the room allocated to more dependent residents because she could not live up to the aesthetic standard set for the residents in Dining Room One. I thought of asking her how she felt about her dining-room assignment, but decided not to, in order to protect her self-esteem.

Resident or Family Preference: Staff members respect residents’ verbalized requests to take meals in particular locations. They rarely, however, solicit such preferences from residents. Only once in the 17 months of data collection did I observe a staff member asking a resident where he wanted to eat. Interestingly, the resident was cognitively intact; staff members may assume that impaired residents do not have preferences. Staff remarks such as “he is confused,” “she doesn’t know where she is,” or “he’s out of it” suggest this is the case. But impaired residents may well have preferences that they cannot articulate. It is

11/10/11 10:11 AM

possible that the agitated behavior seen in some demented residents is a response to not having their desires and preferences met.

Often, family members I interviewed had opinions about where their relatives should eat and made these known to the staff. In one instance, a man's family asked to have him sit in the hallway, which provided more space than either the crowded dining room or the resident's room for the several family members who regularly came to visit at dinnertime.

Some family members decide that their relatives would be better off eating in their rooms, as in the following two examples. In both cases, the residents were dependent enough that they would have been assigned to Dining Room Two, not Dining Room One with its restaurant-like atmosphere. In one case, two daughters agreed that their mother, Mrs. Ishibashi, although needing extensive help with eating, was not as impaired as the other residents in Dining Room Two. One daughter elaborated: "I didn't want mother with all those other people who spill their food and have to be fed. She's not *that* badly off." In another case, the resident's guardian (a family friend) felt that Dining Room Two was too distracting for the resident, Mrs. Manford, making her eat poorly. The guardian also felt that the level of impairment of the other residents would depress her friend, even though Mrs. Manford, an Alzheimer's patient, was very impaired herself—unable to perform any self-care activities and virtually mute.

That family members and friends find Dining Room Two an unpleasant place from which they wish to protect their loved ones suggests that the dining room may not provide the setting for socialization that the nursing home intends.

The Effect of Food on the Mealtime Interaction

The form and quality of the food affect the caregiver-resident interaction. Food that is tasty and recognizable provides a topic of conversation and makes it easier for a caregiver to tempt a resident's waning appetite. A meal is made savory both by the taste of the food and by its texture. Consider the experience of eating a piece of soft, fresh, slightly rough bread with a crispy crust and a thin coat of smooth, slippery, sweet butter; or a crunchy raw carrot stick, hard and cool in the mouth; or a grape with a firm skin that pops when bitten into and shoots its sweet juice onto the tongue. Food textures add to the experience of a meal, differentiating foods and contributing to mealtime enjoyment. When differences between the textures of food are eliminated, an important part of the eating experience is lost.

The dietitian is ultimately responsible for the form and quality of the food. She directs and manages the kitchen staff, chooses resident diets in consultation with the nursing staff and the doctors, and selects recipes. As in most nursing homes, food that has been modified in texture is served to many residents (26 percent). Within the subsample of ten residents chosen for focused mealtime observation, two received food of a regular texture, three received food that was "mechanical soft," and five received puréed food.

The mechanical soft diet does not completely obliterate texture because food is simply chopped fine to make it easier to chew. But the puréed diet makes all food the same consistency. Different flavors are contained within the puréed food, but the contribution of variety in texture is lost. Some foods seem to purée better than others. For example, puréed apricots seem like a fruit glaze or sauce that might be served at any family dinner table, whereas puréed lasagna would offend most dinner guests. Much of the experience of eating lasagna is contained in the texture

of the dish, in biting through the alternating layers of smooth noodles, creamy cheese, and spicy sauce.

Puréed foods are unidentifiable. Puréed ravioli cannot be distinguished from puréed spaghetti or pizza. When food is not identifiable, it loses not only its “mouth feel” but its potential as a topic of conversation, diminishing the ground for interaction. Aides were often unable to identify for me the food they were feeding residents, knowing only that the scoop of brown purée must be some kind of meat, or that the green scoop was probably peas, zucchini, or broccoli.

If food is not palatable, it may thwart even the most skilled caregiver who is trying to feed a resident. Although most residents and family members were fairly satisfied with the meals, there were complaints about the quality of the food. Some family members noted that the food quality declined on weekends, when the dietitian and head cook were not on the premises. Once, when the dietitian was on vacation, I observed two daughters decide not to feed hamburger to their elderly mother because it had been cooked too long and was dry and hard. In this case, the resident’s nutrition was compromised because of the quality of the food.

Keeping the food at the proper temperature also presents a challenge. Insulated tray covers and carts help to keep food warm for a time, but a half-hour or more can easily pass between the moment when the tray is delivered to the floor and the point when it served to the resident, leaving food tepid. Cold foods, like ice cream, often warm or melt. Serving food at less than the optimum temperature detracts from its palatability.

When the food is unpalatable, the caregivers may have to struggle to find something on the tray that the resident will eat. If there is nothing the resident seems to like, the caregiver may be reduced to virtually force-feeding the resident in order

to assure some nutritional intake. Needless to say, such problems strain the caregiver-resident interaction. But an attractive tray with tempting food provides an opening for positive interaction and a focus for encouragement. Consider how an attractive tray with tempting food enabled this middle-aged man, visiting his mother at lunch, to support and encourage her eating:

As the aide delivered the tray to the resident and removed the plate cover, the son set up a folding chair next to his mother's place. He settled down in the chair and took a moment to look over the tray. Then, turning to his mother, he said, "It looks like a nice meal."
(Author's field notes)²

Here the pleasing appearance of the food provided a positive beginning to the mealtime interaction and supported the caregiver in his encouragement of his mother.

The Effect of Kitchen Routines on Mealtime Interaction

Kitchen staff deliver trays to the floor at set hours and collect them one and a half hours later. The trays come up from the kitchen in five carts, each cart being delivered to the floor as soon as it is filled. This system means that though the first cart of trays is delivered at the scheduled beginning of the meal, the last cart will not come up until nearly a half-hour later. By the time a tray is taken from the last cart and delivered to a resident's room, another fifteen minutes may have elapsed. The dietitian requests that all trays be returned to the carts by 90 minutes after the time the first tray is delivered. Thus, residents whose trays are on the last cart have less time with their meals than those whose trays are on the first cart. In one instance, I

²Hereinafter referred to as AFN.

observed an aide feeding dinner to a resident who ate very slowly. Another aide rushed into the room, urging, "Hurry, it's 6:30, and the kitchen wants to take the trays." The first aide speeded up her pace in order to finish giving the meal and return the tray on time. The press to keep up with the nursing home schedule meant that a leisurely interaction became hurried.

The Transfer of Informal Personal Knowledge About Residents

Through the ongoing experience of feeding residents, caregivers acquire much knowledge about particular residents' likes and dislikes, abilities and disabilities, and idiosyncrasies. This knowledge informs and directs caregivers as they plan, strategize, and enact care for the residents. In Chapter 6, we shall see how this kind of knowledge influences the mealtime interactions. Here I will describe how this knowledge is stored, maintained, and communicated throughout the organizational structure.

Knowledge about residents at the supervisory level is confined to issues related to broad institutional goals and state regulations. That is, the supervisory staff keep abreast of residents' overall condition, monitor symptoms of acute illness that might need treatment, and ensure maintenance of proper documentation. They also ensure that prompt and correct administration of medications is practiced and that doctors are notified of significant changes in condition. In relation to mealtime and nutritional issues, as noted, supervisory staff monitor the aides' reports of residents' weight losses and gains and patterns of intake. They also check to see that aides are positioning residents properly and feeding them safely.

Supervisory staff explicitly attend to some aspects of psychosocial care. First, the aides are expected to speak English to one another in the presence of

residents, so as not to exclude them or make them suspicious. Unfortunately, the rubric is not always followed. The Filipino aides (two-thirds of the total) often speak to one another in Tagalog. Second, at lunchtime the aides are encouraged to sit while they feed residents in order to facilitate communication. The staff development coordinator, Ms. Jefferson, is especially interested in encouraging this practice and often reminded aides to do so. Third, the supervisory staff discourage the practice of having more than one aide help a particular resident during the course of a meal. Keeping one aide with the resident allows a sustained and deep interaction during the meal. It also emphasizes the relational aspects of the work and keeps feeding from being completely task-oriented. Finally, both the director and assistant director regularly assist with mealtimes, overseeing tray delivery and often sitting down to feed residents. In the latter activity, they serve as role models for the aides, showing how to feed patients, how to talk with them, and how to use touch in the course of the interaction.

The aides who care for the residents day in and day out are the ones who have the most highly detailed personal knowledge of them. These aides know particular food likes and dislikes, in which order to feed the food, how best to position each person, and how to coax a reluctant person to eat. The aides' extensive knowledge of the residents receives little recognition within the formal organizational structures of the nursing home. Some of the supervisory staff are aware that the aides have this knowledge. For example, one registered nurse, the evening shift supervisor, said to me, "I admire these ladies—they work hard. They're the ones who do the hands-on care and who really know the patients." But for the most part, the aides' knowledge goes unnoticed. It does not figure in care plans and is often ignored when supervisory staff disrupt caregiver-resident

relationships by arbitrary assignment of caregivers.

The nursing home's policy requires that each resident's care plan be reviewed on a quarterly basis. The LVN responsible for chart maintenance posts a list each week of the residents to be reviewed at the 2:00 P.M. care conference. This conference is one formal mechanism that could serve for passing on and evaluating the aides' knowledge. The day-shift aides assigned to residents scheduled for review are encouraged to come to the conference to provide input for the care plan. However, in one conference I observed, the aide was asked about a resident's functional ability in terms that elicited a very gross overview of the situation. The question, "How does Mrs. X. do with her meals?" elicited the response, "She's a total assist." The aide's answer allowed the staff to update the care plan in terms satisfactory to the state. But the aide was not consulted about what difficulties she might have encountered in feeding Mrs. X. or what strategies seemed successful for this particular resident. The aide's intimate knowledge of Mrs. X. remained hidden from the supervisory staff.

There are exceptions to the inadequate and unsystematic transfer of knowledge within the organization. Some knowledge is communicated informally from one aide to another. Naturally, this is most likely to happen in the congregate dining situations, in which several aides are feeding residents together. In these settings, one aide may suggest a tactic or technique of feeding a resident to another aide.

Another route through which knowledge is shared is the mentoring of novice aides by the more experienced ones. One accomplished aide, Sylvia Martinez, a particularly motivated and caring person, especially enjoyed this role:

Sylvia watched as a CNA trainee struggled to feed Mrs. Hyde some puréed meat. Mrs. Hyde kept pushing the trainee's hand away. Sylvia said to the trainee, "Make a sandwich," and showed her how to spread the puréed meat on Mrs. Hyde's bread. Then Sylvia put the sandwich in Mrs. Hyde's hand, and Mrs. Hyde lifted it to her mouth and took a bite. "Oh, like I do for my kids?" asked the trainee. Sylvia nodded. (AFN)

These instances are exceptions to the pattern. Relatively little intimate personal knowledge about residents passes from one aide to another—and even less passes to the staff at the supervisory level. Institutional procedures do not emphasize the value of this knowledge and provide no formal route for recognizing it or passing it on. Furthermore, there is no way to resolve differences of opinion among aides about the best way to handle problems. One aide, for example, fed a particular resident with her dentures in place, explaining that the resident ate better with them. Another aide removed the dentures, saying that food got caught in them. This aide felt that the resident ate better without her dentures. Because there was no forum for a discussion of these opinions, and because the supervisory staff did not know that there was any difference in caregiving practice, there was no attempt to resolve these disparities and determine what really was best for the resident. The lack of a mechanism to evaluate caregiving practice influenced the resident's experience of interaction by failing to provide a consistent approach to care.

CHAPTER 6: CAREGIVER-RESIDENT INTERACTION AT MEALTIME

This chapter describes my observations of the interaction between caregivers and residents during the course of meals. When the interaction begins, the organizational and structural factors discussed in the previous chapter have already determined such things as where the meal takes place, which caregiver is assisting the resident, and what food is on the tray. These forces continue to shape the interaction during the course of the meal, determining the length of the encounter. And, as noted, organizational demands sometimes force a change of caregivers during the meal, as they are called away to assist other residents.

This chapter identifies the kinds of verbal and non-verbal behavior displayed by residents and caregivers in the course of mealtime interactions and shows how the most skillful caregivers use their detailed personal knowledge of residents to guide care. I analyzed these data by using "role-taking," a key concept from symbolic interaction (SI) theory, as the major interpretive device.

Role-Taking

In SI, role-taking refers to the ability to imagine how one looks from another's standpoint and how the world looks from that vantage (Schvaneveldt, 1981). This shift of perspective modifies one's actions (Meltzer, 1972). SI theorists contend that interpersonal competence, the ability to function effectively in relationships, is dependent to a large degree on role-taking ability (Burr, Leigh, Day, & Constantine, 1979). I would add that role-taking forms the basis of

compassion and lies at the heart of respectful care. A caregiver who sees a resident as another human being with a full range of sensory and emotional responses will treat the person differently than a caregiver who views the resident as “out of it” or as just another body needing care.

Role-taking is possible because people act on the basis of commonly held symbolic meanings. Sharing meanings allows people to anticipate how others will interpret their own actions (Denzin, 1972). Caregivers who are sensitive may be able to establish such agreed-upon meanings even with very demented residents who use few words.

The impaired cognitive status and frail physical state of most nursing home residents demand much of the caregiver’s role-taking abilities. Unlike the resident, the caregiver enters the interaction with intact cognitive and physical abilities. This puts the caregiver at an advantage in the relationship, for while the caregiver can direct and influence the course of the interaction, the resident has little intentional power or ability to do so.

Some caregivers are sensitive to the subtle nuances and cues in the residents’ actions and are ready to see patterns in seemingly random behavior. Such caregivers impute meaning to these behaviors; they establish or discover shared symbols with residents that allow them to act with sensitivity. As the following example shows, they use these shared meanings to provide creative and respectful care:

At the end of breakfast, Sylvia Martinez asked Mrs. Schmidt if she wanted more orange juice. Mrs. Schmidt said, “Yeah.” Sylvia left the room and returned with some. She poured part of it into a small glass and mixed it with an equal quantity of water. Later she explained that she did this because Mrs. Schmidt is on a calorie-restricted diet. She won’t drink plain water, but she will drink a

diluted glass of juice. Sylvia said that Mrs. Schmidt “sees the color and then knows that it is not water, and so she drinks it.” (AFN)

In this interaction, Sylvia, exhibiting skill in the role-taking process, acted with sensitivity in responding to Mrs. Schmidt’s needs. She knew that Mrs. Schmidt liked orange juice, not water, and that the color orange signaled juice to Mrs. Schmidt. She gave me her interpretation of what was going on in Mrs. Schmidt’s mind, noting that Mrs. Schmidt “sees the color and then knows that it is not water, and so she drinks it.” Sylvia relied on shared symbolic meaning and past experience to guide her actions.

From a nursing perspective, Sylvia’s action represented a particularly creative response to a nursing-care problem. Dehydration is common in elderly nursing home residents (Morley, 1986). Sylvia knew this and was determined to keep Mrs. Schmidt hydrated. Yet, she had to accomplish this with a resident who did not like plain water and was on a calorie-restricted diet that limited intake of fruit juices. Diluting the juice neatly solved the problem, both pleasing Mrs. Schmidt and maintaining her fluid intake. Sylvia’s careful attention to Mrs. Schmidt’s likes and dislikes and to the shared meaning of the colored liquid allowed her to accomplish her goals.

The next example shows how one caregiver’s role-taking ability made her able to share the meal with the resident in a particularly intimate way.

Mrs. Marshall was an Alzheimer’s victim who rarely spoke, but seemed unusually attuned to visual stimuli. Her eyes were always open wide, and she watched everyone around her, tenaciously tracking staff movements as they pursued their activities about the home.

Jennifer Kalani, an aide, had gotten Mrs. Marshall up and dressed before breakfast and had wheeled her into the empty dining room so that they could share a table. Jennifer had brought toast and coffee from home for herself. She ate it as she fed Mrs. Marshall her

breakfast. Sitting together at a table, they were in the optimum postural relationship to facilitate eye contact and face-to-face interchange. Jennifer looked at Mrs. Marshall and said, "I'm eating, you're eating." Then Jennifer glanced my way, smiled, and said, "Psychology—it always works."

I commented on Jennifer's eating with Mrs. Marshall and asked if she ever ate with other residents. She said she did from time to time, and added, "Sometimes they offer me their food." Mrs. Marshall, who was impaired enough that she rarely spoke, watched us as we talked, and smiled at Jennifer's comment. Jennifer smiled back at Mrs. Marshall and laughingly said, "No one likes to eat alone." Mrs. Marshall returned the smile.

In the seventeen months of observation, Jennifer was the only staff member I saw sit down to eat with a resident at an ordinary meal. (AFN)

Jennifer's simple gestures made the mealtime interaction quite different from others I observed. The caregiver and resident were, in effect, sharing a meal together. Although they did not exchange words, their interaction was rich with non-verbal exchange, especially smiles and laughs. Eating together also lent a leisurely pace to the meal. Rather than sitting idly and waiting for Mrs. Marshall to be ready for the next spoonful of food, Jennifer ate her own breakfast. Because Jennifer had two agendas, helping Mrs. Marshall and eating her own breakfast, the meal had a give-and-take quality that closely approximated a social mealtime with friends.

Jennifer's comment, "No one like to eat alone," is evidence of the conclusions she made through the role-taking process. As Jennifer saw it, no person would want to eat alone, so she made herself a breakfast partner for Mrs. Marshall. She even modified the environment to facilitate this partnership, dressing Mrs. Marshall and bringing her to the dining room so they could sit at the table together.

When caregivers are deficient in their role-taking abilities, they may see

residents' behavior as meaningless, and respond accordingly. As Blumer (1969) points out, humans act on what they take into consideration. Even if well-intentioned, the caregiver who fails to adequately take the resident's role may render insensitive, incompetent care, as in the following example:

Jane Fox volunteered during lunch at the nursing home twice a week. She had become close to the staff when her aunt was a resident in the home, and began to volunteer after her aunt died. She was a pleasant, lively, retired woman who enjoyed lending the staff a hand. Her goal was to help the staff get the job of feeding done. I noticed she paid more attention to the staff than to the residents as she did her work, and that she neglected the aesthetics of feeding. She often fed Mrs. Washington lunch.

Mrs. Washington was a pleasant, longtime resident of the home, who never spoke a word, but had a smile for everyone. She had a tendency to thrust her tongue forward as food was put in her mouth. Some caregivers managed this tendency expertly, knowing just how much food to put in her mouth and where to place it on her tongue so that little or no food spilled out. If some food did spill onto her chin, these caregivers wiped it up promptly. Other caregivers loaded large spoonfuls of food and carelessly placed them in her mouth. Her puréed food then poured out over her chin at nearly every bite. These caregivers were often inconsistent about wiping her chin.

One day, Jane stood by Mrs. Washington's chair at lunch and fed her spoonfuls of food at a rapid pace. Though food dribbled over Mrs. Washington's chin, Jane made no attempt to wipe it off. After watching for about five minutes, I walked over to the table and chatted with Jane as she fed Mrs. Washington. Several minutes into the conversation, I turned to Mrs. Washington and told her who I was and what I was doing in the home. Jane finally looked at Mrs. Washington and wiped her chin, saying to her, "Look, you've got company, and your mouth is all covered with food." (AFN)

Although acting with the best of intentions, Jane failed to see the mealtime situation from Mrs. Washington's perspective. She was focused only on the task of getting food into Mrs. Washington, and was either unaware of or ignored how Mrs. Washington looked. She failed to consider how it might feel to have food dribbling down her own face. It was only when I engaged Mrs. Washington that

Jane focused her attention on her and noticed how much food had spilled on her chin. By acknowledging Mrs. Washington's presence, I changed the context of the interaction. When I did so, Jane *did* pay attention to the condition of Mrs. Washington's chin and decided to act, wiping up the food. Jane acknowledged the changed context of the interaction with her comment, "Look, you've got company." In Jane's mind, I now carried the status of a visitor to Mrs. Washington. Social customs dictate that people should look their best for visitors, so Jane cleaned Mrs. Washington's chin. Even so, Jane did not acknowledge her own part in making Mrs. Washington's chin messy, nor did she seem embarrassed about it. She simply commented, "Your mouth is all covered with food."

With these examples of the importance of role-taking in mind, I will first describe the ways that caregivers frame or orchestrate meals, and I will then classify and analyze specific types of behaviors.

Orchestration of the Meal

Although many of the limits of the mealtime interaction are set by the organizational constraints already described, within these parameters the caregiver creates the overall structure of the mealtime event. One of the chief ways in which the caregiver exercises power in the mealtime interaction is by framing and pacing the meal. Like symphonies, meals are timebound events with beginnings, middles, and ends: the soup, the entrée, and the dessert playing themselves out like movements. Caregivers orchestrate these movements, determine how and when the meal begins, what sequence the food will be eaten in, and how and when the meal will end.

Beginning the Meal

At Central City, greetings or even orienting words are often not part of beginning a meal. In 37 percent of the 57 mealtime observations in which I witnessed the initial contact between caregiver and resident, the caregiver used no words of greeting, orientation, or even the resident's name, but simply began the meal by putting food in the resident's mouth. The following example relates this type of beginning.

An aide entered the dining room and pulled up a chair to the table where Mr. Green sat. Without greeting or even speaking to him, she picked up a spoon and began to feed him. He opened his mouth as each spoonful was offered. The aide watched as she fed him, but never made eye contact. (AFN)

When the meal is begun in this way, the task-oriented focus of the aide becomes apparent. In this instance, the aide was simply getting the job done. She sat down and immediately began to feed Mr. Green. The interaction was one-dimensional and oriented to the single goal of getting the food into Mr. Green's mouth. The behavior evidences minimal-to-deficient role-taking on the part of the caregiver.

This sort of beginning contrasts with those in normal adult society, in which meals generally start with an exchange of words. Greetings, invitations to sit down, comments about the appearance of the food, such as "That looks good," or offers to share the food, such as "Would you like a roll?" are common. When this kind of beginning does happen in the nursing home, it changes the tenor of the interaction between the aide and the resident. Contrast the earlier description of the beginning of Mr. Green's meal with this one by a different aide:

Sarah York came up to Mr. Green at the start of the meal. She looked at him, smiled, and said, "Hi, Bill," as she drew up a chair and sat down with him. She spread a napkin across his chest and fed him several spoonfuls at a time, and then paused to make direct eye contact with him. He looked earnestly back at her. (AFN)

This simple greeting lent an affective dimension to the encounter. Sarah's actions—pulling up a chair, unfolding and placing the napkin, and speaking to Mr. Green—marked a clear beginning to the interaction. Sarah was doing more than simply getting the job of feeding done; by greeting Mr. Green, she was engaging him in a social event.

Formal or ritualized beginnings to meals, such as making toasts, saying grace, or waiting until everyone is served, are also noticeably absent at Central City. The use of this type of formal beginning varies widely in our society. Some families regularly eat together, beginning every meal with grace. Others rarely do so, and instead members help themselves at will from the refrigerator on their own time schedules. Many people reserve toasts or grace for celebratory or holiday dinners. Yet, such beginnings lend an important dimension to the meal, reinforcing a sense of community and bearing witness to the symbolic import of meals. The complete absence of these rituals at Central City indicates that mealtime, rather than being a social event to be enjoyed, is a task to be completed.

Offering the Courses

While some caregivers offer the foods in a conventional order, beginning with soup, moving on to the entrée, and ending with dessert, other caregivers skip around the tray, offering things in random order. The unappetizing approach

(which I witnessed more than once) of offering, say, spinach alternated or mixed with ice cream, generally represents an attempt to find *something* the resident will eat. Because many demented elderly have a preference for sweet foods (Fairburn & Hope, 1988), desserts are generally offered when the resident refuses all else. Sometimes caregivers then return to offering meat or vegetables in an attempt to achieve some nutritional balance in the meal.

Caregivers' rationale for using these unconventional ordering strategies is typically task-oriented. Their goal is to get nourishment into the residents. As one aide said, "Any way to get the food down." Yet, this strategy results in a disordering of traditional mealtime sequences. In her research on mealtime in British families, Douglas (1972; Douglas & Nicod, 1974) found that meals have a well-defined structure and are conducted according to unwritten rules concerning the mixture and ordering of foods by flavor, texture, and type. When such cultural rules are not followed, as in nursing homes, the mealtime participants are excluded from normal societal patterns. Unorthodox ordering and mixing of foods in nursing home meals divides nursing home residents from mainstream adult society, and more importantly, from their own adult memories and expectations, making the mealtime experience foreign and estranged from their past.

Changing Caregivers Mid-Meal

Although supervisory staff members encourage a single caregiver to stay with a resident throughout a meal, I observed as many as three caregivers sequentially assisting one resident. Of 55 individual meals that I observed involving

aides, two or more caregivers assisted the resident on 13 occasions (24 percent).¹ In eight of the 13 cases, the aide who delivered the tray gave the resident a few spoonfuls of food upon delivering the tray and another aide fed the resident the rest of the meal. In five cases, more than one caregiver was substantially involved in the course of a single meal.

Mid-meal changing of caregivers disrupts the development of a cohesive caregiver-resident interaction. Residents often appeared confused as caregivers left them mid-meal, watching wistfully as the aide walked away. Some caregivers, likewise, seemed thwarted by the disruptions, sighing in frustration as they were called away to other tasks. The DON, for example, often showed her disappointment when phone calls took her away in the middle of a meal. One day when the phone was quiet, she remarked with satisfaction, “*Finally*, I get to finish feeding a person without having to leave to answer the phone.” The word “finally” alludes to her genuine frustration that the mutually satisfying interaction of mealtime is so often reduced for her by the many distractions that take her from the residents.

Although generally disruptive to the flow of caregiver-resident interaction, mid-meal change of caregivers appeared beneficial in one situation I observed. When a caregiver found a resident’s behavior or refusal to eat frustrating, a second caregiver was sometimes able to succeed in feeding the resident. Changing caregivers served to dissipate emotional energy and avoid escalation of feelings of frustration on the part of both the resident and the caregiver.

¹I observed nine of the 10 resident subjects during six meals, and the tenth subject during seven meals because I happened to be nearby when she was being served a seventh meal. At 55 of the 61 meals, staff caregivers assisted the residents; at the remaining six meals, which involved only one subject (Mrs. Ishibashi), family caregivers assisted the resident. Some of my conclusions concerning family caregivers are also based on data gathered during my general observation period.

The End of the Meal

Just as caregivers often make no distinctive beginning to the meal, they seldom mark the ending, except by removing trays when residents stop eating. Caregivers did so on their own initiatives, basing their decisions to remove the trays on whether the residents had eaten most of the food on the tray, had stopped feeding themselves, or had begun to refuse food that was offered. Other caregivers responded to verbal or non-verbal cues that indicated that the resident had finished the meal. Such cues included verbal statements like “I’m full—I don’t want anymore,” or non-verbal messages such as raising the hand in a gesture of “stop” or pushing the tray away. Even caregivers who tried to respond to these cues rarely asked the residents if they were finished. Asking people if they are through eating may be a small courtesy, but it shows respect for autonomy and offers people a choice in the ordering of the details of their lives. The absence of this courtesy at Central City is regrettable. Again, it suggests a lack in habitually taking others’ perspectives.

Determining when a resident is finished is most problematic when residents are eating poorly or are difficult to feed. In these cases, the end of the meal often comes when the caregiver gives up in frustration, as in the following example:

Gabriella Sanchez brought Mr. Merchant, the resident with severe dysphagia, his dinner tray. First, she offered him a spoonful of applesauce, which he held in his mouth without swallowing. Seeing this, Gabriella exhorted him to chew and swallow. Mr. Merchant did not do so, and after a minute or two spat the applesauce out. Finding his behavior distasteful, Gabriella grimaced. She waited a moment and then offered him a spoonful of soup. She tried to put the spoon in his mouth, but he kept pushing her hand away, saying “no.” She put down the spoon and, clearly frustrated, looked at me and said, “What can you do?” She took his tray away. The whole interaction lasted only seven minutes.

After just two unsuccessful attempts to give Mr. Merchant food, Gabriella gave up and removed the tray. There was no clear verbal or non-verbal signal from Mr. Merchant that he had finished with the tray. Instead, the meal ended on the caregiver's initiative, to which Mr. Merchant made no protest.

Mr. Merchant was a challenging resident to feed. He needed much encouragement, understanding, and patience. This brief interaction with its abrupt ending could not help him regain the confidence he needed to relearn to swallow, and may have actually hindered him.

The ending of Mr. Merchant's meal contrasts with the following instance in which the caregiver discerned and gave meaning to a subtle cue given by the resident:

After Mrs. Schmidt had eaten nearly all of her food, Sylvia Rodriguez, the private aide who assisted her, lifted a cup of milk to Mrs. Schmidt's lips and said, "Here it goes, Deborah." Then Sylvia pulled the cup away and said to me, "I can feel she is done. I offer the cup, and she pushes back with her tongue, and I know she's finished." (AFN)

In this instance, the resident, who normally ate well, had completed nearly all the food on the tray. Sylvia knew that Mrs. Schmidt was probably close to satisfied, but she was watching for some cue that indicated Mrs. Schmidt was finished. When Mrs. Schmidt pushed back on the cup with her tongue, Sylvia knew she could end the meal. In this case, the ending of the meal was initiated by the resident. But it took a sensitive and thoughtful caregiver to pick up this subtle cue.

In some cases, the end of the meal is quite evident because the resident has consumed everything on the tray. Most of the time, when everything was eaten, the caregiver simply removed the tray. However, in one such case, the caregiver's

charming choice of words provided a pleasant and definitive ending to the meal:

Elena Matigbay fed Mrs. Washington the last of her ice cream and then said, "This is the conclusion of your dinner," and she smiled and laughed. Mrs. Washington, who never spoke words, made a low guttural sound and laughed as she looked at the aide.

This formal ending gave a sense of closure to the mealtime interaction between the caregiver and the resident. In her words and actions, Elena expressed that she and Mrs. Washington had participated in a social and nutritional event and that it had now concluded. Their shared smiles and laughter reinforced the caregiver-resident bond.

Instrumental and Affective Behaviors

The verbal and non-verbal behaviors of the residents and caregivers during mealtimes fell into two general categories, instrumental and affective. Instrumental behaviors were concerned with the task at hand, consuming the meal. Affective behaviors expressed emotions or feelings. Some behaviors fit into both categories. When, for example, caregivers scolded or chided residents, the content of the verbal message was generally related to the task of consuming the meal. The caregiver might say, as a reminder to the resident, "Walter, you must eat your food!" At the same time, such a message might also carry an affective overlay that conveyed the caregiver's frustration or annoyance. Despite this mixed category, for the purposes of this dissertation, I have classified resident and caregiver behaviors into the two general categories of instrumental and affective.

Verbal Behaviors

In general, neither aides nor residents talk much during the course of the meals. Aides' verbal interactions with the residents are almost entirely restricted to sparse language concerned with the task of feeding. Aides made task-oriented comments in 76 percent of the 55 individual meals observed. In only 30 percent of those meals did aides make even a single affective comment, such as "I know what you like," or "It's a nice day," or "How is my friend doing today?" The relative paucity of affective comments betrays the aides' lack of understanding of principles of psychosocial care. A cheerful greeting, an inquiry into how the resident likes the food, or a shared joke provide human connection and convey a sense of respect for personhood. When the caregiver makes such affective comments, she treats the resident as a human being with feelings deserving consideration. In this way, the caregiver demonstrates the ability to assume the role of the resident. When affective comments are absent, care is dehumanizing: the resident is treated virtually as an animal who needs to be fed. Kayser-Jones (1989a) has discussed the negative effects of such dehumanizing care on the mealtime experience.

In contrast to the aide caregivers, family caregivers used affective as well as instrumental comments at *all* meals. In general, they spoke more often and longer to the resident. The liveliness of family-resident interaction contrasted sharply with the passive quality of aide-resident interaction. Family members can, of course, rely on memory of what the resident used to say or how the person used to be. For aides, bringing an interaction to life by role-taking requires far more active imagining of the self of the silent other.

Although the aides used little language in the mealtime interactions, the residents used even less. Except in the family caregiver situations, the residents

spoke little to their caregivers and hardly at all with one another. The scant linguistic exchange among residents makes for a quiet and somewhat dull environment, contrasting with the milieu in other types of public dining rooms like restaurants and cafeterias, which ring with the sound of conversation. A couple or family eating in silence in a restaurant suggests loneliness, sorrow, alienation, depression, or anger. Perhaps impoverished verbal exchange in the nursing home dining room reflects or even shapes the emotional experience of some residents, contributing to their passivity.

Caregivers' Verbal Behavior

Instrumental Utterances: The instrumental utterances that I observed included prompting, giving encouragement, identifying food, offering options, and scolding. Except for the last, most instrumental utterances supported the residents and helped them to eat.

Prompting involved coaching or reminding a resident to take some action. Examples included telling the resident to open his or her mouth or reminding the person to swallow. Such prompts helped the resident to focus on the specific motor task needed for successful eating.

Encouragement took a variety of forms. When a resident was eating well, the aide might say, "Very good," or the aide might urge the resident to try a particular food. Often encouragement took a predictable form at the end of the meal as the aide tried to entice the resident to take "just one more bite." Mr. Merchant, whose dysphagia initially made eating especially stressful and difficult for both him and the aides, warranted a special kind of encouragement, which I termed "pre-meal coaching," seen in the following example:

Lena Hernandez has developed a special bond with Mr. Merchant. One day they sat together in the living center and waited for lunch to arrive. She took his arm, and they began to arm-wrestle playfully at the table. He seemed to enjoy this, smiling as they played. They stopped and she said, "You gonna eat well for me today, papa?" He smiled at her. (AFN)

Encouraging residents often seemed to make a difference in how much food they ate. Left to their own devices, some residents quickly lost interest in meals, but given a word or two of encouragement, they often took a few extra mouthfuls.

Identifying food—that is, telling the resident what item was about to be offered to him or her—often sparked the person's interest in the meal.

Sylvia Rodriguez handed Mrs. Schmidt the glass of milk, saying, "Finish your milk." Mrs. Schmidt sipped away at the milk, finishing all but a little of it, while Sylvia fed her the rest of the meal.

Unfortunately, in only 32 percent of the 61 individual meal observations were *any* of the foods on the tray identified for the resident at any time during the meal. In some cases, caregivers did not identify the food because they themselves could not tell what it was—usually because it was puréed. In failing to identify food as they fed residents, caregivers missed the opportunity to stimulate failing cognition and to restore recognition of particular foods. Moreover, they passed up chances to use food as a topic of conversation in order to connect with the resident.

Offering the residents options about what to eat and in what order gives them control over important details of life, as can be seen in the following example:

Tina Lopez put some mashed potatoes on the spoon and said to Mrs. Schmidt, "Want to start this one? You taste this one? What's this? This is mashed potatoes. Try it." Mrs. Schmidt nodded, and Tina lifted the spoon to her mouth. (AFN)

Regrettably, offering the residents options about food was an extremely rare phenomenon. In only *three* of the 55 individual meal observations involving staff did aides ask residents if they wanted a particular food before offering it. Families, on the other hand, offered options in two of the six meals in which they were observed. Staff caregivers assumed total control of this aspect of the interaction and chose which foods to feed without consulting the residents. As with other aspects of the mealtime interaction, the aides' failure to offer residents choices shows a lack of support for autonomy (Lidz, Fischer, & Arnold, 1992), a tendency to infantilize residents, and a pervasive weakness in their role-taking skills. Recognizing that people have choices, any choices, is essential to identifying with the humanity of the other.

Scolding, although infrequent, further infantilized the residents. Scolding was generally limited to chiding or reprimanding residents for not eating or for behaviors considered messy or distasteful. On three occasions, scolding was accompanied by a threat. The following example involved Walter Chan, the agitated resident who often groaned loudly, irritating staff members:

One day at lunch, Mr. Chan was particularly agitated. The aide who was setting up his tray said, "Stop shouting, promise you'll be quiet, or I won't feed you." (AFN)

The threat did not quiet Mr. Chan; he continued to yell throughout the meal.

Affective Utterances: Caregiver use of positive affective language consisted of using terms of endearment or diminutive names, assessing residents' satisfaction with meals, using humor, and conversing about people, places, or

things. Positive affective utterances generally had a beneficial effect on interactions. Caregivers expressed their interest and care for residents by addressing them with terms of endearment such as “mama,” “papa,” “big daddy,” and “baby,” or by adding the diminutive suffix “-ie” to their first or last names, as in “Markie” or “Smithie.” Whether such terms are infantilizing depends on the nature of the relationship between the caregiver and resident. For example, when Lena Hernandez called Mr. Merchant “papa,” the term reflected the kin-like relationship they had developed over time. Lena and Mr. Merchant were genuinely fond of each another, and smiled and joked frequently. He certainly smiled with affection when Lena called him “papa.” When other staff called him “papa,” however, he did not respond with the warm smile he reserved for Lena.

Assessing the residents’ satisfaction with meals happened in 28 percent of the interactions. The following were two typical exchanges:

Aide: “Did you like your lunch today?”
Resident: “Yes, it was good.” (AFN)

Elena Matigbay asked Mrs. Washington, “You like your dinner? Enjoy, si?” Mrs. Washington made an unintelligible guttural sound. Elena replied, “Did you say yes?” Then the aide smiled and named the foods on the tray. (AFN)

Such inquiries showed the caregivers’ interest in pleasing the residents and reflected their imaginative identification with the residents’ feelings. It is unfortunate that such comments were made in less than a third of the individual meals observed.

Although used rarely, humor added depth and life to interactions, and sometimes, as in the following case, protected residents’ self-esteem:

Emma Pagaduan cut up some beets and fed Violet Iannotta a spoonful. Mrs. Iannotta tried to bite down on them, but they slipped

from her toothless mouth. Emma pointed at the beets and joked, "They're still alive, eh? Never mind, they make a mess." Mrs. Iannotta responded with a smile, "Yeah, okay." (AFN)

This interaction required Emma to imagine and identify with Mrs. Iannotta's feelings of embarrassment.

Finally, very occasionally, caregivers and residents exchanged a few sentences on topics unrelated to food in a way that resembled the give-and-take typical of ordinary adult conversation. This happened with residents who were more able and likely to speak:

Emma Pagaduan chatted with another aide in the dining room about wanting to buy an item and not being sure if she could afford it. Mrs. Iannotta was engaged in the interaction, watching the two aides as they chatted together. Emma turned to Mrs. Iannotta and said, "You have money, Violet." Mrs. Iannotta answered, "Yeah." "How much?" asked Emma. "Don't know," replied Mrs. Iannotta, looking confused. "Let me borrow five thousand dollars," joked Emma. Then she and Mrs. Iannotta both burst out laughing. (AFN)

Emma responded to Mrs. Iannotta's confession of ignorance about her finances with a joke. When Mrs. Iannotta said, "Don't know," the conversation could have come to an impasse. Instead, Emma, through a skillful role-taking process, saw the need to reassure Mrs. Iannotta that she knew more than she thought about her situation, and made a joke at which they both could laugh.

The relative rarity of this type of exchange says much about the peculiarity of the interaction between the residents and their caregivers. Social chatter and in-depth discussion, which fill the days and especially the mealtimes of most adults, are nearly absent in this nursing home's mealtime interactions. It is difficult for a cognitively impaired person to produce much conversational speech, and the caregivers rarely try to overcome that obstacle.

One aide proved a notable exception. Marcia Gomez was a Filipino woman in her thirties. She had been a registered nurse in the Philippines, but had not yet passed her boards in the United States, and so was temporarily working as an aide at Central City. Her perceptive and knowledgeable care showed the marks of experience and advanced education that the other aides lacked.

Marcia had a very lively, warm, chatty personality that shined in her interactions with the residents. One time, for example, she was feeding Mrs. Washington, whose aphasia and dementia rendered her mute. Mrs. Washington often smiled silently at her caregivers and looked intently into their faces. Marcia chatted and laughed with Mrs. Washington as she fed her, and Mrs. Washington fairly beamed, showing her enjoyment in the encounter. Marcia made a lot of eye contact with Mrs. Washington and frequently told her what was on the spoon. In my field notes, I wrote:

Marcia's persistence is a notable quality in her interactive style. She continues to chat and to persevere in making eye contact until she gets a reaction from the resident. She is an expert in holding up a one-sided conversation with the cognitively impaired residents. The small non-verbal responses or occasional single-word responses are enough for her to keep the interaction lively and moving forward. She presents a stream of verbal, visual, and tactile stimuli that demands a response from the residents, and she gets it.

Marcia was a notable exception to the general rule of minimal use of conversation or words. She expressed much interest in the elderly people she cared for and tried to see the world from their perspective. Actively taking their roles, she saw their need for stimulation, conversation, and humor, and she offered these to them.

Residents' Verbal Behavior

Residents' instrumental and affective utterances were both limited. No doubt, much of this limitation was the result of the severe cognitive impairment of the subjects. Caregivers, however, do not encourage residents to make requests or express their feelings. Their failure to do so may dampen any inclination to speak.

Instrumental Utterances: Residents' instrumental utterances mostly involved refusal of food. Statements like "no" or "I don't want that" were typical. For very impaired people, the ability to refuse food is one of the few ways they can exercise control over their world. Perhaps that explains why this was their most frequently expressed type of utterance. Residents also responded to the occasional questions that caregivers asked, usually giving single-word responses. Sometimes residents would request a particular food from their tray. These requests were generally made by uttering a word or two, such as "ice cream" or "bread." The caregivers, however, did not always comply with these requests. For example, one caregiver turned down a request for dessert, telling the resident she first had to eat more of the entrée.

Production of language was clearly a difficult task for most of the severely impaired residents. That they managed to use language at all to express their needs or feelings is significant. Their forceful expressions warranted the caregivers' full attention. Yet, the caregivers sometimes ignored or did not comply with the residents' expressed wishes, often taking a maternalistic attitude toward their vulnerable and powerless charges.

Affective Utterances: Residents' affective utterances were even more limited than their instrumental ones. During the first phase of my observations, I noticed that very few residents made affective comments of any kind. In quantifying this phenomenon later, I found that only three of the ten subjects in the focused observation stage of the study used affective language. Mrs. Schmidt sometimes asked the private duty aide who cared for her to "kiss me." Mrs. Iannotta occasionally asked staff, "How are ya? It's good to see ya." Mrs. Ishibashi, the most verbal of the ten subjects, spoke warmly to her daughters in Japanese. The paucity of affective language may result from three factors. First, only three of these ten residents (Mr. Merchant, Mrs. Marshall, and Mrs. Ishibashi) had family members or friends who visited with any regularity and provided emotional stimulation. Second, five of the ten residents (Mr. Merchant, Mrs. Marshall, Mrs. Washington, Mrs. Bing, and Mr. Green) had such severe cognitive impairment that speaking was extremely difficult and usually limited to single-word responses. Third, most of the aides did not establish emotional bonds with the residents, so there were few stimuli to evoke affective verbal expression from the residents. As noted, caregivers used affective language in only 30 percent of the interactions observed.

Non-Verbal Behaviors

Both caregivers and residents use non-verbal means of communication in the mealtime interactions. This form of communication includes instrumental and affective touch, eye contact, and facial expression. Because dementia and aphasia limit residents' ability to express themselves verbally, non-verbal expression is especially important to both parties. When caregivers are sensitive to these non-

verbal cues, the quality of the interactions is greatly enhanced.

Mealtime equipment, such as spoons, forks, bibs, and napkins, also play an important part in the non-verbal behavior of the caregivers. As extensions of instrumental touch, these items carry symbolic meaning, and whether and how they are used reveals much about the interaction.

Caregivers' Non-Verbal Behavior

Instrumental Touch: Caregivers' positive instrumental non-verbal behaviors, like their positive instrumental verbal behaviors, tended to support the residents in the task of consuming the food. These behaviors generally had a beneficial effect on the interactions. Caregiver use of instrumental touch included stroking the resident's throat to induce swallowing, patting the back or rubbing the chest during coughing, wiping the chin or face to clean it from food, and putting an implement in a resident's hand to encourage self-feeding. Caregivers used instrumental touch in 61 percent of the individual meals I observed.

Instrumental touch was used in a somewhat negative way with one resident. Mrs. Hyde had a tendency to push away an offered spoon with her hand. In order to get her to take food, some caregivers held Mrs. Hyde's hand down while they put a spoon to her lips. Then, in resignation, Mrs. Hyde would often open her mouth and take some food. The technique worked to get food into Mrs. Hyde's mouth, but it seemed unnecessarily restrictive and forceful. Although she had advanced dementia and rarely spoke, Mrs. Hyde projected an air of pride and dignity, sitting up ramrod straight in her wheelchair at all times. She was capable of feeding herself, but tended only to eat her dessert. The aides used the hand-restraining technique in an attempt to help her take in a more balanced diet. While

their objective was laudable, the technique used to accomplish it was not. A more creative approach might have uncovered ways to encourage Mrs. Hyde to feed herself a more balanced diet. For example, the aides could have removed her dessert from the tray and rewarded her with it after she had eaten some of the entrée. The aides could also have taken careful note of those few entrée dishes that Mrs. Hyde did feed herself, so they could be served to her more frequently. In fact, Sylvia Rodriguez, the private duty aide for Mrs. Schmidt, once noticed that Mrs. Hyde would feed herself food spread on bread in sandwich form, and communicated this information to a student aide who was in the facility. However, this observation never found its way into Mrs. Hyde's general care plan, so only a few aides ever tried the technique.

While some caregivers did place implements in the hands of residents who were known to feed themselves, the use of instrumental touch to help residents in relearning to feed themselves was all but absent from the nursing home. I only observed one caregiver, Jean O'Brien, using touch to help a resident relearn to feed himself. Jean, a physical therapy aide, is trained in rehabilitation techniques. She mostly helps residents with walking and exercising, but occasionally feeds dependent residents. The resident I saw her help to eat was a stroke victim. Jean put a fork in the resident's hand and, placing her hand over his, guided the fork to his mouth. After repeating this action several times, she let the resident try on his own. He successfully lifted the fork to his mouth and, with a little more guidance, fed himself much of the rest of the meal. This technique might well help others relearn to feed themselves.

Affective Touch: The caregivers' use of affective touch that I observed included patting or stroking the residents, usually on the arm or shoulder, and sometimes on the head. Some aides kissed the residents during the course of a meal. A typical instance of this kind of touch follows:

Jennifer Kalani was sitting next to Mrs. Marshall, feeding her lunch in Dining Room Two. Jennifer paused and looked right at Mrs. Marshall and patted her arm. Then Jennifer rested her hand on Mrs. Marshall's shoulder in a gesture of affection.

The residents generally responded warmly to such affective touch, smiling at the aides, or returning the touch in some affectionate way. Yet, once again, this potentially beneficial behavior was notable for its absence in many of the interactions. In only 35 percent of the individual meals did caregivers use affective touch.

Mealtime Equipment as a Vehicle of Non-Verbal Expression: In the mealtime interactions, utensils and other mealtime equipment become extensions of the caregivers; and how these are used—roughly, sloppily, or carefully—conveys much about the caregivers' engagement and interest in the work of feeding. As with other aspects of the mealtime interactions, the utensils and their use is under caregiver control.

More than just tools to do work, utensils and other mealtime equipment carry symbolic meaning. A spoon, for example, is a tool for conveying food to the mouth, but it also carries social expectations concerning its use. A spoon is for scooping up food and bringing it neatly into the mouth. Except for occasions of hilarity in a college dormitory, a spoon is not for flipping food across the table at a

dinner partner or for scraping mud off shoes.

At Central City, spoons and other utensils were routinely supplied on meal trays. Sometimes the caregivers placed the utensils in the residents' hands or at least pointed them out to the residents. But on one occasion, I observed what can happen when this is not done:

Mrs. Manford had Parkinson's disease and dementia and often needed help to eat. However, at lunchtime, when her anti-Parkinson medicine was working at its peak, she generally managed to feed herself. One Sunday lunchtime, she was wheeled into Dining Room One to eat with the most functional residents. The living center, where she habitually ate lunch, was closed because of short staffing that day.

Mrs. Manford began to feed herself with her fingers as soon as the tray was presented. She picked up pieces of yam and ate them like apple slices. The activities aide who was supervising the dining room asked the nurse, "Doesn't she need someone to feed her?" The nurse replied, "Look at her, she's doing fine. She's eating with her fingers, but that's okay. We have patients who do."

Mrs. Manford finished the yams and went on to the mashed potatoes. These were difficult to eat with her fingers, and as she scooped them up, the gravy oozed between her fingers and dripped down her chin, spilling onto her dress. I found it difficult to watch her struggling to eat these potatoes. Noticing that her spoon, the only utensil on her tray, was hidden beneath the lip of her plate, I wondered if she would use it if she saw it. I had seen her use utensils before, so I picked up the spoon and showed it to her, saying, "Mrs. Manford, here is your spoon." Then I put it on her plate and went back to my chair across the room. She used her hands to eat a few more pieces of the yams, and then picked up the spoon to eat the mashed potatoes. When using the spoon, she did not spill any more food. (AFN)

Showing Mrs. Manford the spoon was all that was needed to remind her of its appropriate use and to provide her with the route for reclaiming lifelong mealtime habits. She remembered the customary adult eating manners that the spoon symbolized. Being deprived of this symbolic reminder (through the staff's inattention to details) forced her outside of the bounds of conventional society. Her

struggle to eat the mashed potatoes with her hands infantilized her and stripped away her dignity. My giving her a spoon restored her connection to the social rules and conventions she had known all her life.

Caregivers use a variety of equipment to feed residents, including forks, spoons, cups, and straws. Other items, such as napkins and bibs, are used to keep the face and hands clean during the meals and to protect the residents' clothing. A number of conditions, including safety, food texture, perceived convenience, resident handicaps, and staff availability, determine which utensils the caregivers use to feed residents.

Aides perceive forks as dangerous and claim that spoons are safer and easier to use. This concern over safety issues means that spoons are used much more frequently than forks. In 86 percent of the 55 meals I observed in which an aide fed a resident, the aide used only a spoon, and no other utensils, to convey food to the resident's mouth. Family members were more inclined to use forks to feed their relatives. However, the safe use of forks was a concern for at least one family. One of Mrs. Ishibashi's daughters said that at times her mother appeared to have "forgotten how to eat," and snapped or bit at the fork as it came toward her mouth. When this happened, the daughter was afraid her mother might hurt herself. She told her sisters that when they encountered this behavior, they should use spoons.

The choice of utensil is sometimes dictated by the texture of the food. Although spoons are most often chosen by the staff, forks might be used if the food is likely to slip off a spoon. Beets and peaches are examples of foods that I often saw fed to residents with forks to prevent this problem.

Convenience is also a factor. Aides often look for the fastest, easiest, or most efficient way to feed a resident. In doing so, they sometimes resort to highly

unconventional or even distasteful practices. For example, some impaired residents retain the ability to hold and drink from a cup, but cannot manipulate a fork or spoon. In several instances, I witnessed an aide who was caring for such a resident mix puréed food into a cup of milk and then give it to the resident to drink. Since the resident could drink from a cup, this practice eliminated the need to feed the resident by hand. One could argue that this practice encouraged self-feeding. From another perspective, however, the aide's actions promoted highly unusual eating practices that served to distance the resident from normal adult eating conventions and alienated her from her lifelong experience and memories of eating.

Residents' handicaps also dictated the choice of utensils and/or the way in which they were used. Some aides responded to these handicaps with considerable creativity. In their interventions, these aides revealed their intimate knowledge of the residents and tailored their feeding techniques to individual idiosyncrasies. One aide, for example, recognized that a resident, Mr. Chan, with a poor gag reflex often had difficulty swallowing liquids and frequently coughed and sputtered. Her solution was to offer him only small sips of liquid at a time. To do this with ease, she poured his juice into a tiny medicine cup, filling it only halfway, and gave it to him a cupful at a time. This allowed her rigorous control of the amount taken by the resident at each swallow. Yet, over the course of the meal, she was safely able to give him all of his juice.

Aides apply other creative interventions more broadly. For example, they frequently pour liquids from the rigid cups in which they are served into small flexible cups. This allows them to shape the cup into a small spout. The aide can then pour small amounts of liquid into the resident's mouth, using the spout.

Staffing considerations can influence the choice of utensils available to

residents. At Central City, feeding syringes, a very medicalized fashion of delivering nourishment, are not used. When I asked the DON why, she said: "We don't have enough trained staff to do that here. We couldn't do it safely." If she was philosophically opposed to the idea of syringe feeding, she did not say so. Rather, she suggested that staff shortages and safety concerns prevented the nursing home from instituting this procedure.

One factor is glaringly absent from the list of conditions that affect caregivers' choice of implements: the resident's own preference. In seventeen months of observation, I never once saw a resident asked what utensil he or she would prefer to use. As with many aspects of the mealtime interactions, power lies in the hands of the caregivers, and they simply do not ask residents about their preferences.

The importance of how the caregivers handle the power they have in the relationship is critical to the quality of the interaction. In feeding a resident, a caregiver is performing an action that is normally reserved for infants or small children. Yet, the nursing home resident is not a child. The way the caregiver uses implements and other equipment can exacerbate or mitigate the infantilization of the older person.

The pervasive use of spoons, described above, has the effect of infantilizing residents. Babies are fed almost exclusively with spoons. It is not until children are older and sufficiently dexterous that they are trusted with forks. Achieving the ability to use a fork is a cultural symbol of maturity.

That the pervasive use of spoons was a subtle form of infantilization became apparent as I watched family members helping their relatives. These caregivers were more inclined than the aides to use forks. For example, Mrs. Ishibashi's

daughters used forks for most foods, only choosing spoons when the particular foods required it. Watching one of Mrs. Ishibashi's daughters feed her, I found myself thinking how much more respectful it seems to feed someone with a fork. Mrs. Ishibashi was clearly treated as an adult by her daughters, and their respect preserved for her the dignity appropriate to an older person.

The manner in which utensils are used can also be infantilizing. Caregivers often use spoons to scrape dribbling food from residents' chins, a technique commonly used by parents feeding babies. But if caregivers fed residents more carefully, they might often avoid the problem and keep food from dribbling down the residents' chins in the first place. Food on the chin degrades a person's appearance and creates the need for the infantilizing technique of scraping food from the chin. The difference that careful feeding makes is readily apparent in the following example.

Over the study period, I observed several caregivers feed Mrs. Washington, all with the same consequences. Mrs. Washington had a tendency to thrust her tongue forward when food was placed in her mouth, and her puréed food dribbled down her chin with every spoonful. It seemed it was impossible to avoid this problem, until one evening, as I watched Elena Matigbay feed her, I noticed that Mrs. Washington's chin was clean, and that Elena never had to scrape food from it. Elena was careful to put just a little food on the spoon and to put the bowl of the spoon most of the way into Mrs. Washington's mouth. Then she tilted the bowl of the spoon down toward the floor of the mouth as she withdrew it. The result was that Mrs. Washington was fed in a neat way. Elena did not even need to wipe Mrs. Washington's mouth during the course of the meal. (AFN)

Other mealtime equipment can be infantilizing. Terry cloth bibs, which are used for many residents, are an adaptation of infant apparel. Sadly, people become socialized to this infantilization. The activities director noted that he was

encouraging the use of cloth napkins rather than bibs in Dining Room One, where he assisted the most independent residents. However, he added that, to his surprise, many residents said they were used to and preferred the terry cloth bibs.

Use of Eye Contact: As noted, the amount of eye contact that caregivers make with residents is partially dependent on the posture of the caregiver in relation to the resident. I found that, when seated, the caregivers made eye contact with the residents in 84 percent of the individual meal observations. Standing caregivers made eye contact in only 57 percent of these meals.

Perhaps because of residents' poor eyesight, or because of their cognitive deficits, caregivers had to work at making eye contact with some residents. This often involved the caregiver putting her face within a few inches of the resident, looking deliberately into the resident's eyes, and then waiting for the resident to return eye contact:

Mrs. Washington's attention was wandering, and her pace of eating had slowed, as Indira Sahab, a student nurse aide, fed her. Indira, who was sitting at Mrs. Washington's side, then leaned around into Mrs. Washington's view and asked her if she wanted more to eat. Getting no response, Indira put her hand on Mrs. Washington's shoulder and leaned in even closer to make eye contact with her. Again, Indira offered her a spoonful of food. This time, Mrs. Washington opened her mouth and ate the food. (AFN)

The position the aides take in making eye contact is similar to the *en fas* position described by Barnard and Eyres (1979) in their study of maternal feeding of infants. In the *en fas* position, the mother's eyes and the infant's eyes meet fully in the same vertical and horizontal planes. When aides strive to make eye contact with residents, they instinctively seek out this same position.

When caregivers made eye contact in the interactions I observed, it had a positive effect on the residents, helping them to stay engaged with the caregiver and focused on the meal. That eye contact decreased when aides were standing, and therefore not on the same level with residents, points up the importance of having people sit when they feed residents so as to improve the amount of eye contact.

Facial Expression: The facial expressions of caregivers that I observed included smiling, which I saw in 53 percent of the individual meals. In other words, in 47 percent of the meals, the aide did not smile even once. Aides seemed to smile most often when they were encouraging a resident to eat. Residents responded warmly to caregivers' smiles, often returning the smile and opening their mouths to eat.

When aides had difficulty feeding residents, they wore expressions of frustration and distress. On several occasions, when residents acted in ways considered distasteful by the aides, such as spitting out food, the aides openly expressed disapproval or disgust by wincing. The residents generally did not witness the aides' expressions of disgust, because the aides instinctively turned away while making them, perhaps in an unconscious gesture of protecting the residents from negative feelings.

Residents' Non-Verbal Behaviors

Instrumental Touch: Residents used instrumental touch to push the caregivers' hands away when they did not want food, or to point or reach for food that they did want. Unfortunately, residents' non-verbal requests, such as pointing to a particular food or raising their hands in a gesture meaning "stop," were not

consistently attended to:

When Mary Romero offered Mrs. Bing some milk, using a straw, Mrs. Bing took the straw into her mouth and sipped for a moment. Then Mrs. Bing made a wincing face and pulled back from the straw. Mary held on to the straw, keeping it in Mrs. Bing's mouth and thwarting her efforts to turn her head away and release the straw. (AFN)

Mary wanted Mrs. Bing to take her fluids. In her desire to achieve this goal, she overrode Mrs. Bing's non-verbal signals to stop drinking. Focused on getting the milk into the resident, Mary did not consider how Mrs. Bing felt about having milk forced upon her. Mary's failure in role-taking was not only insensitive but potentially dangerous. Mrs. Bing might have choked on the milk.

Affective Touch: Residents' affective use of touch included kissing or patting the caregivers or taking their hands. Like affective verbal expression, this behavior was not universal; I observed it in only four of the ten subjects. That 60 percent of these subjects never once demonstrated affective touch suggests the caregivers' failure to establish a strong bond with the residents. It takes patience to establish such a bond, and the caregivers must allow the residents time to respond. I often spent time with each of the subjects before or after the mealtime observation. I always reintroduced myself and took the subject's hand, frequently holding it while I talked to the person. In every case, after a period of holding the resident's hand, the person would squeeze my hand affectionately, or pat or stroke me. These residents, even with their high levels of impairment, were able to respond in kind to my non-verbal affective behavior. But they needed time to do so. Compelled by a multitude of duties, aides rarely are able to give residents the time they need to

respond. Moreover, aides may not understand or be aware of the importance of including simple non-verbal gestures of acceptance and affection in their care of elderly people.

Eye Contact and Facial Expression: Eye contact and facial expression were important vehicles of communication for the residents. Some of them actively worked at making eye contact with their caregivers. They watched their caregivers and seemed to be looking for them to return their gaze. If the caregiver was distracted, the resident's gaze went unreturned:

Mrs. Washington had such severe aphasia that none of her utterances were intelligible. Yet, sometimes it seemed she really wanted to make contact with her caregivers. From time to time, she looked longingly at them, but often they were distracted and did not return her gaze. (AFN)

Residents with cognitive impairment have limited means for getting caregivers' attention. It is hard for an aphasic, placid resident like Mrs. Washington to get truly focused attention from the staff, and it was sad to watch her try.

A few staff members seemed aware of Mrs. Washington's longing looks and found satisfaction in giving her the attention she so much enjoyed. Actively engaged in a role-taking process, they imputed meaning to her actions and attended to the symbolism inherent in her non-verbal behavior. These caregivers responded with the expectation that Mrs. Washington understood their words and actions:

Elena Matigbay stood by Sarah Washington's bed and fed her some spoonfuls of puréed meat and vegetables. Elena asked, "Sarah, you like your food?" as she gave Mrs. Washington another spoonful. Mrs. Washington opened her mouth readily as the spoon was lifted to her mouth. "Very good," said Elena, as she bent down, smiling and putting her face directly in front of and close to Mrs.

Washington's. Mrs. Washington smiled back.

A few minutes later, Mrs. Washington looked directly at Elena. Their eyes met, and Elena said, "You like your dinner?" Mrs. Washington made a small guttural sound. Elena said, "Did you say yes?" Then Elena smiled and, using her spoon, pointed at some of the foods on the plate, naming them. (AFN)

In this exchange, Elena took the way Mrs. Washington readily opened her mouth to mean that she enjoyed the food. Elena rewarded Mrs. Washington's response by saying "Very good," and then smiled at her. Mrs. Washington responded with a warm smile, acknowledging Elena's gesture of affection. Similarly, Elena acknowledged Mrs. Washington's gaze by asking her a question. Mrs. Washington's gaze carried the same power that words have to demand another's attention. Elena took Mrs. Washington's guttural sound in response to her question to mean that Mrs. Washington liked the food. Then Elena took the "conversation" a step further by identifying some of the different foods on Mrs. Washington's plate. This interchange is a good example of how both caregiver and resident can respond to the symbolic meaning of non-verbal expression.

The Effect of Caregivers' Behaviors on Residents' Moods and Food Consumption: Quantitative Results

The quantitative instruments used in the study were designed to examine the effect of certain key caregiver behaviors on the residents' nutritional intake and mood. Toward this goal, caregivers' scores on the observational checklist were correlated with the percent of food consumed and the mood scale for each of nine subjects.² Results of correlations between the behavioral checklist scores and the

²One subject was dropped from the analysis because she fed herself four of the six meals and so had only two full sets of observational checklist scores from caregivers.

percent of food consumed for the individual subjects ranged from $-.45$ to $.54$. Four correlations were positive, four were negative, and one was 0. The overall trend across subjects showed positive correlations in the moderate range for the observational checklist and the mood states of happiness, contentment, and interest. There were few correlations possible for the neutrality, discontentment, unhappiness, distress, and aggression mood states because the subjects often repeatedly scored 1 on the scale for these moods and showed no variation over the six meals.

The expected trend of positive correlations between the observational checklist and the percent of food consumed was not seen. It may be that repeated measures over a longer period of time would present a different picture. In Mr. Merchant's case, for example, the measurements were taken at the beginning of his stay at Central City, shortly after his stroke. He was having great difficulty swallowing and consumed very little. Lena Hernandez, his frequent caregiver, scored high on the observational checklist, demonstrating a positive style of interaction, which we have already seen confirmed by the qualitative data. Lena worked hard to help Mr. Merchant get over his fear of swallowing. Three months later, her work paid off, for he had greatly improved his food intake. Quantitative data collected over the entire three-month period might have shown the expected positive correlation between her interactional style, as measured by the observational checklist, and his food intake.

Correlations of the checklist and the mood scale were in the expected direction. Higher scores on the observational checklist indicated that a more beneficial style of interaction by the caregivers showed a positive relationship to higher scores on the residents' mood states of happiness, contentment, and interest.

However, the small sample size precludes any definitive statements about the relationship.

One important observation was the low scores on all moods. Most scores for moods across all subjects fell within the 1–3 range on a Likert scale that ranged from 1–5. These scores reflect the generally low or flat affect frequently found in nursing home residents. Perhaps nursing home environments depress or dull residents' affects.

CHAPTER 7: CAREGIVERS' RESPONSES TO COMMON MEALTIME PROBLEMS

The caregivers' responses to residents' common mealtime problems revealed much about the quality of the mealtime interaction. Cognitively impaired, eating-disabled residents displayed behaviors that challenged the caregivers who fed them. Resident behaviors that caregivers found problematic included coughing, holding an awkward or dangerous posture, showing reluctance to eat, keeping the mouth closed, sleeping before or during the meal, and behaving in a combative, disruptive, or distasteful manner.

The caregivers responded to these behaviors in a variety of ways. Their responses were negotiated through the role-taking process as they determined and gave meaning to the residents' behaviors. Some responses were more constructive than others in meeting the goals of providing adequate nutrition and a quality mealtime experience.

Coughing

Many residents cough while eating, especially those with stroke-related swallowing difficulties. I observed that the caregivers invariably dealt with coughing residents in a safe way. The caregivers allowed the residents to cough freely without intervention, waiting until the coughs subsided before offering food or drink.

When residents coughed several times or for a prolonged period, some caregivers used tactile measures to comfort them. These included gently patting the

back, rubbing the chest, and massaging the shoulders. For example:

Mr. Merchant, a stroke victim with pronounced dysphagia, appeared anxious about swallowing and afraid of choking. Once, after taking some liquid, he began to cough. Lena Hernandez massaged his shoulders and rubbed his neck until he relaxed and his cough subsided. (AFN)

Comfort measures such as these were not required to assure the resident's safety. That goal was met by not intervening in the coughing process. However, Lena's actions helped to soothe and quiet the resident. Her actions were effective because she knew the resident well and had learned what worked to help him. Through the role-taking process, she had come to understand the physical and psychological distress that coughing caused Mr. Merchant. She shaped her response according to this understanding. From her experience with him over time, Lena became more adept at helping him through his coughing spells.

Awkward or Dangerous Postures

Some residents habitually assume positions that are awkward or even dangerous for eating. I often observed Mrs. Marshall, for example, hyperextending her head. This position opened her larynx, putting her at risk for aspiration. Her caregivers coped with this problem by repositioning her at the beginning of meals and putting a pillow behind her head in order to tilt it forward. One of her caregivers favored feeding her in bed because the bed gave her head full support and prevented hyperextension of the neck.

Some caregivers used their own arms or hands to support a resident's head and keep it from listing to one side, or to keep a resident from leaning too far forward. Several caregivers placed a hand on a resident's forehead or crown of

head to steady and position the head while giving liquids from a cup. This technique allowed the resident to drink more easily and reduced spilling or leaking from the sides of the mouth. As with coughing, care for residents who assumed awkward positions was primarily directed by the principles of safe feeding.

This appropriate, effective care given to residents who coughed or assumed awkward positions reflects the nursing home's emphasis on safety issues. Aides had been trained and were expected to feed residents safely, and did so without exception.

Reluctance to Eat

Residents typically manifested reluctance to eat by turning their heads away, eating very slowly, or, if self-feeding, by putting down the utensils and stopping eating altogether. Refusal or unwillingness to open the mouth was a specific subset of this behavior that elicited a characteristic set of caregiver responses.

When a resident was known to have a history of eating poorly, the caregivers sometimes responded with pre-meal coaching, a technique already described above in Chapter 6, in which the caregiver let the resident know that a meal was coming and encouraged or enticed the resident to eat:

Mr. Merchant was sitting in the living center as staff waited for trays to arrive. Lena Hernandez came over to him, stood behind him, and put her arms around his shoulders. Then she leaned down to his ear and said, "You gonna have some ice cream." (AFN)

In this interaction, Lena used her knowledge of Mr. Merchant's fondness for ice cream as a way of whetting his appetite. In general, pre-meal coaching helped the residents to anticipate meals and prepare themselves to eat.

When reluctant residents took spoonfuls of food, the caregivers often cheered them on, saying things like "Very good" or "That's the way!" Frequently, the caregivers offered foods that they knew residents liked, adding comments such as "Here's your banana, you *like* banana." Such comments reflected the caregivers' detailed knowledge of the residents' likes and dislikes, and generally proved successful in getting residents to eat.

Residents who did not always need assistance were sometimes offered a special kind of encouragement. Violet Iannotta, for example, often fed herself, but consumed little of the food on her tray. Left to her own devices, she would not eat enough to maintain her weight. To ensure adequate intake, caregivers would come to Mrs. Iannotta at the end of a meal, after she had stopped eating, and would spoon-feed her, often trying several foods before finding one that Mrs. Iannotta would eat:

Gladys Hidalgo came over to Mrs. Iannotta at the end of the meal. Seeing food still on the tray, she picked up a spoon, scooped up some cottage cheese, and lifted it toward Mrs. Iannotta's mouth. "I don't want it," said Mrs. Iannotta. Gladys shook the cottage cheese off the spoon and then scooped up some prunes. Mrs. Iannotta opened her mouth for the prunes. "You like that?" asked Gladys. "Yeah, it's good," replied Mrs. Iannotta. Gladys fed Mrs. Iannotta the rest of the prunes. (AFN)

Gladys's actions went beyond simply using words to encourage eating. She tried different foods on the tray and assessed Mrs. Iannotta's satisfaction with them. When Gladys found something that Mrs. Iannotta liked, the prunes, she was able to feed her the entire portion. In this case, the caregiver's encouragement, persistence, and active intervention meant that the resident was better nourished than if she had been left to eat the meal entirely on her own.

Mrs. Iannotta was a very social individual, who loved to be around activity and enjoyed being touched and hugged by the staff. She especially enjoyed one-on-one attention. In fact, some aides suggested to me that she may even have actively sought out staff contact by eating poorly, thus causing staff to feed her and provide her with the attention she craved. Staff accepted her apparent need for attention.

The caregivers sometimes used artifice, or fooling strategies, to get reluctant residents to eat. The most common of these was masking the taste of a food with something else. One resident, Miriam Hyde, was difficult to feed, often pushing the caregiver's hand away and turning her own head away. However, she loved ice cream. The caregivers discovered that by putting a little bit of ice cream at the very tip of the spoon, they could feed her many different kinds of food. Although this practice produced some unusual combinations, such as ice cream and broccoli, it was effective in getting Mrs. Hyde to consume a more balanced diet. Such combinations distance the resident from normal adult mealtime conventions. Yet, in this case, the strategy may have saved Mrs. Hyde from malnutrition and/or the need for a feeding tube. While good nursing practice rightly discourages unorthodox mixing of food, it may be appropriate in carefully selected cases such as this.

In another form of artifice, caregivers put one food on the spoon and told the resident that it was a different food—one the resident liked. Residents appeared to accept this deception, opening their mouths and consuming the food that was offered.

As a strategy, artifice poses some ethical problems. Modern health-care ethics holds patient autonomy as an important value (Lidz, Fischer, & Arnold, 1992). Patient autonomy means allowing a person to make decisions based on truthful information. Deceiving residents about what they are being offered would

appear to constitute a violation of autonomy. The caregivers, however, stated that in using artifice to ensure adequate nutrition, they were acting in the residents' best interests. Their argument is based on an important ethical principle, beneficence (doing good). In this context, in other words, the caregivers were placing beneficence above autonomy. Their use of artifice was indeed effective. The caregivers relied on their detailed knowledge of particular residents' likes and dislikes. Moreover, they knew which strategies of artifice successfully fooled particular residents—and conversely, which ones failed to work.

Giving rewards for eating was another common strategy employed by the caregivers. Residents were sometimes enticed with the promise of dessert or another favorite food in exchange for eating the main part of the meal. Verbal rewards, such as telling a resident "That's good," and non-verbal rewards, such as patting, touching, or smiling at a resident, were sometimes given as reinforcements for eating. In using strategies like these, the caregivers were relying on common behavior modification techniques to improve resident consumption.

Fortunately, the caregivers rarely used threats to induce a person to eat. The threats I witnessed were relatively mild—for example, "You can't have your ice cream if you don't eat your dinner," or "If you don't eat, you are going to get sick." Still, even weak threats like these infantilized the vulnerable residents and put the interactions on a threatening plane.

Frequently, as noted, the caregivers encouraged residents to "Take just one more bite," or told the residents, "This bite is the last one." Such comments lent the interaction the feel of a game or race. The goal was to get as much food into the resident as possible. Sometimes an aide would take productive advantage of a resident's short-term memory loss to encourage eating. For example, the aide might

tell the resident to take "one last bite," and then the aide would get up and leave—later to return to repeat the process of coaxing the resident to take "one last" spoonful.

Failure to Open Mouth

Sometimes a resident's failure to open his or her mouth appeared to be a conscious refusal to take food. At other times, it seemed that the resident was distracted or had simply forgotten to respond to the offering of food. The caregivers handled a refusal to open the mouth with a combination of strategies, including verbal, visual, and tactile prompting. Verbal prompting involved asking a resident to open his or her mouth. Visual prompting generally began with the aide getting the resident's attention by pursuing eye contact. Then the aide would open her own mouth, miming what she wanted the resident to do. This visual prompt was often accompanied by the caregiver saying, "Ahhh." The caregivers also used tactile prompts to elicit mouth opening, such as touching a spoon to the resident's lower lip. These strategies were generally effective in enticing the residents to cooperate. The caregivers frequently used these strategies in combination, repeating them several times to communicate the need to open the mouth.

Sleeping or Sleepy

Residents sometimes dozed off while waiting for a meal or became sleepy during the course of a meal. This happened most often at breakfast and dinner to residents who ate in their rooms, a less stimulating environment than the congregate dining areas. Because the nursing home meal schedule was relatively inflexible, the residents had to be fed when trays were available. Thus, sleeping residents were

awakened to take their meals, and sleepy residents were stimulated to keep them awake. Physical stimulation used to awaken residents included touching, stroking, or gentle shaking. One of Mrs. Ishibashi's daughters wiped her mother's face every day with a warm washcloth to awaken her for breakfast.

Some caregivers chided residents to stimulate or awaken them:

Jennifer Kalani was called away to help another resident. When she returned at 12:30, Mrs. Marshall had begun to drift off to sleep. "Don't fall asleep," she scolded, "we're not finished!" She gave Mrs. Marshall another spoonful of food. (AFN)

It is unfortunate that caregivers were sometimes forced to wake residents to comply with inflexible nursing home mealtime schedules. Rather than responding to the residents' hunger, the caregivers had to ensure provision of nutrition when food was available during designated mealtimes. A nursing home is an institution with systems in place to manage its missions efficiently. Still, how caregivers responded to these institutional pressures reflected on their skill in coping with them. The caring, thoughtful way that Mrs. Ishibashi's daughter woke her mother contrasts sharply with the abrupt way that Jennifer chided Mrs. Marshall to wake up. While the institution's need to operate efficiently is understandable, it may be possible to be more creative and flexible in scheduling meals so as to accommodate residents' individual needs.

Combative and Disruptive Behavior

Residents' combative behavior manifested itself in attempts to hit caregivers or push them away. The caregivers typically responded to this kind of behavior by restraining the residents' hands with their own hands. One caregiver demonstrated a

different technique in dealing with a resident who kept pushing her hand away. Acting on previous knowledge of the person's ability to hold and use a cup, the aide devised a creative strategy for working with this resident:

Esther Hawkins fed Miriam Hyde breakfast in her room. Mrs. Hyde took the first few spoonfuls readily, but then began to push the spoon away. Esther gave her a cup of juice to hold, and Mrs. Hyde gave herself some sips from the cup. Then Esther went on to feed her some more of the food. Mrs. Hyde's hands were occupied, and so she did not try to push Esther's hand away. (AFN)

Another effective strategy for dealing with combative residents was for the caregivers to withdraw from the scene. When caregivers removed themselves, the residents' agitated behavior generally subsided. The withdrawal strategy gave residents a chance to calm down before the mealtime interaction resumed. In some cases, a different caregiver took over feeding the resident. The change in caregivers also helped to calm an agitated resident. As noted in Chapter 6, this is the only situation in which a change of caregiver mid-meal seemed to benefit residents.

Disruptive behavior included yelling aloud and throwing things. The caregivers told residents who were yelling aloud to stop and sometimes scolded them. The aides often isolated yelling residents from other diners by putting the former in a corner of the room or alone in a hallway. Persistent yelling often frustrated the aides:

Mr. Chan sat in the corner before lunch one day, yelling out "ah-ah," repeatedly. Cara Lozada tuned to him and scolded, "Be quiet, Walter! You're driving me crazy!" (AFN)

Mr. Chan could be demanding and frustrating to work with. But isolating this man by putting him in a corner and scolding him did not meet his needs for attention and

affection. He might have calmed down had the aide sat with him for a few minutes and tried to determine what he wanted.

The difference in how aides handled disruptive behavior is clearly delineated in the following example concerning a resident who often threw things:

Rosa Castillo came over to feed Mrs. Johnson at a table in Dining Room Two. The charge nurse warned me to watch out for this resident. "She throws things," she said, and Rosa nodded. Rosa began to feed Mrs. Johnson, who at first took the food well, but then picked up her glass. Something about the way Mrs. Johnson was holding the glass made Rosa nervous. She stepped back from the table and told me to watch out—Mrs. Johnson was about to throw the glass.

Rick Stern, another aide, was feeding a resident at the next table. He spotted what was going on and stepped over to intervene. He gently took the glass out of Mrs. Johnson's hand and set it on the tray. Then he picked up her spoon and started to feed her. Mrs. Johnson ate the food. Rick had used a simple distraction technique to refocus and help her continue eating. He had a gentle but firm manner that she readily responded to. (AFN)

This example shows two aides making very different responses to a resident, based on the conclusions they made through the role-taking process. Both aides took Mrs. Johnson's role and anticipated her actions. Rosa, anticipating that Mrs. Johnson would begin throwing things, responded by backing away. Rick, also anticipating that Mrs. Johnson would throw things, decided to respond firmly but gently to her by refocusing her attention. His confidence that her response to his action would lead to a favorable outcome was a result of his role-taking. He believed she would respond positively to his actions, would cease her inappropriate behavior, and would begin to eat—and he was proved right.

Distasteful Behaviors

Some residents exhibited distasteful behaviors. For example, Mrs. Bing had

the habit of spitting food onto the floor. This behavior was especially apparent when she fed herself:

At lunch, Mrs. Bing was seated in the dining room. Repeatedly, she put a spoonful of puréed food in her mouth, chewed for a moment, swallowed, and then turned her head to the side and spat about a quarter teaspoonful of food onto the floor. (AFN)

The staff found her behavior offensive and complained about it to each other. They dealt with Mrs. Bing in a variety of ways, which included ignoring her behavior, scorning her, prohibiting her behavior, or attempting to redirect it.

The staff who ignored the behavior saw Mrs. Bing spit, but simply looked away and said nothing. Of those who expressed scorn, one registered nurse commented that the habit was "really gross." A student dietitian, who was at Central City for her training, also expressed negative feelings:

The student sat in Dining Room Two, feeding a resident. She saw Mrs. Bing spit on the floor and, turning to her, said in a disgusted tone of voice, "Why are you doing that?" The student did not await an answer, but sighed and returned to helping the other resident. (AFN)

One aide dealt with Mrs. Bing's behavior in a particularly constructive way, redirecting her and giving her attention at the same time:

Rudolpho Torres approached Mrs. Bing, who was just beginning to feed herself lunch. She had just taken a spoonful of food and was turning her head to the side as though to spit. He said softly, "Don't spit." She stopped. Then he adjusted her wheelchair, moving her closer to her tray. She took another spoonful and was turning her head to spit. He said gently, "No, don't do that, please." Again she stopped. Then Rudolpho took a wooden folding chair and set it up next to Mrs. Bing. As she took more food and turned her head again to spit, he said, "Don't spit," and placed his hand on her shoulder, gently rubbing it. Again she stopped. Then she picked up her spoon, began to eat, and turned her head once more to spit. He said,

"Don't spit," and put his arm around her shoulders and kept it there for several minutes. Then he slid his hand back over her shoulders, ending with a pat to the shoulder closer to him. Mrs. Bing looked up at him, and they made strong eye contact. He mimed drinking from a cup. She copied him, reaching for her cup of milkshake and drinking it all. (AFN)

In his actions, Rudolpho both corrected Mrs. Bing and met her affective needs. He insisted that she adhere to social standards that deem spitting in public taboo. Yet, at the same time, by sitting close to her, making eye contact, and touching her in a physically affectionate way, he conveyed his acceptance of her.

Another aide found a particularly graceful way to handle a resident's habit of swearing:

Mrs. Schmidt repeatedly cried out, "Come on, you son of a bitch." Sometimes she did this when she wanted something; at other times, she did it for no apparent reason. Sylvia Martinez tried hard to anticipate Mrs. Schmidt's needs, but when Mrs. Schmidt swore anyway, she would gently say, "shhh, shhh," sit close to her, touch her, and give her extra attention. The swearing would stop.

One time, two visitors came to visit another resident, who was eating lunch in the living center. While they sat chatting with the resident, Mrs. Schmidt looked at the visitors and called out, "Take me out, you son of a bitch." Sylvia went over to Mrs. Schmidt and said, "shhh, shhh, shhh," putting her arm around her. Sylvia added, "Those are nice people. Say they are nice people. Say, 'Lookin' good!'" (AFN)

Like Rudolpho, Sylvia was helping Mrs. Schmidt to respect a cultural taboo, and attempted to protect Mrs. Schmidt's image in the eyes of the visitors by enforcing the taboo. At the same time, she showed her acceptance of Mrs. Schmidt by her gesture of physical affection.

Sylvia's behavior contrasted markedly with that of another aide who took care of Mrs. Schmidt:

While waiting for her lunch, Mrs. Schmidt called out, "Come on, you son of a bitch." The aide sighed and then mocked Mrs. Schmidt, repeating, "you son of a bitch." (AFN)

The aide's response, born of frustration and boredom, did nothing to restrict or redirect Mrs. Schmidt's behavior.

The importance of maintaining a cultural taboo was discussed by Kayser-Jones (1990a), who described a nursing home she studied where residents were permitted by staff to use their urinals in the hall:

When such actions are permitted and accepted as a matter of course, they degrade and dehumanize those who violate the taboo as well as those who must observe the behavior, for the person violating the taboo obviously is no longer considered part of the social system (pp. 47–48).

In the exemplary cases cited above, Rudolpho and Sylvia strove to keep residents from violating social taboos, using skillful techniques based on their intimate knowledge of the individuals. Nursing homes would be far better places if the supervisory staff and all the aides could learn and use what some of the more creative, insightful, and compassionate aides know. In the next chapter, I will address this subject, and I will also consider some possible structural amendments to allow long-term care institutions to provide a more humane and supportive environment for residents' meals.

CHAPTER 8:

LIMITATIONS AND IMPLICATIONS

This chapter addresses the limitations of the study, discusses implications for nursing, and offers suggestions for further research.

Limitations

Three factors limit the findings of this study: the single-site design, the cross-sectional nature of the focused observation stage, and the rudimentary character of the quantitative observational instruments.

First, the single-site design threatens the generalizability of the findings. However, as noted in Chapter 3, the facility chosen for this study is typical of American nursing homes in many important respects: it is a medium-size, for-profit facility with a population that represents a typical range of age span and disability (Estes, Swan, et al., 1993).

Second, the focused observation phase of the study was confined to a cross-sectional examination of mealtime interactions involving ten subjects, each over the relatively short period of two weeks. The study did not address how caregiver-resident relationships develop over a prolonged period or what factors may affect that process. Nor did the study trace the natural history of eating problems: how they began and evolved over time. The study *did* identify and describe commonly used patterns of interaction and strategies of feeding. The design of the study allowed comparisons of different caregivers' interactions with the same residents. These comparisons illuminated the effects of different styles of

interaction and strategies of feeding.

Third, the quantitative observational instruments used in the study need further development. As indicated in Chapter 6, the quantitative results did not show the expected positive correlation between caregivers' beneficent behaviors and residents' food consumption. The quantitative data did show the expected positive trend with relation to residents' mood states, but the sample size was not large enough to report statistical significance. Yet, the observational checklist did permit quantification of some behaviors identified as important in the mealtime interactions and confirmed impressions I gained in the period of general observation. For example, my impression that the caregivers often began the meal without greeting or talking to the residents in their charge was confirmed by quantitative data that showed that such exchanges were absent in 37 percent of the meals observed.

Implications for Nursing

Training Aides

The standards of training for nursing home aides have greatly improved in the last decade. California now requires six weeks of training for certification of aides. This training includes classroom and clinical components. Aides must also pass a written state certification exam.

The training for the work of feeding currently focuses on critical safety issues. Aides must know how to position and feed a person properly to avoid aspiration or choking. Furthermore, they must know what to do should these adverse events occur.

Data presented in this study, however, suggest that in training aides,

instructors should place greater emphasis on psychosocial issues. Aides need to understand the importance of mealtimes for nursing home residents as periods for refreshment, relaxation, and renewal of social ties. Aides can recognize the functions of mealtimes in their own lives and can learn to empathize with the experience of nursing home residents. Recently, when conducting an in-service on the topic of feeding, I asked aides to take a few minutes to write about an off-duty meal they had recently enjoyed. Then I recruited two volunteers to read aloud what they had written. One aide described a family gathering, telling the group about the food and the conversation she and her relatives had shared, and conveying her feelings of happiness about the event. The other described lunch with a colleague in the hospital cafeteria, telling us how the mealtime served as a setting in which she could share the frustrations and joys of her day. When asked to examine their own lives, people see the significance of mealtimes, recognizing how meals enrich their lives, nourishing body and soul. Understanding the role of mealtimes in our own lives can enhance our empathy and our desire to provide the best possible experience for nursing home residents.

Mealtimes in nursing homes provide an excellent setting for teaching aides about the importance of non-verbal communication. As this study has shown, residents who need help with eating often communicate chiefly through non-verbal means. Educators and supervisory staff can help aides to become sensitive to subtle cues and signals from residents and can assist aides in interpreting and responding to residents' patterns of behavior. Educators and supervisory staff can also stress the impact of non-verbal communication on residents, explaining how powerfully touch, facial expression, and tone of voice affect residents.

Nursing leadership can also assist aides in choosing and evaluating feeding

techniques and can validate strategies that aides discover in their work. During the study, I witnessed the ADON do exactly this. Mrs. Iannotta had been eating poorly for several weeks and began to lose weight. Mrs. Iannotta was assigned to the restorative eating program in the living center. However, even after she was there for a few weeks, her intake still remained inadequate. Some aides had noticed that she liked breakfast foods and generally ate well at that meal. They communicated this information to the ADON, who decided to have the kitchen send breakfast foods at lunchtime. This strategy worked. With the aides' encouragement, Mrs. Iannotta began to eat better and to gain weight.

Using Caregiver Knowledge

Caregivers hold a great store of detailed personal knowledge about the people they help. In the nursing home setting, this knowledge resides primarily with the aides. This study has shown the range, complexity, and effectiveness of this knowledge. The most skilled and sensitive aides learn what foods the residents like, how they like them served and in what order, and what feeding techniques work best. These aides have assigned interpretations to the subtle cues in the residents' non-verbal behavior. Some of this rich store of knowledge is conveyed to other aides and staff, but much of it never gets passed on.

Care plans are typically written in general terms. A resident who eats poorly may have on his or her care plan "Encourage intake." Such a comment represents an important overall goal, but how can we encourage a resident like Violet Iannotta to eat more? Marcia Gomez could tell us. Marcia might begin by saying that Mrs. Iannotta likes to be called "Violet," not "Mrs. Iannotta." She would add that Mrs. Iannotta is sociable and likes company when she eats: an aide should sit down and

chat with her a little. Marcia would know that Mrs. Iannotta always eats her soup, even when she won't eat much else. She would also know that Mrs. Iannotta always eats all of her breakfast, so it is important for her to get what she likes and as much of it as she wants at that meal.

Or what about Mrs. Hyde, who often pushes her caregiver's hand away? Esther Hawkings, as we have seen, could tell us that if you put a glass in Mrs. Hyde's hand, she will drink from it herself, and then she won't push the caregiver's hand away when food is offered. Cara Lozada would add that Mrs. Hyde has a preference for sweets and ice cream, and would show us that a tiny bit of ice cream on the tip of the spoon will entice Mrs. Hyde to take a bite of meat or vegetables.

This kind of knowledge is critical to individualizing care and may mean the difference between a meal that is eaten and one that is left aside. But as the study showed, no formal system for recognition of this kind of knowledge exists. Although sometimes passed informally from one aide to another in a setting such as the dining room, it often goes unacknowledged. Central City deserves credit for including the aides in the care-planning conferences. In these sessions, aides are invited to give their input, and do in fact sometimes reveal this kind of information. However, busy with many duties, aides do not always attend the meetings, so their input is lost. Moreover, the care plans generated are written with an eye to satisfying the state regulators, rather than providing caregivers with the individualized knowledge that really makes a difference to care.

Formal recognition of the aides' knowledge might speed its dissemination and improve care. A forum held weekly or monthly could serve as a channel for the expression of such knowledge. Having the aides lead and direct the forum might

restore a sense of power and worth and give them a stake in the outcome of their work. Supervisory staff could attend the forum regularly, with a commitment to listen carefully to the aides and learn from them. Nursing leadership could also help in facilitating the transfer of knowledge from one aide to another and from one shift to another.

Supervisory staff might also help to resolve aides' differences in opinion about the care of certain residents. Recall the example of Mrs. Marshall. One of her aides thought she ate best with her dentures in place, and another thought she did better without them. The DON might set up an experiment to have Mrs. Marshall eat with her dentures for three days and then without them for another three days. The amounts she consumed in each period could be compared and thus could resolve the question of what worked best for Mrs. Marshall.¹

The attitude of Central City's leadership in conducting such an experiment would be crucial to its success. Such an experiment would not be conducted as a contest to see who was right and who was wrong. Rather, the leadership would welcome such an experiment as a chance to try different care approaches and to see what worked best for the resident.

A written record of the conclusions of the aides' forums could provide an important vehicle of communication. Perhaps a 4-inch by 6-inch index card that listed residents' personal preferences and successful care strategies devised by aides would be helpful. Such cards could be kept in plastic slip covers and carried by aides as they do their work. A copy of each resident's card could be posted at the bedside. It might have several sections relating to various aspects of care, such as

¹I am indebted for this idea to Jeanie Kayser-Jones, RN, Ph.D., Department of Physiological Nursing, University of California, San Francisco.

eating, hygiene, toileting, and recreational activities. Keeping the information in pencil would make it easy to update.

Tapping Family Knowledge

As is typical of nursing home residents, half of the subjects in this study do not have relatives or friends of any kind. However, for those residents who do have them, families and friends can be an excellent source of information. They can report lifelong habits and food preferences and can convey what they have learned through their own experience of caregiving. Supervisory staff should tap this knowledge both at admission and throughout each person's stay. Aides should be encouraged to seek out this information in their encounters with residents' family members and friends and to report what they learn to the rest of the staff. Aides and other staff should also be encouraged to make families and friends feel welcome in the home. Although, at present, the administrator, the ADON, and the DON make an effort to be outgoing to visitors, this attitude has only unevenly trickled down to the nurses and aides.

Recommended Organizational Changes for Central City (and Beyond)

The nursing leadership in institutions like Central City must acknowledge the importance of mealtime interactions and recognize that it takes time for a caregiver to feed a resident. A minimum of twenty minutes should be allowed for feeding each person. Ideally, one aide should not be assigned more than three people who need to be fed. Expecting an aide to feed six or eight people in an hour and a half, as well as serve eight others, is expecting too much. Residents will inevitably receive inadequate attention and may even consume less food than they

might in a lengthier encounter. Cultivating a team atmosphere, in which all the staff work together to ensure that all residents get the maximum possible amount of staff time and attention, might help to distribute work more evenly and improve care.

As much as possible, nursing leadership should respect established caregiver-resident bonds in making assignments. Supervisors should be alert to relationships that seem especially positive and should reward and support caregivers' efforts. This is easily done when the relationship is a particularly warm one and the resident is likable and pleasant. But caregivers should also be recognized for their skillful work with difficult or unlovable residents. Mrs. Bing's habit of spitting, her dementia, her poor command of English, and her frequent episodes of yelling isolated her from the staff. Yet, Rudolpho Torres worked hard to make contact with her and tried to discourage her spitting. His efforts showed persistence and care for this old woman whom no one else seemed to like. Yet, in my presence at least, no staff member ever acknowledged or praised his efforts in working with this challenging resident.

Arranging for maximal use of congregate settings for meals would be another important change at this and most other nursing homes. As this study suggests, congregate mealtimes have certain advantages, allowing staff to give residents more time with their meals and facilitating slower pacing. While some residents prefer to eat alone, others could clearly benefit from congregate experiences at breakfast and dinner. The significant difference in the sizes of the evening and daytime staffs precludes keeping the majority of residents out of bed for dinner. If shift hours were changed or a special short shift were added, it might be possible to make this option available to more residents. In my own experience as an undergraduate nursing student, I obtained part of my clinical practicum at a

nursing home that had a special shift from 5:00 P.M. to 8:00 P.M. Nursing students, who were encouraged to apply for part-time jobs on this shift, helped to feed the residents and get them to bed after dinner. This allowed more residents to stay up for this meal, keeping them more active and socially engaged.

Recommendations for Future Research

This study has raised a number of issues for further research. First, establishing the natural history of eating problems and eating disabilities of residents in nursing homes is a priority. Such research is currently under way (Kayser-Jones, 1993–97). Future research should generate an understanding of how eating difficulties develop, how they are managed, and how residents fare under this management. Such research could also examine how caregivers support or fail to support self-feeding, a subject only briefly touched on here.

Second, a study of the caregiver-resident interaction over a longer period than considered here could examine how the relationship between caregivers and residents develops and changes over time. Such a longitudinal study could also provide for further development and testing of the behavioral checklist tested here. As noted in Chapter 6, study over longer periods of time, and with a greater number of subjects, might show whether caregivers' positive interactional behaviors have an effect on the amount of food residents consume. Videotaping interactions could add depth to the description and analysis of the mealtime events, especially of non-verbal behaviors, and is a planned data-gathering strategy for Kayser-Jones's (1993–97) ongoing research. Athlin and Norberg (1987) have already used this strategy, studying a group of six caregiver-resident dyads. Now the technique is being extended to a larger sample.

Third, there is a need to develop and test educational approaches directed at increasing caregiver sensitivity and knowledge concerning mealtime interactions. I have made some suggestions here about what content might be included in such a curriculum.

Fourth, research could establish the effectiveness of the organizational changes suggested here—in particular, how supervisory use of aides' detailed personal knowledge of residents might improve care. Research could determine if organizational changes resulted in improved nutritional status and quality of life for residents and/or improved job satisfaction for nursing home aides.

Finally, research could examine the economic and human consequences of improved mealtime experiences. If residents eat better when their psychosocial needs are met, they may have fewer complications and hospitalizations and live longer. The economic costs of employing more staff (some part-time or short-shifted) so as to increase caregiver-resident interaction may pay off in better health for the residents, thereby reducing such expenses to the nursing home as tube feedings, nutritional supplements, and the costs of medical complications resulting from poor nutrition.

M. F. K. Fisher (1976), a gourmet whose books about food enchanted the poet W. H. Auden, wrote:

It seems to me that our three basic needs, for food and security and love, are so mixed and mingled and intertwined that we cannot straightly think of one without the others. (p. 353)

We owe it to our elderly nursing home residents to provide the best mealtime experience possible. And we owe it ourselves, too—for one day, we may sit where they do.

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Appendix A: Mealtime Observational Checklist

Ellen Schell, RN, M.S.

Subject no.____ Obs. no.____ Caregiver #1__ #2__ #3__
Time tray delivered____ Meal began____ Meal ended____
Date____ Meal____ Setting____ % Consumed____
Menu_____

OBSERVED INTERACTIONAL BEHAVIOR OF CAREGIVER

(*Scoring:* All "no" answers are scored 0. All "yes" answers are scored +1 except asterisked items, which are scored -1. Total scores can range from -7 to 22.)

	<i>Yes</i>	<i>No</i>
<i>Approach to Resident:</i>		
Greeted resident by name?	___	___
Used affective greeting?	___	___
Used instrumental greeting?	___	___
Positioned resident properly before meal?	___	___
<i>Verbal and Non-Verbal Communication:</i>		
Used affective touch?	___	___
Used instrumental touch?	___	___
Used affective conversation during meal?	___	___
Used instrumental conversation during meal?	___	___
Offered to get or got something not on tray?	___	___
*Threatened resident?	___	___
*Carried on conversations with others without including resident?	___	___
Made eye contact with resident at least twice during the meal?	___	___
Smiled at resident during the meal?	___	___
Gave verbal encouragement for eating?	___	___
Encouraged resident to feed self?	___	___

Timing:

*Fed resident in a hurried manner or acted impatient?	___	___
*Told resident to hurry?	___	___
Sat down to feed resident?	___	___

Concerning the Food:

Told resident what food was on the spoon or fork?	___	___
Asked resident's preference for order of food?	___	___
*Mixed foods together?	___	___
Wiped chin and corners of mouth as necessary?	___	___
Kept tray neat during the meal?	___	___

Use of Implements:***Normal adult implements used:***

Spoon used to put food in mouth?	___	___
Fork used to put food in mouth?	___	___
Cup used to give fluids?	___	___
Napkins used to wipe mouth?	___	___

Infantilizing implements used:

*Bib used?	___	___
*Spoon used as chin scraper?	___	___

Appendix B: Mood Scale

(Clark & Bowling, 1989)

Date_____ Time_____

Happiness:

1 2 3 4 5

Contentment:

1 2 3 4 5

Interest:

1 2 3 4 5

Neutrality:

1 2 3 4 5

Discontentment:

1 2 3 4 5

Unhappiness:

1 2 3 4 5

Distress:

1 2 3 4 5

Aggression:

1 2 3 4 5

For reference

Not to be taken
from the room.

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3 1378 00630 0225

