DINING PRACTICES FOR RESIDENTS WITH DEMENTIA:
Case Studies of Four European Nursing Homes

November 2012

Based on site visits conducted by
International Association of Homes and Services for the Ageing

With support from
Sodexo Institute for Quality of Daily Life

Sodexo Institute for Quality of Daily Life

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Michel Landel, Chief Executive Officer.

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DINING PRACTICES FOR RESIDENTS WITH DEMENTIA:
CASE STUDIES OF FOUR EUROPEAN NURSING HOMES

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IAHSA was founded in 1994 by an international group of leaders who realized that the global ageing crisis would have a profound impact on our earth’s elders.

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For more information, please visit LeadingAge.org/research
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**INTRODUCTION**

During November 2012, the International Association of Homes and Services for the Ageing (IAHSA) and LeadingAge collaborated on a project to examine how four European nursing homes took steps to improve the dining and nutritional experience of residents with dementia.

Sodexo Institute for Quality of Daily Life, a research partner of IAHSA, funded the project.

Researchers made a one-day site visit to each nursing home. During each site visit, the research team interviewed a mix of nursing home staff, which varied depending on the site. During the course of all their site visits, researchers interviewed care aides, nurses, dietary staff, medical directors, administrators, directors of nursing, physical therapists and occupational therapists. Researchers also met with residents, volunteers and family members.

The four nursing homes participating in the study included the following:

- **Sint Vincentius in Meulebeke, Belgium** is one of eight autonomous residential care centers that are members of the Residential Care Group (GVO). The Congregation Sisters of the Faith created GVO in December 1994 to promote its values of solidarity, respect for the person, reciprocity and hospitality. Sint Vicentius consists of 96 rooms for permanent residents, 40 to 50 of whom have dementia. The center also has 10 short-stay rooms.

- **De Wingerd in Leuven, Belgium** serves 137 residents with dementia. In 2009, De Wingerd created 11 small-scale housing units to promote its philosophy of person-centered care. Eight of those units house eight clients each; three additional units house 15 clients each. In addition, the center provides nine flats for couples. In most cases, one partner in each couple has dementia and the other partner assists in caring for that individual.

- **Emile Gerard in Livry-Gargan, France** is a large, public, nursing home accommodating 240 residents. The home’s Protective Life Unit, designated for residents with advanced stages of dementia and behavioral challenges, has 39 beds and currently houses 38 residents. The unit always leaves one bed empty for emergencies. Emile Gerard has a full-time medical director.

- **Opera Pia A.E. Cerino Zejna in Biella, Italy** was founded in 1920 and has specialized in assisting people with dementia since 1996. There are 155 residents living at the home, including 20 who participate in the center’s adult day program and 20 who reside in a controlled Alzheimer’s unit. The center offers activities and specialized rooms to help trigger residents’ memories, calm agitated residents and offer sensory stimulation.
Organization of this Report

Case studies: This report includes in-depth case studies of the dining programs offered to residents with dementia at each of the four nursing homes that researchers visited. These case studies, which begin on page 12, are intended to help IAHSA and LeadingAge members learn about important elements that could be included in a dining program for residents with dementia. Each case study describes the particular nursing home, its approach to dining services, and the practices it uses to improve the dining experience and nutrition of residents. In particular, each case study explores the:

- Development of the dining program
- Nutrition and meals
- Presentation of food
- Scope of assistance provided to residents
- Staff training related to the dining experience
- Monitoring of residents and supervision of staff during meals
- The perceived challenges and benefits of the programs

The case studies are current as of the date the visits were conducted. It is possible that organization and/or program components and characteristics may have changed in the interim. The authors of this report take full responsibility for the accuracy of the information contained here. Each site had an opportunity to review the information contained in this report and to correct any inaccuracies.

Supplemental Information: In addition to presenting case studies of the dining programs at four nursing homes, this document:

- Provides an overview of the policies and systems governing the delivery and financing of long-term care (referred to in this report as “long-term services and supports”) in France, Belgium and Italy
- Identifies major themes in dining practices for residents with dementia. Researchers identified these themes after synthesizing the information they collected from all four nursing homes
Delivery and Financing of Long-Term Services and Supports

Belgium, France and Italy have different structures for their systems of long-term services and supports (LTSS). This section of our report provides an overview of LTSS environments and financing in each country. Please note that none of the nursing homes visited by researchers identified laws or regulations that either hindered or provided incentives for their dining programs.

Belgium¹,²

Belgium is a federal state composed of communities and regions. Different levels of government—community, region and federal state—share and divide the responsibilities for long-term services and supports.

The emphasis of the care for the elderly, ambulatory or residential lies with the communities. They are responsible for the legislation, programming, license and inspection of the LTSS.

LTSS costs are typically divided between care costs and accommodation costs. Care costs are covered by the State: National Institute for Health and Disability (INAMI/RIZIV), a public social security agency that manages and supervises Belgium’s compulsory health care and benefits insurance. The funding that care settings receive from the INAMI/RIZIV varies according the profile of residents in each respective care setting.

The building or construction of nursing and rest homes is partly financed by the regions.

All care is subject to a personal contribution. The recipients of care generally pay accommodation costs, which include board, basic assistance and lodging. These costs average 1,450 Euros per month.

For some services at home (e.g., cleaning, light household work, ironing, laundry, etc.), Belgium created a service-voucher system which makes home care affordable (8.5 Euros per hour) for the consumer. The state compensates around 15 Euros per hour to the service voucher company to make labor costs affordable.

About 17 percent of Belgium’s population is aged 65 or older. This figure is higher than the country average (15%) identified by the Organization for Economic Cooperation and Development (OECD). In 2007, 6.6 percent of Belgians over the age of 65 received LTSS in a formal care environment, compared to the OECD country average, which is four percent. The need for long-term services and supports in Belgium is viewed as a health risk and the LTSS system reflects a “medical model” of care delivery.

² Sodexo Belgium
In 2008, Belgium’s LTSS expenditures were equivalent to about two percent of the country’s Gross National Product (GDP). A lower percentage (1.7%) of GDP was attributed to care provided in a formal care setting.

Belgium’s public health insurance system provides comprehensive universal coverage for all costs associated with acquiring assistance with daily activities in a wide range of different care and housing entities.

The view on care for elderly in Belgium originates in the idea that older people need to function as normally as possible for as long as possible. This means living at home and staying independent as long as possible. Therefore, the government’s view is based on two main principles: living in a normalized (home) environment and tailor-made care.

The authorities view care and housing characteristics as uncoupled. The need for care is detached from the need for housing. This means that the care, if possible, has to reach the older person irrespective of their housing circumstances. Ideally the care provided isn't automatically linked to a certain housing configuration. Elderly desire to preserve their standard and comfort of living and their autonomy to decide for themselves and this is independent of their needs for care.

Belgium distinguishes a path for care and a path for housing, as shown on the two axes in the graph below, existing independently except (for the time being) for the residential setting.

Apart from the residential homes, nursing homes should also be taken into account. Nursing home beds are to be used by residents who are highly care dependent and whose condition requires intensive long-term care. However, nursing home beds can also occur in residential homes. Theoretically, a nursing home bed is “residential home bed certified as a nursing home bed.”
To better meet the needs of the elderly, to relieve stress on home care services and in harmony with the view mentioned earlier, the government introduced day care centers, short-term care centers and service flat complexes (elderly individuals without major health conditions live in independent units but are offered a broad range of services, for example, meals, house cleaning, primary care at home, etc.).

**France**

France is a unitary state that is divided into administration regions. In 2011, about 16.9 percent of France's population was 65 years or older. In 2007, about 6.7 percent of elderly over the age of 65 received long-term services and supports in a formal care setting.

France's public health insurance system and its Personal Autonomy Allowance (APA) primarily support the provision of long-term services and supports, either in the home or in a formal care setting. France considers support for activities of daily living (ADL) and instrumental activities of daily living (IADL) to be a social risk. The public health insurance system plays a major role in financing ADL-related support services.

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The public health insurance system covers health services provided to an individual who requires long-term services and supports due to a chronic or acute medical condition, including services provided in a nursing home. This system fully covers prescribed nursing home care. In 2008, France's total LTSS expenditures were equivalent to about 1.8 percent of GDP, compared to the OECD average of 1.5 percent. More than 70 percent of LTSS expenditures are targeted to care in hospitals, nursing homes and residential care homes.

Approximately 57 percent of French care homes are publically financed; 27 percent are private, not-for-profit homes, and 16 percent are private, for-profit homes. Costs for nursing and residential care homes are split between the health cost, the dependence cost and housing cost. Residents are responsible for the housing cost, but can receive public assistance to cover this cost if they cannot afford to pay it.

Italy

Italy's system for the delivery of long-term services and supports is characterized by significant fragmentation. The country has many regional LTSS systems, rather than one national system. Local and regional authorities share responsibility for funding, governing and managing the LTSS system, and varying principles govern particular models in each region. For example, municipalities, local health authorities (ASL), nursing homes and the National Institute of Social Security (INPS) directly determine the LTSS system's organization. Other entities, such as the central state, regions and provinces, are involved in planning and funding services. Both public and accredited private providers of health and personal social care deliver long-term services and supports.

Italy is one of the oldest countries in the OECD. About 20.4 percent of the Italian population is 65 years or older. In 2008, there were six LTSS recipients per 1,000 people living in formal care settings. This figure is below the OECD country average. Italy’s public LTSS expenditures, currently estimated at 1.7 percent of GDP, could reach nearly four percent of GDP by 2050.

The Italian health system (SSN), the regions/municipalities, the INPS, and care recipients fund the delivery of long-term services and supports. Municipalities fund LTSS that are delivered in formal care settings. Beneficiaries are charged a co-payment that is based on a means test. Co-payments may be required from both LTSS recipients and their relatives.

A variety of benefits are available to Italian LTSS recipients:

- The INPS provides a national disability cash benefit that carries no requirements or restrictions on how the recipient purchases long-term services and supports. Beneficiaries receive this

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benefit every month if they demonstrate that they are 100-percent disabled, not self-sufficient, and not residing in a formal care setting. Costs are charged to the public administration.

- ASL and local authorities provide means-tested care benefits and do not restrict their use. Only a small percentage of Italians over the age of 65 (less than 2%) receive this benefit. The monthly amount of this benefit varies from 240 Euros to 515 Euros, depending on the region.

- The Italian health system provides in-kind health services—including residential and semi-residential services—to the elderly and individuals with disabilities. Social care services are provided at the local level. These services include in-kind interventions managed by municipalities, home-based services and supports, and services provided in formal care settings. Similar to the cash benefits, the eligibility criteria for these regional and local care services are quite heterogeneous. The eligibility criteria may be set at the local level or fixed by the regions. Sometimes they may be mixed.

### Themes across Programs

#### Providing Person-Centered Care

Generally, all of the nursing homes in the study strived to provide person-centered care in their dining programs. Person-centered care typically represented an overarching philosophy that the nursing homes incorporated into all of their interactions with and activities for residents. In carrying out this person-centered philosophy in the dining room, the homes aimed to individualize assistance to each resident and customize the preparation of meals.

Three of the four nursing homes provided services and supports within traditional nursing home settings. This presented challenges in operationalizing person-centered care practices. In addition, nursing homes in the study also experienced staffing challenges because person-centered care models are more time-intensive than traditional care delivery models.

#### Creating Independence

Nursing home staff strived to prevent learned dependency among residents. They created as many opportunities as possible for residents to exercise their independence. In designing customized dining strategies for each resident, the nursing homes used the least restrictive approach required by the individuals. The strategies employed depended on the resident's stage of dementia and the help that particular resident needed.

The initial assistance provided to residents with dementia during mealtime typically involved verbal cues or reminders. Assistance later progressed to incorporate these strategies:
• **Modeling:** Staff initiated the process of eating in order to trigger the resident’s memories of common gestures associated with eating.

• **Making associations between the food and its purpose:** Staff talked with residents during meals about the food they were eating, its color and taste. Staff used this method to trigger a resident’s drive to eat the meal.

• **Hand-over-hand guiding:** This technique helped to restore the repetitive motion involved in self-feeding.

• **Mixed seating:** Independent eaters and residents who needed assistance often sat together. This allowed the dependent eaters to imitate the eating gestures and model the actions of independent eaters. Several of the nursing homes employed this strategy.

• **Contrasting colors:** Using tableware with contrasting colors helped residents with impaired depth perception to better distinguish the food from the dinnerware.

• **Adaptive equipment:** Specially designed utensils, glasses and cups allowed residents to eat or drink on their own.

• **Finger foods:** Providing foods that residents could hold in their hands helped individuals maintain their ability to eat. Two nursing homes implemented this practice.

• **Exercising flexibility:** None of the nursing centers forced residents to eat any portion of their food or their entire meal. Instead, these homes implemented creative strategies to incentivize residents to eat. They also provided residents with the time they needed to finish the meal. Residents who would not eat during mealtime were approached at a later time and offered an additional opportunity to eat.

• **Feeding:** As a last resort, staff fed residents who needed 100-percent assistance.

### Providing a Normal Dining Experience

Each nursing home strived to make the eating process as normal as possible for each resident. For this reason, staff members initially tried to make only discreet adjustments to help residents eat their meals. They gave all residents food from the regular menu and only modified food to address an individual’s specific issues.

For example, nursing homes did not puree all foods served to residents who had difficulty with swallowing and chewing. Instead, they only pureed those foods that presented swallowing difficulties. In addition, staff accepted as normal all behaviors of the person with dementia. They did not get upset over accidents. They guided the behavior of residents with dementia without drawing attention to it.
Part of the normalization process also entailed a concerted effort to limit the use of supplements. While supplements were used when necessary, the nursing homes preferred that residents receive their nutrients from real food. Snacks were available during the day, particularly in the afternoon, to ensure that residents received sufficient calories and had the energy they needed. Staff also added extra nutrients to shakes and soups.

**Offering Mealtime Flexibility**

Some homes had flexible hours and/or offered residents choices for breakfast. However, it was difficult to offer these options during the midday meal, which is the main meal in Europe. In addition, organizational issues stood in the way of efforts to individualize meals or allow residents to choose the time they would eat. Small housing units and dining areas afforded De Wingerd the greatest flexibility to let residents choose their eating time and select the foods they wanted to eat. Other nursing homes offered alternatives to residents who preferred not to eat the planned meal.

**Monitoring Residents**

The four nursing homes differed in how they monitored residents. Several of the homes monitored residents only when problems arose. They then observed the person's food and fluid intake and worked with a team to diagnose the problem and find a solution. One home monitored and observed the food and fluid intake of all residents. For the most part, the decision to monitor a resident was based on observations from the care staff and staff's knowledge of the person. It did not appear that the staff used a standard protocol for food calculation.

**Forming Multidisciplinary Teams and Engaging Staff**

Nursing homes used a team approach to assisting and working with residents, identifying the needs of residents, and finding solutions for residents who had problems eating. Membership of the teams extended beyond the home's nurses and care aides and included the occupational and physical therapist, medical director, dietary staff, and/or housekeeping staff.

Nursing homes also established committees and workgroups that offered a broad range of staff members the opportunity to share their perspectives on the dining program and to provide their input into ways that program could be improved for individual residents. Generally, program-related decisions were based on feedback from multiple perspectives and were not made in isolation.

Nursing homes encouraged aides to develop personal relationships with each resident. In this way, staff could determine more easily when it was necessary to modify a resident's dining experience or to encourage residents to change their eating habits.
Emile Gerard in France has a full-time medical director who initiated the development of a nutrition program. The medical director's goal was to address the problem of malnutrition among residents and to raise awareness among staff about the importance of proper nutrition.

**Tapping Nontraditional Workers**

Nursing homes did not always have enough staff to provide the individualized assistance that residents with dementia required. To address this issue, these homes typically engaged outside help. At De Wingerd, for example, volunteers played a major role in heating and serving meals and assisting residents who could not feed themselves. Volunteers also helped to serve food and assist residents at two other nursing homes. Two nursing homes enlisted the help of their housekeeping staff to assist during meals.

**Training Staff**

Most of the homes did not have a specific program to teach new employees how to assist residents with dementia during meals. Instead, homes operated under the assumption that staff members had received adequate training in this area during their professional training. Many homes offered training throughout the year for all staff. Some of that training addressed nutrition and feeding techniques.

**Addressing Challenges**

Nursing homes in the study experienced many of the same challenges facing all organizations that implement new programs. They found, for example, that it takes time to implement a new dining program and change the mindset of staff. In order to gain staff buy-in, the homes solicited staff ideas regarding the elements of the program and educated staff about the new concepts.

**Identifying Program Benefits**

Staff members, residents and family members identified many perceived benefits that they attributed to the dining programs. These perceived benefits included improved quality of life, more choice, better behaviors and increased satisfaction among residents. In addition, staff noted that residents appeared to have achieved improved clinical outcomes as a result of their improved nutrition.

Staff members appeared to benefit from their increased awareness of the nutritional needs of residents and from their practical knowledge of dining techniques that could help meet those needs. These techniques helped to improve residents’ eating habits by encouraging and incentivizing residents to eat. The dining programs also offered staff from non-nursing departments at some of the homes an opportunity to engage with and have personal interaction with residents.
SINT VINCENTIUS MEULEBEKE
MEULEBEKE, BELGIUM

Overview

Sint Vincentius Meulebeke (Sint Vincentius) is one of eight autonomous residential care centers that are members of the West Flanders-based Residential Care Group (GVO). The Congregation Sisters of the Faith created GVO in December 1994 to promote its values of solidarity, respect for the person, reciprocity and hospitality. Each GVO center is an autonomous entity.

Sint Vincentius consists of 96 rooms for permanent residents, 40 to 50 of whom have dementia. The center also has 10 short-stay rooms. The nursing home has four floors and each floor has 24 residents. The home’s third floor is a secured area housing people with dementia who wander. Residents who have dementia but who do not wander reside on the center’s other floors. Each floor has its own dining room.

The nursing center has a day room called “the porch” because it is enclosed by glass. The nursing home plans to build small home living environments in the next five years.

Sint Vincentius seeks to create a homelike living environment that offers meaningful activities for residents. The center takes an integrated approach to ensuring that this philosophy is evident in all the center’s programs.

Each unit has a multidisciplinary team that provides care for residents with dementia. One of the team’s responsibilities is feeding the residents. The team includes:

- A team coordinator
- Nurses
- An occupational therapist
- A physiotherapist
- Care aides

The team coordinator is responsible for coaching members of the team, developing each resident’s care plan, and assisting family members who have concerns or questions. The team coordinator works directly with 10 to 14 care aides across all shifts.

The principles of dementia-friendly care are ingrained in staff members’ everyday actions. For example, staff members are encouraged to use a soft tone of voice when talking with residents. The design of the physical environment is meant to be healing and to promote wellbeing and good eating habits among resi-
dents with dementia. Sint Vincentius uses smell, color, sound and structure to limit sensory stimuli that might trouble residents with dementia. For example, a color psychologist recommended painting the walls blue to help residents rest.

The dining program is one of several programs designed to support residents in various stages of dementia. Sint Vincentius also has a Dementia Center that provides information and advice to people in the community.

**Program Structure**

Sint Vincentius launched its new dining program in 2009-2010. The center’s director was the driving force behind the organization’s reexamination of its former dining practices. The director’s vision for the new program was based on her belief in the importance of providing residents with independence, choices and quality nutrition. Program design was informed by the director’s experience working in nursing homes, her examination of best practices, and input from staff.

The goal of the dining program aligns with Sint Vincentius’ philosophy to treat residents with dignity and maintain individuality and independence. The program aims to:

- Create as normal a meal as possible for residents
- Maximize independence to preserve residents’ self-esteem
- Create a family atmosphere where residents eat together and have some choices as to when they eat and what they eat (Currently, due to organizational issues, this aspect of the program is only possible during breakfast.)

**Partnership with Mensa and Sodexo**

Sint Vincentius offers three daily meals for residents. Breakfast and the evening meal are prepared by Sint Vincentius staff at the nursing home. The midday meal is provided by Mensa, which is managed by Sodexo.

Mensa works with all eight GVO living centers to prepare meals for residents. Mensa is responsible for meal production and distribution and quality control in the GVO nursing homes. Mensa sources quality food and conducts testing to determine which meals are most appropriate for residents. Mensa carries out this work with a team of chefs and kitchen staff. A production manager who works closely with the Sodexo management team supervises this staff.

Mensa and Sodexo work together to develop all the menus. Mensa personnel meet with center staff once every three months to solicit input on those menus.
Mensa prepares meals for the GVO centers at a central kitchen. It monitors the nutritional content of the food and, as directed, can customize meals to meet the individual needs of residents. After cooking is complete, Mensa chills the food and distributes it in bulk to each nursing home.

Sint Vincentius’ kitchen staff portions out food when it arrives from Mensa. This takes place in the center’s kitchen. Food is then reheated in ovens. All food modifications, including mixing, blending and pureeing (mashing, grinding or chopping food) take place at the center.

The nursing home staff is trained to follow standards and procedures for reheating food, with an emphasis on food safety. Meals or meal components that are not suitable for reheating are prepared at the nursing home. A designated leader in the center’s kitchen has a direct line to Mensa to facilitate discussions about the food’s taste, smell and quantity.

**Nutrition and Dining Committees**

Sint Vincentius has a Menu Commission and workgroups that provide a forum for discussing meal-related issues and making improvements to the dining program. These groups also provide a mechanism for educating staff about dining techniques and nutrition.

**Menu Commission:** The Menu Commission consists of six care aides (two from each floor), the nurse supervisor and occupational therapist, a representative of management, the team coordinator, and two members of the kitchen staff. The group discusses such topics as:

- The residents and their eating habits, including whether residents have too little or too much food
- Resident experiences related to food, including whether a resident is eating the food or is having any trouble swallowing or chewing the food
- Suggested improvements to the dining experience, such as using different color plates
- Preparations of food items for specific residents
- Suggestions for changes in how food is distributed from the kitchen

The committee meets quarterly. However, members will come together more frequently if issues arise that must be addressed immediately.

**ACT in PAS Workgroup:** The center’s workgroup, ACT in PAS, meets monthly. One of the focuses of the workgroup is nutrition and diet. The occupational therapist leads the workgroup, which includes care staff from each unit team, maintenance staff and the chef. The workgroup has standing agenda items that relate to resident care and dining. Workgroup meetings provide an opportunity for the occupational therapist to train care staff and nurses on how to position residents during feeding, assist residents during meals, and
adjust dinnerware to help residents eat. This group has held discussions about the equipment necessary to help residents eat independently and the possibility of adapting existing equipment to meet the needs of residents.

**Resident Council:** The Resident Council is an avenue for residents to voice concerns and make suggestions about a variety of topics. The center’s chef meets with the members of the Resident Council four times a year to exchange information and solicit suggestions about the dining program.

**Family members:** Family members have opportunities to express their grievances on a monthly basis. Family members told researchers that they feel that center staff pays attention to these grievances. For example, family members asked that the center change the plastic tumblers used at mealtime because they were difficult to clean. The center provided new tumblers within two days.

### Elements of Dining Practices

#### Dining Environment

Sint Vincentius tries to create a calm environment in the dining area.

**Noise:** Noise is kept at a minimum. There are no loud televisions or radios in the dining area.

**Natural light:** The dining room is lit with a combination of natural light and artificial light. Sint Vincentius will soon make changes to the lighting of the secured, third-floor dining room where residents with dementia who wander and have behavioral problems eat their meals. The new lighting system will mimic the natural light cycle, with the room kept darker in the morning, bright in the afternoon, and darker in the evening. This system will help stabilize residents’ day/night rhythms and should help minimize unrest among persons with dementia.

**Dining décor:** Residents eat together in a home-like atmosphere. Each dining room has its own décor. Room design, table design and dining practices differ from one dining room to the next, depending on the needs of the floor’s residents.

**Tableware:** Each table has a tablecloth. Placemats are given to residents who prefer them. In order to promote a healing environment, Sint Vincentius uses contrasting colors to help residents distinguish between the plate and the table or place setting. For example, the nursing home does not use white plates on white tablecloths. This color choice is designed to help residents increase their independence and caloric intake.

Sint Vincentius uses red cups because it feels the color encourages more consumption of fluids among people with dementia. Residents use glasses for their drinks if they are able. This choice is designed to keep the eating process as normal as possible. Residents who tend to drop their cups are given plastic cups.
Seating of Residents

**Eating in the dining room:** All residents were invited and encouraged to eat in the dining room, and about 90 percent of residents accept this invitation. Group meals are a social event with two important functions: they allow residents to interact with one another and they encourage residents to eat more food. During special events like birthday parties, the center tries to pair each resident who needs assistance with a staff member, volunteer or family member.

Some residents choose to eat in their own rooms. Others may eat in their rooms based on the recommendation of staff. Staff may make this recommendation because the resident has trouble concentrating in the dining room or because the resident has a negative influence on the dining room atmosphere.

One gentleman told researchers that he chooses to eat in his own room because people in the dining room watch him and that upsets him. Eating in his room also allows the resident to take his time. Another resident reported eating in her room because she does not like to hear other diners eat or to see food on their faces.

**Dining room chairs:** Sint Vincentius has special chairs that make it easier for employees to take a seat next to a resident and help him/her with the meal. The special chairs allow residents, including those who are bedridden, to sit upright and have their heads supported. The chair’s design insures that the resident can maintain continual eye contact with the care aide. This allows the care staff to follow the individual’s swallowing rate. It also ensures that staff does not talk above the head of the person.

**Table seating:** An average of 8 to 10 residents sits at each dining room table. The number and placement of residents may differ depending on the floor and on the behaviors, personalities or preferences of residents. For example, some residents may prefer to sit at a more social table while others may prefer a quiet table. Staff continuously evaluates and adjusts seating assignments in consultation with the resident if they observe that the seating arrangement is not working.

The nursing center also sits independent eaters with residents who have more advanced stages of dementia and require more assistance. An independent eater can stimulate the independence of a dependent eater. For example, a resident requiring assistance may butter his/her own bread when he/she sees an independent eater doing this. Staff members report good success with this seating arrangement.

Staff and family members had different perceptions regarding the seating of residents who are in wheelchairs. Family members expressed the belief that residents in wheelchairs were kept in the wheelchair and not provided seats at the table. Staff, however, expressed a different view. They reported that while some of the residents are kept in their wheelchairs, either at the table or away from the table, other residents who have wheelchairs are moved from the wheelchair to a chair at the table.
Meals and Meal Preparation

**Meals:** Every resident of Sint Vincentius has a personal dietary plan that specifies portion sizes. These portions are based on the assessment that the resident received when moving to the center. Food quantities are determined by the kitchen staff and are calculated individually to ensure that each resident receives the proper amount of protein and other nutrients. The center adjusts the caloric intake of residents who are inactive or who have a medical condition like diabetes.

Sint Vincentius serves three meals each day, including breakfast, a midday meal and an evening meal. As is the custom in Europe, the midday meal is the main meal of the day. This meal includes meat, vegetables and a starch. Residents are not able to choose what they will eat at this meal. However, if a resident does not like what is being served that day, alternatives are available in the freezer and can be heated and served quickly.

The center has just started offering residents the ability to choose items for breakfast and the evening meal, including breads and fillings or spreads. Members of the kitchen staff interact with residents as they explain meal options and distribute the bread and spreads.

Despite this new policy, residents interviewed during the site visit did not believe they could choose or had input into meals. These residents reported that they were required to eat what they were served. However, residents did state that if a person did not like a food item, staff would remove that item from his/her plate.

Meals are delivered to each dining room on a cart that staff brings from the kitchen. The cart contains all of the plates for a particular meal. Those plates are already filled with the food specified for each individual. Soup is the exception. Staff serves the residents this food item from a large bowl placed on each table.

**Meal modifications:** Sint Vincentius encourages residents to have a regular diet to the fullest extent possible. As dementia progresses and the capabilities of a resident declines, the nursing center will make alterations to the food—mashing it, for example—to help the resident chew and swallow. Residents who receive mashed food are eating the same food served to other residents. However, their food has a softer and more fluid consistency.

Food modification takes place in the center’s kitchen. In the past, staff mixed the vegetables, potatoes and meat portions together before mashing them. Now, staff uses a special Sodexo blender to mash each food item separately. Each mashed food item is then portioned out and served on its own plate.

Sodexo found that residents eat more food when food is mashed separately because:

- The food is more visually appealing.
- A resident can choose what he/she wants to eat.
- The resident can enjoy a separate taste experience for each food.
• The resident eats more food. When several food items are mashed together, a resident will not eat any food if he/she does not like one of the food items in the mix.

In the past, staff at Sint Vincentius mashed a resident’s bread by pouring coffee and milk over toast. In a recent change, staff members now offer residents nutrient-rich shakes as an alternative once each week. The nursing home is currently evaluating this new menu addition.

Sint Vincentius is considering the introduction of finger foods like hot dogs or grilled sandwiches (croquet monsieur) as an option for residents who are unable to use cutlery. These foods can help residents with limited strength or limited fine motor skills. A staff member who is completing his degree in dietary studies will soon begin testing and evaluating the use of finger foods.

**Snacks:** Snacks are available between meals in the tea room. Each day, residents can visit the tea room to drink coffee, tea, sparkling water, low-alcohol beer or a milkshake. They can also purchase a dessert or cake. Coffee is also available for purchase from the coffee cart.

Staff and volunteers monitor the tea room, which is equipped with a book containing a list of all residents and their pictures. A nurse will bring residents who use wheelchairs to the tea room. However, the nurse does not stay in the room during the snack time.

**Meal Times**

Different floors have different policies governing whether residents can choose when they eat. Some floors require residents to eat every meal at a set time. Residents on other floors can choose when they will eat breakfast between 7:15 to 9:30. Organizational issues prevent residents from choosing the time they will eat the midday meal. The nursing home is evaluating whether to allow residents a choice of when they eat the evening meal.

**Adaptive Equipment**

Sint Vincentius provides adaptive equipment to help residents use dinnerware. Care is taken to choose equipment that can help people be more independent without making them seem different than their peers. Adaptive equipment includes:

- Adaptive spoons for people unable to hold a knife or fork
- Dessert spoons or teaspoons for residents who bite down on utensils and could hurt themselves with a fork
- Lighter, plastic glasses that allow residents who have difficulty holding normal glasses to drink on their own
- Lids that prevent a resident with shaking hands from spilling the contents of a glass
Staff Assistance

Staffing ratios in dining rooms: Each floor has 24 residents. During the week, the ratio of staff to residents is 4 staff to 24 residents during the morning and evening meals, and 5 to 8 staff for 24 residents during the midday meal. On the weekends, only three staff persons are on duty during the midday meal. Two volunteers provide additional assistance during this meal. Four staff members are available during morning and evening meals on the weekends. This is the same number of staff that is available during the week at these meals.

As a rule, the same employees do not consistently feed the same residents. Sint Vincentius has a significant number of part-time staff members who are not at the site every day. Given this staff mix, it would be challenging for staff to assist the same residents at each meal.

Role of staff: Care aides and housekeeping/support services staff offer residents assistance during the meals, with care aides taking the lead. These workers help prepare breakfast, serve food to residents, and offer assistance to people who are no longer independent. This assistance includes feeding residents, cutting crusts off bread, and spreading chocolate on bread. Staff members from different departments also assist during mealtimes:

- **Counselor:** The counselor works with people who are showing signs of dementia or need socialization. Her role is hands-on, since these residents require constant contact with staff. Residents come to the counselor’s working area (the “veranda”) each morning to make choices for the midday meal. In addition, the counselor assists residents who cannot eat on their own during the meal.

- **Reference Dementia Consultant:** The Reference Dementia Consultant explores how services and supports could be improved or changed in all areas of dementia care, including dietary. In recommending needed changes, she considers the dining atmosphere, food presentation, the way in which food is served, and whether certain tools might help improve the dining experience of particular residents.

- **Dietary manager:** The dietary manager, in consultation with the nurse supervisor, determines the type of assistance that a resident might need, and explores alternatives for meeting the dietary needs of particular residents. The dietary manager is responsible for the processing of food and the preparation and reheating of meals. She sources high-quality food and tests these food products to determine which foods are most appropriate to serve residents.

- **Kitchen aides:** Kitchen aides are responsible for warming, blending and portioning out the food. These aides also set and clear the tables, and serve the food to residents, during the midday meal. Members of the kitchen staff are starting to have more direct contact with residents in order to listen to their wishes and ask for feedback. The only exception to this
policy is the dining room on the secured third floor. Members of the kitchen staff have little contact with residents on this floor. Instead, the nurse, care aides and occupational therapist serve the food on the third floor.

- **Nurse Supervisor:** The nurse supervisor ensures that a meal is prepared for each resident and that each resident’s meal contains the correct nutritional value and portion size. A nurse supervisor is available during breakfast and oversees staff while she is present in the dining room. However, this is not her primary responsibility. Generally, nurse supervisors and team coordinators are not present at every meal. However, they might stay in the dining room if they know there is a problem or if the center is short of staff.

- **Occupational Therapists:** Sint Vincentius recognized the critical role that occupational therapists could play in assisting residents with dementia during meals. The nursing center has expanded its number of therapists from one to three over the past three years. An occupational therapist is present in every dining room during all three meals to observe residents and to provide supervision and guidance to care staff.

- **Team Coordinator:** The team coordinator oversees the meal and quality of food, handles complaints about the meal, and addresses any staff shortages during meals.

- **Volunteers and family members:** Volunteers provide extra assistance on the weekends by serving soup and the midday meal to all residents except those who live on the third floor. Volunteers do not have specific training, but they work under the close guidance and supervision of the team members. Volunteers receive assistance and advice from the counselor and from their peers. Family members also assist residents during the meals.

**Time to assist residents:** Staff members have one hour during the midday meal to serve residents, assist during the meal, and clear the tables. Family members report that it takes approximately 30 minutes to complete the same tasks during the breakfast and evening meals.

Staff, residents and family members expressed the opinion that there is enough time for staff to help residents during the weekday meals. The time spent with each resident depends on the amount of assistance the resident requires. Staff members do not rush a resident to finish meals and will lengthen the time it takes to assist a resident if necessary.

One resident reported that if a resident has not finished eating by the time staff is ready to take dishes away, staff is willing to give that resident more time to finish the meal.

**Techniques and Strategies to Help Residents during Meals**

The care and supportive services staff provide most of the assistance offered to a resident during meals. Staff members are guided in this work by the center’s philosophy to:
• Foster independence among residents
• Keep the meal as normal as possible
• Encourage residents to eat their food

The center does not have formal protocols that care staff must follow during meals. The strategies that staff uses in the dining room are based on their experience and knowledge of the resident. Team members are educated about the organization’s basic mission to encourage independent eating. They are also encouraged to ask questions that will help determine if a resident’s needs are being met.

Staff members use different approaches to assist residents during the morning and evening meals, even though residents are eating the same types of food during both meals. This is because residents are tired in the evening and respond better at that time to different techniques.

Care staff first attempt to prompt or encourage the resident to eat. For example, the staff member offering assistance will motivate the resident by repeating certain phrases like “Come on, eat,” while putting a slice of bread in his/her hand. Only when the resident is incapable of feeding him/herself does the care staff assist and feed the resident. Staff provides the minimum amount of assistance required by the resident.

Staff members follow the tempo of the residents when helping them eat. If staff members are moving too quickly, the dining experience becomes unpleasant and inhibiting for the resident. The person may then become resistant to the meal. Slower eating helps to increase the likelihood that the resident will swallow the food. A staff member is also careful to adjust the volume of his/her voice so it is not too loud for the person who is eating.

Generally, staff uses these techniques and strategies when helping residents to eat:

• Encourage residents to eat through repetition of the eating process. For example, a staff member will sometimes put pieces of bread in the person’s hands.
• Sit in front of the residents calmly and maintain continual eye contact. This helps the resident focus on the meal. Center staff can adjust the height of the resident’s dining room chairs in order to position the resident at eye level.
• Touch the lips of a resident with a spoon so he/she will automatically open his/her mouth for eating.
• Speak with family members to find out what foods a resident likes and does not like. Staff uses this information to accommodate a resident’s needs during mealtime.
• Remove some of the food on the plate of a resident who refuses to eat, and encourage the resident to eat the reduced amount of food. Later, staff will then try to persuade the person to eat the food that was removed from the plate.

• Motivate a resident by having favorite foods available. Family members can bring a resident’s preferred food to the center, where it is stored in the kitchen. Staff can then use this food as a way to motivate the resident to eat the food being served. For example, staff will offer one resident her favorite smoked salmon if she eats the bread that is served with her meal. Similarly, staff members will supplement a resident’s plate with food they know the resident likes. For example, the addition of apple mash can provide an incentive to eat for a resident who likes sweets.

• Ascertain why the resident is not eating. Staff will observe the resident to make sure he/she has no physical limitations, such as sickness or toothache. Staff members will also ask the resident questions to understand why he/she refuses to eat. If the resident still does not eat, staff may:
  - Motivate the resident as described above.
  - Walk alongside a resident who tends to wander in the dining room while he/she eats.
  - Offer sandwiches to a resident who does not like cooked food.

• Offer bread with the crust. The center staff used to slice the crusts off bread before giving the bread to residents. Now it lets residents choose how they would like to eat their bread. Staff members work at the table to cut away crusts for residents who do not want to eat them.

• Offer a liquid breakfast for residents who have swallowing difficulties. This approach is in the testing stage.

• Spoon feed residents who can no longer feed themselves.

Care aides take care of all residents, including independent eaters, those who need assistance, and those who exhibit challenging behaviors during meals. Members of the care staff do not defer to the nurse supervisor when making decisions about how to assist individuals. However, care aides do report to the nurse supervisor any problem or concern they have about a resident. The nurse supervisor then reports these issues to resident’s doctors. In addition, the care team observes and evaluates the resident, informs other staff about the issue in question, and consults with the doctor or chef to find a solution.

Family Member Perspective of Staff during Meals

Family members interviewed for this case study reported that their relatives moved to Sint Vincentius as recently as six months ago and as long as 4.5 years ago. Relatives had mostly positive things to say about the center’s care staff. They described these staff members as patient, and affirmed that staff members carry
out the organization's mission to treat each person as an individual.

**Person-centered assistance:** Family members reported that staff take each resident and his/her needs into account when assisting individual residents and making daily changes to accommodate the resident's preferences and needs. The care staff is solution-oriented, according to family members. They make mistakes, but readjust their practices based on feedback from residents and family members.

**Independent eating:** Relatives and staff members gave concrete examples of how care aides encourage independent eating among residents and provide prompts or cues that are based on the stage of dementia and the residents’ capabilities.

Family members expressed only one major concern: that some care assistants are not patient and should not be working at the nursing home. In one instance, for example, a care aide called attention to a woman who spilled her food. The care aide talked about the incident and the trouble the woman had caused. This approach goes against the nursing home’s intent to treat all behaviors as normal.

**Impressions of staff:** Family members recognize that staff shortages limit the scope of what staff can do during meals. They understand that people with dementia can exhibit behavioral problems associated with the disease and that these behaviors can tax staff. Family members expressed their support for the nurse leader of the care team. They felt she encouraged the team to do its best.

Family members also reported that the center is honest and open with family members when problems arise, and that staff members look for solutions to those problems. In general, family members felt that its individualized approach to caring for residents set Sint Vincentius apart from other nursing homes in the area. They also applauded the center’s transparency and its willingness to address issues even after normal business hours.

**Difficult situations:** Family members felt that staff handled well most difficult situations. One family member praised the steps that staff takes to calm residents with behavioral issues. The mother-in-law of this family member disturbed her tablemates during meals and would not eat. Staff helped the mother-in-law move to a separate dining room with her own table and her back turned away from the other residents. The mother-in-law became quieter and ate her meal.

**Resident Perspective of Staff during Meals**

Researchers interviewed residents who had moved to the center as recently as three months and as long as three years ago. These individuals reported that many of their fellow residents are independent eaters who do not receive much assistance from staff. Care aides encourage residents to eat and help those who need assistance.

According to residents, staff members insist that residents cut their own food. They only help residents who are unable to do it themselves. Residents affirmed that staff members never force residents to eat food
they refuse to eat. Care aides and supportive services staff will ask the resident why he or she does not want to eat the food, they say. But residents only have to eat the food they choose to eat.

### Assessment and Monitoring of Residents

#### Screening and Assessment of Residents

When a resident enters Sint Vincentius, he/she and family members meet with the nursing home’s cook and nurse supervisor to identify food preferences and to decide whether the resident’s food will be prepared normally or if it will be modified by pureeing. Based on the outcome of this meeting, nursing home staff determines the dietary needs and portion sizes for each resident. Sint Vincentius would like to develop an improved dietary plan that is more comprehensive. The group of eight GVO homes is currently discussing the creation of such a plan.

#### Monitoring Resident Food and Fluid Intake

The nurse and supportive services personnel only monitor the food and fluid intake of the residents when a problem arises. The center does not have an instrument to measure whether residents are underfed. They also lack a scale to measure malnutrition. Staff only report whether or not the resident has eaten his/her meal or if a meal was skipped. This information is recorded in the care plan. Any problems are reported to the nurse supervisor.

If a resident does not eat the midday and the evening meal, and does not partake of the afternoon snack, staff conducts an examination to determine if the person has a health issue. The team will note the person’s symptoms, observe the resident, and then devise a solution, sometimes after consulting with the family physician. The occupational therapist and nurses meet monthly to discuss their concerns about particular residents.

The kitchen staff and head nurse monitor food waste among residents. If the head nurse notices that food is being wasted, she works with the dining staff to tailor the food for the resident and readjust the portion size. These adjustments are recorded in the resident’s chart.

### Training of Staff

Every care assistant at Sint Vincentius completed a mandatory training curriculum before becoming a professional caregiver. This training included such topics as nutrition and dementia. New staff members are expected to incorporate into their day-to-day work the skills they learned during this initial training. They are also expected to learn from their colleagues at the nursing center and experiment with new techniques.

Workgroups and committees can develop additional training programs for staff. For example, one of the
The center’s workgroups has discussed the possibility having a regular training program for new staff members that might be held every six months. The center’s occupational therapists also provide educational opportunities for new employees.

The center holds additional training for current staff. Any decisions to provide these additional training sessions is based on a variety of factors, including the needs of the organization, requests for additional training from the team or an individual employee, or the need to respond to a particular problem that arises.

The center’s director hopes to hold future training sessions on such topics as monitoring of residents during meals, malnutrition and food presentation techniques. Other training programs include:

1. **Mensa Training**: Mensa provides training to Sint Vincentius staff on nutrition and dining. One recent training addressed such topics as safely reheating food, presentation of food and the taste of food. All nursing center employees attended the training. In addition, kitchen staff receives annual training on food safety standards.

2. **Occupational Therapist**: Once each year, an occupational therapist trains the entire staff, including the nurses, care aides and support services (maintenance and reception) staff. The occupational therapist also provides training to members of the Act in Pas workgroup. The members of this workgroup are expected to educate the rest of the care team on their floor. Therapists have taught staff how to sit at the same level as the resident and have advised staff not to provide drinks to residents when they are lying down. One session explored how to help residents who refuse to eat a meal.

3. **Menu Commission**: Members of the Menu Commission received training on dining and nutrition. One of the trainings focused on serving techniques.

4. **Nursing students**: The Residential Care Group provides two-day training for nursing students on how to work with residents. The students and staff live as if they were a resident at the center, and eat meals with the residents. One of the training sessions addressed how to stimulate residents so they will eat.

**Costs**

The director of Sint Vincentius believes costs have increased at the center since implementation of the new dining program. The center attributes these higher costs to the purchase of higher quality dinnerware and an increased investment in labor. Increased labor costs are attributed to:

- **Occupational therapists**: The center increased the number of occupational therapists from one to three because it needed their expertise to guide the dining program.
• **Housekeeping employees:** Costs increased when the center began using housekeeping employees during meals. The center provided support for the housekeeping staff and educated them on how to assist residents.

• **Nurses:** The center also increased the number of nurses who provide individualized assistance to residents during meals.

While labor and dinnerware costs have increased, the center’s director noted that these changes led to gains in other areas. For example, the director cited research suggesting that:

• Underfed residents have more physical problems.
• Increased staff can help to ensure residents eat properly.
• People are happier and healthier when they are able to make choices.
• Proper assistance during mealtime can reduce the number of wounds that residents receive. This translates into labor-related savings, since it takes staff time to address a wound.

It should be noted that the nursing center does not have data to support these claims.

**Suggestions for Improvement**

The center’s director, care aides, family members and residents have suggested additional improvements to the dining program. The center is taking these recommendations under advisement:

• **Improve nutrition:** All stakeholders are concerned about the consequences of residents being underfed, especially following extensive media attention to this issue.

• **Create a food file for each resident:** This file would include a dietary plan that identifies each resident’s dietary restrictions and food preferences. The center has a food file but it is not “professional” and could be enhanced.

• **Observe residents better:** This would include adopting more objective measures of food intake, such as a nutritional scale that measures malnutrition and provides more accurate and objective measurements of residents’ food intake.

• **Offer more choice for the midday meal:** The fact that the morning and evening meals are prepared onsite by Sint Vincentius staff gives the center the flexibility to offer residents the ability to choose the foods they will eat at these meals. Offering this choice is more challenging at the midday meal, which Mensa provides to several nursing homes. It may be difficult for Mensa to accommodate the requests of Sint Vincentius residents.
• *Increase the portion sizes of fruit and vegetables*: Family members reported that staff mixes peaches and pears to encourage residents to eat. However, they feel the portion size is too small.

• *Increase available staff and time for meals*: The increased staff would allow for more staff available to provide assistance during meals. Residents also reported they would like more time to eat their meals.

**Challenges**

During their interviews with staff, residents and family members, researchers identified the following challenges associated with the dining program at Sint Vincentius:

• *Keeping track of likes and dislikes*: Staff can find it challenging to involve family members in the meal so staff can better know the residents and their preferences.

• *Balancing multiple organizational goals*: The organization has a desire to give residents more input into the dining program and to make necessary changes to improve the program. However, these desires must be balanced with the increased time pressure on care staff as they implement changes and meet resident preferences. The center has addressed this challenge by involving other staff, such as supportive services and kitchen staff, in the dining room.

• *Working around organizational schedules*: Life in a nursing home tends to be heavily scheduled and it is sometimes difficult to provide choice within such a rigid time frame. The residents at Sint Vincentius can choose when they will eat breakfast. However, the center has found it more challenging to offer this choice at other times of the day, including the midday meal.

• *Family-style meals*: The midday meal is brought to the center from an offsite Mensa kitchen and then warmed by the onsite chef. The Mensa staff sets all the menus, although members of the Sint Vincentius staff have the opportunity every three months to offer their input into the foods that are featured on that menu. This arrangement has challenged the center’s goal to create a family-style atmosphere during meals because residents and staff do not have timely influence over the menus.

• *Physical infrastructure*: There are limits to what center can do in its current building. For example, the center would like residents to participate in preparing meals, but this is not possible in a large building. These challenges may be addressed when the center builds a smaller scale building in 5 years.
Benefits

Staff, residents and family members report that changes to the Sint Vincentius dining program have yielded many benefits. These benefits, which have not been documented, include:

- Residents have more choices during mealtime.
- Mensa brought food expertise and quality control to the preparation of the midday meal.
- Residents appear to be more content and have improved quality of life.
- Residents have more time to eat. Mealtime goes more smoothly than before the dining program changed.
- Kitchen staff is more involved with the residents. For example, once a week during the evening meals, the kitchen staff works in the dining room to offer a choice of breads and fillings to the residents.
- Music and tablecloths make dining more attractive for residents.
Established in the 1980s, the De Wingerd nursing home in Leuven, Belgium focuses exclusively on providing services and supports to 137 residents with dementia who reside at the center. In 2009, De Wingerd decided to reinforce its philosophy of person-centered care by creating 11 small-scale housing units (referred to as “homes” in this case study). The homes—which feature private bedrooms, a kitchen/dining area and a living room—enable residents to live in an atmosphere that more closely resembles their own homes.

Eight of the new homes each house eight residents; three additional homes each house 15 residents. One care aide works in each of the eight-unit homes while one nurse and one care aide staff the 15-unit homes. Four coordinators or team leaders provide oversight of staff working in all 11 homes. De Wingerd makes placement decisions based on the personality of the individual and how he/she will fit with current residents in the home.

The nursing center plans to split each 15-person home into two separate homes of eight residents each. One staff person reported that the center’s upper management believes residents in the 15-person homes feel isolated when the nurse and care aide talk to one another rather than to residents.

In addition to the small-scale homes, De Wingerd houses couples in nine flats. In most cases, one partner in each couple has dementia and the other partner assists in caring for that individual. In the case of two couples, however, both spouses require assistance from staff.

According to the rules of the center, spouses who do not have dementia must move from De Wingerd when the dependent spouse dies. Focus group participants were quick to note that the De Wingerd staff helps the surviving spouse find alternative living arrangements when he/she can no longer remain at the center.

Other Services

In addition to the small homes and flats, De Wingerd also offers:

- Two adult day centers serving 23 clients who can move to one of De Wingerd’s small homes as their needs change
- A short-stay center with 10 rooms
• A service center featuring a café, conference rooms, public bathroom, media and an Internet desk

• A center that offers information and consultation about dementia care to people in the community

De Wingerd is a practicum site for nursing students. Nursing students pursuing a certificate or degree must complete a mandatory practicum with an aging service provider. Information about each center is provided to nursing students to give them facts about the population of the center. De Wingerd serves as one of the sites for practical training. As part of the practicum, nursing students spend time caring for residents in the small-scale homes.

Positive Impact of Small-Scale Design

De Wingerd takes a multidisciplinary approach to assisting its residents. Each home has a team that includes nursing staff, housekeeping staff, volunteers and family members. Staff believes that the small-scaled housing design positively impacts both residents and team members, as shown in the chart below.

<table>
<thead>
<tr>
<th>Group</th>
<th>The Small-Scale Housing Model Helps Members of this Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Staff</td>
<td>• Work more autonomously</td>
</tr>
<tr>
<td></td>
<td>• Take part in daily activities of the residents</td>
</tr>
<tr>
<td></td>
<td>• Conduct multiple tasks, including medical care and housekeeping</td>
</tr>
<tr>
<td></td>
<td>• Communicate more efficiently</td>
</tr>
<tr>
<td>Team Leaders</td>
<td>• Guard the concept of person-centered care</td>
</tr>
<tr>
<td></td>
<td>• Coach and listen</td>
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<tr>
<td></td>
<td>• Offer productive feedback to staff</td>
</tr>
<tr>
<td></td>
<td>• Educate staff</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>• Play a more visible role on the team</td>
</tr>
<tr>
<td></td>
<td>• Encourage residents to take part in housekeeping by cleaning, cooking and washing</td>
</tr>
<tr>
<td></td>
<td>• Assist residents in their daily activities</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>• Maintain a presence in residents’ home</td>
</tr>
<tr>
<td></td>
<td>• Support residents in daily activities</td>
</tr>
<tr>
<td></td>
<td>• Stimulate autonomy and independence</td>
</tr>
<tr>
<td></td>
<td>• Offer advice on ergonomics</td>
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<tr>
<td></td>
<td>• Organize resident routines</td>
</tr>
<tr>
<td>Volunteers</td>
<td>• Add important value to the care team</td>
</tr>
<tr>
<td></td>
<td>• Support daily activities</td>
</tr>
<tr>
<td></td>
<td>• Fill in for professionals when needed</td>
</tr>
<tr>
<td></td>
<td>• Take part in housekeeping activities</td>
</tr>
<tr>
<td></td>
<td>• Provide extra staff to individualize care for residents</td>
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<tr>
<td>Family</td>
<td>• Get involved in decoration of the personal rooms</td>
</tr>
<tr>
<td></td>
<td>• Take part in daily activities, such as preparing meals</td>
</tr>
<tr>
<td></td>
<td>• Join family members during doctor’s house calls and participate in other care activities</td>
</tr>
</tbody>
</table>
De Wingerd conducted a survey of relatives and staff to measure its progress in transitioning from a traditional nursing home to a small-scaled housing model. Survey results show that the new housing design resulted in higher levels of satisfaction among employees. In addition, the survey also identified these benefits for residents:

- Use of fewer sedatives
- Decreased malnutrition
- Fewer falls
- More involvement with family members
- Longer self-sufficiency

**Program Structure**

**Partnership with Sodexo**

Sodexo has managed De Wingerd's kitchen and meal preparation for 25 years. Sodexo's onsite staff consists of the director of food service, a dietician, kitchen aides, one chef/manager and three cooks. The director of food service has overall responsibility for food preparation from the time food is purchased from suppliers to the time it leaves the kitchen for delivery to individual homes. The dietician is responsible for nutritional oversight and quality control of the meals, proper preparation of food and selection of food suppliers.

Sodexo operates what it calls a “cold chain” process at De Wingerd. Sodexo cooks the food at its kitchen, cools the food, and then divides the food into bulk (not individual) portions for each home. After the food is delivered to the individual home, staff in the home reheat and portion out individual meals. Sodexo delivers the equivalent of two days of meals at a time.

Sodexo employees deliver but do not serve the meals. Cost may have driven the adoption of this arrangement. Sodexo reports that its price to deliver and serve food is high because the company is required to charge a 21-percent value-added tax on the joint service. The tax for the delivery-only service is six percent.

**Nutrition and Dining Committees**

De Wingerd has a Menu Commission that meets every six weeks. Group members include the center’s director, department heads, the chef and Sodexo’s onsite director of food service. During their meetings, commission members discuss needed changes to the dietary plans of individual residents. Care aides do not belong to the commission or attend its meetings. Therefore, it is not clear if or how their input is incor-
porated into meeting discussions.

Family members and residents bring their questions about meals directly to the dietary staff. For example, one daughter of a resident recently asked about the nutritional value of mixed meats. Sodexo provides a special e-mail address that family members and others use to ask these questions.

The care staff holds monthly meetings to focus on any issues that arise in the course of caring for residents. These meetings do not focus exclusively on dining and meals. However, these topics can be addressed during care staff meetings, which staff members from eight homes attend on a regular basis.

**Elements of Dining Practices**

**Dining Environment and Seating of Residents**

Each home’s dining area is furnished with either square or round tables that each seat four or five residents.

All residents, except those who are bedridden or have serious disabilities, are free to decide whether to eat in the dining room or in their bedrooms. Eating with other residents in the common area is not mandatory and residents know that staff will respect their preferences.

Most residents choose to eat in the common dining area. Those who choose to eat in their rooms are regularly invited to join fellow residents in the common area because staff believes that residents benefit when eating and socializing with others.

Within the common dining area, staff decides at which tables the residents will eat. Staff members consider the resident’s functionality and compatibility when deciding on his/her placement at a table. Once a resident is assigned to a table, he/she will stay at that table or with the same tablemates. Seating changes may occur if a new resident moves to the home or if the dementia of a current resident progresses.

In a recent change to dining practices, dining room tables generally include a mix of independent eaters and people who need assistance. Seating the two groups together helps to prompt residents who need assistance to imitate the independent eaters. The center made this change because it found that seating together residents who needed assistance or were difficult caused problems during mealtime.

The couples who reside in the center’s flats eat breakfast and the evening meal in their flats. Most couples choose to eat the midday meal in the common area, even though they have the option of eating that meal in their flats.

**Meals and Meal Preparation**

*Meals:* The standard meal at De Wingerd meets the general nutritional requirements established by the National Council for Health. The nursing department communicates individual dietary needs to kitchen
staff. The goal is for residents to eat regular food to the extent they are able to consume and digest that food.

De Wingerd serves three meals each day:

- During the morning meal, residents have a choice of breads, cheeses and spreads or toppings.
- The evening meal is similar to breakfast and features breads, spreads and delicatessens like ham or sausage. Residents are occasionally served quiches, croquettes or macaroni in cheese sauce.
- The main meal of the day is served hot at midday. Residents do not have a choice of what they will eat for the midday meal. Instead, each home receives a standard meal from the kitchen.

Sodexo’s contract with De Wingerd lists the grams of food that the company will serve to residents as part of a proper diet. When the chilled food arrives in home, it is stored in the refrigerator until it is needed. The food is reheated in the home’s kitchen and placed in steam trays to keep it warm. Then, members of the care staff portion out meals based on the needs of each resident.

The aroma of the food penetrates throughout the home and helps stimulate the appetites of residents. This makes residents more relaxed and open to eating. This is an improvement from the old system. Previously, residents dined in big groups and food was brought up from the kitchen. Residents did not see the process of warming the food and did not always understand that it was mealtime. The larger setting also created more noise and disruption, which can be challenging for some people.

Sodexo develops menus in consultation with its onsite director of food service. The company is flexible when developing menus. Sodexo staff discusses possible changes with the center’s director and is usually willing to make suggested adjustments.

Each home has a weekly budget that it can use to purchase additional food items based on the preferences of residents. A basket of fruit and salad ingredients are available in each home as a regular alternative for residents who do not like the standard meal. Staff also prepares soups that residents can enjoy in addition to the meal or as a replacement for another food.

The small homes have experimented with using spices to enhance the flavor of food before it is served. Some spices have worked well, but not all residents are open to these new changes. Some residents want to eat traditional foods—like potatoes and meats—that are familiar to them. These residents are not receptive to new foods, like rice and pasta, or to the different tastes provided by the spices.

**Meal modifications:** Sodexo has three levels of food preparation: normal, mixed/blended, and shakes. Special diets are only served when they are medically prescribed, as in the case of lactose intolerance.

Whenever possible, Sodexo provides residents with a regular or “normal” meal. However, in addition to its standard menus, Sodexo also offers menus that have been adapted for people with chewing or swallowing
challenges. Nurses and care aides can request these adapted menus from Sodexo staff.

Residents who have trouble chewing are provided the same meal as other residents, but in a blended form. Each food item is blended separately so that a meal’s meat, vegetable and starch can be kept separate from other food items in the meal. This process allows residents to taste the individual foods and identify different foods by their corresponding colors. For example, carrots will still be orange and peas will be green.

Sodexo staff adapts the food in the kitchen. De Wingerd staff can make adjustments to the food in the home kitchen if necessary. Sodexo staff members do not generally alter an entire meal for residents who have difficulty eating. For instance, a resident might need the meat modified, but not the vegetable. In addition, some foods—like salad—cannot be blended. Other foods—like rice pudding—cannot be swallowed easily. In the case of these foods, kitchen staff will provide an alternative food for the individual. For example, vanilla pudding can substitute for rice pudding and blended broccoli can take the place of a salad.

Sodexo also offers shakes for residents who have trouble swallowing. These shakes are nutritionally equivalent to a regular meal. Members of the care staff make each shake in the home’s kitchen so they can control its ingredients.

De Wingerd operates a Grand Café. Residents can dine in the café with family members. Some residents will eat in the café if they do not like the meal being served at home. If the resident orders the same meal that is being served at home, he/she will not pay an additional cost. If a resident chooses a different meal, he/she pays for the meal at a discounted rate.

Meal Times

Staff members in De Wingerd’s homes have the flexibility to change the timing of meals. This flexibility, which aligns well with the nursing center’s person-centered care philosophy, is possible because:

- The population of each home is small.
- The same staff members work in the home each day.
- Each home can store meals in its own refrigerator.

Residents can decide when they will eat their meals. In addition, they can take as long as they want to eat any of the daily meals.

Residents can even decide to change the orders of their meals. One volunteer reported that he recently prepared eggs and bacon for residents in the late morning. After the meal, residents decided to switch the main meal and the evening meal because they preferred to eat a smaller midday meal after their late breakfast.
Adaptive Equipment

The occupational therapist has been instrumental in bringing adaptive equipment to De Wingerd in order to help residents with limited abilities. The adaptive equipment enables residents to eat more independently and to be less reliant on staff. The therapist observes residents to determine which types of equipment will be applicable to their particular need. The equipment includes:

- A cone-shaped glass fits inside a regular-shaped glass. Residents do not have to tilt their head to drink the liquid.
- A lightweight, spill-proof drinking cup, called a Kennedy Cup, is used with a straw.
- A plate with high lips around the edge helps residents move food onto their spoons.
- A plate with textured bottoms assists residents who can only eat with a spoon and one hand. The texture keeps the plate from sliding around the table while the resident eats.
- A straw with one-way flow keeps the liquid from flowing back through the straw. These straws are useful for residents who cannot use a regular straw.

Staff Assistance

De Wingerd takes an integrated team approach to supporting residents during mealtime. Each home has a nurse and care aides who have overall responsibility for the home and are involved in all tasks to help residents and keep the home running efficiently. These staff members:

- Administer medicines, if needed
- Prepare the dining table
- Warm food in the home’s oven
- Make the soup, if necessary
- Portion out food for each resident based on his/her dietary requirements
- Help serve food
- Blend food for residents who have difficulties swallowing
- Assist residents who need help with eating, after positioning the resident properly
- Wash dishes
Since care aides and nurses are assigned to only one home, they interact and feed the same residents daily. Nurses/care aides are assisted by:

- **Housekeeping staff**: In addition to helping residents with activities of daily living, members of the housekeeping staff help cook the meals and wash the dishes. They also assist residents during the meals.

- **Occupational and physical therapists**: Occupational and physical therapists "guard the comfort of people with dementia." The occupational therapist will observe residents to determine their need for adaptive equipment. Both physical and occupational therapists offer advice to the care staff about how best to position residents for optimal chewing and swallowing. The therapists only work half days so they generally are not at the home when residents are eating and have little involvement in directly assisting residents with eating. These therapists may observe residents at breakfast if they happen to be in the home for a therapy session. However, they receive most of their information about resident eating habits from the nurses.

- **Volunteers and family members**: Volunteers play a prominent role in the delivery of person-centered care at De Wingerd. They fully support residents throughout the day and usually set the table, feed residents and clean dishes at mealtime. Along with family members and housekeeping staff, volunteers allow De Wingerd to meet the needs and preferences of residents in a way that other nursing homes with limited staff cannot.

**The Role of Volunteers**

Because the involvement of volunteers is a unique aspect of person-centered care at De Wingerd, the volunteer program deserves to be addressed separately in this case study.

A staff person at De Wingerd specializes in hiring volunteers and educating them about their role at the center. De Wingerd sets high standards for its volunteers and seeks quality people to fill these roles.

Placement of volunteers is determined by the attributes of the volunteer and his/her fit with residents and staff in the home. When making a placement, the volunteer coordinator considers the strengths and personalities of the home’s nurse, as well as the nurse’s ability to work with and support the volunteer. Volunteers are not allowed to work in a home where a family member lives.

The volunteer coordinator gets to know each volunteer and what he/she can handle, according to reports from volunteers. The coordinator also provides help to volunteers who are dealing with emotional issues related to their work. Volunteers say that the coordinator is vigilant about ensuring a good match between them and staff and residents at the home.

Volunteers also receive support from staff working in the home. One volunteer reported that the nurse and care aides in her home were expert at teaching her what she needed to know about the residents. These
staff members consciously helped the volunteer work with and respond to residents in an appropriate way.

Volunteers have various reasons for working at the center. One volunteer described the feelings of loneliness and guilt that come with leaving a loved one at the center. He decided to volunteer at De Wingerd because he felt it would help him address these feelings and would provide him with a support group of staff and other volunteers.

**Techniques and Strategies to Help Resident during Meals**

De Wingerd staff, volunteers and family members—collectively referred to as “caregivers”—have four goals when assisting residents during mealtime:

- Make each person comfortable
- Respect each individual
- Individualize care
- Encourage independence

By pursuing these goals, caregivers work to create a positive dining experience that puts the resident in charge. This means accepting as normal all behaviors of the person with dementia. Caregivers do not get upset over accidents, and they work hard to guide the behavior of residents without drawing attention to it.

**Fostering independent eating:** Residents require different levels of assistance, and caregivers customize their techniques to meet each resident's specific needs. For example, if a person is having difficulty using a fork, the caregiver might slip behind him/her and provide a little nudging. Caregivers will cut the meat for a resident who can no longer use a knife. A resident who has trouble swallowing may need to be positioned properly to facilitate independent eating. If a resident is distracted by what is going on in the dining room, caregivers may remove whatever is keeping the resident from focusing on the meal.

Caregivers strive to give residents as many incentives as possible to eat independently. To accomplish this goal, caregivers may use a number of techniques to remind the resident of patterns and movements associated with eating. These techniques might include initiating the resident's first movements to eat the meal, modeling eating and offering foods that are more stimulating to the taste buds. The caregiver might also sit a resident who needs assistance next to an independent eater so he/she can see and model the actions of the independent eater.
Offering assistance to those who need it: Caregivers provide full assistance to residents with more progressed stages of dementia who cannot feed themselves.

At times, caregivers are called on to ensure that these residents do not overeat. People who have dementia often keep eating because they cannot recognize when they are full. Caregivers will distract the resident in order to lower his/her food intake. Over time, the resident begins to eat less and his/her feeling of constant hunger disappears.

Caregivers will gently offer food to a resident when dementia prevents him/her from feeling hungry. The caregiver will not push or force the resident to eat. Instead, the resident will be encouraged to eat at least some of the food on the plate.

Supervision

The nurses and care aides work as a team in the dining room and monitor the volunteers, family members and housekeepers. It does not appear that nurses directly supervise care aides during the meals. While a team coordinator oversees the operation of a group of homes, this coordinator is not present during meals.

Monitoring Resident Food and Fluid Intake

Nurses and care aides observe whether a resident eats or does not eat and enter this information onto the computer. Staff members do not document the quantity of food consumed. If a resident is not eating, care staff will investigate the cause and find a solution to help the person consume more food.

Sodexo is informed if food is not consumed. The nurses and care aides work with Sodexo staff to adapt the food either in the kitchen or in the home kitchen.

Training

New staff members do not attend formal trainings at De Wingerd. Instead, new nurses and care aides are expected to put into practice the lessons they learned during their professional training. Most new learning takes place on the job with the help of colleagues. When there is a specific problem, members of the care staff can bring the issue to their monthly team meetings.

Training Presented by Sodexo

Sodexo conducts several training sessions for current staff throughout the year.

Annual in-service: Sodexo holds an annual in-service training for the chef and kitchen staff. In addition, newly hired Sodexo kitchen staff members receive training on nutrition and dining practices.

Ongoing training: The Sodexo dietician provides ongoing training to De Wingerd staff. The training curriculum is based on the results of an audit that Sodexo conducts regularly to gauge the success of the din-
ing program. The company issues a post-audit report on what elements of the dining program are running smoothly and what elements could be improved. The latter elements are addressed during training sessions for nursing staff, care aides, kitchen staff and doctors. Past training sessions have included:

- **Spice Your Mind**: Sodexo offered this session to help care staff in the homes understand the use of spices to enhance the flavor of food. Center staff members can add spices to food after Sodexo delivers it and before it is served to residents. This session helped staff understand and taste different spices.

- **Heating a meal**: Sodexo held a special training session on the preparation of meals and how to use the home’s rewarming oven properly when reheating food for residents.

- **Home Serve**: This session focused on the resident dining experience and included tips on setting the table, preparing the meal, helping residents, and displaying a friendly demeanor when serving food.

**Family support**: Sodexo provides information to family members upon request.

**Training Presented by De Wingerd**

**Physical therapist**: De Wingerd’s physical therapist has organized several training sessions for the nursing staff. One session focused on feeding and positioning residents to prevent choking and swallowing problems. During this session, the nursing staff learned how to use thickening agents to stimulate a resident’s swallowing reflex, making it easier for him/her to drink liquids and less likely that he/she will choke.

**Volunteer training**: Once or twice a year, all volunteers are invited to attend an optional training session focusing on proper techniques for feeding residents with dementia. Center staff explains dementia and the progression of the disease to help volunteers understand what residents are experiencing. The training session also provides guidance on how to work with residents. One volunteer expressed her gratitude for the training. She described it as an “evening of explanation” that helped ease some of the difficulties associated with working with individuals who are gradually losing contact with others. The volunteer reported that the session validated some of her methods of working with residents and that the instructor corrected other methods that needed adjusting.

**Costs**

Increased costs for the dining program are incorporated into Sodexo’s contract with De Wingerd. The higher costs can be attributed to the additional staff hours required to modify food for residents.
Changes to the Program

Overall, volunteers and family members expressed positive feelings about De Wingerd and about the nursing center’s dining program. They credited staff with managing the care of people with many different characteristics and for handling conflicts among residents living in the homes.

One family member described a problem that arose during the midday meal when staff shortages made it difficult to prepare and serve the meal to residents in a timely fashion. Family members voiced their discontent with the situation. The center’s director responded to the complaints by asking members of the housekeeping staff to help out during the midday meal so residents could have additional assistance.

One care aide described his ideal dining program. He suggested that individual homes furnish each table with a tablecloth or placemats to make their dining rooms more homelike.

In addition, he expressed his desire to see the center’s staff to prepare meals, instead of Sodexo. This arrangement might cost more, he conceded. However, it would allow more flexibility during mealtime. Staff could fully prepare meals in the kitchens of each home, instead of reheating the food and preparing select items. Staff could also go shopping for the food, and residents could be fully involved in preparing the meal, if they were able. Residents unable to help would benefit from the aromas associated with cooking, which might encourage them to eat their meals. The staff member acknowledged that there would be safety issues associated with allowing residents to participate in preparing meals.

Challenges

During their interviews with staff and volunteers, researchers identified the following challenges associated with the dining program at De Wingerd:

- **Residents who refuse to eat or skip meals:** If people are skipping meals, staff and volunteers must find out why, since observation of whether or not a resident eats can be an indicator of health and wellbeing. Getting these answers can be challenging, especially if residents are not responsive to questions.

- **Resident table manners:** Some residents take food from their tablemates or wash their teeth in their glasses. These behaviors can create problems at mealtime and require staff to redirect the attention of a resident to his/her own plate.

- **Not enough attention to color/contrast in ordering adaptive equipment:** All the plates at De Wingerd are white. While colored dinnerware can help residents distinguish between the plate and the tablecloth, administrators shy away from colored dinnerware for fear that residents would identify this dinnerware with children. Center staff does not want to infantilize older adults.
• Clear meal trays: The Plexiglas meal trays that are attached to wheelchairs during mealtime confuse some residents. Residents can see their own legs through the tray and fear that items they put on the tray will fall on the floor. De Wingerd is working with its supplier to purchase opaque trays.

**Benefits**

Family members, volunteers and staff expressed the opinion that De Wingerd is quite advanced compared to other nursing homes in the area. They offer these examples to back up their opinions:

• Residents receive their food on plates instead of trays.

• Residents have more choices during meals.

• Staff attempts to personalize the meal and the assistance they offer in order to meet the needs of each individual.

• De Wingerd has been creative in involving a variety of staff and volunteers to provide the necessary support during mealtime. These staff and volunteers feel empowered as they interact with the residents in a more personal way.

• The small-home environment permits residents to sit in smaller groups at the table.

• Staff assists the same residents each day. They can observe what a resident is eating, or not eating, and can more easily notice changes in behavior that might indicate that something is wrong with the individual.
Residence Emile Gerard (Emile Gerard) is a public nursing home in Livry-Gargan, France that houses 240 residents on four floors. Emile Gerard is considered to be one of the top five nursing homes in the region because of the quality of its care. It is also a large nursing home by French standards. The typical French nursing home houses only 80 residents.

Emile Gerard's large size means that it is required by law to employ a full-time medical director. This is a fairly unique arrangement. A smaller French nursing home typically has a part-time medical director who continues to maintain his/her own practice.

The Protective Life Unit at Emile Gerard is designated for residents with advanced stages of dementia and behavioral challenges. This unit has 39 beds and currently houses 38 residents. The unit always leaves one bed empty for emergencies.

Role of the Medical Director

The medical director does not monitor each Emile Gerard resident individually or write prescriptions for them. Instead, he supervises the 33 external physicians who come to Emile Gerard to see their patients. Some of these physicians care for multiple patients living at the nursing center. The medical director’s job is to ensure that Emile Gerard residents receive appropriate care from their physicians. All physicians must seek the approval of the medical director before they prescribe medications for a resident.

The medical director reports that he has a “good” relationship with the physicians who treat Emile Gerard residents. He knows the strengths and weaknesses of each doctor. These external physicians sometimes delegate medical authority to the medical director if they need his assistance.

The medical director plays a prominent role at both the nursing home and in its nutrition program. He is in charge of coordinated care and is expected to:

- Ensure that the nursing home meets the public health requirements of the region, which include rules aimed at preventing contagious diseases.
- Work to prevent malnutrition. To address this important issue, the medical director initiated and helped develop the nutrition program.
• Educate staff members so they understand the importance of nutrition and its connection with medical care.

**Caregiving Staff**

Emile Gerard has several levels of caregiving staff that support and assist residents. Caregiving staff members include:

• Nurses
• Nurse aides
• Hospital service agents

The nurse aides and agents assist residents with activities of daily living. Nurse aides can distribute medications, but agents cannot. The agents can assist in feeding the residents, but they are not entrusted with residents who have respiratory problems or serious illnesses. The center has two nurse aides who specialize in geriatrics. These nurse aides take care of residents who are hyperactive or agitated.

Emile Gerard has two, 10-hour staffing shifts. The number of aides and agents on duty during any one shift will depend on the size of the unit and the needs of its residents. In general, the ratio of nurse aides to residents is 1:10. Approximately two nurse aides and one agent are available on each unit during the morning shift. One nurse aide and one agent work on each unit during the afternoon shift. The Protective Life Unit has a total of 10 nurse aides for its 38 residents. Nurse aides distribute medications to residents during the morning shift.

Nurse aides with demonstrated skills in nutrition and dining also serve as dietary references at Emile Gerard. The nursing home has four certified dietary references. Each dietary reference is responsible for a floor of the nursing home.

Serving as a dietary reference is generally an additional responsibility for a nurse aide. Nursing homes need special permission from the Ministry of Health to have the dietary reference staff position. The nurse aide and dietary reference assist residents with nursing care, activities of daily living and meals. They also monitor residents for symptoms of illness. The dietary reference serves as an intermediary between the Emile Gerard administration and nurse aides and between nurse aides and residents.

**Program Structure**

The medical director’s concerns about the risks and consequences of malnutrition provided the impetus for developing the nutrition program at Emile Gerard.

Malnutrition is a common problem among people with cognitive impairments. Approximately 15 to 40
percent of incoming residents suffer from malnutrition. Hospitals see the most severe cases of malnutrition, and nursing home residents are exposed to a 40-to-60-percent greater risk of malnutrition after hospital admission.

When he arrived at Emile Gerard, the medical director launched two nutrition-related initiatives:

1. An audit of residents to determine the extent of malnutrition at the center and to identify specific residents affected by malnutrition
2. A questionnaire to assess resident preferences regarding the center’s meals and eating environment (Nurse aides assisted residents who lacked the cognitive ability to complete the questionnaire.)

The medical director convinced the center’s director that Emile Gerard needed to take a proactive role in helping residents eat better, and he continues to be a strong supporter of the nutrition program. In designing the nutrition program, the medical director drew on his experiences as a hospital practitioner and Director of Certification Programs in Nutrition at the hospital.

At the same time that Emile Gerard was conducting its internal fact-finding, circumstances outside of the center proved favorable to the nutrition program’s launch. Specifically, a number of entities—including the French health agencies—were identifying nutrition and nutritional improvement for seniors as a priority. Increased national awareness of this issue prompted the regional health agency to publically identify Emile Gerard as a nursing home with the potential to contribute to the field of nutrition. It also agreed to provide financial support for the center’s nutrition program. Emile Gerard is one of seven nursing homes participating in a pilot study on nutrition. A report describing programs operating at each of the study sites will be distributed to other nursing homes throughout France.

**Launching the Nutrition Program**

Emile Gerard launched its nutrition program in November 2010 by making an organizational commitment to redesign how residents eat. The program’s goal was to improve eating habits and enhance each person’s quality of life.

The program’s launch was not without its challenges. The medical director realized early that he would have to convince members of the center’s staff that the program was worthwhile. He would also have to change the mindset of nurse aides who, up until that time, focused exclusively on the medical care of residents. If the program was to succeed, nurse aides had to broaden their jobs to include a focus on nutrition. They would also need to recognize the link between nutrition and medical care. The medical director worked closely with aides until they made that connection.

The team leading the nutrition program was interested in improving food quality and quantity. It worked
with the center’s chef to create meals that provide:

- The right amount of food
- Foods that have visual appeal
- Foods that residents can easily identify

These were and continue to be the key concepts of the nutrition program.

**Partnership with Sodexo**

Emile Gerard has partnered with Sodexo for food preparation and dining oversight for the past year. The center selected Sodexo because the company operates worldwide and would bring its extensive knowledge of and experience with dining practices to the center’s nutrition program. Emile Gerard also wanted Sodexo to provide high-quality and nutritious meals while reducing food costs. Sodexo provides the center with nutrition expertise, trained personnel, and financial management services.

The kitchen staff at Emile Gerard is a mix of Sodexo and nursing home personnel. Sodexo employees include the dietician and the manager of food supply. Emile Gerard kitchen staff includes the chef, who has been with the center for 20 years, and 5 kitchen assistants.

The Sodexo manager of food supply is responsible for sourcing and ordering the food that will be served to Emile Gerard residents. He provides menus and recipes to the chef. The chef and Sodexo manager discuss any disagreements regarding the menu and make joint decisions to revise it. The Sodexo dietician, who comes to the nursing home twice each week, also monitors the menu and makes needed adjustments.

Emile Gerard and Sodexo have a contract with a budget for meals that is set one to two years in advance. Sodexo exercises fiscal oversight over the menu to ensure food expenses are within the prescribed budget. The center’s chef works closely with the Sodexo manager of food supply and the Sodexo dietician to make sure the budget is managed well. For example, if the chef requests a more expensive item for a meal, such as fish, Sodexo will choose a less expensive fish to offset the cost.

The arrangement between Sodexo and Emile Gerard differs from Sodexo’s usual practice in three ways:

1. Usually, Sodexo brings its own chef and kitchen staff to a property. However, Emile Gerard wanted to have its own staff in the kitchen.

2. A Sodexo dining program usually employs only two or three staff members. The Emile Gerard kitchen staff is larger.

3. Sodexo usually does not have a dietician at a property. However, the presence of a dietician was one of the medical director’s specifications for the center’s nutrition program.
Nutrition and Dining Committees

France requires nursing homes to establish a Menu Commission that provides an opportunity for residents to meet cooks and discuss the meals and their dining preferences. In implementing its Menu Commission, Emile Gerard has exceeded government requirements for these bodies.

The Emile Gerard Menu Commission is composed of cooks, Sodexo staff, dieticians, dietary aide references, the medical director, the hospitality manager, and residents. Residents offer the commission important feedback about what is working and what is not working in the nutrition program.

The commission explores all aspects of nutrition, including resident preferences. Commission members collect information from residents and develop a report that outlines major issues and offers recommendations for improvement. The hospitality manager and medical director weigh in on whether the commission is asking the right questions and whether commission members have done their best to answer those questions adequately.

Following the medical director's example, the Menu Commission expects every person associated with Emile Gerard to take responsibility for carrying out the nutrition program. In this way, every staff member—even those who are not considered "medical staff"—are encouraged to take action to improve resident wellbeing. Even residents have a share in the program's outcomes.

Elements of Dining Practices

Dining Environment

Emile Gerard's hospitality manager is responsible for the presentation of food at each table in the center's 17 dining halls, including the dining area in the Protective Life Unit. For example, she makes sure that each table has a tablecloth and flowers. The hospitality manager also meets with staff to discuss improvements to the meal presentation.

Emile Gerard and Sodexo have put a great deal of thought into the setting of the table and use of dinnerware and cups to stimulate resident appetites and help residents enjoy their meals.

**Transparent dinnerware and cups:** Sodexo implemented an initiative to change the dinnerware and cups that Emile Gerard residents use each day. As a result, residents now use transparent dishes and cups that enable them to see the food on the plate—as well as a knife and fork that might be resting under the plate rim—at all times during the meal. This is especially helpful to residents with frontal dementia, who have difficulties seeing and organizing space. If these residents are unable to see and grasp their forks, they will eat food with their hands. Being able to see the fork, knife and contents of the meal helps remind residents to eat and reinforces the purpose of the dish. These cues can also help stimulate the appetite.
**Familiar table settings:** Emile Gerard uses placemats and dishes that residents recognize from their younger years. The center's dishes are the same type used in college dormitories. Staff found that using dishes from the past helps to keep residents calmer and encourages them to eat because they associate the dishes with the meals they ate in the past. In this way, familiar dishes serve as a reminder to the resident that it is time to eat.

**Glass cups:** Residents at Emile Gerard believe that a cup should be made of glass. As a result, many residents will not drink from plastic cups. The nursing center switched from plastic to glass cups when it realized that the plastic cups were causing behavioral problems at mealtimes and making it necessary for staff to assist residents who could have been more independent. The use of glass cups has calmed these residents and allowed them to be more autonomous. Residents can drink by themselves because they understand the use of the glass cup. Residents also use small pitchers to pour water for themselves and to serve their neighbors.

**Seating of Residents**

Most residents eat in the dining or common area instead of their own rooms. Residents decide where they will to eat for each meal and are not obligated to eat in the common dining area. Residents may prefer the quiet of their own room and may choose not to socialize or eat with others. Staff will decide where a resident will eat if that resident is incapable of making the decision or is bedridden, or if there are other special circumstances.

Staff may decide to isolate a resident with behavioral issues. A resident will be taken to his/her room to finish the meal if he/she is agitated, hyperactive or bothers other residents. This move can help calm the resident and helps staff ensure that the resident eats his/her meal.

Each table in the dining area accommodates four people. Staff decides the seating of residents based on the education and habits of the individuals. Staff mixes residents who need assistance with the meal and those who can eat independently. They do not place all residents with behavioral problems or challenges together. Residents sit with the same people at each meal.

One resident reported that staff members are skilled in identifying the personalities and education of the residents and in predicting which residents will get along with each other. This resident said he is content with his tablemates. They have similar interests and get along well.

**Meals and Meal Preparation**

**Meals:** Meals are fully prepared in the kitchen and are delivered to each dining area on individual plates that have the right quantity of food for each person and the right proportion of protein, calcium and fiber. The dietician draws up a chart for each individual that lists his/her specific diet. Staff members review the chart to become familiar with each resident's nutritional needs.
If a resident feels that his/her portion is too large, staff will split that portion into smaller portions that can be presented to the resident over the course of a meal. Staff members also make sure that the consistency of the food is appropriate for the resident. For example, some residents require that food be mixed or blended to facilitate chewing and swallowing. All the meals are warmed before they are served to residents.

Breakfast consists of bread, butter and jam with coffee or tea. The midday meal is a hot meal that features vegetables (or delicatessen, eggs or fish), meat or fish, starches, cheese and dessert (fruit, cake or dairy). Dinner is a lighter version of the midday meal and soup replaces the vegetables. Bread is served with each meal. Alternative foods with similar nutrients are available for residents who do not like the food being served. If a resident refuses solid food, he/she will receive enriched liquids, soups and yogurt to make up for what he/she refuses to eat.

Meal modifications and use of supplements: Food is modified for individuals who have difficulty swallowing or chewing their food. Food can be modified by cutting meat into small pieces, mixing food in a blender to soften it, or mashing the food. The resident’s doctor determines the need for any food modifications. The team of nurses, nurse aides and dietician coordinate these modifications with the individual’s health practitioner.

Supplements and enriched foods are available for residents who refuse a meal or are malnourished. However, the staff at Emile Gerard prefers to give residents natural foods—including milk, chocolate milk or bread—instead of supplements. Staff members feel that offering natural foods whenever possible is the right thing to do, reminds the resident of childhood, and is a much better option than chemical supplements. When necessary, supplements are added to the soups that residents like to eat.

Sodexo introduced the Un Air de Famille program to encourage sensorial and cognitive stimulation at mealtime. Through this program, staff offers finger foods to residents who are no longer able to use traditional tableware. This allows residents with severe impairments to eat in a dignified way.

Snacks: Residents are given a choice of snacks, like fruit juice and cake or tea and cake, which they can enjoy at 4 p.m. each day. One resident described these snacks as “empowering,” because residents can choose what they will eat. A resident who is autonomous can decide whether to eat his/her snack in the dining hall or bedroom. A resident who is incapable of making a decision will usually be served in his/her own room. According to one resident, it takes too much time and trouble for staff to take these residents to the dining room for the snack.

Meal Times

Residents eat together during set meal times. During interviews, residents and staff acknowledged that the structure and size of the nursing home made it difficult for residents to choose their meals and the time of the meal. Allowing this choice would create chaos at the home, they said.
Staff Assistance

Staffing ratios in dining rooms: The number of staff members assisting residents in the dining room depends on the meal. Approximately three to four nurse aides assist residents at the morning and evening meals. About eight nurse aides help residents during the midday meal.

Assisting residents: Only nurses and nurse aides help in the dining room. This differs from the approach of nursing homes in Belgium, where volunteers supported staff during meals and fed residents. Volunteers at Emile Gerard carry out other roles, like taking residents to church.

Nursing center policy stipulates that only health practitioners can assist a resident with eating. This policy is designed to reduce the risk of choking among residents and to prevent a volunteer from offering foods that a resident cannot eat. For example, a resident who has diabetes could suffer health consequences if a volunteer unwittingly gave him/her a sweet food.

For the same reasons, family members are only allowed to feed their own relatives. Family members are prohibited from feeding other residents because they are unfamiliar with their health conditions and eating-related challenges.

Program oversight: The medical director plays a significant role in guiding the direction of the nutrition program and educating staff about the program goals. The dietary reference works closely with the medical director, dietician, chef, hospitality manager and other staff to implement the program. This team met after the site visit to discuss how the nutrition program could be improved. During this meeting, the team expected to tackle such issues as:

- Improving the presentation of meals
- Motivating colleagues to monitor the needs of residents more closely
- Training new nurse aides who are not familiar with the nutrition program

Time to assist residents: It takes an average of 10 to 15 minutes to feed a resident with a mild-to-moderate need for assistance. However, it takes up to 30 minutes to feed a resident with significant swallowing challenges. The nurse aides spend more time with residents who require the most assistance, and less time with those who can eat more independently. One resident interviewed by researchers expressed positive perceptions of the staff and said he had sufficient time to eat and did not feel rushed. The resident required little assistance with his meals.

Techniques and Strategies to Help Residents during Meals

Many residents at Emile Gerard suffer from dementia and cognitive diseases. The residents who have severe forms of dementia and other behavioral disorders live in the Protective Life Unit. The goal of staff is to help residents maintain as much independence as possible.
The nursing home does not have standard protocols for feeding residents with dementia. However, it does have a scale that outlines the normal progression of the disease and the types of assistance that could be provided by staff at each stage. The following examples illustrate the different challenges facing residents and the techniques that staff might use to offer assistance.

**Challenge: The resident does not react when the meal is served.**

- Make the resident aware of the plate. Initiate the process of eating by taking the spoon or fork and feeding the resident until he/she has the drive to begin self-feeding. Do not assist another resident until this happens.

- Stimulate the appetite and trigger the drive to eat by making associations between the visual appearance and the taste of the food. Point out that the green food is broccoli and the orange food is a carrot. Continuously remind the resident about what he/she is eating.

**Challenge: The resident needs moderate assistance.**

Cut the meat when the resident is unable to do it.

**Challenge: The resident has severe disability.**

Do not do the job for the resident. Instead, try to rekindle what eating is all about. Help the resident grasp the spoon. Guide the spoon to his/her mouth. This helps trigger the resident’s memory of the gesture. Make sure the resident participates in the eating process.

**Challenge: The resident cannot grasp utensils. Seeing food does not mean anything to the resident.**

This resident requires 100-percent assistance and must be fed. Sit next to and in front of the resident to feed him/her the meal. Tell the resident what he/she is eating.

Researchers interviewed one resident whose wife also lives at Emile Gerard. The wife has advanced dementia and is no longer capable of feeding herself. She has a special nutrition program to meet her needs. The resident is very satisfied with staff. He said that staff members are attentive and treat the residents well. He feels there is sufficient staff to assist residents during meals.

**Supervision**

Nurses do not supervise aides and agents during meals. The responsibility of the nurse is to delegate and instruct nurse aides and agents regarding what they need to do at the nursing home. Emile Gerard only has three to four nurses for its 240 residents. The home also has 17 dining halls. It would be impossible to have a nurse present at each meal to supervise the aides and agents, provide guidance, or assist with more challenging residents.
Assessment and Monitoring of Residents

Screening and Assessment of Residents

When residents come to Emile Gerard, they receive a clinical examination. The staff looks at each resident’s weight, height and mobility. They also measure albumin, a marker for malnutrition. Based on the results of the assessment, the doctor determines any necessary modification in the preparation of the resident’s food. The results of the assessment are communicated to a team of nurse aides, nurses and the dietician. The team works with each resident’s personal health practitioner to ensure that the resident’s dietary needs are met.

Monitoring Resident Food and Fluid Intake

Nurse aides do not monitor food intake for each resident during every meal. They will observe residents to determine who refuses to eat or who has suffered a weight loss. The results of this observation are used to identify residents who may have problems associated with eating less food or not eating at all.

When staff members observe that a person is eating less than usual, they will monitor the individual for three days. During that time, staff will calculate the caloric intake the person needs in order to improve his/her nutritional health. Nurse aides report any concerns about specific residents to the nurse. Nurses and nurse aides then discuss the resident, and record the information in the resident’s medical file. All staff—including doctors, nurses, nurse aides and agents—can access this file. The team will discuss the resident during meetings in order to find a solution to the eating issue.

When malnourishment is suspected, the nurse monitors what the individual consumes during meals, calculates the caloric value of that food, and compares that value to the resident's required calories. The resident’s caloric requirements are based on his/her height, weight and mobility. In addition, a medical exam is conducted to determine if the resident is depleted of nutrients and needs to be fed. The health practitioner looks at factors like height and weight, as well as the preferences and mobility, when assessing the resident’s nutritional health. This information is used to determine the resident's nutritional needs and to identify ways to help the resident consume needed calories.

Training

When a new aide comes to Emile Gerard, he/she has already learned about nutrition and feeding techniques during formal professional training. However, the center supplements this training with some in-services for care staff. The director of nursing is in charge of training programs at the center.

Nutrition will be the focus of the center’s training initiatives during 2013. The center will be conducting an audit of its nutrition program to make sure the nutrition program is meeting residents’ needs. This audit
will reveal the program’s strengths and weaknesses. The director of nursing will use this information to choose specific nutrition-related training topics for nurse aides.

When Emile Gerard implemented its new nutrition program, the medical director educated staff on a new culture of eating. Prior to the new program’s launch, the job of the nurse aide was limited to taking care of residents’ medical needs. Now, the center expects nurse aides to help socialize residents as well. Aides also have gained a new understanding of the link between good nutrition and the health of residents.

Nurse aides have participated in trainings held outside of Emile Gerard. One session focused on the nutritional needs of residents. Another focused on providing high-quality service and attention to residents during meals. The center wants customer service during meals that is similar to the service offered in a five-star restaurant, rather than a cafeteria.

The Menu Commission at the center is planning a nutrition program for new nurse aides. While these aides already have experienced general training and education on nutrition, that training was not specific to the concepts and philosophy of the center and was not aimed specifically at meeting the needs of Emile Gerard residents.

**Suggestions for Improvement**

Interviews with researchers demonstrated that, overall, residents are content with the meals and dining experience at Emile Gerard. Residents did not recommend any changes to the presentation of meals. They described staff as “top notch,” very conscientious, helpful when serving and assisting people, and responsive to the needs of residents.

One resident interviewed requested that barbequed meat and rare steaks be offered as a meal option. In response, Sodexo pointed out that logistics and the size of the home would make it difficult to meet this request. The center’s weak electrical system would also pose a challenge. The electrical system can barely handle all of the center’s toasters, let alone the equipment required to barbeque meat.

**Challenges**

Emile Gerard faced several challenges at the start of the nutrition program. As mentioned previously, the team had to change the thinking of nurse aides so they would begin to focus on both nutrition and medical care. The team educated and worked with staff to make this connection and to integrate nutrition into the medical care of residents.

The size of the nursing home, and its budget, also posed a challenge. The overall financial budgets are established one or two years in advance. It takes time to implement new projects and to develop policies for new initiatives. The medical director has acted as a catalyst to instill a willingness among staff to make the
nutrition program succeed.

Benefits

Staff and residents report that the nutrition program, driven by the vision of the medical director and implemented by a passionate team at the home, has been beneficial. The program’s perceived benefits, which are not all supported by data, include:

- Nurse aides now connect nutrition and health. This change has yielded positive results. Nurse aides now report when a resident does not eat. In addition, nurse aides have developed good work habits around nutrition.

- Nurse aides are trained to feed residents with swallowing difficulties. This can help reduce the number of aspiratory problems and lung infections associated with choking and improper swallowing.

- The cost of swallowing-related hospitalizations has been reduced. Staff is more aware of the fact that choking is caused by improper swallowing. Nurse aides now actively encourage residents to eat slowly. This can help reduce choking and swallowing problems.

- Resident mobility is improved. Well-nourished individuals have greater capacity and mobility. Physical therapists now work with more people who have greater mobility and are better at performing exercises.

- The number of residents with skin abrasions has been reduced. Bed sores often indicate a nutrition problem. When the medical director arrived at Emile Gerard, 10 residents had skin abrasions. Such abrasions are no longer a problem at the center.
The center uses a number of tools to help it assist residents with all forms of dementia:

- **Strategies to trigger memories**: Staff members work with residents to link a current event to a past event that residents will remember. In November 2012, staff led a discussion about the election of Barack Obama by linking that event to the election of John F. Kennedy.

- **White Room**: The center has a room that is entirely white. The psychomotor therapist and nurse aides sit residents in the white room who are agitated or exhibiting problem behaviors during meals and at other times. The room’s décor helps residents become calm again. The
room is quiet and safe. Staff can provide the necessary stimulation to connect with the person and change their behavior. Residents remain in the white room for as long as a staff member deems it necessary.

- **Sensory Room:** The distractions of the outside world are completely absent in this room, which offers sensory stimulation and relaxation through lights, sounds, smells and textures. Cerino Zegna uses the Sensory Room to help calm aggressive behaviors and improve the moods of residents. Each resident using the Sensory Room has a customized “Box of Memories,” which is filled with memorabilia designed to help the resident recall an earlier period in his/her life.

- **Color:** The center uses colors to help residents with Alzheimer’s disease and other dementias. For example, all the floors in the home are one color. The center adopted this décor when it realized that residents stopped walking when they encountered a change in the color of the floor.

- **Special projects:** Each year, the center adopts a special project to engage residents and staff. The current project is a garden patch of yellow flowers that residents and staff plant and tend. The center sells the flowers when they bloom and uses the proceeds to purchase more plants.

**Program Structure**

Cerino Zegna changed its dining program in 2008 when it discovered that residents were not eating well and were losing weight. The home needed a strategy to compensate for the energy consumption, hypoglycemia, and dehydration resulting from some typical behaviors of dementia like wandering. The center also wanted to better manage problems related to dementia.

The head nurse of the Alzheimer’s unit, medical director, the nurses, family, and the administration board worked together to make the changes. The team participated in multidisciplinary focus groups to determine the design of the meal plan. Their goals were to help residents by:

- Rebalancing and/or maintaining their body weight by providing adequate caloric intake
- Preventing physical problems associated with constipation
- Reducing behavioral disorders sometimes linked to digestion and poor nutrition
- Providing a comfortable environment during meals

Cerino Zegna partnered with its local health department and Sodexo on the new dining initiative. Changes to the menu were based on studies from the Alzheimer’s Studies Centre Perusini of Pordenone and discussions with Cerino Zegna staff. Those changes included:
- Adding three small snacks throughout the day (morning, afternoon and bedtime)
- Changing the components of the midday and evening meals to help with digestion (The center now offers residents only carbohydrates at midday. Residents eat only protein at the evening meal.)
- Increasing the center’s emphasis on hydration

**Partnership with Sodexo**

Sodexo and Cerino Zegna have worked together since 1992. Sodexo has an onsite dietician and division head who oversee the dietary program. In addition, 12 Sodexo employees work in the center’s kitchen.

The Sodexo dietician sets the menu after matching the nutritional quality of the food with residents’ caloric requirements. She shares the proposed menu with both the chef and the nurse aides, who have an opportunity to review and suggest improvements before the final menu is implemented.

Members of the kitchen staff prepare the food for each meal. These staff members do not have direct interaction with residents during meals. After preparing the food, members of the kitchen staff place it on a lift, which delivers the food to the center’s dining areas. Cerino Zegna personnel portion out and serve the food to residents after it arrives in the kitchen on each floor of the nursing home.

**Elements of Dining Practices**

**Dining Environment**

The staff of Cerino Zegna pays extra attention to the home’s dining environment. They want to create a relaxing environment that reduces unnecessary distractions. The caregivers speak with a moderate tone of voice to the residents. The tablecloths are white and do not have any decorations or designs. This is to avoid possible visual hallucinations.

Cerino Zegna began emphasizing the presentation of food after staff realized that some residents were not eating or drinking because they could not see or distinguish between foods and drinks that were the same color. To address this problem, staff began putting foods and drinks in dishes of contrasting colors so residents could better see the dishes and the food on the plate. Staff members also limit the number of items that they place in front of a person. Staff found that too much visual stimulation can be confusing to residents.

**Seating of Residents**

All residents eat in the dining area. A maximum of three residents sit at each table. Residents can have a say about who their tablemates will be. Residents that share similar characteristics and stages of dementia
sit together. This makes it easier for staff to offer assistance during the meals. Residents who are highly irritable, aggressive or wander are isolated to a quiet section of the dining room. This prevents overstimulation of other residents. It also helps the resident finish their meals.

Residents in wheelchairs are not moved to chairs in the dining room. The residents of the Alzheimer’s unit are seated in a wheelchair because they tend to be aggressive and are more content in their wheelchairs.

**Meals and Meal Preparation**

*Meals:* Sodexo’s contract with Cerino Zegna requires that each resident be provided 2,200 to 2,500 calories per day. The dietician prepares the menu based on that specification and the preferences of residents. To meet these requirements for caloric intake, residents receive three meals and three snacks each day. The snacks provide additional calories for residents who burn a significant amount of calories each day while wandering.

The dietician works in collaboration with the nursing team to ensure that residents receive their required calories each day. The dietary hospital provides a chart with its recommendations for the amount of nutrients/calories center residents need in order to be nutritionally healthy. Staff members use special serving spoons to portion out the correct amount of food for each resident. Generally, two serving spoons of food are sufficient for most residents, although the portion sizes can be personalized for each person.

Prior to the launch of Cerino Zegna’s new dining program in 2008, the center served residents multiple courses during the midday meal. This practice was discontinued when it became evident that residents were not consuming all the food they were served and that a significant amount of food was being wasted. Now, staff members are following hospital guidelines for the quantity of food that residents should receive during their three daily meals and three snacks. As a result, residents eat more of their food and there is less wasted food. In addition, residents appear to be feeling better.

Smaller meals also allow residents to finish their meals more quickly. As a result, they do not sit at the table for long periods of time. Residents who like to move around are less agitated.

Cerino Zegna strives to serve foods that will help improve mental wellbeing, hydration, weight and intestinal/bowel health. Meal design is based on a study of the calories needed for people with behavioral disorders. The following foods might be offered at each of the center’s meal times:

1. *Breakfast:* The first meal of the day features milk and coffee, biscuit, or a sandwich with a hazelnut spread, jam or honey. Residents with bowel or intestinal issues also receive three spoons of vegetable oil (olive, almond, and paraffin) infused with pureed fruit. This helps to prevent constipation and elimination from laxatives and enemas. In addition, a mini-breakfast of warm milk with sugar, served before breakfast, helps ease intestinal problems.
2. **Mid-morning snack:** Fruit or cooked fruit is served a few hours after breakfast. The center adds a mixture of three oils to cooked fruit in order to promote bowel health. Residents with severe bowel issues receive more oil than those who have only mild bowel issues.

3. **Midday meal:** The main, midday meal consists of equal ratios of carbohydrates and vegetables. Bread, fruit and water are also available. This meal is quite abundant. Portion size is based on the recommended quantity for each person that is established by the dietician in collaboration with the local hospital.

4. **Mid-afternoon snack:** This snack alternates between sweets, like a roll or cake with fruit juice, and a salty food like quiche, salami or ham. Ice cream is available in the summer.

5. **Dinner:** The evening meal features protein, fruit, water and bread. Because protein takes longer to digest, a person who eats protein later in the day can sleep longer, and with less agitation, during the night.

6. **Nighttime snack:** Before bedtime, residents receive a bar of chocolate.

Staff members provide water during the day with the goal that each person should consume two liters each day. Staff members sometimes encourage residents to consume water by adding sweet syrup to the liquid.

The dietician tries to personalize the center’s menu by soliciting the nurse aides’ opinion about the food preference of residents. Residents can substitute food items like yogurts, cream desserts and ice cream for foods they do not like. Staff members evaluate which foods residents prefer and will eat more readily.

Family members of day program clients rate highly the food provided at the center and feel there is good selection, especially compared to other nursing homes. The center provides relatives of day center clients a list of foods that it recommends families feed to the client at home. The center also provides recommendations for food presentation. Several family members reported during interviews that they follow the recommended menus at home. The family members confirmed that the all-protein evening meal helps their relatives rest better at night.

**Meal modifications and use of supplements:** The kitchen staff modifies the food of residents based on the stage of dementia and the degree of difficulty that a person has swallowing or chewing. A nurse aide will report to the kitchen if a resident is having problems eating and will work with the kitchen staff to determine the appropriate texture of the food to address the issue. The modified food is an adaptation of the food menu items. For example, a person with difficulty swallowing may be given chopped or blended foods or a smoothie. Staff may place corn flour in the food to soften it and to help a person avoid choking. Staff might add sugar to a food for a person with advanced dementia who has difficulty tasting food. Residents with weight loss are prescribed dietary supplements.
Sodexo staff members modify food in their kitchen. In addition, some modifications can be carried out in the small kitchens located on each floor of the center. Center staff may use the floor kitchen to peel apples or mash cooked fruit with a fork. Floor kitchens are equipped with a mixer in case food is too thick and needs to be modified before serving. The nurse aides are responsible for making these minor food modifications.

**Meal Times**

Residents eat at different times, depending on the person. Staff members make this decision, based on their observation of the person and the time he/she is most likely to eat well.

**Adaptive Equipment**

The severity of a resident's dementia will dictate the particular challenges the person has while eating. Cerino Zegna has three types of equipment for residents facing severe challenges at mealtime:

- A very small spoon that has been found to work well
- A bottle, which is used by a resident at the end of life
- A cup with a spout, similar to those used by children

When a resident will not drink from a cup, staff puts the liquid in a bowl and gives him/her a spoon with which to ingest the liquid. Using the spoon helps the person feel “normal,” report staff members. This technique also helps a resident take in fluids without fear of spilling the contents of his/her cup.

**Staff Assistance**

**Staffing ratios in dining rooms:** Staff-to-resident ratios are the same for each meal. Three caregivers and the nurse psychologist are always available during meals. The center assigns certain residents to each nurse aide. The nurse aides know everything about these residents. If other staff members have any questions about a resident, they address those questions to that resident's nurse aide. Cerino Zegna does not assign the same caregivers to help the same residents during each meal. The nurse aides can help anyone during meals, even people who are not assigned to them.

**Role of staff:** Cerino Zegna relies on the nurse psychologist, nurses and nurse aides to serve meals and provide assistance to help residents avoid the risk of malnutrition. The nursing center does not use other staff to provide support during the meals. However, volunteers provide additional support during mealtime.

- Nurse psychologist (head of the Alzheimer's unit), nurse and nurse aides: The psychologist and nurse place the food on plates and make sure the food quantity is correct for each resident. Nurse aides offer plates to the independent eaters first and supervise these residents to make sure they have no problems eating. After the independent eaters are served, the psychologist,
nurses and nurse aides assist residents who need assistance. Caregivers work one-on-one with any resident who is agitated. The nurses supervise staff and resolve any conflicts. The nurse psychologist, nurses and nurse aides meet once each week to discuss residents who have eating challenges. Staff members pay extra attention to these residents during mealtime.

- **Family members:** Family members can assist a relative during mealtime. However, staff will ask a family member to leave the dining area if his/her presence agitates the resident.

- **Volunteers:** Volunteers split their time between meals and activities, depending on the need.

**Time to assist residents:** The meals usually last 90 minutes, but staff give residents the time they need to finish the meal. Staff also will put meals aside and offer it at a different time of day if a resident does not want to eat. Family members reported that their relatives have sufficient time to finish their meals.

**Techniques and Strategies to Help Residents during Meals**

The main objective of the dining program at Cerino Zegna is to get each person to eat the meal. To reach this goal, it is important for staff members to have a relationship with residents who have advanced Alzheimer's disease. Staff must be able to encourage these residents to eat their food, even if this means making multiple attempts to offer food during mealtime. Staff is less concerned about the process of eating than they are about getting the person to complete the meal.

Staff members use a combination of tools to encourage center residents to eat:

- **Verbal cues:** Staff provides residents with verbal reminders to start eating or resume eating. Some people begin to eat but then forget what they are doing and stop eating. Staff reminds them to continue eating.

- **Mirror imitation:** Caregivers—including staff, family members and volunteers—will model eating and place a mirror in front of the resident or client to encourage him/her to imitate their gestures. Staff members will also sit beside the person to encourage them to eat.

- **Visual stimulation:** This might include using colored glasses or placing colored food on white plates. In addition, staff may only offer foods of a certain color to people who prefer that color. Center staff asked Sodexo to prepare colorful food to stimulate the senses of the residents and entice them to eat.

- **Supervision:** Staff members supervise residents who still have autonomy in the use of one or more pieces of cutlery.

- **Temporary segregation:** Some residents will stop eating in the company of others. These individuals may be segregated from their tablemates when they are eating and then seated with others after they complete the meal.
• Finger foods: Finger foods, such as mixed steamed vegetables and potatoes formed into little balls, are available to help residents who are unable to hold a knife or fork. Cerino Zegna began offering finger foods after members of its staff visited a center in Switzerland that serves small pieces of food that has different colors. This approach appealed to Cerino Zegna for several reasons:
  • Residents can eat finger foods more independently.
  • People with dementia enjoy picking food up in their hands and eating it.
  • Residents who wander can pick up finger foods that are left at different parts of the room. These individuals eat while they explore different areas of the dining room.
  • The center’s finger foods resemble snacks that Italians traditionally eat before meals.
  • Finger foods allow the center to count a diner’s caloric intake more accurately. If a resident eats four pieces of finger food, staff members can easily calculate the number of calories they have ingested.

Assessment and Monitoring of Residents

Screening and Assessment of Residents

Each resident who comes to Cerino Zegna is evaluated to determine his/her stage of dementia and to help the center create a customized program of activities and dining assistance. The following tests are administered by the psychomotor therapist, whose work focuses on the relationship between the mind and body:

• Functional Assessment Staging of Alzheimer’s Disease (FAST) Scale: This scale gauges the progressive activity limitations associated with Alzheimer’s disease. Staff rates an individual on a scale of one to seven. A rating of “one” indicates the person is independent and can feed and cut food by him/herself. A resident will receive a rating of “seven” when advanced dementia severely limits the ability to eat independently.

• Global Deterioration Scale for Assessment of Primary Degenerative Dementia (GDS): Staff members use this scale to assign a resident to one of seven stages of cognitive decline.

• The Mini Mental State Examination (MMSE): This examination diagnoses dementia and assesses its progression and severity.

Once all three assessments are complete, staff members use a chart to match a resident’s score to his/her mental age. The referring physician, medical director and nursing staff also assess the resident. Then, the psychomotor therapist works with the nurse, and the nurse aides who feed the resident, to determine that
person's dietary needs and food-related preferences. The specific feeding approach is a group decision in which the entire team participates.

The team may decide to feed finger foods to a person with a mental age of 17 or 18 months. A person with a mental age of only a few months will require total assistance while eating. These residents may be given liquids, a bottle or soft foods, depending on their ability to swallow.

**Monitoring Resident Food and Fluid Intake**

Staff members observe residents and record the food and fluid intake of each person throughout the day. Staff records the information on the medical record and in journal diaries. Nurses check the journals and may, if deemed appropriate, work with the physician to devise solutions. They may also seek the advice of a dietician hospital regarding dietary supplements and aids for swallowing difficulties (dysphagia).

**Training of Staff**

Nurse aides are required to have 1,000 hours of initial training. The training is divided into 300 hours of classroom time and 700 hours of practical training. Feeding residents is one of the topics covered during the classroom training. Nurse aides also learn feeding techniques through on-the-job experience. Experienced nurse aides and nurses at the center educate new staff and verify their training.

While training is considered important, experience and knowledge of individual residents are also important tools that can help a staff member successfully assist residents during mealtime. Staff members used both tools while helping a young woman with advanced dementia transition from being a day program client to being a full-time resident at the center. The woman stopped eating and displayed increasingly agitated behavior, including screaming and yelling. After trying several techniques to calm the resident, staff began singing a particular song to her during mealtime. This helped calm the resident so she could eat.

Cerino Zegna holds a yearly training program for all care staff. Training topics vary, depending on specific issues that staff members have had to address during the year. Training can incorporate dietary issues.

Staff members have also attended training at the International Study Centre Alzheimer Perusini. The research center provides information about Alzheimer's disease care and how to create suitable environments for those suffering from the disease. During these training sessions, staff members learn techniques for assisting people with dementia.

Sodexo trains nursing center staff when it introduces a new component to the dining program. For example, after introducing finger foods in November 2012, Sodexo trained the center's staff on the new food. In addition, the center's chef offers courses for the kitchen staff on such topics as swallowing, eating and weight problems. While members of the kitchen staff do not feed residents, this information helps them understand better the residents for whom they were preparing food.
Costs

Cerino Zegna has seen an increase in labor and meal costs since revising its dining program. These costs include:

**Labor**: Cerino Zegna invested in additional workers to help serve the center’s three extra meals (snacks). The extra meals required more preparation time. Labor costs rose as a result. In addition, several staff members attended training in Pordenone, which involved travel and education expenses.

**Food**: The three new meals cost the equivalent of $2 (1.5 Euros) per resident. Food costs have risen by 40 percent since the new program was launched.

Benefits

The center continues to remain open to new ideas, projects and strategies to ensure residents meet their nutritional requirements and to create a dignified dining experience for residents. Staff reports that the changes to Cerino Zegna’s dining program have yielded many benefits for residents. Staff members report that residents are enjoying these benefits:

- *Increased weight*: Residents are gaining weight because they are eating more of the food served to them at each meal and because they are eating more meals per day.

- *Improved intestinal health*

- *Improved behavior*: Staff members report that one of the most important outcomes of the nutrition program is that residents are calmer than they were prior to 2008.

- *Some changes in medication use*: While there is no cure for Alzheimer’s disease, the center’s goal is to provide a better quality of life for each person for as long as possible. One way to achieve this goal is to decrease use of medications. For example, staff members report that they prefer to give residents something to eat or drink—rather than medications—in the evening so they sleep better. This policy has resulted in some small changes in overall medications use.

- *Improved public relations*: The dining program has become a marketing tool for the nursing home. Staff feels the program is a great advertisement for the center and helps it attract new residents.

Researchers interviewed family members of the day program clients. The family members expressed satisfaction with the center’s dining program. They reported having less stress because they only have to prepare one meal for their relative each day. In addition, the center provides guidelines for meals that fam-
ily members can prepare at home. Family members report that the new dining program has resulted in these benefits to clients:

- **Improved eating**: Family members, who follow the center’s guidelines for providing six daily meals, report that their relatives have experienced improved eating and weight gain. One family member reported that her father sleeps better because his evening meal consists of vegetables and protein.

- **More liquid intake**: Staff encourages clients to drink more, which is beneficial for both their physical and mental health. Clients are asked to drink a glass of water each hour and are consuming two to three liters of liquid a day.

- **Opportunities for family involvement**: Family members are better able to assist residents and to provide nutritious meals. The center provides guidelines for the preparation of meals not served at the day center as well as techniques to incentivize a family member to eat. For example, following center guidelines, one family member encourages her father to drink water by drinking it first. He automatically follows her movements.
Conclusion

Four nursing homes in Belgium, France and Italy used innovative approaches to improve the dining experience and nutrition of residents with dementia. Guided by a philosophy of person-centered care, staff members implemented a customized dining strategy for each person. The dining programs focused on fostering independence, improving nutrition and creating an environment in which each resident could enjoy a dignified dining experience.

The four homes created opportunities for residents to eat as independently as possible. Initially, they provided the minimum amount of assistance required by the resident to eat. They added hands-on strategies as the person's stage of dementia increased and his/her capabilities declined. The homes used adaptive equipment, including specialized dinnerware and utensils, to enable residents to eat on their own.

Each nursing home strived to make the eating process as normal as possible for each individual. For this reason, staff members preferred to make only minor adjustments in the dining process in order to help residents eat their meals as discreetly as possible. Staff gave all residents food from the regular menu and only modified food to address an individual's specific challenges. Staff members treated as normal all of a person's behaviors during the meal.

Many of the nursing homes used a team approach to assist and work with residents. The nurses and nurse aids took the lead in helping residents during the meals. The homes engaged other staff and outside help—including housekeeping and dietary staff, volunteers and family members—to provide extra support at mealtime. The additional assistance allowed the homes to provide residents with more individualized care and choice, which can be time consuming. Staff members established connections with the residents so they could better understand their needs.

Staff members, residents and family members identified many perceived benefits that they attributed to the dining programs. These perceived benefits included improved quality of life, more choice, better behaviors and increased satisfaction among residents. In addition, staff noted that residents appeared to have achieved improved clinical outcomes as a result of their improved nutrition.

Staff members appeared to benefit from their increased awareness of the nutritional needs of residents, and from their practical knowledge of dining techniques that could help meet those needs. These techniques helped to improve residents' eating habits by encouraging and incentivizing residents to eat. The dining programs also offered staff from non-nursing departments at some of the homes an opportunity to engage with and have personal interaction with residents.

Nursing homes can replicate the techniques and concepts used by the homes featured in this report. Such replication could help offset the adverse effects that dementia has on nutrition, hydration and socialization. It could also enhance clinical outcomes for residents and improve their quality of life.