Eating Together: staff and care home residents sharing food and drink

Written by Peter Bates as part of Time to Connect.

Some practical implications of this paper are set out in this poster or as this leaflet.

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Introduction

When people living in care homes have lunch or go out for a meal or a drink, what do the staff do? Some organisations, such as Certitude[1], encourage staff to eat with the person whenever possible, rather than just helping them, in line with longstanding advice from Grethe Berg[2] and others[3]. But if the staff eat, who pays for the food? Are they on duty? We begin with a declaration by Professor Jane Murphy of Bournemouth University[4]:

> *"Through our research we have demonstrated improvements in eating and drinking for people living with dementia in care homes when staff care givers (and family relatives) eat together with residents at mealtimes."*

This paper begins with a short review of the evidence about what makes a successful mealtime in a care home, but then moves on to the specific issue of staff eating with residents, both in and out of the care home environment. It has been written to close a gap in the literature[5].

The importance of mealtimes

Challenge #1

Are the mealtimes in your care home arranged in the light of the available research evidence?

People need food security – enough food of the right sort – to stay healthy into old age[6]. Eating has many benefits in addition to its nutritional value – it is often a social occasion[7] and it helps to structure the day[8]. Choice of where to sit, what to eat, when to eat it and with whom helps to create a feeling of home[9], improves cognitive function[10] and enhances wellbeing. Mealtime behaviour exercises implicit and procedural memory, the ability to complete routine tasks without deliberate thought and recollection, such as loading a fork, wiping one's mouth and passing condiments, which often outlasts other memories and can be supported through good care. This happens when the practical arrangements for the mealtime and the attention of care workers is focused on supporting and promoting independence rather than taking over and doing things for people.

Sarah Barnes and her colleagues noted[11] with some disappointment that some staff would often add milk and sugar to residents' cups of tea when they were entirely capable of completing these tasks for themselves, so depriving them of choice, control and dignity. Despite these attempts to save time, staff still spend a considerable part of each day assisting residents to eat and drink[12]. Of course, many residents can eat independently, or almost independently, and others can do so if they are provided with a plate guard, specialist cutlery and drinking vessels or other adaptations.

Further initiatives have been taken[13] to improve the texture, taste, appearance and nutritional value of food eaten by older people. Some care homes buy moulds to shape pureed food into the appearance of familiar vegetables and other items, but busy kitchen staff do not always use them. It helps when the person can easily 'read' the table, menu and plate, sit well, and manage the risks associated with eating. Improvements to the dining environment are worth making too, such as use of the colour blue which hints at cleanliness, as does sunlight, greenery and wholesome-looking crockery and utensils. It helps when distractions and interruptions are reduced, and when people have access to nutritious snacks between meals. One consequence of dementia experienced by some residents is that the smell and taste of familiar food changes[14], and staff may respond to the person's uncertainty by emphasising their own response – one often sees exaggerated lip-smacking and other expressions of obvious enjoyment from staff who hope to convince the waverer that the food is good.

"The elderly gentleman sat directly across from my family in the diner. Our waiter, Dylan, dropped to one knee to look him eye-to-eye as he took his order. The man talked about how he lost his hearing during the war. Dylan patiently listened giving him his full attention. Eventually, the man apologized, "I'm alone now and I don't often have someone to talk to." Dylan smiled and said he enjoyed listening. He then helped him decide what to order. After the man received his food Dylan came back, said he was on a break and asked if he could sit with the gentleman as he ate."[15]

The culture of dining appears to be changing rapidly in many countries, moving from traditional family mealtimes around a table to a blend of TV dinners, solitary snacks, takeaway food and restaurant visits[16]. Despite this, sharing a meal together continues to have rich symbolic meanings[17] and culturally defined table manners endure, perhaps more so amongst older people.

A specific illustration of this is the way in which people in many cultures offer food and drink to guests as a way of demonstrating welcome and hospitality, the way in which refusal of this offer is deemed rude, and the awkwardness that accompanies the experience of eating while others are not.

Challenge #2

Are residents supported to act as host to their guests?

We might hope that in offering accommodation to residents, care homes also help people to feel at home by enabling them to observe these traditions. Individual residents can be enabled to provide refreshment to their guests, with staff perhaps fetching the drink and biscuits and even serving it where the resident cannot do so while finding ways to emphasise that it represents the resident's act of hospitality, not their own. In addition to these incidental moments of sharing refreshment, some homes[18] permit visiting relatives to enjoy a meal and so enable them to eat with their relative, adding to the sense of homeliness[19]. Some places are even more hospitable, such as St Christopher's[20] where "Family and friends are welcome to join our residents for a meal whenever they like – at no cost whatsoever." In at least one similar setting, the presence of relatives stimulated meal table conversation and led to relatives helping several of their table companions as well as their family member[21], thereby reducing workload pressures on staff. Researchers who visit the home may have a similar impact if they eat with residents[22].

A second implication is that residents should have access to the kitchen and an opportunity to prepare the food and beverages that they share with their guests. So, for example, residents may bake a cake in anticipation of a visit by relatives or add the milk jug and sugar bowl to a tray before staff carry it to the kitchen to add boiling water and return with drinks for the guests.

Thirdly, respecting the importance of sharing food means that residents routinely share meals with other residents and with staff. Indeed, one worker observed that residents would often offer them a morsel of food from their own plate in consideration of these cultural norms[23], while a researcher found staff sharing their own food with residents and residents wishing that they could prepare food as a thankyou gift for staff[24]. Such moments give a nod to the restaurant scene in which lovers offer one another a forkful of their own meal. Sharing food together also overcomes the principle in many cultures that prohibits eating while people around them (including staff) do not. There is no neutral option here – care homes either honour and uphold these courtesies or ride roughshod over them.

Making the most of mealtimes in care homes

Harnett compared institutional, hotel and homely approaches to mealtime and found that it was hard to establish and sustain a homely approach[25]. Others have asked residents what they think about meals and mealtimes and found that they prefer a homely format[26]. Similarly, when restaurant-style options were introduced in some care homes, staff needed to skilfully navigate between their roles as carer and waiter and some staff had no prior experience or training for the waiter's role[27]. McGilton and colleagues found that care staff offered fewer relational interventions – smiling, slowing down to the pace of the resident and attentiveness – during mealtimes compared to other periods of the day, and that this led to increased levels of distress and challenging

behaviour[28]. Large dining rooms can be over-stimulating and poor staffing levels can lead to residents being rushed through the meal, so that on occasion their efforts at self-care and social engagement with others are blocked by staff[29]. Residents may give up asserting their preferences[30], and trying to manage independently[31], leading to malnutrition[32]. Risk is increased if the resident receives partial rather than total help with eating[33] or eats alone in their rooms[34], where they can be forgotten and so miss meals entirely[35]. In contrast, managers at Jewish Care have found that where staff eat with residents, this leads to a reduction in inappropriate and challenging behaviour during mealtimes, as well as the promotion of positive communication, etiquette and respect[36].

Simple strategies can improve nutritional intake, such as changing portion size, responding to appetite variations through the day[37], adding variety on the plate and placing serviettes and condiments on the table[38], although the research evidence supporting these strategies is not especially strong. Homely settings provide many hints that a meal is imminent, as pleasant kitchen smells stimulate appetite[39] and preparing the table increases anticipation, in contrast to institutional regimes which lack these aids. At Overdale, the Christian ethos of the home means that grace is said before each meal, potentially increasing anticipation, and a reading is given after the meal is over, strengthening the sense of occasion.

Staff sometimes use negative prompts to try and persuade residents to eat independently or more quickly, but this abuse triggers feelings of intimidation, depression and anxiety[40]. Staff vary from neglectful to highly skilled practitioners[41], so the daily routine of sharing the meal table has the potential to provide a stable point of contact with the resident, an opportunity for a growing sense of familiarity for those who are confused, a chance to learn more about the resident's past life, and a setting for the assessment of skills.

All care staff sit down to eat together with residents at every meal at the specialist dementia care home run by Eothen[42] in Wallsend, where people sit in family-sized groups and interesting objects are placed on the table to prompt discussion. A fragrant bunch of seasonal flowers or a hand cream, a recipe book or a reminiscence object creates common ground and stimulates memories and conversation. Food choices are plated up and brought to each person so that they can look and choose right there. People are encouraged to wait for one another, so that the meal, from anticipating the smells and sounds of food preparation to the companionable sharing of the teapot at the end, is a communal event reminiscent of home. Some of the thinking from the Slow Food[43] movement is applied, as the home deliberately enjoys seasonal vegetables and at some meals there may even be a raw vegetable at the centre of the table as a reminder to help people connect with the meal in front of them. Creating a stimulating and pleasant mealtime environment has reduced the amount of distress and challenging behaviour.

Others too have reinforced the importance of mealtimes as a social experience rather than just a nutritional one[44], although this is more difficult to measure. Hall and Gilliland note that, where staff encouraged conversation, this inconveniently lengthened the duration of the mealtime for staff who wanted to get on with clearing up and moving on to the next task[45]. If one staff member, attentive to the relationship potential of a shared mealtime, sits down with a group of residents, do his or her colleagues resent their apparent 'laziness' and press them to refocus on tasks?

From the residents' perspective, however, conversation can enrich the mealtime and eating with staff or other visitors can be highly valued[46]. This means that staff may inadvertently create a 'top table effect' by sitting down with one group or even perching on an armrest and exchanging a few words, favouring these residents with their attention[47]. The quality of the dining experience can be assessed using the Dining Environment Assessment Protocol[48] and the Mealtime Social Interaction Measure for Long-Term Care[49] and staff can be trained to make more of mealtimes[50]. There is clearly a relationship between these factors and increasing the amount of social interaction at the meal table does improve food intake[51].

Challenge #3

Are staff permitted to eat and drink with residents?

Nijs and colleagues[52] compared traditional and family-style mealtimes in which a great deal was done to create and protect a homely format, short of staff actually eating with residents, as shown in the following comparison. In their study, family dining delivered significantly better results[53].

Family style	Pre-plated service
Table dressing: Tablecloth; drinking glasses (no plastic cups); normal plates; full cutlery; napkins; subtle flower arrangements	No tablecloth; plastic cups; predesigned plate, divided into three sections; residents wear bibs
Food services: Cooked meal served in dishes on table; menu choice between two types of vegetables, meat, and staple foods; no ready to eat sandwiches during breakfast or supper	Cooked meal served on individually pre-plated tray; residents choose meals two weeks beforehand; ready to eat sandwiches during breakfast and supper
Staff protocol: Staff sit down at tables and chat with residents; minimum of one nurse or nutrition assistant or volunteer per table; drugs handed out before start of meal; no change of staff during mealtimes; dining room tidied up directly after meal, when everyone finished	Staff do not sit down; two staff members hand out trays, another staff member hands out drugs, and one staff member helps residents who prefer to stay in their room; family and volunteers sit down with residents they prefer; staff leave for lunch when they think nobody needs help; tray put away as soon as residents finish their meal; residents who finish early are helped to toilets or to leave the dining room
Residents' protocol: Balanced seating of residents (typically six per table); residents decide when food is served; most residents serve themselves, with some help from nurse or table companion; mealtimes begin when everybody is seated; before eating there is a moment for reflection or prayer	Seats assigned on basis of availability (typically six residents per table); residents cannot change meal if they dislike it; mealtime begins when trays arrive; residents hold their own moment of reflection.
Mealtime protocol: No other activities (for example, cleaning, visits from doctor); dining room closed for visitors and healthcare providers (except where observation by healthcare giver is necessary or visitors help residents), in both cases they have to be in the room at start of mealtime and remain until end; meal carriages for drugs and residents' files have to be out of sight	Diverse activities take place (cleaning, doctor visits, laundry arrives); family and friends walk in and out of dining room, disturbing other residents

Different cultures adopt slightly different versions of this protected mealtime or family meal, such as in France, where Charras and Fremontier describe residents being offered a glass of wine before the meal, which was then presented in four courses, with each plate being cleared away and the group moving on to the next one only after everyone has finished. This, of course, breaks up the timing differences between fast and slow eaters and encourages conversation. Enjoying culturally specific food brings joy and delight to people with dementia, reminding them of childhood and home[54]. In one study, residents were involved in menu planning and sometimes directed the cooks in preparing traditional cuisine[55]. No doubt more recent studies would include a ban on mobile phones at the table in the rules for a protected mealtime!

Eating with staff in the care home

It is unusual for staff to share a meal table with residents and eat with them[56]. However, it is not unknown, especially if one counts festivals and celebrations as well as everyday meals and cake as well as full meals. Some residents need practical help with eating the meal as they cannot use utensils or are at risk of choking, while others need reassurance or encouragement to eat safely, sufficiently and with appropriate conduct. Modelling (rather than merely instructing) mealtime behaviour and helping another person to eat are both deeply nurturing, reminiscent of the intimacy of family life and some care staff would like to have the option of eating with residents[57]. One staff member commented on the value of simply sitting down at the table with residents, '*One of us has to sit with glue on our bottom during the meal, otherwise the residents start to walk around.*'[58] Furthermore, interventions designed to improve quality of life, such as person-centred care and intensive interaction[59], demand flexibility of response which would be blocked by a blanket prohibition on eating together.

There is a wealth of research about how to make the most of mealtimes in congregate care settings. Increasing choice for residents is one consistent recommendation. For example, one resident with dementia might 'forget' to chew and swallow so that food falls from his mouth, but will then rapidly consume a soft, sweet dessert, and this may indicate that both food choices and mouth care matter. Similarly, people eat more when they have the choice of where and with whom to sit[60]. We might hope that poor eaters would copy their more adept table companions, but it is perhaps more likely that residents will move away from those who lack speech, cough, spill their food or need constant help. In addition, some residents simply do not want to eat with others, especially people they do not know or like[61].

At the same time, we might hope that both residents and staff would employ 'civil inattention' to overlook the poor table manners of their companions[62], but some are unable or unwilling to exercise such courtesies. Staff could be dining companions for such individuals, modelling the desired behaviours and encouraging mimicry as they eat their own meal. In some settings, eating together in this way and for this purpose is an accepted option within the repertoire of ways to support the resident at mealtimes. It must also be borne in mind that a few residents will require the full attention and help of a staff member at mealtimes and that worker would be quite unable to do anything else at all at the same time as providing assistance – even eating their own food.

Training for staff can focus on the emotional experience of being fed, such as closeness, intimacy and care, or perhaps vulnerability, disgust or distress. In one example, staff worked in pairs, with one worker feeding their colleague. The person being fed was variously blindfolded, unable to move their hands or wore headphones to simulate deafness. During the exercise, one or other member of the pair was silently given a written instruction such as:

- Mix together all the different kinds of food on the plate until it looks like a cowpat

- Be in a hurry and give the person another spoonful before they are ready
- Move away for a time and then return to the task without communicating with the person
- Leave food on the person's face rather than cleaning it up
- Switch from main course to dessert without a break, drink or explanation
- Decline the food by turning your face away.

In considering relationships at the meal table, few research papers consider staff as potential meal partners, and most focus entirely on relationships between residents, as if the staff are somehow invisible beyond their role as caregivers. Guidance from the Care Quality Commission focuses on nutrition, hydration, independence, choice and preference, but does not say anything about our question, although an inspection report praised a home where staff and residents shared meals together[63]. An exception is found in a publication from My Home Life that explains that research shows that social mealtimes shared with staff are helpful to residents in terms of nutrition, hydration and relationship-centred care.

Staff need a break

While staff sometimes forego their break in order to share a meal with residents, they also enjoy some time off from the challenges of supporting residents and eating their own meal in a chosen location is, for some, an essential part of their break[64]. Indeed, a break from work is an employment right under the European Working Time Directive[65]. Staff who are asked to forego their lunchbreak and instead eat with residents can rightly negotiate a break at another time or a shorter working day. However, not all care homes assume that staff will want to take their break away from residents. At the Lodge Trust, staff who miss their break to support residents during mealtimes are offered a free meal. In another home[66], there was no staff room at all, and staff took their breaks in the dining room shared with residents. Conversations between staff and residents flourished in these shared mealtimes, although few of these particular residents were incapacitated by dementia and so engaging with them in conversation was not especially burdensome. Elsewhere, volunteers have been engaged as Mealtime Volunteers to help people eat, but not eat with them[67]. With all these options, common sense needs to be applied, as in the home where people with learning disabilities prepared some of their own individual meals. A lone worker could help several residents prepare their meal for one over the course of a shift, but would obviously not wish to eat each time.

Challenge #4

Do staff get a proper break?

Anecdotal evidence from children's nurseries may shed some light on how clear employment rights can be re-interpreted in local services. In one nursery, the manager mistakenly thought that staff who ate with the children were gaining some benefit for themselves, and so could be denied their full breaktime, in direct contravention of the rules, which are entirely clear that these staff are on duty and should be paid for this time. This amalgam of work and break time can occur in care homes too, especially where staff are expected to write up records whilst taking their break. In a second nursery the children were fed first and staff were permitted to eat the leftovers, an approach that was unlikely to lead to staff and children regularly eating together, but rather led to staff sometimes overriding these rules and taking food for themselves anyway and potentially depriving the children. In a third environment, sufficient food was prepared to permit the staff to eat a small amount and they adjusted the size of their own lunchboxes to accommodate for this. Here, staff were encouraged to eat with the children and were not charged for the food or assigned a reduced break.

Being obliged to eat the same diet that is served up to the residents will sometimes deny staff their individually tailored diets and preferences as expressed through their own lunchboxes. This is only the case where residents are denied their personal preferences too, and so asking staff to eat with residents will serve as a test of whether meal choices are restricted or person-centred. Eating slowly to keep pace with residents will mean that food served hot will go cold before it is consumed, and this may make it unappealing. On the positive side, chefs will improve the choice, quality and presentation of the meal when they know they are cooking for guests or colleagues[68].

Money matters

Where staff are on breadline wages, the incentive of a free or competitively priced meal[69] may be sufficient to encourage them to eat with residents, while others may feel that they are simply too busy to sit down, especially if they are expected to keep pace with the resident rather than rush their own meal and move on to another task. Sadly, some staff do not even sit down with the person they are feeding – Pearson et al[70] describe sitting down with the person as 'a small way to show respect'. Worse, a stressed and frantic worker is likely to pass on their restlessness to people with dementia, as well as confusing them with multiple tasks, instructions and hurry. But there is no doubt that mealtimes are busy for staff, described by Watkins as a 'pinch point'[71] in the day.

Challenge #5

Who pays for staff meals that are eaten with residents?

Low wages and difficulties with recruitment can place additional demands on the depleted workforce, which will result in even less time to pause and speak to a resident or share a few moments over food. As the shrinking resource of staff time is allocated to those who need the most help, the quality of care deteriorates for everyone else and researchers have noted that more staff become 'technical feeders', focusing on hygiene and dietary intake while suppressing conversation, rather than 'social feeders', who make the mealtime a social occasion as well as a nutritious one[72].

There can be severe consequences for staff who break the rules[73], as eating the food without permission may be viewed as theft. Managers who are trying to deal with spiralling costs levied by recruitment agencies may consider free meals for staff as an unnecessary additional expense, and the tax office view them as a salary perk, and levy tax accordingly. Even if it is permitted for care staff to eat with residents, financial pressures may restrict this benefit to some rather than all employees, potentially creating dissent within the workforce. On the other hand, improving the quality of mealtime experiences has been found effective in reducing the need for expensive nutritional supplements, so inviting staff to eat with residents may pay for itself[74], while inviting people to choose their own portion size can reduce food waste. In one home, Charras noted[75] that the kitchen staff were always over-catering and then throwing a great deal of food away, Changing the rules to permit staff to eat the same food as residents did not increase the food bill; it simply reduced wastage.

A taxing problem

The UK taxation system[76] starts with the view that food provided by the employer and eaten at work is a potentially taxable benefit for the employee, and so we need to consider if there are implications for staff.

There is a tax exemption that states that where food is provided free, or on a subsidised basis, to all employees at the place of work, there is no tax liability. Not everyone has to accept or partake in the

arrangements, but all employees must have access to it on the same basis. If staff had the choice to have the same meal that was prepared for residents, there would be no tax implications.

If staff only had access to the meals provided by choosing to eat with residents, providing everyone could choose to do this, again, no tax implications would arise. Even if an individual Tax Inspector considered that by limiting access to meals to employees who chose to eat them with the residents was effectively restricting the access to the staff meals, as it is likely that the cost of providing meals for staff to eat with residents was marginal to the overall cost of the food for residents, in other words, no additional significant cost was incurred, again, no tax liability would arise.

Her Majesty's Revenue and Customs (HMRC) look carefully at food provided or reimbursed to staff at an outside establishment, i.e. a restaurant, café or pub. Their starting point is that this is a taxable benefit in kind. However, where it is clearly documented that there is a good business reason for the meal to be provided, and the meal is not just for a group of staff but also involves customers or business associates, (in this case care home residents), the food and drink becomes an allowable business expense. As the residents are unable to leave the care home without a member of staff accompanying them, due to safety issues, if the resident requests to go to a café, restaurant or pub for food or drink, and this is in line with their care plan as part of their social interaction, a member of staff will be required to accompany them. As part of the social interaction, it would be expected that the member of staff accompanying them will also order food or drink and be reimbursed for that expense either by the employer or the resident or the resident's family. For the member of staff, this is an expense incurred whilst carrying out employment duties, and if it is clear from the policies and care provision that joining the resident on these outings involves having food or drink as part of the social care, this reinforces the business nature of the expense.

The reimbursed expense must be fully receipted, and on the receipt and claim, full details of all participants (indicating which are residents and which are carers), together with a business or care reason for the expense should be clearly documented. Providing the documentation is very clear and the food provided to the member of staff is similar (or less) in value to that of the resident, HMRC will not seek to argue that a benefit in kind arises. If the carer is seen to take advantage of the opportunity, and have more lavish food or drink, or the food and drink is not appropriate for the occasion, this will be regarded as a taxable benefit by HMRC. It is good practice for the carers accompanying residents on outings to be varied, if possible, unless there is a specific reason for a particular carer to be involved.

Another consideration is compliance with the National Minimum Wage (NMW) Legislation, which is also monitored by HMRC. When staff have meals with residents, or accompany them on trips out, this is regarded to be working time for NMW purposes and must, therefore, be paid time. For NMW purposes, only time away from residents and time not doing other administration work will be considered a break, which is not working time for NMW purposes. If breaks are not paid, this should be clearly documented in the contract of employment to avoid any contention that breaks are working time for NMW purposes.

Professional distance

Professional distance is a pervasive concept in health and social care that seeks to avoid abuse by regulating the so-called professional boundary between staff and the people they support. Adopting the idea may reduce the number of serious cases of exploitation, lessen the risk of staff becoming

over-involved and work well in specialised settings such as psychotherapy, but it can also harm by erecting and justifying an apartheid-style culture and institutional approach. Charras[77] described a home where staff were encouraged to eat with the residents and did so by bringing their own food with them – which must have sent a signal about the social distance between staff and residents. Indeed, mealtimes can be a moment when these formal relations between staff and residents become especially visible, as illustrated by Hung & Chaudhury[78]:

> *'Distancing was particularly noticeable at Gardenview mealtimes. Staff talked among themselves and ignored the presence of the residents. Staff would switch tone to authoritative when they had to speak to residents.'*

Language also changes to reflect this institutional approach, as staff speak about feeding rather than eating, and about nutrition and hydration rather than food and drink[79]. Moving staff around may share out the difficult work of helping those who present the most challenges, but it weakens the bonds of connection between the individual worker and resident, adding to the risk that staff become faceless operatives rather than known persons. Indeed, in one study[80], increasing the number of staff shortened the mealtime, rather than lengthening it, revealing that the staff were focused on completing the nutritional project, rather than enjoying the meal as a social occasion and opportunity to connect.

In wider society, a shared mealtime is an ancient bonding ritual that strengthens community and reduces unwanted divisions between people. Charras and Fremontier[81] observed that residents talked more about their lives over the shared meal and staff heard new stories. Hall and Gilliland[82] found that when the dining experience improved, so did the quality of relationships within the resident group, and the quality of relationships within the staff team. Berg[83] indicates that sharing a meal together will lower barriers between different professions and grades of staff and between fulltime and guest staff (such as drivers or doctors), thus enhancing multidisciplinary assessment and therapy[84]. Indeed, when staff share mealtimes with residents, we might expect to see social hierarchies dissolving and human connections forming. This can then form part of an alternative approach[85], based on shared humanity and the similarities rather than the differences between staff and residents.

For an example, see this description of shared therapeutic meals at Huntercombe and the report about a care provider called Belong where staff and residents eat together[86]. Similarly, in a nursing home in Sweden[87] *'staff were obliged to sit down and eat with residents as a way to create a more homelike atmosphere'* and this is also common in Dutch care homes[88]. Indeed, sharing meals with staff has measured clinical benefits, as found in a study by Charras and colleagues[89] which has been described elsewhere as a *'promising intervention'*[90].

Watkins and his colleagues include staff sitting down and eating with residents amongst their improvement strategies[91]. Murphy and colleagues[92] suggest that when staff eat with residents, they stimulate 'copy-cat' behaviour in which the resident imitates the staff member and begins to eat and drink themselves, a similar finding to that of Clarke who introduced shared meals for people with dementia and staff to eat together in Ashton-under-Lyne[93]. From time to time at Westerley, staff and residents order a takeaway fish and chip supper and enjoy it together.

Challenge #6

Do mealtimes strengthen divisions between staff and residents or celebrate shared humanity?

While an occasional shared meal might deliver these benefits, frequent repetition can be expected to enhance these gains. Similarly, the review by Reimer and Keller[94] includes a positive recommendation that staff *'join in the meal by eating with residents or having a beverage'* and suggest that residents should have the opportunity to go out to eat as well, perhaps by joining a dining club in the community.

For some people, eating together provokes powerful and intensely personal emotions. Since Medieval times or earlier, good manners[95] have included a rejection of spitting, slurping and burping, almost certainly driven by the human disgust response, which in turn is a biological strategy for reducing the threat of infection by pathogens[96]. Sitting opposite someone who eats with their mouth open is an unpleasant experience for many people, while facing someone who is coughing or choking due to swallowing difficulties can be especially challenging. The level of risk and its associated fear is amplified when the spitter is sick and the spat-upon is eating or drinking, leading people to respond by dropping their own food, leaning back and covering their own mouth with a hand, a serviette or a mask. These emotions do not simply disappear if they are ignored, and they can influence both staff and residents' behaviour and their ability to be fully present with their meal companion or even their willingness to share a mealtime together.

The foregoing paragraph rather implies that all of these 'intensely personal emotions' are negative, but this is far from the case. At the Lodge Trust, Sunday lunch is a special time, drawing on both family and Christian traditions, and forms a vital element of the community's life as it demonstrates their common humanity as everyone eats together, staff and residents alike[97]. Similarly, Nightingale Hammerson introduced shared meals where staff took turns to each with residents as part of their programme of delivering person-centred care but this generated some difficulties at first, as both residents and relatives expected to see staff on their feet, rushing round and helping people. Only when they decided to dispense with uniforms and staff sat down with residents in a more informal manner did the barrier of social distance melt away and relationships grew much stronger over the meal table.

Eating with staff in the community

The answer to misuse is not disuse but right use, so safeguards should be put in place to ensure that staff share meals in the right way with the people that they support rather than banning the practice. After all, one of the most blatant examples of marking the person out in public as a recipient of care is for staff to sit and watch while the person eats or drinks alone[98]. So, at Westerley care home, staff, residents, friends and relatives go out for lunch together once a month at a local restaurant and 'eat together as one big family'.

Some residents are self-conscious or embarrassed about their diminished ability to eat daintily and so prefer not to eat in public[99], and staff also have a duty to uphold the dignity of those who do not appear to be aware of any problems with their table manners. Creative solutions could be sought rather than using these sensitivities as a reason to prevent people eating in the community. These issues arise in the care home too and remind us that some residents have had a lifelong reluctance to eat in front of others, so every arrangement should be tailored to the individual.

Challenge #7

How person-centred and varied are mealtimes and funding arrangements or is there one rule for everyone?

Under Article 8 of the Human Rights Act 1998 and Article 19 of the Convention on the Rights of Persons with Disabilities[100], care home residents have a right to support so that they can participate in all spheres of life in the community, and this includes eating at cafes, restaurants and pubs. Indeed, preventing a person having reasonable access to a restaurant is expressly outlawed[101].

Cassolato and colleagues carried out research[102] into eating out by community-dwelling people living with dementia who were being supported by informal family carers. They found that these shared experiences spiced up life, as people took a break from domestic routine and chores, dressed up to go out, enjoyed their own favourite food or experimented with unfamiliar foods and venues,

plugged into a long tradition of celebration, and found new topics of conversation. It seems reasonable to think that some of these benefits will also be achieved by outings from care homes. Cassolato and colleagues also remind us that the attention paid in this paper to shared meals with staff must take its place as decidedly subordinate to the importance of meals with family and friends.

Some community food outlets need to make reasonable adjustments so that disabled people can utilise their facilities. For some diners, carers need to be confident that the food does not contain allergens (and they can be more confident about this with home-cooked food), and others may need their meal prepared in a particular way. For example, one restaurant chain only agreed to puree food for a customer after multiple requests to their head office. Advocating for such opportunities will build the capacity of community food outlets to respond to all disabled customers and is a vital aspect of the role of health and social care providers.

When staff accompany residents out into the community, it is likely that they will stop for a drink, ice cream or a meal. Such events add to the richness of the experience enjoyed by residents, enhance choice and often elicit unexpected disclosures and choices. At the Lodge Trust, it is impractical for staff to take a break away from residents during outings, and so they are considered to be at work (perhaps incurring overtime or time in lieu entitlements during the course of the long day out) share a meal with residents, and have this paid for by the care provider up to a fixed amount.

Similarly, while staff at Liverpool Adult Services bring their own packed lunch when they are working at a resident's home, it is recognised that on days out, staff are unable to leave the people they are supporting, and most cafes, restaurants and pubs forbid customers from consuming their own food and drink while on the premises. This leaves staff no alternative but to eat with the residents, unless they are expected to fast for a whole shift, as Muslims may wish to do during Ramadan. Such a solution is impractical for others, and dangerous for those staff who need to take prescribed medication with food during the working day.

Some care homes also arrange holidays for residents and under these circumstances, funding will be provided to enable staff to eat with residents at the organisation's expense. Others who expect staff to work out in the community all day provide for staff to have hot drinks to stay warm in the winter and cool drinks to stay hydrated in the summer, just as they would provide drinks for staff working at the base.

In Certitude and at Liverpool Adult Services, the principles of the Mental Capacity Act, appointeeship rules and safeguarding procedures are applied to the decisions surrounding eating out and associated support. As a result, each person who is supported has a decision-making agreement in place that includes financial decisions in general and, in particular, decisions about meals out. This means that the person, their next of kin, appointee or deputy makes decisions in advance about funding for meals, including provision for staff to eat with the person or not, frequency of dining out and budget. Costs are reduced when several residents go out and share the cost of feeding their staff supporter. Arrangements differ from one person to another and are recorded, monitored and reviewed. These arrangements allow for self-funders as well as those who are supported by the state. A further small protection against financial abuse is set in place by one provider[103] where receipts for a staff meal must never exceed the amount spent on food for the person being supported.

Other care providers consider the ice cream, coffee or meal eaten by the staff member is accepted as part of their role and the out of pocket expense is reimbursed. Elsewhere, is the staff member expected to pay for their own food and drink, and what happens if the resident chooses an expensive à la carte restaurant? Or will the attraction of good quality free food seduce staff into manipulating the situation for their own gastronomic or financial benefit, even persuading the person to 'choose' the eating place that staff favour and then paying little attention to the person while they relish the outing for their own pleasure. The worker may even make the person wait while they eat their own food before it goes cold. It is to avoid these hazards that, back in 2006, Berg advised care providers that residents must remain the focus of attention during shared meals and that help must be available to them.

Challenge #8

Do people have opportunities to eat out and to share meals with staff, alongside proper protections against financial abuse?

If there is no petty cash system, staff who accompany residents on an outing may need to treat the meal or drink as an out of pocket expense and then claim reimbursement, which may result in a delay in payment. Unfortunately, one sometimes hears of managers who have a decent income assuming that arrangements which work for them are entirely acceptable for their poorly paid colleagues who may have more serious cashflow challenges. Frontline care staff are more reluctant than other groups to make a claim[104], either due to personal values (self-reliance, independence, altruism), challenges with literacy and form-filling, or an obscure and shaming procedure.

Challenge #9

Do reimbursement systems work well?

When these administrative impediments are cleared away by solution-focused management and reflective supervision, sharing a meal in a restaurant can have significant benefits[105].

This section has focused on meals eaten in cafés, restaurants and pubs, but we must briefly acknowledge here that some people in residential care settings have retained their own home or have relatives who might invite the residents to share food at their own house. Unlike venues that are regulated by Food Hygiene professionals, these meals are prepared and served in ordinary homes. Cooks may be cordon-bleu qualified, occupying a kitchen that is scrupulously clean and preparing an award-winning, mouth-watering dish to share with the person and their support staff – or they may not. Community staff who make numerous domiciliary visits become highly skilled in deploying strategies that enable them to avoid accepting food and drink from homes that they deem to be unhygienic, and reluctance to eat in grubby environments was a key reason that some staff refused to engage in a project designed to promote dinner parties amongst people with mental health issues[106].

Conclusion and the way forward

Some observers note that the most empathic and social-orientated staff are finding ways to eat and drink with residents in the home or out of it, whether that is a cup of tea, a piece of birthday cake or a full meal[107]. Perhaps the most vivid illustration of a positive culture occurs where enabling mechanisms are put in place, staff are not obliged to use them, but then choose to sit and eat with residents. We conclude with a proposed manifesto for inclusive mealtimes that makes the following seven demands:

1. **Policy** clearly indicates that staff may eat and drink with residents without censure.
2. **Benefits** to individual residents of sharing a meal with staff are fully recognised.
3. **Training** and access to expert help[108] helps staff make the most of mealtimes.

4. **Culture** where shared mealtimes reduce social distance between staff and residents.
5. **Working time** arrangements support staff breaks.
6. **Outings** enable residents to go out from the home for food and drink.
7. **Financial procedures** support shared meals and are fair to the resident, staff and employer.

What is the status of this paper?

Most of the documents we read are finished pieces of work, carefully crafted and edited in private before being shared with anyone else. This is a different kind of paper – it was shared online here from the first day, when the initial handful of ideas were incomplete, poorly phrased and tactless. The work has been edited many times, and on each occasion a revised version has replaced the earlier material online. This process is still under way, and so this paper may still be lacking crucial concepts, evidence, structure and grammar[109]. As readers continue to provide feedback[110], further insights will be used to update it, so please contact peter.bates@ndti.org.uk with your contributions[111].

It is one of a suite of over 30 documents available here that try to open up debate about how in practical terms to empower disabled people and share decision-making in health and social care services – in research, implementation and evaluation.

This way of writing is risky, as it opens opportunities to those who may misunderstand, mistake the stopping points on the journey for the destination, and misuse or distort the material. This way of writing requires courage, as an early version can damage the reputation of the author or any of its contributors. At least, it can harm those who insist on showing only their 'best side' to the camera, who want others to believe that their insights appear fully formed, complete and beautiful in their simplicity. It can harm those who are gagged by their employer or the workplace culture, silenced lest they say something in a discussion that is not the agreed party line. It can harm those who want to profit from their writing, either financially or by having their material accepted by academic journals.

In contrast, this way of writing can engage people who are not invited to a meeting or asked for their view until the power holders have agreed on the 'right message'. It can draw in unexpected perspectives, stimulate debate and crowdsource wisdom. It can provide free, leading edge resources. It can stimulate others to write something better than this.

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[1] Gianluca Zucchelli, personal communication, 20 August 2019.

[2] Berg G (2006) *The importance of food and mealtimes in dementia care: the table is set.* Oslo, Norway: Jessica Kingsley.

[3] Klaassens and Meijering found that staff and residents eating together enhanced the sense of homelikeness. See Klaassens M & Meijering L (2015) Experiences of home and institution in a secured nursing home ward in the Netherlands: a participatory intervention study *Journal of Aging Studies* vol. 34, no.3, pp.92–102.

[4] Professor Jane Murphy, personal communication July 2019. See also Murphy J, Holmes J & Brooks C (2017) Nutrition and dementia care: developing an evidence-based model for nutritional care in nursing homes, *BMC Geriatrics* Volume 17, Article number: 55. DOI: 10.1186/s12877-017-0443-2.

[5] For example, a team in the Netherlands developed an eating club for people with psychosis where nursing staff supported individuals to prepare and share a dinner with two friends from the service. The nurse attended the meal, made some brief interventions as needed to help the conversation go well and ate the

food, but the academic paper reporting this makes to reference to the fact that there were four people at the table, not three. In personal correspondence with the lead author it became clear that the role of the nurse was highly valued by the patients (personal correspondence from J. S Vogel, January 2020), but it was unclear whether the simple fact of sharing food together contributed to this or whether the positive effect was derived from goal attainment by the host and members, the low-key support provided to help sustain the conversation or the personal attributes of the staff guest. See Vogel, J. S., Swart, M., Slade, M., Bruins, J., van der Gaag, M., & Castelein, S. (2019). Peer support and skills training through an eating club for people with psychotic disorders: a feasibility study. *Journal of Behavior Therapy and Experimental Psychiatry*, 64, 80-86. DOI: 10.1016/j.jbtep.2019.02.007. In 2020, this research team will complete their randomised controlled trial of this approach.

[6] See Browning C, Qiu Z. Yang H, Zhang T & Thomas S (2019). Food, Eating, and Happy Aging: The Perceptions of Older Chinese People. *Frontiers in Public Health.* 7. DOI:10.3389/fpubh.2019.00073.

[7] See Chiao E, Yang L & Khoo-Lattimore C (2015) Food and the Perception of Eating: The Case of Young Taiwanese Consumers, *Asia Pacific Journal of Tourism Research*, 20:sup1, 1545 1564. DOI: 10.1080/10941665.2014.998248

[8] Philpin S, Merrell J., Warring J, Hobby D & Gregory V (2014). Memories, identity and homeliness: The social construction of mealtimes in residential care homes in South Wales. *Ageing and Society, 34*(5), 753-789. doi:10.1017/S0144686X12001274. Also Palacios-Cena DE, Losa-Iglesias ME. et al (2013) Is mealtime experience in nursing homes understood? *Geriatr Gerontol Int.* Apr 13 (2): 482-9

[9] Wada M, Canham S, Battersby L, Sixsmith J, Woolrych R, Fang M, & Sixsmith A. (2019). Perceptions of home in long-term care settings: Before and after institutional relocation. *Ageing and Society,* 1-24. doi:10.1017/S0144686X18001721.The sensory experience of eating specific foods can evoke memories of home – see Seremetakis CN (1994) *The senses still: Perception and memory in material culture in modernity* Chicago: University of Chicago Press.

[10] Mamhidir AG, Karlsson I, Norberg A, & Mona K (2007) Weight increase in patients with dementia, and alteration in meal routines and meal environment after integrity promoting care. *Journal of Clinical Nursing*, 16, 987–996.

[11] Barnes S, Wasielewska A, Raiswell C and Drummond B (2013), Exploring the mealtime experience in residential care settings for older people: an observational study. *Health and Social Care in the Community*, 21: 442-450. doi:10.1111/hsc.12033.

[12] Barratt found that around 25% of the costs of caring for people with dementia may be attributable to the time carers spend helping with eating and drinking. See Barratt, J. (2004) Ensuring good nutrition in dementia care. *Reviews in Clinical Gerontology*; 14: 3: 247–251.

[13] Whear R., Abbott R., Thompson-Coon J. et al (2014) Effectiveness of mealtime interventions on behaviour symptoms of people with dementia living in care homes" *JAMA* 2014 March Vol 15 (3) pp 185-93. Also Vucea V, Keller HH, Ducak K 2014, "Interventions for improving mealtime experiences in long-term care" *J Nutr Geronto* 2014; 33 (4):249-324. Also Dunne TE, Neargarder SA, Cipolloni PB, Cronin-Golomb A (2004) Visual contrast enhances food and liquid intake in advanced Alzheimer's disease. *Clin Nutr.* 23(4):533–8. Also Chaudhury H., Hung L., Rust T., Wu S. (2016) "Do physical environmental changes make a difference? Supporting person-centred care at mealtimes in nursing homes." *Dementia* 1471301215622839 Jan 12. Also Lorefält B, Wilhelmsson S. (2012) A multifaceted intervention model can give a lasting improvement of older peoples' nutritional status. *Nutr Health Aging.* Apr; 16(4):378-82. Also McDaniel JH, Hunt A, Hackes B, Pope JF. Impact of dining room environment on nutritional intake of Alzheimer's residents: a case study. *Am J Alzheimers Dis other Demen.* 2001;16(5): 297-302. Also The Social Care Institute for Excellence (2007) *Dignity in Care* Report. Also Ruigrok J, Sheridan L (2006) Life enrichment programme; enhanced dining experience, a pilot project. Int *J Health Care Qual Assur.* 2006; 19(5):420–9. Also Ullman S (2009) "The contribution of care *home* staff to nutrition and hydration." *Nurs Residential Care,* Mar; 11(3): 128-132

[14] The ability to sense both smell and taste varies considerably through the ageing process, and changes in each sense is independent of the other, so someone who has lost the ability to taste food may retain an ability

to smell it and vice versa. See Sulmont-Rossé C, Maître I, Amand M, Symoneaux R, Van Wymelbeke V, Caumon E, Tavarès J & Issanchou S (2015) Evidence for Different Patterns of Chemosensory Alterations in the Elderly Population: Impact of Age Versus Dependency *Chem. Senses* 40: 153–164, 2015 doi:10.1093/chemse/bju112,

[15] Abridged from buff.ly/2ZuCKC0 accessed 5 October 2019.

[16] Fieldhouse P (2015) (Still) Eating Together: The Culture of the Family Meal, *Transition* Vol. 45 No. 1.

[17] See Mäkelä J & Niva M The meal as the proper context for food and drinks Chapter 9 **in** Meiselman HL (ed) (2019) *Context: The Effects of Environment on Product Design and Evaluation.* Pages 191-207. Woodhead Publishing. https://doi.org/10.1016/B978-0-12-814495-4.00009-X.

[18] Springwood House posted a photo of a resident and her daughter sharing a meal together at a table for two in their newly refurbished dining room. Hillsborough say 'Visitors are welcome for meals, especially on special occasions such as birthdays.'

[19] van Zadelhoff E, Verbeek H, Widdershoven G, van Rossum E & Abma T (2011) Good care in group home living for people with dementia. Experiences of residents, family and nursing staff," *Journal of Clinical Nursing*, vol. 20, no. 17-18, pp. 2490–2500.For example at Woodlands, 'Family and friends can dine with a resident whenever they wish' – see https://www.woodlands-hillbrow.co.uk/wp-content/uploads/2012/04/Woodlands-and-Hillbrow-brochure.pdf

[20] At Ascot Residential Homes it is common for residents and friends to enjoy a meal with residents, especially at the weekend. There have been occasions when people have brought in and prepared their own food in a kitchen available for the purpose. Large family groups or a wake need to book in advance and can be accommodated in a separate dining room. Even large groups of guests are not charged, but sometimes insist and so are invited to make a donation to the resident's fund. Care home fees are above local authority levels. Nobody takes advantage of the offer, and guests understand that the priority for staff is to look after residents. Staff sometimes eat with residents too. It is all part of making mealtimes pleasant and enjoyable experiences, which adds to quality of life and reduces the challenges that staff sometimes face.

[21] Anne Holdoway, personal communication August 2019.

[22] For an example of researchers and staff eating with residents, see Kofod J & Birkemose A (2004) Meals in nursing homes *Scand J Caring Sci*; 18; 128–134.

[23] Personal communication with Samantha Shune, August 2019.

[24] Mikelyte, Rasa (2017) *Improving Care for People with Dementia in NHS Continuing Care Facilities: Enhancing the Mealtime Experience for Older Patients, their Relatives and Staff.* Doctor of Philosophy (PhD) thesis, University of Kent. Download from https://kar.kent.ac.uk/66260/

[25] Harnett T, & Jönson H (2016). Shaping nursing home mealtimes. *Ageing & Society*, 1-22. https://doi.org/10.1017/S0144686X1500152X

[26] Sidenvall, B., Fjellstrom, C., & Ek, A. (1994). The meal situation in geriatric care— Intentions and experiences. *Journal of Advanced Nursing*, 20, 613-621. See also Crogan N L et al 2004 Improving nursing home food service: uncovering the meaning of food through residents' stories. *J of Gerontol Nursing* Feb; 30 (2) 29-36

[27] Kenkmann A. and Hooper L (2012) The restaurant within the home: experiences of a restaurant-style dining provision in residential homes for older people *Quality in Ageing and Older Adults* Vol. 13 No. 2, pp. 98-110. https://doi.org/10.1108/14717791211231184. Lack of foodservice training was a finding from a study in New Zealand – see Chisholm A., Jensen J., Field, P. (2011) Eating environment in the aged-care setting in New Zealand: promoters and barriers to achieving optimum nutrition. Observations of food service, menu and meals. *Nutrition and Dietetics* Jun ; 68 (2): 161-166. See https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1747-0080.2011.01510.x

[28] McGilton KS, Sidani S; Boscart VM.; Guruge S & Brown M (2012) The relationship between care providers' relational behaviors and residents mood and behavior in long-term care settings. *Aging Mental Health*), May; 16(4): 507-515.

[29] Lee SY, Chaudhury H & Hung L (2016). Exploring staff perceptions on the role of physical environment in dementia care setting. *Dementia*, *15*(4), 743–755. https://doi.org/10.1177/1471301214536910. Also Keller H., Carrier N., Steele, C. (2014) "Making the most of mealtimes (M3): grounding mealtime interventions with a conceptual model" *J of American Medical Directors Association* March 15 (3): 158-161

[30] Milte R, Shulver W, Killington M, Bradley C, Miller M, Crotty M (2017) Struggling to maintain individuality – Describing the experience of food in nursing homes for people with dementia *Archives of Gerontology and Geriatrics* Vol 72, pages 52-58, ISSN 0167-4943. https://doi.org/10.1016/j.archger.2017.05.002.

[31] Independent eating is often 'the first to go in a chain of self-management behaviours'. See Baltes MM & Zerbe MB (1976) Reestablishing self-feeding in a nursing home resident *Nursing Research* 25(1) 24-26. Quoted in Altus DE, Engelman KK, Matthews RM (2002) Using family-style meals to increase participation and communication in persons with dementia *Journal of Gerontological Nursing*; Sep 2002; 28, 9, 47-53.

[32] Reimer HD & Keller HH (2009) Mealtimes in Nursing Homes: Striving for Person-Centered Care, *Journal of Nutrition For the Elderly*, 28:4, 327-347, DOI: 10.1080/01639360903417066. Also Arvanitakis M, Beck A, Coppens P, De Man F, Elia M, Hebuterne X, Henry S, Kohl O, Lesourd B, Lochs H, Pepersack T, Pichard C, Planas M, Schindler K, Schols J, Sobotka L, AVan Gossum A (2008) Nutrition in care homes and home care: How to implement adequate strategies (report of the Brussels Forum (22–23 November 2007)) *Clinical Nutrition* Vol 27, Issue 4, Pages 481-488. ISSN 0261-5614. https://doi.org/10.1016/j.clnu.2008.04.011. Also Abbott RA, Whear R, Thompson-Coon J, Ukoumunne OC, Rogers M, Bethel A, Hemsley A & Stein K (2013). Effectiveness of mealtime interventions on nutritional outcomes for the elderly living in residential care: a systematic review and meta-analysis. *Ageing Research Reviews,* 12(4):967-81. https://doi:10.1016/j.arr.2013.06.002.Also Crogan NL; Shultz JA; Adams CE; Massey LK (2001) Barriers to nutrition care for nursing home residents. *Journal of Gerontological Nursing* Dec; 27(12): 25-31.

[33] Keller HH, Carrier N, Slaughter S, Lengyel C, Steele CM, Duizer L, Brown,KS, Chaudhury H, Yoon MN, Duncan AM, Boscart VM, Heckman G, Villalon L (2017) Making the Most of Mealtimes (M3): protocol of a multi-centre cross-sectional study of food intake and its determinants in older adults living in long term care homes *BMC Geriatrics* 15, 17, 1. https://the-ria.ca/project/making-the-most-of-mealtimes-m3/

[34] Wright L, Hickson M. and Frost G. (2006), Eating together is important: using a dining room in an acute elderly medical ward increases energy intake. *Journal of Human Nutrition and Dietetics,* 19: 23-26. https://doi.org/10.1111/j.1365-277X.2006.00658.x.

[35] Flynn M (2015) *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine,* https://gov.wales/sites/default/files/publications/2019-06/in-search-of-accountability-a-review-of-the-neglect-of-older-people-living-in-care-homes-operation-jasmine_1.pdf

[36] Personal communication with Gaby Wills, January 2020.

[37] The website at Hawkinge House explains, 'We have recognized that many of our residents have their best appetite of the day at breakfast time. For this reason we have introduced cooked breakfasts…' - see https://hawkingehouse.co.uk/services/food/

[38] Divert C, Laghmaoui R, Crema C, Issanchou S, Van Wymelbeke V (2015) Improving meal context in nursing homes. Impact of four strategies on food intake and meal pleasure *Appetite* 84, 139-147 https://www.sciencedirect.com/science/article/pii/S0195666314004723?via%3Dihub#!

[39] Research by Sulmont-Rossé and team found that 'olfactory priming' by introducing a smell of cooking meat into a dining room for 15-30 minutes before the meal stimulated Alzheimer's patients to eat more during the meal. As an aside, we note. Intriguingly, Sulmont-Rossé's team found that the effect had disappeared when it was tried again two weeks later with the same patients. The authors suggest that a principle of 'perception by exception' operates and we only notice smells that are unfamiliar or unusual in that context. This may explain the way in which perception of a new odour is intense at first and quickly fades until we no longer notice it. See Sulmont-Rossé C, Gaillet M, Raclot C, Duclos M, Servelle M and Chambaron S (2018) Impact of Olfactory Priming on Food Intake in an Alzheimer's Disease Unit. *J Alzheimers Dis.* 2018;66(4):1497-1506. doi: 10.3233/JAD-180465. Ramaeckers and colleagues found (unsurprisingly) that that non-food smells, perhaps especially unpleasant smells such as stale urine or disinfectant, have the opposite effect by triggering a

generalised disgust response. See Ramaekers MG, Boesveldt S, Lakemond CMM,vanBoekel M, Luning PA (2014) Odors: Appetizing or satiating? Development of appetite during odor exposure over time. *Int J Obes* 38, 650-656.

[40] Palese A, Gonella S, Kasa T, Caruzzo D, Hayter M & Watson R (2018) Negative prompts aimed at maintaining eating independence. *Nursing Ethics* 26(7–8), 2158–2171. https://doi.org/10.1177/0969733018819124. Pressure doesn't help children to eat either – see Galloway AT, Fiorito LM, Francis LA, Birch LL (2006) 'Finish your soup': Counterproductive effects of pressuring children to eat on intake and affect, *Appetite*, Volume 46, Issue 3, Pages 318-323, ISSN 0195-6663. https://doi.org/10.1016/j.appet.2006.01.019. In this study, researchers simply asked 4 year old children to, 'Finish your soup, please' in a normal tone of voice once a minute for the five minutes of the intervention (4 prompts) and found that there was a significant inverse relationship between being prompted and consuming the soup.

[41] Barnes et al 2013 op cit. Staff at the O-SEE Lab are studying swallowing disorders in the context of a shared mealtime – see https://eatinglab.uoregon.edu/. For an evaluation of mealtimes in care homes in North Tyneside, see https://healthwatchnorthtyneside.co.uk/wp-content/uploads/2017/06/HWNT-care-home-food-experience-270617-final.pdf.

[42] Christine Henderson, personal communication January 2020. Christine confirmed that residents of this home experience advanced dementia and that fees are not significantly above local authority approved levels.

[43] Honore C (2004) *In praise of slow* London: Orion.

[44] Shune SE & Linville D (2019) Understanding the dining experience of individuals with dysphagia living in care facilities: A grounded theory analysis. *International Journal of Nursing Studies.* Apr; 92:144-153. doi: 10.1016/j.ijnurstu.2019.01.017.

[45] Hall K & Gilliland H (2019) Changing the Long-Term Care Culture Through Interprofessional Practice: A Speech-Language Pathologist–Led Initiative *Perspectives of the ASHA Special Interest Groups* Apr. https://pubs.asha.org/doi/10.1044/2019_PERS-SIG2-2018-0005.

[46] For example, Adriano Maluf carried out an ethnographic research project in care homes and found that eating with residents was valued and provided a natural way to unobtrusively gather data, even when residents have given their permission for the study to be undertaken. See Maluf A (2017) *The social lives of older men living in care homes and the Implications for their wellbeing* https://ueaeprints.uea.ac.uk/67656/1/Adriano_Maluf%2527s_thesis__-_FINAL_SUBMISSION_VERSION_(1).pdf.

[47] Roberts E. Six for lunch: a dining option for residents with dementia in a special care unit (2011) *J Hous Elderly.* 25(4):352–79.

[48] Hung L, Chaudhury H & Rust T (2015) The Effect of Dining Room Physical Environmental Renovations on Person-Centered Care Practice and Residents' Dining Experiences in Long-Term Care Facilities *Journal of Applied Gerontology* Vol: 35 issue: 12, pages: 1279-1301. DOI: 10.1177/0733464815574094.

[49] Keller HH, McLeod J, Ridgeway N (2012) Development and reliability of the mealtime social interaction measure for long-term care (MSILTC). *Journal of Applied Gerontology* June.

[50] Watkins R, Goodwin VA, Abbott RA, Tarrant M (2019) Eating well in care homes: Testing the feasibility of a staff training programme aimed at improving social interaction and choice at mealtimes. *International Journal of Older People Nursing.* https://doi.org/10.1111/opn.12247. Also Perivolaris A, LeClerc CH, Wilkinson K, Buchanan S (2006). An enhanced dining program for persons with dementia. *Alzheimers Care Q*. Also Bennett MK, Ward E, Scarinci N, Waite M (2014) Perspectives on Mealtime Management in Residential Aged Care: Insights From a Cross-Disciplinary Investigation *J Nutr Gerontol Geriatr.* 33(4):325-39

[51] Pearson A, Fitzgerald M, Nay R. Mealtimes in nursing homes: the role of nursing staff. *Journal of Gerontological Nursing*. 2003; 29(6):40–7.

[52] Nijs KAND, de Graaf C, Kok FJ, van Staveren WA (2006) Effect of family style mealtimes on quality of life, physical performance, and body weight of nursing home residents: cluster randomised controlled trial *BMJ* 332: 1180. https://www.bmj.com/content/bmj/332/7551/1180.full.pdf

[53] It must be observed that a systematic review of the evidence regarding the impact of protected mealtimes on nutrition and hydration in hospital patients found no robust evidence. This does not mean, of course, that properly constructed research would find no link (as absence of evidence is not evidence of absence), that protected mealtimes do not deliver any benefits beyond the narrow outcomes selected, or that these findings are applicable to care homes. See Porter J, Ottrey E, Huggins CE (2017) Protected Mealtimes in hospitals and nutritional intake: Systematic review and meta-analyses *International Journal of Nursing Studies.* Jan; 65:62-69. doi: 10.1016/j.ijnurstu.2016.11.002.

[54] Hanssen I., Kuren B.M., (2016) "Moments of joy and delight: the meaning of traditional food in dementia care" *J of Clinical Nursing* Mar 25 (5-6) 866-74. Also Evans BC, Crogan NL, Shultz JA. The meaning of mealtimes: connection to the social world of the nursing home. *J Gerontol Nurs.* 2005; 31(2):11–7.

[55] Kofod and Birkemose 2004 op cit.

[56] Philpin et al 2014 op cit, p781.

[57] Kellyn Hall, personal communication, July 2019.

[58] Kofod and Birkemose 2004, op cit.

[59] In the early stages of establishing a rapport through intensive interaction approaches, the worker responds to the person by reproducing each of their actions until they realise that they are 'controlling' the worker. This creates a link which empowers the individual, reveals their ability to shape their environment and, in turn, can be used to shape the person's behaviour. Such an exercise would be weakened if the worker was unable to mirror their actions in eating and drinking. See https://www.intensiveinteraction.org/.

[60] It is notable that advice from a specialist service treating children who exhibit a worrying level of food refusal is to… "Model eating. Sit with the child if they are happy with that, talk about anything other than the food, give small portions, calorie dense, and think about the child's taste preferences." Personal communication from Gillian Harris, February 2020.

[61] Kofod and Birkemose 2004 op cit found that some residents directed visitors to eat elsewhere rather than join them at the table, while others welcomed them.

[62] Goffman referred to 'civil inattention' which is sometimes granted by potential observers in order to support the dignity of others in social settings. See Goffman E (1963) *Behavior in public places: notes on the social organization of gatherings.* New York: Free Press; pp83-88.

[63] See the CQC report on Green Pastures Christian Nursing Home, page 11 at https://www.cqc.org.uk/sites/default/files/new_reports/INS2-4228156059.pdf, which says 'We observed staff sitting and eating with people and talking to them whilst supporting them to have their meals at a relaxed pace. Some people chose to have meals in their rooms and staff respected that. People had the same pleasant dining experience despite where they were.'

[64] Philpin et al 2014 op cit.

[65] Workers have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. This could be a tea or lunch break. See https://www.gov.uk/rest-breaks-work.

[66] Personal communication, 12 August 2019.

[67] Howson FFA, Robinson SM, Lin SX, Orlando R, Cooper C, Sayer AAP,4,5 Roberts HC (2018) Can trained volunteers improve the mealtime care of older hospital patients? An implementation study in one English hospital *BMJ Open* 8:e022285. Available at https://bmjopen.bmj.com/content/bmjopen/8/8/e022285.full.pdf. The Royal Voluntary Service has provided volunteers for a Mealtime Volunteer service designed by the dietitians team at the Royal Lancaster Informary, but the RVS have no involvement with any projects where meals are shared between staff and residents. Similarly, Imperial Health Charity provides mealtime volunteers, but they do not eat with patients (Matt Hatt, personal communication 20 September 2019).

[68] See Keller et al 2012, op cit. See also Feunekes GI, de Graaf C, van Staveren WA (1995). Social facilitation of food intake is mediated by meal duration *Physiology & Behavior*, 58, 551-558.

[69] Kevin Charras describes a home where charging staff for their meal prevented ineligible staff becoming envious of their colleagues, while the price was competitive enough to persuade them to pay. Personal communication August 2019.

[70] Pearson et al 2003 op cit.

[71] Watkins R, Tarrant M, Goodwin V, Abbot R (2017) *On eating well: A guide for mealtime staff in care homes* University of Exeter.

[72] See Wu S. (2006) Institutional Mealtimes and Family Caregiving for Chinese Nursing Home Residents. *UC Berkeley: /UCSF Joint Medical Program*. Retrieved from https://escholarship.org/uc/item/8sg379p5 at https://escholarship.org/uc/item/8sg379p5. Also Pelletier CA. Feeding beliefs of certified nurse assistants in the nursing home: a factor influencing practice. Journal of Gerontological Nursing. 2005; 31(7):5–10. Also Philpin S; Merrell J, Warring J, Gregory V, Hobby D (2011) "Sociocultural context of nutrition in care homes." *Nurs Older People,* May; 23(4): 24-30. Also Pietro MJS, Boczko F (1998) The breakfast club: results of a study examining the effectiveness of a multi-modality group communication treatment. *Am J Alzheimers Dis Other Demen.* 13(3):146–58.

[73] Lynn Smith was employed by Little Chef where she was allowed to eat company food on the premises. One day she did not have time to eat her food allocation at work and so broke the rules by taking the apple pie home. She was sacked for this breach of the rules - see https://www.doihaveacase.co.uk/case-review-little-chef-employee-sacked-for-stealing-pie/. Ralph Brombley, employed to collect shopping trolleys from the car park, was sacked by Waitrose for eating six grapes that had been left behind in a trolley – see here. A customer sent a cake back at Harrods, claiming it was too dry, so employee Juan McKenzie ate a piece to test it and was sacked for this - see here.

[74] Fry GL, Brown F, Cawood AL, Cotton J, Stratton RJ. Appropriate management of disease related malnutrition in GP practices improves nutritional status & reduces healthcare use, with potential cost savings. *Clinical Nutrition* ESPEN, Dec 2018; vol 28, p271

[75] Charras, personal communication, August 2019. He further noted that this arrangement required food to be served from common serving dishes at the table, rather than being plated up in the kitchen.

[76] This section has benefited from advice from Laura Parr, January 2020.

[77] Personal communication, August 2019.

[78] Hung L, Chaudhury H (2011) Exploring personhood in dining experiences of residents with dementia in long-term care facilities. *Journal of Aging Studies* 25(1):1–12. doi: 10.1016/j.jaging.2010.08.007.

[79] Reimer HD & Keller HH (2009) op cit.

[80] Littlewood S & Saeidi S (1994) Therapeutic mealtimes *Elderly Care* 6, 6, 20-21.

[81] Charras K and Frémontier M. (2010). Sharing meals with institutionalized people with dementia: A natural experiment. *Journal of Gerontological Social Work,* 53, 436-448.

[82] Hall and Gilliland 2019, op cit.

[83] Berg, op cit.

[84] Anne Holdoway reported that multidisciplinary teams in a head injury unit and a hospice routinely ate meals with patients as this was considered a powerful way to obtain evidence about the person's cognitive, functional and social competencies and so achieve an accurate formulation and treatment plan. Personal communication, August 2019.

[85] See Bates P. 'Thinking about professional boundaries in an inclusive society' in Gilbert P (2010) *Social Work and Mental health: The Value of Everything* Lyme Regis: Russell House Publishing. Chapter 2, pp18-24.

[86] See a description of the culture at Belong reported in Ahmed A, Ormandy P, Seekles M (2019) An Examination of How the 'Household Model' of Care Can Contribute to Positive Ageing for Residents in the 'Fourth Age' *OBM Geriatrics* Vol 3. http://usir.salford.ac.uk/id/eprint/49954/1/obm.geriatrics.1901030.pdf. Belong aims to provide "marvellous mealtimes" where staff and residents share meals together both in and

out of the care village and the cost is included in the annual food budget. Within the staffed households, residents, relatives and friends are free to help themselves and others to refreshments throughout the day. Meals for support workers who accompany day trips are typically included in the cost of the trip as paid for by our customers and are open to residents in day care, staffed households, apartment tenants, and people using domiciliary support in their own home. There is a bistro within each village, and all employees enjoy a staff discount there.

[87] Harnett, personal communication, July 2019.

[88] Ashcroft J, Arnold S, Jones R, Kelly D, Meyer J, Patel C and Pelham C. (2014). *A vision for care fit for the twenty-first century: Commission on Residential Care*. UK: Demos. http://www.demos.co.uk/files/Demos_CORC_report.pdf?1409673172

[89] Charras K and Frémontier M (2010). Op cit.

[90] Bunn DK, Abdelhamid A, Copley M, Cowap V, Dickinson A, Howe A, Killett A, Poland F, Potter, JF, Richardson K, Smithard D, Fox C & Hooper L (2016) Effectiveness of interventions to indirectly support food and drink intake in people with dementia: Eating and Drinking Well IN dementiA (EDWINA) systematic review *BMC Geriatrics* 89*,* 16, 1. DOI 10.1186/s12877-016-0256-8. Also Abelhamid A., Bunn D., Copley M. et al (Jan 2016) "Effectiveness of interventions to directly support food and drink intake in people with dementia: systematic review and meta-analysis" *BMC Geriatr* (1) 26 See https://bmcgeriatr.biomedcentral.com/track/pdf/10.1186/s12877-016-0196-3

[91] Watkins et al op cit.

[92] Murphy JL, Holmes J & Brooks C (2017) op cit.

[93] Clarke L. (2009) Improving nutrition in dementia through menu picture cards and cooking activities. *Nursing Times* 105:30.16-18 See https://www.nursingtimes.net/clinical-archive/nutrition/improving-nutrition-in-dementia-through-menu-picture-cards-and-cooking-activities-31-07-2009/

[94] Reimer HD & Keller HH (2009) op cit.

[95] Nichols, S. (2002) On the genealogy of norms: a case for the role of emotion in cultural evolution. *Philosophy of Science* 69, 234–255. (DOI:10.1086/341051)

[96] Curtis V (2013) *Don't look, don't touch* Oxford OUP. Also Tybur JM, Lieberman D & Griskevicius V (2009) Microbes, Mating, and Morality: Individual Differences in Three Functional Domains of Disgust *Journal of Personality and Social Psychology*, 2009, Vol. 97, No. 1, 103–122.

[97] Inquiries have been sent by email to some faith-based care homes to check out if they link spiritual traditions with eating together – Bethany Homestead, Bethel House, Cedars, Christian Care Homes, Eckling Grange, Eothen, Green Pastures, Jewish Care, Jewish Choice, Keychange, Lindfield, LWPHomes, Melbourne Home, MHA, Mission Care, Nightingale Hammerson, Overdale, Pilgrims Friend, Salvation Army, Sanctuary Care and Woodleigh.

[98] See Bates P, Hardwick K, Sanderson K, Sanghera R & Clough J (2012) Almost invisible - providing subtle support in community settings *Tizard Learning Disability Review* Vol. 17 Iss: 4 pp. 156 – 162. DOI:10.1108/13595471211272497.

[99] These feelings can also lead to residents feeling awkward about eating in the care home and may even lead to reduced intake and undernourishment. See Sidenvall B, Fellström C, Ek A-C. The meal situation in geriatric care – intentions and experiences. *J Adv Nurs* 1994; 20: 613–21.

[100] See https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-19-living-independently-and-being-included-in-the-community.html.

[101] The Explanatory Report to Protocol No. 12 to the *Convention for the Protection of Human Rights and Fundamental Freedoms* (European Treaty Series No. 177) expressly cites access to restaurants as aright that must be upheld. See https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016800cce48 para 28.

[102] Cassolato CA, Keller HH, Dupuis SL, Schindel-Martin L, Edward HG & Genoe MR (2010) Meaning and experience of "eating out" for families living with dementia, Leisure/Loisir, 34:2, 107-125, DOI:10.1080/14927713.2010.481107.

[103] Zucchelli op cit.

[104] Professor Alan Gordon has led many research studies in care homes and reports that care home staff are substantially less likely than other groups to claim expenses and fees. Personal communication, July 2019.

[105] Wu S, Barker JC. Hot tea and juk: the institutional meaning of food for Chinese elders in an American nursing home. *Journal of Gerontological Nursing*. 2008; 34(11):46–54.

[106] JS Vogel (personal correspondence, January 2020) discussing the background to Vogel et al (2019) op cit.

[107] Schell ES, Kayser-Jones J. The effect of role-taking ability on caregiver-resident mealtime interaction. *Applied Nursing Research.* 1999; 12:38–44.

[108] Swallowing problems are technically known as dysphagia and Speech and Language Therapists have relevant skills. Online training in understanding and responding to people with dysphagia is available at https://devicesfordignity.org.uk/2020/07/dysphagia-guide-e-learning-resource-now-live/. A variety of other issues can affect people's willingness to eat, ranging from dental pain and gum disease to the effects of a stroke that mean the person cannot easily clear food from the affected side of their mouth.

[109] As a result, the author assumes no responsibility or liability for any errors or omissions in the content of this paper. The information contained is provided on an "as is" basis with no guarantees of completeness, accuracy, usefulness or timeliness. Whilst every reasonable effort has been made to comply with UK legislation, if you believe that the public display of this document or any of its contents breaches copyright please contact peter.bates@ndti.org.uk providing details, and public access to the offending work will be removed immediately.

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[111] This document was begun on 27 July 2019. Undated or early versions should be replaced with the most recent, available here.