The realization of person-centred mealtime care

An action research based on emancipatory practice development strategies

Naam student	M.A. van Dorst, (Marcella Antonia)
Studentnummer	3858316
Status thesis	Definitief
Datum	1 juli 2014
Universiteit	Universiteit Utrecht
Master programma	KGW, Verpleginswetenschap
Begeleider	Dr. Margreet van der Cingel
Cursusdocent	Drs. Claudia Gamel
Stage-instelling	Hogeschool Windesheim, Zwolle
Aantal woorden	3472
Aantal woorden (Engelse abstract)	292
Aantal woorden (Nederlandse samenvatting)	299
Referentiestijl	Vancouver
Criteria transparante beoordeling	STROBE checklist of observational studies
Tijdschrift	Practice Development Journal
Tijdschrift eisen	5000-7000 woorden inclusief referentielijst.
Tweede onderzoeker data-analyse	Cilleke Breekveldt

Introduction

Weight loss in dementia care is associated with increased falls, disease progression, accelerated cognitive decline, infection, depression, decreased quality of life and significant morbidity.[1] Yet causes of this weight loss remain poorly understood.[2] Nurse-assistants in nursing homes are responsible for mealtime care. Eating difficulties can make providing sufficient intake for residents with dementia a challenging job.[3] The weight loss of residents is often interpreted as a failure and raises feelings of inadequacy and guilt in the staff.[2]

Stated in a recent review, mealtime care typically focuses on promoting nutritional intake of residents with dementia.[4] When care is too focused on satisfying the physical needs, care becomes task-oriented, this can come at the expense of psychosocial needs of residents.[5] A model of care that includes psychosocial needs of residents during care is person-centred care (PCC). PCC is a widely used concept for best-practice care of people with dementia.[6] In a review by Edvardsson et al PCC is defined as: “supporting the rights, values and believes for the individual; involving them and providing unconditional positive regard; entering their world and assuming that there is meaning in all behavior, even it is difficult to interpret; maximizing each person’s potential and sharing decision making”.[5] A recent study showed that residents living in wards with higher measured rates of PCC had a higher quality of life and better ability to perform daily activities compared to wards with lower PCC rates.[7] Furthermore, nurse-assistants working according PCC are more content with their job.[8,9] From a person-centred perspective it is more important to make a care activity a pleasant experience rather than a time-efficient process.[10]

Contextual factors pose the greatest challenge to PCC and the development of such cultures.[11] The context of care refers to work culture, physical care environment and learning culture.[11] This study is focused on the context of care during the mealtime-practice, which includes the preparation of the meal until the finishing of dessert. By realizing a PCC context of care, it was assumed by the researchers of this study, that this would positively affect the mealtime-experience for residents with dementia. Mealtime-experience refers to the outcomes of PCC such as satisfaction of care, involvement of care and feeling of well being.[12]

Previous studies demonstrate that mealtime-experience depends on various factors such as the type, quality and heat of the served food[13], the social atmosphere [8,14-16], the dining-room environment[17], nurse skills[14], music[18-20], homelike contributors[15,16,21] and various other factors. None of these studies have a specified PCC focus to improve the context of care of

the mealtime-practice, or have studied the context of care of the mealtime-practice in an action research based on emancipatory practice development (EPD). Action research refers to dynamic interaction of actions and reflections to solve problems.[24] EPD is a scientific method to set PCC cultures.[22,23] The stakeholders of a ward for residents with dementia were empowered in this study to change in the context of care. This study is different from other mealtime-studies due to its focus on PCC and the used study methodology.

With this study a contribution was made in how to achieve a PCC context of care during the mealtime-practice, which is assumed to enhance the mealtime-experience for residents. It is important for society to study practices as these, especially since residents with dementia are challenged in their communication and they cannot always voice their concerns.

Problem statement

It has been established that mealtime care should be changed from a task-driven activity towards a PCC activity that includes psychosocial needs. When providing a PCC context of care during the mealtime-practice it was assumed by the researcher that this would positively influence the mealtime-experience for residents. To empower the nurse-assistants to realize a PCC context of care of the mealtime-practice an action research study was performed.

Study aim

The aim of this study was to realize a PCC context of care during the mealtime-practice. With this study a contribution is made to scientific knowledge on realizing PCC practices.

Research question

What is the process of realizing a PCC context of care during the mealtime-practice on a ward for residents with dementia?

Method

This study used an action research design based on EPD strategies.[22,23,24] Action research created the ability of in-depth learning by integrating various learning methods.[24] The advantage of EPD is the specific focus on PCC in the design and emancipatory focus, which means that it is participant driven. Study results provide in-depth knowledge on the realization of the PCC context of care.

EPD is known for its six steps[23], which were followed in this study by a workgroup of stakeholders (table 1). Meetings were held with prefixed themes. The researcher facilitated the EPD process. This facilitating role is vital in achieving a PCC culture by helping stakeholders to integrate planning-action-evaluation-learning though the EPD steps.[22]

Alongside EPD, participatory observations were made during the mealtime-practice. Participatory observation of the residents is enabled by the researcher taking part in the resident's everyday life.[26] Findings of participatory observations were used to facilitate EPD meetings and to get insight of the mealtime-practice. The flowchart illustrated how EPD steps and participatory observations were executed in this study.

Participants

The study was performed in a ward housing seven residents with dementia between March and May 2014. The ward includes private bedrooms with bathrooms and one common dinning room. The dining room consists of a small kitchen, two dining tables, two separate fauteuils, a television set and a radio. Before 2012 the ward was a part of larger ward that included 21 psychogeriatric residents. In 2012 the large ward was split into 3 smaller wards. This was in line with the trend to create small-scale living environments with homelike features, which is assumed to increase quality of life for residents.[21] Although the split was aimed to create a small-scale living environment, a number of institutional influences remained, such as delivery of pre-prepared food.

Stakeholders of this ward are seven residents, their informal caregivers, thirteen nurse-assistants, one nurse, one team leader and other health care professionals (such as a physician and a psychologist). The rationale for selecting the members of the workgroup was maximum variation between participants.[27] This was done for two reasons: to enrich the meetings by maximizing valid information and as a strategy to achieve the study goals. The last was obtained by including early adopters and informal leaders. Early adopter refers to a person's willingness to adopt changes.[28] Informal leaders do not have formal leadership but

do play a dominant role in the team, gained by clinical experiences and reputation amongst peers and have the power to accept or reject changes.[29] By including these specific types of stakeholders it was assumed that they could influence the team in benefit of the study. After careful consideration the team leader and researcher selected nurse-assistants, informal caregivers and other stakeholders. It was decided to create a workgroup of no more than eight participants to keep the attention focused during meetings. To be included members needed to be a stakeholder of the ward. Exclusion criteria were: the inability to communicate in Dutch, as a member must be able to contribute in meetings, and not belonging to the regular nursing team since members should be familiar with the unit. The researcher personally invited all workgroup members face to face. Not included were the residents of the ward since they suffer from severe dementia, which creates barriers in communication as keeping the attention focused. However, behaviors of residents were carefully observed during participatory observations.

Informed consent and ethical approval

This study was conducted according to the principles of the Declaration of Helsinki.[30] The regional ethical committee of the Isala Clinics (Zwolle, Overijssel, The Netherlands) reviewed and approved the study protocol, declared that further approval conform the Dutch law was not necessary.[31] The residents with dementia are all incapacitated and therefore their legal representative was asked for Informed Consent. All participants signed an Informed Consent form prior audiotaping and before participatory observations. Participants were able to withdraw from the study at any time.

Data collection

Workgroup meetings were audiotaped and transcribed word-by-word including sounds as laughing, which could be helpful to understand the context. Participatory observation was completed with the help of an observational protocol including three topics (Table 2). Topics “Environment” and “Work Culture” were referring to the context of care[11], and topic “Miscellaneous” gave the researcher freedom to write about other significant matters. Furthermore, to respond to the factual descriptions a column with “reflective notes” was included in the protocol.[27] After completing the observation the researcher wrote a reflection.

Throughout the study the researcher wrote memos about method, theories and reflections.[27] Assumptions that could have shaped the interpretation and approach of the study due to past experiences of the researcher were obtained. Critical reflections on the process were essential due to intertwined roles of the researcher: observer, facilitator and being a nurse in the practice. Peer debriefing of the study process, methodology and results happened

regularly in a researchers group providing an external check.[27] Validation strategies were data triangulation, peer debriefing and reflections.[27]

Data-analysis

Data was analyzed by coding with assistance of topics, which is common in action research.[24] Each EPD step was analyzed separately. Data was analyzed on printed-paper and in Word 2011.[32] Two researchers M.D. and C.B. separately analyzed data of the first meeting. Their findings were compared and when there was a difference in opinion, discussions were held till consensus was found. This intercoder agreement was completed for reliability of the data-analysis.[27] One researcher analyzed the remaining data. To counteract bias, member-validation was performed to ensure that participants of the workgroup could verify analyzed data as their own.[33] For example: after formatting the plan of action based upon the analyses of the second meeting the plan of action was deliberately discussed with participants of the workgroup.

Results

Two spouses (average age of 82) and four nurse-assistants (average age of 54) agreed to join the workgroup. Other stakeholders refused due to the required time investment. Prior meeting one, two and four several nurse-assistant(s) withdrew, due to events in their private lives (sickness or sick relatives at home).

The participants completed four meetings with EPD themes (table 1). After orienting during the first meeting, the researcher asked the participants during the second meeting *"What must be changed in order to realize a PCC context of care during the mealtime?"* The first theme was Time, which was followed by Homelike, Choices, and Smell. Each theme was given an aim and subsequent actions to achieve the goal. These were formatted into a plan of action and tested in the practice. In the third meeting the participants shared their experiences regarding the altered mealtime-practice, and whether there was any need for further adjustment of the plan of action. In the final meeting achievements of the EPD goals were discussed. It must be acknowledged that the EPD process was influenced by the facilitating role of the researcher, for example by asking directive questions in meetings. Overall participants were eager to contribute in discussions. It can be stated that a mutual understanding of PCC was present. Furthermore, in observations and discussed in meetings was the vital role and skills of the nurse-assistant to mange the mealtime-practice and their major importance in achieving PCC. The four themes, initial status and their transformations are described below.

Time

"I think that dinner starts to early" (nurse-assistant). All participants were in agreement that time was an important factor that requires change. Time was explained as starting time, which had to be later in the evening and duration of mealtime, which had to be longer. Five p.m. was the initial time to start mealtime, which differs from mealtime routines before hospitalization. By increasing time between lunch and mealtime it was assumed that residents would have an increased appetite. Besides, by postponing the starting time of mealtime it was assumed that residents would want to go to bed later. Time in bed would be decreased and it would create more possibilities in the evening for snacks, drinks and social activities. In the initial mealtime-practice the first resident asked to go to bed at 18:30. The participants found the mealtime-practice a hasty activity. It was observed that in the initial mealtime-practice the main dish and dessert were given simultaneously as desserts were

placed in front of the slow eating residents. One of the residents got confused and started eating dessert and main dish at once.

The participants found Time to be the most accomplished since starting time has shifted to 5:30 p.m. and even later. According to a participant the first resident asks to go bed at 8 p.m. Furthermore, the observed mealtimes were more structured, as dessert is given just after the main dish is finished.

Choice

"Food is served on plates at the kitchen sink. With their back turned to residents (referring to colleagues). *Besides, they do not always ask what they want to eat" (nurse-assistant).* This quote illustrates what was seen in observations during the initial mealtime-practice as residents did not get an opportunity to choose between dishes or this was done partially. The aim of Choice was to involve residents in choices regarding foods and beverages. It was assumed that residents were able to make choices regarding their own preferences. Examples of actions referring to this goal were introducing serving bowls and asking residents what they would like to eat and wait for the answer.

Participants found it difficult to judge if Choice was accomplished since they were not always aware of what other nurse-assistants did, although serving bowls were found to be effective. In observations serving bowls encouraged residents to decide on type and amount of food. Some residents refilled their plates when serving bowls were in their reach. For two male residents in particular this was an improvement since they normally refused any refills. Furthermore, serving bowls made the options between different types of foods visible. *" I ask them: escarole or spinach? You see them look at bowls and than they point out which one they would like to eat. It feels much better when they are able to make a choice regarding food" (nurse-assistant).*

Homelike

The word "home" was a keyword in meetings. For participants PCC was linked to feelings, traditions and a cosy atmosphere of home. *"At home me and my husband used to drink a glass of wine during mealtime" (wife).* The aim of Homelike was to create a domestic atmosphere by introducing familiar customs and traditions. Several actions were referring to the role of the nurse-assistant. These could be social, task driven or about the limitation of disturbing activities. Observed disturbing activities of nurse-assistants during the mealtime-practice were: walking around, cleaning, passing out medication, making coffee etc. *"Just like at home you don't walk around during dinner" (nurse-assistant).* Another action was the

introduction of music during the mealtime-practice. According to participants several residents were used to listen to music or television at home during mealtime and other residents were known to have interest in music.

The participants found Homelike partly successful due to occasionally missing goods such as table linen. Achievements to Homelike were observed. Nurse-assistants had less disturbed activities during the mealtime-practice due to good preparation. Mealtime was more sociable and peaceful when the nurse-assistant was sitting at the table. *"I chat about how they used to prepare their meatballs" (nurse-assistant).* Residents were inclined to talk about the past. A participant experienced relatives who came to visit their father, stayed and helped serving food. During the observations music resulted in residents humming, tapping with the music or even at some point residents were singing songs of their past.

Smell

On the ward meals were heated in the oven. Residents could smell cooking aromas when they were close to the oven. The aim was to set more cooking smells in the entire ward, which was believed to increase the sensation of mealtime and to increase appetite. One action was mentioned to achieve this goal: when the type of food and the situation (enough other nurse-assistants) allow it, prepare food on the stove.

During the observations baking was seen once. Baking was according to participants too difficult to accomplish due to limited staffing.

Discussion

This study demonstrates that a task-driven context of care can be changed towards a context of care that meets person-centeredness. Serving bowls and offering decisions support abilities of residents in making choices, regarding their own unique preferences. Music made the environment more PCC, since it better fit the world of the residents and therefore increased well being. Homelike lead to an increased social atmosphere and stimulated a peaceful mealtime-practice. Residents, more at ease in the changed mealtime-practice, had lucidity moments and talked about the past. The work-culture changed from a nurse-assistant driven focus on the mealtime-practice, towards a resident's centred driven work-culture. Furthermore, highlighted is the vital role of nurse-assistants in achieving a PCC mealtime-practice.

In a review of Reimer et al[33] four key elements of PCC mealtime were described: providing choices and preferences, supporting independence, showing respect and promoting social interaction. These items were similarly present throughout this study. Respect was not an explicit stated in this study but was an important value that was taken into account, for example by creating a peaceful mealtime-practice. Serving bowls and sitting down with residents in other studies yielded similar findings.[15,16] In the first meeting it was remarkable that all stakeholders had mutual understanding how PCC context of care should be. In accordance to the study of McCormack et al[11] nurse-assistants of the workgroup had previously experienced PCC moments. Although mutual understanding of PCC was present no actions to establish a change were previously taken. EPD empowered and united the stakeholders to achieve a PCC context of care. Limited staffing was an explanation of the failure of Smell. In accordance to a recent study PCC mealtime-practice demands adequate staffing levels.[33]

A major strength of this study was the insider's knowledge about the role of stakeholders in the team, which created the possibility to select early adopters and informal leaders. They were skilled to be a role model towards other colleagues. The visualization of the altered mealtime-practice via a colleague was a suitable strategy to determine the goals of the study. Another strength was the insider's role during the participant observer, as residents were not distracted during mealtime-practice. Study limitations were found in the workgroup of stakeholders. EPD aims to involve all types of stakeholders, but in exception of the spouses and nurse-assistants other stakeholders refused.[22,23] Involvement of other stakeholders could have resulted in obtaining other perspectives during the meetings. Another limitation is found in the inter-observer reliability as one person performed participatory observations.

Although reflective descriptions were made and other measures were taken throughout the study, still the problem of blinding, which could have lead to bias could have been present due to the close involvement. The study setting is transferable for to other wards, which are aimed to be small-scale living environments with a number of institutional influences.[21] Nevertheless, generalization of study results is limited due to the specific setting.

To determine a PCC context of care during the mealtime-practice the study implies to consider the use of serving bowls, stimulate resident's choices, play music and reconsider mealtime routines. Besides, nurse-assistants social and managing role must be taken into account, as they are vital in achieving a PCC context of care during the mealtime-practice. Finally, including specific stakeholders to the EPD workgroup appears to be a suitable strategy.

Conclusion

It is concluded that the mealtime-practice is changed from a task driven activity to a PCC activity within the respective ward. Instead of institutional features, person-centred needs of the residents are considered during the mealtime-practice. Action research based on EPD is a useful design to realize a person-centered context of care during the mealtime-practice. This study has shown a positive effect on the well being of the studied residents by implementing PCC on the context of care during the mealtime-practice.

Recommendations

Further comparative EPD studies are recommended to include a larger workgroup with more diverse types of stakeholders. This in accordance to the EPD theory and the larger workgroup is advised due to the frequency of withdrawal. Comparative studies are advised to include an extra observer not committed to the practice for the reliability of the study. Furthermore, by completing this study new challenging's arise such as embedding the study results. Therefore comparative EPD studies are recommended to increase the timespan of the study as follow-up. More investigation is required on the role of specific stakeholders and their value in EPD.

Based on the study results policymakers aiming for a PPC context of care during the mealtime-practice are advised to consider the methodology of action research based on EPD, to consider the use of serving bowls, to stimulate choices, play music, reconsider mealtime routines and to focus on nurse-assistants skills.

List of references

[1] Lou MF, Dai YT, Huang GS, Yu PJ. Nutritional status and health outcomes for older people with dementia living in institutions. J Adv Nurs 2007 Dec;60(5):470-477.

[2] Wolf-Klein GP, Silverstone FA. Weight loss in Alzheimer's disease: an international review of the literature. Int Psychogeriatr 1994 Fall;6(2):135-142.

[3] Pasman HR, The BA, Onwuteaka-Philipsen BD, van der Wal G, Ribbe MW. Feeding nursing home patients with severe dementia: a qualitative study. J Adv Nurs 2003 May;42(3):304-311.

[4] Liu W, Cheon J, Thomas SA. Interventions on mealtime difficulties in older adults with dementia: a systematic review. Int J Nurs Stud 2014 Jan;51(1):14-27.

[5] Edvardsson D, Winblad B, Sandman PO. Person-centred care of people with severe Alzheimer's disease: current status and ways forward. Lancet Neurol 2008 Apr;7(4):362-367.

[6] McCormack B. Person-centredness in gerontological nursing: an overview of the literature. J Clin Nurs 2004 03/02;13(3):31-38.

[7] Sjogren K, Lindkvist M, Sandman PO, Zingmark K, Edvardsson D. Person-centredness and its association with resident well-being in dementia care units. J Adv Nurs 2013 Jan 21.

[8] Athlin E, Norberg A, Asplund K. Caregivers' perceptions and interpretations of severely demented patients during feeding in a task assignment system. Scand J Caring Sci 1990;4(4):147-155.

[9] Hoeffer B, Talerico KA, Rasin J, Mitchell CM, Stewart BJ, McKenzie D, et al. Assisting cognitively impaired nursing home residents with bathing: effects of two bathing interventions on caregiving. Gerontologist 2006 Aug;46(4):524-532.

[10] Sloane PD, Hoeffer B, Mitchell CM, McKenzie DA, Barrick AL, Rader J, et al. Effect of person-centered showering and the towel bath on bathing-associated aggression, agitation, and discomfort in nursing home residents with dementia: a randomized, controlled trial. J Am Geriatr Soc 2004 Nov;52(11):1795-1804.

(11) McCormack B, Dewing J, McCance T. Developing person-centred care: addressing contextual challenges through practice development. Online J Issues Nurs 2011 May 31;16(2):3.

(12) McCormack B, McCance TV. Development of a framework for person-centred nursing. J Adv Nurs 2006 Dec;56(5):472-479.

(13) Beattie ER, Algase DL, Song J. Keeping wandering nursing home residents at the table: improving food intake using a behavioral communication intervention. Aging Ment Health 2004 Mar;8(2):109-116.

(14) Amella EJ. Feeding and hydration issues for older adults with dementia. Nurs Clin North Am 2004 Sep;39(3):607-623.

(15) Mamhidir AG, Karlsson I, Norberg A, Mona K. Weight increase in patients with dementia, and alteration in meal routines and meal environment after integrity promoting care. J Clin Nurs 2007 May;16(5):987-996.

(16) Charras K, Fremontier M. Sharing meals with institutionalized people with dementia: a natural experiment. J Gerontol Soc Work 2010;53(5):436-448.

(17) Edwards NE, Beck AM. The Influence of Aquariums on Weight in Individuals With Dementia. Alzheimer Dis Assoc Disord 2012 Nov 7.

(18) Ho SY, Lai HL, Jeng SY, Tang CW, Sung HC, Chen PW. The effects of researcher-composed music at mealtime on agitation in nursing home residents with dementia. Arch Psychiatr Nurs 2011 Dec;25(6):e49-55.

(19) Chang FY, Huang HC, Lin KC, Lin LC. The effect of a music programme during lunchtime on the problem behaviour of the older residents with dementia at an institution in Taiwan. J Clin Nurs 2010 Apr;19(7-8):939-948.

(20) Thomas DW, Smith M. The effect of music on caloric consumption among nursing home residents with dementia of the Alzheimer's type. Act Adapt Aging Jan 2009;33(1):1-16.

(21) Verbeek A, Van Rossum E, Zwakhalen SMG, Kempen GIJM, Hamers Januari JPH. Effecten van kleinschalig wonen voor ouderen met dementie. January 2011;ISBN 978-94-6159-031-2.

(22) McCormack B, Manley K, Titchen A. Practice Development in Nursing and Healthcare. 2nd ed. West Sussex: Wiley-Blackwell; 2004.

(23) Munten G, Legius M. Practice development naar duurzame verandering van zorg en onderwijspraktijken. Den Haag: boomlemma; 2012.

(24) Migchelbrink F. Actieonderzoek voor professionals in zorg en welzijn. Amsterdam: SWP; 2007.

(25) Lofland J, Lofland LH. Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. Belmont, CA: Wadsworth; 1995.

(26) Creswell JW. Qualitatieve inquiry & research design: Choosing among five approaches. second ed. London: Sage Publications; 2007.

(27) van Linge R. Innoveren in de gezondheidzorg: theorie, praktijk en onderzoek. Amsterdam: Reed business; 2006.

(28) Grol R, Wensing M. Implementatie, effectieve verbetering van de patiëntenzorg. Amsterdam: Reed business; 2011.

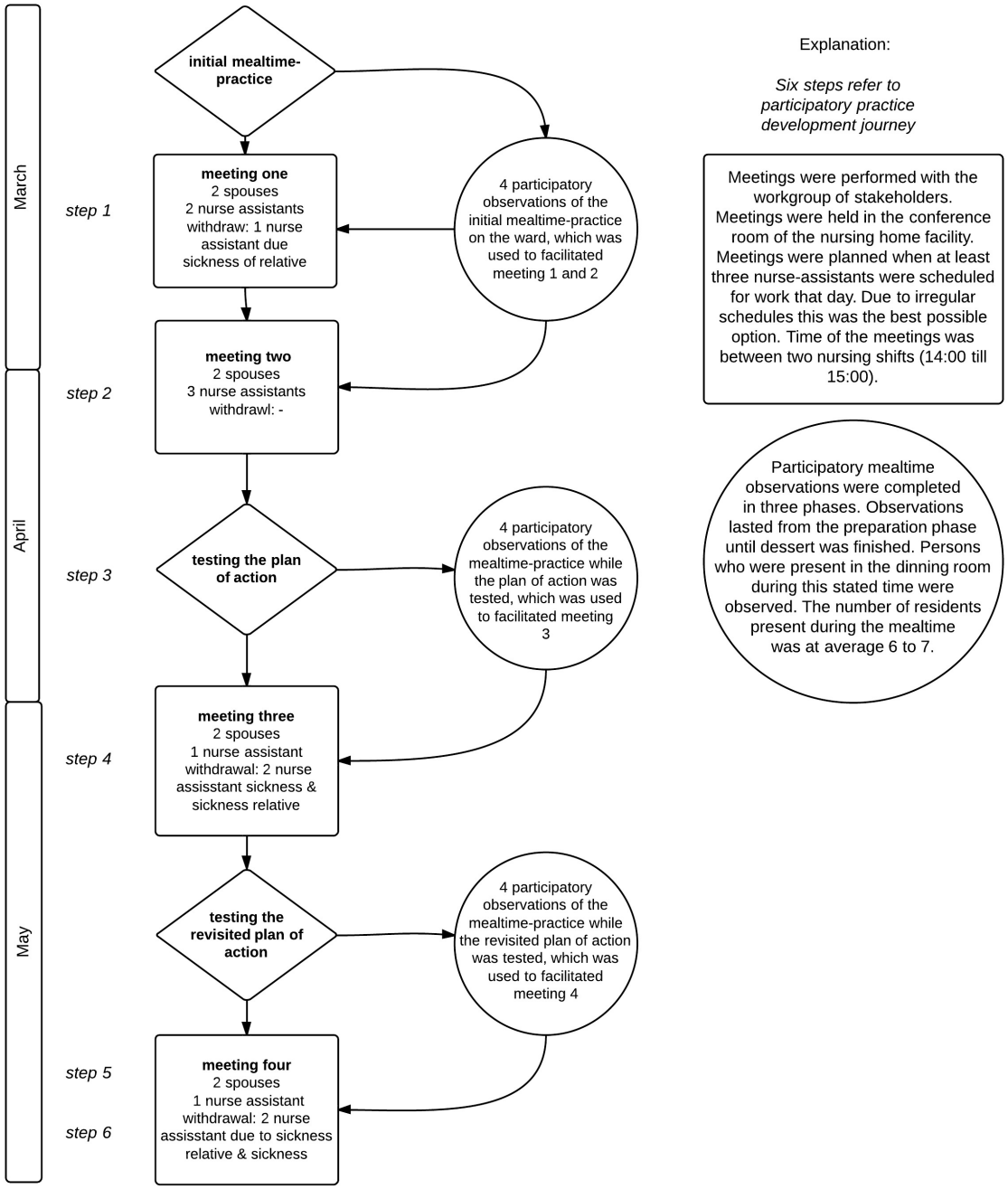
(29) World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. J Postgrad Med 2002;48(206).

(30) Wet medisch-wetenschappelijk onderzoek met mensen. 1998. Available at: http://wetten.overheid.nl/BWBR0009408/geldigheidsdatum_01-07-2014

(31) Microsoft Word 2011.

(32) Boeije H. Analysis in qualitative research. Oaks, California: SAGE Publications Ltd; 2010.

(33) Reimer HD, Keller HH. Mealtimes in nursing homes: striving for person-centered care. J Nutr Elder 2009 Oct;28(4):327-347.



Flowchart: Study procedure over time

The journey of the participatory practice development steps [22,23]	EPD steps established in this study via:	
Step one: Orienting	Meeting 1	The facilitator asked the participants to clarify the present mealtime care context and to share dreams and hopes about the desired PCC context of care during the mealtime-practice. Examples of what was seen in participatory observations of the initial mealtime practice were used to facilitate the meeting.
Step two: Goals. What do we want to accomplish? Creating a plan.	Meeting 2	In meeting two the facilitator summarized the topics of first meeting and asked the participants to focus on what the most important changes had to be in order to realize a PCC context of care during the mealtime-practice. Examples of what was seen in participatory observations of the initial mealtime practice were used to facilitate the meeting. The outcome of the meeting was a plan of action.
Step three: Testing the plan.		The researcher translated what was said to a plan of action on printed-paper. This formatted the plan of action was deliberately spoken through with the members of the workgroup and adjustment were processed. After consensus was reached the researcher and members of the workgroup introduced the plan of action in a team meeting. In addition, the nurse-assistants received the action-plan via email and a printed version was available in the dinning room.
Step four: Sharing experience about the plan in practice. New knowledge? Do we have to change the plan?	Meeting 3	The third meeting started with a brief introduction. The participants were asked to share their experience with the action-plan. The facilitator shared the findings of the observations and the action-plan was carefully reviewed. One action was added to the plan of action. Serving coffee after the mealtime. Coffee was allready served but not written down on the plan of action. Examples of what was seen in participatory observations while the plan of action was tested were used to facilitate the meeting.
Step five: Evaluation of the EPD procces. Sharing expierence, learning for each other. **Step six:** New round. Is the EPD accomplished? Questions about embedding and ensuring of continuety.	Meeting 4	During the forth meeting step five and six were combined. Evaluation, reflection, conclusion and plans for embedding were carefully discussed. Examples of what was seen in participatory observations while the revisited plan of action was tested were used to facilitate the meeting.

Table 1: Practice Development steps, specified this study

Participatory observation protocol Date: Starting time & end: Number of residents: Number of nurse-assistant(s):	
Descriptive	**Reflective**
Physical environment *(Including a sketch of the setting)*	
Work culture	
Miscellaneous	
Reflection observer:	

Table 1: Protocol of participatory observations

Nederlandse Samenvatting (Dutch Summary)

Titel: Het realiseren van een persoonsgerichte zorgcontext tijdens de maaltijd.

Inleiding: Lange tijd was dementiezorg voornamelijk taakgericht zoals het zorgen voor voldoende intake tijdens de maaltijd. Echter gaat taakgerichte zorg vaak voorbij aan psychosociale zorgvragen. Persoonsgerichte zorg is een zorgmodel die de mens achter de dementie centraal zet. Van het inrichten van een persoonsgerichte zorgcontext tijdens de maaltijd werd verwacht dat dit het welzijn van bewoners met dementie zou verbeteren.

Doel: Het realiseren van een persoonsgerichte zorgcontext tijdens de maaltijd.

Onderzoeksvraag: Wat is het proces van het realiseren van een persoonsgerichte zorgcontext tijdens maaltijd op een psychogeriatrische afdeling?

Methode: Actieonderzoek gebaseerd op de methodische stappen van emancipatory practice development (EPD). Een groep van zeven bewoners van een psychogeriatrische afdeling in een verpleeghuis werd centraal gezet tijdens de maaltijd. Een werkgroep van stakeholders werd gevormd en participeerde in vier vergaderingen met als doel de zorgcontext te verbeteren. Daarnaast werd de maaltijd geobserveerd om praktijkvoorbeelden terug te kunnen koppelen in vergaderingen.

Resultaten: De deelnemers uit de werkgroep kozen vier doelen en bijbehorende acties om een persoonsgerichte zorgcontext tijdens de maaltijd te bewerkstelligen. Deze doelen waren (1)later in de avond beginnen met de maaltijd, (2)aanbieden van keuzemogelijkheden, (3)een huiselijke omgeving te creëren en (4)het tot stand brengen van meer etensgeur op de afdeling. Acties bijbehorend aan deze doelen werden in een werkinstructie omschreven. Deze acties waren onder andere taakgericht op verandering van de werkroutine van de verzorgende, introductie van serveerschalen en het afspelen van rustige muziek. Toepassen van de nieuwe werkmethodiek resulteerde in een socialer, rustiger en beter georganiseerd maaltijd.

Conclusie: De zorgcontext tijdens de maaltijd is persoonsgericht geworden en het welzijn van de bewoners van de afdeling was verbeterd.

Aanbevelingen: gebruik van serveerschalen, spelen van muziek, veranderen van de werkroutines, rol van de verzorgende en het gebruik maken van specifieke stakeholders.

Trefwoorden:

persoonsgerichte, maaltijd, actieonderzoek, “emancipatory practice development”, context

English Abstract

Title: The realization of person-centred mealtime care

Background: When mealtime care is mainly focused on satisfying physical needs such as providing sufficient intake, care fails to support psychosocial needs of residents with dementia. Person-centred care (PCC) is a care model that recognizes psychosocial needs and includes the uniqueness of the person with dementia. By adopting PCC in the context of care during the mealtime-practice it was assumed that resident's mealtime-experience would be enhanced and therefore well being would increase.

Aim: Realization of a PCC context of care during the mealtime-practice.

R**esearch Question**: What is the process of realizing a PCC context of care during the mealtime-practice on a ward for residents with dementia?

Method: An action research based on emancipatory practice development strategies (EPD). Seven residents with dementia were studied. A workgroup of stakeholders was selected to complete EPD steps via meetings. Alongside meetings, participatory observations were completed to get insight in the mealtime-practice and to facilitate meetings.

Results: The participants of the workgroup selected four goals and subsequent actions to set a PCC context of care: (1)to start mealtime later, (2)to provide residents with choices, (3)to set a homelike mealtime environment and (3)to set more cooking smells. To achieve the goals, actions were formatted into a plan of action and tested in the mealtime-practice. Actions could be linked to the role of the nurse-assistants, or referring to attributes such as the introduction of serving bowls and music. Main achievements were a peaceful structured mealtime-practice and an increased social environment.

Conclusion: The mealtime-practice changed from a task driven activity to a PCC activity, which increased well being of residents.

Recommendations: serving bowls, adjustments in the mealtime routines, introduction of music, the role of the nurse and the close involvement of dominant stakeholders.

Keywords:

person-centred, mealtime, "emancipatory practice development", context, "action research"