

Living with Dementia: Plotting a Revolution in Care Home Catering Provision through Resident Directed Services

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I hope I die before I get old (Townsend, 1965)

There is no doubt that many Baby Boomers will be pleased not to have fulfilled The Who's wish just yet. It should though be recognised that many of the current, and near future, intake of care home residents will be from the 'Baby Boomer' generation, rather than the stoic generation who had survived the privations of war, rationing and sacrifice. The first waves of the Baby Boomer generation are already in their mid-sixties to seventies (Kahana and Kahana, 2014, pp 380-384). The expectations of the coming generation are far higher with an ingrained sense of entitlement, with food being a major component in residents' health and happiness (Egan, 2013). This sense of entitlement may well prove to be a significant challenge, requiring a revolutionary paradigm shift, to future care home management, staff and caterers.

Motivation for the Study

I have witnessed, first hand, the often poor standards of food, hydration and service in Long Term Care Homes (LTCH). Having seen such events unfold, and supported by reports of nursing complaints (Cooper, 2013, p 6), I was determined to help find a solution. Many LTCHs are now outsourcing their catering requirements to specialist catering companies. The commercial companies have to make a profit and the not-for-profit or community interest companies (caterers) have to limit their losses and hopefully return a surplus. There are also many companies now promoting their ranges of ready-made, frozen, ready to heat, convenience foods, some of which, whilst fulfilling a gap in the market, can hardly be considered the production of the finest culinary artists. How can the quality of Food and Beverage (F&B) Services be improved, whilst maintaining a healthy Profit and Loss (P&L) account? Under current market and financial pressures there is little room for manoeuvre in costs and every caterer is under constant threat from competitors eager to take away business (Ahmed, et al. 2015, 40). This is the problem which the research hopes to address.

Research Objectives

Many reports on caring for people living with dementia identify nourishing food and drinks as an essential requirement. The ultimate research study will aim to investigate methods and constructs by which caterers can improve the F&B services they offer to people living with

dementia (PLWD) in LTCHs whilst improving and maintaining their competitive edge, unique service proposition and profitability.

The objectives are:

- To explore food service delivery methods and quality constructs suitable for deployment within LTCH catering environments;
- To establish the need for creativity and innovation in LTCH catering.

My Research Questions

The literature review has confirmed the stated aims and objectives of the research and has suggested a number of further research questions to be considered in the work.

- What gaps exist between what PLWD, or their relatives, expect of food service quality in LTCHs and what is actually delivered?
- Would the philosophy of Resident Directed Foodservice (RDF), using a systems approach, assist Caterers deliver a more hospitable, yet cost effective product?
- What would be the implications for caterers in providing RDF in LTCHs?

Consequently, the aims, objectives and research questions lead to business research which is regarded as Business Research in Care Home Catering, as stated by Brotherton (2015, pp 12-13) as exploratory research which may include descriptive elements but then proceeds to explore and identify the latent causes at the root of the effects and the relationship between the two.

The extant research

This review is divided into six sections, exploring each theme in order. This review considers the extant research in catering within LTCHs and investigates how caterers are currently delivering the F&B service. This is followed by a review of the literature on Hospitality and Catering Management and the relationships which could be applied to LTCH catering.

Dementia in context

The root of dementia is from the Latin: 'de' which means without and 'ment' which means mind historically described as being 'out of one's mind'. The word dementia describes a set of symptoms that may include memory loss

and difficulties with thinking, problem-solving or language (Alzheimer's Society, 2014). The most common form of dementia is Alzheimer's disease with vascular dementia and Lewy-body dementia frequently seen – all forms are progressive in nature and lead to functional losses (Amella, Grant and Mulloy 2007, pp 360-361). In recent years as our understanding of the experience of dementia has advanced, so too has our understanding of how to improve the quality of life and well-being of people with dementia in care homes.

McFadden and McFadden (2011, p 12) refer to the unprecedented numbers of the ageing 'baby boomer' generation who are getting the dreaded dementia diagnosis. Their viewpoint, however, has not been negative and they suggest that the fear and anxiety should be replaced with courage to lead a more fulfilling life. There are, however, many PLWD who must seek out the care and support provided by specialist care homes. The Alzheimer's Society UK Dementia Report Statistics (2014) state there are already 850,000 PLWD in the UK and suggest that within the next decade, by 2025, there will be one million PLWD in the UK.

According to the Alzheimer's Society (2014) eighty per cent of care home residents have dementia. And one in three care home residents are admitted already suffering from malnutrition (BAPEN, 2012, 6). Lui, et al (2014) in a recent systematic review noted that 'the quality of current research of the effect of mealtime interventions in dementia was poor'.

Dementia is proving to be one of the fastest growing illnesses and estimated to cost the UK £26.3 Billion per year, £17.4 Billion of that picked up by PLWD and their families and a further £8.8 Billion directly paid for by the Exchequer, with £0.1 Billion taken up by other costs. Despite those costs only £74 Million had been spent on dementia research in 2013 – but nothing could be found on expenditure on research into foodservice provision in LTCHs. (The Alzheimer's Society UK Dementia Report Statistics 2014). If catering businesses can improve the nourishment of PLWD in LTCHs there will be savings to the exchequer, the LTCHs and increased profitability, through better reputation, for the catering service providers. It is hypothesised that if catering services were improved there would be savings to the exchequer.

Taste and texture perception is reduced with older age, and some research indicates that environmental factors also influence the amount of food which dementia patients are able to eat (Dunne et al., 2004, pp 533-538). This research, however, does not suggest any changes to food and hydration delivery other than changing plate and cup colours. A holistic approach using expert knowledge from hospitality, nourishment (gastronomy), and sensory science disciplines will allow the development of the catering professional leadership, competence and forward-thinking which is fulfilling its social and ethical agenda.

There has also been some discussion on whether or not to legislate or regulate for the standards of food provision in LTCH's for the elderly and PLWD. Sheppard (2010, p 29)

questioned whether or not the Care Quality Commission (CQC) Review: Meeting the healthcare needs of people living in care homes ^{2009/2010} (CQC 2012, pp 5-7) would call for the introduction of legislation, regulation or stronger guidance – or a combination of all three. This did not happen.

Shortly after that review was completed the Department of Health rearranged the responsibilities of the CQC and a further review, regarding thematic inspections on dignity and nutrition, was commissioned for 2012. Although the reports fell short of suggesting the introduction of legislation or regulation the CQC report, Time to listen: In care homes – Dignity and nutrition inspection programme 2012 – National overview, found several common failings in the care homes inspected.

Several of these concerns were related to the feeding of residents:

- Staff and managers in some homes: did not always give people a choice of food or support them to make a choice; failed to identify or provide the support that people who were at risk of malnutrition needed; did not ensure that there were enough staff available to support people who needed help to eat and drink:
- 14% of homes failed to have enough staff to meet people's needs.
- Homes caring for people with dementia, including those with a dedicated dementia unit, were less likely to be meeting the standards relating to respect and safeguarding.

What, then, is to be made of this? Are catering services, hospitality management and the culinary arts – cooking, serving and feeding – too commonplace or quotidian to be studied seriously or to be able to contribute to the well-being of PLWD?

Long Term Care Homes - Catering Definition

Catering services within LTCHs is a large consumer-facing service business where the primary function is the provision of F&B services to residents and staff. That simplistic definition, however, does not fully convey the true outputs. LTCH caterers are also responsible for ensuring adequate nourishment is available through the food they produce and serve, not just basic energy. The provision of nourishment, compatible with the primary requirement of human life, is about more than mere food and drink (Caldecott 2014).

To imply that the consumption of food and drink is a vital part of the chemical process of life is to state the obvious but we sometimes fail to realise that food is much more than vital. The only other activity we engage in that is of comparable importance to our lives and the life of our species is sex. Appetite for food and sex is natural, but these two activities are quite different.

Catering, in general, is a fundamental subset of many sectors of society, including the fields of hospitality, healthcare, schools, prisons and so on. LTCH resident

feeding, as with employee workplace feeding, is perhaps one of the largest single elements of the catering sector, but its importance is generally overlooked, both inside and outside the hospitality industry (Edwards. 1993, 10-14). What then is LTCH catering? The historical categorisation suggests: cost sector – as opposed to profit sector; non-commercial – as opposed to commercial. The common theme, however, throughout those descriptions is the inference that care home catering, for many years, has been ignored as a commercial undertaking. The last few decades have seen changes, however, with commercial contract caterers coming to the fore (Earls 2011, p 36, The NACC 2016).

A significant anomaly within the sector, as in other branches of catering, is that to be a care home caterer there is no requirement to hold formal qualifications, not even care credentials (Mamzoori-Stamford 2015). Too many catering jobs in LTCHs are preoccupied with table clearing, plate scraping and pot washing, and, very often little or no understanding of the food being prepared and served and even less about the residents' needs (Murray 2015).

Fortunately, there are many people employed in LTCH catering services who are excellent at their jobs, evidence a real understanding of nutritional needs and how to prepare nutritious and appetising food, there is however, significant anecdotal evidence that these enlightened souls are in the minority. Both the National Care Forum (NCF) and the National Association of Care Catering (NACC 2016) offer support, advice and training for care home caterers

Dementia and Hospitality Business

'Food is your medicine – hence let your medicine be your food' (Hippocrates, circa 400 BC). Many academic commentators have attempted to define hospitality and the term has been described as both commercial and social activities (Brotherton 1999, pp 165-173; Brotherton & Wood 2000, pp 134-154). Within a LTCH environment there are competing values and priorities. Managers are urged to change perpetually, yet maintain order; to make the numbers, yet nurture their staff; to think globally, yet act locally (Gosling and Mintzberg 2003). Care home nursing managers may be more concerned about the medical status of their charges, rather than the state of hospitality or their immediate comfort, whereas the catering staff may well place more emphasis on the feeding and hydration routines and creature comforts of their 'guests'. Surely though we should not confuse hospitality with hospitableness (Brotherton, 1999 pp 165-173).

Dementia and Hospitableness

There is a small, but growing, body of research questioning the philosophy of, and critical studies of, hospitality and the limited interactions between the different academic traditions, with even less interaction between practitioners and academics. In one overlapping area of the hospitality

disciplines, care home catering, sometimes referred to as institutional catering, there appears to be even less interaction between the caterers and nursing or medical staff, as explored in the following sections. In this case we could consider the phenomenon of 'hospitality as care'; 'hospitality as medicine'; 'hospitality as ethics' and; 'hospitality as culture'.

It could be suggested that 'Catering', in the context of the 'principles of hospitality' demands a sacred obligation not just to accommodate the guest, but to protect the stranger, especially the patient living with dementia who arrived at the door of the care-home. The constantly evolving understanding of hospitality, including reference to cultural and religious meaning within our history have been followed, and commented on, by historians of hospitality. Within those studies the definitions of hospitality are wide ranging, including comment on the provision of food and drink, the ethics of welcoming strangers and the etiquette expected of societies (Browner 2003; Pohl 1999)

Should then, a patient resident within a LTCH be considered as a guest and in receipt of hospitality? Should that hospitality be viewed as Derrida (2000, pp 3-18) identified hospitality? In truth, Derrida's explanation of hospitality was far removed from the commercial realities of the hospitality business sector. Nonetheless, hospitableness needs both a host and a guest as there must be an exchange of giving and receiving between the two. Within a LTCH the exchange of giving and receiving is that of money, or other consideration such as insurance premiums, in return for accommodation, medication, nursing care, food, hydration and cleanliness. Who then is the host in the context of LTCH hospitality? Should this be the Care Home Manager; the Nutritionist; the Hotel Services Manager, Catering or Hospitality Manager? For clarity then, the definition of commercial hospitality used throughout the rest of this paper is that of the functional form of hospitality rather than the emotional form of hospitality. That is to say, hospitality services are given in exchange for a consideration.

Catering within LTCHs – Systems, Nutrition, Methods and Gastronomy

It must be accepted, however, that a LTCH is not a hotel, where the daily rates fluctuate according to demand. You cannot just log on to Trip-Advisor or Booking.com to change bookings if you and your family don't like the services offered or the prices charged. Once in a care home the resident is more or less a hostage to the status quo. The Care Quality Commission (CQC) do publish a ratings guide, varying from outstanding to inadequate, but do not publish, or advise, on costs and rates. From April 2016, all care homes are expected to display the results of CQC inspection ratings in a prominent position on their premises, much like the 'Scores on the Doors' systems for restaurant food safety.

Just one of the major problems facing those PLWD in LTCHs is the reduced intake of nourishment, leading to malnutrition, regardless of the hospitality services. The potentially harmful effects include dysphagia, apparent food refusal, stress and panic expressed by the resident when fed (DiMaria-Ghalili, 2014, pp 420-427, Amella, Grant and Mulloy, 2008, p 360-367). None of the current research includes mention of the catering support and service staff, chefs, supervisors or catering managers as being part of the multi-disciplinary care teams; people who are usually in close contact with the residents.

There are, however, recent initiatives in the United States of America to integrate healthcare and hospitality services, The Beryl Institute (2016) has reported on an initiative, between the Christiana Care Health System and the University of Delaware Hospitality Associates for Research and Training, bringing together expertise in health care and expertise in the hospitality industry to create a unique training program that will give staff the skills and tools needed to achieve excellence in delivering an exemplary patient experience. Although this initiative was for a large hospital complex the results may well be replicable within LTCHs.

Despite past and current government strategies to improve the nutritional intake for PLWD in LTCHs, surprisingly little research has been carried out into the operational, practical and staffing aspects of feeding those people. From a caterer's point of view there has been much advice as to what to feed to the people within their domain: See, for example the myriad information from the Voluntary Organisations Involved in Caring in the Elderly Sector [VOICES] (1998), The Caroline Walker Trust (1995, 2009), Biernaki and Barrett (2001, pp 1104-1114) and Crawley and Hocking (2011), to name but a few. There has, in fact, been a long history of dietary and nutritional advice most of which seems to be both accurate and well intentioned.

The complexity of LTCH resident feeding, and the management of the process, continues to challenge medical, nutritional, dietitian and operational staff in equal measure (Miller and Kinsel 1998, pp 177-181, Mathey et al 2001, pp 416-423, Remsburg et al 2001, pp 1460-1463, Wilson, Evans and Frost 2000, pp 271-275). Kitwood (1997), together with Miller and Kinsel (1998, pp 177-181), were early promoters of Patient-Focused Care. Kitwood (1997) challenged what was considered to be the standard paradigm within residential care, emphasising the need for a change within the culture of service providers if significant, long-term, improvements were to be made. There are, however, aspects of his work which raise questions as to the viability of Patient Focussed Care, not least of which are the potential increase in costs of providing that care. Nonetheless, with improved technology and innovative advances in catering services, since Miller and Kinsel's (1998) paper, there is hope that improvements can be made.

Miller and Kinsel also recognised the need for change but did not include the food production and service staff in their suggestions for changes though the American model for long term care uses differing terminology. Remsburg et al (2001, pp 1460-1463) referred to several studies which had identified reversible factors associated with malnutrition in nursing home residents in the USA. Those factors included lack of sensitivity to residents' needs and food preferences, poor food quality and poor food choice. Consequently, the suggestion is made that for too long the traditional dining strategies within the LTCH settings have been responsible for under nourishment and that those strategies are in need of re-evaluation.

Considering that such reversible factors have been identified there is a paucity of research into the role of the caterers or catering systems employed within a LTCH setting, particularly within the UK. Nonetheless, diagnostic and treatment options are continuously evolving and new nutritional imperatives for PLWD are being discussed as never before, together with other non-pharmaceutical interventions (for example, see: Bakker 2003, pp 46-51; Baptiste, Egan and Dubouloz-Wilner 2014, pp 38-44; Biernaki and Barratt 2001, pp 1104-1108; Brush and Calkins 2008, pp 24-25; Chang and Roberts 2011, pp 36-46; De Bruin et al 2010, pp 352-357; Mathey et al 2001, pp 416-423; Remsburg et al 2001, pp 1460-1463; Wilson, Evans and Frost 2000, pp 271-275).

Stemming from the above it is clear that the dominant area of research in terms of increasing or bettering the nourishment intake for PLWD is focussed on nutritional aspects – the 'what should be fed to the patient residents' rather than the 'how it should be fed to the patient residents'. Within the world of hospitality however, a more prosaic preoccupation with getting things done suggests Brillat-Savarin's 'Physiologie du gout' (1982) has long been considered by professional caterers as still the only science that deals with everything pertaining to the nourishment of man.

As human beings do we have a right to the foods we have enjoyed throughout our lives as we enter the later stages of life or even succumb to the ravages of dementia? Access to foods enjoyed throughout life in a pleasant environment with close friends and family is desired, but often unavailable, to people in long-term care. The mealtime experience in a LTCH can often be associated with dour, institutionalised, canteen like service (Perivolaris 2006, pp 258-267) and far removed from the pleasant atmosphere needed.

Innovation in LTCH Catering, Hospitality and F&B Service

Innovation – defined here as the successful commercialisation of novel, disruptive ideas, (or the Eureka, AHA!! or light-bulb moments) includes new products, services, processes and business models – is a

critical component of hospitality & catering business growth. The importance of innovation as a driver of hospitality growth and competitiveness has and will continue to increase in the foreseeable future. Hennessey and Amabile (2010, pp 569-598) state that human progress depends upon the psychological study of creativity, and that strides will not be made until we achieve a far greater understanding of what drives the creative processes. They have identified that research into creativity does not usually cross from one discipline to another, with investigators in one subfield often not even knowing what is going on in another. Perhaps this review will encourage further studies in hospitality and catering innovation for LTCHs.

Since Kitwood (1997) first proposed his theories little movement, if any, has been seen within the UK LTCH market. The majority of care homes, with the exception of those using the Steamplicity brand, or similar methods, are still utilising the same F&B production and service techniques which have been in use for decades.

Epp (2003, pp 14-18) supports the introduction of Person Centred Care in the care home environment and called for a shift in culture and away from the task oriented model and towards a more holistic model. He defines Person Centred Care as being founded on the ethic of all human beings, regardless of disability, being of absolute value and worthy of respect and suggests that:

1. Person Centred Care is centred on:
 - a. The whole person, not on the diseased brain;
 - b. Remaining abilities, emotions and cognitive abilities – not on losses;
 - c. The person within the context of family, marriage, culture, ethnicity, gender.
2. Care that is centred within a wide society and its values.

It is intended to adapt the above to formulate a paradigm for Resident Directed Food Services.

Early conversations with catering managers in care homes suggest they increasingly find themselves assigned the role of 'the rope' in a very real 'tug of war'—pulled in one direction by residents', or their relatives', mounting demands, and in the opposite direction by the company's need for growth and profitability. Residents in care homes and hospitals living with dementia or any other mental disorder, are increasingly seen as a management problem and solutions are expected to be found in this context (Donini et al 2007, pp 105-114).

The goal now, then, is to identify methods of preventing the caterers' rope from snapping by identifying revolutionary and innovative methods of foodservice delivery, calling on the best practices identified in the commercial world of catering services and hospitality. This can be a challenge because of all the other professions involved in caring for patients in care homes. Who are these? How do they interact? What is the role and status of

the caterer as a member of the care giving team? Are the caterers viewed as part of the care team, or merely as service providers? Are the caterers sufficiently educated or trained to fully understand the needs of their customers? These are some of the questions which is believed will be answered through the continuing research. The next step in deduction therefore is to ask the essential question: Would the revolutionary philosophy of RDS of F&B provision assist the F&B Service providers deliver a more hospitable, sustainable, yet cost effective product and service? Investigation of the food chain in its entirety has been used to determine all aspects of nutritional care, including F&B service, by Iff et al (2007, pp 800-805).

This section now takes a broad, exploratory, look at the potential benefits for care home catering companies in adopting such strategies and critically assesses the application of hospitality theory to a medically dominated care home environment.

Such a revolutionary shift in the accepted paradigm of how care home F&B provision is managed and delivered should be of particular interest to the wider catering, hospitality and care home community, due to the totally uncharted waters which the research seeks to navigate. This is particularly relevant given the current debate over standards of care within care home environments. I intended to investigate to what extent RDS is in use, if at all, in long term care homes and what the main forms of service delivery are in use, for comparison. Unfortunately the search so far has not revealed any reference to the use of RDS or Patient Directed Foodservice at all. It has already been suggested by some care home operators that as a philosophy for food service delivery, such a proposal may well cause significant upheaval in the care home food service industry, not least due to the perceptions of increased costs. Other impacts are considered and seek to establish benefits for residents' quality of life. It should be recognised also, that there are likely to be some significant barriers and challenges within the sector.

Kitwood's (1997) theories gained credence in the 1990's with Person Centred Care but it was recognised that the transition to the new way of doing things, new cultures and new challenges would be faced with significant resistance from, not only the residents but also family and staff (McFadden and McFadden. 2011). Since Kitwood (1997) first proposed his theories little movement, if any, has been seen within the UK LTCH market. The majority of care homes, with the exception of those using the Steamplicity brand, are still utilising the same F&B production and service techniques which have been in use for decades.

The emergence of culinary styles, and the use of what some regard as revolutionary culinary technologies, which ignore the traditional have been coming to the fore in recent years. There has been Cuisine Nouvelle; Asian - Western Fusion; Molecular Cuisine (This 2009), (also referred to as Molecular Gastronomy) and, more recently, Cuisine Note à Note (This. 2012) to name but a few, but

how many of those have made it into the lexicon of LTCH catering? A web search of the most prominent LTCH websites, where menu choices are available, show a decided lack of imagination in the culinary offer. It is also apparent that most care homes expect their residents to order their meals well in advance and will serve those meals at fixed times of the day, ignoring the evidence that PLWD do not respond well to fixed dining times, preferring to eat when hungry (Amella, Grant and Mulloy, 2008, pp 360-367; Boczko, 2004, pp 64-67).

Both creativity and innovation, as part of New Product Development (NPD), have played significant rôles in the strategies of many hospitality businesses. Outside the realms of hospitality there is a wide range of products, spanning new-to-the-world, high technology innovations, to what has been described as simple improvements, adaptations and imitations of competitive products. The hospitality industry is no different, being a fast moving environment reliant on ensuring a competitive edge. Yet within that environment little has been published, historically, within the research field of care home catering services on creativity, innovation and NPD.

Moving forward, my conclusion is that catering services within the LTCH market have stagnated somewhat and are in need of re-energising in order to meet the demands of the emerging new clientele, the baby boomer generation, whose expectations are significantly different from the Vera Lynne listening generation (Carter, 2014).

In short, care (clinical and dietician) staff and catering staff need to talk, much more than they do at present, in order to improve the quality of F&B products and service. The lack of literature specifically dealing with care home catering in the LTCH industry appears to indicate a failure to either define or understand the rôle of the caterers and catering staff. This has led to what may be described as a polarisation within the industry which threatens to hold back essential advances.

It must be recognised that the baby boomers will not happily accept what is thrust upon them without a say in the choice of products offered. Current research is indicating that many PLWD do not thrive on fixed mealtimes and benefit from less rigid regimes, allowing for a form of 'grazing' whereby foods of different types are available for most of the day (Chang and Roberts, 2011, pp 36-46).

A form of Resident Directed Foodservice is proposed whereby the residents will actually have access to food when they have the inclination and / or time to eat it. Depending on the care home layouts this could be via room service, table service, buffets or micro food centres. The future research stemming from this review will fully investigate all possibilities for innovative and creative change.

There are several other areas of interest which may prompt further research. Critical Success Factors (CSF) for Catering / F&B Services in LTCHs, sometimes

considered essential for commercial prosperity, is an area which seems in need of investigation. Performance Management and Performance Measurement are other areas where there is a paucity of research. The literature search demonstrated a clear lack of applied research in the areas and could not find any reference to studies of SERVQUAL in the provision of F&B products and services within the LTCH industry.

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