



## ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

### Promoting independence at mealtimes for older persons with severe dementia

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#### Abstract

*Background:* Maintaining independence in activities of daily living, including when eating meals, may be challenging for persons with dementia. To uphold person-centred care there is a need for knowledge of how to facilitate mealtimes in such circumstances.

*Aims:* To develop knowledge of how nurses promote independence at mealtimes for persons with severe dementia, and to explore their practice from a person-centred perspective.

*Methods:* A collaborative action research project was conducted over two years in a Norwegian hospital for older persons with mental health challenges and severe dementia. The nurses conducted observations at mealtimes and presented narratives as a basis for group reflections, care planning and individualised adjustments. In the qualitative analysis, commonalities and differences in meal situations were explored and a constructed narrative was designed to identify the nurses' actions and attitudes.

*Results:* Person-centred practice and different levels of simplification in the planning and facilitation of meals for older persons with severe dementia seemed to help uphold their independence and dignity. This was achieved by careful observations during meals, when the nurses took the role of hostesses. Promoting independence for persons with severe dementia requires ongoing commitment, with practical reflection among the nurses and evaluation in everyday practice.

*Conclusions and implications for practice:*

- Facilitation of meals for older persons with severe dementia using a person-centred approach seems to increase the nurses' attention to people's independence and dignity
- Sharing narratives from meal observations in reflective dialogues promotes the nurses' competence in planning meals with different levels of simplification
- Building in systematic attentive observations and sharing narratives in everyday practice may be an important step in practice development
- Critical dialogue seems to strengthen awareness of person-centred facilitation of meals for persons with dementia, and also strengthened the staff's interest in exploring practical issues in their practice

**Keywords:** Action research, dementia, person-centred practice, meals, older people

## Introduction

Many countries have developed national strategies and guidelines to meet the challenges facing the increasing number of persons living with dementia. In 2007, the Norwegian government was the first to develop a national dementia strategy. It was revised in 2011 to focus on meaningful activities of daily living, increase knowledge in the caring services and society, and boost capacity in nursing homes and accommodation with onsite service staff (Ministry of Health and Care Services, 2011). The UK, among other countries, documented the need to improve quality of life for people with dementia, their families and carers in its national strategy (Department of Health, 2009), while the government of the Australian state of Victoria has authorised web-based guidelines to support the development of dementia-friendly environments (Victorian State Government, 2011). These programmes provide healthcare professionals with guidelines and support to develop, implement and evaluate locally focused innovations in their practice and move away from a strictly medical model of care towards a model centred on the individual's needs. This paper presents how nurse-led teams engaged in critical reflection and promoted development and implementation of practical knowledge, and highlights their awareness of person-centred facilitation during meals for persons with dementia. The paper emphasises the importance of continuing practice development to facilitate meals that promote independence and dignity among older persons with severe dementia.

## Background

Practice development in nursing and healthcare has in recent decades shown a growing awareness of the importance of safeguarding individual needs and wellbeing. It has also emphasised the embedding of evidence-based care and workplace cultures within person-centred processes, and learning in and from practice (McCormack et al., 2013). The delivery of person-centred dementia care has been largely inspired by Tom Kitwood (1997), who criticised traditional approaches for focusing on dementia rather than the person with dementia. Different models of dementia care have now been developed that draw attention to the person and not just the condition. Inspired by Kitwood, one model of dementia care highlights four components in person-centred approaches (Brooker, 2007):

1. Valuing people with dementia and those who care for them
2. Treating people as individuals
3. Looking at the world from the perspective of the person with dementia
4. Creating a positive social environment in which the person living with dementia can experience wellbeing

This practice development study concentrates on the importance of social environment in person-centred care and the manner in which care is provided at the level where healthcare is experienced and given – the microsystem level. This approach is consistent with the principles of practice development as a continuous process of improvement aimed at embedding person-centred care and integrating work-based learning (McCormack et al., 2013).

As a starting point in the journey of practice development, the authors addressed the complexity around meals themselves. Preparing meals and eating are complex activities of daily living. Older persons with severe dementia who experience loss of function in these activities may require assistance to remain as independent as possible and prevent malnutrition (Dunne, 2010; Chang and Roberts, 2011). The eating process may be confusing and overstimulating for those unable to cope or focus on completing their meals (Holmes, 2008). Food- and eating-related problems associated with dementia include lack of appetite, perception disturbances with impaired ability to recognise food and eating inappropriate types or amounts of food (Manthorpe and Watson, 2003). There can also be difficulty in transferring food from plate to mouth and spillage, and the person may forget how to eat. In the later stages of dementia, challenges such as not recognising food or understanding that a meal is to be eaten are common (McNamara and Kennedy, 2001; Dunne, 2010). Some persons eat more food than they need as they forget that they have eaten (Dunne, 2010), whereas others forget to eat.

Therefore, facilitating meals for older persons with severe dementia so that they consume an adequate diet poses many challenges. Meals combine activities with social, psychological and biological aspects (Dickinson et al., 2007). Meal planning and interventions must balance environmental and relational factors, as well as person-centred processes. The importance of the environmental and social aspects of taking part in a meal with others and the presence of specific mealtime companions play important roles in appreciation of meals (Kofod and Birkemose, 2004; Gibbs-Ward and Keller, 2005). Older residents in long-term facilities like nursing homes often dine together in family-style settings around a big table or several small tables. In Norway, hospitals for older persons with mental health problems and severe dementia also try to serve meals in homelike surroundings. Sounds and noises may occur when meals are prepared and served in homelike open kitchens where people can socialise (Chang and Roberts, 2011). The personality of those with dementia will affect how they respond to noise and other environmental disturbances (Meins, 2000) but unpleasant sounds are likely to distract them from the eating process (Holmes, 2008; Dunne, 2010). On the other hand, sounds such as relaxing music may be comforting during meals (Hicks-Moore, 2005).

Person-centred practice emphasises 'knowing the patient' as an important aspect for assessment (Dickinson et al., 2007). This includes a true grasp of a person's values and biographical details (McCormack and McCance, 2010); biographical approaches enable practitioners to gain a better understanding of the person's life (Clarke et al., 2003). Incorporating this information into care assessments and planning can give nurses a clearer picture of how the person wants their care delivered (Buckley et al., 2013). For those with severe dementia, this planning will also involve family members and friends (Dickinson et al., 2007).

Persons with dementia who have become malnourished or who are at risk of this often need further assessment and nutritional support (Holmes, 2008). Those caring for them in nursing homes and hospitals often use verbal prompts or cues to encourage eating during mealtimes (Archibald, 2006; Holmes, 2008; Dunne, 2010; Chang and Roberts, 2011). A 'dementia friendly' environment is defined as a cohesive system of support that recognises the experience of the person with dementia and provides the necessary assistance for them to remain engaged in everyday activities in a meaningful way (Davis et al., 2009). Staff in institutions must be sensitive to individual needs and aware of a resident's residual abilities when judging what assistance to provide with meals (Holmes, 2008). Close attention and observations can be used to detect any change in a person's eating functions and help clinicians tailor the level of assistance (Stockdell and Amella, 2008; Chang and Roberts, 2011). Encouraging the person to follow his/her own wishes while offering personal support are also important values in person-centred care (McCormack and McCance, 2010).

Person-centred care acknowledges the complexity of clinical practice and highlights clinical expertise as a product of practical evidence that practitioners acquire over time (Titchen, 2000; Dewing, 2004). Titchen (2000) suggests that professional experience-based knowledge can be made widely available if it is articulated, reviewed and validated by individual practitioners and their peers through critical reflection on practice. Critical reflection promotes learning through practice by conscious consideration and discussion of experiences, examination of the actions involved and the reactions that occurred, followed by analysis. (Scott, 2013).

Against this background, the practice development study here explores the nurses' mealtime practice and experiences from a person-centred perspective. The study has two goals:

- To develop knowledge of how nurses facilitate and support independence in eating meals for persons with severe dementia
- To explore what the specific environmental arrangements around mealtimes for persons with dementia look like

## Setting and participants

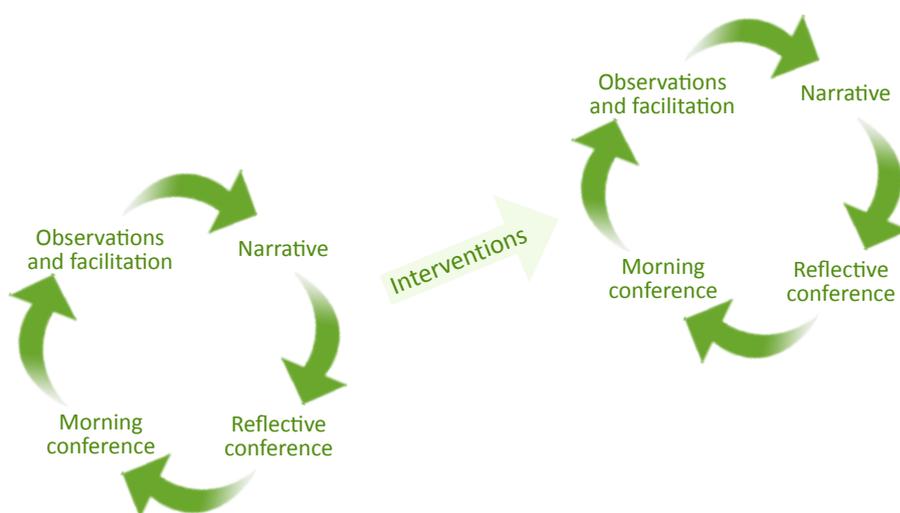
The project setting was a hospital department for older persons with mental health problems and dementia. The department has a unit with six beds for persons with severe dementia, aged 67 years or older, who are admitted from their homes or nursing homes for assessments, diagnosis and treatment of dementia and often display a high level of neuropsychiatric symptoms. The average length of stay is 40 days. The unit has a leader and 12 full-time and 10 part-time members. All staff were invited to participate in the study and 12 accepted: the unit leader (KHR), two registered and four enrolled nurses, two social workers, two healthcare assistants and a kitchen assistant. Additionally, nursing students participated in the reflective dialogues during their practice periods in the unit. The unit leader had a combined function as a practitioner researcher, while the university researcher (LHJ) functioned as an external supervisor and involved departmental leaders and the interdisciplinary participants in an ongoing learning on action process (Reason and Bradbury, 2007).

## Method

For this study action research was chosen. It aims to take action and to create knowledge about that action (Coghlan and Brannick, 2010). Unlike traditional research approaches whose sole aim is to create knowledge, the action research process is collaborative. In this study, the members of the system, both leaders and interdisciplinary personnel, wished to study their own actions in order to improve their practice, and study the process in order to learn from it. Hence, action research is related to experiential learning and critical reflection in practice. The participants are active in a cyclical process of consciously and deliberately planning, observing and taking actions. Evaluating those actions leads to adjustments to explore how they can change or improve practice (Coghlan and Brannick, 2010).

In this study the cyclical research processes were adjusted to continue data generation and qualitative analysis, where the nurses conducted observations and facilitated mealtimes in accordance with the abilities of the persons with dementia. Each cycle consists of a morning conference (planning), observations and facilitation of person-centred care (taking actions), written narratives and reflective conferences (evaluation), as illustrated in figure 1.

**Figure 1: The research process**



The morning conference is a daily event where staff plan, discuss and agree how to undertake each person's care. The planning includes which persons to observe that day during meals, how to observe them and how to facilitate this with respect to the person's resources and situation. The internal researcher (KHR) who was also leader of the unit encouraged the staff present to articulate their experiences by asking them questions. The observations were performed at mealtimes, usually at

breakfast so that observations could be discussed later. The nurse facilitated the meal situation, observed how the person managed and what help was needed. Shortly afterwards, the nurse wrote her observations in a narrative form with concrete descriptions of what happened during the meal, how the person reacted and the effectiveness of the interventions. Some wrote only a few lines, others more.

Later in the same day, the nurse presented her written observations in a reflective conference with the same personnel as had attended the morning meeting. The staff present commented and used their experiences to interpret the person's resources and responses as well as the nurse's actions in the meal situation. Together with the internal researcher they looked for important details and discussed alternative interventions to support person-centred care. The nurses, as well as the first and second authors, also searched the literature, based on questions raised in these reflective conferences to promote understanding of individualising meals for persons with dementia. As a result, concrete and individualised care plans were developed.

The study prior to data collection consist of 17 narratives from person-centred observations of meals and the second author's field notes from the reflective conferences. In the qualitative analysis patterns were sought within the data, focusing on the nurses' person-centred practice and practical knowledge combined with findings from systematic literature search. The action research process was therefore interlinked with practice development and the construction of new knowledge in practice (Coghlan and Brannick, 2010).

### **Quality and rigour**

In action research, quality and rigour refer to how data are generated, explored and evaluated, and how this enables the core activities in each cycle to be made explicit. In this study's knowledge-building process, two cycles operated in parallel (Coghlan and Brannick, 2010). One was the core action research cycle, with the activities described earlier – observations and facilitations during meals, and reflective dialogues in which the staff and students used their experience and competence. The other cycle was a reflection on reflection, a process that incorporates the actions and learning processes and enables a process of knowledge construction, a meta-learning process (Coghlan and Brannick, 2010).

In contrast to systematic textual content analysis, meta-analytic reflections involve noticing patterns, looking for contrasts and identifying inter-relationships (Coghlan and Brannick, 2010). In the first steps of the analytic processes, all the material generated by the study was studied to look for commonalities between different meal situations. In the next analytical step, a case example (not a real case, but one representing the typical findings across all observations and reflections) was constructed from the narratives and data from the critical group reflections. The authors worked back and forth with the entirety of the material and the case example to compare interesting experiences, and looked for patterns that expressed different actions and attitudes. The analysis was repeated several times and led to the following themes:

1. Person-centred assessment and support
2. Planning and simplifying meals
3. Building practice development into everyday practice

### **Ethical considerations**

The Norwegian Regional Committee for Ethics in Medical Research approved the study, and permission was obtained from the administrator of the hospital department. All personnel in the unit received oral and written information before participation and an information leaflet was available on the ward.

Special consideration of persons with severe dementia is needed in the process of informed consent. Standard consent approaches may be both alienating and disruptive (Dewing, 2007) and were found not to be suitable. Consent processes with persons with dementia must be flexible and continuous (Dewing, 2007). In this study, the nurses that took part in the observations and facilitation of meals

knew the persons and acted in their best interests. The unit leader, as a practitioner researcher, took the function of internal facilitator in the study and was actively engaged in the process of care and in managing the consent process. The first researcher participated only in the reflective dialogues after observations with the unit leader and interdisciplinary staff, and was not in direct contact with patients. The internal facilitator anonymised all data before further analysis.

## **Results**

The nurses demonstrated a person-centred focus during mealtimes; the constructed narrative from their reflective dialogues highlights this. The findings from these dialogues are presented under three themes, which were extracted as critical elements in the process of promoting independence during meals for persons with severe dementia. In this presentation, the terms person and patient are used in accordance with the nurses' practice in the hospital.

### **The constructed narrative**

In the morning conference after Mr. H's admission, the personnel discussed how to work with Mr. H and facilitate his meals.

Mr. H is 85 years old and living alone. He has dementia, diagnosed four years ago, and he was admitted two days ago. His son told us that he is unable to prepare his own meals and refuses help from home care. He is thin and his clothes are several sizes too big. The personnel observed him to be restless, wandering about and only sitting down for short periods. He made jokes about what other people said and did and disturbed other patients. He was sarcastic and quarrelsome.

Mr. H took no initiative to eat when seated at the breakfast table, but when the nurse acted as a hostess by handing him his bread, he was able to help himself by putting it onto his plate. However, he ate the bread without butter or breakfast spread. He ate well and drank milk, as well as coffee and juice. While eating, he was talkative. After breakfast he was observed being even more restless.

During the staff's working lunch the same day, the nurse presented her observations from breakfast. The nurses on shift commented, asked questions, discussed the facilitation and interpreted the patient's reactions and behaviour as the environmental effects of overstimulation due to a new setting. To maximise his coping abilities, they decided to serve breakfast in his room the next day with one of the staff present. They expected him to be more able to help himself in a quiet surrounding. The next morning, breakfast was prepared with open sandwiches. The nurse quietly facilitated the meal, and talked as little as possible to minimise disturbance. Compared with the day before, Mr. H was more relaxed and ate well, and the nurse experienced that simplifying the meal was effective. Observations during and after the meals that day showed that a supportive structure and well-facilitated meals seemed to calm Mr H and maximised his coping abilities during meals.

### **Person-centred assessment and support**

In order to give support during meals and integrate personalised information into the care plan, an understanding of what is important to the person with dementia was seen as highly valuable.

### ***Preferences***

When assessing individual preferences, the nurses collaborated with the person with dementia and relevant family members to learn about cultural and dietary needs. The nurses worked out eating lists, specifying amounts and the person's likes and dislikes to minimise questions at each mealtime and overstimulation from too many choices. They prepared food according to the person's function, together with the kitchen assistant, taking into consideration levels of simplification, likes and dislikes. The kitchen assistant took part in the critical dialogues and gained awareness of why individual arrangements were necessary. With this knowledge, she was able to ensure the correct amounts of food were ordered for the unit.

### ***Supporting sequences of actions: the hostess function***

The nurses supported the person's own resources and acted as attentive hostesses, observing needs, guiding, prompting and facilitating natural sequences of actions, such as by moving food closer to a person who was not taking the initiative to begin eating. Even if the meal was organised to support the person's independence, they still had to monitor closely and facilitate according to the person's abilities. The nurses gave them time to eat at their own pace, providing the necessary support and help. They responded to cues and maximised coping resources while at the same time attempting to participate as a role model in sequences of action during the meal. The nurses stressed the importance of eating together, with one saying: 'If I sit at the table without my own plate, the patients often want to share their food with me, but then they lose attention to their own eating process.' Another said: 'I just eat little and very slowly.'

### ***Socialising versus eating alone***

The nurses agreed about the value of socialising during meals, but acknowledged that many older persons have lived by themselves for years and so are accustomed to being alone when eating. They felt a preference for this should be respected, since socialising at mealtimes can be tiring as well as disturbing to some. They also recognised that some patients desired privacy due to swallowing problems or other difficulties. In the reflective conferences, the staff often discussed the question of socialising versus privacy as a difficult ethical matter because eating together and small talk are customary in Western culture. The nurses also gave each other reminders to respect quietness and reduce disturbances, such as telephone calls, during the meals.

### ***Planning and simplifying meals***

The nurses encouraged independence by setting the tables and preparing the dining room with the necessary equipment to promote a calm atmosphere, and removed tablecloths and flowers if they were distracting persons with dementia. They helped with seating, taking into consideration talkative persons and those who needed peace and quiet surroundings. Special attention was given to those who had impaired vision or hearing. They also evaluated where to seat themselves. Acting as attentive hostesses looking after their guests, the nurses supported the persons' own resources. To enhance autonomy and increase independence, the nurses stated: 'A patient should not be given more help than necessary'. They emphasised that taking time to assess and maximise a person's capabilities could lessen the risk of increasing disability.

All nurses tried to achieve a caring environment at mealtimes without interruptions, focusing on eating. However, time constraints did challenge their best intentions. They felt responsible when a person ate inadequately.

The nurses observed that persons with dementia might need help to understand and handle the meal due to the cognitive impairment. To enhance independence, the nurses identified four levels of simplification when preparing meals (table 1).

<b>Table 1: Four levels of simplification for meals</b>	
<b>Level</b>	<b>Actions</b>
<b>1 Simplified meals</b>	<ul style="list-style-type: none"> <li>• The table is set for a traditional meal with three to four choices</li> <li>• One or more fellow patients and staff are present</li> </ul>
<b>2 Prepared meals</b>	<ul style="list-style-type: none"> <li>• The table is set with prepared food on the plate for the person and one or more fellow patients, with staff present</li> <li>• In prepared meals, the person is able to cope with several pieces on the plate and drinks. The person manages to use cutlery and napkins</li> </ul>
<b>3 Finger food</b>	<ul style="list-style-type: none"> <li>• The table is set with only one dish/one sandwich and one drink at a time</li> <li>• When the person is easily distracted, confused or does not understand the situation, open sandwiches are preferred; the crust is removed if the person has chewing difficulties</li> </ul>
<b>4 Bitesized pieces (cut up)</b>	<ul style="list-style-type: none"> <li>• The table is set with a plate, on which are pieces of food, and one drink</li> <li>• For some patients, the food has to be placed in their hand and guided to their mouth, and some need reminders and prompting</li> <li>• A glass with two handles makes it easier to drink independently</li> </ul>

The nurses prepared small portions to simplify the situation and placed food in front of each person to help the person overcome any difficulties; they did not comment on difficulties during the meals. The nurses maintained hygiene standards by serving appropriate amounts.

#### **Building practice development into everyday practice**

Promoting independence at mealtimes for persons with dementia is not a one-off event. It requires ongoing commitment with practical reflection and evaluation in everyday practice.

#### ***Report, planning and reflections***

During the morning conferences, the unit leader, an experienced psychiatric nurse, asked open questions to promote reflection and solutions, for example: 'Liza, what will you do when you set the table for Mr. H today?' If appropriate, nurses were challenged to explain their reflections. The unit leader also used 'naïve questions' starting with 'What if..?' to promote alternative thinking and critical reflection.

The nurses reported their experiences in narrative form during their working lunch. The group listened, asked questions and took part in practical reflections with their experiences. To interpret the situation they focused on the person's ability to handle action sequences during the meal, his/her wellbeing and how the nurse facilitated the processes. The group identified the person's resources and neuropsychiatric symptoms, and discussed how to adjust his/her next meals within the care environment. The assessments and interventions were documented in the patient's care plan.

#### ***Narratives increased efficiency in assessment and facilitation***

The dialogues at the morning conferences and reflective dialogues at working lunches included all staff. By using narratives, the nurses articulated their experiences in contextual stories of what happened and their reflections during specific meals. The narratives included preparation of meals, interactions between the nurse and patient, definitive changes, spur-of-the-moment interventions and outcomes. Focusing on table settings improved the nurses' clinical ability to look for small changes, which also helped them recognise the person's resources and needs at an earlier stage. Table setting was improved. The practice development and research processes were in this way incorporated into everyday practice.

During the project period, the social workers and some nurses were more active participants and articulated their observations with enthusiasm after the meals, while others waited to do so in the reflective conferences. In the evaluations, one nurse said: 'I learned to articulate my experiences in a new way – tiny interventions became more important.' An enrolled nurse expressed her learning outcome in this way: 'For the first time, I have been involved in a study which focuses on my tasks and responsibilities.' Another was satisfied with the communication structures: 'We did not have to leave for research activities outside the unit, and we were always talking about important matters.' This practical knowledge made the meals accessible for critique, improvement and change.

### ***Keeping up***

The participants in the morning conferences and reflective working lunches experienced the immediate response to their planning and interventions in facilitating person-centred mealtimes. They were committed to the practice-development process, and involved students and new colleagues in the new practice. To enhance independence for persons with severe dementia as an ongoing process, they photographed the four levels of table settings for use in internal training.

In the final evaluation, systematic planning and sharing narratives in reflective dialogues were highlighted as effective to strengthen awareness of person-centred facilitation of mealtimes for persons with dementia. Critical dialogues also strengthened alternative interpretations and the nurses' interest to explore the research literature to identify other challenges and see how they had been addressed.

### **Discussion**

Promoting independence at mealtimes for persons with severe dementia and exploring this practice from a person-centred perspective were the aims of this study. Interpretation of strengths and challenges in eating, as well as attention to environmental settings and social interaction, appeared to be key components to achieve these objectives.

The importance of careful table settings and different levels of simplification were identified as important factors for optimising the meal situation and respecting the dignity and identity of the persons with dementia. The study highlights the importance of physical details in preparation to support the ability to handle mealtime situations. The nurses made simplifications and searched for alternatives to maintain independence, for example by preparing finger food that could be eaten by hand instead of with cutlery. By responding to cues that maximise coping resources during meals, the nurses recognised and made changes of great importance in the person's daily life. The approach of making such simple changes corresponds with values of person-centred practice development (McCormack et al., 2013). Similarly, a randomised controlled trial of prevention of unintentional weight loss in nursing home residents showed that simple changes to meals were more effective in improving residents' calorie consumption than traditional feeding assistance (Simmons et al., 2008).

The social environment plays an important role in the facilitation of meal situations (Archibald, 2006; Chang and Roberts, 2011). In hospital mental health departments, it is common to eat together in small groups. Some persons with dementia prefer a calm atmosphere without sources of sound such as a television, and our findings suggest it can be important to reduce unnecessary noise to support the person's own abilities. This corresponds to the conclusions of Chang and Roberts (2011), who found that institutional mealtime environments with open kitchens and a large dining table are often too crowded, chaotic and noisy, and subject to frequent disruptions. Other efforts to manage and simplify mealtime practice using routine seating plans are reported by Cleary et al. (2008).

The creation of mealtime situations that are familiar to persons with dementia has also been found to promote independence. Familiar presentations of food common to the person's culture in nursing homes have been reported (Evans and Crogan, 2006; Hargreaves, 2008). It was observed that peaceful

surroundings and different levels of simplifications are significant factors to support independence during meals for those with severe dementia. They explained that they wanted to be independent, and that old habits helped them to manage mealtime tasks despite their cognitive impairment (Johansson et al., 2011). The nurses in this study acted as attentive hostesses and their emphasis was placed on practical issues to promote patients' sense of dignity and mastery at mealtimes. Their observations and interpretations underlined the value of the social environment in terms of helping persons with severe dementia manage mealtimes. Cognitive impairment means it is important to focus on facilitation of natural sequences of actions to support independence.

To promote independence the nurses in this study always looked for the older person's resources and encouraged their coping strategies. The nurses learned that persons with severe dementia often had more capabilities than they were aware of. However, the situations were delicate and easily disrupted. This corresponds to what Alnes et al. (2011, p 249) describe as 'frail capabilities', where persons with severe dementia are dependent on nurses' attention at all times. By focusing and reflecting on micro-situations, the nurses were able quickly to recognise unnecessary disruptions in meal situations. They also improved their awareness of the person's responses in these situations and how they interacted. This is a dynamic process where the cues and nuances of the person's behaviour directed nurses' actions (Cohen-Mansfield, 2000). The person with dementia therefore has agency in the relationship; the nurse does not see herself as being in charge, but is guided by the person's values (McCormack and McCance, 2010). Nurses' decisions about organising meals were primarily steered by the person's abilities, likes and dislikes, and by practical factors, such as giving the person food in hand if they were restless. They recognised eating independently rather than feeding as beneficial to the person's sense of dignity. Hence, facilitation of meals involves a process of adaptation and negotiation (McCormack and McCance, 2010).

The staff in this study constructed knowledge of specific interventions from observations and writings in a narrative form, while the values and beliefs that enhanced their practice became visible in the reflective group processes. Practical situations presented in narrative form with the context intact are rich in assumptions, expectations and know-how that may not be a part of formally recognised knowledge (Benner, 1984). On the other hand, healthcare personnel in hospitals are also expected to assess and diagnose the complexity of aging processes, functional decline and multiple losses endured by older persons with dementia and their families (Archibald, 2006). In the meta-reflective processes findings were compared with international research on supporting mealtimes in older persons with dementia (Chang and Roberts, 2011), guidelines on nutritional support (National Institute for Health and Clinical Excellence, 2006) and international dementia care strategies (Department of Health, 2009; Victorian State Government, 2011). The nurses validated the knowledge from these processes. Their interpretations of the persons' eating abilities, and the meaning of details to support independence during meals, were included in individualised care plans. New, person-centred mealtime practices were standardised at the unit level. The tasks have been endorsed by expert nurses and other personnel, and described as good, person-centred practice.

Promoting independence at mealtimes for older persons with severe dementia within a mental hospital setting is complex. The collaborative action research framework used in this project is systematic, easy to perform, inexpensive and includes all staff members in important reflective processes. The processes do not take significantly more time once they have been built into everyday practice. The challenge is for staff to maintain attention to practical details without becoming too task oriented. Findings in the study highlight the unit leader's twin role as situational leader and internal facilitator in the practice development processes. Situational leadership implies behaviours such as listening, providing feedback and encouraging, and adopting different styles based on the situation/environment in which care is delivered (Lynch et al., 2011). Depending on the staff present at each shift, the unit leader facilitated person-centred care by using open questions and challenging experienced nurses to explain their critical reflections during the morning report and later in reflective dialogues. Sharing experiences

provides opportunities for interdisciplinary personnel to learn from their practice, to explore and clarify their values and to enable the development of person-centred care, while strengthening their individual and collective competence. This approach uses a high level of support, involving all participants in sharing their experiences and stimulates active learning in and from practice, which is a key strategy in practice development processes (McCormack et al., 2013). Sharing experiences is also about perception, recognition of the person as a human being, reflections on interactions and shared understanding (Buckley et al., 2013). Narrative knowing is a way of perceiving and understanding each person's biographical story and taking into account salient aspects of their present story in the care processes.

With an increasing need for efficiency in healthcare, the importance of clinical professional management should not be underestimated. Quality in dementia care requires both active leadership and opportunities for critical reflection.

### **Conclusion and clinical implications**

Promoting independence at mealtimes for older persons with severe dementia requires a person-centred approach with a focus on environmental and social aspects. Noise reduction and simplification of table settings seem to be important prerequisites for facilitating independence at mealtimes. Narratives and a new type of conference based on a dynamic reflexive approach, adapted to the actual need for education and clinical improvements, enhance understanding and interpretation of individual preferences, needs and remaining resources. Paying attention to micro-situations in complex settings like mealtimes creates greater awareness about the often-hidden skills of persons with dementia and how to support their dignity and independence. With this in mind, there needs to be a shift in care planning and practice; nurses should adopt a hostess-like role to facilitate the meals, supporting patients' resources and paying close attention so as to be able to make small but vital changes. Collaborating with families is important to know more about the patients' preferences and biographical details; the latter is key to working with people from a person-centred perspective and maintaining focus on their dignity. However, this person-centred approach in micro-level situations does not occur in isolation. In this study, staff and leaders were collectively engaged in the central focus of promoting independence at mealtimes for persons with severe dementia. At mezzo- and macro-levels, effective workplace cultures, values and beliefs and leadership are all key elements and core components of person-centred care.

The key limitation of this study is its small sample size, with 17 narratives and a single setting. However, the results could potentially be transferred to other complex care situations for people with severe dementia, but there is a need for further studies in different settings and with multiple narratives in order to draw further conclusions.

### **References**

- Alnes, R., Kirkevold, M. and Skovdahl, K. (2011) Marte Meo Counselling: a promising tool to support positive interactions between residents with dementia and nurses in nursing homes. *Journal of Research in Nursing*. Vol. 16. No. 5. pp 415-432. doi: 10.1177/1744987111414848.
- Archibald, C. (2006) Meeting the nutritional needs of patients with dementia in hospital. *Nursing Standard*. Vol. 20. No. 45. pp 41-45. doi: 10.7748/ns2006.07.20.45.41.c4467.
- Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, California: Addison-Wesley.
- Brooker, D. (2007) *Person-centred Dementia Care: Making Services Better*. London: Jessica Kingsley.
- Buckley, C., McCormack, B. and Ryan, A. (2013) Valuing narrative in the care of older people: a framework of narrative practice for older adult residential care settings. *Journal of Clinical Nursing*. Vol. 23. Nos. 17-18. pp 2565-2577. doi:10.1111/jocn.12472.
- Chang, C. and Roberts, B. (2011) Strategies for feeding patients with dementia. *American Journal of Nursing*. Vol. 111. No. 4. pp 36-44. doi: 0.1097/01.NAJ.0000396553.01996.5e.

- Clarke, A., Hanson, E. and Ross, H. (2003) Seeing the person behind the patient: enhancing the care of older people using a biographical approach. *Journal of Clinical Nursing*. Vol. 12. No. 5. pp 697-706. doi: 10.1046/j.1365-2702.2003.00784.x.
- Cleary, S., Hopper, T., Forseth, M. and Soest, D. (2008) Using routine seating plans to improve mealtimes for residents with dementia. *Canadian Nursing Home*. Vol. 19. No. 3. pp 4-10.
- Coghlan, D. and Brannick, T. (2010) *Doing Action Research in Your Own Organization*. (3<sup>rd</sup> edition). London: Sage.
- Cohen-Mansfield, J. (2000) Use of patient characteristics to determine nonpharmacologic interventions for behavioural and psychological symptoms in dementia. *International Psychogeriatrics*. Vol. 12. No. 1. pp 373-380. doi: 10.1017/S1041610200007304.
- Davis, S., Byers, S., Nay, R. and Koch, S. (2009) Guiding design of dementia friendly environments in residential care settings: considering the living experiences. *Dementia*. Vol. 8. No. 2. pp 185-203. doi: 10.1177/1471301209103250.
- Department of Health (2009) *Living Well with Dementia: A National Dementia Strategy*. Retrieved from: [tinyurl.com/national-strategy](http://tinyurl.com/national-strategy). (Last accessed 27<sup>th</sup> June 2016).
- Dewing, J. (2004) Concerns relating to the application of frameworks to promote person-centeredness in nursing with older people. *International Journal of Older People Nursing*. Vol. 13. No. 3a. pp 39-44. doi: 10.1111/j.1365-2702.2004.00925.x.
- Dewing, J. (2007) Participatory research: a method for process consent with persons who have dementia. *Dementia*. Vol. 6. No. 1. pp 11-25. doi: 10.1177/1471301207075625.
- Dickinson, A., Welch, C. and Ager, L. (2007) No longer hungry in hospital: improving the hospital mealtime experience for older people through action research. *Journal of Clinical Nursing*. Vol. 17. No. 11. pp 1492-1502. doi: 10.1111/j.1365-2702.2007.02063.x.
- Dunne, A. (2010) Nutrition and dementia. *Nursing and Residential Care*. Vol. 12. No. 3. pp 112-116. doi: 10.12968/nrec.2010.12.3.46666.
- Evans, B. and Crogan, N. (2006) Building a scientific base for nutritional care of Hispanic nursing home residents. *Geriatric Nursing*. Vol. 27. No. 5. pp 273-279. doi: 10.1016/j.gerinurse.2006.08.006.
- Gibbs-Ward, A. and Keller, H. (2005) Mealtimes as active processes in long-term care facilities. *Canadian Journal of Dietetic Practice and Research*. Vol. 66. No. 1. pp 5-11. doi: 10.3148/66.1.2005.5.
- Hargreaves, T. (2008) Nutritional issues for people with dementia. *Nursing and Residential Care*. Vol. 10. No. 3. pp 118-122. doi: 10.12968/nrec.2008.10.3.28583.
- Hicks-Moore, S. (2005) Relaxing music at mealtime in nursing homes: effects on agitated patients with dementia. *Journal of Gerontological Nursing*. Vol. 31. No. 12. pp 26-32. doi: 10.3928/0098-9134-20051201-07.
- Holmes, S. (2008) Nutrition and eating difficulties in hospitalised older adults. *Nursing Standard*. Vol. 22. No. 26. pp 47-57. doi: 10.7748/ns2008.03.22.26.47.c6424.
- Johansson, L., Christensson, L. and Sidenvall, B. (2011) Managing mealtime tasks: told by persons with dementia. *Journal of Clinical Nursing*. Vol. 20. No. 17-18. pp 2552-2562. doi: 10.1111/j.1365-2702.2011.03811.x.
- Kitwood, T. (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham, UK: Open University Press.
- Kofod, J. and Birkemose, A. (2004) Meals in nursing homes. *Scandinavian Journal of Caring Science*. Vol. 18. No. 2. pp 128-134. doi: 10.1111/j.1471-6712.2004.00276.x.
- Lynch, B., McCormack, B. and McCance, T. (2011) Development of a model of situational leadership in residential care for older people. *Journal of Nursing Management*. Vol. 19. No. 8. pp 1058-1069. doi: 10.1111/j.1365-2834.2011.01275.x.
- Manthorpe, J. and Watson, R. (2003) Poorly served? Eating and dementia. *Journal of Advanced Nursing*. Vol. 41. No. 2. pp 162-169. doi: 10.1046/j.1365-2648.2003.02520.x.
- McCormack, B. and McCance, T. (2010) *Person-centred Nursing. Theory and Practice*. Oxford: Wiley-Blackwell.
- McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare*. (2<sup>nd</sup> edition). Oxford: Wiley-Blackwell.
- McNamara, E. and Kennedy, N. (2001) Tube feeding patients with advanced dementia: an ethical dilemma. *Proceedings of the Nutrition Society*. Vol. 60. No. 2. pp 179-185. doi: 10.1079/PNS200083.

- Meins, W. (2000) Impact of personality on behavioral and psychological symptoms of dementia. *International Psychogeriatrics*. Vol. 12. No. 1. pp 107-109. doi: 10.1017/S1041610200006852.
- Ministry of Health and Care Services (2011) *National Dementia Strategy 2015 (Demensplan 2015: Den Gode Dagen)*. Oslo: Ministry of Health and Care Services.
- National Institute for Health and Care Excellence (2006) *Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition*. Retrieved from: [nice.org.uk/CG32](http://nice.org.uk/CG32). (Last accessed 27<sup>th</sup> June 2016).
- Reason, P. and Bradbury, H. (Eds.) (2007) *Handbook of Action Research*. Thousand Oaks, California: Sage.
- Scott, A. (2013) Don't fix – facilitate: the role of reflection in successful change processes. *International Practice Development Journal*. Vol. 3. No. 1. pp 1-6. Retrieved from: [fons.org/library/journal/volume3-issue1/article7](http://fons.org/library/journal/volume3-issue1/article7). (Last accessed 27<sup>th</sup> June 2016).
- Simmons, S., Keeler, E., Zhou, X., Hickey, K., Sato, H. and Schnelle, J. (2008) Prevention of unintentional weight loss in nursing home residents: a controlled trial of feeding assistance. *Journal American Geriatric Society*. Vol. 56. No. 8. pp 1466-1473. doi: 10.1111/j.1532-5415.2008.01801.x.
- Stockdell, R. and Amella, E. (2008) How to try this: Edinburgh Feeding Evaluation in Dementia Scale. *American Journal of Nursing*. Vol. 108. No. 8. pp 46-55.
- Titchen A. (2000) *Professional Craft Knowledge in Patient-centred Nursing and Facilitation of its Development*. Oxford: Ashdale Press.
- McLeod, T., Nolan, J. and Dewing, J. (2012) The Kuranya/'Rainbow' service for indigenous Australians, in New South Wales: innovative practice. *Dementia*. Vol. 11. No. 5. pp 703-706.
- Schein E (2010) *Organisational Culture and Leadership* (4<sup>th</sup> edition). London: Jossey-Bass.
- Victoria State Government (2011) *Dementia-friendly Environments. A Guide for Residential Care*. Retrieved from: [tinyurl.com/victoria-dementia](http://tinyurl.com/victoria-dementia). (Last accessed 27<sup>th</sup> June 2016).

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