Moving Toward Culture Change: Defining Skilled Nursing Facility Residents Dining Style Preferences

Katheryn Adams
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MOVING TOWARD CULTURE CHANGE:
DEFINING SKILLED NURSING FACILITY RESIDENTS’
DINING STYLE PREFERENCES

by
Kathryn Adams, RD CSG LD

A plan B report in partial fulfillment
of the requirements for the degree
of
MASTER OF DIETETICS ADMINISTRATION
in
Nutrition, Dietetics and Food Sciences

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UTAH STATE UNIVERSITY
Logan, Utah
2012
ABSTRACT

Moving Toward Culture Change: 
Defining Skilled Nursing Facility Residents’ 
Dining Style Preferences 

By 

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Master in Dietetic Administration 

Utah State University, 2012 

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Department: Nutrition, Dietetics and Food Sciences 

Background  Public policy fulfillment coupled with skilled nursing facility’s desire to increase quality of service to meet changes in residents’ expectations and improve marketability warrant a new look at culture change and home like dining as defined by the residents in skilled nursing facilities. 

Objective The objectives of this study were to determine residents’ home dining practices, define residents’ desired dining style practices in the skilled nursing facility and determine the relationship between at home dining and dining preferences in skilled nursing facilities. 

Design The quasi-experimental study started with a convenience sample taken from a facility generated potential participant list. 

Participants One hundred and four residents in three skilled nursing facilities in the central Texas area who met the cognition criteria and consumed facility-provided food.
Measurements  Participants were engaged in a standardized interview using the Resident Dining Style Preferences Survey. The data was then analyzed to determine the degree to which home practices determined skilled nursing facility dining preferences.

Results  Participants want hot home cooked meals served in the dining room at the table with everyday plates in a quiet atmosphere seated with friends and neighbors with food served restaurant or table service style. Length of stay and generational group were not statistical indicators of skilled dining style preferences.

Limitations  Limitations were two fold: sample size and lack of ethnic diversity.

Conclusions  Culture change can not be defined as fine dining or home like dining. Removing dining time restrictions may be the most valuable adaptation for a facility looking to initiate culture change.  (83 pages)

Key Words: Culture Change, nursing home, food service, long term care, skilled nursing facility, home like dining, elderly, dining preferences.
DEDICATION

To my family; especially my husband, daughter, parents and parents in law. Without their unconditional support I would not be who or where I am today.
Thank you for your love and support.
ACKNOWLEDGEMENTS

I would like to thank my committee members for their persistent positive outlook and dedication to this project. I would also like to thank Xin Dai for her statistical knowledge and instrumental assistance in setting up the survey and score sheets; as well as Roxanne Pfister for expert statistical analysis and explanation.

I would like to extend sincere appreciation to the three facilities and their Administrators (Shannon McBride, Ken Watson and Lillian Hayden) that agreed to participate in this research, allowing me access to participants and information.

Katy Adams
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LIST OF ACRONYMS

SNF=Skilled Nursing Facility
AMDA= American Medical Directors Association
CMS=Centers for Medicare and Medicaid Services
DADS=Department of Aging and Disability Services
OBRA=Omnibus Budget Reconciliation Act
MDS=Minimum Data Set
BIMS=Brief Interview for Mental Status
F-tag=Federal Nursing Home Tag
CNA=Certified Nursing Aid
LTC=Long Term Care
AL=Assisted Living
RD=Registered Dietitian
CDM=Certified Dietary Manager
LNHA=Licensed Nursing Home Administrator
LNFA=Licensed Nursing Facility Administrator
ADL=Activities of Daily Living
CHAPTER 1

Since the 1987 Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act (OBRA) passed emphasizing residents’ rights and quality standards for long term care, there has been a national impetus toward resident centered care coined “culture change” (1,2). However twenty years later, a 2007 study investigating the extent to which nursing homes had embraced culture change showed only 31% could be titled culture change adopters (1). Since culture change adopters receive significantly higher satisfaction scores, it should come as no surprise then, that long term care food service continues to get poor satisfaction scores (3-5). One study surveyed an ill elderly who justified living in unfit conditions because, “he would rather die than enter a nursing home” (6).

In addition, the number of long term care facilities grows each day and continues to saturate the market with similar products and services (7). One way facilities have begun to differentiate themselves is through food service and dining practices (8, 9). Regardless of ethnicity, socioeconomic status or disease process, food is a key indicator of satisfaction and therefore facility choice (10-14).

Nursing home populations and resident demographics are changing and with them residents’ preferences and expectations (15-17). United States (US) Census Bureau data indicated 20.9% of the population was older than 65 years of age in 2010. However, that number is projected to increase to 24.6% by 2020 and 35.5% by 2050. By 2020 the percent of persons greater than 65 will increase by 36%; greater than 75 years of age will increase by 20%; and greater than 85 years of age will increase by 14.7% (18). In 2010, 1.5 million elderly resided in institutional settings while another 875,000 lived in senior
housing with at least one supportive service available (19). The next years will see a skilled nursing facility population with merging generations of Baby Boom (1946-1964), Silent generation (1925-1945) and the Greatest generation (1901-1924). The Greatest Generation (or GI Generation) came of age and identifies with the times of the 1920s. They lived through the Great Depression and World War II (WWII) (20). The Silent Generation was born during the Great Depression and WWI. This nickname was coined after a *Time* article that noted the generation to be silent: working hard and awaiting the hand of fate, not making speeches or issuing manifestos (21, 22). The Baby Boom Generation was born in the post WWII baby boom. They remember the post war ‘American High’ and are the healthiest and wealthiest generation to that time and grew up expecting America to improve (23). The type of food service acceptable for residents of the current majority, the Silent Generation, is not appropriate for the next generation, Baby Boomers (24, 25). The combination of generations will want diverse choices and to have an active voice in activities of daily living including eating, bathing, waking, sleeping, dressing (26).

Most definitions of culture change include the phrase “resident centered” or “home like”. However, preferences of the resident can be overlooked in lieu of pleasing the caregiver or decision maker (6). The need for culture change is apparent; however, the interpretation of culture change is vast. Therefore the need arises to define culture change as it pertains to the dining experience in terms of its customers.

**Statement of the Problem**

Research and literature reviews regarding the effect and implementation of culture change are abundant. Most researchers start by defining culture change and resident
centered care without involving residents or determining their individual preferences. Then, facilities implement administratively mandated changes and assess the effect on residents, quality of life indicators, staff, and financial markers. Ample studies have shown the importance of food and foodservice to the residents (26). However, very few studies put the residents at the center of the planning process for culture change. Public policy fulfillment coupled with nursing facility’s desire to increase quality of service to meet changes in residents’ expectations and improve marketability warrant a new look at culture change and home like dining as defined by the residents in skilled nursing facilities.

**Purpose and Objectives**

The purpose of this study is to determine if residents’ home dining practices are congruent with residents’ dining style preferences in skilled nursing facilities in order to provide recommendations to facilities on how to incorporate culture change and improve dining and food service based on resident’s dining style preferences.

**Objectives**

1. Determine the home dining practices of current residents’ of skilled nursing facilities in Central Texas.

2. Identify dining style preferences of current residents’ in skilled nursing facilities in Central Texas.

3. Determine the relationship between the home dining practices and dining style preferences in a skilled nursing facility by current residents’ of skilled nursing facilities in Central Texas.
**Review of Literature**

Research and literature reviews regarding the effect and implementation of culture change are abundant. Most researchers start by defining culture change and resident centered care without involving residents or determining their individual preferences. Then, facilities implement administratively mandated changes and assess the effect on residents, quality of life indicators, staff, and financial markers. Ample studies have shown the importance of food and foodservice to the residents (26). However, very few studies put the residents at the center of the planning process for culture change.

**Definitions of Culture Change**

Culture change focuses on more personalized choice in decision-making about the resident’s daily life and being treated with dignity by staff and caregivers (27). It intends to transform the long term care medical model to one that both nurtures and caters to the individual and meets medical needs (28). The California Healthcare Foundation further defines culture change within five points: establishing inclusive decision-making, redefining staff roles, de-medicalizing the physical environment, redesigning the organization, and creating new leadership practices (29). The Pioneer Network defines culture change as an ongoing transformation in the physical, organizational and psychosocial-spiritual environments based on person-centered values and restoring control to elders and those who work closest with them (33).

The Foundations of Culture Change as defined by the Institute for Caregiver Education asserts five core principles: Emphasis on Respect, Empowerment, Choice, Relationships and Community (30). These foundations are defined in Figure 1.
<table>
<thead>
<tr>
<th>Emphasis</th>
<th>Definition</th>
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<tr>
<td>Respect</td>
<td>Each member of the community regardless of positions [resident, Administrator or Certified Nursing Assistant (CNA)] has the right to voice views, ideas and opinions without fear. Each person’s view should then be considered prior to a decision.</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Everyone, including staff, residents and family members need to feel as though they make a difference and should be recognized as valued, contributing members of the community.</td>
</tr>
<tr>
<td>Choice</td>
<td>Everyone in the community should be given a range of options that reflect personal preference allowing for flexibility.</td>
</tr>
<tr>
<td>Relationships</td>
<td>Bonds among residents, among workers and between residents and workers should be an on-going focus.</td>
</tr>
<tr>
<td>Community</td>
<td>Social, emotional, spiritual, cognitive and cultural needs should receive as much attention as medical care.</td>
</tr>
</tbody>
</table>

Figure 1: Foundations of Culture Change

Models of Culture Change

The five most prevalent models of culture change include Eden Alternative, The Green House Project, Pioneer Network, Wellspring Nursing Home Alliance, and Plantree.

*Eden Alternative*

The Eden Alternative is a not-for-profit organization founded by Dr. William Thomas that believes “that aging should be a continued stage of development and growth, rather than a period of decline” (31). Dr. Thomas’ first model for change included adding plants, animals, gardens and patient contact with children. His idea expanded to encompass the physical layout of long term care facilities, called Green Houses (31).
Green House Project

The Green House Project is a model in which the home for the elder is an independent, self-contained home for six to twelve people, designed to look like a private home or apartment in the surrounding community (32). Green House homes are typically licensed as skilled nursing facilities and meet all applicable federal and state regulatory requirements. Each person who lives in a Green House home has a private bedroom and full bathroom, opening to a central hearth/living area and an open kitchen and dining area. Each home is staffed by a team of universal workers, known as Shahbazim. Instead of specialized positions such as a shower aid or a feeding assistance, the Shahbazim provide all the elder’s direct care needs. Dr. Thomas also redefined and emphasized the concept of convivium, the pleasure that accompanies sharing good food with the people we know well (32). Convivium is encouraged through elders sharing meals at a common table. Also, family members, friends and staff are welcome to join the community at mealtimes and other activities.

Pioneer Network

Pioneer Network was formed in 1997 by a small group of prominent professionals in long-term care to advocate for person-directed care. Pioneer network encourages research supporting culture change, hosts national conferences, and creates strategic partnerships with leading organizations including The Commonwealth Fund, Centers for Medicare & Medicaid Services (CMS), and The American Medical Directors Association to advance their goals and embed principles into practice. Pioneer Network focuses on caregivers developing relationships with each person, knowing the individual person and promoting the growth and development of all to change the culture of aging (33).
**Wellspring Nursing Home Alliance**

The Wellspring Nursing Home Alliance encourages facilities to form support groups, called alliances to work together to improve care. The Wellspring Model aims to enhance the quality of resident care and improve the working life of nursing home staff. It provides a structure and set of processes for quality improvement, supported by a network of colleagues that work together to achieve shared goals (34). One such alliance is the Wellspring Innovative Solutions, Inc., a group of 11 nonprofit nursing homes in Wisconsin formed in 1994, seeking to improve care principally by empowering staff. Facilities belonging to the various alliances provide their frontline workers with training in nationally recognized best practices while at the same time allowing all staff a voice in how their work should be performed. In addition, each home in the alliance participates in joint training sessions on clinical care and organizational change and each shares the results of its quality-improvement activities (34).

**Plantree**

Plantree is a patient-centered model of care that began in hospitals under the direction of Angelica Thieriot (35). Plantree affiliates focus on providing comfort foods, creating kitchens in patient care areas for families to prepare their relative’s favorite foods and never turning down a request for food any time day or night. The first facility to adopt the Plantree model was Wesley Village in Shelton, Connecticut. (35).

**Implementation of Culture Change**

Implementation of culture change varies greatly across the research spectrum. One difficulty within the culture change movement is evaluating the degree of
implementation from facility to facility. It is because of this lack of common definition or nomenclature to describe the culture change process that two models have been proposed: A Stage Model of Culture Change in Nursing Facilities by Grant and Norton and a Continuum of Person-Directed Culture by Misiorski and Rader (36, 37).

*Stage Model of Culture Change in Nursing Facilities*

Grant and Norton proposed categorizing culture change into four stages. The stages, delineated in Figure 2, are comprised of Institutional (traditional, no change); Transformational (beginning stages of change); Neighborhood (smaller resident centered living areas within a larger whole); and Household (small self-contained living areas) (36). As organizations move from stage I to IV, innovation occurs in five organization systems: decision making, staff roles, physical environment, organization design and leadership practices.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Traditional medical model organized around a nursing unit without permanent staff assignments.</td>
</tr>
<tr>
<td>The Institutional</td>
<td></td>
</tr>
<tr>
<td>Stage II</td>
<td>Characteristic of permanent staff assignments, a physical environment that is less institutional and awareness and knowledge of cultures spreads among direct care workers and the leadership team.</td>
</tr>
<tr>
<td>The Transformation</td>
<td></td>
</tr>
<tr>
<td>Stage III</td>
<td>Breaks up traditional nursing units into smaller functional areas and introduces resident-centered dining. Neighborhoods are given unique identifiers or names.</td>
</tr>
<tr>
<td>The Neighborhood</td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>Consists of self-contained living areas with their own full kitchen, living room and dining room and cross trained staff (23).</td>
</tr>
<tr>
<td>The Household</td>
<td></td>
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</tbody>
</table>

Figure 2: Stages of Culture Change
Similarly, Susan Misiorski and Joanne Rader developed a Continuum of Person-Directed Culture, illustrating the degree of change from provider directed care throughout the continuum to person directed care (33). This continuum of direction focuses on the person(s) in charge of decision making and delineates examples of specific practices (care assignments, dining, bathing, moving in, death and dying, providing assistance at night and medication administration) throughout culture change (37). The four phases are summarized in Figure 3.

<table>
<thead>
<tr>
<th>Provider Directed</th>
<th>Staff Centered</th>
<th>Person Centered</th>
<th>Person Directed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management makes most of the decision with little conscious consideration of the impact on residents or staff</td>
<td>Staff consult residents or put themselves in residents’ place while making the decisions.</td>
<td>Resident preferences or past patterns form basis of decision making about some routines</td>
<td>Residents make decision every day about their individual routines. When not capable of articulating needs, staff honor observed preference and lifelong habits.</td>
</tr>
<tr>
<td>Residents accommodate staff preferences; are expected to follow existing routines</td>
<td>Residents accommodate staff much of the time but have some choices within existing routines and options</td>
<td>Staff begin to organize routines in order to accommodate resident preferences – articulated or observed</td>
<td>Staff organize their hours, patterns and assignments to meet resident preferences.</td>
</tr>
</tbody>
</table>

Developed by Mary Tess Crotty, Genesis Healthcare Corp, based on the Continuum of Person Directed Culture Model, developed by Susan Misiorski and Joanne Rader, distributed at Pioneer Institutes, 2005 Reprinted with permission.

Figure 3: Continuum of Person Directed Culture
Culture Change in Food Service

Culture change runs the gambit of the physical facility, staffing, medications, activities of daily living (ADL) schedules and dining practices. For the purpose of this research, culture change will focus on the dining experience where the resident is allowed to make true choices of when, where and how to eat and the facility and staff organize around the resident’s preferences.

Changes to dining practices can be as small as the addition of a selective style menu or full scale dining service change including staffing, equipment, facility design and dining atmosphere. Among dining style practice studies, restaurant style has been a popular theme (38-47). In one study, twenty-four hour dining was initiated after a facility owner was delivering breakfast trays and noted several residents sleeping and thought it ridiculous to wake someone just to eat (42). The Wesley Village started with a continental breakfast buffet and worked their way up to trayless buffet for all three meals (43). Additional culture change ideas for the dining experience that have been used are summarized in Figure 4.
• Food Service Methods
  o Specialty Stations: Omelet, soup, pasta and salad bars, pizza, grills
  o Open dining – extended hours, 24 hour dining
  o Room service, Buffet style dining, Restaurant style dining
• Resident Involvement
  o Preparation of a favorite recipe
  o Culinary School Demonstrations
  o Menu development committees
• Open Dining
  o Kosher café open to residents, families, staff and the public
  o Cocktail/coffee shop that is open to residents and families
• Meal Time Activities
  o Aromas of baked goods in the dining rooms and into the halls
  o Staff sitting and sharing meals with residents (28)

Figure 4: Culture Change Implementation Examples

Benefits of Culture Change

Numerous studies delineate the benefits of culture change. Most facilities boast resident reported improvements in quality of life, emotional well being and behavioral measures. Other benefits include a decrease in the number of residents on therapeutic diets, residents with unintentional weight loss and pressure ulcers (42, 44, 45). While a financial commitment to culture change is assumed, studies have shown an off-set to the cost in savings such as decrease in plate waste, employee turner over and training, care for unintentional weight loss and pressure ulcers, and supplement usage (27, 43). The Texas Department of Aging and Disability Services in a 2011 Symposium, Culture Change: Enriching Lives in Nursing Homes, provided a summation of benefits to culture change affecting resident, staffing and additional areas (28).
Resident

An evaluation of Eden Alternative homes found a decrease in the average number of prescriptions per resident, average cost of medication, use of mind altering drugs, infection rate and mortality (46). A reduction in loneliness, helplessness and boredom was found by a similar examination of Eden alternative homes (47). Culture change also improved the physical health of the resident (reduced frequency of pressure ulcers, restraints and bedfast residents) and mental health of the resident (reduced depression and behavioral problems, increases social function) (42, 48-50). A dining related benefit was increased caloric intake and reduction of unanticipated weight loss (51).

Staffing

Implementation of culture change with changes in staffing assignments reduced employee turnover, minimized temporary agency staffing and mandatory overtime and reduced workers’ compensation claims and associated costs (28). Added benefits included employee job satisfaction and increased volunteerism both from employees and outside sources (43).

Additional

Culture change significantly improved employee, resident and family satisfaction (45). Referrals from residents or family members also increased due to increased satisfaction (27, 52). Aspects of culture change models increase involvement with the outside community including children, students, clubs and religious organization, consequently increasing resident satisfaction (53). Several facilities, including Wesley Village, experienced an increase in admissions and a decrease in nutritional
supplementation costs (43). Also of importance is a reduction in facility deficiencies and fines issued by Centers for Medicare and Medicaid Services, less than one-third the average of comparison facilities (54).

*Regulatory Process and Culture Change*

The regulatory interpretive guidelines for Federal Nursing Facility (Ftag) F240 Quality of Life states, “The intention of the quality of life requirements specify the facility’s responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident” (28). F242 Self Determination and participation, includes language that gives the resident the right to “choose activities, schedules, and health care consistent with his or her interest, assessments and plans of care.” It also provides the resident the right to “make choices about aspects of his or her life in the facility that are significant to the resident” (28). Centers for Medicare and Medicaid Services (CMS) and the Department of Aging and Disability Services (DADS) Regulatory Services are both concerned about culture change and regulatory compliance in skilled nursing facilities. “Nursing homes can actually reduce their deficiencies by seeking positive person-centered outcomes” (28). CMS offers clarification that “clearly promotes a resident’s right to choose and to exercise his or her autonomy. It also provides nursing home providers with some assurances that the regulations and regulatory agencies are supportive of individualized, resident-centered care that provides options for resident choice” (28).
Residents’ Expectations

The 2009 National Survey of Consumer and Workforce Satisfaction in Nursing Homes found among the factors that drive consumer recommendation of a skilled nursing facility that resident choices/preferences, quality of dining experience, and quality of meals are all listed in the top twenty (45). Dining location, dining room ambiance and socialization with other residents were also important (51, 56, 57). Several researchers have conducted focus groups or personal interviews with residents and have concluded that food is vital to the residents’ well being and satisfaction and that a focus on resident’s preferences increases food intake (4, 10, 58-66).

Researchers Kane, et al. found that older people want, but do not get, the same chance that young people have to choose autonomy in long-term care: control, individuality and continuity of a meaningful personal life (6, 67, 68). Older people want to live in a setting that is home-like and allows them to make decisions they are accustomed to making for themselves. They also found that the elderly would prefer to stay at home or in a home-like environment and receive care where they live, rather than live in an institution that focuses on care (6, 67, 68).

In a 2005 publication, Linda Bump, Pioneer Network member and culture change leader, emphasized resident centered dining and encouraged, “excellence in individualization” and indicated that in order to accomplish that, each facility must provide choice, accessibility, individualization, liberalized diets, food first, quality services and responsiveness (69). Bump defines each term as follows. Choice is the choice of what, when and where to eat, who to eat with and how leisurely to eat. Choice should be true choice, not token choice; choice of what the resident wants without facility...
imposed limitations. Accessibility is the access to foods of choice available when hungry, or when just longing for a specific food. Food should be available 24 hours a day, 7 days a week and someone should be available to help prepare it. Individualization is specific attention to the elder’s favorite foods, comfort foods, ethnic foods, foods prepared from their own favorite recipes, foods they choose to eat in their own home. The foods offered should make them look forward to the day, warm their heart and soul, as well as nourish their bodies (69). Liberalized diets should include the elder’s right to choice in whether or not to follow a restrictive diet. The diet should not be based solely on diagnosis, but on the individual. Food first is the ability to choose food before supplements and food before medication. This is a natural decision and should be fostered. Quality service focuses on relationships that are the key to quality care giving and quality service in dining. Knowing the elder, their choices, their preferences and their daily pleasures in dining results in quality service that encourages optimal intake. Lastly, responsiveness refers to relationship based services, resident access to the refrigerator whenever desired, and quiet attention to every need. Regardless of the method of delivery, Bump concludes, “food is the heart of the home. . . The ideal is to have what the residents want to eat available 24 hours a day, seven days a week, with the opportunity to eat with whom they wish, in places they choose to be” (69).

Current Food Service Atmosphere

Several Registered Dietitians (RD and Licensed Dietitians (LD) were interviewed regarding the current food service practices in facilities they were contracted in the central Texas area (70). These professionals were asked what culture change food services practices they have seen implemented, what barriers they see to culture change
and what they would like to know about residents’ preferences regarding culture change. Additionally, the Dietitians provided anecdotal information regarding experiences in adopting culture change in their facilities.

The barriers to culture change were summed up by one RD. She felt as if there were too many choices of what to implement and no direction given as to where to start. Additionally, she felt that if the wrong choice was made, there was the potential of tremendous cost at no additional benefit to the resident (70).

One account of an unsuccessful culture change implementation was a facility attempting room service (70). The facility allowed for residents to call in and request meals if they did not want to go to the main dining room. However, in a three month period only one resident participated in the new program. The Dietitian admitted that the facility did not ask the residents if room service was something that they wanted prior to the program initiation. This was an administrative decree that resulted in minimum users for the program and no changes in customer satisfaction (70).

Another culture change blunder occurred when a facility owner decided to implement fine dining by changing all the glassware to heavy crystal glasses and fine china plates (70). The administration was determined that in order to adopt culture change they needed to change to fine dining. The glasses were beautiful and sparkled on the table but they were too heavy for the residents to lift and were consequently unable to drink from them. The needs of the resident were not attended to and therefore the change was unsuccessful (70).

The common theme that emerged from the question regarding what they would like to know about residents’ preferences regarding culture change was “what do the
residents want” (70) The requests may have been slightly different (do they want room service, buffets, china dishes, convenience stores), but the end result was the same: what does the resident really want (70)?

According to the literature, culture change should home-like, resident-centered care that is focused on improvements in quality of life. Studies have also shown how integral food is to the resident’s overall satisfaction with the facility. Further research is needed and requested by professionals in the field to determine residents’ home practices and assess residents’ preferences for dining style in skilled nursing facilities. This data could then be generalized to the larger population and facilities could then merge culture change and resident’s choice regarding the dining experience. Culture change needs to be defined by the customer, the resident of the skilled nursing facility.
References


70. (Chilton A, Dietze J, Elliot A, Emerson M, Piland C, Regetz H, Roberts L. Personal communication)


CHAPTER 2

Introduction

Since the 1987 Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act (OBRA) passed, emphasizing residents’ rights and quality standards for long term care, there has been a national impetus toward resident centered care coined “culture change” (1, 2). However twenty years later, a 2007 study investigating the extent to which nursing homes had embraced culture change showed only 31% could be titled culture change adopters (1). With the shortage of facilities implementing culture change and lack of focus on resident’s preference, it should come as no surprise that long term care food service continues to receive poor satisfaction scores (3-5). While there are many factors which contribute to this low level of satisfaction, a major concern and area the facility can control is food service and dining through the implementation of culture change.

Research and literature reviews regarding the effect and implementation of culture change are abundant (6, 7-10). However, very few studies put the residents at the center of the planning process for culture change and thus facilities never get to the heart of culture change: the resident’s preferences. Public policy fulfillment coupled with nursing facility’s desire to increase quality of service to meet changes in residents’ expectations and improve marketability warrant a new look at culture change and home like dining as defined by the residents in skilled nursing facilities (11).
Definitions of Culture Change

Culture change focuses on more personalized choice in decision-making about the resident’s daily life and being treated with dignity by staff and caregivers (12). It intends to transform the long term care medical model to one that both nurtures and caters to the individual and meets medical needs (13). The Pioneer Network defines culture change as an ongoing transformation in the physical, organizational and psycho-social-spiritual environments based on person-centered values and restoring control to elders and those who work closest with them (14).

Culture change runs that gambit of the physical facility, staffing, medications, bathing and activities of daily living (ADL) schedules and dining practices. For the purpose of this research, culture change will focus on the dining experience where the resident is allowed to make true choices of when, where and how to eat and the facility and staff organize around the resident’s preferences.

Benefits of Culture Change

Numerous studies delineate the benefits of culture change. Most facilities boast resident reported improvements in quality of life, emotional well being and behavioral measures. Other benefits include a decrease in the number of residents on therapeutic diets, residents with unintentional weight loss and pressure ulcers (7, 9, 10). While a financial commitment to culture change is assumed, studies have shown an off-set to the cost in savings such as decrease in plate waste, employee turnover and training, care for unintentional weight loss and pressure ulcers, and supplement usage (6, 8).
Residents’ Expectations

The 2009 National Survey of Consumer and Workforce Satisfaction in Nursing Homes found among the factors that drive consumer recommendation for skilled nursing facilities, resident food choices and preferences, quality of dining experience, and quality of meals are all listed in the top twenty (15). Several researchers have conducted focus groups or personal interviews with residents and have concluded that food is vital to the resident’s well being and satisfaction and that a focus on resident’s preferences increases food intake (4, 16-28).

Researchers Kane, et al found that older people want, but do not get, the same chance that young people have to choose autonomy in long-term care: control, individuality and continuity of a meaningful personal life (26-28). Older people want to live in a setting that is home-like and allows them to make decisions they are used to making for themselves: when, where and what to eat (26).

Demographic Changes

Skilled nursing facility residents’ preferences and expectations are changing due to changes in the facility populations and resident demographics (29, 30). In additional to the growing market segment of skilled nursing facility potential residents, generational differences appear to affect the type of dining styles preferred. The next years will see a skilled nursing facility population with merging generations of Baby Boom (1946-1964), Silent generation (1925-1945) and the Greatest generation (1901-1924). The type of food service acceptable for residents of the current majority, the Silent Generation, is not appropriate for the next generation, Baby Boomers (31, 32). The combination of
generations, will want diverse choices and to have an active voice in activities of daily living including eating, bathing, waking, sleeping, dressing (6).

Current Food Service Atmosphere

Registered Dietitians (RD) and Licensed Dietitians (LD) were interviewed regarding the current food service practices in facilities they were contracted in the central Texas area (33). These professionals were asked what culture change food services practices have been implemented, what barriers they see to culture change what they would like to know about residents’ preferences regarding culture change. Additionally, the Dietitians provided anecdotal information regarding experiences in adopting culture change in their facilities (33).

The barriers to culture change were summed up by one RD, who felt as if there were too many choices of what to implement and no direction given as to where to start (33). Additionally, if the wrong choice was made, there was the potential for tremendous cost at no additional benefit to the resident (33).

One account of culture change implementation that was unsuccessful sited a facility attempting room service (33). The facility allowed for residents to call in and request meals if they did not want to go to the main dining room. However, in a three month period only one resident participated in the new program. The Dietitian admitted that the facility did not ask the residents if room service was something that the residents wanted prior to initiation. This dining change was an administrative decree that resulted in minimum users for the program and no changes in customer satisfaction (33).

Another culture change blunder occurred when a facility owner decided to implement fine dining by changing to heavy crystal glasses and fine china plates (33).
The glasses were beautiful and sparkled on the table but they were too heavy for the residents to lift and were consequently unable to drink out of them. The administration was determined that in order to adopt culture change they needed to change to fine dining. The needs of the resident were not attended to and therefore the change was unsuccessful (33).

The common theme that emerged from the questioning of dietetics professional regarding what they would like to know about residents’ preferences regarding culture change was “what do they want?” (33). The requests may have been slightly different (do they want room service, buffets, china dishes, convenience stores), but the end result was the same: what does the resident really want (33)?

According to the literature, culture change is home-like, resident-centered care that is necessary for improvements in quality of life. Studies have also shown how integral food is to the resident’s overall satisfaction with the facility. The purpose of this research, as requested by professionals in the dietetics field, is to determine residents’ home practices and assess residents’ preferences for dining style in skilled nursing facilities. This data could then be generalized to the larger population and facilities could then merge culture change and resident’s choice regarding the dining experience. Culture change needs to be defined by the customer, the resident.

**Methods**

*Population and Sample*

The study population consisted of residents in skilled nursing facilities in the Central Texas area. Facilities were selected with consideration for accessibility for the interviewer and the facility’s agreement to participate in the study. For confidentiality
purposes, the facilities were labeled Facility A, Facility B, and Facility C and are defined in Table 1. Each facility included resident payer sources of Medicare, Medicaid, Insurance and private pay. Residents were at the facility for rehabilitation services, post acute stays or long term stays. A convenience sample of 104 communicative residents eating facility-provided food was taken from the three facilities. The survey participation rate is shown in Table 1 with an overall participation rate of 28.3%.

Table 1: Rate of Participation by Residents of Skilled Nursing Facilities in Resident Dining Style Preferences Survey

<table>
<thead>
<tr>
<th>Facility</th>
<th>Facility Type</th>
<th>Average Census</th>
<th>Sample Size</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Chain, corporate owned</td>
<td>123</td>
<td>38</td>
<td>30.9%</td>
</tr>
<tr>
<td>B</td>
<td>Chain, non-profit</td>
<td>111</td>
<td>35</td>
<td>31.5%</td>
</tr>
<tr>
<td>C</td>
<td>Independently owned</td>
<td>134</td>
<td>31</td>
<td>23.1%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>368</td>
<td>104</td>
<td>28.3%</td>
</tr>
</tbody>
</table>

*Design*

The quasi experimental study was given approval through Utah State University Institutional Review Board (IRB) and permission was obtained from each facility’s administration. A convenience sample was taken from a facility-generated potential participant list of residents who consumed food from the facility and were both cognitively capable and willing to participate. Initial cognition was determined by the social worker’s assessment of the resident. Then, the Minimum Data Set (MDS) 3.0 Section C Brief Instrument of Mental Status (BIMS) Interview, intended to determine the resident’s attention, orientation and ability to register and recall new information, was reviewed for each resident by the facility Social Worker or designated nursing staff (34). A sample BIMS Interview is included in Appendix A. A score of 0-7 indicates severe
impairment, 8-12 moderate impairment and 13-15 cognitively intact (34). If the resident received a score of less than 8, the name was removed from the potential participant list. If the resident was not their own responsible party and therefore was unable to give consent, a letter was mailed requesting consent from the responsible party on behalf of the resident. The signed letters were returned to the facility and collected by each facility administrator.

On the day of the interview, the cognition status was confirmed by the charge nurse who verified the resident had no change in condition. Then, residents were asked to participate in an interview regarding dining practices and preferences. Verbal consent was documented. A letter of information describing the research study was provided to the resident. The interviews were identically administered, lasted approximately thirty minutes and were documented on the Dining Style Preferences Survey.

Data and Instrumentation

The Resident Dining Style Preferences Survey, included in appendix B, was developed by the graduate student along with faculty on the research committee. An extensive literature review revealed no published surveys regarding resident’s dining style preferences in skilled nursing facilities. Several surveys were found addressing dining satisfaction; however, no surveys were found focusing on both home dining practices and skilled nursing facility dining preferences to accomplish the set objectives.

The Resident Dining Style Preferences Survey was developed, standardized and face and content validity were obtained. Content validity was accomplished by soliciting review and making the recommended changes suggested from 16 Registered Dietitians (RD) working in skilled nursing facilities, one RD working with Pioneer Network (a
leading organization in culture change) and one researcher specializing in research in culture change, also working with Pioneer Network.

Face validity was gained through two pilot studies with residents at two of the study sites. The initial intention of the survey was to have the participants complete the survey individually. However, after a pilot with ten elder persons, it was deemed necessary by the graduate committee to verbally administer the surveys in a structured interview and document the answers verbatim. This allowed for greater understanding on behalf of both the participant and the interviewer regarding question intention and answer.

Analysis

Interview answers were transcribed verbatim into score sheets developed in Microsoft Excel. Data were analyzed using Statistical Analysis Software (SAS). Descriptive statistics were used to define the study population and demographics. Frequencies and percentages were determined for meal time preferences, types of meals and dining style. Numerical and trend comparisons were made for these parameters. In addition, dining conditions (location, tables, company, plates, and atmosphere) at home and preferences in the facility and the influence of age and length of stay on these factors were further analyzed using chi-square. A paired samples t-test was used to determine if there were differences in meal frequency between home practices and skilled nursing facility preferences. Open ended questions were analyzed for recurrent themes by noting the number of times similar responses were given.
Results

Demographics

A total of 104 individuals were surveyed and the demographic characteristics of the population are shown in Table 2. Three quarters of the residents surveyed were female. The average age of the survey population was 81.4 years with the youngest participant being 51 years and the oldest being 104 years. The largest generational representation was the Silent generation (ages 65-86), followed by the Greatest generation (86+) and then the Baby Boomer generation (47-64). The ethnic majority was White (88.5%). Over half of the residents surveyed indicated a household income of less than twenty five thousand dollars.

The majority of resident’s current length of stay in a skilled nursing facility was at least one year but no more than five years. The smallest representation of the survey population for length of stay were participants living in skilled nursing facilities greater than ten years.
Table 2 Demographic Representation of the Dining Preference Survey Population

<table>
<thead>
<tr>
<th>Demographic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>104</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>75</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47-65</td>
<td>103</td>
<td>11</td>
</tr>
<tr>
<td>66-86</td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>87+</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>104</td>
<td>88.5</td>
</tr>
<tr>
<td>African American</td>
<td></td>
<td>6.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$25,000</td>
<td>103</td>
<td>59.2</td>
</tr>
<tr>
<td>25001-50,000</td>
<td></td>
<td>29.1</td>
</tr>
<tr>
<td>50,001-75,000</td>
<td></td>
<td>11.7</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>104</td>
<td>20.2</td>
</tr>
<tr>
<td>1-4.9 years</td>
<td></td>
<td>54.8</td>
</tr>
<tr>
<td>5-9.9 years</td>
<td></td>
<td>19.2</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td></td>
<td>5.8</td>
</tr>
</tbody>
</table>

*Home Dining Practices*

Table 3 delineates the results for the surveyed population’s home dining practices.

Almost half of the participants lived with family prior to admission into a skilled nursing facility. However, another forty six percent lived alone; the remaining six percent had in-home care prior to admission.
Table 3 Responses to Home Dining Practice Questions of the Resident Dining Style Preference Survey

<table>
<thead>
<tr>
<th>Response Item</th>
<th>n</th>
<th>Answer result (% participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Meals</td>
<td>104</td>
<td>2 (17.3) 2.5 (1.0) 3 (80.8) 5 (1.0)</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>104</td>
<td>Alone (46.2) Family (48.1) HomCare (5.8)</td>
</tr>
<tr>
<td>Meals Prepared by</td>
<td>104</td>
<td>Self (72.1) Family (21.2) Packaged (2.9) Deliver (1.0)</td>
</tr>
<tr>
<td>Snacks Consumed</td>
<td>104</td>
<td>Yes (76.0) No (24.0)</td>
</tr>
<tr>
<td>Snack Timing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of Meals</td>
<td>102</td>
<td>Dining (33.3) Kitchen (49.0) Living (17.6)</td>
</tr>
<tr>
<td>Companion at Meals</td>
<td>102</td>
<td>Self (40.2) Family (55.9) Friends (3.9)</td>
</tr>
<tr>
<td>Table at Meals</td>
<td>102</td>
<td>Table (83.3) TVTray (14.7) Coffee Tb (2.0)</td>
</tr>
<tr>
<td>Plates at Meals</td>
<td>102</td>
<td>Paper (16.7) Everyd (80.4) China (2.9)</td>
</tr>
<tr>
<td>Atmosphere at Meals</td>
<td>102</td>
<td>Quiet (48.0) TV (44.1) Radio (7.8)</td>
</tr>
<tr>
<td>Frequency of Meal Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch/Dinner (# per week)</td>
<td></td>
<td>0 1-2 3-5 &gt;5</td>
</tr>
<tr>
<td>Hot Meals</td>
<td>101</td>
<td>0 10.9 21.8 67.3</td>
</tr>
<tr>
<td>Quick Meals</td>
<td>97</td>
<td>12.4 38.1 34.0 15.5</td>
</tr>
<tr>
<td>Convenience Meals</td>
<td>99</td>
<td>47.5 34.3 18.2 0</td>
</tr>
<tr>
<td>Fast Food</td>
<td>100</td>
<td>71 23 6 0</td>
</tr>
<tr>
<td>Dine in restaurant</td>
<td>100</td>
<td>69.0 25.0 5.0 1.0</td>
</tr>
<tr>
<td>Buffet restaurant</td>
<td>100</td>
<td>87.0 12.0 1.0 0</td>
</tr>
<tr>
<td>Home delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breakfast (# per week)</td>
<td></td>
<td>0 1-2 3-5 &gt;5</td>
</tr>
<tr>
<td>Hot Meals</td>
<td>102</td>
<td>20.6 20.6 27.5 31.4</td>
</tr>
<tr>
<td>Quick Meals</td>
<td>101</td>
<td>4.0 19.8 47.5 28.7</td>
</tr>
<tr>
<td>Convenience Meals</td>
<td>101</td>
<td>84.2 8.9 3.0 4.0</td>
</tr>
<tr>
<td>Fast Food</td>
<td>101</td>
<td>94.1 5.0 1.0 0</td>
</tr>
<tr>
<td>Dine in restaurant</td>
<td>102</td>
<td>88.2 8.8 2.9 0</td>
</tr>
<tr>
<td>No Breakfast</td>
<td>86</td>
<td>84.3 8.8 4.9 2.0</td>
</tr>
<tr>
<td>Other</td>
<td>95</td>
<td>97.9 2.1 0 0</td>
</tr>
</tbody>
</table>

Almost three fourths of those surveyed prepared meals themselves while at home. Family support during meal time was twenty-one percent. Packaged, delivered and other methods of food preparation were utilized cumulatively less than seven percent of meal times.

Home meal times varied greatly and are represented in Figures 5-7. However, each meal time had a concentration around at least one time. Breakfast times ranged
from 5:00am to 10am with modes at 7:00am and 8:00am (Figure 5). Meal times for lunch while at home ranged from 10:00am to 3:00pm with the mode at 12noon (Figure 6). Dinner meal time ranged from 3:00pm to 9:00pm with modes at 5:00pm and 6:00pm (Figure 7). Three fourths of the participants consumed snacks while at home; with little consensus on timing of snacks. Very few residents indicated a time in which they consistently snacked. The majority (86%) responded they snacked occasionally or when desired.

Figure 5: Home Breakfast Time Responses to Resident Dining Style Preference Survey

Figure 6: Home Lunch Time Responses to Resident Dining Style Preference Survey
The majority of the survey population ate in the kitchen during meal times with the remaining one third eating in the dining room and one fifth eating in the living room. Companions at meal times were most frequently family, then friends and neighbors, while one third ate meals alone. The largest segment of the population ate meals at the table; almost fifteen percent ate on a TV tray and about four percent at a coffee table. Most meals were consumed on everyday china plates; however, a small survey representation ate meals on paper plates. Almost half of the population ate meals in a quiet atmosphere, while a close second in meal time atmosphere was with the television.

Sixty seven percent of the participants indicated while at home they consumed five or more meals per week that were hot/ home style cooked meals. The majority of participants while at home did not consume meals from fast food, dine in restaurants, buffets or home delivery. Greater than half of the individuals surveyed ate between two and five quick meals such as soup, salad or sandwiches per week while at home. Breakfast meals consumed while at home were also predominately hot meals or quick meals.
Skilled Nursing Facility Dining Style Preferences

Table 4 represents the skilled nursing facility residents’ dining preferences. The majority of individuals surveyed want three meals to be provided by the facility. Three fourths of the population surveyed want snacks available in skilled nursing facilities. Almost half want the snacks available at any time.

The surveyed majority reported they would choose to eat in the dining room with friends and neighbors at the table on everyday plates in a quiet atmosphere.
Table 4 Responses to Skilled Nursing Facility Dining Preference Questions of the Resident Dining Style Preference Survey

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Answer result (% Participants)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Meals</td>
<td>103</td>
<td>0 (1.)</td>
<td>2 (15.5)</td>
</tr>
<tr>
<td>Snacks Offered</td>
<td>104</td>
<td>Yes (73.1)</td>
<td>No (26.9)</td>
</tr>
<tr>
<td>Snack Time Preferred</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Location of Meals</td>
<td>103</td>
<td>Dinner Room (82.5)</td>
<td>Room (15.5)</td>
</tr>
<tr>
<td>Companion at Meals</td>
<td>103</td>
<td>Self (17.5)</td>
<td>Family (8.7)</td>
</tr>
<tr>
<td>Table at Meals</td>
<td>103</td>
<td>Table (86.4)</td>
<td>Tray (8.7)</td>
</tr>
<tr>
<td>Plates at Meals</td>
<td>103</td>
<td>Paper (1.9)</td>
<td>Every (94.2)</td>
</tr>
<tr>
<td>Atmosphere at Meals</td>
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<td>Quiet (65.0)</td>
<td>TV (20.4)</td>
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<tr>
<td>Meal Service Style</td>
<td>103</td>
<td>Yes</td>
<td>No</td>
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<td>Family Style</td>
<td></td>
<td>13.6</td>
<td>86.4</td>
</tr>
<tr>
<td>Buffet Style</td>
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<td>19.4</td>
<td>80.6</td>
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<tr>
<td>Plate/table service</td>
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<td>79.6</td>
<td>20.4</td>
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<tr>
<td>Restaurant Style</td>
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<td>35.3</td>
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<tr>
<td>Room Service</td>
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<td>68.6</td>
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<tr>
<td>Frequency of Meal Type</td>
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</tr>
<tr>
<td>Lunch/Dinner</td>
<td>103</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hot Meals</td>
<td></td>
<td>99.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Quick Meals</td>
<td></td>
<td>80.6</td>
<td>19.4</td>
</tr>
<tr>
<td>Convenience Meals</td>
<td></td>
<td>16.7</td>
<td>83.3</td>
</tr>
<tr>
<td>Fast Food</td>
<td></td>
<td>19.6</td>
<td>80.4</td>
</tr>
<tr>
<td>Ready to Eat</td>
<td></td>
<td>23.3</td>
<td>76.7</td>
</tr>
<tr>
<td>Breakfast</td>
<td>102</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hot Meals</td>
<td></td>
<td>78.4</td>
<td>21.6</td>
</tr>
<tr>
<td>Quick Meals</td>
<td></td>
<td>92.2</td>
<td>7.8</td>
</tr>
<tr>
<td>Convenience Meals</td>
<td></td>
<td>12.7</td>
<td>87.3</td>
</tr>
<tr>
<td>Fast Food</td>
<td></td>
<td>14.7</td>
<td>85.3</td>
</tr>
<tr>
<td>Ready to Eat</td>
<td></td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td>No Breakfast</td>
<td></td>
<td>2.9</td>
<td>97.1</td>
</tr>
<tr>
<td>Meal Time Satisfaction</td>
<td>104</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Availability of food</td>
<td></td>
<td>24.0</td>
<td>76.0</td>
</tr>
<tr>
<td>Variety of menu</td>
<td></td>
<td>13.5</td>
<td>86.5</td>
</tr>
<tr>
<td>Power to choose</td>
<td></td>
<td>60.6</td>
<td>39.4</td>
</tr>
<tr>
<td>Texture of food</td>
<td></td>
<td>10.6</td>
<td>89.4</td>
</tr>
<tr>
<td>Taste of food</td>
<td></td>
<td>43.3</td>
<td>56.7</td>
</tr>
<tr>
<td>Temperature of food</td>
<td></td>
<td>64.4</td>
<td>35.6</td>
</tr>
<tr>
<td>Appearance of food</td>
<td></td>
<td>23.1</td>
<td>76.9</td>
</tr>
<tr>
<td>Service/available staff</td>
<td></td>
<td>27.9</td>
<td>72.1</td>
</tr>
<tr>
<td>Table companions</td>
<td></td>
<td>35.6</td>
<td>64.4</td>
</tr>
<tr>
<td>Noise level in DRM</td>
<td></td>
<td>25.0</td>
<td>75.0</td>
</tr>
<tr>
<td>Location of DRM</td>
<td></td>
<td>8.7</td>
<td>91.3</td>
</tr>
<tr>
<td>Décor of DRM</td>
<td></td>
<td>10.6</td>
<td>89.4</td>
</tr>
</tbody>
</table>
Preferred meal times in skilled nursing facilities ranged extensively Figures 8-10. Requested breakfast times requested ranged from 6:00am to 10:00am (Figure 8); lunch ranged from 10:00am to 4:00pm (Figure 9); dinner ranged from 3:00om to 8:00pm (Figure 10). Just as in the home dining practices, skilled nursing facility preferred meal times reported revolved around central peaks: breakfast: 7:00am and 8:00am; lunch: noon; dinner: 5:00pm and 6:00pm.

Figure 8: Skilled Nursing Facility Preferred Breakfast Time

Figure 9: Skilled Nursing Facility Preferred Lunch Time
Participants ranked plate or table service and restaurant style service first and second respectively for preferred meal service method. More participants, given the choice of meal service styles did not want family style, buffet style or room service.

As depicted in Figure 11, types of meals preferred in a skilled nursing facility dining ranked as the top two were hot meals and quick meals. Consequently, convenience meals, fast food and ready to eat foods were not important to residents in skilled nursing facilities; all scoring with less than 25% of those surveyed wanting these types of meal. Therefore, ninety nine percent of those surveyed wanted hot meals / home style cooking available for lunch and dinner at the skilled nursing facility and eighty percent also wanted quick meals such as soups, salad, and sandwiches available.

Breakfast meal type top three preferred meals were quick meals, hot meals and ready to eat foods (Figure 12). Again, fast food and convenience foods were not as desirable to residents of skilled nursing facilities. Skipping breakfast was also not popular with less than three percent surveyed indicated no breakfast as a preferred meal type for breakfast.
The most important indicator of satisfaction was temperature of food. The top three choices for indicators of meal time satisfaction ranked of primary importance were temperature of food (24.5%), taste of food (17.6%) and power to choose (16.7%). The rank of second indicator of satisfaction was temperature of food (25.5%), power to choose (14.3%) and taste of food (13.3%). The rank of the third indicator of satisfaction was a little more varied: power to choose (31%), service (14.9%), table companions (11.5%).
Relationship of Home Dining Practices versus Skilled Nursing Facility Dining Style Preferences

Table 5 shows the relationship between home dining practice questions and the parallel skilled nursing facility preference question. Meal frequency was not significantly different (compared with a t-test, p= 0.101. Frequency of meals at home was the same as the preference in skilled nursing facilities: three per day.

Table 5: Resident Dining Preference Survey Questions: Home Dining Practices as Compared to Skilled Nursing Facility Preferences

<table>
<thead>
<tr>
<th>Home Practice Question</th>
<th>Parallel Dining Style Preference Question</th>
<th>Dining Style Practice or Preference Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many times per day did you eat a meal?</td>
<td>9. How many times per day do you want to eat meals?</td>
<td>Frequency of meals</td>
</tr>
<tr>
<td>4. At what times did you eat your meals?</td>
<td>10. At what time do you want the following meals to be available to you?</td>
<td>Timing of Meals</td>
</tr>
<tr>
<td>5. Did you eat snacks? If so, at what times did you eat a snack?</td>
<td>11. Do you want snacks available? If so, at what times would you like them available?</td>
<td>Availability of snacks, Timing of snacks</td>
</tr>
<tr>
<td>6. How did you most often eat? (location, company, table, plates, atmosphere)</td>
<td>12. How do you want to eat? (location, company, table, plates, atmosphere)</td>
<td>Location of meals, Company at meal times, type of table, type of plates, atmosphere of dining area</td>
</tr>
<tr>
<td>7. How many times per week did you have the following meals?</td>
<td>14. Which of the following types of meals do you want to be available to you?</td>
<td>Types of food / meals</td>
</tr>
<tr>
<td>8. How many times per week did you eat the following types of breakfast items?</td>
<td>15. Which of the following types of breakfast meals do you want to be available?</td>
<td>Types of breakfast foods</td>
</tr>
</tbody>
</table>
Regarding home practices compared to skilled nursing facility preferences, only two statistical significances emerged (Table 6). Regardless of home plate usage, participants preferred to eat on everyday plates in the skilled nursing facility. Even if participants watched television during meal time at home, they were more likely to prefer a quiet atmosphere in the skilled nursing facility.

Table 6: Resident Dining Style Preference Survey Responses: Home Dining Practices Compared to Skilled Nursing Facility preferences

<table>
<thead>
<tr>
<th>Survey Question Topic</th>
<th>Chi²</th>
<th>n=104</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of meals</td>
<td>0.531</td>
<td></td>
</tr>
<tr>
<td>Company at meal times</td>
<td>0.273</td>
<td></td>
</tr>
<tr>
<td>Type of table</td>
<td>0.115</td>
<td></td>
</tr>
<tr>
<td>Type of plates</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>Atmosphere of dining area</td>
<td>0.011</td>
<td></td>
</tr>
</tbody>
</table>

The skilled nursing facility dining style preferences were cross referenced to length of stay and generation of the participant. There were no statistical significances in difference of dining style preferences in skilled nursing facilities by length of stay or generation.

The open ended question regarding what was missed most about eating at home, described in Table 7 were quantified by listing the responses and determining the frequency. Participation in the open ended questions (n=86) was three quarters of total participants (n=104). Of those who responded, the majority indicated that what they missed most about food service and dining in skilled nursing facilities was home cooking. Whether the response was “my cooking,” “home cooking” or “spouses’ cooking”, the
food served at home was greatly missed. This response could encompass both missing the types of foods consumed at home as well as the cooking process. About a quarter of participants missed their family being present at meals time and being able to share meals with loved ones. The next most common response was the ability to have what the resident wanted when they wanted it.

Table 7 Open Ended Question Responses to Resident Dining Style Preference Survey

<table>
<thead>
<tr>
<th>Category from Resident Responses</th>
<th>Quotations from Resident Responses</th>
<th>% of Participants, n=86</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooking</td>
<td>“Cooking”, “My Cooking”</td>
<td>30.2</td>
</tr>
<tr>
<td></td>
<td>“Home Cooking”, “Spouse’s Cooking”, “Being able to fix it myself”, “Way I cooked it”, “Preparing own food”</td>
<td></td>
</tr>
<tr>
<td>Having what I want, when I want it</td>
<td>“what I want, when I want it”, “Eating what and when I want to”, “Being able to have what I want”, “Cook what I want”</td>
<td>14.0</td>
</tr>
<tr>
<td>Independence</td>
<td>“Independence”, “Choices”, “Freedom of Choice”, “Sit where I want”</td>
<td>7.0</td>
</tr>
<tr>
<td>Going out to Eat</td>
<td>“Experience of eating, especially out to eat”, “Going out to eat”, “Out to restaurants”</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Discussion**

The results of the Dining Style Preference Survey support much of the literature and current research regarding resident control and the importance of food and dining in a skilled nursing facility. Several topics warrant further discussion including resident expectations, meal time preferences, dining style preferences, meal time satisfaction, preference consensus, and the definition of culture change.
Resident Expectations: Involvement and Participation

The results of resident’s expectations are congruent with Kane and the Pioneer Network’s emphasis on restoring control to the elders (4, 11). With nearly three-fourths of the participants responsible for preparing meals while at home, the need for resident involvement in meal planning and preparation becomes apparent due to both the social need for involvement in daily decision making and the established routine and division of duties prior to admission in a skilled nursing facility. Additionally, the most commonly sited response when asked what was missed most about eating at home was the cooking. Whether the response was “my cooking” or “my spouse’s cooking”, participants want to be involved in decision making for dining services or food preparation when appropriate. This assertion further validates the numerous studies that have concluded that food is vital to the residents’ well being and satisfaction and that a focus on resident’s preferences increases food intake (4, 16, 17-25).

Meal Time Preferences: Open Dining

Residents want to be able to “eat what they want when they want.” The vast variation regarding preferred meal times where participants requests meals starting at 6:00 am and ending at 8:00 pm, strongly supports the argument for open dining with no restriction on meal time availability. Twenty-four hour dining has been successful in numerous facilities and the results support the implementation of open dining or always available food (7). Even if dining times were chosen based on the most common response, a section of the population would be over looked. Allowing open dining provides ‘true choice’ not token choice for when to eat (35). Open dining could be
determined as 7-9 for breakfast, 11-1 for lunch and 5-7 for dinner. Then a select menu, with resident input, can be available between meals.

Along the same lines of true choice, snacks should be available at all times with a variety of options. This is congruent with previously suggested always available food (7, 8, 35). Participants wanted snacks available when they were desired. Since there is no way to determine when the need may arise, snacks should always be available to residents. Instead of snack carts passed at specified times, an area could be designated as a nourishment location; allowing residents to select snacks when they are desired.

*Dining Style Preference: Table or Restaurant Service*

A section of culture change advocates promote the use of buffets and room service dining styles (7-10, 36-39). However, those surveyed were not interested in these delivery methods. In contrast, they preferred table or restaurant style service. Restaurant service has been a popular theme in culture change literature and is supported by the research (7-10, 36-39).

Many facilities are already providing modified table service. However, a little education of the serving staff, generally nursing staff could facilitate the restaurant atmosphere. If nursing is required to serve, training should be provided that focuses on customer satisfaction not just serving a patient meal.

*Indicators of Meal Time Satisfaction*

It is notable that above all other indicators of meal time satisfaction, temperature of food ranked number one. Temperature of food dominated other indicators that emerged such as taste of food, power to choose, service and table companions. This
result supports the statement made by Sue Grossbauer in the Dietary Manager’s Association Foodservice Management and Food Safety textbook indicating that seniors rate temperature over flavor in defining good quality (40). Therefore, food temperature and quality should be of utmost importance prior to decisions made regarding the dining style or service method.

**Majority versus Minority**

At no point in the results to the dining preferences survey was there a one hundred percent consensus of residents’ preferences indicating there is no one answer on how to adopt culture change. Only accounting for the majority responses would alienate residents. The Foundations of Culture Change as defined by the Institute for Caregiver Education asserts five core principles: Emphasis on Respect, Empowerment, Choice, Relationships and Community. These principles apply to all members of the community (41). Culture change is not designated to make most of the residents happy, most of the time; but should focus on all resident’s preferences, all of the time.

**Definition of Culture Change**

Culture change can not necessarily be defined as fine dining or home-like dining as indicated by the survey results. Residents in skilled nursing facilities want home like meals but not family style service. While at home, participants may have eaten on paper plates by themselves while in front of the television. However, participants in skilled nursing facilities would prefer hot home cooked meals served in the dining room at the table with everyday plates in a quiet atmosphere seated with friends and neighbors. Culture change should focus on a dining experience where the resident is allowed to
make true choices of when, where and how to eat and the facility and staff organize around the resident’s preferences.

**Conclusion**

While culture change is a vast area of research, studies have neglected to define preferences of the customer in skilled nursing facilities, the resident. Additionally, the choices available in the spectrum of culture change appear to be a barrier for implementation. Therefore, a study examining the dining style preference of residents in skilled nursing facilities with results suggesting practical application was warranted. The results and interpretation of the Dining Style Preferences Survey suggested the following, as summarized in the Take Away Points: Resident Involvement and Participation, Open Dining, Table or Restaurant Service, Focus on Food Quality and Temperature, Mindfulness of the Minority Voice and Culture Change with a Focus on True Choices.

**Take Away Points**

- Residents should be involved in decision making regarding dining services. Where appropriate residents should also participate in the cooking process.

- Open dining may be the most valuable adaptation a facility looking to initiate culture change may make. While there appeared to be clustering of meal time preferences, the vast ranges of desired meal times would invariable leave some needs unattended.

- According to this research, more preferred dining styles in skilled nursing facilities are table and restaurant service over buffet and room service.
Regardless of culture change implementation, temperature and taste of food are keys to satisfaction. The most progressive culture change experience can be ruined by cold or unappetizing food.

Ever keep in mind the minority. Only appeasing the majority will alienate some residents. All residents should have a voice.

Culture change should focus on a dining experience where all residents are allowed to make true choices of when, where and how to eat and the facility and staff organize around the resident’s preferences.
Bibliography


33. (Chilton A, Dietze J, Elliot A, Emerson M, Piland C, Regetz H, Roberts L. Personal communication)


CHAPTER 3

Twenty years after the 1987 Nursing Home Reform Act passed, emphasizing residents’ rights and quality standards for long term care, with an impetus toward resident centered care coined “culture change”, a mere 31% of skilling nursing facilities surveyed could be titled culture change adopters (1, 2). Since culture change adopters receive significantly higher satisfaction scores, it should come as no surprise that long term care food service continues to get poor satisfaction scores (3, 4, 5). One major concern and area the facility can control is food service and dining.

Previous studies have demonstrated the benefits of culture change. However, recent studies have neglected to define residents dining style preferences in relation to their home dining practices and preferences in skilled nursing facilities. Therefore, the objectives of this study were to

1. Determine the home dining practices of current residents’ of skilled nursing facilities in Central Texas.
2. Define dining style preferences in a skilled nursing facility by current residents’ of skilled nursing facilities in Central Texas.
3. Determine the relationship between the home dining practices and dining style preferences in a skilled nursing facility by current residents’ of skilled nursing facilities in Central Texas.
Project Implementation

The following figure summarizes the steps taken to implement and conduct this study.

![Flow Chart of Project Implementation]

Figure 13 Flow Chart of Project Implementation

Survey Development

The Resident Dining Style Preferences Survey, included in Appendix B, was developed by the graduate committee. An extensive literature review revealed no published surveys regarding resident’s dining style preferences. Several surveys were found addressing dining satisfaction. However, no surveys were found focusing on both
home dining practices and skilled nursing facility dining preferences to accomplish the set objectives.

The Dining Style Preferences Survey (Appendix B) took approximately three months for development. After the objectives of the study were outlined, questions were formulated. The demographic information was included at the beginning of the survey. Data included gender, ethnicity, average household income and length of stay in a skilled nursing home. This information was gleaned to ascertain their impact on dining style preferences in a skilled nursing facility inclusive of home dining practices. Tables 8A and 8B demonstrate the relationship between parallel questions for home practice and skilled nursing home preference with the corresponding dining style addressed.

Table 8A: Development of Dining Style Preferences Survey Parallel Questions

<table>
<thead>
<tr>
<th>Home Practice Question</th>
<th>Parallel Dining Style Preference Question</th>
<th>Dining Style Practice Addressed</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many times per day did you eat a meal?</td>
<td>9. How many times per day do you want to eat meals?</td>
<td>Frequency of meals</td>
<td>6, 28, 67, 68</td>
</tr>
<tr>
<td>4. At what times did you eat your meals?</td>
<td>10. At what time do you want meals to be available?</td>
<td>Timing of Meals</td>
<td>6, 28, 42, 67, 68</td>
</tr>
<tr>
<td>5. Did you eat snacks? If so, at what times did you eat a snack?</td>
<td>11. Do you want snacks available? If so, at what times would you like them available?</td>
<td>Availability of snacks, Timing of snacks</td>
<td>28</td>
</tr>
<tr>
<td>7. How many times per week did you have the following meals?</td>
<td>14. Which of the following types of meals do you want?</td>
<td>Types of food / meals</td>
<td>28</td>
</tr>
<tr>
<td>8. How many times per week did you eat the following breakfast items?</td>
<td>15. Which of the following types of breakfast meals do you want?</td>
<td>Types of breakfast foods</td>
<td>28</td>
</tr>
</tbody>
</table>
### Table 8B: Development of Dining Style Preferences Survey Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Dining Style Practice or Preference Addressed</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-survey Questions</td>
<td>Demographics used to relate the facilities to the elder population as a whole and to determine if demographic information is significant to home dining practices or preferences in skilled nursing facilities.</td>
<td>19</td>
</tr>
<tr>
<td>2. Did you live alone, with family or have in home care?</td>
<td>Support system at home</td>
<td>19</td>
</tr>
<tr>
<td>3. How were your meals prepared?</td>
<td>Home method of meal preparation, availability of food.</td>
<td>19</td>
</tr>
<tr>
<td>13. Which style of dining do you want to be available to you?</td>
<td>Dining style preference in skilled nursing facilities</td>
<td>28, 38-47</td>
</tr>
<tr>
<td>16. Regarding dining and food service in skilled nursing facilities, what is the most important indicator of your satisfaction?</td>
<td>Meal time and dining satisfaction indicators</td>
<td>69, 70</td>
</tr>
<tr>
<td>17. What is the most important thing that you want to be the same as what you did at home?</td>
<td>Defining relation of home like dining practices to skilled nursing facility dining preferences</td>
<td>28</td>
</tr>
<tr>
<td>18. What is the most important thing that you want to be different that what you did at home?</td>
<td>Defining relation of home like dining practices to skilled nursing facility dining preferences</td>
<td>28</td>
</tr>
<tr>
<td>19. What do you miss the most about eating at home?</td>
<td>Defining relation of home like dining practices to skilled nursing facility dining preferences</td>
<td>28</td>
</tr>
</tbody>
</table>

Home dining practice information was gathered; specifics included the number of meals consumed per day and the time each meal was consumed. The purpose of the meal time questions was to determine consistency with current practices and regulations. The Centers for Medicare and Medicaid Services (CMS) Federal Regulation F368 Frequency of Meals dictates three meals per day must be offered. It also mandates no more than fourteen hours between the evening meal and breakfast the next day. CMS has written
language clarification noting that F368 does not outweigh F242 Self-determination and Participation (28). However, identification of home practices and subsequent desired preferences could be considered justification for resident’s sleeping in and skipping breakfast or a facility offering 24 hour dining for residents wanting to eat at midnight.

Residents were asked how they lived (alone, with family or with in home care) and how meals were prepared (self, family, packaged, delivered, other) prior to admission into a skilled nursing facility. The purpose for determining living situations prior to skilled nursing home residency was to evaluate if residents’ home dining practices and skilled nursing facility preferences differed if they previously lived alone. About 29% of non-institutionalized older persons (65 years of age or greater) lived alone and 47% of women 75 years of age or greater lived alone (19).

It was questioned whether or not a resident consumed snacks at home and at what times. FTag 368 also mandates an evening snack be offered. However, many facilities offer snacks three times at day, at designated times. This question is intended to justify the need for around the clock snack availability.

The next questions get to the heart of the survey gathering information on how residents ate at home and what kinds of foods were consumed. The survey looked at where, how and with whom residents ate meals. Further information was gathered as to the types and frequency of foods consumed per week. Were residents accustomed to ordering food or going out for meals? There were three questions directed at dining service and types of foods to examine the resident’s home dining practices.

The next focus on the survey was breakfast and the frequency of certain types of foods. Consulting dietitian interviews indicate residents in skilled nursing facilities
generally prefer a consistent breakfast of eggs, toast, breakfast meat and cereal (70). The purpose of this question was to provide factual data as to breakfast preferences in skilled nursing facilities.

The next section, skilled nursing facility dining preferences, was formulated parallel to the home dining practices section. For example, the home dining practices question indicated the number of times per day the resident consumed a meal. Therefore, the skilled nursing facility dining preferences question elicited the desired number of times the resident would like to consume meals in a skilled nursing facility. The relationships between the questions were examined to determine if home like practices predicted dining style preferences in a skilled nursing facility.

A historical study conducted to determine residents’ quality indicators of meal satisfaction was duplicated in part (72). Indicators influencing meal time satisfaction were listed. The resident was to respond as to whether or not the indicator was important and then rank the top three indicators as measures of dining experience satisfaction. The dining experience is more than food and how it is served. This question was developed to determine the importance of certain factors including staff, table companions and dining atmosphere in the dining experience.

The last three questions were opened ended questions in an attempt to obtain additional information on how dining and food service in skilled nursing facilities should be the same or different than home and what is most missed when meals are provided from skilled nursing facilities.

Content validity was accomplished by soliciting review and making the recommended changes suggested from 16 Registered Dietitians (RD) working in skilled
nursing facilities, one RD working with Pioneer Network (a leading organization in culture change) and one researcher specializing in research in culture change, also working with Pioneer Network.

Face validity was gained through two pilot studies with residents at two of the study sites. The initial intention of the survey was to have the participants complete the survey individually. However, after a pilot with ten elder persons, it was deemed necessary by the graduate committee to verbally administer the surveys in a structured interview and document the answers verbatim. This allowed for greater understanding on behalf of both the participant and the interviewer regarding question intention and answer.

**Discussion**

*Future Repeat Implementation of Dining Style Preferences Survey*

For future implementation of the Dining Style Preferences Survey several key areas should be considered: Study Approval, Consents and Interview.

*Study Approval*

Permission to conduct research by the IRB required about one month. However, arrangements with each of the three facilities, distribution and collection of consents forms took upwards of three months. This process was tedious for the corporate owned facility. There were far more levels of approval that needed to be obtained and required approximately three months to determine the appropriate person to provide approval and means with which the consents would be obtained. The privately owned facility was approved within about one week after discussion with the owner. In the future it may be
wise to start at the corporate level to gain approval rather than trying to work up the chain.

**Consents**

Consent approval rates from responsible parties were roughly 50% but required multiple follow up requests. In total, over 145 consents were requested; 116 consents were mailed out with 59 returned; 18 were obtained via phone follow up; the remaining 27 residents interviewed were their own responsible party. Mailing out consents was the fastest but not the most effective means of gaining consent. The most successful, however time consuming means of verifying consent was via phone with the resident’s responsible party. Facility staff calling the resident’s responsible party would the most effective means to obtain consent.

**Interviews**

The interviews were conducted using the validated Dining Style Preferences Survey by one interviewer for consistency in scoring and interpretation of resident responses. Each interview took approximately thirty minutes with data collection required on-site visits for each facility: A – 22 hours, B – 19.5 hours, C – 20.75 hours. This time was spread over the course of two months. Each on-site visit required approximately one hour of confirmation of information. Additional time was spent to follow up on unreturned consents. An estimated time spent on data collection was 87 hours spread over two months.

While a one interviewer system was beneficial for consistency, a consideration for repeat implementation would be a team approach to distribute the over all time required
to complete the data collection. The team approach would require each interviewer to be trained and be CITI certified.

*Culture Change Implementation and Practical Application*

The results of the Dining Style Preferences Survey suggested the following:

- Resident Involvement and Participation, Open Dining, Table or Restaurant Service,
- Focus on food quality and temperature, Mindfulness of the Minority Voice and Culture Change with a focus on true choices.

*Resident Expectations: Involvement and Participation*

With nearly three-fourths of the participants responsible for preparing meals while at home, the need for resident involvement in meal planning and preparation becomes apparent due to both the social need for involvement in daily decision making and the established routine and division of duties prior to admission in a skilled nursing facility. Additionally, the most commonly sited response when asked what was missed most about eating at home was the cooking. Whether the response was “my cooking” or “my spouse’s cooking”, participants want to be involved in meal time preparation. This assertion further validates the numerous studies that have concluded that food is vital to the residents’ well being and satisfaction and that a focus on resident’s preferences increases food intake (4, 10, 58-66).

Residents should be involved in decision making regarding dining services as well as in meal preparations. This does not mean they should be in the kitchen preparing all meals. However, they should be consulted and involved in menu planning; allowed to
provide recipes; participate in a cooking class; select items to be included in meals (such as an omelet station or made your way sandwiches or burgers).

**Meal Time Preferences: Open Dining**

The vast variation regarding preferred meal times strongly supports the argument for open dining with always available food. Even if dining times were chosen based on the most common response, a section of the population would be over looked. Allowing open dining provides ‘true choice’ not token choice for when to eat (69). Along the same lines of true choice, snacks should be available at all times with a variety of options. Study participants wanted snacks available when they were desired. Since there is no way to determine when the need may arise, snacks should always be available to residents.

Open dining may be the most valuable adaptation for a facility looking to initiate culture change. While there appeared to be clustering of meal time preferences, the vast ranges of desired meal times would invariable leave some needs unattended. There is no consensus to meal times. Each resident should have the choice of whether or not to stay in bed or get up at seven in the morning for breakfast. Practicality does not lend itself to short order cooking every meal for every resident. However, choices can be made, with resident input. Open dining could be determined as 7-9 for breakfast, 11-1 for lunch and 5-7 for dinner. Then a select menu, with resident input, can be available between meals.
Dining Style Preference: Table or Restaurant Service

A section of culture change advocates promote the use of buffets and room service dining styles. Those surveyed in this study were not interested in these delivery methods. In contract, they preferred table or restaurant style service.

Many facilities are already providing table service. However, a little education of the serving staff, generally nursing staff would go a long way in making meal times more pleasant. If nursing is required to serve, training should be provided that focuses on customer satisfaction not just serving a patient a meal.

Indicators of Meal Time Satisfaction

It is notable that above all other indicators of meal time satisfaction, temperature of food ranked number one. Temperature of foods dominated other indicators that emerged such as taste of food, power to choose, service and table companions. This result supports a the statement made by Sue Grossbauer in the Dietary Manager’s Association’s Foodservice Management and Food Safety textbook indicating that seniors rate temperature over flavor in defining good quality (71). Therefore, food quality should be of utmost importance prior to decisions made regarding the packaging or delivery method.

Regardless of culture change, temperature and taste of food are keys to satisfaction. The most progressive culture change experience can be ruined by cold or unappetizing food. The facility should master the basics of meal preparation before tackling culture change. If staff can not get meals out on time or there are numerous food complaints, dining style or atmosphere will not enhance the dining experience. The focus should be on quality before additional requirements are implemented.
**Majority versus Minority**

At no point in the results to the dining preferences survey was there a one hundred percent consensus. This means that there is no one answer on how to adopt culture change. The Foundations of Culture Change as defined by the Institute for Caregiver Education asserts five core principles: Emphasis on Respect, Empowerment, Choice, Relationships and Community. These principles apply to all members of the community (30). Culture change is not designated to make most of the residents happy, most of the time; but should focus on all resident’s preferences, all of the time.

Ever keep in mind the minority. Only appeasing the majority will alienate some residents. Again, there is no consensus or recipe for the perfect culture change dining practices. All residents should have a voice.

**Definition of Culture Change**

Culture change cannot be defined as fine dining or home like dining. Neither of these ring true with the population served. At times the older American does what is convenient, what they are capable of or what is affordable. However, this is not the expectation in skilled nursing facilities. In general, participants want hot home cooked meals served in the dining room at the table with everyday plates in a quiet atmosphere seated with friends and neighbors. However, culture change should focus on a dining experience where the resident is allowed to make true choices of when, where and how to eat and the facility and staff organize around the resident’s preferences.
Limitations

The limitations to this study are two fold: sample size and cultural diversity. Eligibility and subsequent participation rates allowed for 30.9% at Facility A, 31.5% at Facility B and 23.1% at Facility C; for a total of 28.3% of residents in the possible sample participating. Therefore the total number of participants in this study was one hundred and four. Several residents were excluded due to cognition, communication ability, source of nutrition, lack of consent or willingness to participate and unavailability in the facility (doctor’s appointment, dialysis, hospitalized, out on pass with family) at time of interview.

The demographic representation in the survey was compared to Texas and United States of America demographics. The median income of older persons in 2009 was $25,704 for males and $15,072 for females. US Households containing families headed by persons 65+ reported a median income of $45,763. About 6.3% of elderly households had incomes less than $15,000 and 64.1% had incomes of $35,000 or more. (19) These statistics are more in line with the demographic representation of the survey participants found in Table 9 as compared with Texas Households in general.

Table 9 Household Income

<table>
<thead>
<tr>
<th>Household Income</th>
<th>% Survey</th>
<th>% of Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 25000</td>
<td>59.2%</td>
<td>29.7%</td>
</tr>
<tr>
<td>25000-49999</td>
<td>29.1%</td>
<td>37.6%</td>
</tr>
<tr>
<td>50000-74999</td>
<td>11.7%</td>
<td>17.7%</td>
</tr>
<tr>
<td>75000-99999</td>
<td>n/a</td>
<td>10.4%</td>
</tr>
<tr>
<td>100000 - +</td>
<td>n/a</td>
<td>14.6%</td>
</tr>
</tbody>
</table>
The ethnic make up of the participants was predominantly white with much smaller representations from the Hispanic and African American populations. United States and Texas ethnicity percentage can be found in Table 10. Texas has a large Hispanic population that was not represented in the participant mix.

Table 10 Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Survey</th>
<th>Texas</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>88.5%</td>
<td>48.3%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6.7%</td>
<td>36.0%</td>
<td>14.8%</td>
</tr>
<tr>
<td>African American</td>
<td>4.8%</td>
<td>11.4%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>5.0%</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

The study population is partially congruent with the US population in which over half the older noninstitutionalized persons lived with their spouse in 2010. Contrary to the sample group, about one third of all noninstitutionalized older persons lived alone prior to admission into a skilled nursing facility in 2010. Additionally, 11% of older Medicare enrollees received personal care from a paid or unpaid source. Over 90% of these older persons with chronic disabilities received informal or formal care in the home (19). This group is grossly under represented in the study population. The difference between live in family and occasional help may influence home dining practices.

Further research needs to be done to conclude to what degrees ethnicity and culture play in dining style preferences. A more ethnically diverse population could be obtained by sourcing and then utilizing facilities in ethnic rich areas. Additionally, a higher participation rate and larger sample size would strengthen the results.
Conclusions

Profound research exists for the need and benefits of implementing culture change. However, it continues to be poorly integrated into main stream skilled nursing facilities. This study sought to determine the home dining practices, define dining style preferences in a skilled nursing facility and determine the relationship between the two based on interview with current residents’ of skilled nursing facilities in Central Texas.

The results of the Dining Style Preferences Survey suggested five specific areas of culture change focus. Consulting Dietitians can use these findings to make recommendations and encourage change in facilities with support from empirical data of residents’ preferences in skilled nursing facilities. Facilities wishing to implement culture change with some guidance could, in turn, administer pages two and three of the Dining Style Preference Survey to determine the specific preferences of their residents.
References


70. (Chilton A, Dietze J, Elliot A, Emerson M, Piland C, Regetz H, Roberts L. Personal communication)


APPENDIX A

MDS 3.0 Section C BIMS Interview
SECTION C
BIMS INTERVIEW FOR MDS 3.0

Assessment Reference Date: ___________

Does resident need or want an interpreter to communicate with the doctor or health care staff?
☐ No ☐ Yes ☐ Unable to determine ☐ Preferred language:

Is the resident able to express ideas and words (consider both verbal and non-verbal expression)?
☐ Understood ☐ Usually understands ☐ Sometimes understands ☐ Rarely/Never understands

SECTION C COGNITIVE PATTERNS

C0100. Should Brief Interview for Mental Status (C6200-C0500) be Conducted? – Attempt to conduct interview with all residents

- No (resident is rarely/never understood) ➔ Complete Staff Assessment
- Yes ➔ Continue to C0200. Repetition of Three Words

C0200. Repetition of Three Words

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."

Number of words repeated after first attempt:
- None
- One
- Two
- Three

After the resident’s first attempt, repeat the words using cues ("sock: something to wear; blue: a color; bed: a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: "Please tell me what year it is right now."

A. Able to report correct year:
- 0. Missed by >5 years or no answer
- 1. Missed by 1-5 years
- 2. Missed by 1 year
- 3. Correct

Ask resident: "What month are we in right now?"

B. Able to report correct month:
- 0. Missed by >1 month or no answer
- 1. Missed by 6 days to 1 month
- 2. Accurate within 65 days

Ask resident: "What day of the week is today?"

C. Able to report correct day of the week:
- 0. Incorrect or no answer
- 1. Correct

C0400. Recall

Ask resident: "Let’s go back to an earlier question. What were those three words that I asked you to repeat? If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock":
- 0. No - could not recall
- 1. Yes, after cueing ("something to wear")
- 2. Yes, no cue required

B. Able to recall "blue":
- 0. No - could not recall
- 1. Yes, after cueing ("a color")
- 2. Yes, no cue required

C. Able to recall "bed":
- 0. No - could not recall
- 1. Yes, after cueing ("a piece of furniture")
- 2. Yes, no cue required

C0500. SUMMARY SCORE

Add scores for questions C0200-C0400 and fill-in total score (00 - 15); Enter 99 if the resident was unable to complete the interview.

BIMS Score can be Interpreted as follows:
- 13-15: Cognitive intact
- 9-12: Moderately impaired
- 0-8: Severe Impairment

Refer to RAI Version 3.0 Manual pages C-1 through D-9 for coding guidelines and time frame for interview completion.

Interview Conducted By: ___________ Title: ___________ Date: ___________

Resident Name: ___________ ID #: ___________ Room #: ___________ Physician: ___________
APPENDIX B

Dining Style Preferences Survey
# Dining Style Preferences Survey

I am conducting research under the supervision of Professor Janet Anderson at Utah State University to find out more about dining style preferences in skilled nursing facilities. There will be a one-time interview of about 30 minutes and your answer will be recorded just as you express. There will be approximately 40 participants at this site and approximately 120 participants total. Participation is voluntary and you may withdraw consent at any time. There is no anticipated risk and no cost or compensation for participation. Information will be kept confidential and your name will not be recorded on the interview.

The above statement was read to the participant and verbal consent was provided.

*Please provide the following information. Gender: Male / Female Age: ________

*Please indicate your ethnicity. Circle one below.
  - White
  - African American
  - Hispanic
  - Asian
  - Mixed
  - Other: ______________________

*What was the average annual household income while you were living at home? Please circle one.
  - (less than 25,000)
  - (25,001-50,000)
  - (50,001-75,000)
  - (75,001-100,000)
  - (greater than 100,000)

*How long have you lived in a skilled nursing facility? ________________

Please consider your routine and usual dining habits while living at home.

1. While at home, how many times per day did you eat a meal? ____________________

2. While at home, did you live alone, with family or have in home care?
   - alone
   - family
   - in home care
   - other: ______________________

3. While at home, how were your meals prepared?
   - self
   - family
   - packaged
   - delivered
   - other: ______________________

4. While at home, at what times did you eat your meals? Breakfast ________ Lunch ________ Dinner ________

5. While at home, did you eat snacks? Yes / No If so, at what times did you eat a snack? ________________

6. While at home, how did you most often eat? (Please check one on each row)
   - a. In the dining room
   - b. In the kitchen
   - c. In the living room
   - d. By yourself
   - e. With family
   - f. With friends or neighbors
   - g. At the table
   - h. On a TV tray
   - i. On a coffee table
   - j. On paper plates
   - k. On everyday plates
   - l. On good china plates
   - m. In a quiet atmosphere
   - n. In front of the TV
   - o. With the radio or music on

7. While at home, how many times per week did you have the following meals?
   - Hot meals (home style cooking eaten at home) 0 1-2 3-5 more than 5
   - Quick Meals (soup, salad, sandwich) 0 1-2 3-5 more than 5
   - Convenience Meals (microwaveable dinners) 0 1-2 3-5 more than 5
   - Fast Food (McDonalds, Wendy’s, etc) 0 1-2 3-5 more than 5
   - Home delivery (pizza, meals on wheels, etc) 0 1-2 3-5 more than 5

8. While at home, how many times per week did you eat the following types of breakfast items?
   - Hot Meal (eggs and/or bacon/ sausage) 0 1-2 3-5 more than 5
   - Quick Meal (cereal, oatmeal, toast, bagel, muffin) 0 1-2 3-5 more than 5
   - Convenience Meal (granola bar, Ensure, etc) 0 1-2 3-5 more than 5
   - Fast food (McDonalds, Wendy’s, etc) 0 1-2 3-5 more than 5
   - Dine in restaurant 0 1-2 3-5 more than 5
   - No breakfast, just coffee or juice 0 1-2 3-5 more than 5
   - Other: ______________________ 0 1-2 3-5 more than 5
When answering the following questions, please consider your preferences and desires without boundaries or preconceptions of skilled nursing facilities.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a skilled nursing facility, how many times per day do you want to eat meals?</td>
<td>____________</td>
</tr>
<tr>
<td>In a skilled nursing facility, at what times do you want the following meals to be available to you?</td>
<td>Breakfast ____________ Lunch ____________ Dinner ____________</td>
</tr>
<tr>
<td>In a skilled nursing facility, do you want snacks available? Yes/No</td>
<td>If so, at what times would you like them available? ____________</td>
</tr>
<tr>
<td>In a skilled nursing facility, how do you want to eat? (Please check one on each row)</td>
<td></td>
</tr>
</tbody>
</table>
  a. In the dining room ___ In your room ___ In the living room / day room  
  b. By yourself ___ With family ___ With friends or neighbors  
  c. At the table ___ On TV tray ___ On a bedside tray  
  d. On paper plates ___ On everyday plates ___ On good china plates  
  e. In a quiet atmosphere ___ In front of the TV ___ With the radio or music on |
| In a skilled nursing facility, which style of dining do you want to be available to you? | Please determine which are wanted and rank your top three choices from below.  
  Wanted? Rank top three  
  Family style (sharing/passing serving dishes at table) Yes No  
  Buffet style (serve self at buffet, help available) Yes No  
  Plate or table service (daily special served to you at table) Yes No  
  Restaurant Style (order off menu, deliver to table) Yes No  
  Room service (order off menu, deliver to room) Yes No  
| In a skilled nursing facility, which of the following types of meals do you want to be available to you? | Please indicate which are wanted and rank your top three choices.  
  Wanted? Rank top three  
  Hot meal (home style cooking) Yes No  
  Quick Meals (soup, salad, sandwich) Yes No  
  Convenience Meals (microwaveable dinners) Yes No  
  Fast Food/Short Order Foods (burger, pizza, burrito) Yes No  
  Ready to eat foods (snacks, sandwiches, microwaveable dinners, salads, etc) Yes No  
| In a skilled nursing facility, which of the following types of breakfast meals do you want to be available? | Please indicate which are wanted and rank your top three choices.  
  Wanted? Rank top three  
  Hot Meals (eggs and/or bacon/sausage) Yes No  
  Quick Meal (oatmeal, toast, bagel) Yes No  
  Convenience Meal (granola bar, Ensure, etc) Yes No  
  Fast food / Short order foods (breakfast sandwiches, burritos, etc) Yes No  
  Ready to eat foods (cereal, muffin, fruit) Yes No  
  No breakfast, just coffee or juice Yes No |
16. Regarding dining and food service in a skilled nursing facility, what is the most important indicator of your satisfaction? Please indicate importance and rank your top three choices.

<table>
<thead>
<tr>
<th></th>
<th>Important?</th>
<th>Rank top three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of food at any time</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Variety of foods offered on menu</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Power to choose meals or request alternate</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Texture of food</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Taste of food</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Temperature of food</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Appearance of food</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Service / availability of staff</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Table companions</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Noise level of dining area</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Location of dining area</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Décor of dining area</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

17. Regarding dining and food service in a skilled nursing facility, what is the most important thing that you want to be the same as what you did at home?

18. Regarding dining and food service in a skilled nursing facility, what is the most important thing that you want to be different than what you did at home?

19. What do you miss the most about eating at home?

Thank you for your time. Your input is greatly appreciated!
APPENDIX C
Reprint Permission
Request Sent to Pioneer Network via email on Fri, 23 Mar 2012

Dear Pioneer Network:

I am in the process of preparing my thesis in the Nutrition Department at Utah State University. I hope to complete my Master in Dietetic Administration in May of this year.

I am requesting your permission to include the below material as shown. I will include acknowledgments and/or appropriate citations to your work as shown and copyright and reprint rights information in a special appendix. The bibliographical citation will appear at the end of the manuscript. Please advise me of any changes you require.

Please indicate your approval of this request by reply email indicating consent or attaching any other form or instruction necessary to confirm permission. If you have any questions, please email or call me at the number below.

I hope you will be able to reply immediately. If you are not the copyright holder, please forward my request to the appropriate person or institution.

Thank you for your cooperation,

Katy Adams, RD CSG LD
Piland, Adams, and Associates, Inc
For Quality Healthcare Services
kadamsrdld@hotmail.com
cell: 979-249-7555

Permission obtained via reply email on Fri 3/30/12 1:21 PM from Amy Elliot

Hi Katy! I hope that all is well. Congratulations on completing your Masters. Please feel free to use the Continuum of PDC in your publication with a citation for Pioneer Network.

Also, I’d love to know any outcomes of your Dining Preferences survey. I remember that you sent it. Did you test it in homes through your work? Are there any next steps with it?

All the best,

Amy E. Elliot, PhD
Director of Research and Evaluation, Pioneer Network
35 East Wacker Dr, Suite 850
Chicago, IL 60601
(614) 378-5367