Culture Change: Offering Buffet Meals and Restaurant-Style Service in the Nursing Home

Sylvia Williams, RN, MA, Lorraine Breuer, MA,
Nicole A. Andreoli, MS & Michael N. Rosenblut, MBA, L.N.H.A, RHP

Parker Jewish Institute for Health Care and Rehabilitation, New Hyde Park NY 11040-1433

BACKGROUND:

The nutritional status of hospital and nursing home residents typically is poor and often results in negative health outcomes such as increased illness, disability and psychological complaints, as well as unintended weight loss and dehydration, all of which are central issues of concerns in many nursing homes.[1]

Estimates indicate that up to 85% of long-term care residents are at risk of malnutrition which can lead to increased mortality and morbidity. Soini et al (2004) found almost 50% of a sample of 178 home-care patients to be at risk for malnutrition. Furthermore, dissatisfaction with food and the dinning experience are significant drivers of overall resident unhappiness.

Duggal & Lawrence (2001)[2] claimed that the food refusal seen in the elderly mirrors that seen in at other points in the developmental process, particularly at extremely difficult time points, such as those characterized by conflict. Specifically in the elderly, the authors claim the refusal to eat is a manifestation of 'feelings of frailty and increased dependency," (p. 216).

Food is one of the few remaining pleasures for many nursing home residents. Pleasant dinning experiences increase food and liquid intake. The choices individuals make related to eating, such as who to eat with and what to eat, are habits developed over one's lifetime and are reflective of lifelong habits and preferences. However, once an individual checks into a nursing home or hospital, the control they have over meal times becomes severely limited, a significant source of resident unhappiness.[3] Additionally, Kane et al (1997)[4] found that nursing home residents stressed the importance of exerting control over choices at meal time.

PARTICIPANTS:

44 participants (11 male, 33 female) received the Buffet Style Dining Program, Average age was 82. Additionally, 37% of these individuals are a special diet, such as low salt, diabetic or renal. The control group consisted of 32 participants (7 men, 24 women). Average age was 80. Forty -eight percent of these individuals were on a special diet. In both groups, those on severely restricted diets, such as pureed-foods only, and tube-feeders were excluded from the analysis. At the pretest, intervention group weights ranged from 73 to 252 pounds. Preintervention weights for the control ranged from 80 to 329 pounds.

METHODOLOGY:

In an attempt to enhance the dining experience, Parker Jewish Institute implemented a Buffet -Style Dining Program (BSDP), offering freedom of choice, eating independence and dining room ambience to a sample of their residents, hoping to increase each resident's desire to eat. The BSDP was created in the dining room and offered residents healthy meal options. Each individual received a tray and plate, and were able to select entrees, vegetables and side dishes. Those individuals with eating problems, such as messy eaters, or those who had difficulties chewing and were considered disruptive or inappropriate at mealtime ate in a smaller lunch room adjacent to the main cafeteria. The purpose of this separation was to recreate an enjoyable atmosphere, similar to one the residents may have encounter at home or in a restaurant.

The BSDP was implemented on one floor of the nursing home. A separate floor served as the control group, who did not received the BSDP but continued to have dinner trays delivered to their room.

Patient weight for both floors was obtained via archival records for several months prior to the study. Patient satisfaction surveys were also distributed to patients on both floors. Patients were able to complete the surveys with the assistance of a family member, friend or hospital volunteer as needed.

RESULTS:

There were no statistically significant differences between the intervention and control groups over time (see table 1). At time one, intervention group weights ranged from 77 to 244 pounds, and 73 to 326 pounds in the control group. At time two, intervention group weights ranged from 88 to 253 pounds and 72 to 332 pounds in the control group.

Within the intervention group, differences in weight from the pretest to time one (approximately one month later) ranged from a weight loss of 7 pounds to a weight gain of 13 pounds, whereas weights ranged from a loss of 26 pounds to a gain of 17 pounds in the control group. Weight differences from pretest to time 2 weights (approximately two months later) ranged from a loss of 11 pounds to a gain of 15 pounds in the intervention group and a loss of 26 pounds to a gain of 20 pounds in the control group. Comparing weight fluctuations from time 1 to time 2, the intervention group showed a loss of 8 pounds and a gain of 11 pounds, while the control group showed a loss of 17 pounds and a gain of 9 pounds.

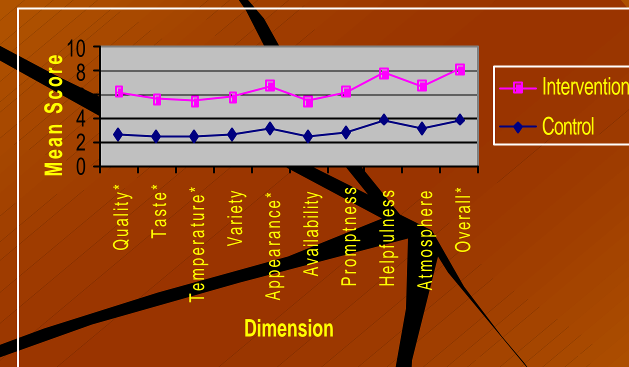
While none of these results were found to be statistically significant, these trends may reflect clinical significance. The differences in the amounts of weight lost between the intervention and control groups across all three time points is considerable, at pretest 7-26 pounds; at time 1, 11-26 pounds and at time 2, 8-17 pounds for the intervention and control groups, respectively. Additionally, during the first month of the buffet dining program, on average, participants gained one pound, and were able to sustain it throughout the second month of the program, whereas the control group continued to lose weight through the second month.

Compared to a control group, patients experiencing the BSDP not only had significantly higher levels of overall dining satisfaction, but also reported higher satisfaction with food quality, food taste, temperature, variety of choices, food appearance and availability.

CONCLUSIONS:

Culture change is a vision that recognizes that to give truly individualized care to residents, we have to change the whole "culture" of today 's nursing homes. The purpose of culture change is to re-orient nursing homes from an institutional culture that is concerned with operating according to specialized institutional routines to one that is focused on the daily routines and preferences of residents. Culture change can be measured by assessing the degree to which a home seeks to respect the individual routines of residents. This small study showed that by improving the dining experience by allowing choice, independence and increased ambience, both psychological and medical outcomes could increase in nursing home residents. Patients who are eating more and maintaining weight stand a better chance of remaining healthy and evading additional illness. This increased satisfaction not only has countless benefits on the residents' health, but also makes the nursing home a home.

Mean Satisfaction Scores
Intervention and Control Groups



* Statistically significant differences found between intervention and control groups.

REFERENCES:

[i] Soini, H., Routasalo , P. & Lagstrom, H. (2004) Characteristics of the Mini-Nutritional Assessment in elderly home-care patients. *European Journal of Clinical Nutrition, 58,* 64-70.

[ii] Duggal, A. & Lawrence, R.M. (2001) Aspects of food refusal in the elderly: The "Hunger Strike." *International Journal of Eating Disorders, 30,* 213-216.

[iii] Berry, E.M. & Marcus, E.L. (2000) Disorders of eating in the elderly. *Journal of Adult Development, 7,* 87-99.

[iv] Kane, R.A., Caplan, A.L., Urv-Wong, E.K., Freeman, I.C., Aroskar, M.A. & Finch. M. (1997) Everyday matters in the lives of nursing home residents: Wish for and perception of choice and control. *Journal of the American Geriatrics Society, 45,* 1086-1093.