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Transitions to Long-Term Care: How Do Families Living With Dementia Experience Mealtimes After Relocating?

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Abstract

Food and mealtimes play a central role in our lives and often hold great meaning. This study is a secondary analysis of a subset of data collected from a 6-year longitudinal qualitative study called Eating Together (ET), which sought to better understand the experiences around food and mealtimes for community dwelling persons with dementia (PWD) and their primary care partners (CP). Several PWD and, in some cases, their spousal CP, relocated to long-term care (LTC) during the conduct of the ET study. To understand how this relocation influenced the meaning of meals, a subset of those who experienced this transition were selected and analysis specific to this issue was undertaken. Seven families were included in this thematic inductive analysis. Findings revealed five themes related to the different mealtime experience in the LTC home, including *systemizing the meal, adjusting to*

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dining with others, holding on to home, evolving mealtime roles, and *becoming "at home."* Understanding how families adapt to commensal dining in LTC may be relevant to successful relocation. This work furthers this understanding and provides a basis for person-centered mealtime practices that promote adaptation.

Keywords
mealtimes, long-term care, dementia, transition, home

According to the World Alzheimer Report, an estimated 35.6 million people across the globe are currently living with some form of dementia; this number is expected to double every 20 years (Alzheimer's Disease International, 2009). As dementia progresses, it affects the ability to carry out tasks independently (Bellenir, 2003) and persons with dementia (PWD) eventually need support and care from others (Berg, 2006). Care within the home by a family care partner (CP) is the most common; however, there often comes a time when dementia progresses to the point where, for some, care needs exceed resources available to remain at home. Thus, as the journey with dementia progresses, there is often a need to shift focus from community care to the acceptance of long-term care (LTC) as the most suitable form of support (Cohen et al., 1993). It is estimated that approximately 70% of nursing home residents have a diagnosis of dementia (Macdonald & Cooper, 2007).

Life in a LTC home is often very different from living in the greater community; relocation to a LTC home is a major life transition, requiring considerable adaptive efforts (Aminzadeh, Dalziel, Molnar, & Garcia, 2009; Davies & Nolan, 2004). Relocation represents the end of an era and the beginning of a new way of life (Aminzadeh et al., 2009). Relocating often involves apprehension as PWD and their families are not fully prepared for what is to come (Davies & Nolan, 2004; Gilleard, Hyde, & Higgs, 2007; Reuss, Dupuis, & Whitfield, 2005). It means uprooting oneself from a familiar environment to move to a place that is not fully equipped to accommodate the various material possessions, individual activity, mealtime preferences, and social relations that have served to define the individual (Davies & Nolan, 2004; Groger, 1995). Living in a LTC home often means living in a more protected, dependent, structured, routinized, and communal environment (Aminzadeh et al., 2009).

Relocation also means becoming accustomed to a new mealtime experience. At home, PWD often hold some control over the foods that are prepared and that they eat, which helps to foster their identity (Genoe et al., 2010). Foods prepared at home are familiar to the person, holding memories of the past (Berg, 2006; Genoe et al., 2010). As well, family members are further able to support their loved one's identity, by encouraging them to become involved with tasks they feel comfortable with (Genoe et al., 2010), within the activities of grocery shopping, meal planning, and food preparation.

In LTC homes, new residents can lose, at least to some extent, their influence over what they eat, when they eat, how much, for how long, with whom, and in what surroundings (Berg, 2006). The traditional meal environment in LTC is comprised of large dining rooms, pre-plated portions of food, staff assistance as required, and an overall discontinuity with the mealtime standards and rituals of home (Sandman & Norberg, 1988). Social models of care that recognize and support social connectedness, the resident as a person, staff–resident relationships, and resident-centered care are seen as a preferred option for LTC (Chang, Li, & Porock, 2013; Kitwood, 1997; McCormack, 2004). Understanding how residents and families view mealtimes as they transition into LTC will support improved practices specific to mealtimes within a transition to a more social model of care.

Although research has begun to capture the impacts of relocating to LTC on residents and family members (e.g., Aminzadeh et al., 2009; Davies & Nolan, 2004; Dobbs, 2004; Dupuis & Norris, 1997, 2001; Kahn, 1999; Reed & Payton, 1996; Wiersma & Dupuis, 2010), currently, there is limited literature to help us understand how families living with dementia describe the mealtime changes on relocation to a LTC home and how families attempt to adjust to these changes. The purpose of this study was to examine post relocation (a) the experience of mealtimes and how they differ from meals at home; (b) how the LTC home environment contributes to this experience; and (c) the strategies that PWD and their family CP use to respond to these new mealtime experiences that resulted from the relocation to LTC.

Method

The Eating Together (ET) Study

This research is a secondary analysis of data collected for the ET Study (Genoe et al., 2010; Genoe et al., 2012; Keller et al., 2010), a 6-year longitudinal grounded theory study with the purpose of developing a substantive theory on the mealtime experience for PWD and their primary family CP. Person-centered and relational care frameworks and work on social aspects of mealtimes informed this study (e.g., Barnett, 2000; Brooker, 1995; Kitwood, 1997; Nolan, Davies, Brown, Keady, & Nolan, 2004; Sabat, 2001);

transition theories were not explicitly used to frame the original research. Areas specifically probed in the primary study were how the participants' mealtime experiences changed as the disease progressed, how these changes affected individual and family relationships, and how families learned to cope or adapt to these changes. Earlier publications provide a detailed description of methods, sample, and experiences while still living in the community (Genoe et al., 2010; Genoe et al., 2012; Keller et al., 2010; Keller, Martin, Dupuis, & Genoe, 2012).

Twenty-seven families living with dementia were recruited from the community using snowball and theoretical sampling; inclusion criteria included the dyad living within the same community, the person with dementia being in the early to mid stages of the disease and greater than 55 years, the CP being a family member, and all participants being able to communicate in English. Although not selected by ethnicity, the resulting sample was Caucasian with diverse European backgrounds represented. Each year of data collection, the Functional Assessment Scale was used to stage dementia (Auer & Reisberg, 1997). Active interviews (Holstein & Gubrium, 1995) were conducted on a yearly basis with the dyad and individually with the PWD and their CP. Active interviews allow for an interactional process, recognizing that all knowledge is co-constructed (Holstein & Gubrium, 1995). Toward the end of the 6 years of data collection, some PWD were no longer able to participate in interviews as communication challenges increased. Individual interviews were done typically 2 to 3 weeks after the dyad interview, and an individual interview with PWD was always attempted if they were able to express their experiences. For PWD, discussing the last meal in the LTC residence and what they enjoyed or did not like helped to elicit comments. For the most part, the same interviewers conducted yearly interviews and knew the participants well; interviews were conversational in nature with issues identified by participants followed up by the interviewers to provide a rich description of mealtimes. As the study progressed, the conversation was directed to fill out categories in the substantive theory (the Life Nourishment Theory) being developed in the primary study. Data were transcribed verbatim and analyzed by the individual interviewer and by the team using constant comparative analysis and other analytical techniques consistent with interpretivist grounded theory methodology (Charmaz, 2006).

Secondary Analysis as Method

Secondary analysis was selected as the method for the current study. The rationale for this was that the new questions for the current study emerged as a direct result of analysis from the primary study. The researchers of the primary study noted that many of the study participants who had transitioned into facility-based care made comments about the difference in the mealtime experience with residential living. These comments were rich and interesting, but were not the focus of the primary study. The goal of this secondary analysis was to subject the transcripts of those primary study participants who had commented about their transition into LTC to thematic content analysis (Baylor, Burns, Eadie, Britton, & Yorkston, 2011; Peacock, Hopton, Featherstone, & Edwards, 2012). This secondary analysis provided an opportunity to better understand a newly emergent component of the phenomenon of mealtime experiences in the dementia context (Liebel, Powers, Friedman, & Watson, 2011). Furthermore, we felt it important to acknowledge the full contributions of these study participants by extending the use of their primary data without further intruding on their lives (Stajduhar, Funk, & Outcalt, 2013).

Selection of Families for Secondary Analysis

The families included in the secondary analysis were purposefully selected (Holen & Ahrenkiel, 2011; LeCuyer, Christensen, Kearney, & Kitzman, 2011). Eligible families for inclusion in this secondary analysis had to have experienced a move into a LTC home (retirement or nursing home) during the first 5 years of data collection and had to have participated for a minimum of 4 consecutive years. Eleven dyads met these inclusion criteria. Due to the magnitude and depth of data collection (more than 150 transcripts for these eligible dyads) analysis was limited to 7 families purposefully selected to represent diverse transition experiences and family relationships. Based on consultation with the original interviewers/investigators, dyads were chosen that provided the richest description from both members of the dyad. Table 1 illustrates characteristics of these families. Participants provided written consent if able on a yearly basis. If written consent was not possible, the PWD provided verbal consent and the family CP provided written consent. This consent included provision for further secondary analyses pertinent to the topic of mealtimes. Ethical clearance for this study was obtained from the University of Guelph, the University of Waterloo, McMaster University, and Ryerson University.

Analysis

The paradigm used for this secondary analysis was that of social constructivism, which holds the belief that there are many interpretations possible that can help us understand reality (Daly, 2007). The authors acknowledge that

Table 1. Characteristics of Relocated Dyads (*n* = 7) Included in Secondary Data Analysis.

Dyad number	CP's relationship to PWD and age	Gender and age of PWD	Year relocated	Type of placement (nursing home/ retirement home)	Number of interviews prior to relocation	Number of interviews post relocation	Breakdown of interviews (# by: PWD, CP, Dyad)
8	Niece 39 years	Female 57 years	Five	Nursing home	Twelve	Three	PWD-five CP-five DYAD-five
10	Spouse 84 years	Female 84 years	Two	Nursing home	Three	Eight	PWD-four CP-six DYAD-one
11	Ex-spouse 64 years	Male 67 years	Three	Retirement home	Six	Five	PWD-four CP-four DYAD-three
12	Spouse 66 years	Male 73 years	Four	Nursing home	Nine	One	PWD-three CP-four DYAD-three
19	Spouse 88 years	Female 86 years	Four	Nursing home	Nine	One	PWD-three CP-four DYAD-three
21	Spouse 87 years	Female 85 years	Two and five	Retirement then nursing home	Three	Eight	PWD-four CP-three DYAD-four
23	Daughter 47 years	Female 80 years	Two	Retirement home	Three	Twelve	PWD-five CP-five DYAD-five

Note. CP = care partner; PWD = persons with dementia.

the findings of this study are based on the interaction between the researcher who originally conducted the interviews and the participants, as well as the interpretation of the interviews by the researcher who analyzed them. Transition frameworks specific to the transition process from community to LTC homes informed this analysis (Davies & Nolan, 2006; Heliker & Scholler-Jaquish, 2006; Reuss et al., 2005; Wilson, 1997) as did concepts and literature on the meaning of place (Buttimer, 1980; Chaudhury, 2008; Gustafson, 2001), place attachment (Cookman, 1996; Mitty & Flores, 2009; Wiersma, 2008), and the meaning of relocation (Aminzadeh et al., 2009; Davies & Nolan, 2004).

All transcripts from the first year of data collection through to the fifth year of data collection for the seven dyads were analyzed using the thematic analysis steps of Braun and Clark (2006). A total of 83 transcripts ranging in length from 30 min to 1 hr were hand coded by one researcher. Key sections of the interviews that addressed the transition and mealtime experience in the LTC home were selected for the most detailed analysis and involved extensive line-by-line coding. The research questions (described above) guided this analysis. Thematic analysis was used to identify, synthesize, and report patterns and themes within the data (Braun & Clark, 2006; Luborsky, 1994), and was well suited for analyzing semi-structured, open-ended interviews (Burnard, 1991). Two techniques were specifically used to develop themes: (a) the constant comparison of segments of text across interviews and dyads (Charmaz, 2006) and (b) the identification of themes through coding, grouping, and recoding of the data (Braun & Clark, 2006). As themes were being developed, drafts of concepts (memos, diagrams) were reviewed and discussed with the second author, resulting in further analysis. Once themes were refined and labeled, and key quotes were chosen, the themes were discussed among the authors, who were also the primary study investigators. This resulted in further insights and clarification, due to re-emergence in the data and further analysis.

Results

Relocating to a LTC home posed some challenges for PWD and their primary family CP. Themes relate not only to the experience of mealtimes in the new setting but also to the strategies families used to adjust to these changes and include Systemizing the Meal, Adjusting to Dining With Others, Holding on to “Home,” Evolving Roles, and Becoming “at Home” (see Table 2). Most often, dyads initially focused on the experience of mealtimes in the new setting, followed by how they attempted to adapt or adjust to the new mealtime experience, and finally the outcome of adapting to the new mealtime setting, and for some, becoming “at home.”

Systemizing the Meal

Participants saw meals in the LTC home to be highly organized, typically in ways that were foreign to them; they were much different than the more relaxed and relationship-focused mealtime experience participants were accustomed to at home. From their perspective, the focus of mealtimes in the LTC setting was on the progression of the meal or “system” and less on the individual residents involved in the experience. Specifically, interactions with staff members were described as being more focused on the task at hand rather than on interacting on a personal level with residents, as there were a series of activities that often needed to be carefully timed to ensure a smooth process. Participants stated that they left mealtimes well fed but without the social interaction and staff attention that could have enhanced this experience for them.

Table 2. Supporting Quotes for Themes.

Themes	Supporting quotes
Systemizing the meal	Interviewer (I): . . . if the food is presented to him, does anyone say something like, "Here's chicken noodle soup. Can you smell it? It will be nice and warm. Why don't you take a bite and tell me if it tastes good." So, people don't say these kinds of things to him? Care partner (CP12): —No— I: —it's not like . . . CP12: encouragement. I: No encouragement, no instructions, no cueing. CP12: They don't have time. They don't take time. Maybe they have it. I don't know, but they don't take it. PWD23: We were served. We pass it to the person it is set for, and it's always the same people that you're sitting with. So there are no surprises there. It's quite routine. CP21: . . . like it or not, feeding what, about a hundred and twenty-six people in here now. Ah, the dining room, or, or the chef, is not unable to (um) possibly satisfy everybody's. I: Right, yeah. CP21: Appetites and, and tastes. And certainly not mine.
Adjusting to dining with others	PWD23: We're not nearly. We don't know nearly enough about each other here as a family would. And we wouldn't dare say the same things we'd say to family either, you know. (Chuckles) Yeah, we can be frank and honest and, and you just don't do that with . . . I: With the tablemates. PWD23: No. CP19: . . . there's some people there that are really right out of it in a bad way. In fact there is one woman there that she cries all the time and wants help and they can't do anything with her, and it's not very nice to have a meal and sit and listen to that. . . . .I: What's that like? PWD19: Not very nice. CP10: . . . nice enough people and but, I don't have the same relationship with [PWD10]— . . . Well it's like you know if you wanna talk about some situation or whatever situation that I have here and I would like to talk to her about, you just don't do it and you're always trying to do it before or after [the meal]. But that's kind of the thing.
Holding on to home	PWD11: Now when I go home to [CP11], we're still eating together, we do a lot of our conversations the same as we did it in the past, over something to eat. PWD8: What was dinner like last night? Pretty darn good with Shish kabobs I'll tell ya! I noticed when we go they try to have something that I may not have at the (nursing home) home. They're [family] very tuned to this and they try to BBQ or something different. PWD23: [chuckles] Well we still are eating together quite a bit. We still get together quite often. And it's certainly been good for me because you know, all the changes don't hit me all at once, you know. I've still got [daughter] so that makes a big difference. PWD8: Yeah it does happen once in a while. "Oh I remember when I used to make this." And then we talk about it at the table and everyone says, "Well we can't anymore so we might as well enjoy it." I: And it sounds like you probably talk with her as well like bring news from outside in, is that sort of what happens. CP10: Oh yes, oh definitely yes. If I know anything about our friends or whatever, always try to do something. Sometimes I come with a list of number of things. And I told her about the chap that passed away up the street and that really struck her pretty hard. And so yeah, I feel it's important to let her know what, you know her friends and that sort of thing.

(continued)

Table 2. (continued)

Themes	Supporting quotes
Evolving mealtime roles	I: Why is food an important part of celebration? PWD23: Isn't it for everybody? I: Why is it for you? PWD23: Because it's creative I think, and I love food and I love working with food, and I always have. I: Do you miss that when you're here? PWD23: I do yes. I do miss that. It just kind of—Suddenly I'm faced with that and I think ah I can't do that here. PWD11: Well, at this point in time it's a relief to have someone doing all the things like that. CP21: I buy the makings, I make the wine, I bottle it, I serve it. It's my entity in here and they all know me, he's the wine man. One of those silly things, yah.
Becoming home	CP10: It's home now for a change more than before, and they look after her quite well and she knows the staff, and they're always very kind to her and joke with her and so on. So, you know, it's quite a nice atmosphere. CP23: I felt very sad when she left her home and moved to [facility name], because I never . . . I mean when she moved in I thought this will never feel like my home or like my mom's home, but it does now you know. It's smaller (her room) but we do feel, I do feel like this is her space. CP8: . . . just like when she went to the hospital, they [fellow residents] were concerned. They asked. I went back in and got some stuff and, "How is she? Are things ok? Is she coming back?" They were concerned. PWD8: Genuinely concerned too. CP8: Yeah like they do bond. They do make that family kind of family atmosphere. PWD11: Well, this is where eating together helps a lot, because by doing that, we can share without being troubled with the dementia. When we're talking, none of us seems to indicate, oh, we're a little goofy, you know.

Note. I = Interviewer; PWD = person with dementia; CP = care partner; BBQ = barbeque.

Part of the meal being seen as a system was the perceived over-adherence to rules and procedures that ensured that mealtimes ran smoothly. Some of these were formal rules such as giving 24-hr notice for family to attend meals, signing out when accompanying family to meals in restaurants or at home, or designated seating at mealtimes. Other rules were less formal such as what chair was to be used and where guests were to be seated in the dining room. The need for some degree of structure related to mealtimes was often understood; however, the perception of a fixation on the rules influenced the feeling of being welcomed and comfortable, or not. PWD also felt that the rules and procedures affected their ability to make decisions around mealtimes and this in turn affected their mealtime experience, as there was limited spontaneity and flexibility. For example,

> It's astounding in this place, if there are 90 people in here I bet 70 of them enter the dining room at one minute after 5:00. Now I can't eat dinner that early, I never could, we used to eat at 6:30 at night and so on, always have done, but now we go down at about quarter to 6, and um, but it's astounding how dinner has become the clock in this place. Breakfast, everybody is down at 8:00, everybody's down at 12 for lunch, and everybody's down at 5 o'clock for dinner. I can't be that way; I've got to go down at 8:30 for breakfast. (CP21)

Mealtimes were generally characterized as being at set times, with a predetermined menu and a designated place for residents to sit. Consequently, participants described dining in LTC to not live up to their expectations. Furthermore, participants who were accustomed to home-cooked meals indicated that the quality of food being served in the LTC home often did not compare (e.g., temperature, appearance, flavors, and variety).

Adjusting to Dining With Others

Participants described needing to adjust to dining with their new companions at mealtimes, at their table and in the dining room. Dining with others encompassed the social interactions among residents and family members. However, eating with relative strangers required adjusting to individual personalities, behaviors, and conduct, which affected the individual mealtime experience.

Dining halls tended to be large, noisy, public spaces not affording the privacy and intimacy of dining at home. Participants described extended family preferring to not eat in these spaces, as this required interacting with tablemates and others in the dining room. Eating with others was described as a big adjustment, especially when participants were not able to choose with whom they sat. Some tablemates not only had different interests and personalities but were also of different cognitive abilities. Participants discussed how they found it difficult to make conversation with their tablemates and that they often ran out of things to talk about. As a result, social interactions among residents were sometimes described as unnatural and forced. Distracting behaviors of other residents also required adjusting to, for example,

> Well we had this one person at the table, who is inclined to be touchy. She'll, I haven't seen her do it, but I have heard that she is liable to snatch from other peoples plates you know that sort of thing. Some of their table manners are kind of careless. And they don't realize it; you know they are handling food in a strange way and that sort of thing. (PWD23)

For others, table manners, which changed with declining cognitive ability, eyesight, or dexterity, were described as something to adjust to when eating with others. Adapting to eating with relative strangers, especially if mealtime manners were lacking, often lead to unpleasantness at mealtimes that reduced the overall enjoyment of the meal. Despite these differences from home, some participants also described positive mealtime interactions:

> And I think that's what I was missing living alone, having the company for supper. (PWD8)

> You build camaraderie over supper, the kibitzing, the joking, the talking, the moaning the groaning, the hatching over of what's going on or who's doing what. You grew up on that family atmosphere. I grew up on that family atmosphere. That's what you do. That's supper. (CP8)

> And that's probably part of why I enjoy the food so much, is that I'm not eating by myself now. (PWD8, nursing home)

Having the opportunity to dine with others allowed for the fostering of new connections and social interactions. For some, it was the key time for new relationships to be formed, with participants being and giving recognition and appreciation. Some participants described how their tablemates would look out for each other, and this helped them feel accepted.

Holding on to Home

Participants described taking actions and using strategies to retain some of the experiences around food and mealtimes that were common prior to relocating to a LTC home. These were undertaken to foster continued connections with family as well as to help with adjustment to the LTC home. For example, one participant described what it is like to leave the facility for a meal with their care partner:

PWD11: For me it [leaving the facility] is. For me it definitely is [important]. When [CP 11] and I go out, we—"Let's go to Tim Horton's for whatever, or let's go to Timothy's." We always do that. It's so much fun to be able to do that."

I: And what would you talk about when you go out to have a coffee?

PWD11: Oh, gosh, it can be almost just about anything.

Dyads also described retaining routines and traditions around food that were established prior to relocating into a LTC home. For some, this meant continuing to eat out, some attended clubs and activities that involved sharing food, while others enjoyed cooking at family member's homes. Families also described creating new traditions such as relocating family gatherings to the facility. Furthermore, participants described actively holding on to memories of home post relocation. Specifically, they reminisced, retained objects and experiences associated with home, were interested in being informed about community news, and strove to retain past relationships. Remembering home was a way that newly relocated participants could hold on to the feelings associated with home with mealtimes providing opportunities for this reminiscence with family, tablemates, and staff.

Evolving Mealtime Roles

Participants, whether the PWD or CP, described developing new mealtime roles that better suited their latest eating environment and mealtime routines. This meant that some roles were relinquished while others were renegotiated. Some roles were lost to the experience of relocation and the changing abilities to complete these roles. For some, the roles of cooking and nurturing others through food were meaningful losses, while for others, it was a welcome change to no longer be responsible for these activities. In other cases, roles were renegotiated. In the following quote, a participant describes how she managed to retain her role of hostess after relocating to a LTC home:

PWD23: Yes, yes she does but she lets me pay for it too, if we go out together.

I: Why is that important to you [PWD23]?

PWD23: Oh I like to pay my way and I know that they have a lot more [expenses] . . . I just have fixed expenses mostly. You know my expenses are pretty. So it's kind of nice to have something to spend, somebody to spend money on . . . To be the hostess.

I: Yah, rather than providing a meal in your own home, you are providing a meal . . .

PWD23: Yes this is the alternative for that.

Important previous mealtime roles were altered so that they were not lost all together but were simply redefined. For example, participants took advantage of hosting family at the facility, taking part in cooking activities in recreation programs, and being the "host" at the table.

Becoming "at Home"

Some participants described beginning to feel "at home" in the LTC setting. For some, this feeling occurred soon after relocation, but for others, it never fully happened, and they did not describe the LTC facility as their home in our interviews. Becoming at home could be a lengthy process, as participants described needing to create new ties and beginning to accept the LTC home as their own; adjusting to new mealtime routines and making new connections at mealtime helped with this transition. Data suggested that becoming "at home" was a fluid and dynamic concept for dyads that was constantly negotiated; depending on the day, their current experience and perspective they could consider the LTC facility as their home. Feeling a sense of belonging in a community, most notably at mealtimes, helped to feel that one was "at home," and this concept applied to PWD and CP. Connections were made with the physical space itself, residents, and staff. Part of becoming at home was rationalizing the move and accepting their new circumstances. For example,

> But as far as living at home vs. [facility name], yeah I'm glad to be there and have the regular meds because I was forgetting my meds to have them on time, and I wasn't eating anywhere near what I should've been. (PWD8)

This rationalization process involved reflecting back on their situation prior to relocating, which allowed residents to see the benefits of living in a LTC home. Some participants started to use the word "home" when describing the LTC facility, emphasizing their acceptance of this new place as their home.

Discussion

This study is the first of its kind to examine how PWD and their CP describe how mealtimes change after relocating to a LTC home. It helps us understand the significance these families attribute to mealtimes and how families learned to cope with the mealtime changes after relocation. The results of the current study, in conjunction with literature in this area, highlight the need for improvements to the mealtime experience in LTC homes. Although this study did reveal that many families in the sample adjusted to some of the mealtime changes in the new environment, too often, the mealtime experience did not live up to the expectations of family caregivers and PWD. This evidence confirms that there is a need to begin to "blur the boundaries" (Evans, Crogan, & Shultz, 2003, p. 14) between mealtimes in LTC settings and mealtimes at home by making mealtimes in the facility more homelike.

A shift in focus away from an institutional model of care that impedes individuality and choice (Davies, Byers, Nay, & Koch, 2009) toward a more person-centered, relational, or family model of care (Kitwood, 1997; Reimer & Keller, 2009; Voelkl, Battisto, Carson, & McGuire, 2004) is needed. Person-centered care recognizes residents as individuals who have different histories, preferences, customs, expectations, and needs at mealtimes (Reimer & Keller, 2009). The Family Model of Care provides direction for nursing homes that wish to create a more homelike environment that helps to foster family-like bonds among residents, staff, and family members (Voelkl et al., 2004) and the Patient and Family Centred Geriatric Care framework provides principles of dignity, open communication and sharing unbiased information, focusing on strengths to support participation, and collaboration (Institute for Patient- and Family-Centred Care, n.d.). These models and principles are consistent with approaches being taken as part of the culture change movement in the United States and Canada (Dupuis, McAiney, Ray, Go, & the Partnerships in Dementia Care Alliance, 2011; Fagan, 2003). They highlight the need to focus on the individuals experiencing the meal environment in LTC homes and not the task at hand; meaning that mealtimes need to be less systemized and more flexible. It is confusing for residents when LTC homes call themselves "home" and include some home routines but then, force residents and their families to conform to institutional practices through their daily routines, policies, and procedures (Weber, 2000; Whyte, 2013).

Recent evidence suggests that mealtime practices consistent with culture change (e.g., offering choice) continue to be problematic, even when a LTC home has undergone transformation to person-centered models of care (Simmons et al., 2013). Thus, there is a need for theory and explicit strategies (discussed below) to promote change in the mealtime culture of LTC. The Life Nourishment Theory emerged from the analysis of the primary study (Keller et al., 2012) on which this secondary analysis is based. This substantive theory provides further detail on how social connectedness and identity can be supported, especially in the evolving lives of PWD. Based on the findings of this secondary analysis, staff members in LTC homes need to evaluate which procedures can be modified or changed to make the mealtime experience in LTC closer to that of home. This will require some shifts in policy and best practice expectations. By acknowledging the unique needs and desires of residents at mealtimes and allowing for more flexibility, individualization of the mealtime experience can be promoted.

It is anticipated that making changes to the current mealtime situation in LTC homes as part of a social model transformation could improve the quality of life of those who reside there and enhance relationships between staff, residents, and family members. Further research focused on mealtime processes, quality of life, and social interaction among staff and residents is needed to support this contention; recent work in the development of measures for social interaction at mealtime can assist with such research (Keller, Laurie, McLeod, & Ridgeway, 2013). This thematic analysis provides the voices of residents and their family members to this area of research, supporting these theories and extending them specifically to mealtime strategies identified by families. A practical guide (By Us For Us [BUFU]) written for families and persons living with dementia based on the ET study also provides strategies to support mealtimes (BUFU/Murray Alzheimer Research and Education Program [MAREP], 2012).

Limitations

Secondary data analysis of qualitative work has some limitations; however, the research team included steps to overcome these challenges (Thorne, 1994). Although the primary author was not involved in the original data collection, she had access to reflection notes from the original researchers, who are coauthors of this work. These data were not originally collected for the purpose of looking at mealtime changes specific to relocating to facility-based care; however, research questions were sufficiently close to the purpose of the original research (Thorne, 1994). Although the methodology of analysis was not the same as the original study, thematic analysis, which is primarily descriptive with minimal interpretation, is consistent with a grounded theory analysis, and data were sufficiently rich to saturate themes.

To maximize the amount of data, eligible dyads needed to have been in the study for a minimum of 4 years and were selected for the rich accounts of their experience. There is the potential that the four relocated families not included in this analysis were not adapting as well or the person with dementia had a faster progression. Yet, it is anticipated that the experience of those who were included, although potentially more resilient, still reflects the experience of others in our sample. For the primary study, retention of 18 of 27 dyads after 3 years demonstrates that much of the sample was resilient. In addition, recruitment for the primary study occurred in Southwestern Ontario, excluding Toronto. Thus, the sample and subsequent subsample were Caucasian of European or Canadian descent, likely influencing their experience of mealtimes and translocation to LTC. A final challenge that was encountered during analysis was that over time, some of the PWD were sufficiently far along in their journey with dementia and their perspectives were not fully represented.

Future Research

Forthcoming research should consider using a grounded theory methodology to elucidate the process by which families and PWD adapt to the new mealtime experiences after a move to a LTC home. Inclusion criteria should comprise PWD who are still able to share their experiences and data collection methods should include observation as well as interviews. Families seeking retirement and supportive living services as well as nursing home care should be included to further explore differences in the mealtime experience across different LTC settings. Families should also be recruited shortly after relocating to LTC so that PWD are still able to reflect on their mealtime experience prior to the move. It would also be helpful to obtain the staff members' perspective on the challenges newly admitted residents face and also to receive feedback on how they feel mealtimes can be improved and the roles they might play in enhancing mealtimes. Finally, future research should also examine the impact of relocation to LTC on mealtimes in different cultural groups. Some cultures have strong mealtime traditions and unique customs and practices that may be especially disrupted when relocating to a LTC home that may not cater to their cultural traditions.

Implications

The results of this study are pertinent to families living with dementia, researchers, and health professionals who work with older adults who have relocated to a LTC home. The study highlights some of the initial challenges and discontinuity that newly relocated residents and their family members experience after moving to a residence and how this affects their mealtime experience. Several strategies at the family, staff, and policy level have been identified.

Newly relocated residents (PWD)

- Retain meaningful relationships and food-related experiences associated with home (e.g., assist with food preparation while at home).

- Become involved in the LTC community, specific to mealtimes (e.g., join the resident food committee).
- Recognize that mealtimes are not only about food but also about social activity and support from fellow residents. Identify residents you would like to share meals with and request them as tablemates.

Families

- Provide staff with a history of rituals, habits, activities, and specific foods that make mealtimes meaningful for the PWD.
- Participate in eating activities at the LTC home with the resident.
- Cultivate a sense of belonging in the LTC home for themselves and the PWD (e.g., make friends with relative's tablemates; participate in special food-related events at the facility).
- Identify ways where mealtime experiences associated with home can be retained (e.g., return home for celebratory or traditional meals; move family traditions to the home).

Staff and LTC management

- Admission assessment should include a fulsome collection of history around food preferences and the social rituals and activities that make mealtimes meaningful.
- Focus on the experience of mealtimes for residents rather than on the task (e.g., consider how to make the experience enjoyable for each resident; cater to resident likes, dislikes, and food-related practices; promote flexibility in dining around seating arrangement, timing, choice of food, and need for assistance to promote the individual experience).
- Seat residents with tablemates with whom they are comfortable and can socially interact.
- Identify ways in which family members can be included at mealtimes and encourage them to participate in mealtimes (e.g., make them feel welcome at mealtimes).
- Critically reflect and consider where current routines, rules, and other organizational structures can be made flexible to promote personalization of mealtimes.
- Work with residents and family members to enhance the dining environment (e.g., identify meaningful personal touches in the dining room decorations, consider family style dining).

Health care policy and standards

- Create smaller and more intimate dining rooms.
- Have kitchenettes available for residents and family to cook for their own enjoyment or as a contribution to life in the home.
- Allow flexibility in regulations for including residents in meal preparation; having refrigerators in resident rooms to allow consumption of food outside of meals; offer flexible timing for meals and food-related routines to allow for personalization of the experience.
- Critically reflect on and change LTC regulations and policies that limit the ability of staff in providing person-centered and relational care at mealtimes (e.g., allowing staff and residents to share meals together).

Education policy

- Include person-centered care frameworks and strategies; focus on considering the uniqueness of each resident with respect to how food is offered and meals are conducted.
- Encourage students to value and encourage family input in the care of their residents, especially with respect to getting to know the resident's past mealtime routines and preferences.
- Teach students to value mealtimes as a chance to make a difference in the lives of their residents and as a social opportunity in which to get to know their residents better.

Conclusion

This research is significant in that it advances our knowledge of the LTC home mealtime experience for family CPs and PWD. This study highlights the discontinuity that participants experience at mealtimes after relocating and discusses strategies that families use to adapt to these changes. It places emphasis on the continued importance of the bond between the family CP and the person with dementia, as well as the importance of forming attachments to the new setting. This was accomplished when participants formed relationships with other residents and staff and began to establish their place in the LTC community. Mealtimes were an important venue for this to take place.

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