

Geriatric Rehabilitation Patients' Perceptions of Unit Dining Locations



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ABSTRACT

Background

Eating together is promoted among hospitalized seniors to improve their nutrition. This study aimed to understand geriatric patients' perceptions regarding meals in a common dining area versus at the bedside.

Methods

An exploratory qualitative study was conducted. Open-ended questions were asked of eight patients recruited from a geriatric rehabilitation unit where patients had a choice of meal location.

Results

Eating location was influenced by compliance with the perceived rules of the unit, physical and emotional well-being, and quarantine orders. Certain participants preferred eating in the common dining room where they had more assistance from hospital staff, a more attractive physical environment, and the opportunity to socialize. However, other participants preferred eating at their bedsides, feeling the quality of social interaction was poor in the dining room.

Conclusions

Participants' experiences of, and preferences for, communal dining differed. If the benefits of communal dining are to be maximized, different experiences of this practice must be considered.

Key words: acute geriatric rehabilitation, eating environment, patients' perception

INTRODUCTION

Nutrition plays a major role throughout life, and is especially important for seniors for whom malnutrition is very

common.⁽¹⁾ A large proportion of seniors are undernourished, particularly those who are admitted to hospital.⁽²⁻⁶⁾ A review of several North American studies indicated a higher prevalence of protein-energetic malnutrition in older people admitted to hospital (35% to 65%) and in residential care (25% to 60%), compared with individuals living in the community without home care support (3% to 7%) and those living at home with home-care services (5% to 12%).⁽⁷⁾

It appears that hospitalization worsens protein-energy malnutrition in older adults.^(8,9) Indeed, hospitalization may result in the deterioration of nutritional status for 46% to 100% of elderly patients.⁽⁷⁾ There are multiple risks associated with malnutrition among hospitalized seniors. Poor nutritional status can have negative effects on rehabilitation, lead to longer stay in hospital, and may even quadruple the risk of mortality.^(7,10-13) Malnutrition is largely caused by either an increase in nutritional needs or a decrease in food intake due to many factors.⁽¹⁴⁾ In addition to factors related to aging or poor health, a decrease in food intake may be associated with environmental characteristics.

The eating environment has an effect on food intake.^(15,16) A good social environment and a pleasant physical atmosphere during meals can have beneficial effects on food intake.⁽¹⁵⁾ Studies show a positive effect on food consumption due to social facilitation when people eat with family and friends.⁽¹⁷⁻²¹⁾ Good relationships between relatives create an atmosphere of comfort and relaxation, and can increase time at the table. Higher food intake has been observed among seniors who ate in a dining room regardless of whether they lived at home, in an institution or were hospitalized.^(16,22-24) Convivial atmosphere and patient interaction with staff during meals may increase food intake.⁽²⁵⁾

Such findings regarding increases in food intake, and reasoning about other potential benefits of communal dining, have led providers to favour communal dining for hospitalized seniors, where possible.⁽²⁶⁾ However, there is a lack of information regarding patients' experiences of eating location in hospital, particularly communal versus bedside meals. For example, we do not know whether some patients enjoy and benefit from communal meals more than others.

On a geriatric rehabilitation unit located in Ottawa (Ontario, Canada) all patients take breakfast in their rooms, but are encouraged to dine communally at lunch and dinner. Each room contains two beds, two television sets, two telephones, and two windows; one window offers a view onto the corridor and the other window provides a view of the walls of surrounding buildings. The dining room is 20 meters long and 7 meters wide, has two banks of windows: one providing a city view and the other a scenic view of the Parliament Buildings. The walls are decorated with pictures of the Parliament Buildings, a cathedral, and a war monument. There is seating for 24 people at tables of 4 persons each. The room also includes a refrigerator, a microwave, a coffee maker, and a toaster, as well as a piano, a television set, a DVD player, books, and a dart board.

This care setting provided an interesting and appropriate environment to investigate patient perceptions regarding dining location. The goal of this study was to explore geriatric patients' perceptions regarding eating at bedside versus in the common dining room. The research questions were: What factors influence dining location when patients are given a choice? What are the perceived benefits and disadvantages of each location?

METHODS

Participants

Participants in this exploratory qualitative study were adults, aged 65 years or older, admitted to a geriatric rehabilitation unit in Ottawa. Inclusion criteria included the ability to speak French or English, and to provide own consent to participate in the study. This research proposal was reviewed by the Research Ethics Boards of the hospital and the University of Ottawa (project # M16-11-012).

The geriatric rehabilitation unit contains 60 beds. However, it was impossible to know if all beds were occupied during the research because the Research Ethics Boards did not allow access to this information. Data regarding participants' diagnoses could not be accessed. However, the unit typically provides care for frail seniors recovering from lower extremity fractures, other orthopaedic problems, and general deconditioning related to a range of medical diagnoses.

Occupational therapists on the unit approached potential participants who met the inclusion criteria. We had planned to recruit three categories of participants according to their usual eating location for lunch and supper: those who eat only at their bedsides, those who eat only in the common dining room, and those who dine in either location. However, we found that all potential participants approached had experienced both locations and this was, in fact, the experience of most patients treated on the unit. Eight participants in total were approached, agreed to be contacted by the first author, and provided their contact information to her with

their consent. Among the participants were five women and three men. Eight was seen as an adequate number to begin to understand this experience.⁽²⁷⁾

Data Collection

Semi-structured individual interviews were conducted by the first author. Based on the literature review, an interview guide with open-ended questions was constructed to explore the perception of participants on their dining location at the unit. This guide was reviewed by two occupational therapy students and some modifications were applied (Appendix 1). Interviews took the form of conversation and covered determinants of eating location choice, benefits, and disadvantages of each eating location, and participants' eating location preference. These topics were organized in a logical sequence to facilitate the interview.

All interviews took place on the hospital unit in a location of the participant's preference (the participant's room, common dining room or occupational therapy kitchen), and lasted about an hour. All interviews were audiotaped and transcribed verbatim.

Data Analysis

For each transcript, meaning units regarding participants' experiences related to the goal of this study were identified. Then, meaning units that addressed the two research questions were selected and condensed according to similarities and differences. The condensed meaning units were placed in a matrix to compare positive and negative experiences by patient, as well as perceived benefits of group dining for recovery.

Validation criteria for qualitative research were applied to attain methodological rigor, as described by Cresswell.⁽²⁸⁾ Actions included preserving the authenticity of the participants' speech, bracketing of the researcher's experiences, and peer checking (transcripts were coded by the first author, reviewed by the two others authors, and revised by consensus).

RESULTS

Results are classified into three main areas related to the research questions: i) determinants of a dining location, ii) benefits and disadvantages of each dining location, and iii) participants' preference related to each location.

Determinants of a Dining Location

As a general rule, breakfast is served in the patient's room. Factors influencing an eating location for lunch and dinner are presented in Table 1.

Most participants (6 out of 8) reported limited perceived control in choosing the location of their meal. These participants reported that, on admission, nurses informed them that breakfast is served in the room, lunch and dinner in the

TABLE 1.
Factors influencing a dining location

<i>Research Question 1</i>	<i>What factors influence a dining location?</i>
Participants' perceptions	a. Compliance with the perceived rules of the unit b. Physical and emotional state c. Quarantine orders

common dining room, and that this rule must be respected as soon as possible by each patient. Yet, some participants felt free to choose to eat in their rooms if, on anyone day, they felt tired or emotionally low.

Participants reported that their mood influenced their eating location. If they felt sad, they did not want to socialize and preferred to eat alone in their room. One participant said: "The few times, I stayed in my room it's because I'm tired and I do not want to see anyone on those days." However, another participant added: "When I feel happy, I like to go there (dining room)." It seems that emotional state plays an important role in the selection of eating location.

In addition to emotional state, physical abilities also played a major role in determining eating location choice. Pain and fatigue were particularly important. "If I do not feel good I eat here ... Because I have problem with my leg. I have a problem (pain) with my back."

One participant stated that he preferred the common dining room, but was forced to eat in his room because his condition required quarantine. The participant found this experience difficult, and hoped to recover as quickly as possible in order to enjoy eating in the dining room.

It was noted that all participants stated that, at home, they eat in the kitchen or dining room. None reported eating in their bedroom at home.

Benefits and Disadvantages of Each Eating Location

All participants, except one, identified at least one benefit or disadvantage of each eating location. These benefits could be classified as benefits to the patient and benefits to the unit (Table 2).

Participants appreciated being served in their rooms because it allowed them to avoid waiting to be served in the common dining room. They also reported that they could take more time to eat in their rooms. Also, eating in the room offered the opportunity to engage in other activities after eating, saving personal time. One participant explained, "In the room, when you finish, you look around and you see the work that you should probably still do, whether it's the mail, whether it's a book, whether it's a job" [author's translation from French].

While some participants found benefits to eating in their rooms, others mentioned disadvantages. Participants

TABLE 2.
Benefits and disadvantages of each location

	Benefits	Better personal time management
<i>Bedroom</i>	Disadvantages	Loneliness "Boring" experience Limited food choices and assistance from service staff
<i>Dining Room</i>	Benefits for the participant	Promote movement Attractive physical environment Socialization
	Benefits to the unit	Facilitate service staff
	Disadvantage	Poor social interaction

reported feelings such as loneliness and boredom: "When I am here (the room), I'm more alone." As noted above, one participant who was forced to eat in his room due to quarantine found this experience extremely boring. He did not have the opportunity to socialize with others as he could in the common dining room.

The meals of the participants eating in their rooms were limited to the food on their trays. In the dining room, there was access to additional food items. One participant shared her experience. "In the dining room, if you need extra butter or anything, they're right there to get it. Like in your room, you're here and nobody looks in to see if you're, you know. They have not got time to see that you want butter, you want this or that." It was noted that none of the participants has reported better appetite, or increased food consumption in the communal dining room.

Eating in the common dining room provided additional benefits, according to the participants. One participant mentioned that walking to the common dining room was an activity he found highly beneficial to physical and psychological well-being. He preferred eating in the dining room because it gave him an opportunity to practise his walking.

Participants also found that the common dining room offered a more attractive physical environment; it is spacious and is arranged in a way that is similar to a usual dining room. In addition, participants enjoyed a particularly scenic view from the windows of the dining room, compared to limited view from the windows of their rooms. "You can look out the window and see something above the roofs of downtown. While in my room, I look at the stone walls of three buildings." This aspect contributed to the enjoyment of their meals.

The opportunity to meet and talk to other people was another one of the benefits of eating in the common dining room mentioned by most participants. Eating in that room

allowed being with other people and sharing a pleasant activity. As one participant stated: "The benefit I see is for me to be with people.... Get out of my room." For some participants, being with others prevented loneliness and offered an opportunity to speak to others. Two participants spoke of a special relationship with another patient. "There's one that adopted me there. He still comes to sit down with me ... It is almost always at the same table. We are used to be together and it is fine." Pleasant relationships are built during these experiences. "I made a nice friend in the dining room and it's better to eat out than to eat in your room." These participants believed that the common dining room offered a better social environment than their rooms. However, the social aspect of the dining room was not viewed positively by all participants.

One participant declared that he ate in the dining room just to facilitate the work of the unit staff: "It's much less trouble just to go to the dining room, sit down, and get a tray in front of you and eat and then leave. Better than [the staff] lugging it over to my room. I don't want them to do that."

While for most participants the common room was the ultimate place to socialize, others considered this environment not so pleasant. For example, one participant considered his table companions too reserved or shy. They did not engage in conversation and hardly answered questions. This behaviour did not facilitate communication and created an atmosphere of tension. "It's hard to make conversation with people who answer but are pretty unfriendly" [author's translation from French]. This participant seemed willing to socialize, but was distressed when his attempts to speak to others were rebuffed. Another participant seemed indifferent to other diners. "I do not mind who sits beside me or across from me. I just look at my food and eat it and finish."

Dining Location Preference

As stated previously, most participants felt they did not really have a choice of dining location for lunch and dinner. However, the interviewer did ask what their preferred eating location was when this option was permitted. Two participants, for distinct reasons, confirmed that they preferred to eat in their rooms. One complained about his tablemates' unfriendly behaviour, while the other felt forced to speak with his tablemates against his will.

Two other participants had no preference in regard to eating location. Half of the participants expressed their preference for the common dining room. This location seems to allow more assistance from unit staff and opportunities for socialization. For most, this possibility of socialization was seen as potentially beneficial. Notably, for one participant, such benefit was experienced only when she felt up to socializing.

DISCUSSION

Hospitalized older adults are at high risk for malnutrition.⁽²⁻⁹⁾ Communal dining for elderly patients has been recommended

on the basis of observations that it is associated with increased food intake⁽²⁶⁾ and speculation that higher intake seen during meals with family and friends may also be observed in the social setting of a communal dining room.⁽¹⁷⁻²²⁾ The goal of this study was to uncover patients' perceptions of the benefits and limitations of communal dining in a setting where patients could choose to eat privately in their own rooms or in the communal dining room.

Interestingly, not all patients perceived that they had a choice of dining location. It is difficult to say why this was so, as we did not interview the staff. However, it is possible that during their orientation to the unit, each patient was strongly encouraged by the staff to take their meals in the communal dining room. However, if on a day during their stay a patient was perceived by staff to be feeling low, physically or emotionally, that patient may have been reminded of the possibility of choosing to dine in his or her own room. Indeed, the patients who stated that they used both locations related that their choice rested on their physical and mental state. When they did not feel up to dining communally, they appreciated the choice of eating in their own rooms. Conversely, one patient who was forced to eat in his room due to quarantine seemed to be particularly disappointed not to be able to partake in the social atmosphere of the dining room. Again, choice appears to be an important consideration in ensuring that potential benefits of communal dining are realized.

Our findings add to the discourse on communal dining by providing preliminary evidence of the wisdom of the unit policy of allowing choice of dining location. This is consistent with the idea that perceived choice is a critical factor in supporting autonomy,⁽²⁹⁾ and that ensuring choice is an important way to support autonomy and well-being in geriatric care.⁽³⁰⁾

As well, our participants shared additional positive aspects of communal dining. In addition to a potentially pleasant social atmosphere, participants shared that dining together provided the opportunity to forge relationships. They also noted that they could more easily access additional food items and receive help from staff, as needed. This may be an important aspect of the nutritional value of communal dining that has not yet been explored. It may be that patients take in more calories when dining communally because of greater availability of condiments that make their food more personally appealing, or the possibility of obtaining additional items if they are still hungry or thirsty (such as an extra bread roll or beverage). The presence of staff, both to ensure that such items are available and to provide any requested assistance, may therefore be an important element in ensuring communal dining results in greater food intake.

While the benefits of communal dining are generally described in terms of benefits to patients, participants perceived eating in the communal room as helpful to the unit staff. Participants did not see this as negative, but rather welcomed the opportunity to reciprocate by making the life of the staff a bit easier. It might be useful for staff to present communal dining to patients as an opportunity not only to improve their

own health (as was noted, through extra walking practice), but also to contribute to the work of the staff.

While many of the potential benefits of communal dining have been noted in previous research,^(16,22-24) potential disadvantages have not been discussed. Some of the participants in this study did have negative experiences of communal dining. One participant noted that he did not find communal dining efficient—he had many activities that he wished to complete (reading, corresponding) and he had more time for these if his food was delivered to his room. It was noted that this participant spoke of current and past intellectual pursuits in a reserved and measured manner that contrasted quite a bit with the more gregarious nature of most of the other participants. While his words could certainly be taken at face value, they may also have been concealing his discomfort with socializing with other patients. Another participant who had lived alone for 10 years stated that he was quite indifferent to eating alone or with others. The opportunity to socialize was not universally seen as something positive.

Interestingly, our findings included that, while socialization was an important potential benefit of communal dining, it was not always possible. Some participants reported that they felt particularly uncomfortable sitting beside other patients who did not respond to their efforts to engage in a conversation. Staff awareness of potential patient discomfort in such situations and active involvement in coordinating seating may be helpful.

There were a number of limitations to this study. First, due to ethical issues, we did not have access to participants' clinical records. We are, therefore, unable to provide a detailed description of participant characteristics that could help readers to transfer results to other contexts and make decisions about transferability. Second, while eight participants may be an adequate sample size to understand experiences within a group,⁽²⁷⁾ we do not feel that saturation was completely reached. In spite of the redundancy of certain information, new elements emerged gradually as we conducted the interviews. Also, given the short stay of the participants in rehabilitation, we were not able to validate the results with them. However, despite these limitations, we were able to shed light on a number of issues regarding communal dining that have not been previously discussed.

CONCLUSION

Previous studies have shown nutritional benefits among elderly patients eating in a communal dining room, but have not taken into account their perceptions of this experience. Our results reflect that patients perceive potential advantages of communal dining. These include providing the opportunity to socialize and potentially develop relationships with other patients, and the opportunity to get further exercise from the walk to the dining room. In addition, there is greater access to additional condiments and food and access to help, if needed. However,

the possibility of taking a meal alone in the one's hospital room was welcomed on days that patients did not feel physically or emotionally up to group dining. Clearly, eating with other people in a common dining room does not always offer a good social environment that could facilitate food consumption. A good atmosphere in the common dining room depends on the personalities of patients, lifestyles, and the characteristics of other patients on the unit. If communal dining is to be experienced positively, staff may need to accommodate seat partner preferences, including the option to dine alone. Further research should explore the impact of such interventions.

Key messages

- Patients identified benefits of communal dining including opportunities to socialize and practise walking, availability of additional food items and staff assistance, and a chance to help the staff
- Patients appreciated having the choice of dining communally or alone, particularly if they did not feel physically or emotionally up to dining with others
- Intervention by staff may be required to ensure a positive social atmosphere

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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APPENDICES

Appendix 1. Individual Interview Guide

Introduction

1. What is your favourite meal?
2. Please tell me about where you usually eat at home. With who and where do you eat?
Who prepares your meals? What kind of foods do you usually eat? Why?
3. Are you always satisfied with your meals? Why?
4. What does influence your meal choices?
5. Did you know that while you are on this unit you have the opportunity to eat in your room or in the communal dining room? How did you hear about this choice?
6. Where do you normally eat your meal? Why?
7. What do you like best about eating in the dining room/your room? Least?
8. Do you see any benefits to eat in the dining room/your room? Do you see any disadvantages?
9. Do you intend continuing to eat where you eat now? Why?
10. Is there anything that you would like to add?

Thank you for your participation!