

Chapter 1 Executive Summary



Problem Statement

“Therapeutic kitchens,” also referred to as “country kitchens,” “domestic kitchens,” or “activity-based kitchens,” have been cited in the literature as supportive environmental spaces for residents with dementia. In the long-term care industry, nursing homes and assisted living facilities are increasingly incorporating some sort of kitchen for resident, staff, and family use through remodeling efforts or new construction. Despite the popularity of therapeutic kitchens, few researchers or designers have clearly articulated what the components of a therapeutic kitchen actually are. There is also little, if any, empirical evidence to support the efficacy and utilization of such spaces. Consequently, “therapeutic” kitchens are often comprised of various arrangements and equipment and are used in a variety of ways to support the daily program for residents. The purpose of this research is to identify physical features that are typically included in therapeutic kitchen design and to explore how these features support daily use for residents and staff in relation to food service systems and activities programming.

Research Method

The exploratory study included two phases of data collection. In the first phase, four half-day site visits were conducted in the northern Ohio area at facilities with a therapeutic kitchen. Facilities were selected with kitchens that varied in terms of design, activities programming, and food service systems. At each site, a physical features checklist was completed, four interviews were conducted with staff, and residents and staff were observed in the kitchen during a meal and structured activity. For the second phase, a two page questionnaire was developed using information gleaned from the site visits. The questionnaire was distributed to 631 nursing homes and assisted living facilities located in nine of the 22 largest chapters of the Alzheimer’s Association in different regions of the United States. For facilities in five of the chapters, each facility was contacted directly by telephone to determine whether a therapeutic kitchen existed. If a kitchen was present, the survey was mailed directly to a director or activities coordinator. Questionnaires were mailed to facilities in the other four chapters without ascertaining whether kitchens were present in those facilities.

Results

Several major themes were identified across the four case studies based on interviews with staff and observations. In general, baking is the main activity that takes place in the kitchens that were visited, and some (usually three or four)

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residents are involved in meal set-up and clean-up. With the exception of one site, food is typically cooked in a commercial kitchen of the facility and transported on a cart to the therapeutic kitchen. Snacks and beverages are available to residents between meals, but most residents either access these items with staff assistance or prefer staff to wait on them. Staff use the kitchen to complete their care plans but always take their breaks off the unit away from the kitchen and residents.

Overall, 116 questionnaires were returned, yielding a response rate of 18%. Thirty-one surveys were not useable because 30 participants indicated that they did not have kitchens and one indicated that the kitchen was part of a group home. The resulting sample size is 85. Due to the low sample size, the extent to which generalizations can be made are limited. Nevertheless, the data can be used to describe characteristics of the kitchens that were sampled in the study. Fifty-seven percent of the facilities surveyed are nursing homes while 43% are assisted living facilities. The majority of the sample (60%) identified themselves as non-profit as opposed to for-profit (40%) facilities. In addition, the majority (61%) of the sites are located in a suburban setting as opposed to 34% in urban locales and 15% in rural areas. On average, the kitchens were constructed or updated in 1993, although construction and remodeling dates ranged from 1942 to 1999.

With respect to design components, over half of the respondents indicated that their kitchen is part of an activities room, and the majority indicated that the configuration of their kitchen is a counter against one wall. The most common physical features included sinks, full refrigerators, ovens, cooktops, microwaves, and standard height counters. The majority of respondents described their kitchens as residential and indicated that certain features including decor, wood cabinets, and plants and flowers contribute to that image. Safety features mostly included some sort of shut-off device for the stove and locked cabinets. Respondents suggested making kitchens larger, more homelike, and more accessible to improve the designs. With respect to activities programming, a higher number of residents participate in more recreational activities such as sitting and socializing, arts and crafts, and baking while a lower number participate in household activities such as meal set-up, meal clean-up, and housekeeping. The majority of respondents indicated that all meals are prepared in the commercial kitchen of the facility, and the use of food trays for meal service is prevalent. The therapeutic kitchen was considered quite important for residents, staff, and families, but declined in importance for facilities with residents in the later stages of the disease.

Implications

Although the study was exploratory in nature without intentions of drawing definitive conclusions from causal relationships, the results have direct implications for design,

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activities programming, and food service. The findings can also serve as a foundation for future research. With respect to design, it appears that universal design features should be incorporated to a greater extent in therapeutic kitchens. Common features that should be incorporated as well include certain appliances (sinks, full refrigerators, ovens, cooktops, microwaves, dishwashers, and bread machines), windows with views to the outdoors, and counters or islands that provide sufficient space to work at or sit around and socialize. Homelike imagery is important and can be reinforced through the decor, wood cabinetry and furniture, greenery, knickknacks, countertops, and windows. Safety features related to the stove and suggestions for restricting access to potentially dangerous supplies or the kitchen in general are provided. In addition, activities that are familiar but more recreational in nature, as opposed to mundane household chores, are recommended for therapeutic kitchens. Staff education appears to be an important concern since there is some confusion regarding the definition, use, and value of therapeutic kitchens. There may also be a need for staff to examine appropriate ways to use kitchens depending on the cognitive status of the residents. Finally, cooking one or more meals in therapeutic kitchens is suggested to help make these spaces more integral to food service systems.