
Chapter 3 Research Methods



THERAPEUTIC KITCHENS IN DEMENTIA CARE SETTINGS

Therapeutic kitchens have been cited in the literature as supportive environmental spaces for residents with dementia. Kitchens, in relation to activities and food service, have also been discussed at various gerontological conferences. In addition, 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 references to therapeutic kitchens, few researchers or designers have clearly articulated or documented 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.

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. This was accomplished through a research design that combined components of both qualitative and survey approaches. More specifically, the study included two distinct phases: (a) a preliminary ethnographic component consisting of a physical features checklist, observation, and semi-structured interviews with staff at four different dementia care facilities in Ohio and (b) a two page mailed-out questionnaire that was distributed to 631 facilities in the United States. The ethnographic portion served as a foundation for the questionnaire. Both phases of research were exploratory in nature and are intended to serve as a basis for future research. A more detailed description of the two phases of research follows.

Phase 1 - Site Visits

In the first phase, four facilities in the northern Ohio area were selected with therapeutic kitchens that varied in terms of design, activities programming, and food service systems. Three were located in assisted living facilities and the fourth was part of a nursing home. A kitchen in a nursing home was identified as a fifth site, but it was decided that a sufficient amount of data had been generated after four site visits. The fifth one would have been redundant. Each site visit took approximately four and a half hours.

During each site visit, the investigator, with the permission of the director of each facility, initially walked through the therapeutic kitchen and photographed it. The investigator also completed a physical features checklist that addressed the location of the kitchen and its relationship to adjacent spaces, accessibility of the space, types of appliances, safety features, storage, work space, furnishings, lighting, finishes, decorations, and the presence or absence of windows. (Refer to Appendix A). The investigator then observed residents, staff, and visitors in the therapeutic kitchen for about 3 hours, recording activities taking place, resident and staff behavior as they used the space, and the general surroundings. Observation occurred during one meal time (typically lunch) and one scheduled activity (typically baking). Once observations had taken place, the

Half day site visits, consisting of observation, staff interviews, and the completion of a physical features checklist, were conducted at four facilities with a therapeutic kitchen in northern Ohio.

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investigator met with four staff at each facility for individual, open-ended, semi-structured interviews. Those interviewed included caregivers, activity directors, staff in dietary and housekeeping, and facility directors. Interview questions addressed the types and frequency of activities that take place in the kitchen, meal preparation and distribution, the involvement of residents in meal preparation and clean-up, resident access to snacks and beverages, staff use of the space for work-related activities and breaks, and satisfaction with the kitchen. (Refer to Appendix B). Each interview ranged in duration from ten to fifteen minutes.

Phase 2 - Mail Questionnaire

For the second phase, a two page questionnaire was developed using information gleaned from the site visits. Several questions addressed design issues including the location and configuration of the kitchen, appliances, counters, storage, imagery, and safety features. Other questions addressed the types and frequencies of activities that take place in the kitchen, food preparation and distribution, and food items that are regularly accessible to residents. In addition, participants were asked to indicate, using a five point rating scale, how important the kitchen is to staff, residents and family members. They were also asked to provide some background information about the cognitive status of the residents and the facility in general. (Refer to Appendix C). Once the questions were formulated, the questionnaire was pilot tested and revised.

Information from the sites visits was used to develop a questionnaire that was mailed to 631 nursing homes and assisted living facilities throughout the United States.

The questionnaire was distributed to a total of 631 nursing homes and assisted living facilities in the United States. A cover letter, accompanying the questionnaire, explained the purpose of the study and requested participation. A bright colored sticker was placed on the cover letter indicating that the questionnaire could be completed in less than ten minutes. Participants were instructed to return the questionnaire in a pre-addressed, postage paid envelope. (Refer to Appendix D).

The following procedure was used to identify potential participants. The investigator initially contacted nine of the 22 largest chapters of the Alzheimer's Association in the United States. The nine chapters were selected to represent different regions of the country and included: (a) Southeastern Pennsylvania, (b) Central Maryland, (c) Atlanta, (d) Minnesota Lakes, (e) St. Louis, (f) Dallas, (g) Rocky Mountain (Colorado), (h) Western and Central Washington, and (i) San Diego. Each chapter furnished contact information for nursing homes and assisted living facilities that provide dementia care.

The investigator telephoned each facility directly for five of the nine chapters (Southeastern Pennsylvania, Atlanta, Dallas, Rocky Mountain, and San Diego) to increase chances of positive return rates. The receptionist (or whomever answered the telephone) was asked the following question: Does your facility have any kind of kitchen or

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kitchenette for activities, such as baking, for residents with dementia? If the receptionist indicated that the facility did not have a kitchen, the investigator asked whether the activities room included a refrigerator, sink or microwave and whether any kind of household tasks took place there. This was to determine whether a facility did indeed have a space that was used as a kitchen (even if it was not defined as a kitchen). Nourishment centers that were part of nursing stations or kitchens that were only used for rehabilitation were not considered for the study. If the receptionist indicated that the facility did have a kitchen, the investigator asked for the name of the director or activities coordinator and stated that a short survey would be mailed to that person in the future. A total of 276 phone calls were made to facilities in the five chapters. Of those, 167 (60%) indicated that a kitchen for resident use was present in the facility. Questionnaires were distributed to the 167 facilities.

Questionnaires were mailed directly to the nursing homes and assisted living facilities of the remaining four chapters (Central Maryland, Minnesota Lakes, St. Louis, Western and Central Washington) without ascertaining whether kitchens were present in those facilities. A total of 464 questionnaires were distributed for this portion of the mailing to the attention of directors or activity coordinators.