

Chapter 4 Results: Phase 1



THERAPEUTIC KITCHENS IN DEMENTIA CARE SETTINGS

Four half-day site visits were conducted in the northern Ohio area at facilities with a therapeutic kitchen. The following chapter describes the kitchens for each site visit and documents the information that was gleaned from observations and interviews with staff. In addition, several major themes are identified across the four case studies and discussed in detail.

Site Visit A

Facility A is a nursing home with an open plan. The kitchen is centrally located on a unit that accommodates 15 residents and is within view from the resident bedrooms that surround the space. The kitchen essentially consists of a standard height counter against one wall and a standard height counter that separates the kitchen from the adjacent dining area. (See Figure 3. A portion of the counter between the kitchen and dining area projects beyond the lower cabinets but is not low enough for those in wheelchairs to comfortably use. A staff work space abuts the other end of that counter, and a notch is cut out of the center of the counter so that staff can move closer to residents in the dining area. (See Figure 4). Although the kitchen is generally accessible, it can be closed off with a half height door when staff are cleaning the area. Appliances are similar to ones typically found in a residential kitchen and include a double sink, full refrigerator, cooktop, oven, microwave, coffee maker, and toaster. Cabinets are only located below the counters. Safety features include a fire extinguisher, smoke alarm, and sprinkler system. The kitchen appears institutional in nature due to the high ceiling height, clerestory windows, pink colored, laminate counters and cabinets, and its location in a larger space. This is offset somewhat by the painted drywall, refrigerator magnets, and a decorative quilt on the wall.

Based on interviews with staff, the kitchen is primarily used for baking activities, although the adjacent dining area is used for music groups, bridge, ice cream socials, visiting with families, and newspaper reading. Food is cooked in a central kitchen, placed in steam wells, transported in a heated cart to a pantry that is located off of a service corridor behind the therapeutic kitchen, plated in the pantry, transported in a cart to the therapeutic kitchen, and served to residents in the dining area. Toast for breakfast is the only food that is made in the kitchen. Some residents help a little with meal set-up and clean-up. Residents have access to beverages and snacks in the kitchen between meals. In particular, coffee is made throughout the day. However, residents generally do not retrieve these items on their own, often because they do not know where these items are. Consequently, staff serve residents. In addition, staff often fill out care plans and other paper work in the kitchen and will talk to other staff in the space at the shift change.

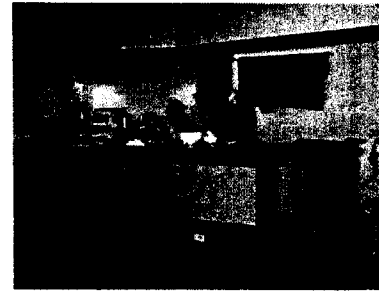


Figure 3. The therapeutic kitchen of Facility A consists of a standard height counter against one wall and a second standard height counter that separates the kitchen from the adjacent dining area.

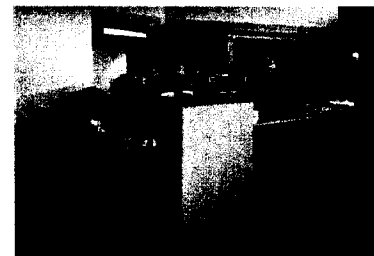


Figure 4. A staff work space abuts one end of the kitchen counter.

Site Visit B

Facility B is an assisted living special care unit for 18 residents, that is part of a larger continuing care retirement community. The kitchen is an open space, off of a circulation route, and accessible from two ends. It consists of a standard height counter and cabinetry that wrap around three sides of a pentagon-shaped space that accommodates a staff work area. An opening above the sink overlooks the staff space and is adorned with curtains to simulate a window. A second standard height counter mimics the flow of the counter against the wall and acts as an island separating the kitchen from an adjacent dining area. The second counter also includes a lower portion to accommodate those in wheelchairs. (See Figures 5 and 6). Newspapers are usually placed on that portion of the counter. Appliances include a full refrigerator, oven with cooktop, microwave, coffee maker, dishwasher, juice machine, a glass enclosed cooler for snacks, and steam wells. Dark wood cabinets and drawers are located above and below the counters. Safety features include a fire extinguisher, smoke alarm, and sprinkler system. (See Figure 7). Finishes are residential in nature. Magnets and artwork are on the refrigerator, and holiday decorations are often displayed. In addition, views to an enclosed outdoor courtyard are provided in the dining area.

According to staff who were interviewed, baking is the primary activity that takes place in the kitchen. The adjacent dining area, however, is used for cards, bingo, puzzles, manicures, and musical entertainment. Three to four residents regularly help with meal set-up. Staff will put items such as glassware, silverware, and linens out on the counter to encourage residents to set the tables. With staff supervision, some residents may also help with the meal preparation by cutting up vegetables for salads. Food is transported on carts from a central kitchen and placed in steamer wells in the unit kitchen to keep the food warm. Staff plate the food, show the two entree choices to residents, since they might not understand "chicken" or "pork," and serve the residents. The same three to four residents who assist with meal set-up will also help to clean up by bringing plates from the tables to the counter. Residents will help themselves to the juice machine and to items in the glass cooler, but generally like to be waited on. The space was described as "kind of like their own kitchen and a restaurant at the same time." Breakfast is not served at a set time; residents can have breakfast whenever they wake up.

Site Visit C

Facility C is an assisted living special care unit for 12 residents. The kitchen is located right near the entrance to the unit and is adjacent to a dining area. (See Figure 8). Staff, residents, and visitors must walk through the dining area (right near the kitchen edge) to get to the living room

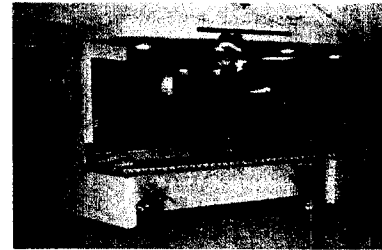


Figure 5. In Facility B, the therapeutic kitchen has an opening above the sink that overlooks a staff work space. There is also a low counter for those sitting.



Figure 6. The therapeutic kitchen is separated from the adjacent dining area by a counter with steam wells.



Figure 7. The kitchen has residential features including wood cabinets and standard home appliances.

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and resident bedrooms. Based on observations, this can be distracting at times. The kitchen is a U-shape configuration, with cabinets and standard height counters against two walls and a standard height counter that functions as an island between the kitchen and dining area. Two large windows are located above the sink, and two small openings on each side of the oven provide views into a living room. Finishes are very residential and include wood cabinetry and drawers, drywall, vinyl flooring, and other items one would find in a home such as a draining board, fruit bowl, cake plate, cookie jar, etc. Appliances include an oven with a safety switch, microwave, double sink, and toaster. Some locked cabinets, a fire extinguisher, smoke alarm, and sprinkler system are safety features. (See Figure 9).

Interviewees indicated that all meals are cooked in the therapeutic kitchen. However, fried foods or foods that require more space, such as a turkey, are cooked in the commercial kitchen. The intention is to fill the unit with aromas at meal time to stimulate the residents' appetites. Residents help with meal preparation by stirring food, requesting spices, buttering bread, and tasting soup. After the food is prepared in the therapeutic kitchen, it is plated by one staff member on the kitchen side of the island and handed across the counter to another staff member in the dining area to carry to the residents. Table setting occurs a few minutes before the meal service to deter residents from taking items on the table. Residents do not help with table setting, but three to four residents help with meal clean-up, drying dishes and wiping tables. For breakfast, items (dry cereal, muffins, rolls, breakfast bars) are set on the counter for residents to choose. Snacks and beverages are available between meals, but residents are used to being served. If no one is around, they may go into the refrigerator or cabinets to help themselves. The main activity that takes place in the kitchen is baking, although residents are constantly socializing at the counter. Three to four ladies will tidy the drawers from time to time, and one woman likes to vacuum. In addition, staff will use the area to review paperwork.

Site Visit D

At full occupancy, 17 residents can use the therapeutic kitchen in Facility D. Ten residents are currently occupying the assisted living special care unit. The kitchen is an open space, off of a circulation route, and accessible from two ends. It consists of a standard height counter and white cabinets above and below the counter against one wall. A second standard height counter with cabinets below separates the kitchen from an adjacent dining area. (See Figure 10). A living room with a television is adjacent to the dining area. Appliances in the kitchen include a full refrigerator, oven with cooktop, and microwave. There is also a soap dispenser and pencil sharpener. Safety features include a fire extinguisher, smoke alarm, sprinkler system, and automatic shut-off stove. Views to an enclosed outdoor courtyard are provided in the dining area. (See Figure 11).



Figure 8. The kitchen of Facility C is located near the unit entrance and is adjacent to the dining area.

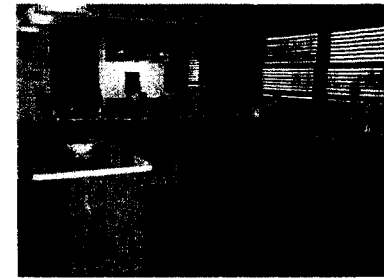


Figure 9. The kitchen has a U-shape configuration, residential finishes, and windows above the sink.

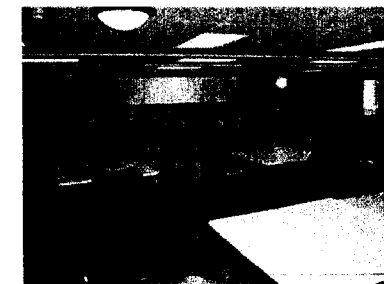


Figure 10. The kitchen of Facility D is adjacent to the dining area.

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Based on information gathered from the interviews with staff, meals are prepared in a central kitchen for each unit, transported in casserole dishes (Corning ware) on a cart to the therapeutic kitchen, plated by staff from the cart, and served to residents. The microwave in the therapeutic kitchen is used to warm food for those who eat slowly. All table supplies are brought from the central kitchen to the therapeutic kitchen approximately one half hour before each meal. Residents do not help with meal preparation or set-up but a few will help clean up. Two entrees and five alternates are offered at lunch and dinner. Theme dinners, including Hawaiian, Italian, and Oriental, are provided twice a week. Finger foods are also offered for those who have greater difficulty eating. Residents are asked to offer suggestions for meals or to share recipes once a month. Like a restaurant, residents can order breakfast. The breakfast is made in the central kitchen and brought to residents in the dining area adjacent to the therapeutic kitchen. Fruit is always on the kitchen counter for residents to help themselves, and crackers and popcorn are kept in the cabinets. Liquor is kept in a locked cabinet; one resident receives a shot of liquor before dinner. The only activity that is offered in the therapeutic kitchen is a weekly cooking class.

Major Themes

Several major themes were identified across the four case studies based on interviews with staff and observations. These themes are related to activities programming, food services systems, and staff use of the kitchen.

Activities Programming

Aside from household activities associated with meal set-up and clean-up, baking is the main activity that takes place in the therapeutic kitchen. Based on observations, baking consists of pouring ingredients (usually measured out by staff) in a bowl, mixing ingredients, frosting or decorating desserts, washing and drying dishes afterwards, and smelling and eating the baked goods. It appears that residents need specific directions to participate in the baking activity and do best with one-to-one interaction with staff. (See Figure 12). Staff often ask residents several times if they would like to help. Two to three residents usually participate, although several others may sit and watch. A few residents may walk through the kitchen periodically to assess what is going on or to receive hugs and kisses from staff. Interviewees indicated that the baking activity is offered anywhere from twice a week to twice a month.

Interviewees from all sites that were visited for this study also indicated that male-specific activities are not offered. Ethnic activities are limited to different holiday dinners or crafts (Christmas, Thanksgiving, Hanukah). Other household activities were evident at Facility C. At that facility, some residents would tidy drawers, sweep or

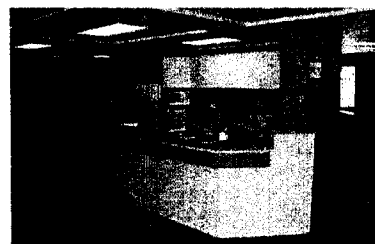


Figure 11. The kitchen consists of one counter with white cabinets and appliances against a wall and a second counter that acts as an island.



Figure 12: Residents appear to need specific directions to participate in baking activities and do best with one-to-one interaction.

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vacuum, season vegetables or add spices during meal preparation.

Food Service

Except for Facility C where meals are actually cooked in the therapeutic kitchen, interviewees at the other facilities indicated that lunch and dinner are cooked in a central kitchen, placed in either warmers, a heated cart or Corning ware on a cart, transported to the therapeutic kitchen, plated by staff, and served to residents. (See Figure 13). For breakfast, items are usually left out on the counter for residents to help themselves, with some staff guidance. Generally two to four residents will help with meal set-up a few minutes before meal time. Staff often put items out on the counter (from cabinets in the kitchen) and ask residents to help set the table. Residents will pour drinks in glasses, fold napkins, and set tables with silverware, salt and pepper. Residents help with clean-up less frequently than they do with meal set-up. For those that do help, cleaning rags are usually provided by staff, and residents will wipe tables or bring their plates to the counter in the kitchen. Observations revealed that most residents leave the kitchen or dining area as soon as they are finished eating. During meal times, residents will often signal to staff, as if they are waiters or waitresses, to request something.

Interviewees indicated that residents have access to snacks and beverages between meals. Fruit is often placed in a basket on the kitchen counter, and residents will help themselves to these items. Other snacks are kept in cabinets and cold beverages are kept in the refrigerator. Interviewees also indicated that residents like staff to wait on them, and they generally will not retrieve snacks or beverages on their own. One facility kept cold beverages and some snacks in a glass enclosed cooler, in an attempt to encourage residents to help themselves. At other times, staff will serve residents because they do not know where to find these items. Locked cabinets are used for knives and cleaning supplies.

Staff Use

Staff indicated that they will use the kitchen to complete their care plans or daily paper work, especially if the books are kept in the cabinets. (See Figure 14). Some of the paper work is filled out at tables in the adjacent dining area in these facilities since this area is open and staff can monitor residents at the same time. At shift changes, staff tend to talk to the next shift in the kitchen area. Staff do not use the kitchen as a break area. The staff who were interviewed indicated they feel compelled to take breaks off the unit, out of the view of residents, in order to ensure that their break is a break.

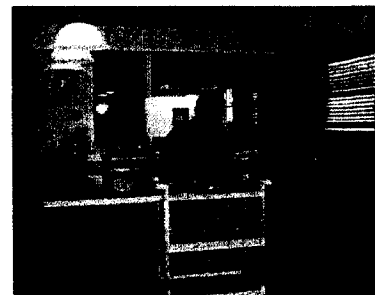


Figure 13. Most meals are cooked in central kitchens and transported on carts to therapeutic kitchens.



Figure 14. Staff often use the kitchen to complete care plans.