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Eating well in care homes: Testing the feasibility of a staff training programme aimed at improving social interaction and choice at mealtimes

Short running title:

Eating well in care homes: A training programme

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Abstract

Background: The health and wellbeing of care home residents is influenced by their experience of mealtimes, which provide an opportunity for residents to socialise and exercise control over their lives, as well as providing essential sustenance. Care home staff are pivotal to this experience, responsible for the provision of meals and eating assistance, but also for establishing a positive mealtime culture valued by residents. Despite this, mealtimes can be task-focussed, as the pressure on staff to perform multiple duties in limited time, or a lack of knowledge and awareness, mean that resident needs and preferences risk being neglected.

Methods: A staff-focussed training programme aimed at improving social interaction and resident choice was developed and delivered in a workshop. Intervention feasibility was assessed using a qualitative survey and workshop observations. A combination of descriptive and content analyses were conducted on the data.

Results: Thirteen women and one man took part in the workshops, representing multiple roles within two homes in the South West UK. The workshops were found to be deliverable and practicable. Participants responded positively to the workshops, anticipating that improvements to the mealtime experience would result from their workshop outputs.

Conclusion: This study suggests that staff training workshops based on improving the mealtime experience are feasible to deliver within the day-to-day running of a care home, and are acceptable to staff. Positive changes resulting from these workshops could improve the health and wellbeing of residents.

Keywords: Residential care, older adults, mealtimes, staff training

Summary statement of implications for practice

What does this research add to existing knowledge in gerontology?

- Previous research has found that mealtimes could be improved through increased social interaction, choice, and independence. It is also clear that the provision of care is pivotal to regulating these aspects of the mealtime.

- This study is an essential step in developing interventions that aim to enhance residents' mealtime experiences by targeting the providers of care.

What are the implications of this new knowledge for nursing care with older people?

- Whilst it is acknowledged that mealtime staff have a profound influence on residents' experience, the staff themselves are influenced by management and the infrastructure within which they operate.

- This study suggests that it is feasible to introduce a staff training programme, which is both a tool for managers, and a means by which staff are empowered to reflect on current practice and co-create strategies and techniques for improvement.

- A copy of the training guide developed during this study, which accompanies this staff training programme, is available upon request from the corresponding author.

How could the findings be used to influence policy or practice or research or education?

- This study demonstrates that it is possible to integrate training workshops, facilitated in-house by care home managers and delivered to staff, within the day-to-day running of the home. This has important

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implications for replicability and flexibility, as the training may be done in any care home setting, and at any time.

- It might be possible to carry out this training at little or no cost (though this has not been evaluated), which would be particularly pertinent for a sector which is largely under-resourced and cash-strapped.

- On a practical level, it may be an option to link this training to pre-existing staff performance reviews in individual care homes in order that it becomes part of the ongoing professional development of staff. This may have important implications for sustainability.

Background

The wellbeing of care home residents is poor in comparison to their community-dwelling peers, and is characterised by low levels of social interaction and loss of personal control(Gleibs et al., 2014, Ellis, 2010). Staff pressures, reduced resources and the ageing population all contribute to this "crisis of care" and raise urgent questions concerning how to meet the wellbeing needs of individual residents in a way that is both scalable and sustainable(Reimer, 2009, BGS, 2011). Decisions about the care of residents are commonly made based on physiological or medical needs. This deeply entrenched biomedical model has adversely affected residents' social identity, and loneliness and depression remain a persistent problem across the spectrum of residential care(Theurer et al., 2015). The need for improved psychosocial care has been widely recognised, but not adequately addressed. Residents continue to report frustration due to their lack of influence and independence(O'Dwyer, 2013, Timonen and O'Dwyer, 2009), and the paternalistic behaviour of staff(Baur and Abma, 2011).

Developing an intervention starts by assessing the needs of the target group at risk of one or a number of health problems and conducting an analysis of the possibilities to address these problems using an evidence-based approach(Leerlooijer et al., 2011). Two published studies by this research group established that mealtimes were a focal point of residents' broader experiences of living in a care home, and that these experiences were framed by their social interactions, self-efficacy, and a wider "culture of care"(Watkins et al., 2017a, Watkins et al., 2017b). This is consistent with research which shows that, for many residents, the mealtime can be the highlight of the day, providing opportunities for social interaction and developing relationships with dining

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companions as well as providers of care(Curle and Keller, 2010). Furthermore, the mealtime is recognised by some researchers as the single most accessible, manageable and effective means of delivering improved care(Keller, 2014), therefore providing a good staging post for interventions.

Building on the findings of our qualitative systematic review of mealtime experiences(Watkins et al., 2017a), a resident interview study (Watkins et al., 2017b) found that the socio-cultural context of mealtimes, that is, resident interactions, choice and independence, had a profound influence on the dining experience. The existing model of care provision may have a negative effect on mealtimes because resident choice is limited, independence is curbed, and social interaction stifled due to the paternalistic tendencies of staff, and time and/or resource pressures, that result in staff being task- rather than resident-focussed(Reimer, 2009).

Inadequate staffing levels, poorly trained mealtime assistants and insufficient time for eating have been identified as barriers to maintaining health, wellbeing and good nutritional status among residents in care homes(Crogan and Shultz, 2000, Crogan et al., 2001, Reimer, 2009), and numerous studies have called for staff training and education programmes that prioritise the provision of care at mealtimes(Pearson et al., 2003, Sidenvall, 1999, Reimer, 2009). As care homes face resource constraints, creative solutions are needed to improve the mealtime experience. Interventions that focus solely on the physical needs of residents, for example, through the use of oral liquid nutrition supplements to improve nutritional status, fail to address the complex issues associated with mealtimes. Rather than treating the symptoms of a poor mealtime experience, it is argued that interventions should adopt a holistic approach to mealtimes: One which recognises the biological, social,

psychological, moral, and spiritual needs of residents(Gastmans, 1998). Empowering staff to facilitate a change in mealtime culture by enhancing social interaction, choice and independence may result in mutual benefit for residents and staff, and may provide a cost-effective solution to financial and time pressures. Interactive workshops could provide a flexible, replicable and convenient staff training option, as workshops could be delivered in-home by a senior member of staff, as and when required. The current study tested the delivery feasibility of a new staff-focussed workshop.

Feasibility questions:

1. Is the proposed content acceptable to all stakeholders?

2. Are facilitator(s) able to deliver workshops as intended?

3. Can the workshops be delivered within the time allocated?

4. Are the workshops practicable? (e.g., are staff able to attend as planned? are they called away mid-training? can homes be run without significant disruption during workshops?)

5. Was the training received positively?

6. Do staff feel better equipped to address residents' needs as a result of the training workshops?

The intervention was aimed at a population of people who are often excluded from training programmes due to a lack of resources. Care home staff regularly express dissatisfaction at a lack of support(Reimer, 2009, Dunn and Moore, 2014), so it was anticipated that the intervention would be received positively. Moreover, as the training was based on interactive workshops, it was anticipated that staff would feel more engaged with the training.

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Methods

Ethical approval for the study was given by the University of Exeter Research Ethics Committee (Reference Number: 17/04/122). Written informed consent was given by all participants prior to the study. Each participant who gave their consent to take part in the study was assigned a unique reference number (e.g., STAFF01).

The intervention was comprised of two workshops: (1) improving social interaction, and (2) promoting resident choice. Each participating care home chose one workshop topic to evaluate. The feasibility study was intended to inform the design of a potential future cluster randomised controlled trial exploring the effectiveness of a staff training programme to improve social interaction, promote resident choice, and encourage resident independence. The Medical Research Council (MRC), a UK funding agency dedicated to improving human health by supporting research, stipulates that a "multiple-methods" approach is essential to identify potential barriers and facilitators to delivering interventions: therefore a qualitative component will be integral to the feasibility study(Craig et al., 2008). The multiple methods analysis sought to answer the question of *why* the intervention is (or is not) acceptable and feasible to deliver.

Intervention development

The intervention was based on the findings of two precedent studies (Watkins et al., 2017a; 2017b) and the expertise provided by a stakeholder group. Stakeholders including two care home managers, two senior staff, and two experts in the field with combined experience of more than 70 years were consulted on the development of a mealtime training guide. This took place through a series of informal face-to-face meetings in which the mealtime

experience was discussed, and the design, content and tone of the emerging training guide was scrutinised. Once an initial draft of the training guide had been developed, a consensus meeting was then organised with four of these stakeholders to discuss the content, make amendments, and agree a standardised protocol for the delivery of training workshops to mealtime staff. The development of the training guide as part of the wider research process is illustrated in Figure 1 below.
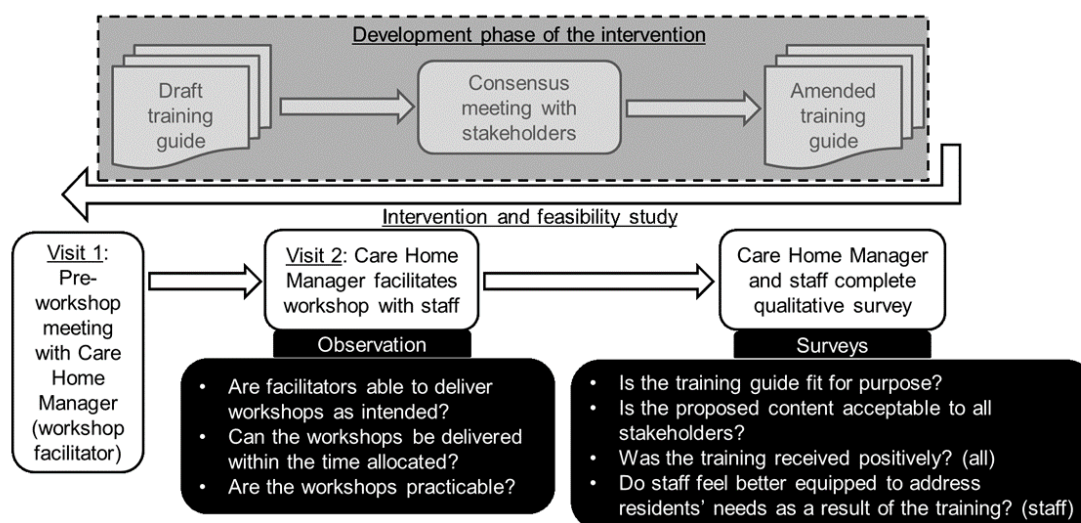
Figure 1. Design of feasibility study

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Intervention and feasibility study

The feasibility study was conducted over two visits to each participant care home. During the first visit, the lead researcher (RW) held a meeting with the Care Home Manager, who had agreed in each case to facilitate the workshop. During the first visit, the content of the training guide was discussed, along with the protocol for delivering workshops. This is shown as Visit 1 (Figure 1). Following the pre-workshop meeting (Visit 1), a single arm, multiple methods study was undertaken with two participant care homes to assess the feasibility and acceptability of the training workshops. This included a qualitative survey which was completed by the workshop facilitator (the Care Home

Manager) as well as the staff recipients, designed to evaluate their experiences of the intervention. RW observed the workshop. Data from the observations and qualitative surveys was analysed using a combination of descriptive and content analysis, an approach suitable when analysis involves triangulation of data from different sources. This approach is aligned with the methodological framework stipulated in the MRC guidance for development and evaluation of complex interventions(Craig et al., 2008).

The Care Home Managers in the two participant homes selected workshops on resident choice and social interaction: Feasibility testing of the workshop on resident independence is still needed**.** The workshops were intended to be interactive and participatory, lasting approximately one hour. Despite focussing on different aspects of the mealtime, the workshops had the same format and structure, designed to raise awareness of the mealtime experience, increase empathy for residents, and enable staff to reflect on their approach to care. The workshops were comprised of four activities (Figure 2). Activity one asked participants to consider the extent to which they agreed with a statement related to mealtime care in their home. In activity two, participants were invited to problem-solve six resident-specific scenarios. In the third activity, participants took part in role-play where one member of staff assumed the role of a resident. In the final activity, participants made some recommendations for strategies or techniques that could be adopted in their care home.

The training materials were designed to ensure that they required minimal explanation and could easily be replicated by facilitators. Instructions on how to conduct the workshops were detailed in the training guide. In each case, the Care Home Manager facilitating the workshop chose the topic to be

covered (i.e., social interaction, choice, or independence) based on which one they believed required most attention. The flexibility of being able to run a topic-specific workshop as and when required was a key feature of the intervention design. As well as providing an opportunity to reflect on current practice, the workshops were intended to encourage staff to collaborate, share ideas, and build on existing approaches to mealtime care. In this regard, it was hoped that good practice could be sustained over the long-term.
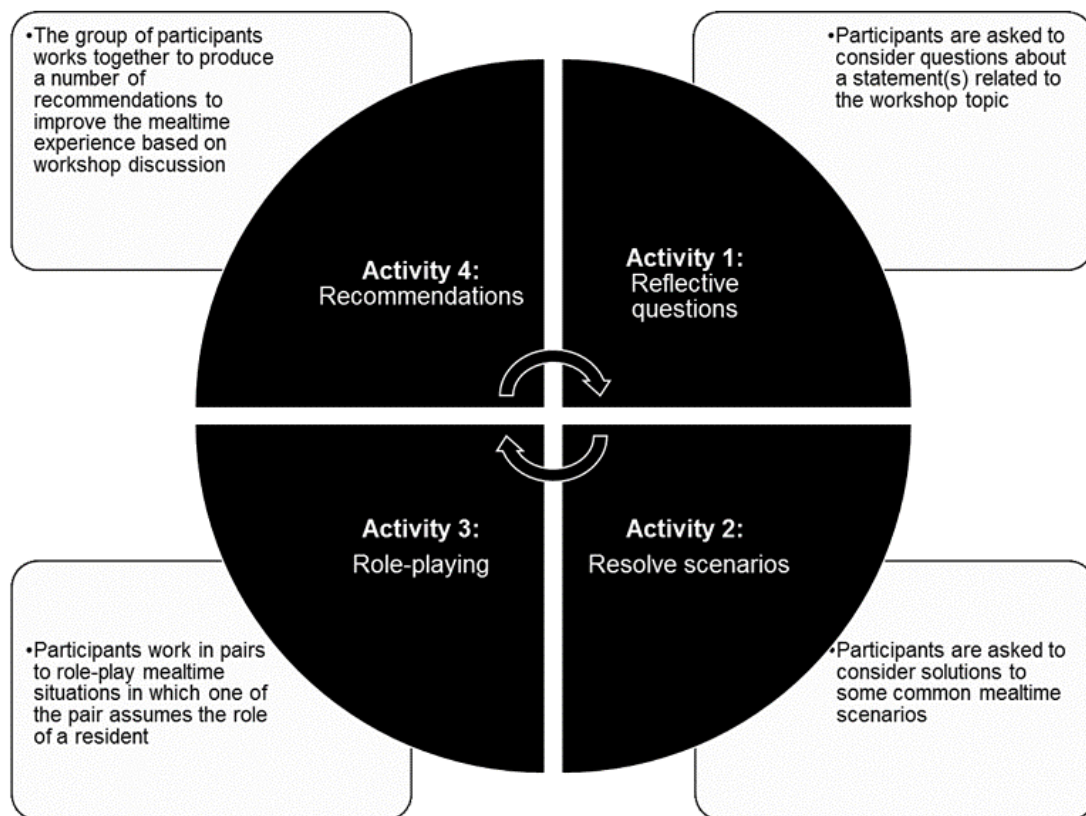
Figure 2. Workshop components

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Recruitment, setting, participants and sample size

Recruitment took place through personal and professional networks, including research networks of the UEMS and PENCLAHRC's network of contacts for patient and public involvement in research (PPI) team. Invitations to participate were emailed to care home managers and followed up with a telephone call. Consideration was given to the profile of the care homes

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included in the study to ensure that they were broadly representative of care homes in the South West UK. In the current study, the criterion was to include privately-run, mid-size care homes from both a rural and urban locale. Once a care home had registered its interest, potential participants were informed that the study consisted of a workshop followed by a participant survey to be completed immediately after the workshop. Before providing consent, participants were made aware that they could withdraw from the study at any time without needing to give a reason, and could refuse to participate in workshop activities or answer any question posed in the survey.

As a feasibility study, a formal sample size calculation was not necessary. Although there is currently no guidance as to appropriate sample sizes for feasibility studies, 12-15 participants would be considered appropriate in a pilot study(Julious, 2005), and therefore this number was used as a guide. Participants included both the workshop facilitators and the workshop recipients (staff).

Data collection

Participant data was collected using a survey, comprised of six open and ten closed questions. The feasibility of the delivery of the training (e.g., attendance, timings) was evaluated by the workshop facilitator and through observation by the lead researcher (RW). Acceptability of the intervention was rated by all participants. Descriptive data including participant characteristics (age, job role, length of service etc.) was elicited in the survey, along with questions designed to elicit participants' experiences of facilitating or receiving training as measured on a Likert-type scale (e.g., "extremely relevant" to "not relevant at all"). In addition, the survey included open questions designed to gauge participants' opinion of the workshop, how they believed the training (or

the workshop theme) might enable them to improve residents' mealtime experience, and how the workshops could be improved. These responses were intended to help guide the adaptation of the intervention for a possible future trial. This open-endedness allowed the participants to contribute as much detailed information as they wanted and express their views in their own words.

Observations

The workshops were observed by RW, but did not involve any participation. This served to help evaluate the feasibility of workshop delivery. A template for the capture of observational data was developed. Verbal informed consent was sought from the Care Home Manager prior to each observation. Observational data included factors that may have influenced the running of the workshop and notes on anything else that may have been helpful for data interpretation (e.g., Did the workshop run to time?, Did the workshop take place uninterrupted?).

Data analysis

Data from the closed questions was analysed descriptively. Familiarisation of the data from the open questions was undertaken first and was followed by a process of open coding(Elo and Kyngäs, 2008). From this open coding, themes were collated and core categories identified. Data from the observation sheets were analysed and integrated into a categorisation matrix.

Results

Fourteen staff members, thirteen women and one man, were recruited from two care homes in the South West UK. Table 1 below details workshop recipient responses to the closed questions. One participant from each of the two care homes performed the role of workshop facilitator, conducting respective workshops on resident choice and social interaction at mealtimes.

	Q1: Job role	Q2: Gender	Q3: Nationality	Q4: Length of service	Q5: Workshop attended	Q6: Enjoyed the workshop?	Q7: Able to reflect on residents' experiences?	Q8: Able to express thoughts / contribute ideas to workshop?	Q9: How relevant was the workshop to addressing needs of residents?	Q12: Likelihood of adapting approach to mealtimes as a result of the training?
STAFF1	Chef	Male	British	Fewer than 5 years	Choice	Yes	Yes	Yes	Extremely relevant	Extremely likely
STAFF2	Activities Co-ordinator	Female	British	10-15 years	Choice	Yes	Yes	Yes	Extremely relevant	Extremely likely
STAFF4	Senior Carer	Female	British	5-10 years	Choice	Yes	Yes	Yes	Very relevant	Extremely likely
STAFF5	Senior Carer	Female	British	10-15 years	Choice	Yes	Yes	Yes	Very relevant	Very likely
STAFF6	CH Manager	Female	British	Over 20 years	Choice	Yes	Yes	Yes	Extremely relevant	Extremely likely
STAFF7	Nursing Assistant	Female	British	5-10 years	Social interaction	Somewhat	Yes	Somewhat	Very relevant	Very likely
STAFF8	Nursing Assistant	Female	British	15-20 years	Social interaction	Yes	Yes	Yes	Very relevant	Very likely
STAFF9	Nursing Assistant	Female	British	Fewer than 5 years	Social interaction	Yes	Yes	Yes	Very relevant	Very likely
STAFF10	Mealtime Assistant	Female	British	5-10 years	Social interaction	Yes	Yes	Yes	Very relevant	Very likely
STAFF11	Nursing Assistant	Female	British	Fewer than 5 years	Social interaction	Yes	Yes	Yes	Very relevant	Very likely
STAFF12	Nursing Assistant	Female	British	5-10 years	Social interaction	Yes	Yes	Yes	Very relevant	Very likely
STAFF14	Mealtime Assistant	Female	British	5-10 years	Social interaction	Yes	Yes	Yes	Very relevant	Extremely likely

Table 1. Workshop recipient responses to closed questions in survey

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Facilitator responses to the closed questions are detailed in Table 2. Participants represented a diverse range of staff roles including senior carers, nursing assistants, mealtime assistants, an activities co-ordinator and a chef. Further recruitment was not undertaken as participant responses were unanimously supportive of intervention feasibility. Thirteen out of the fourteen participants reported enjoying the workshop, with one participant describing the workshop as "somewhat enjoyable". All participants agreed that the workshops enabled them to reflect on residents' experiences, and thirteen out of the fourteen felt able to express their thoughts or contribute their ideas to the workshop. All recipients of the training described the workshops as either "extremely relevant" or "very relevant" to addressing the needs of their residents, and both workshop facilitators found the training materials "extremely useful". In addition, all participants reported that they were "extremely likely" or "very likely" to adapt their approach to mealtimes as a result of the workshops, and both facilitators thought that it was "very likely" that mealtime practices would change as a result of the training.

Participants offered a variety of suggestions for how the workshop could be improved (Figure 3). Three participants suggest that more time be allocated for the workshop, and there were two references to the inclusion of more dementia-specific content and examples of mealtime practice in other homes. Resident involvement, a follow-up session, and a preview of the training guide were also suggested.

The workshop facilitators offered similar suggestions for improvement. One facilitator suggested that more time was allocated to the workshops in order that consensus could be reached on recommendations, and the othe

	Q1: Job role	Q2: Gender	Q3: Nationality	Q4: Length of service	Q5: Workshop attended	Q6: Enjoyed facilitating the workshop?	Q7: Participants able to reflect on residents' experiences?	Q8: Participants able to express thoughts / contribute ideas to workshop?	Q9: How useful were the training materials?	Q11: How likely do you think that mealtime practices will change as a result of the training?
STAFF3	CH Manager	Female	British	10-15 years	Choice	Yes	Yes	Yes	Extremely useful	Very likely
STAFF13	CH Manager	Female	British	Over 20 years	Social interaction	Yes	Yes	Yes	Extremely useful	Very likely

**Table 2.** Workshop facilitator responses to closed questions in survey
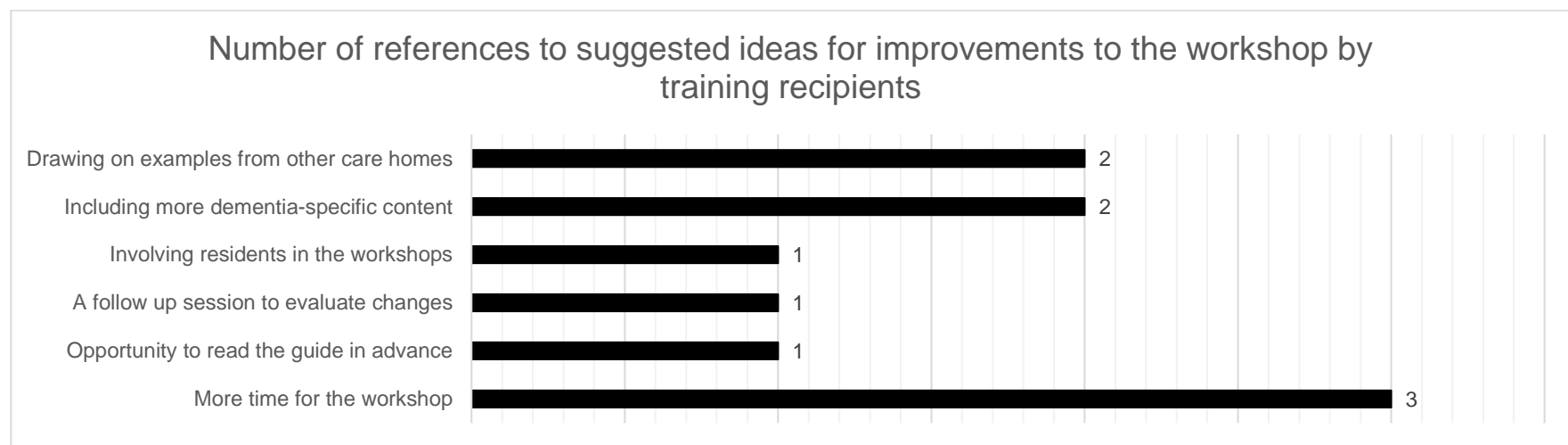
Figure 3. Participant responses to question 13 of recipient survey

suggested that participants reviewed the training guide in advance so that they came to the workshop with initial thoughts or ideas.

Participant responses to the remaining open questions in the survey were analysed using a deductive approach to content analysis, where data were coded and used to develop a categorisation matrix (Figure 4). Data was pooled from all participants (i.e., both workshops). In addition to the workshop themes of choice and social interaction, participants alluded to the importance of creating a pleasant dining atmosphere, recognising that this could impact the social aspect of meals, as well as the overall mealtime experience.

Participants acknowledged that choice gave residents a sense of control. However, pressures on staff meant that mealtimes could become task-focussed and this could adversely impact choice, reducing staff capacity to accommodate individual needs and preferences. For example, one participant referred to serving residents appropriate portion sizes and offering them seconds, rather than adopting a "one size fits all" approach to plating meals. Dementia was also highlighted as a major barrier to choice, as residents with severe cognitive impairment lose their ability to make choices such as what to eat, or who to eat with. Choice was described by participants as "reactionary" for residents with dementia (i.e., made in the moment). They reasoned that strategies are needed to address this, such as enabling residents to make menu choices at the last minute or serving them at the table:

> *"Sometimes residents with dementia find it hard to make choices because they can't recall what the food is or they just say they'll have the last thing that you offer them because they can't remember the other options. And sometimes they see what other residents are having and want that, so it's important to show them what they can have."* (STAFF2)
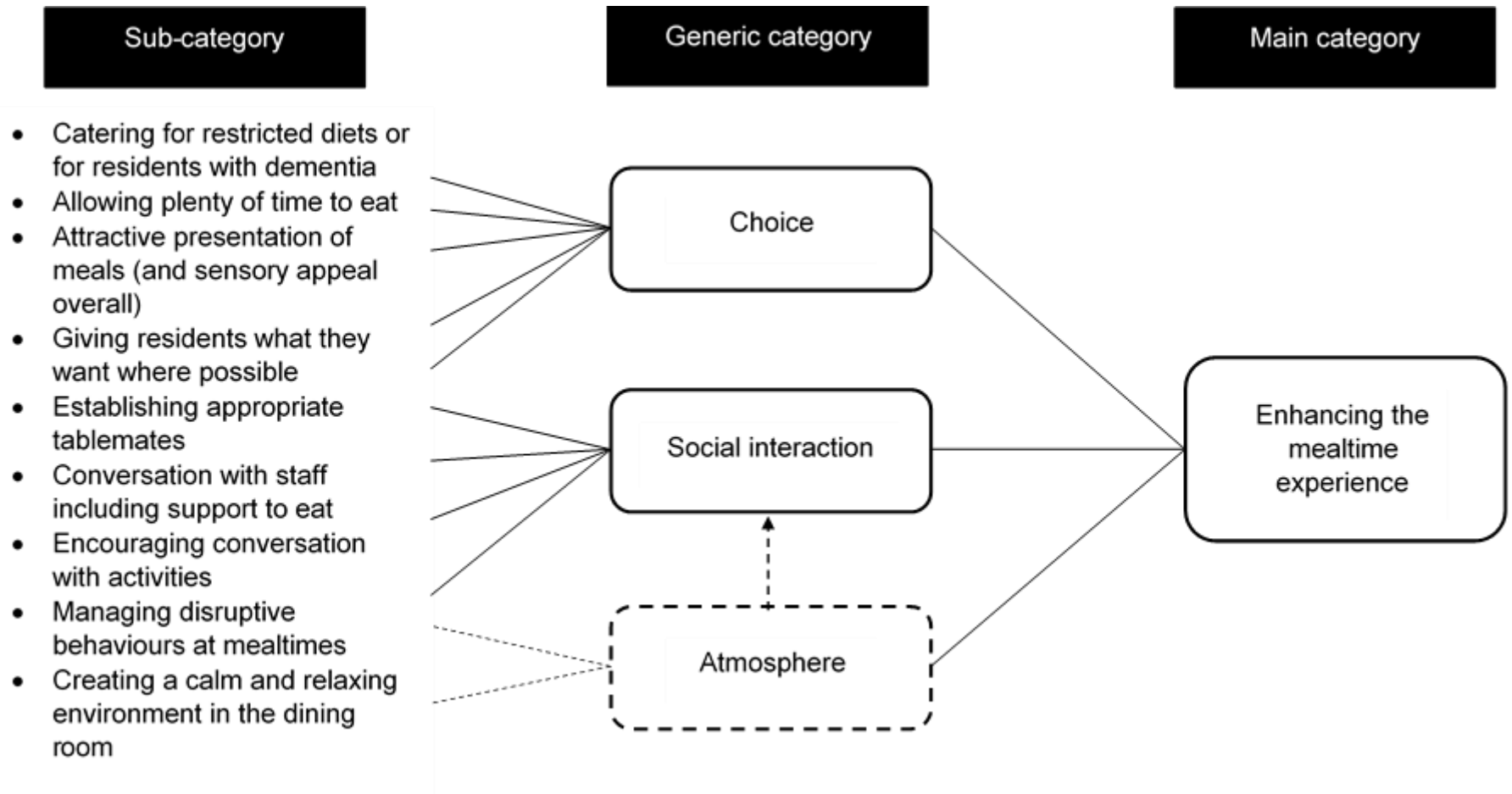
Figure 4. Categorisation matrix of participant responses to open questions in survey

Some participants advocated the ongoing involvement of relatives to ensure that residents' needs and preferences were being met, though it was acknowledged that the needs and preferences of cognitively impaired residents were constantly changing and that a flexible approach was required to offering choice. In addition, providing choice was regarded as integral to managing residents' transition to care:

"You could find out more about people's preferences before they arrive in the care home to make sure we make them feel as at home as possible and that the move is not too much of a shock for them." (STAFF5)

Participants also touched on the socio-cultural significance of mealtimes, recognising that they offer more than simply an opportunity to eat and drink. For example, some participants referred to ways in which residents could be involved in meal preparation, as this may have been a pivotal part of their day-to-day activity prior to moving into care. Thus, mealtime choice was seen to extend beyond menu options to having the choice to be involved in an array of meal-related activities.

"We discussed how we could get residents more involved in meal preparation, anything from peeling carrots to laying tables, so they feel more involved in mealtimes." (STAFF6)

The workshop on social interaction prompted discussion around seating allocation and the implications this had for both choice and social interaction. Participants alluded to the need to strike a balance between enabling residents to seat themselves freely, placing residents with similar personality traits together, and managing seating according to residents' needs. One of the challenges highlighted by participants was reconciling the tendency amongst

some residents with dementia to sit anywhere at mealtimes with the preference of many residents to have the same seat at each meal. As well as managing the competing interests of residents, seat allocation was recognised as a means to manage disruptive behaviours, and improve the atmosphere in the dining room. Moreover, seating was regarded as an important catalyst for companionship, especially when residents first arrived at the care home:

> *"It helps to think about where to sit people and how this could help them to make friends with residents and feel more at home, especially when they first come into care."* (STAFF9)

In addition to seating allocation, participants acknowledged that staff played a pivotal role in facilitating social interaction during mealtimes. As well as interacting directly with residents, it was suggested that staff could initiate topics of conversation at mealtimes or put on themed meals designed to generate conversation and / or enable residents to reminisce.

> *"We thought about how to get staff to talk more to residents during mealtimes, getting them to start conversations or thinking about interesting things to talk about over meals (e.g., their past history, important days to celebrate in the year etc.)."* (STAFF8)

Increasing social interaction was also seen as associated with an improved atmosphere in the dining room, and both a pleasant dining atmosphere and social interaction were thought to improve residents' appetites. In referring to the atmosphere in the dining room, the workshop facilitator wrote: *"It promotes overall wellbeing and encourages social interaction, which has a positive impact on appetite, nutrition and hydration."* (STAFF13)

Workshop observations

Six participants took part in the workshop on choice and eight participants attended the workshop on social interaction, including the two workshop facilitators. Both workshops started on time and were completed within an hour, with approximately fifteen minutes allocated to each of the four activities. However, additional time was required at the end of each workshop to agree action points and allocate responsibilities (i.e., changes to mealtime practice – new strategies, techniques, ideas to implement – agreed by participants following the workshop). Staff showed a willingness to contribute their thoughts and ideas from the outset, and the facilitators were able to generate lively discussion. Familiarity amongst staff members and with the facilitator (i.e., the Care Home Manager) may have put participants at ease and able to offer their opinions freely. Staff did not appear to have any difficulty in understanding the instructions given by the facilitators and were largely enthusiastic in giving their responses. Facilitators adopted a similar style in eliciting responses from staff participants, ensuring that everyone had an opportunity to feedback following each activity. Where appropriate, facilitators also referred to the training guide for additional ideas and discussion points. At one stage during the workshop on social interaction, a resident expressed his irritation at the noise generated by the group. The situation was resolved by closing the door to the training room and by staff lowering their voices, but it served as a reminder that measures should be taken to avoid disruption to residents.

Discussion

This study demonstrates that it is feasible to deliver a package of mealtime workshops to care home staff that are facilitated and conducted in-house. Moreover, the workshops in this study were found to be practicable –

deliverable within an hour, during staff working hours, and with minimal disruption to the delivery of care. Workshop content was also found to be acceptable to participants, with participants reporting the workshop to be enjoyable, interactive and relevant to addressing resident needs. The ease with which the facilitators were able to communicate activities, elicit ideas and generate discussion may have been due to their relationship with staff, who clearly felt comfortable contributing in the group. Participants also reported that they were highly likely to adapt their approach to mealtimes as a result of undertaking a training package which enabled them to reflect, discuss, and collectively develop some recommendations to improve aspects of the mealtime experience. For their part, the workshop facilitators described the training materials as "extremely useful" and were optimistic that the workshops could result in positive changes to mealtime practices.

The current study findings build on those from other studies which have similarly encouraged self-reflection on mealtime practices. For example, a study by Bonnel based on an education programme for mealtime staff, aimed to increase empathy for residents(Bonnel, 1995). Sensory experiences (e.g., activities using taste and sound) and action-oriented experiences (using specific resident situations to illustrate key points) were used to help staff imagine what it is like to be a resident at mealtimes(Bonnel, 1995). Similarly, more recent innovations such as the Virtual Dementia Tour(Beville, 2002), which is designed to simulate the effects of dementia and used for training purposes, can raise awareness amongst staff of some of the difficulties facing residents and enable them to reflect on their approach to caring for them. A reflective approach to care was the focus of a study by Simmons and Schnelle in which nursing staff were asked to provide weekly self-assessments on five nutritional care quality

indicators(Simmons and Schnelle, 2006). This process of self-auditing was found to improve performance across all indicators, suggesting that reflection is a valuable practice for changing behaviour.

In addition to raising awareness and offering an opportunity for reflection, a key aspect of the mealtime workshops is that they encourage collective engagement amongst participants, resulting in co-produced outputs or recommendations. This type of intervention likely imparts its effects partly because those ultimately responsible for delivering care do so on the basis of a commitment to shared values or ways of working(Ellemers et al., 2004). Moreover, this approach is intended to provide staff with a sense of empowerment, positively impacting attitudes and behaviours. Empowerment has been posited as a means of motivating staff and enabling them to find meaning in their work(Cho et al., 2006). This may be particularly pertinent in the care sector, where the work can be physically and emotionally demanding, and where staff are often poorly paid and undervalued(Bjerregaard, 2014). It follows that motivated staff are more likely to achieve work-related goals and empower others, and that this leads to greater organisational effectiveness(Kanter, 1979). Thus, in the context of this study, it might be reasoned that greater staff empowerment results in increased motivation (e.g., to enhance the mealtime experience for residents), and that ultimately, this may improve resident wellbeing.

By encouraging staff to think about how they do things and how this may impact residents, it is anticipated that this type of training may be the catalyst for a culture shift within care homes. According to Schein, culture is a set of shared and implicit assumptions held by individuals within an organisation, which determines how they perceive, think about and react to things(Schein, 2010).

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Collectively challenging the prevailing culture, "the way things are done around here", can help to reshape or refocus an organisation's values. For example, reflecting on mealtime practices may lead staff to consider promoting values such as resident agency in favour of a more paternalistic approach which currently typifies much care. As organisational culture is dynamic, regular opportunities for reflection and collaboration help to ensure that core values are maintained, and that staff old and new, feel a sense of enfranchisement.

The most important determinant of change in culture, practice, or behaviour is leadership. Leaders make choices about the organisational structure, they control resources, and they have the capacity to inspire. Moreover, good leadership is likely to result in staff behaving more co-operatively and empathetically, whilst a lack of leadership is unlikely to result in positive change(West et al., 2014). Thus, successful implementation of this intervention is dependent on the leadership in care homes (e.g., the Care Home Manager) recognising the value of improving the mealtime experience, engaging staff during workshops, and ensuring the any co-created recommendations are adequately trialled. With good leadership, it follows that staff will be motivated to honour their commitments to trialling measures aimed at positive change.

The process by which increased motivation results from trust in leaders is explained by transformational leadership theory, first posited by Burns in the 1970s(Burns, 1978). A later iteration of this theory proposed by Posner and Kouzes identifies five characteristics of successful leadership: Acting as a role model, inspiring a shared vision, facing adversity, empowering others to act, and generating enthusiasm(Posner and Kouzes, 1988). These tenets seem particularly poignant within a care home setting and integral to the efficacy of

any manager-led, staff-focussed intervention. In recent years, Haslam et al. have proposed a "new psychology of leadership" which attributes effective leadership to an ability to shape what followers actually *want* to do rather than enforcing compliance through punishment and reward(Haslam et al., 2010, Reicher et al., 2007). According to this view, effective leadership is based on collaboration with followers and on garnering constituent support, rather than invoking a top-down approach(Reicher et al., 2007). In care homes, a co-operative relationship between management and staff may be particularly important given that staff are generally low-paid and turnover is high: In this scenario, enforcing compliance through punishment and reward may be even less effective.

Limitations

The feasibility of this training programme was tested in two care homes in South West UK amenable to participating in research and with a good track record of care provision. The care homes opted to run a workshop on social interaction and choice, but the theme of resident independence still needs to be tested for feasibility. Both training facilitators and recipients broadly recognised the importance of the mealtime experience and had already adopted a number of strategies and techniques to improve choice and social interaction. It needs to be determined whether the enthusiasm for this type of training would be replicated in care homes where less emphasis is placed on the mealtime experience. Moreover, it is possible that levels of workshop productivity may be reduced in care homes where there is less awareness of the social and psychological dimensions of mealtimes, or in which a culture of paternalism is more entrenched.

Successful implementation of this intervention is dependent on a facilitator organising workshops and delivering them as intended. Thus, further research is required to understand how this intervention could be implemented and sustained outside of a research context. Further research is also necessary to determine whether mealtime recommendations (i.e., workshop outputs) are put in place, and whether these recommendations have a positive effect on the health and wellbeing of residents. This feasibility study has answered the key questions necessary to progress to the next stage of evidence generation. A pilot study followed by a definitive trail are now needed to fully evaluate the effectiveness of this intervention before it can be recommended for use.

Given the generic approach of the workshops, it should also be recognised that more work is needed to develop specific strategies and techniques aimed at improving the experience for residents with dementia. Although improved social interaction, choice and independence are valid ideals in most circumstances, dementia requires that alternative approaches are taken, such as providing residents with opportunity to make "reactionary choices", or creating safe environments which enable residents with dementia to maintain more of their independence.

Conclusions from the feasibility study

Whilst the ultimate goal of mealtime interventions is to improve resident health and wellbeing, their experience of mealtimes is entirely dependent on staff. Care home staff, in turn, are largely dependent on good leadership. Therefore, interventions are needed that target the management and processes in care homes and equip senior staff with tools to empower and motivate staff, and inspire change. This study indicates that it is feasible to run staff workshops aimed at improving the mealtime experience of residents. It is now to be

determined whether these workshops are effective at prompting behavioural

changes in staff during the mealtime routine, and whether these changes lead

to improved health and wellbeing outcomes for residents.

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