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ARTICLE

# Exploring food choice and flexibility practices among staff and residents at care homes in Denmark

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**Abstract**

With a growing number of people reaching older age, the need for care provided in long-term care institutions is increasing. Although the goal is to deliver person-centred care that includes choice and flexibility opportunities, pre-scheduled mealtimes and set menus are still used. The aim was to explore how *food choice and flexibility practices* were perceived and performed by residents and staff at three care homes in Denmark. Three food journey interviews with eight residents (aged 83–96) and three focus groups with 12 people from the care and kitchen staff were conducted. Food choice and flexibility practices were mainly performed *informally* and *selectively* by the staff, and through *personal* practices by the residents, implying that many residents were excluded from food choice and flexibility opportunities. However, food choice and flexibility practices were also *inhibited* by the staff's time pressure and unfamiliarity with choice possibilities, and by the politeness of the residents. Our findings suggest that food choice and flexibility practices must be understood and performed broadly, and include various ways of listening and responding to the residents' needs and preferences. The study highlighted the importance of incorporating the essential embodied knowledge and emotional know-how, inherent in food choice and flexibility practices, into formal and inclusive strategies concerning how to think and act in relation to the food and meal situation.

**Keywords:** care home residents; practices; care homes; food choice; flexibility; meals

## Introduction

The ageing population in Europe is growing rapidly and it is estimated that over 30 per cent of the European population will be over 65 years old in 2050 (Giacalone *et al.*, 2016). In Denmark, one in four inhabitants are older than 60 years, a ratio that has increased from one in five since 2000 (Statistics Denmark, 2019). Even though many older persons continue to live in their own homes, the number of people in need of the extra care and medical support provided by various forms of care institution is increasing due to more people reaching older age. In Denmark,

about 41,000 people, or 3.8 per cent of the population over 65 years old, are living in a care home environment (Ministry of Health, 2016). This often implies being dependent on the food and meals that are prepared, cooked, served and also decided upon by others. The times for meals are generally scheduled in advance, with breakfast, lunch and evening meal served at specific, pre-defined times. In addition, coffee and snacks may also be served at times decided upon by the institution. Harnett and Jönsson (2017) found that the 'institutional frame', which includes clear medical routines and guidelines, a social script in relation to the meals served, and clear roles for care recipients and care providers regarding who decides what and when, was still the most common way to frame mealtimes in care homes.

In recent decades, the importance of providing person-centred or individualised care for older people has been clearly stated, emphasising the essentiality of autonomy, self-determination and participation in everyday life decisions (National Board of Health and Welfare (Sweden), 2012; Rodgers *et al.*, 2012; Fine, 2013; AGE Platform Europe, 2017). Providing choice and flexibility opportunities and satisfying individual preferences (Winterburn, 2009; Wada, 2016) also entered the agenda as a response to the goals of providing non-institutional or more home-like care environments (Dorner, 2010; Milte *et al.*, 2017).

Reimer and Keller (2009) identified four central aspects related to person-centred care during mealtimes and what should be included: providing choices and preferences, supporting independence, showing respect and promoting social interaction. Participating in meal-related activities, including menu planning, has been associated with greater autonomy and control (McKinley and Adler, 2006; Wikström and Emilsson, 2014; Abbey *et al.*, 2015; Divert *et al.*, 2015) and has also been discussed in terms of helping individuals to maintain a sense of identity (Sidenvall *et al.*, 2001). In the study by Carrier *et al.* (2009), greater involvement in regular menu revisions based on the wishes of the participants seemed to increase mealtime satisfaction and the overall quality of life of the care home residents. The possibility to choose the food and to be included in the decisions made regarding food and meals has also been defined as part of a quality dining experience and a way of showing respect for the residents (Evans *et al.*, 2003). Furthermore, it has been used as a strategy to increase the desire to eat (Dorner, 2010) and to prevent malnutrition (Carrier *et al.*, 2007). Allowing more flexibility regarding mealtimes and food choice opportunities, as well as creating opportunities for involvement in planning and preparation of meals, has been shown to improve both life satisfaction and health among older residents (Mahadevan *et al.*, 2013).

However, there are also research findings suggesting that providing unlimited choice for care home residents is not necessarily the best way of delivering either person-centred care, in general, or choice and flexibility, in particular. In the study by Milte *et al.* (2017), the complexity in understanding choice and flexibility in relation to autonomy and satisfaction was highlighted, indicating that not all residents might be positive about having flexible mealtimes and that older persons, in particular, can find this a burden. This has also been acknowledged in other studies focusing on the ability to make choices in relation to matters of everyday life (Gilleard and Higgs, 1998; Meinow *et al.*, 2011). Moreover, ideas of choice and flexibility are further challenged in relation to people with cognitive and

physical impairments (National Board of Health and Welfare (Sweden), 2012). In Denmark, for example, it is estimated that approximately 60 per cent of those living in long-term care facilities have a dementia diagnosis (Commission on Quality of Life and Self-determination in Care Homes and Nursing Homes (Denmark), 2012). This highlights questions regarding who is able to make choices, how and when, as well as who is given the chance to choose. It also raises questions of how choice and flexibility in relation to food and meals should be understood, and how this is practised in everyday life in a care home environment. The specific aim of this study was, therefore, to explore how food choice and flexibility practices were perceived and performed by residents and staff in care homes in Denmark.

## Perspectives on practices – a theoretical framework

In this study, the concept of practice has been used as a theoretical and analytical framework to understand human activities in a particular context, and the relationship between what is being said and being done is to be understood in the practical acting out of something. Sociologist Andreas Reckwitz defines practice as

> a routinised type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, 'things' and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge. (Reckwitz, 2002: 249)

Practices are routinised ways of acting, thinking and saying, which should be understood as both bodily and mental activities. Earlier, Schatzki (1996: 89) presented a similar definition, stating that a practice could be seen as 'a temporally unfolding and spatially dispersed nexus of doings and sayings'. However, he also stated that practices can be understood as performances, which refers to the actual carrying out of practices, performing the doing and the saying. Based on the work by Schatzki (1996) and Reckwitz (2002), Shove *et al.* (2012) have defined materials, competence and meaning as three central elements or components of practices. Physical objects and things, but also the body itself, are included in materials and, in this sense, food and food-related objects might be seen as being part of food choice and flexibility practices. Competence, on the other hand, is seen as both the more formal knowledge, including guidelines and procedures of what should be done and how, and the embodied 'know-how', including informal norms and ideas regarding, for example, food behaviour and how to engage in the food and meal situation. Finally, meaning refers to the social and symbolic importance of a certain way of doing and saying things, and the motives and emotions related to practices, something that is often strongly related to the performance of food and meal activities.

In practice theory, the practice rather than the individual is in focus; however, this is not to be understood as the individual being a 'passive' recipient of a certain way of doing things. Instead, doing and saying are only defined as practices if the individual (the actor) provides them with meaning and structure (Schatzki, 1996). Furthermore, it is the individual who chooses which practices to take part in and

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the person who is in charge of modifying and changing them. In other words, practices will stop being practices if the individuals do not engage in them. Several practices might be interconnected, associated with but also in part dependent on each other (Schatzki, 1996; Warde, 2016). Based on this, practices can also be understood as a repertoire of a number of possible ways of acting. In this case, food choice and flexibility practices consist of several ways of acting, doing and saying in relation to providing and promoting choice and flexibility possibilities, which are, to a large extent, routinised in terms of what, when and where choice and flexibility are performed. Furthermore, these practices are embodied by and based on a certain emotional concern, implying a specific way of approaching and relating to food and meals in the care home environment, with the overall aim of providing the residents with food and meals based on individual health needs and preferences.

## Data and methods

### *The context*

The study was part of an overall project conducted in collaboration with the Copenhagen House of Food in Denmark, with the purpose of exploring methods and strategies for developing public meals for different target groups. The Copenhagen House of Food is a non-commercial foundation established by the City of Copenhagen in 2007, aiming to improve the meals served in schools and preschools, care homes and other institutional settings in Denmark. They operate as a project partner to professional kitchens, municipalities and organisations, including canteens, day care centres and care homes.

Three care homes in a suburban municipality close to Copenhagen participated in this study. All cared for older persons with various degrees of physical and/or mental impairments, including dementia. The municipality had a local political goal to work with improving choice and flexibility opportunities for residents in their care homes. The care homes were selected based on their geographical location, representing different parts of the municipality, and varied in size, ranging from 14 to 72 residents, and with two or more wards. Each care home had its own preparation kitchen that delivered the food, ready to eat, to the wards. However, decisions regarding the menu and the main cooking were made in a central kitchen in the municipality. Each ward in the care homes also had a small common kitchen and a dining area, and all the residents had their own small apartment, including a kitchenette with a small fridge. Breakfast, lunch, evening meal and snacks were served daily in the dining area for residents who had chosen in advance to receive the meal service. Lunch consisted of a pre-defined hot dish, which could be meat or fish with sauce and potatoes accompanied by either a starter, for example soup, or a small dessert. The evening meal consisted of a small hot dish, for example a small fish fillet on a piece of bread or soup and a choice of ready-prepared cold open sandwiches. In general, all meals were served in the dining area, however, the afternoon coffee/tea could be served either in the dining room or in the residents' apartments, often depending on the routines of the specific ward. At the time of the study, a new snack assortment system including different kinds of hot and cold soups, mousses, sorbets, bread and

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yoghurt had been introduced at the municipality care homes, aimed at facilitating choice and flexibility in the food and meals served.

### Choice of methods and implementation

Food journey interviews were conducted with groups of residents using an interview guide focusing on their perceptions and practices related to choices and flexibility regarding the food and meals served at the care homes. The food journey interviews were conducted using a long piece of paper on a roll, put on the table in front of the participants, and which included a timeline with pictures symbolising the different meals served. This was used to take the residents on 'a visual food journey' through the day, focusing on 'how food practices are embedded in daily routines and social relations' (O'Connell, 2013: 33). The use of food journey interviews was inspired by user-generated maps (Wheeldon and Faubert, 2009), experience maps and *brugerrejser* (Danish for user journeys) through their ability to provide visual representations of experiences. At the same time, these illustrations frame experiences and offer a creative and participatory way of stimulating engagement and interaction in relation to the topic in question (Wheeldon and Faubert, 2009), which was important in developing the food journey interview. The study also included focus group interviews with care staff from the three care homes and staff working in the local kitchens. Focus group interviews have frequently been used as a method in discussions about food and meal experiences (*see e.g.* Mahadevan *et al.*, 2013). During the focus group interviews, an interview guide was used focusing on perceptions, practices and challenges related to food choice and flexibility at different times and on different occasions.

The food journey and focus group interviews were conducted by both authors and lasted between 45 and 60 minutes. They were all held in a separate room at the care homes to reduce the risk of interruptions. The focus group interviews with the staff were audio-recorded and the food journey interviews with the residents were video-recorded in order to be able to analyse the food journey as a visual tool in the interview situation. All material was transcribed verbatim and, during the transcription phase, the material was first transcribed from Danish to Swedish, as this was the native language of the researcher, and then translated into English for publication.

### The participants

The residents were initially asked if they were interested in participating in the study by the staff at each of the care homes, since they knew which residents would be able to participate in terms of their mental and physical condition. The inclusion criteria were being physically and mentally healthy enough to participate in the food journey interviews and able to sit down and concentrate for approximately one hour. Furthermore, they should also be able to give their written and oral informed consent to participation and being video-taped. Many residents were therefore not perceived by the care staff as being able to participate in the study. Some residents who participated had minor speech difficulties, occasionally expressing themselves in an unclear and inconsistent way, however, using the

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timeline and the pictures as part of the food journey could, in part, compensate for this. A few residents who had earlier agreed to participate declined on the day of the planned interview due to feeling unwell. In the end, three food journey interviews at two of the care homes were conducted. Eight residents (five women and three men) aged between 83 and 96 years participated in groups of two or three.

In total, three focus groups with care and kitchen staff were conducted. Each focus group consisted of two or three persons from the care staff from different care homes and one person from the local kitchen staff at the care home where the focus group interview was conducted. The composition of the groups, with staff from different care homes in each focus group, aimed to create greater dynamics in the discussions and facilitate the sharing of experiences, practices and thoughts. In total, 12 persons participated, nine care staff and three local kitchen staff, all were women of different ages. The participants were selected to include those working both day and evening shifts and, when possible, those with different working experience and number of years working at the care home.

### Ethical considerations

Care home residents have been identified as a vulnerable group as many of them are living with various degrees of physical and/or cognitive impairment, including dementia (Bollig *et al.*, 2016). This also implies that special consideration has to be made regarding the information provided and the possibility of giving consent (Hall *et al.*, 2009). In this study, residents with moderate and severe cognitive disabilities, including dementia, were excluded, and those participating in the food journey interviews were all able to give oral and written consent. They received thorough information about the study and, prior to the interviews, were given the opportunity to ask questions regarding their participation. They were also informed of their right to withdraw their participation at any time. Written and oral information was also provided to the staff participating in the study and informed consent was obtained before the focus group interviews.

### Data analysis

A thematic analytical framework consisting of six main steps or phases was used to analyse the material (Braun and Clark, 2006). However, as in all qualitative research, the analytical process started in the field while taking notes and forming initial ideas about matters that could be of interest. The analytical process is seldom linear, instead it should be defined as a recursive or circular process moving back and forth between the phases as well as between the data material and the theoretical framework, constantly keeping the aim of the study in mind.

During the first phase, 'familiarisation with the data', the transcribed material was read several times to become familiar with the data and start the more active search for patterns and meanings in the material. Notes made in the margins during this phase were then used in the next phase, 'generating initial codes', where a more formal coding of the data began. In the third phase, 'searching for themes', the focus moved to the relationship between the codes and how the codes could be sorted and combined into potential themes. The themes identified were further

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elaborated on and reviewed several times as part of the fourth phase, 'reviewing the themes', in order to ensure that they fully and correctly described the material. The fifth phase, 'redefining and naming themes', involved identifying what should be included in each theme and its relevance in relation to the overall aim of the study. After this process, four main themes could be identified: informal practices, selective practices, personal practices and inhibited practices, which together captured the essence of how food choice and flexibility practices were perceived and performed by both staff and residents at the care homes, and also what challenged these practices. The final phase deals with producing the actual analysis in text. Quotations have been used in the results to illustrate the content of the themes. In the presentation of the results, the quotations are denoted to indicate whether they were made by care staff (CS), kitchen staff (KS) or residents (R) (the interviewer is labelled 'I').

## Results

The findings are based on the food journey interviews with the residents and focus groups with the care and kitchen staff at three care homes in a municipality near Copenhagen, Denmark. The four main themes identified in the analysis – informal practices, selective practices, personal practices and inhibited practices – all related to different aspects of how food choice and flexibility were perceived and performed by staff and residents, focusing on practices as routinised, embodied and emotional ways of acting and thinking in the specific care home context.

### *Informal practices*

Food choice and flexibility practices were often performed informally. Some of these practices were performed individually by the staff, while others were performed collectively by a group of care staff working on the same ward. This was typically expressed by the care staff as 'this is how we do it here', but also by the local kitchen staff as 'Just ask!', in that the care staff and the residents could just ask if they would like something else to eat or drink. Both staff and residents highlighted that many of the food choice and flexibility practices performed by the staff were person-dependent:

> It depends on who is working, and who is on the ward. There are many [staff members] who put a lot of effort into it, and there are some who don't make so much of it. You can see this when the orders are being made. (KS3)

Several informal initiatives and ideas for providing the residents with choice and flexibility opportunities were discussed by the staff during the focus group interviews. Food choice and flexibility were generally understood by both residents and staff as possibilities to choose the food to be eaten and being offered a choice of food at other times. For instance, when rice pudding was on the menu when it was not Christmas, the staff on one particular ward described how they made sticky chocolate cake for the residents instead, in order to meet the residents' desire for an alternative:

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> …our residents don't get rice pudding, they get sticky chocolate cake instead. And all our residents agree, all of them love it, even those who have eating difficulties can eat it. We have done this on purpose. Before when we got rice pudding, they looked at us and said 'that's what we eat at Christmas!' (CS2)

This care employee further explained how she used to include the residents when deciding what food to order, asking them if they had any specific requests when she made the weekly food orders every Sunday. Sometimes they mentioned a particular kind of soup as a minor dish in the evening, which the staff on the ward knew the residents really liked:

> Yes, they love it and then I order 20 portions, we have 17 residents, but I order 20 in case someone wants an extra portion, and then they don't eat the sandwiches. (CS2)

The care staff gave several examples of how personal preferences were taken into account and how choice opportunities were provided through informal practices performed by a certain person or group of staff on a specific ward. Some of these practices were mostly conducted during the weekends, *e.g.* when the care staff offered soft-boiled eggs as something extra for the residents. Those residents who were up late in the evening watching television were also offered something to eat, motivated by 'you sometimes feel that they might want something extra then'. One care employee talked about how she used to make banana or tomato sandwiches as snacks, not as part of the regular assortment provided for the residents, but as a treat for those who wanted them:

> We have some residents at our place who love banana sandwiches … sometimes when we just have plain bread with nothing on it I try to find a banana in the fridge and make banana sandwiches for them. Sometimes I also make a tomato sandwich if someone wants one. (CS3)

Another story the staff told dealt with how, on one ward, they had decided to arrange all the cheese available for making the sandwiches served in the evening on one plate so that the residents could choose for themselves how much they would like. The staff also noted that this resulted in the residents eating more. One staff member also talked about how she used to give a resident, who was unable to express herself verbally, biscuits for lunch (as she usually only wanted something to drink):

> There is one person who always says no thanks to lunch because she just wants to drink something … So what I do is ask her if she wants biscuits instead of the hot food, but sometimes it is difficult to know what biscuits she wants, and then I choose for her. But step by step I look at what she has eaten and what she has not eaten, and then I know for next time. (CS4)

As part of the informal practices, the staff 'learned' what to do by observing and through 'trial and error'. Another way of performing food choice and flexibility

practices was described by a staff member on one of the wards who, although not part of her formal schedule, routinely started her afternoon shift a little earlier to help out with the coffee trolley. However, on another ward, this had been formally implemented in order to manage the serving of afternoon coffee, and to be able to offer the residents other choice possibilities than those prepared for the day:

> Well we have a person who starts at 2 o'clock, we are two staff members who work until 3 o'clock, sometimes we are three, then it is the person who works the evening shift who starts at 2 o'clock, so from 2 until 3 o'clock it is this person's duty to go around and serve coffee. Then it is easier for them when a resident wants a cheese sandwich, then they can go and make that and then come back again. (CS5)

Whether flexible mealtimes were offered or not was, to a large extent, dependent on collective decisions made by the staff as to what was possible:

I: What about the time – is it possible to choose other times to eat?
CS5: I think it may differ from ward to ward, so if we have a resident who wants to eat later we can save the food, if not, it is usually lunch at 12 o'clock, at least on our ward…
CS4: Yes, we also eat at fixed times, but as she said, if anyone wants to eat later, we put the food aside until later. But not before [lunch], it must be later.

This could be seen as a kind of regulated or institutionalised flexibility, exemplified by the possibilities to eat later, but not earlier, on particular occasions. However, some of these informal choice and flexibility practices were also part of what could be considered to be 'forbidden practices' as the reheating of food was not formally allowed. However, if a resident had a doctor's appointment over lunch, the care staff often did so anyway. Saving food for later because a resident was not hungry at 12 o'clock when the lunch was served was, however, not considered to be an option:

> Well, yes, during the evening they can, but during the day it is difficult, because we are not allowed to save food in that way. But of course, if anyone is out of the building, then we do, but we can't save all the food for eating an hour or two later. (CS6)

### *Selective practices*

Food choice and flexibility practices were described by both residents and staff as being performed selectively, implying that these were not the same for everyone and were also dependent on the time of day and the specific meal served. Residents who often ate too little at mealtimes, or who were malnourished and in need of a higher nutritional intake, were more often asked by the care staff if they would like something else to eat and drink during the day:

> I think we focus more on those who do not eat very much when it comes to the snacks, it is probably those we focus most on, that they should have something. (CS5)

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However, asking the residents if they wanted something else or something extra to eat or drink as part of overall food choice and flexibility practices was dependent on the resident's cognitive status and whether the staff perceived it to be useful to ask:

CS6: For example, if there is someone who cannot speak or is very passive, it is very rare that you ask because it can take a long time to get an answer. And we might not have time for that.
CS1: And then there are those who probably shouldn't have that many choice opportunities.
CS6: Yes, there are also, for example, those with dementia. For people with severe dementia, it doesn't work giving them all the options because then they get totally confused. You can try with a few alternatives and see what they like the most.

The staff perceived that many of the residents, because of their cognitive status (*e.g.* dementia), were unable to make choices or even remember what they had eaten the day before. Instead, the staff stated that increased food choice opportunities, *e.g.* during lunch, could result in increased anxiety and unease among such residents:

I: What do you think it would mean for the residents if a few days in advance they could sit down and say that now I would rather have sausages instead of pork steak, so that they would actually eat different things at lunch?
KS1: Ohh no (laughs).
CS5: No, I don't think so.
I: Why not?
KS1: 'Why didn't I get that, it looks much better?'
CS5: And then there are those who cannot choose, then it is the staff who choose for them. And then they don't want that this day, and then they would rather have what the person on the other side of the table is having. I think it would be chaos.
KS1: It would result in anxiety.

Being offered a choice regarding what, when, where and with whom to eat was also perceived by the residents to be dependent on who was on duty that day. One of the residents described how he often ate a late breakfast and seldom had lunch. He did not like to have hot food for lunch, however, a cold dessert could work. He said that occasionally he was asked if he wanted something extra from the snack assortment in the afternoon, however, it depended on who was on duty that day:

I: If it is cake in the afternoon and you would rather have a cheese sandwich, can you have that?
R4: No (he says somewhat slowly).
R6: Sometimes, it is so different.
I: What do you say, would you rather have a cheese sandwich?
R4: Yes, but it depends on the staff as to how many of your wishes are fulfilled.

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When talking about opportunities for having something to eat during late evenings and nights, another resident described how he often woke up in the middle of the night wanting something to eat. However, when he asked the staff this was not always possible:

> Well, many times they go out and make me a cheese sandwich, and I like that, but many times they don't. (R3)

Food choice and flexibility practices were also performed selectively in relation to the various meals. Lunch was perceived to be the least flexible meal with regard to time and opportunities for making food choices. This also resulted in the staff seldom asking the residents if they would like something else to eat if they did not appreciate the food. In contrast, the evening meal was perceived to be much more flexible and with greater choice possibilities:

CS1: At lunch you often avoid asking because there is what there is. 'What would you like to eat?' You have this to choose from (everyone laughs). Then you don't really ask…

CS6: For the evening meal you ask a lot, because there we have different open sandwiches and there is also this smaller hot dish. And they can have soup if that's what they like.

The possibility of having something to eat other than what was on the menu for lunch was described as being largely dependent on whether the resident had a medical prescription to avoid certain food. This could be based on intolerances or allergies, or other medical diagnoses:

> We only report if someone doesn't want to eat offal and/or fish. For example, we have a woman who doesn't like onion. But there we have been told that if she wants a special diet that does not contain onion, her doctor has to prescribe a special diet, because there is onion in most of the food served. (CS8)

Being given something else to eat due to 'not liking' a food or personal taste preferences was not possible to the same extent. Offal and fish were defined as foods that were legitimate dislikes or preferences, which then allowed other food options. A resident who wanted sushi was mentioned as an example of people having food preferences that were not possible to fulfil. There were clear limits on what and when personal preferences were to be acknowledged, and most often a cultural and normative picture of what was considered appropriate to eat sets the frame for the food served.

### *Personal practices*

In order to secure individual food choice and flexibility opportunities regarding what and when to eat, the residents used different personal practices based on what was possible to have stored in their own fridge or in their apartment. These personal practices were motivated by the desire to be able to choose food as well as when to eat, and the resident's own fridge was central for this objective. This

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food could either be brought out to be eaten at breakfast or, more commonly, be consumed in their own apartment. This also implied that, to a certain extent, the possibilities for food choice, flexibility and satisfying personal preferences were located outside the formal meal system. There were not the same choice opportunities for those who did not have relatives who visited. However, the care homes had recently introduced a system based on so-called 'punch tickets' that could be used, for example, to facilitate personal food choices for those who did not receive assistance from relatives. As part of this system, the residents had a specific number of occasions when they could, for instance, visit a local supermarket or do other errands with a member of the care staff:

> Then we have something that is called 'punch tickets' and then we can go out and buy something. If they don't have these tickets we can't, and we are not allowed to either. (CS4)

The importance of having their own fridge was repeatedly mentioned by the residents as it provided them with choice possibilities:

R6: You know what, I have my fridge, and I have a daughter who comes once a week and checks what I need and then she buys it, so it is just perfect…
I: And the things you have in your fridge, for example the yoghurt, when do you eat that?
R6: Whenever I want to. And nobody barks at me (laughs).

These opportunities created a sense of freedom and independence from institutional order, choices and times. In addition, another resident talked about the importance of having his own coffee and biscuits to eat whenever he wanted to:

> But I have my own coffee because I don't like their coffee, it's too strong, so I make my own coffee. And then I have some delicious big oat cookies that I eat and they taste great … In the morning I take a cup of coffee by myself at half past five, six o'clock, and eat rolls or some bread or whatever I might have. I think their bread is boring. (R5)

Another resident also highlighted the importance of always having something to eat in her own apartment. This was partly to manage the perceived unpredictability of when breakfast was served in the morning, which was not always ready at 8 o'clock as promised:

> I have yoghurt in my own fridge and if it [breakfast] goes totally wrong I take a portion of yoghurt by myself … You buy the yogurt yourself, you order that yourself. I may be hungry at night and then I get up and take a portion of yoghurt. (R2)

One resident pointed out that she was grateful to her son who lived across the street for providing her with the food and spices she wanted. Relatives played a special role in fulfilling the residents' personal preferences and in enabling food choice and flexibility opportunities. This might also be seen as part of the food choice

and flexibility practices that are performed and acted out individually, but also as a collective by the residents, practised beyond the formal meal system.

### *Inhibited practices*

Providing the residents with food choice and flexibility opportunities was, in general, perceived by the staff as important, but challenging. Several of the more formal food choice and flexibility possibilities seemed to be unknown to many of the staff members, which were expressed by 'Is it possible to just go down to the kitchen and ask if they have anything extra?' The snack assortment was often described by the staff as something that should facilitate food choice and flexibility, however, the actual possibilities and use of this was not self-evident. The residents also expressed uncertainties regarding where the food was cooked and prepared, and if it was possible at all to ask for anything else to eat and drink. The institutionally decided mealtimes resulted in the conception that it was not worth trying to alter them. For example, one of the residents thought that there was too much mayonnaise on the sandwiches, but was convinced that this was impossible to change:

R4: And we have talked about this, with the person I sit next to at the table, that it is a machine that puts the mayonnaise on the bread, it is not humans who do it. So it goes through a … well, yes, it is put on the bread by the machine and 'squish, squish'.
I: Have you told the staff that you would like the sandwiches without mayonnaise?
R4: No, not without mayonnaise, but less mayonnaise, but I don't think this is possible as it is mechanical.

Moreover, the residents repeatedly expressed their belief that they should not complain about the food served nor ask for alternative food options or possibilities to eat outside the scheduled mealtimes. This was often an expression of not wanting to be a burden:

> I think you should eat and you should behave properly at the table … For example, I don't like pork liver, we have had it twice here and I have eaten it because it's not inedible, it's just my impolite stomach that doesn't want it, so I eat it anyway. (R2)

The urge to show politeness and to behave properly often resulted in eating the food served despite preferring something else. This politeness could also be understood in relation to the institutionalisation of eating that, to a large extent, was becoming internalised and normalised. This politeness, or what might be seen as part of an institutionalised food culture, could be an obstacle to food choice and flexibility practices performed by the residents. For example, this was expressed by residents when talking about the times when the meals were served in relation to their perceived hunger:

I: Are you always hungry when it is lunchtime?

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R6: You know, we are creatures of habit, we have become creatures of habit here, we get food in the morning and then at lunch and then afternoon coffee and then dinner in the evening and then evening coffee…
I: So you eat even though you are not hungry?
R6: Yes, yes.

Furthermore, lack of time and high workloads were perceived as inhibiting the staff in the provision of food choice and flexibility. The following quotation deals with the afternoon coffee and the possibility of having something else to eat:

I: But can they have a cheese sandwich if they would like that, if they don't want the cake?
CS8: Yes.
CS6: Yes, you can get that, but I'm not saying we offer it, if I'm honest.
KS3: Well, I guess it depends on how stressful it is.

This was further emphasised in another focus group interview:

> Yes, if we are in a hurry. If you did that [ask the residents] then you would need to go out into the kitchen and ask 'do you have this or that'? Sometimes, if it takes too much time, we avoid doing it [asking], because we don't have time to do it. If they say that they are really hungry, ok, then you should do everything possible so they can get something to eat. (SC4)

Food choice and flexibility practices were thereby perceived to be inhibited by several factors, including staff stress and high workload, the politeness of the residents, as well as uncertainties regarding what was actually possible for the staff to offer and what the residents could ask for.

## Discussion

This study qualitatively investigated food choice and flexibility practices and how these were perceived and performed by residents and staff at three care homes in Denmark. By focusing on practices (Schatzki, 1996; Reckwitz, 2002; Shove *et al.*, 2012), people's routinised, embodied and emotional acting, thinking and responding were explored in relation to providing and promoting food choice and flexibility opportunities. The main findings of the study showed how food choice and flexibility practices were, to a large extent, performed informally by the staff, implying that these were mainly conducted by single individuals or groups of individuals working on a specific ward rather than being part of the formal food and meal system. They were also performed selectively, meaning that not all residents were included in the food choice and flexibility practices. The practices performed were often based on earlier experiences as well as a certain engagement in food and meals. In this sense, they were to a large extent based on emotional know-how, embodied knowledge and experience. These aspects are all part of the meaning and competence needed to fulfil the practices (Reckwitz, 2002; Shove *et al.*, 2012), here with the aim of providing the residents with food and meals based on their needs and preferences. Moreover, food choice and flexibility were performed by the

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residents through various personal practices. This has also been reported in other studies where having their own fridge gave residents the opportunity to buy food and drink for themselves (Winterburn, 2009; Gröndahl and Aagaard, 2016). The fridge became the material or 'thing' needed in order to practise food choice and flexibility (Shove *et al.*, 2012).

However, and importantly, these practices were both an expression of inclusion and exclusion, exemplified by the staff primarily asking and involving residents without cognitive impairments who were able to express themselves verbally, and those in need of extra nutrition. In the study, the staff stated that residents who often ate small portions or were at risk of becoming malnourished were more often provided with food choice options. In general, nutritional and/or medical conditions promoted food choice and flexibility practices being performed by the staff, something that has also been stated in other studies (Gröndahl and Aagaard, 2016). By focusing on choice as a tool for mastering nutrition-related problems, food choice and flexibility practices tend to be medicalised in terms of the motives legitimising other choices. For example, being a 'no-chicken' or 'no-onion' person based only on individual preference was not possible, which was also highlighted in the study by Harnett and Jönsson (2017: 829): 'an increase in food diversity based on preferences was impractical "in a place like this", but diversity that was medically motivated was acceptable'.

Residents with cognitive disabilities, including dementia, were also often excluded from the food choice and flexibility practices performed, generally motivated by their inability to benefit from being offered plenty of choice or flexible mealtimes. Previous research has also noted the importance of acknowledging the staff's own beliefs and attitudes towards the residents and their abilities and disabilities, in relation to who is, or is not, provided with choice (Sydner, 2002; Carrier *et al.*, 2007; Norheim and Vinsnes, 2012; Tuominen *et al.*, 2016). In addition, residents with cognitive and/or physical disabilities were often excluded from being able to perform personal practices in relation to food choice and flexibility, as they were seldom able to visit the local supermarket to buy their own food and drink. Consequently, many of the care home residents were excluded from involvement, thus having no voice in decisions about their food and meals.

The study further highlighted several challenges related to food choice and flexibility in a care home environment. Stress and lack of time were repeatedly mentioned by the staff as something that inhibited the provision of choice and flexibility opportunities for the residents. This indicates that food choice and flexibility possibilities were related to other care practices and priorities defined by the institution (Persson and Wästerfors, 2009). Furthermore, this implies that the institutional frame, including predefined times for meals, an already set menu, certain seats at the dinner table and defined decision-making roles, set the conditions for eating and food choice and flexibility practices. However, as Harnett and Jönsson (2017) argue, it might be in the intersection between the institutional frame and a more private frame that practices related to choice and flexibility are made possible. They found in their study that practising food choice and flexibility was more often conducted at times when regular, institutional activities were on hold, *e.g.* during weekends and evenings. In the current study, a similar scenario was described by the staff where the residents staying up late in the evening watching

television could be offered other food choice opportunities. This further points to the idea that food choice and flexibility practices were not only performed informally and selectively but also often outside the stricter institutional time-frame.

Food choice and flexibility practices were also, in part, inhibited by the residents' lack of insight into their choice opportunities and by uncertainties among the staff regarding what other food options were available to offer the residents. Practising food choice and flexibility were also inhibited by politeness as expressed by the residents, that is in behaviour based on the idea of not being a burden. This was also part of the perception of being in an institutional collective where the place for individual voices was limited. This has been stated in other studies where the residents did not want to be inconvenient to the care staff (Pearson *et al.*, 2003; Reimer and Keller, 2009; Bollig *et al.*, 2016). Being polite might also be seen as part of a (silent) institutional food culture where following the mealtimes, accepting what is served and not asking for other options were part of everyday life in the care home (Sidenvall, 1999). This implies that food choice and flexibility need to be understood both in relation to the institutional frame with a number of care tasks being performed by the staff, pre-set menus and mealtimes, and the residents not wanting to be a burden.

There are also challenges in providing food choice and flexibility opportunities whilst, at the same time, arranging shared meals to promote social interactions (Reimer and Keller, 2009). Mealtimes in care homes are often described as essential for exchanging experiences and for promoting companionship among the residents (Mahadevan *et al.*, 2013; Philpin *et al.*, 2014; Watkins *et al.*, 2017), as well as providing comfort and solace (Edfors and Westergren, 2012). In addition, defined times for eating might help people to remember the time of the day based on the meals served. This was apparent among some of the residents in this study, where routines and fixed mealtimes were appreciated (*see also* Watkins *et al.*, 2017). This further emphasises the complexity in understanding and performing food choice and flexibility practices in a care home setting, and the need to manage the balance between structure and routines, on the one hand, and choice and flexibility possibilities, on the other.

Choice and flexibility opportunities for care home residents are frequently stated as being crucial to providing more person-centred care, implying that the care relationship should be based on ideas of individualisation and autonomy (Morgan and Yoder, 2012; Fine, 2013). However, the existence of this in practice has been questioned (Eyers *et al.*, 2012; Watkins *et al.*, 2017), not least in relation to the many people living in various forms of long-term care institutions who live with multimorbidity and cognitive impairments (Hung and Chaudhury, 2011; Meinow *et al.*, 2011; Milte *et al.*, 2017). When discussing individualisation and person-centred care in relation to mealtimes, choice and preferences, as well as independence, respect and possibilities for social interactions, have been included (Reimer and Keller, 2009). Based on this, it is important to consider how food choice and flexibility practices do not necessarily mean providing all residents daily with a multitude of different choices of what to eat, at what time, where and with whom (Milte *et al.*, 2017). Instead, food choice and flexibility practices also include concrete ways of continuously relating to the residents, finding alternative ways or methods of listening, as well as responding to the voices of the residents in

order to understand their needs, wishes and preferences (Tutton, 2005; Edvardsson *et al.*, 2010; Hung and Chaudhury, 2011; Rodgers *et al.*, 2012; Wada, 2016; Milte *et al.*, 2017). Those with cognitive impairments or limited ability to express themselves verbally (which is actually the majority of the residents in care homes) and those who never ask for anything out of politeness, might also be included through care providers gaining knowledge of what is important for the residents.

It has been argued that practices consist of, and should be understood as, an integration of material, competence and meaning (Shove *et al.*, 2012). In the context of food choice and flexibility practices, these are mainly performed using food and food-related items in providing, asking and responding to needs and preferences by the residents. They are, to a large extent, performed informally based on embodied knowledge and previous experiences, being part of the competence needed for the practices. Moreover, these practices are based on emotional know-how incorporated in the meanings attached to the practices, and to the ambitions of providing and responding to the residents' needs and preferences. However, this deep, personalised, embodied and essential knowledge of how to think, act and respond, inherent in the practices (Reckwitz, 2002), also contributes to vulnerability in how, when and where food choice and flexibility are performed. Therefore, by using this knowledge and experience to develop a common understanding of how to perform food choice and flexibility in the care home context, there are opportunities for integrating these practices into more formal guidelines, still fostered by the important relationship between staff and residents.

### Study strengths and limitations

The study limitations primarily concern the limited number of residents who participated in the study. The inclusion criteria for participating in the food journey interviews, that the residents should be physically healthy and with no cognitive impairment, turned out to exclude most residents at the care homes. This also made the recruitment process much more challenging than expected, and resulted in not being able to conduct food journey interviews in one of the care homes, as was planned, within the time-frame of the study. Due to the researchers' lack of insight into the health status of the residents, recruitment was assisted by the care staff who knew the residents. Care and kitchen staff from the three different care homes participated in each focus group. With respect to both work schedules and interest in participation, it was a prerequisite that the local care home management helped with composing the groups. This could raise concerns about how this might have impacted the study result, for example through staff selecting those residents they knew had positive experiences of being provided with food choice and flexibility opportunities. However, this potential bias was not noticed when conducting the interviews and analysing the material. During the focus group interviews, most of the care staff had an interest in food and meals which probably had an impact on how they prioritised and worked with this in relation to the residents.

Despite the limitations regarding the number of residents and care homes in the study, there is great potential in qualitatively exploring these aspects to gain a deeper understanding of the practices performed, as well as the limitations and opportunities connected to them. Conducting food journey interviews with a small

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number of participants meant that they could relate and visually illustrate their experiences and thoughts and, at the same time, interact with each other and the visual timeline in front of them. This was a valuable approach and deserves to be further developed with the ambition of exploring methods and strategies to involve residents who, due to speech limitations, are often excluded from research.

## Conclusions

Food choice and flexibility practices, understood as routinised behaviour based on embodied knowledge and experiences, were, to a large extent, performed informally and selectively by the staff and through personal practices by the residents. However, food choice and flexibility practices were constantly challenged and perceived to be inhibited by lack of time for the care staff and by politeness expressed by the residents. Not having the time nor the tools to respond to and involve residents with cognitive and speech impairment implies that the majority of the care home residents were excluded from choice and flexibility practices. This further points to the importance of understanding and managing food choice and flexibility practices broadly, and to go beyond the notion of food choice and flexibility involving more choice, to also include various ways of relating, listening and responding to the residents' needs, desires and preferences. Moreover, the embodied knowledge and experience as the fundament for practising food choice and flexibility also needs to be incorporated into a more formal care home strategy on how to think and act in relation to the food and meal situation. Lack of insight into, and knowledge about, the opportunities for residents to make choices and for the staff to provide choices further highlights the importance of incorporating informal and personal practices into the more formal food and meal offerings at the care homes. In doing so, food choice and flexibility practices have the possibility of being both inclusive and less vulnerable. However, this also includes stimulating an overall 'choice and flexibility culture' among both staff and residents, aiming at facilitating person-centred care in relation to the food and meals served, responding to and respecting both abilities and disabilities of the residents as well as specific needs and preferences. Future research needs to delve deeper into how food choice and flexibility are experienced by care home residents and how they can be practised and transformed into formal practices. This should also include an ambition to explore the tools and methods needed for increased inclusion and involvement of all care home residents, giving consideration to individuals' cognitive impairments and speech difficulties.

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