DIETITIANS' EXPERIENCE OF CLINICAL PRACTICE IN LONG TERM CARE

by

HEATHER LOUISE WASSINK

BASc, The University of Guelph, 1985
MCS, Regent College, 1991

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE STUDIES

Human Nutrition

THE UNIVERSITY OF BRITISH COLUMBIA

November 2005

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ABSTRACT

The purpose of this research was to gain insight into the experience of dietitians as they practice clinical dietetics in the Long Term Care (LTC) setting, with a particular interest in identifying and understanding elements of LTC that help or hinder clinical dietetic practice to the benefit of LTC clients. Eleven dietitians were recruited for this qualitative study using purposive sampling. The sample included participants with varying lengths of practice since internship; different lengths of time working in LTC; both those working under contract (individual and corporate) and those working as employees; and both those with and without administrative responsibility. Effort was also made to include participants from a variety of sizes of LTC facilities and both government funded and private facilities. Semi-structured interviews were tape-recorded and transcribed verbatim. Transcripts were initially coded using a content analysis method. This was followed by thematic analysis during which three major themes emerged: teams and teamwork, philosophy of nutritional care for LTC, and dietitians' roles in the LTC setting. Teams were identified as a significant feature of the culture of LTC. The measure of effective teamwork was the extent to which teams provided individualized nutritional care to LTC residents. Participants identified several features of a philosophy of care for the LTC setting. These included the obvious, but sometimes neglected fact that residents need to eat real food, that nutritional care be resident focused and that it addresses quality of life issues as identified by residents. Dietitians identified several tasks that they completed in the course of their work. However, they spoke in greater detail about self-assigned roles that promoted effective teamwork. A model was developed as a result of this research that describes the relationship between a philosophy
of nutritional care for LTC and teamwork. A philosophy of nutritional care directs teamwork and effective teamwork is essential for applying a philosophy of care in practice. While there is a great deal of literature to inform the theory of each of these elements, this research highlights the importance of the relationship between them.
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DEDICATION

Be,

You will understand that in dedicating this thesis to you, and thanking you for your love and support, my heart is turned in thankfulness to God. You will also understand that for me, there is no better way to express this than in song.

LOBE DEN HERREN. 14 14 4 7 8.  
Moderately slow.  
STRAUSUND GESENGEBUCH, 1555.

Praise to the Lord, who o'er all things so wondrously reigneth,  
Shelters thee under His wings, yea, so gently sustaineth:  
Hast thou not seen  
How thy entreaties have been  
Granted in what He ordaineth?\(^1\)

Joachim Neander (1640-1680)

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\(^1\) The Hymnary of The United Church of Canada (with music). (1930) Toronto: The United Church Publishing House.
Identification and Design of Research Program
The idea for this project came out of a conversation between HLW\(^2\) and her supervisor, Dr. GE Chapman. During this conversation, in which they were discussing possible research topics, Dr. Chapman commented that what interests her is why people do the things that they do. For Dr. Chapman this has often taken the direction of why people eat as they do. HLW realized that her interest was in pursuing why dietitians practice in the way that they do.

From this seminal idea, discussions continued and HLW prepared a proposal that was reviewed by Dr. Chapman and HLW’s thesis committee members. The specific design of the project was developed by HLW with guidance from Dr. Chapman.

Performing the Research
HLW completed the following aspects of this research:
- obtained list of potential participants / short-listed same
- mailed out letters of contact (signed by both Dr. GE Chapman and HLW)
- made follow-up contact with potential participants via telephone
- scheduled interviews
- conducted all 11 qualitative interviews
- transcribed all 11 qualitative interviews
- data analysis and manuscript preparation as described below

Data Analysis
Data analysis was primarily completed by HLW. It began during data collection and interview transcription, which is consistent with general qualitative methods. Analysis was focused through the manuscript preparation process described below as well as through conversations with other qualitative researchers. A group of graduate students working with Dr. GE Chapman reviewed one interview transcript. Feedback from these reviews was helpful in the early stages of the analysis. Manuscript preparation, described below, also contributed to the analysis.

Manuscript Preparation
HLW prepared the manuscript with critique and editorial review / input by Dr. GE Chapman. Multiple drafts of each paper were exchanged between HLW and Dr. GE Chapman. In effect each draft sharpened the data analysis and worked toward writing papers that would be ready for publication in nutrition journals. Committee members also reviewed one chapter prior to a review of the complete manuscript.

\(^2\) HLW = Heather L. Wassink
CHAPTER ONE

Introduction
MY STORY

What dietitians do, why they do what they do and how they go about their work are all questions that interest me – particularly as they apply to clinical practice in the Long Term Care (LTC) setting. My interest comes out of my own experience, having worked as a dietitian in the LTC setting, in the Lower Mainland of British Columbia, since early in 1989. During this time I have always worked as a consultant and as a sole dietitian and have experienced many rewards and frustrations in that work.

Rewards, for me, are associated with being able to put my dietetic knowledge and expertise into practice to the benefit of the residents. This can be in the form of working directly with a client (e.g. encouraging a severely underweight resident to take a nutritional supplement or helping him to identify a high-energy snack that he will actually eat). However, it can also take a more generalized form. For example, after providing in-service education to staff on dysphagia, it is gratifying to see them applying this knowledge themselves and bringing to my attention those residents who may be at risk for aspiration or who are demonstrating difficulty with swallowing. Underlying these rewards is a desire to see the dietitian and her skills recognized by the rest of the health care team in order that nutrition would be seen as being more than simply feeding the residents three times each day and the work associated with it.

There are other benefits to working as a dietitian within LTC. I enjoy a great deal of freedom to define and direct my own work. I enjoy knowing and working with the residents over many years and thus not being pressured to complete diet teaching in a few
minutes nor in one or two sessions. I can instruct and encourage diet compliance on the
spot at meals or at tea time and develop rapport with the residents in a variety of settings,
over time. Each of these things enhances dietetic practice and assists me in providing
individualized client-centred care.

On the other hand, I also experience frustrations associated with feeling blocked as I try
to promote nutrition and nutrition interventions among the residents and within the
facility. I vividly remember working in a facility where evening nourishments were not a
treatment option because the Director of Care did not feel that it was the responsibility of
her staff to “hand out sandwiches” in the evening. Another time, at a different facility, I
wanted to colour code the dining room table tents in order to identify clearly those
residents who were at risk for choking. Beyond the safety issues, I wanted staff to be
aware of those residents who could direct texture modifications at point of service and
those who could not. Some only needed certain types of meats cut up due to chewing
difficulties, for example, whereas others required that all foods have a texture
modification. In this instance, the food service manager stated, “I don’t want to get into
that” (with respect to identifying dysphagic residents) and thus nothing was done. While
it was frustrating to be stopped from implementing a system that I thought was beneficial
to resident meal service, a bigger frustration came from having staff ask me on an
ongoing and individual basis if “Mr. or Mrs. so-and-so could have the chicken leg
today?” Those who served the residents recognized their need for this information and
yet I was not allowed to systematically give it to them.
There are two sides to this frustration. To be sure, I have been frustrated with other people who appear to stand in the way of dietetic knowledge being applied. Nevertheless, I have also been frustrated with myself when I have failed to defend what I perceive to be the benefits of my professional skill over another person’s or group’s goals. One story from a colleague illustrates this well. At a multidisciplinary meeting some of the care staff were reporting their concerns about a resident gaining weight. When the dietitian told those present at the meeting that the resident was still underweight and that even further weight gain was desirable she was told that it was getting difficult to transfer the resident and that they were concerned about back injuries. My friend silenced the meeting when she reminded them that there were mechanical lifts available for use when transferring heavy residents and that “to keep a resident underweight for nursing convenience was unacceptable.” While she might have found a more tactful way to communicate her thoughts, I was secretly proud of her forthrightness and wondered if I would have been as direct.

In reflecting on LTC and how its culture may support or fail to support dietetic practice (i.e.: the application of dietetic knowledge by the dietitian), my colleague’s story recounted above challenged me to consider my frustrations both objectively and subjectively. A solely subjective assessment of the above scenario allowed me to blame others for getting in the way of me being able to set appropriate nutrition goals for a resident. However, an objective assessment forced me to question whether I am doing an adequate task of advocating on behalf of the resident and of presenting the rationale for appropriate nutritional care. Further, I was forced to consider how and how well I work
with others at my facilities. For in the end, nutritional care is not just the job of the dietitian. It depends on a great variety of people working together. This is the context of dietetic practice in LTC.

Finally, I was also left asking, “do others have similar stories? Do they share my feeling that the work is both rewarding and frustrating?” More importantly, “why, specifically, is it sometimes easy and sometimes difficult to carry out dietetic practice within LTC?” Because I have always worked independently it was difficult to know if my own biases were due primarily to my personality and approach to practice, or whether they were suggestive of deeper issues that exist within the culture of LTC. With this in mind, I embarked on the research reported here.

PURPOSE AND METHODS

The purpose of this research was to gain insight into the experience of dietitians as they practice clinical dietetics in the LTC setting, with a particular interest in elements of LTC that help or hinder clinical dietetic practice to the benefit of LTC clients. More specifically, I identified the following preliminary research questions:

- How do dietitians working in LTC define the work that they do?
- What elements of the LTC setting help or hinder dietitians as they carry out clinical practice?
- How do these elements affect the application of dietetic knowledge to the benefit of LTC clients?
What vision do dietitians working in LTC have for their work in the future that would either change what they do or how they go about doing their work?

Any hypotheses that I had as to why dietetic practice is sometimes ineffective were very subjective in nature, being based on my own experience. Thus, so as to avoid assuming that my own experience was the norm, or using that as the measuring stick against which others' experiences could be measured (as would have been the case if I had, for example, designed a survey), I chose a qualitative approach to research. In addition, there was nothing in the academic and professional literature that directly addressed these issues.

The nature of qualitative research is such that projects typically evolve. That is, initial research questions may serve to identify other questions that are then described or theorized. That is certainly the case here. As I began to talk to other dietitians about their experiences in LTC, and look at aspects of LTC culture that shaped those experiences I developed a deeper understanding of dietetic practice within LTC. In addition, my understanding of this culture and its workings were enhanced in general, and I was led to more specific research questions about dietitians' roles in healthcare teams in LTC, and dietitians' philosophies of care in LTC.

This evolutionary process speaks to the issue of credibility, an aspect of rigour (1). In brief, credibility has to do with ensuring that the research reports the experiences and perspectives of the participants, not those of the researcher. Thus, the fact that my
findings report aspects of LTC culture that I did not initially identify suggests that these findings have a good degree of credibility.

On a practical level this has implications for the literature review presented below. The place of literature reviews within qualitative research is varied. Whereas some believe that conducting any literature review prior to the research threatens the validity of the research, others conduct extensive literature reviews before data collection. Those who ascribe to the first perspective run the risk of "reinventing the wheel" (1, p. 46) and those who ascribe to the second perspective risk allowing the literature to drive the project rather allowing the findings to direct the research. I tried to find a balanced approach by conducting two literature reviews.

The first part of the literature review presented below describes literature I examined while developing my research proposal, which addressed aspects of culture of LTC that I suspected influenced or affected dietetic practice. As such, it describes where the project began. However, because these areas did not end up being the aspects of culture that participants addressed in a meaningful way, further review of the literature was needed. Thus, the first literature review is useful in that it describes some aspects of LTC within the province of British Columbia and connects my initial research interest to previous literature. The second literature review aided my understanding of the findings.
INITIAL LITERATURE REVIEW

The practice of dietetics is one that brings together basic science (biology, physiology and biochemistry) with psychology and social science. In doing so it acknowledges that knowing what or how to eat, in response to any given physical condition is not, in itself, necessarily sufficient to promote compliance with diet therapy. Dietitians are faced with the challenge of assisting clients to develop strategies for diet compliance that overcome obstacles and which identify and embrace those aspects of their context that facilitate compliance.

This understanding of the relationship between dietitian and client is simplistic, however, in that it fails to recognize that while clients live within a context, dietitians work within one as well. Indeed, the American Dietetic Association (ADA) suggests that the context in which the dietitian works is fundamental in determining how dietitians carry out their practice. In offering an answer to what has been suggested as the most commonly asked question of dietitians, “what do you do?”(2) ADA states, “Who and what are dietitians? is determined largely by the nature and purpose of the institution within which they work” (3). In other words, the context in which dietitians work shapes dietetic practice.

In this project the term culture is used to encompass and expand on the ideas of nature and purpose as we consider the context of the clinical dietitian. Culture has been defined as the “body of learned behaviours common to a given human society” (4). Thus it is an appropriate term to use as we explore the experiences of dietitians in clinical practice within LTC facilities. Institutions, as micro-societies, develop a culture of their own (5).
In light of the lack of literature directly addressing this area of inquiry, I will consider three bodies of literature for the purpose of deepening our understanding of the culture of LTC. These areas are: the legislation that governs LTC facilities within British Columbia; dietetic practice and diet counselling theory; and management theory as it applies to health care and dietetic practice.

**LTC Legislation in British Columbia**

Because LTC facilities in British Columbia are licensed through the provincial government, it could be said that the culture of LTC facilities is, to some extent, determined by external legislation. Further, a basic understanding of this legislation is helpful for establishing an operational definition of *LTC facility*.

What are typically referred to as *LTC facilities* in British Columbia are technically *residential care facilities*. Residential care facilities provide assistance to individuals who cannot live independently for health reasons that do not require acute or rehabilitation health services. When a person applies to enter or is referred to residential care they are assessed by a Case Manager and assigned a Level of Care. These levels are Personal Care (PC), Intermediate Care (IC) Level 1, 2 or 3, and Extended Care (EC) (Appendix 1). For the purposes of this research, the term *LTC facility* refers to facilities that provide care to residents assessed at an Intermediate Level of Care (i.e.: IC 1, 2 or 3) or that provide Multilevel Care (i.e.: IC 1, 2, 3 and EC).
When this project began, the British Columbia Facility Standards Act (6), which came into force July 1, 1990, designated what services are considered to provide Continuing Care. At that time LTC facilities typically provided Intermediate Levels of Care (i.e.: IC 1, 2, and 3), sometimes in conjunction with Extended Care. Prior to this Act, Intermediate Care provided by LTC facilities was governed by Long Term Care Program (hence the name LTC facility). In 2002, the Facility Standards Act (6) was replaced by the Community Care and Assisted Living Act (7). Thus, now LTC facilities are residential care facilities that provide Complex Care (IC 3 and/or EC only).

The three levels of IC and Extended Care “recognize a need for care planning and supervision under the direction of a health care professional by introducing a combination of professional and non-professional (lay) supervision”(6). Dietitians are included in the component of professional supervision provided, although there is no longer a formula for determining how many hours/week a facility must secure the services of a dietitian.

At the time that this research was conducted, people assessed as needing PC or IC Level 1 were not admitted to LTC facilities, and fewer people assessed as IC Level 2 were being admitted. The needs of these people are met through other services (homemaker services, adult day care services, Meals on Wheels). The change in legislation (2002) has resulted in IC 2s no longer being admitted to LTC facilities. Thus, LTC facilities have seen a marked rise in the acuity of their clients over the past 15 years. The possible need of clients for therapeutic diets is clearly identified in the Service Provider Policy Handbook (8) and with the increased medical acuity of clients there has been an

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1 Extended Care facilities are currently legislated under the Hospitals Act in British Columbia.
associated increase in the variety and intricacy of therapeutic diets managed by dietitians within LTC facilities.

Dietitians working in LTC facilities may be hired either as employees or on a contract basis; they may or may not be considered part of the management team; and whereas some are unionized, others are not. Dietitians typically report to either the Administrator or the Director of Care (typically a Nurse) but are required to provide a significant amount of self-direction for their work. This is particularly true where only one dietitian works in a facility. Where they work as part of a team of dietitians, there is typically one head dietitian.

While LTC dietitians may assume both clinical and administrative responsibilities, many do primarily clinical work and Food Service Managers direct food services. As such, the primary functions of clinical dietitians in LTC facilities generally include the following activities:

- Completing nutritional assessments on all residents (at admission and at least annually thereafter) (7),
- Creating, updating and monitoring the implementation of nutrition care plans (7),
- Attending annual Multidisciplinary Conferences for each resident,
- Participating in Medication Review Committee meetings,
- Providing nutrition education to facility staff,
- Liaising with family, physicians and other health care professionals regarding the nutritional care of residents,
• Providing direction to the Food Services department regarding therapeutic diets.

Despite these general trends and the body of legislation that governs LTC facilities in British Columbia which formally sets, or at least directs, the nature and purpose of them, individual facilities do take on a culture of their own. It is specifically this culture and the effect that it has on clinical dietetic practice that I wanted to better understand through talking with dietitians who work in LTC.

**Dietetic Practice and Dietetic Counselling Theory**

Dietitians have traditionally been trained to be client-focused (2). That is, nutrition counselling and any resulting nutrition intervention strategies must take into account the client’s context (9, 10, 11, 12). Thus, in addition to medical diagnosis, economic, social, spiritual, and personal factors will determine what dietary modifications, if any, are possible or what shape those that are possible will take.

Books that discuss nutrition counselling and dietetic practice typically make no mention of the dietitian’s context as having significant relevance to his or her practice. Some do discuss personal factors that dietitians will do well to consider and skills that need to be honed in order to optimize the effectiveness of counselling (13). Nevertheless, there is an underlying assumption that this is an individual pursuit by dietitians. How, or even that, facilities could support this process is absent in much of the literature.
For example, in her book, *Dietetic Practitioner Skills – Nutrition Education, Counseling, and Business Management* (14), K.C. Bartley outlines and discusses seven learning principles without mentioning how the person imparting information affects the process beyond having a solid understanding of who is their client. It is interesting to note that in discussing different perspectives on learning this does not change. Bartley refers both to behaviourist and humanist perspectives to learning without making mention of setting. While humanists believe that the motivation for learning comes from within a client, behaviourists suggest that learning takes place in response to external stimuli. In doing so, the ways in which clients internally process information is of little importance to the learning process. Thus, while it is possible that the dietitian and her context may indeed affect client learning (i.e. diet counselling) Bartley does not comment or reflect on this possibility. This is perhaps all the more curious when we later read that the second section of her book “deals with putting theory in to practice in the various settings in which dietetic practitioners work” (14). It is as if there are some assumptions about what she calls “traditional settings for dietetic practice” (14) that do not warrant discussion. It is precisely these assumptions that I am keen to learn more about from dietitians working within LTC.

This shift toward client-centred counselling began with the work of Carl Rogers in the 1940’s. (15) While his area of expertise was specifically that of personal therapy, his approach has been applied to a variety of types of counselling, including diet counselling. This shift from a diagnosis-centred care to client-centred care has unquestionably brought many positive changes to diet counselling; at the same time, it seems to have rendered the
context of the dietitian (counsellor) irrelevant. In this study, I want to ask whether this is indeed true, from the perspective of dietitians. In other words, do dietitians feel that their context affects their ability to provide nutrition care to their clients and if so, how does it do so?

In the case of LTC it is also interesting to note that part of the client's context, his or her physical setting, is shared with the dietitian. While for clients the facility is their home and for the dietitian it is his or her workplace, it seems simplistic to assert that for the client this context is important to consider and yet for the dietitian it is irrelevant. Thus, it is interesting that this major shift in health care (i.e.: from diagnosis-focused to client-focused care) has not gone further in examining how the context of the practitioner affects the provision of health care. There is literature discussing the setting of health care facilities, however, it is generally limited to describing management theories and how to effectively organize or lead a department. While this is not irrelevant to our discussion, it remains theoretical and formal, whereas in this study I wanted to hear about the practical and informal ways in which facilities operate and how they affect clinical dietetic practice.

As stated earlier, some literature does acknowledge that clinical practice takes place within the context of a variety of goals, set by a variety of people (2). The dietitian is then, one player within the health care facility who establishes (independently or as part of a team) one set of goals. Nevertheless, this admission does not expand on how diet counselling and diet therapy are carried out within the culture that this mix of formal
goals works to establish. It is specifically this actual experience that I wanted to hear about.

MANAGEMENT THEORY

The primary assumption about the culture of LTC that is made in the literature is that good management theory is typically translated into good practice. Kramer and Kramer make this point as they describe what they call a “therapeutic community” within LTC (16). The culture of LTC that they describe moves beyond being multidisciplinary to being interdisciplinary. The former, they suggest, merely requires that a variety of different health professionals offer care within a facility whereas the latter requires that health professionals work together in a cooperative fashion. They assert that it is the nursing department that is solely responsible for resident care and that the other health professionals “work with and through nursing to accomplish their specific goals” (16). As they go on to describe how this works in practice it is evident that this perspective is not an attempt to give one department power as much as to have them be empowered by others who have an expertise. In addition, in promoting interdisciplinary care, and in describing their experience of establishing it within a facility setting, Kramer and Kramer suggest that the culture or setting in which practitioners work does indeed influence the care which clients receive. Further, they firmly place the responsibility for establishing a ‘therapeutic community’ on the shoulders of administrators and managers. The people in these positions have a responsibility to ensure that the culture within their facility facilitates clients receiving the full benefit of having a variety of health professionals working to help them.
It is interesting to note that despite work such as this, much of the literature describing multidisciplinary care continues to assume that simply having different disciplines represented on the health care team is sufficient to ensure that clients benefit maximally. They do not generally consider whether health professionals are able to bring the full benefit of their training and expertise to the client.

Other literature also focuses on the importance of good management as a necessary element of health care organizations that support health professionals, such as dietitians, in their practice. For instance, this is the focus of work such as that of Mason et al (2), who, in developing a model for the practice of clinical dietetics, do acknowledge that the dietitian–client relationship takes place in a complex context. The counselling relationship takes place in the midst of a variety of goals, set by a variety of players – one of whom is the dietitian or team of dietitians. The following figure depicts this context.

Figure 1-1  Context of Diet Counselling within Institutions (2)
Within British Columbia, licensed LTC facilities do have clearly identified goals. Typically, these exist for an institution as a whole and for its various departments. These are articulated in the form of mission and vision statements and departmental goals and objectives. Further, dietitians as a profession have codes and regulations to guide them in their work as well as in maintaining professional competence (17, 18). Thus, Mason’s model is helpful in depicting the context in which clinical dietitians in LTC facilities work. It is worth asking, however, whether this literature is sufficient to fully understand the context or culture in which dietitians work within LTC and the benefits and challenges that dietitians face in clinical practice as a result of this culture. Recall that the term ‘culture’ refers to the social environment out of which facilities actually operate – be it because of or in spite of officially stated goals.

CONCLUSION

It is evident that the culture in which dietitians practice in LTC is shaped not only by individual facilities but also by external factors. Provincial legislation may be the most significant external factor as it shapes the resident population within each facility and guides facilities in responding to these needs with respect to nutritional care. Dietitians certainly work to address the unique needs of the specific resident group within their facility. However, within British Columbia, legislative changes have increased the potential for individual facilities to expand or limit the role of the dietitian. Legislation that previously dictated the amount of time that a dietitian was to be present in a facility has been removed. In its place, LTC legislation now identifies two specific tasks that a registered dietitian must perform (completion of formal nutritional assessments and
One area of potential impact is on nutrition counselling. Recall that the importance of the context of dietitians has not been widely considered. This may be due to an underlying assumption as to what that context is. However, as individual facilities are freed to shape their own vision for dietetic practice the role of the dietitian may differ more and more among facilities. Thus the potential variety of contexts in which dietitians practice increases. Understanding the impact of different choices with respect to the dietitian’s role and the context within which she therefore works may now be even more important in understanding the culture of LTC and its impact on nutrition counselling in this setting.

Finally, it is essential that administrators and other managers keep in mind that they are responsible for considering the possible impacts of the choices that they make in shaping dietetic practice within their facility. Books on management in LTC are clear that those in management positions are responsible for the processes for providing care established within their facilities. As legislative requirements have changed with respect to dietetic practice within LTC, those in leadership roles within facilities take on more responsibility to ensure that adequate care is provided to residents. Facilities must increasingly consider the impact on the provision of nutritional care to residents of their choices with respect to dietetic practice.
FURTHER REVIEW OF THE LITERATURE

Conducting this research has given me rich insight not just into dietetic practice, but the workings of LTC. Specifically, it has drawn me to focus on four different discussions in the literature: teams and teamwork; philosophies of care promoted by LTC dietitians; quality of life for LTC residents; and the roles dietitians identify for themselves as the dietitian within a LTC facility.

TEAMS AND TEAMWORK

References to teams and teamwork are commonplace in healthcare literature including that specific to the topic of this research, the LTC setting. Teams have, for the most part, replaced what are often referred to as “traditional hierarchical systems” (19) in which the physician determined what care was necessary and a variety of health professionals carried out his or her orders. Teams, in contrast, encourage mutuality amongst all healthcare professionals, of whom the physician is one member.

The concept of teamwork in healthcare was adopted from the business and manufacturing sectors. There, teams have been very successful in improving outcomes and in facilitating organizational change, particularly toward flatter management structures (20). In an era of frequent change, reduced management and limited budgets it is not surprising that a team approach has appealed to the healthcare sector, with the hope of a similar degree of success. The use of teams within health care has also emerged as nurses have sought to work more collaboratively with doctors, breaking out of their traditional role of following orders, in order to more actively contribute to patient care (21, 24, 25).
Teamwork has been clearly shown to improve outcomes within industry. In healthcare there is a widespread assumption that well-functioning teams will also result in better outcomes, specifically improved resident care. However, there is little empirical data to support this assumption (19, 20, 24, 25, 26, 27). This lack of evidence is due to several factors, the first of which has to do with outcome indicators. In industry there are very specific, universally desired outcomes (profit and growth) that are straightforward to measure and that provide clear goals on which team members can focus their work. In contrast, healthcare has a unique mix of possible outcome markers, some of which are not easily measured. Jayasuria & Sim (28) attribute this to the variety of stakeholders (e.g.: government, professional groups, management) within healthcare, each of whom may have different outcome indicators or goals. For example, much of the literature about teams and teamwork is focused on the outcome of job satisfaction for professional staff, with improved resident care and fiscal responsibility mentioned only tangentially, if at all (19, 21, 29).

Another reason for the lack of evidence as to the benefits of teamwork in healthcare settings is that very few studies exist that have actually measured the impact of teamwork on resident care or resident outcomes. One study that did look at resident outcomes was a qualitative study among community health nurses. It found that a self-reported effective team actually limited treatment options available to clients and often was the cause of inefficiencies in nursing care (30). Other studies that consider resident outcomes often include only a few subjects and therefore lack statistical power (27, 31). Also,
much of the literature that suggests positive resident outcomes as a result of a team approach to care is anecdotal in nature (25). While this literature must not be dismissed, further research is essential in order to understand what impact, if any, teamwork has on resident-specific outcomes and standards of care (20).

Despite these gaps in our understanding of teamwork within healthcare there is a proliferation of ‘how-to’ literature for establishing teams in various healthcare settings (25). Some of this literature attributes success to a thorough understanding of team structure and formal working relationships (29, 32). Thus, authors suggest that problems related to teamwork may be explained by a lack of understanding by team members of the type of team (eg: multidisciplinary, interdisciplinary, transdisciplinary, network-association team etc.) and the formal roles of and relationships among the various team members. Other literature suggests that the team is comprised of a number of teams, each of which has a different task or focus (eg: planning, problem solving, service provision) which contributes to the whole. Whereas healthcare has traditionally had a single team focus (production / service), quality improvement programs are applying this business theory to encourage the current trend toward the development of a variety of types of teams, each with its own task or focus. This shift will require close study of healthcare teams in a variety of healthcare settings in order to ensure that this theory is transferred appropriately from business to different healthcare settings (20).

Thus, when reading team literature it is essential to keep in mind that there is much about teams and teamwork within healthcare that we do not know. At the most basic level it
remains empirically unknown if teamwork results in better resident care. It is unknown what team structures are most effective or appropriate in healthcare, nor is it established how to measure effectiveness or appropriateness. Further, there are few studies that consider what makes an effective team member or whether various healthcare staff hold the same meanings of team and teamwork (26, 33, 34).

Addressing each of these issues is complicated by a number of factors. Firstly, there are many different healthcare settings (acute care, LTC, assisted living, mental health, extended care), each serving a unique population. Team research that is specific to each of these settings is needed for a thorough and comprehensive understanding of teamwork in healthcare in general.

Secondly, there are currently a limited number of voices in the team literature. Much of what is written is from a nursing perspective. Dietitians are only occasionally mentioned in team literature and rarely given a voice. In our post-modern culture it must be assumed that multiple meanings of team and teamwork exist. Indeed, as McCallin (26) points out, “descriptions [of teams] in the professional literature are so diverse that meaning is murky.” If this is true in literature that is predominantly from one voice, then hearing from other perspectives is even more crucial. Further, in addition to hearing from other professional groups, research on teams must acknowledge that nonprofessional staff such as care aides are part of the healthcare team in LTC. How or if this affects the working of teams or their needs is only beginning to be considered in the literature.
One study that has done so was conducted in a large multilevel care facility in Toronto (25). Social network analysis identified professional and nonprofessional subteams that functioned almost independently from one another thereby forming “subteams.” Subteams functioned differently and held different meanings of teamwork. Whereas the professional subteam functioned “organically”, that is with little formal structure or authority and a focus on problem-solving, the non-professional subteam functioned “mechanistically,” having clear lines of authority and a focus on completing tasks. A head nurse was the liaison between the two subteams and functioned both organically and mechanistically depending on the subteam she was working with. It is important to note, however, that in Cott’s study non-professional staff were not included in formal team meetings. More research is needed to determine if subteams exist in situations where formal team structures do not encourage distance between professional and non-professional staff and to establish if and what unique teamwork issues arise for teams that include non-professional staff.

PHILOSOPHY OF CARE

A philosophy has to do with the “systematized principles of any subject or branch of knowledge” (35). With respect to a philosophy of nutritional care, these principles then guide decision-making and policy-making, be it for individual residents, LTC facilities or government. In practice, a philosophy of care contributes to an ethical framework for decision-making. However, ethical discussions within LTC tend to focus on nutrition support. I found no literature that outlines the elements of a philosophy of care held by dietitians working in LTC for the regular nourishment of residents. The need for this is
crucial in light of the well-documented reality that despite an adequate supply of food within most LTC facilities, malnutrition, undernutrition and dehydration persist among LTC residents (10, 36, 37, 38, 39).

Nevertheless, there is a great deal of literature available to guide the nutritional care of the elderly and even that which is specific to the regular nourishment of the institutionalized elderly. This growing body of literature specific to nutrition in LTC serves to inform a theoretical philosophy of care that can then be compared to and contrasted with an actual philosophy of care held by LTC dietitians.

Some studies have documented the attitudes toward nutrition among various staff within LTC and considered the impact of staff attitudes on residents’ food intake. Christensson et al. (40) concluded that staff attitudes toward nutrition were primarily formed by social influence within a facility and not by education. Further, they found that staff had less positive attitudes toward self-ability at meals, something that has been shown to be of high importance to residents. West et al. (11) compared the importance of various aspects of food services to residents with staff’s perception of their importance to residents. They found that staff frequently did not know what foodservice issues were important to residents. For example, they minimized the importance of independence in eating and overestimated the importance of having special meals and occasions. Pierson (41) conducted an ethnomethodological study looking at the process of feeding demented LTC residents. She highlighted the complexity of the work of feeding residents and suggested the importance of staff attitudes toward this work by documenting that staff
use “common sense” to make many feeding decisions because “complete instructions for feeding . . . can never be [fully] written.” (41, p. 131) Together, studies such as these highlight the importance of a philosophy of care that promotes positive attitudes toward food and eating among LTC staff and ensures that nutritional care address residents’ actual priorities.

Other literature focuses on organizational issues within LTC facilities and makes suggestions as to how nurses, dietitians and facilities in general can work to improve nutritional care and therefore the nutritional status of residents. Thus, dietitians should push for lab work (37) or evaluate residents’ micronutrient needs along with protein and energy needs (10). Nurses are to provide better supervision of non-professional staff at mealtimes (38); and facilities must train staff who feed residents (36, 40) and give attention to atmosphere in LTC dining rooms (42, 43). Supplements should be used sparingly and not replace the consumption of real food (10). Thomas (43) stressed the importance of focusing on individual residents and ensuring that those who need assistance to eat are given adequate time and attention by staff at meals. Implicit in this is the need for there to be adequate staffing in facilities, including both nursing / care staff and dietitians (11, 38).

Kayser-Jones (39), a nurse, suggested that nutritional care is one of the most important aspects of care within LTC facilities. She emphasized the importance of offering residents choice at meals and of addressing physiologic, psychological, social, and cultural aspects of eating so as to maximize intake among residents. She concludes,
"Nutrition is just one part of a resident’s care, but in some ways it is the most important part. If we do not provide food and water to residents in their last days of life, if we allow them to become malnourished and dehydrated, then what point is there in giving them medications, physical therapy or other treatments?" (39, p.58). This literature can help to direct a theoretical philosophy of nutritional care for the LTC setting. Moreover, it starkly points out the need and urgency of doing so. How to go about it in practice and what it requires to do so remain relatively unstudied.

QUALITY OF LIFE

The importance of quality of life (QOL) in LTC and the contribution of nutrition to it are referred to often in the literature. No one questions that nutrition contributes to QOL but there is discussion as to how it does so. Indeed, there is no one, agreed-upon definition of QOL (44, 45) and a great variety of dimensions are thought to contribute to or influence it.

Some studies focus on a specific type of QOL. In the extreme there are two of these: psychosocial QOL and health related QOL (HR-QOL). The first focuses on aspects of general life satisfaction, whereas the second focuses on aspects of physical / mental health, including functional status (44). Regardless, however, of the focus of the research, it is agreed that nutrition and eating are multifaceted processes that embrace both psychosocial and physical dimensions.
Kayser-Jones (42) examined the importance of the environment in influencing quality of care (and therefore QOL) for LTC residents. Residents reported three main environmental factors that affected their quality of life related to food and meals: the physical features of the dining room; staff attitudes toward them at mealtimes; and quality of the food. Crogan and Pasvogel (45) studied the influence of protein-calorie malnutrition (PCM) on QOL in nursing homes and found a significant inverse relationship between PCM and both functional status and psychosocial well-being. In a study about nutrition and QOL for older adults Amarantos et al. (44) looked primarily at HR-QOL and therefore dimensions associated with functional status. Again, although they make a good case as to the importance of nutrition in avoiding health complications that negatively affect QOL they are careful to point out that both physical and psychosocial dimensions influence QOL with respect to nutrition and eating. This understanding of nutrition is supported by findings of a study that sought to identify specific parameters that contributed to the psychosocial QOL of nursing home residents. Kane et al. (46) identified parameters such as choice, individuality, enjoyment, and functional competence as specific features of psychosocial quality of life. In the end, functional status cannot be neatly isolated from psychosocial aspects of QOL, at least with respect to nutrition and eating.

**DIETITIANS’ ROLES**

While the literature is clear that successful teams have clearly identified roles for their members (20, 29, 32, 47) there is little written specifically on the dietitian’s role in LTC. One attempt to bridge this gap was a paper by Lilley and Gaudet-LeBlanc (48), in which
they suggest that promoting QOL within the LTC setting is the role of the dietitian. They
go on to identify specific tasks for dietitians to take on to do so. These include recipe
development, menu planning, empowering the resident, providing leadership in
optimizing the dining experience for residents, marketing good nutrition to residents,
evaluating eating ability, and providing eating rehabilitation. Other than this, dietitians’
roles are often only implied in the literature, generally with reference to nutritional
assessment and care planning.

CONCLUSION

It is likely not unusual to learn that within LTC jargon has developed. Team language is
pervasive in both books and professional literature related to LTC and yet common
definitions among the large variety of professional and non-professional staff who work
in LTC have not been established. Facilities would do well to examine the assumptions
that lie behind terms such as team, teamwork and quality of life in order to identify and
synthesize the variety of meanings that may exist. The significance of doing so lies not
in establishing succinct definitions but in providing effective, resident-focused care.

Further, the process of establishing common ground among staff with respect to team
functioning (including the role of the dietitian) and the promotion of quality of life for
LTC residents is foundational for implementing an appropriate philosophy of care. There
is a great deal of literature available to inform a theoretical philosophy of care.
Consideration and understanding of how teams work within the LTC setting is essential
for translating this theory into practice and for ensuring that nutrition interventions
promoted in the literature are made available to residents in reality.

Indeed, it is the expressed purpose of this research to better understand the culture of
LTC and the realities of dietetic practice within it in order that theory might better be
applied in practice. As a result there are a number of possible stakeholders who will find
this research of interest. We will briefly consider several of these.

ANTICIPATED SIGNIFICANCE

I expect that dietitians will be interested to hear what others within their profession have
to say about their experience of practice. Those who participated in this study will
hopefully be empowered as they are given a voice, especially any who feel that they are a
lone voice within their workplace. For other dietitians also working in LTC, there may
be elements that ring true for them, offering insight into the dynamics of the culture of
LTC. In bringing together the voices of several dietitians, dietitians may be better
equipped and empowered to make or instigate positive change within their facilities.

I also hope that administrators, as they work to establish therapeutic communities within
their facilities, will be keen to learn from dietitians working within LTC. More
specifically, I hope that the themes that emerged in the analysis will assist administrators
as they seek to implement management theory in a practical manner, shaping the culture
within their facilities so as to promote effective, resident-focused care. This may be
particularly true with respect to issues as to how various departments and disciplines
interact and affect each other’s work and in establishing a common understanding of a
number of terms that have become jargon within LTC. These same elements are likely to
be of interest to Directors of Care.

I also hope that the findings will be of interest to other health professionals working
within LTC facilities. There will likely be a number of issues that ‘ring true’ for others
who, like dietitians, are seeking to apply their knowledge to the benefit of clients. Non­
professional staff within LTC may better understand how they can promote the
implementation of dietetic knowledge for the benefit of residents. Further, I hope that a
greater understanding of the culture that develops within LTC facilities will enlighten
everyone who works in one as to how care can be optimized and how to avoid developing
or perpetuating negative elements of culture.

Finally, I hope that educators who are preparing dietetic students to practice dietetics will
find this information useful. There may be new aspects of competence that will be
necessary for dietitians to hold in order to promote optimal nutritional care within the
LTC setting.

LOOKING AHEAD

The chapters that follow present the findings of this research. Chapter Two is a paper on
the topic of dietitians’ roles and teamwork within LTC. In addition to identifying various
roles that dietitians take on, this paper discusses the roles identified by study participants
with respect to how they contribute to healthcare teams and teamwork within LTC.
Chapter Three presents the elements of a philosophy of nutritional care for the LTC setting identified by my participants and discusses them in light of other research which suggests specific nutrition strategies for caring for LTC residents. Quality of life is also discussed as a key component of a philosophy of care in LTC. Finally, Chapter Four discusses the interaction of the findings of Chapters Two and Three and presents a model for understanding this interaction with respect to providing resident-focused care. In addition strengths and weaknesses of the research are identified and aspects of the overall significance to dietetic practice of this research are discussed.
REFERENCES


CHAPTER TWO

Dietitians' Roles and Teamwork in Long Term Care

\[1\] A modified version of this manuscript will be prepared for submission to The Canadian Journal of Dietetic Practice and Research as: Wassink, H.L., Chapman, G.E. Dietitians' Roles and Teamwork in Long Term Care.
INTRODUCTION

It has been suggested that “what do you do?” is the most commonly asked question of dietitians (1). The American Dietetic Association states that, “Who and what are dietitians? is determined largely by the nature and purpose of the institution within which they work” (2). Thus, studying dietitians’ roles within specific contexts is appropriate. In this study, which was designed to explore dietitians’ experience of clinical practice in the Long Term Care (LTC) setting, we asked participants to identify and elaborate on their role as a clinical dietitian working in LTC. As they did so, they identified themselves as team members and spoke of their role in relation to teams and teamwork within their facilities. Thus, teams and teamwork emerged as significant themes in our research which were further explored to understand dietitians’ roles in relationship to them.

Both research and how-to books on teamwork assert that clearly identified roles are an essential element of, indeed a prerequisite for effective teams (3, 4, 5, 6). However, there is little literature that discusses dietitians’ role(s) within LTC and none that specifically reflects on the contribution that they make to teamwork. In contrast, references to teams and teamwork are now commonplace in healthcare literature including that specific to LTC. Teams have, for the most part, replaced what are often referred to as ‘traditional hierarchical systems’ in which the physician determined what care was necessary and a variety of health professionals carried out his or her orders (7). Teams encourage mutuality amongst healthcare professionals of whom the physician is but one member.
The concept of teamwork was adopted in healthcare from the business and manufacturing world. There, teams have been successful in improving outcomes and in facilitating organizational change, particularly toward flatter management structures (5). In an era of frequent change, reduced management and limited budgets, it is not surprising that a team approach has appealed to the healthcare sector, with the hope of a similar degree of success. The use of teams within health care has also emerged as nurses have sought to work more collaboratively with doctors, breaking out of their traditional role of following orders, in order to more actively contribute to patient care (8).

Despite the appeal of teamwork in healthcare there is much about it that remains unknown. For example, it remains empirically unknown if teamwork results in better resident care (5, 6, 7, 9, 10, 11, 12). It is unknown what team structure(s) are most effective or appropriate in healthcare, nor is it established how to measure effectiveness or appropriateness (6, 13). At a more basic level, however, is the fact that there are no universally accepted definitions of team or teamwork. McCallin (6) points out that, “descriptions [of teams] in the professional literature are so diverse that meaning is murky.” Few studies have investigated whether various healthcare staff even hold the same meanings of team and teamwork (6, 13). Thus, research is needed to identify these meanings and increase our understanding of what team means to healthcare workers and professionals. Only then can there be useful discussion about or evaluation of teamwork in healthcare.
Despite these gaps in our understanding of healthcare teams there is a proliferation of literature detailing how to establish teams in various healthcare settings (10). Formal critique of this 'how to literature', in light of current practice, is needed. It must be specific to each of the many different healthcare settings (acute care, LTC, assisted living, mental health, extended care) that exist. Further, because much of the healthcare team literature is written from a nursing perspective, research that brings new voices into this discussion is essential for broadening our understanding of teams and teamwork. Currently, dietitians are only occasionally mentioned in team literature and rarely given a voice.

The purpose of this paper is to begin to address some of these gaps in understanding by exploring the meanings that dietitians working in LTC hold of team and teamwork and their understanding of dietitians’ roles within those teams.

METHOD

Because the goal of this study was to understand dietitians’ experience of clinical practice in LTC from the perspective of dietitians, and because of the absence of any literature specific to this general topic, a qualitative research approach was used. Morse and Field (14) suggest that qualitative methods are most appropriate when a concept under investigation is immature. As the themes of roles, and team and teamwork emerged this choice remained appropriate. There is little literature on dietitians’ roles and dietitians’ voices are relatively silent in team literature. In addition, the anecdotal nature of much of the team literature within healthcare and the many assumptions regarding the application
of team literature from the business sector to the healthcare sector all contribute to the immaturity of our research topic.

The motivation for conducting this study came from a mutual interest in increasing understanding of dietitians' experience of practice. The first author (HW) has worked as a clinical dietitian in LTC for 13 years, and wanted to learn more about the culture of LTC and how/if it affects nutritional care. The second author (GC) has worked with dietetic students for 14 years, and wanted to address the dearth of information available to students about this growing area of dietetic practice.

After gaining ethical approval from the University of British Columbia Behavioural Research Ethics Board, we sent a recruitment letter to 20 dietitians working in LTC in the Vancouver Lower Mainland. Names of potential participants were selected from a list of dietitians working in LTC, Extended Care and Mental Health facilities in one jurisdiction of a regional health authority. The letter requested that interested dietitians contact HW by telephone. Those who did not do so within two weeks of the letter being sent received a follow-up telephone call. Convenience sampling criteria used for contacting potential participants by letter were that they had to be Registered Dietitian/Nutritionists working in British Columbia who were currently working (full- or part-time) in a LTC facility (may or may not have been working in other settings as well). They had to be responsible for clinical nutrition within their facilities but could also be responsible for administrative dietetic functions. This information was available on the original list provided by the regional health authority.
Repeated attempts were made to contact all 20 potential participants by telephone. Fifteen were eventually contacted by telephone and of these, 13 were willing to participate. Eleven study participants were selected to maximize variation on several sampling criteria, using information obtained during the initial telephone contact. As summarized in Table 2-1, the final sample included participants with varying lengths of practice since internship; different lengths of time working in LTC; both those working under contract (individual and corporate) and those working as employees; and both those with and without administrative responsibilities. Effort was also made to include data from a variety of sizes of LTC facilities and both government funded and private facilities.

The first author conducted an individual, semi-structured interview with each participant at the location of the participant’s choice, using the interview guide shown in Table 2-2. Questions were designed to encourage participants to reflect on their role as ‘the dietitian’ within a LTC facility and to tell stories of self-identified successes and failures in their work. Probes encouraged reflection on factors that contributed to these successes or failures. All of this was aimed at gaining thick, rich descriptions of dietetic practice and nutritional care within the LTC setting. Note that teamwork was not identified as an area of interest in the initial interview guide. It emerged as a theme through the analysis and influenced probing in later interviews. Specifically, the broad question of “what makes dietetic practice work (or not)?” was explored more in terms of “what makes the team work (or not)?” Interviews lasted 45 – 75 minutes each. Prior to being interviewed,
Table 2-1. Participant and Facility Characteristics.

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<table>
<thead>
<tr>
<th>Facility size (# residents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15</td>
</tr>
<tr>
<td>15-49</td>
</tr>
<tr>
<td>50-99</td>
</tr>
<tr>
<td>100-149</td>
</tr>
<tr>
<td>&gt;150</td>
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</table>

<table>
<thead>
<tr>
<th>Dietitian Time at Facility (hours / week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
</tr>
<tr>
<td>10-19.9</td>
</tr>
<tr>
<td>20-29.9</td>
</tr>
<tr>
<td>&gt;30</td>
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<table>
<thead>
<tr>
<th>Dietitian Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>contracted</td>
</tr>
<tr>
<td>employee</td>
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</table>

<table>
<thead>
<tr>
<th>Dietitian’s Area(s) of Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>clinical</td>
</tr>
<tr>
<td>clinical and administrative</td>
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<table>
<thead>
<tr>
<th>Facility Funding</th>
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</thead>
<tbody>
<tr>
<td>private</td>
</tr>
<tr>
<td>government</td>
</tr>
<tr>
<td>government funded with some private beds</td>
</tr>
</tbody>
</table>

² Because several participants worked at more than one LTC facility, the number of facilities is greater than the number of participants.
Table 2-2. Interview Guide

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1.</td>
<td>I’m interested in hearing about your work as a clinical dietitian within a LTC facility. Maybe we can start with you telling me what you see your role as within the facility.</td>
</tr>
<tr>
<td>2.</td>
<td>I’m interested in learning about conditions and factors that affect dietitians’ abilities to do their work in LTC settings. To get us thinking in that area, I wonder if you can tell me about a specific example of something you’ve done at work that you’re really proud of – something that made you think, “yes! I’m doing a good job.”</td>
</tr>
<tr>
<td>3.</td>
<td>Now can you tell me about a situation where you felt that you weren’t able to do your job well?</td>
</tr>
<tr>
<td>4.</td>
<td>What needs to be in place for you to do your work?</td>
</tr>
<tr>
<td>5.</td>
<td>Are there any key players who make it easier / possible for your to do your work?</td>
</tr>
<tr>
<td>6.</td>
<td>In what ways does nutrition matter to others working in your facility? How do these perspectives affect you in your work?</td>
</tr>
<tr>
<td>7.</td>
<td>Has your experience of practicing dietetics within LTC changed over time? If so, how? How would you like to see it change in the future?</td>
</tr>
<tr>
<td>8.</td>
<td>Is there anything else that you would like to tell me about your experience of clinical dietetic practice within LTC?</td>
</tr>
</tbody>
</table>
participants signed an informed consent form and understood that they could refuse to answer any question and that they could withdraw from the study at any time. Interviews were tape recorded and transcribed verbatim. Each participant was assigned a pseudonym and real names were disassociated with the data at the point of transcription. Field notes were written soon after each interview.

Data analysis was conducted concurrently with data collection. Throughout this process, extensive memo writing, and meetings both between the researchers and with other qualitative researchers enhanced rigour of the analysis. These activities were helpful to identify issues to be bracketed by the first author while interviewing and conducting analysis. Awareness of the interviewer's opinions and assumptions, that emerged from her own experience, discouraged leading questions and encouraged appropriate probing that deepened and clarified the data to ensure that the results report the participants' experiences. At the same time, the interviewer's experience in LTC helped to develop rapport with participants.

Transcripts were initially coded using a content analysis method as described by Morse & Field. (14) Both categories (e.g.: teaching; care aide) and themes (e.g.: dietitians' roles; job classifications) were identified and then compiled in lists for each transcript. Thematic analysis followed the initial coding and focused on the major messages that each participant identified. Transcript summaries were prepared for each interview. Thematic analysis progressed through writing lengthy documents that sought to clarify and synthesize the data. Ongoing discussion of these documents between the authors and
subsequent revisions facilitated a thorough understanding of each theme and how they related to each other in describing the experiences of clinical dietitians working in LTC. Through this process our initial interests of dietitians’ roles and the general culture within LTC facilities were narrowed to focus on dietitians’ roles in relation to one universally reported feature of that culture, i.e. teams and teamwork.

FINDINGS

As participants shared their experience of clinical practice they made frequent team references. A team was the context and sometimes focus of their work. This was particularly evident as dietitians answered the question, “what do you see your role as within your facility?” As they spoke about their experiences in general and their roles in particular participants addressed three main topics: their understanding of what it means to work in a team, their description of the features of effective teams, and discussion as to how their roles contribute to the team and teamwork.

MEANINGS OF TEAM AND TEAMWORK

Participants attached the term team to various groups of people with whom they worked. The “multidisciplinary team” was described by participants as consisting of all staff, managers, consultants, residents and their families associated with a facility. There were references to the “management team” and a “group of professionals” who made up a core group for care conferences. Team was also the label attached to the dyad of dietitian and food service manager. Other references that explained who was on the team suggested that team membership varied depending on the setting. For example, one participant differentiated between the team that was at the facility every day and the “other team”
(which included the physician) that was present at care conferences. Some teams were ward or unit specific and others facility-wide.

When asked, participants identified residents as team members. At the same time, residents were sometimes spoken of in terms that distanced them from the team, making them the focus of team activities. This shift generally came with a shift in team task. Residents were active team members for assessment and problem solving tasks but not necessarily included for care plan implementation. At this point they became the consumer or beneficiary of the work that the rest of the team was doing.

Teamwork was defined as a cooperative approach to working together and was considered vital to several aspects of nutritional care. These included ongoing resident observation, information gathering, problem identification, problem solving and delivery of service (including implementation of nutrition interventions). Further, dietitians reported that they cannot do nutritional care on their own, it requires a team of people. On a practical level this was because dietitians had limited time at LTC facilities and typically there was only one dietitian at a facility. But our participants also valued a team approach for reasons beyond it being helpful to them in their work of providing nutritional care; it was vital to the work of providing nutritional care to residents. Participants were clear that nutritional care was not a protected domain of the dietitian to which others could only contribute in prescribed ways. Participants spoke with great regard for staff who took initiative in providing nutritional care to residents, and were clear that effective nutritional care depended on the team.
... it's the team. Nutrition is a team [effort]. A nutritionist is totally ineffective without
nursing behind them because we only consult, we don't actually do. We can show, but
we're not there very often really in a residential situation ... it's really only our
recommendations and then the follow up is very, very important. And I think that's
where you include your staff.

Helen 7:11 - 22

Finally, the terms team and teamwork were inextricably combined and in effect defined
each other. Thus a cooperative approach to work did not just define teamwork, it defined
team. That is, although participants defined team broadly and inclusively according to
membership, they also defined team according to how well everyone worked together.
Being a team meant working like a team. Hence, real teams were only those that worked
effectively.

FEATURES OF EFFECTIVE TEAMS

Detailed analysis of participants’ descriptions of effective teamwork revealed four
primary markers of effective teams: team members had shared goals and purpose,
individuals on the team contributed to team functioning, there was strong leadership, and
the dietitians were self-reflective regarding their own roles on the team.

For participants, the goal or purpose of effective teams was to provide resident-focused
care. Firstly, this entailed establishing systems that were sensitive to the needs of the
residents as a group. For example, one participant described a major menu revision
because of a change in population over time.

... we used to have a huge German population, well we served more German food. And
then we had a lot of Ukrainian people so we had a lot of Ukrainian [food]. So as our
population changes we change our menu ...

Helen 16:42 - 46
Secondly, resident-focused care required providing *individualized care* that ensured that each resident within the group received care that was sensitive to his or her unique needs.

The following quote suggests that staff getting to know residents is foundational to providing individualized care.

> And I think the more directly you, a person works with the resident, the more resident focused they are. The less interaction, the more task-oriented. So, I find it’s really good when dietary staff are out of the kitchen and actually serving. They’re suddenly not having lunch ready at 12 o’clock they’re having lunch ready for all these residents. You know, and it makes a difference. If somebody needs a special order it’s not a special order anymore it’s, “I’m looking after Mrs. Jones” or whatever.

*Alana 17:37 - 45*

The second characteristic of effective teamwork related to attributes of individuals on the team or, as one dietitian described it, the individual pieces of a puzzle or links in a chain.

> And, you know we’re only as good as the weakest link. That’s how I always think about it. You know [the facility we’re at today] is a good example of a place that actually works fairly well. And most of the pieces of the puzzle are very good, and I think why is that? But then I look at each individual person and I think, “you’re a great worker”, “you’re a great worker”, “you’re a great worker”, different personalities completely. They work together. But they’re all very good at doing what they do. And devoted to their jobs. I think of the other [facility I work at] . . . and I think, “talk about weakest links, we don’t actually have a strong link”. And it’s just so easy to see it all fall apart.

*Devony 23:49 - 24:11*

Participants typically identified differences in personality, level of education and job satisfaction as the main factors that influenced individuals’ contributions to team functioning within their facilities. Hallmarks of staff who promoted and contributed to effective teamwork included that they maintained a clear resident focus in their work; provided constructive input regarding residents to other team members; participated in
problem-solving; respected team decisions in carrying out the specific tasks associated with their unique role on the team; and were keen to learn and use new information.

The third mark of an effective team identified by study participants was strong leadership. Administrators, directors of care and food service managers were identified as forming a core group of managers who shaped the team and whose support dietitians reported as “essential” for providing individualized nutritional care to residents.

Administrators, through their own attitudes toward residents and their care, played a vital role in establishing and maintaining the team’s focus on residents and their needs.

I can really see how an administrator and an administrator’s philosophy can affect nutrition . . . because it affects the attitude of the care aides, I think, and the nurses . . . It filters down just by [being] a more caring facility. One where there’s more respect . . . I hadn’t worked very long before the new administrator came . . . but I felt like there was big change [in] the attitude of the staff toward the residents.

“Good administrators” were those who were “good with people,” “easy going,” and “all for the resident.” Dietitians said that it was “helpful,” “empowering” and that “it just makes the job a whole lot easier” when administrators left their desks, made themselves available and worked to promote a positive attitude toward residents within their facilities. When administrators focused only on financial issues they reportedly became “short sighted” and didn’t see the “smaller picture” of individual resident care issues.

“Good directors of care” modelled respect toward residents and who gave voice to the fact that care must be resident-focused. They set high standards of care for the team and
reminded staff of their specific roles and tasks on the team. Further, they established open communication amongst team members and addressed staff needs alongside resident needs. Participants credited directors of care who lead their teams in the above-mentioned ways for making innovation and change possible within their facilities.

Participants also reported that overall team effectiveness was enhanced when they and the food service manager (FSM) worked together as a team, especially in sharing a philosophy of nutritional care. Participants believed that their expertise and knowledge base was broader than that of FSMs but clearly spoke about wanting to work together with mutual respect.

Finally, when participants spoke about teamwork they were not just identifying what it meant with respect to what others needed to do or do differently in order for the team to function effectively. They reported that teamwork meant that they must continually reflect on issues such as how well they were doing their jobs; what they could do better or differently; and what others on the team needed from them. For example, dietitians considered the workload issues of other staff when making decisions regarding nutrition interventions. They reported that the purpose of this was to ensure that interventions were practical from others' perspective. In addition, it worked to establish trust between dietitians and care staff, in particular. Dietitians actively sought input from all stakeholders when working to establish new systems and they realized that teamwork

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3 Although not all facilities have both an administrator and a director of care, this was the norm in our study.
required that they sometimes had to accept “no” as an answer from their superiors if a new idea could not be implemented.

But, you know, what I’ve learned is sometimes you just need to sit back and see why they’re saying [“no”]. Maybe there’s a good reason why they’re saying it. Sometimes you come in and you want to change everything because you think you’ve got all the right ideas and you think, “well, I don’t know let’s just sit back and watch this for a while and see if it’s actually working”. Sometimes you actually realize there is a good reason why this is happening, so maybe we don’t need to change this.

Devony 8:7 - 16

In summary, on effective teams there was a prevailing attitude of priority for resident issues that was promoted by managers and embraced by all other staff. This made for teams that worked like teams.

DIETITIANS' ROLES AS TEAM MEMBERS

The beauty of my job is I always make my job. No one has ever had a job description [for me]. You know, and I’ve never been trained for a job, ever...[I] come in cold because that [previous dietitian] has already left, and I get the 20-minute spiel and then I just go for it.

Helen 23:13 - 22

So, what do dietitians do when they “just go for it”? Although participants were directly asked what they considered their role within their facility to be, the topic of dietitians’ roles came up throughout each interview, not just in response to this question. As participants spoke about their experience of clinical practice in LTC they continually identified roles that they took on or, how they “just go for it.” No one reported being assigned a role. In fact, one participant reported that when she was signing a contract with the administrator at her facility he asked, “can I get a list of what you provide?” (Fiona 11:40 – 41). In response, she identified a number of things that she did, or could
do, as the dietitian, including tasks such as “provide nutritional assessments⁴ as per certain schedules . . . certain quality assurance checks, attending care conference meetings, liaising with community nutritionist, [providing] continuing education. Just basically everything” (Fiona 11:46 – 12:2). Fiona’s comment “just basically everything” suggests that there are basic tasks associated with being a dietitian in LTC that she didn’t need to explain in detail when speaking to another LTC dietitian. Certainly other participants agreed that it was the role of the dietitian to do the specific tasks such as those identified above, but they were more concerned with how the details of these were applied in practice. The following story emphasizes this perspective.

And it’s not about doing quality assurance surveys, it’s not about that, and it’s not about how pretty the charting is. That’s where I think the health unit people are lost. They’ll look in your charts. ‘Cause I inherited a facility and it had wonderful charting about all of these people on No Added Salt diets. So I walked into the kitchen and I said to the cook, “so, this No Added Salt diet that you’ve got for so and so and so and so and so and so, what do you do when bacon’s on the menu?” And he looked at me and said, “what are you talking about?” So it was in the chart – they weren’t following it at all.

Gayle 14:24 - 26

This does not mean that dietitians didn’t see merit in having assessment schedules⁵ or value in completing thorough nutritional assessments to file in medical records. Rather, it highlights that participants’ primary concern was ensuring that residents received appropriate nutritional care. While this required ongoing assessment it was not dependent on the completion of assessment forms. This concern was the motivation behind the many other roles that they took on. These other roles focused on encouraging and equipping the teams in their facilities to provide resident-focused nutritional care. In

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⁴ Here completing nutritional assessments refers to completing assessment forms and is distinguished from the process of ongoing nutritional assessment.

⁵ In British Columbia there is legislation that outlines the frequency and timeliness with which nutritional assessments must be filed in residents’ medical records. These standards are often referred to as assessment schedules.
speaking about these other roles, participants referred not to things that they had to do, but things that they had to be.

The distinction between things that they had to do and things that they had to be is important. Roles of doing had to do with completing specific tasks, such as completing nutritional assessment forms. Tasks associated with these roles were identified by government or administrators and were assigned to dietitians. These tasks were easily measured and once done were considered completed. In contrast, roles of being were not assigned, they were not easily quantified, nor were they ever completed. The tasks associated with roles of being were taken on out of the dietitian’s sense of responsibility. Finally, many of the roles of being taken on by dietitians addressed residents’ nutritional needs through addressing perceived or observed needs of team members, including factors that participants identified as influencing individuals’ effectiveness on the team (personality issues, education, job satisfaction).

Participants clearly saw themselves in the role of food and nutrition expert on a multidisciplinary team. This did not mean that dietitians solved every nutrition problem. Rather, it meant that they brought experience and expertise along with an extensive knowledge about nutrition to the team. This required being present in a facility in order to know the staff and to know the residents so that nutrition knowledge was applied appropriately and individually. Participants often contrasted this with nutritional care that was provided in their absence according to “the rules” (eg: Canada’s Food Guide),
stock solutions (such as providing high-calorie supplements to all underweight residents) or foregone conclusions ("when you get old you just lose weight").

Dietitians also identified themselves as being educators. This role was much broader than just providing formal inservice education. Participants constantly looked for opportunities to teach fellow team members about nutrition in situ and it was typically linked with their assumption that education would improve staff participation in nutritional care. Ward rounds, meal times, multidisciplinary meetings and impromptu conversations about specific residents all became opportunities for staff education. Education of team members was aimed at equipping and empowering them to identify and solve nutrition problems. Moreover, in educating the staff about nutrition, participants sought to increase their awareness and understanding of the complexity of feeding the institutionalized elderly.

Participants identified many aspects of the role of being a communicator using both written and verbal forms of communication. This role went far beyond just making sure that all charting, food service production lists and communication books were up-to-date, that staff had been made aware of diet changes or that residents had been spoken with. The main emphasis expressed by participants about the role of being a communicator had to do with being a skilled communicator not only with respect to what was communicated but also how it was communicated. Participants were proud of their listening skills, especially with respect to communicating with residents. They reported that residents often told them about all sorts of problems or issues and attributed this to the fact that
they took time to listen to residents and worked to understand what they were saying. Participants also spoke of their skill in communicating when they identified the related roles of being mediators, and bridges between different staff members and different departments. In effect, dietitians applied their skills as communicators to assist others on the team to communicate effectively.

Participants identified roles of being a mentor, role model, and coach to staff. The work associated with these roles focused both on addressing nutrition issues and establishing an atmosphere that supported individualized nutritional care. Implicit in these roles was the work of negotiating and establishing good working relationships with staff. In these relationships dietitians were not restricted by formal lines of communication or reporting outlined on organizational charts. In the following quote one participant describes how she works to establish relationships with care aides directly.

I believe that if I’m really passionate about my nutritional care, that I put a lot of effort into that, that they will take it seriously. . . also another thing, that I’ll do for them so hopefully they will do it for me. Anything that they ask from me, anything! . . . They come to me with any kind of information . . . I acknowledge them. I make them feel important. So we work as a team. I do take their comments as important so I’m hoping that with that they will understand that that when I need them they will, they should be there for me.

Cindy 18:8 – 25

Another participant, who had been working in LTC for almost 20 years, stressed the importance of simply spending time with staff to establish good working relationships.

It’s very important that I spread my time that I’m there so that I’m not seen as ignoring anybody. ‘Cause I go into the unit and [the staff] go “we haven’t seen you for days and days, where have you been?” . . . they all need to feel that you’ve spent some time with them.

Gayle 8:29 – 35
A dietitian who was new to dietetics and to LTC agreed that good relationships among team members were crucial to nutritional care in LTC. Beyond simply establishing rapport with coworkers, however, she was surprised to discover that it was her role to “make sure that they listen to you and... feel that nutrition is important and they’re always willing to approach you whenever there’s a problem with a resident.” (Ina 3:15 – 20)

Overall, dietitians reported that taking on these roles of being was personally satisfying, particularly when they promoted successful teamwork, evidenced by residents receiving individualized nutritional care. When team efforts fell apart, having invested themselves in these ways was frustrating. Two responses were identified. Sometimes a breakdown in teamwork made them want to focus on their doing tasks and retreat from the team.

The following story describes a situation that started out with the team working together well as they planned to reorganize the dining room. This section of the transcript contains lots of “we” language, suggesting that the team worked together effectively: “We had decided we were going to reorganize our dining room... And we actually had a committee... So we compromised, and we moved all these people... after much debate about how we were going to do this...” Then, things fell apart and ‘we’ is mostly replaced by ‘I’ and ‘them’ and further investment in the team (e.g.: “calming people down”) was clearly not fulfilling and left the dietitian wanting to focus on her doing tasks.

I came back one day to work to find out that the one gentleman who was supposed to sit by himself and never have anyone with him because he’s aggressive, loud, and umm, well just vulgar... So we decided never to sit anyone with him and they had a new admission and they sat them with him, and they fought. So, instead of moving the new
admission and leaving this poor gentleman alone, like we had agreed, they moved him to a different table who he subsequently fought with. . . . and then I came back to work on the Tuesday and by then everything had three days to fester. And then in the meantime, all my serving guides, because everybody else had domino effect had moved. I spent half the day updating my records, calming down people, trying to catch all the nurses that were on to reiterate what had happened and what we had to do to correct the problem. And I find myself sometime, just fixing errors like that, instead of getting on with what I needed to do, you know, clinically.

Bethany 8:41 – 9:18

The other response when teamwork failed was for dietitians to work harder at fulfilling their roles of being, thinking that more education or better relationships would lead to improved nutritional care for residents.

As dietitians shared their experiences of clinical practice in the LTC setting it was clear that they were not just happy, but keen, to contribute to teamwork. In addition to completing specific assigned tasks, dietitians invested themselves in the team by taking on a great variety of roles. Beyond providing leadership to the team, these roles often specifically addressed the factors that they believed affected individual team members’ effectiveness (education, personality and job satisfaction) which in turn affected team effectiveness.

DISCUSSION

The primary goal of this research was to better understand the experiences of clinical dietitians within the LTC setting. Stories of participants’ experiences revealed a wide and inclusive definition of team and that they understood the purpose of teamwork to be primarily about providing individualized resident-focused care. While this involved completing certain tasks, these tasks were not the focus or measure of effective
teamwork. These findings were frequently identified as participants spoke about their roles and discussed how they understand them to contribute to team effectiveness. Thus, it is appropriate to now consider these findings in light of literature discussing meaning, culture, and structure of healthcare teams in LTC.

**Dietitians' Roles and the Meaning of Teamwork**

While there is a great deal written about the nutritional needs of the elderly there is little written specifically on the dietitian's role in LTC. One attempt to bridge this gap was a paper that reflected on literature specific to nutrition and the elderly and then suggested roles for the dietitian working in LTC (15). These suggested roles focused on specific tasks for dietitians to take on to promote quality of life for residents. However, our participants were clear that they did not primarily define their role in terms of tasks even though all roles certainly include specific things that people do.

This understanding of their role offers insight into the meaning that dietitians hold of teamwork. Just as dietitians do not view their role in terms of task, they do not consider teamwork to be mainly about tasks. Our findings suggest that dietitians focus primarily on the purpose of their work. Tasks are never isolated but always part of a bigger picture, i.e.: the provision of resident-focused nutritional care. Similarly, Cott (13) found that for professionals, including dietitians, teamwork in LTC had to do with cooperation around problem solving in order to improve the quality of the work. This was in contrast to other staff for whom teamwork focused on completing tasks so as to make the work easier for each other.
Our findings suggest that dietitians perceive other team members to hold different priorities for teamwork than their own. For example, our participants believed that workload issues were of prime importance to care aides and that addressing these was important if the team was to be effective. While we cannot comment as to the accuracy of this perception our findings do demonstrate that synthesizing or bringing together different meanings is possible in practice. For example, participants reported that teamwork was more effective when they considered workload issues when planning individualized nutrition interventions. While the need to synthesize differing meanings of teamwork has been suggested in other literature (5, 7), most studies simply identify the meaning of teamwork held by various team members and do not discuss how to bring them together into a single, functional understanding of teamwork. Further, studies tend to focus on professionals (3, 6, 8, 24) and do not meaningfully include the perspectives of non-professional staff (e.g.: care aides, food service workers) in discussions on teamwork. Doing so is essential if the broad definition of team held by our participants is common within LTC.

Beyond dietitians’ reluctance to discuss their role or teamwork in terms of task, there are potentially negative consequences of doing so. Discussing roles in terms of tasks can lead to defining teamwork in terms of accomplishing specific tasks (13). This can disassociate tasks from their purpose as in the situation where “beautiful [nutrition] charting” exists that has no bearing on or connection to the nutritional care provided to residents. Further, it can equate providing care with completing tasks. Gibbs-Ward and
Keller (21) reported the negative effects on nutritional care when caregivers “approach meals as a task (21, p9). In contrast, when staff are encouraged to focus on activities over tasks and processes over outcomes then meals can be viewed “as a positive therapeutic, social and sensual experience for residents” (21, p9). The benefits of this to residents and their nutritional status and quality of life are well-documented (19, 20, 22, 23). Many of the roles taken on by our participants promoted teamwork that focuses on activities and processes and links tasks with their purpose.

Secondly, focusing on tasks promotes efficiency as an aspect of teamwork often in order to control costs. Thus, the faster a dietitian completes nutritional assessment forms, the less time she is needed at a facility. This contradicts studies that show that it is the dietitian’s time and presence in facilities that provides cost-effective benefits (16, 17). Many tasks associated with nutrition and eating cannot be made increasingly efficient because it takes time for residents to eat. Further, many nutrition-related tasks cannot easily be itemized or assigned (18, 19). These include such things as monitoring residents’ intake, assessing eating/swallowing ability, advising staff re: nutritional care, addressing individual needs of residents. The potentially negative consequences of a task focus to the dietitian’s role and the work of nutrition in LTC has perhaps been best demonstrated by the fact high levels of mal- and undernutrition remained a significant problem in nursing homes even ten years after legislation was introduced in the USA that outlined, among other things, specific tasks for dietitians to accomplish (20).
DIETITIANS’ ROLES AND THE CULTURE OF TEAMS

Institutions are micro-societies and, as such, develop their own cultures (25) which form the environment in which teams function. Factors such as “existing norms, values, activities . . . the attitudes and beliefs of the caregivers, and the personal interactions of all who are part of the institutions” (22, p125) shape the culture within facilities. Many of the roles that dietitians take on seek to influence these factors especially as they relate to nutritional care. As food and nutrition experts and educators they work to influence team norms, values and activities related to nutrition. As role models they seek to influence staff attitudes (and actions) toward residents. And in working to establish good relationships with staff and among staff (mediator role) dietitians seek to positively influence personal interactions.

In addition to culture being the environment in which teams function, Manion et al (4) identify specific cultural requirements of teams. These include items such as conflict resolution skills, coaching, education and being able to negotiate priorities. Again, many of the roles that our participants identified for themselves addressed these specific needs of the team. Regardless of whether dietitians’ roles work to influence, reinforce or change the culture within a facility or to meet specific cultural needs of team members the purpose of their roles remains to promote individualized, resident-focused nutritional care.

It is interesting to note that essentially all of the roles identified by our participants addressed some cultural component of teams or facilities. This is significant in that
teams also have other components that need to be addressed in order to establish effective teams. Kayser-Jones (22) identifies organizational aspects of the environment (culture) of facilities such as, “policy, staffing and financing” (22, p125) and other formal structures. Manion et al (4) discuss structural requirements of teams and state, “Teams simply cannot succeed without striking the crucial balance between their cultural and structural requirements – no matter how many team-building workshops they attend or videos they watch” (4, p. 10).

**DIETITIANS’ ROLES AND THE STRUCTURE OF TEAMS**

Teamwork is more than collegial relationships and requires more than agreeable personalities to succeed. Teams have structural requirements that have to do with how team members are organized to do their work, how the workflow is planned and how performance is monitored and, when necessary, corrected (4). Structures may be very formal and operate according to an established hierarchy or very informal with little or no hierarchy.

Cott (10) identified both of these structures within the multidisciplinary team at a large LTC facility in Toronto. Nurses (including care aides) were hierarchical in their work, whereas professionals, including dietitians, were not. In addition to contrasting these different approaches to teamwork she suggests that they entrench and distance team members into subteams. Our findings challenge this conclusion and demonstrate how dietitians, in the roles they take on, actively work to avoid this. For example, they
solicited input from all staff on nutrition issues and took on many roles that sought to
draw others, regardless of their position, into the work of problem-solving and decision-
making. This was further evidenced by the importance they placed on open
communication among team members that was not bound by formal lines of authority,
and by the value they saw in the contributions of care aides at team meetings.

Regardless of the type, our findings emphasize the importance of having some
functioning structure in place. Hence, the measures of effective teamwork had to do with
specific outcomes, not with any one way of coordinating teamwork. Our participants
certainly related to a more informal structure of teamwork, evidenced in the roles that
they identified for themselves. However, they still valued elements of hierarchy on their
teams. For example, they valued directors of care who reminded staff of their roles and
tasks. Hierarchy was valued as a tool, not to distance staff from decision-making or to
silence anyone's voice, but to support effective teamwork. Moreover, in affirming this
element of structure for teamwork our participants suggest that hierarchical and collegial
approaches to teamwork need not merely co-exist in LTC, least of all on insulated
subteams. Indeed, Manion et al state, "teams and hierarchy are not a contradiction but
complementary structures" (4, p10).

Finally, it is interesting to note that staff roles themselves are typically identified as a
structural element of teams in the literature. Moreover, it is agreed upon that it is the
responsibility of 'higher level management' to identify and assign roles (3, 4, 5, 6). For
our participants, most roles were self-labelled and often self-appointed; they both
emerged and evolved through their tenure at a facility. Cott (13) found that in speaking about their work, professionals tended to speak not about tasks but about roles. Thus it is not surprising that our participants spoke at such length about their roles even though little was formally assigned. Further, Cott suggests that being part of a team is part of the social identity of multidisciplinary professionals like dietitians. Thus the team is important to them because it is not just about their work but rather, about who they are. In taking on a variety of roles to promote team effectiveness participants, even with a clear ethic of resident-focused care, may have been addressing issues related to their feelings of personal effectiveness.

STRENGTHS AND LIMITATIONS

One limitation of this research is a small sample size, although saturation was reached with respect to the question guide. A larger sample would have allowed for more specific exploration of the themes reported in this paper. It is acknowledged that in choosing to hear only from dietitians this research cannot claim to be a comprehensive study on teamwork in LTC. It does, however, add a previously unheard voice to this discussion. As with any qualitative study, the transferability of findings cannot be assumed. Dietitians’ roles and the structure of teams may vary among health regions in BC, provinces in Canada and other countries.

CONCLUSION

Dietitians take on a variety of roles on multidisciplinary teams within LTC. When clear roles are not assigned dietitians create and label their own roles on the team. Most of the
roles participants identified addressed the cultural aspects of teamwork. In these roles dietitians work to establish a supportive culture (environment) in which nutritional care takes place, and contribute to specific needs of healthcare teams. Dietitians acknowledge the limitations of their roles through their valuing of structures that promote consistent delivery of individualized nutritional care and those team members whose role it is to establish them.

Dietitians do not understand their roles or teamwork primarily in terms of tasks. Rather they focus on the purpose of tasks. With respect to nutritional care this purpose was identified as providing individualized, resident-focused care. Several potentially negative consequences of discussing teamwork in terms of task were discussed. Perhaps most notable was the fact that a task-oriented approach may promote increasing efficiency. Nutritional care cannot be increasingly made efficient because mealtimes are governed by residents’ needs and abilities.

Finally this study highlights the possibility and importance of synthesizing various definitions of teamwork that may exist within a facility. Until now there has been no literature identifying or discussing dietitians’ views on teams and teamwork. Moreover, much of the literature, particularly the ‘how to’ literature fails to even mention dietitians as part of the multidisciplinary team. Non-professional staff must be included in such discussions.
REFERENCES


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CHAPTER THREE

Dietitians' Philosophy of Nutritional Care in Long Term Care

A modified version of this manuscript is planned for submission to The Journal of the American Dietetic Association as: Wassink, H.L., Chapman, G.E. Dietitians' Philosophy of Nutritional Care in Long Term Care.
INTRODUCTION

Despite an adequate supply of food within most Long Term Care (LTC) facilities, malnutrition, undernutrition and dehydration persist among LTC residents (1, 2, 3, 4, 5). Indeed, as Kayser-Jones (6) points out, the tragedy of people starving in the midst of plenty in healthcare settings is not a new phenomenon, having been reported by Florence Nightengale in the middle of the 19th Century. In the growing body of literature that is specific to nutrition in LTC many aspects of this problem are identified and addressed. However, none of this literature synthesizes what we know about the nutritional care of the institutionalized elderly into a philosophy of care that guides dietitians and other LTC staff as they address the nutritional needs of individual residents. Additionally, the "systematized principles" (7) that form a philosophy of nutritional care may also guide decision-making and policy-making for facilities and government.

Certainly the existing literature is helpful to dietitians practicing in LTC particularly in providing guidance for medical nutritional therapy. There are studies that document staff attitudes toward nutrition (5, 8, 9, 10). Other papers focus on organizational issues within LTC facilities and make suggestions as to how nurses, dietitians and facilities in general can work to improve nutritional care (2, 11, 12, 13, 14, 15). Finally, there are studies that focus clinically on either specific medical conditions (8, 9) or the nutritional care of the elderly in general (13, 16, 17, 18). Nevertheless, in order to establish a useful philosophy of nutritional care the findings of such studies must be applied in practice.
This is where the professional literature appears to be silent. We found no studies describing how dietitians working in LTC put their philosophies of care into practice or that identify the principles that guide them in their day-to-day decision-making. Thus, while there are studies and papers to inform a philosophy of care, there is little that tells us about the actual philosophies of care held by dietitians working in LTC. Further, much of this literature, especially that pertaining to attitudes toward nutritional care, addresses nurses or is from a nursing perspective. Thus, we sought to identify and describe the elements of a philosophy of nutritional care held by dietitians working in LTC. In addition, we wanted to understand some of the challenges that dietitians face as they seek to apply their philosophy of care within their facilities and how they meet them.

METHOD

This research began with a desire to understand dietitians' experience of clinical practice in LTC from the perspective of dietitians and to identify possible features of the culture of LTC that support dietitians in their work. As participants told stories about their work it was evident that their efforts focused on trying to apply a philosophy of care with respect to nutritional care within their facilities. This paper describes the key features of this philosophy: that residents need to eat food; that nutritional care must be resident-focused and quality of life.

Morse and Field (19) suggest that qualitative methods are most appropriate when a concept under investigation is immature. Because dietitians experiences of clinical practice within LTC had not been previously well-studied we chose a qualitative
approach to research. Further, qualitative research assumes that the setting of a phenomenon is a part of the phenomenon (20). Thus, our interest in the culture of LTC and how it influences dietetic practice also made this choice appropriate.

After gaining ethical approval from the University of British Columbia Behavioural Research Ethics Board, we sent a recruitment letter to 20 dietitians working in LTC in the Vancouver Lower Mainland. Names of potential participants were selected from a list of dietitians working in LTC, Extended Care and Mental Health facilities in one jurisdiction of the regional health authority. The letter requested that interested dietitians contact HW by telephone. Those who did not do so within two weeks of the letter being received, received a follow-up telephone call. Convenience sampling criteria used for contacting potential participants by letter were that they had to be Registered Dietitian/Nutritionists working in British Columbia who were currently working (full- or part-time) in a LTC facility (may or may not have been working in other settings as well). They had to be responsible for clinical nutrition within their facilities but could also be responsible for administrative dietetic functions. This information was available on the original list provided by the regional health authority.

Repeated attempts were made to contact all 20 potential participants by telephone. Fifteen were eventually contacted by telephone and of these 13 were willing to participant. Eleven study participants were selected to maximize variation on several sampling criteria, using information obtained during the initial telephone contact. As summarized in Table 3-1, the final sample included participants with varying lengths of

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Table 3-1. Participant and Facility Characteristics

<table>
<thead>
<tr>
<th>Participant Characteristics (n = 11)</th>
<th>Years since completing dietetic internship</th>
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<tbody>
<tr>
<td></td>
<td>&lt;1</td>
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<td>10-19.9</td>
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<table>
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<th>Years working in Long Term Care</th>
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<tr>
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<td>10-19.9</td>
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<table>
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<td>2</td>
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Facility Characteristics (n = 19)

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<td>&lt;1</td>
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<td>1-4.9</td>
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<td>≥10</td>
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<tr>
<th>Facility size (# residents)</th>
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<td>15-49</td>
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<tr>
<td>50-99</td>
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<tr>
<td>100-149</td>
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<tr>
<td>≥150</td>
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<table>
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<th>Dietitian Time at Facility (hours / week)</th>
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<tr>
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<table>
<thead>
<tr>
<th>Dietitian Status</th>
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<tbody>
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<td>employee</td>
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<tr>
<th>Dietitian’s Area(s) of Responsibility</th>
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<tbody>
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<td>clinical</td>
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<tr>
<td>clinical and administrative</td>
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<table>
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<th>Facility Funding</th>
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<tbody>
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<td>private</td>
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<tr>
<td>government</td>
</tr>
<tr>
<td>government funded with some private beds</td>
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Because several participants worked at more than one LTC facility, the number of facilities is greater than the number of participants.
practice since internship; different lengths of time working in LTC; both those working under contract (individual and corporate) and those working as employees; and both those with and without administrative responsibilities. Effort was also made to include participants working in a variety of sizes of LTC facilities and in both government funded and private facilities.

The first author conducted individual interviews with each participant at the location of the participant's choice, using the semi-structured interview guide shown in Table 3-2. Questions were designed to encourage participants to reflect on their role as 'the dietitian' within a LTC facility and to tell stories of self-identified successes and failures in their work. Probes encouraged reflection on factors that contributed to their success or failure. All of this aimed at gaining thick, rich descriptions of dietetic practice and nutritional care within the LTC setting and at understanding what promotes quality nutritional care to LTC residents. Prior to being interviewed, participants signed an informed consent form and understood that they could refuse to answer any question and could withdraw from the study at any time. Interviews were tape recorded and transcribed verbatim. Pseudonyms were assigned to each participant and real names disassociated with the data at the point of transcription. Field notes were written after each interview.

Data analysis was conducted concurrently with data collection. Preliminary data influenced the areas that were probed in later interviews although the basic interview questions did not change substantially through the study. Probes focused on identifying
Table 3-2. Interview Guide

| 1. | I’m interested in hearing about your work as a clinical dietitian within a LTC facility. Maybe we can start with you telling me what you see your role as within the facility. |
| 2. | I’m interested in learning about conditions and factors that affect dietitians’ abilities to do their work in LTC settings. To get us thinking in that area, I wonder if you can tell me about a specific example of something you’ve done at work that you’re really proud of – something that made you think, “yes! I’m doing a good job.” |
| 3. | Now can you tell me about a situation where you felt that you weren’t able to do your job well? |
| 4. | What needs to be in place for you to do your work? |
| 5. | Are there any key players who make it easier / possible for you to do your work? |
| 6. | In what ways does nutrition matter to others working in your facility? How do these perspectives affect you in your work? |
| 7. | Has your experience of practicing dietetics within LTC changed over time? If so, how? How would you like to see it change in the future? |
| 8. | Is there anything else that you would like to tell me about your experience of clinical dietetic practice within LTC? |
the people and systems that supported the implementation of a philosophy of care,
specific challenges that dietitians faced when promoting the implementation of their
philosophy of nutritional care, and the strategies that they used to overcome these
challenges. Throughout this process, extensive memo writing, and meetings both
between the researchers and with other qualitative researchers enhanced rigour of the
analysis. These activities helped in identifying issues to be bracketed by the first author
while interviewing and conducting analysis. This in turn encouraged appropriate probing
that avoided leading questions. Probes aimed at deepening and clarifying the data were
essential to the process of obtaining rich data that truly came out of the participants’
experience. Nevertheless, the interviewer’s experience in LTC made probing more
specific and helped to develop rapport with participants.

Transcripts were initially coded using a content analysis method as described by Morse &
Field (19). Both categories (eg: food first) and constructs (eg: philosophy of care) were
identified and compiled for each transcript. Thematic analysis followed the initial
coding, focusing on the major messages identified in each transcript. Transcript
summaries were prepared for each interview. Thematic analysis continued with the
writing of lengthy documents that sought to clarify and synthesize the data. Ongoing
discussion of these documents between the authors and subsequent revisions facilitated a
thorough understanding of each theme and how they related to each other in describing
the experiences of clinical dietitians working in LTC. Through this process our initial
interest in the broad culture within LTC facilities was narrowed to focus on a few key
themes. One of these themes was labelled ‘philosophy of care’. This paper presents the
key features of dietitians' philosophy of care in the LTC setting and discusses them in light of the literature specific to nutritional care in LTC and quality of life issues for people living in LTC facilities.

FINDINGS

As participants spoke about their work and shared their experiences in the LTC setting, three main principles within their philosophy of nutritional care were apparent: LTC residents need to eat, nutritional care must be resident-focused, and nutritional care is about promoting quality of life. In looking at each of these principles we will consider challenges to applying them identified by our participants and strategies that they used for meeting these challenges.

(1) **Residents Need to Eat Food**

Although it may appear obvious, participants emphasized that, “having people eat their meals is very important” (Ethel 18:47). Promoting residents’ food intake was an important part of the dietitian’s role within LTC. Participants identified two distinct focuses of this principle. The first focus was that residents need to eat food and that this is preferable to consuming high-energy hi-protein nutritional supplements as a primary form of oral nourishment. As one participant stated, “[my] philosophy has always been real food first then you go with supplements” (Bethany 6:11). The second focus was that residents need to eat, that is, actually consume food. One participant went as far as saying that eating anything is better than eating nothing.
Participants identified several social and physical benefits of ensuring that residents eat. These included improved quality of life, less illness, fewer hospitalizations and avoidance of weight loss.

One challenge to applying this principle that participants identified was the unfortunate reality that not all staff share it. This was especially true of ensuring that residents consume food that is served to them. Participants attributed this to work ethics, workload issues and staff education/understanding. Dietitians met this challenge through formal and informal education to staff about food and nutrition issues; by being a role model to staff, particularly at meal times; and by considering staff workload issues when planning interventions. The following quote illustrates how one dietitian addressed this challenge by working to ensure that residents ate (i.e.: actually consumed food) when she was at work.

If I see that the residents turn down the food, aren’t touching that food I go right to the kitchen get sandwiches made — something different — you know, I make sure that that resident eats something . . . I don’t see that the care aides will do that. They just want to quickly get it over with. They have many residents to look after.

Cindy 4:2 – 15

(2) NUTRITIONAL CARE MUST FOCUS ON RESIDENTS’ NEEDS

Without exception, participants identified the importance of providing resident-focused nutritional care. Again, there were two aspects to this. The first had to do with ensuring
that resident population profile informed food services activities. Participants spoke
about the food and food service preferences and the nutritional needs of their residents as
a group. For example, a participant spoke about increasing the calcium intake of all
residents, without sacrificing food quality.

... because we have so many residents with osteoporosis ... we look at first diet. What
can we do in our general menu? ... just adding extra calcium ... and still trying to make
it palatable.

Devony 4:1 – 32

Participants pointed out that the profile of a resident population within a facility could
change over time, requiring that some aspects of nutritional care change too. For
example, a participant told of a significant ethnic shift within her facility that eventually
required a major menu revision. It is essential to know the unique population within each
facility in order to identify and meet their unique nutritional preferences and needs.

Participants also used the expression ‘resident-focused care’ to refer to individualizing
nutritional care for specific residents. That is, while residents are rightly treated as a
group for functions such as menu planning, they must be known and considered apart
from the group when planning specific nutrition interventions, even ones as basic as
serving the general menu a resident. Individual nutrition goals are not primarily set by
external measures such as Canada’s Food Guide to Healthy Eating or licensing standards,
but by the unique situation of each resident. Residents require one-on-one attention, at
meal and snack times, to promote intake. Further, individualizing nutritional care means
offering residents choice. Participants stressed that choice has to do with more than just
what people eat, it is a principle that must be applied to all aspects of eating, and even whether they eat.

It’s more of a, “let’s get organized with this resident really define the resident’s needs and then as a group [of staff] see if we can implement this plan”. But it goes right down to the Care Aides and the Dietary Aides. [It’s] not just me saying, “this is the diet” and the cook making it and bringing it to the table. It’s how we’re going to approach them, what time, the quantity of food we’re going to give them, and then what we do when they don’t eat.

The challenges to providing resident-focused care are many and addressing them often required establishing balance. For example, balancing food preferences and nutritional needs was a significant challenge for both group and individual nutritional care. This is in part due to the first principle: residents need to eat food. Identifying resident preferences is a vital aspect of promoting intake. Whenever possible, resident preferences take priority. However, specific nutritional needs of the residents cannot ethically be ignored. Dietitians used their expertise as food and nutrition experts to address some of these tensions. They also valued meeting with other dietitians in order to share ideas for creatively meeting common nutritional needs of LTC residents.

Often budgetary, staffing or workload issues needed to be balanced with the importance of resident choice. Participants reported that they did consider these issues when making decisions about nutritional care. The following quote outlines how one participant balanced resident choice with food service limitations.

... my vision is resident-focused. It is their home and that we shouldn’t cater to their every whim because nobody has a 12-course meal at home. You may have two choices, right? ... You don’t get a third, third one’s bread and butter and cheese. Or bread and butter and peanut butter. That’s what it would be at home. ... And it still serves our needs
in the kitchen because we can’t produce four different entrees.

(3) **QUALITY OF LIFE**

Although considering quality of life was often spoken of in relation to providing individualized nutritional care it was also referred to as an important principle within a philosophy of nutritional care in LTC in itself. Quality of life was frequently equated with pleasing residents and respecting their choices with respect to food and diet. It was often contrasted with and considered more important than quantity of life, in the LTC setting. Improving quality of life was identified as a goal of nutritional care.

I think in Long Term Care it basically says, ‘quality of life is more important than restricting them to the last minute.’ I mean if a person was suffering and they really had to have a bit of a fluid restriction or something ... we might look at it then. Obviously, we don’t want to hurt anybody.

Several factors had to be weighed in making quality of life decisions. The above quote identifies that potential harm or risk as well as benefits (physical and psychological) must be considered. When assessing risk, particularly with respect to swallowing safety, staffing ratios and workload were identified as important considerations. Resident autonomy was also a key factor in determining quality of life. Thus, quality of life was sometimes given as a rationale for accepting diet non-compliance from a resident. It was difficult for dietitians to accept this when they knew that the resident would “feel better” as a result of dietary intervention and it presented a significant challenge to dietitians, especially when resident safety was at risk. The following story tells how a dietitian changed her practical application of the principle of ‘quality of life’ as her clients
changed. Initially, she sought to make sure that residents were happy but in time had to weigh residents’ preferences with safety issues.

... but [back then] my philosophy was a lot different: Strive to get as many people off thickened fluids that didn’t really need it. There might have been some silent aspiration there that I kinda overlooked, but my goal was quality of life and keeping people happy. But I’m finding now that -- maybe because the clientele has gotten heavier and heavier -- we’re back up - we’ve got lots of pureed food and thickened fluid. And, we’ve had a couple of incidents recently where we’ve had scary choking episodes and, darn, those people are back on pureed foods just because sometimes you have to [protect yourself]. Even though I really know they love those tuna fish sandwiches, they can’t manage bread – I war with myself all the time in my heart with what is right sometimes. Looking at quality of life, what the resident really wants, what they can safely manage. Who’s going to monitor them when you’ve got 20 people that need feeding and only five care aides ... and that lady really wants bread but who’s going to sit with her and make sure she doesn’t choke? That’s a tough one.

For our participants a philosophy of nutritional care was something that evolved through their years of practice. At the same time, even dietitians who had been in practice a short time (i.e.: weeks or months) identified each of the components discussed above. A philosophy of care outlines what dietitians believe clinical dietetic practice in LTC is all about. It explained how they approached practice and what factors they considered in decision-making.

DISCUSSION

GROUNDING A PHILOSOPHY OF CARE IN THE LITERATURE

The elements of a philosophy of nutritional care described by our participants are, for the most part, not surprising. Dietetic practice has always sought to apply basic science (biology, physiology and biochemistry) in light of psychology and social science (21, 22). As such, it takes into account not just diagnoses but the client’s context, which
includes physical, economic, social, spiritual, and personal factors. Further, it has always acknowledged that while trends or norms within a population exist, an individual’s situation remains unique. As well, recent literature on nutrition and nutritional status among nursing home residents continues to assert the basic principles of resident-focused care that promotes quality of life (4, 13, 22, 23).

Given this support for the philosophy of care articulated by the study participants, what is surprising about these findings is that participants typically presented the principles of their philosophies of care as personal perspectives. Rarely did they refer to their education, or academic or professional literature to substantiate their philosophy. Philosophies were presented as a set of personal beliefs that had come into being as a result of their experience in practice in LTC, be it short or long.

In addition to it being possible to ground a philosophy of nutritional care in current research, doing so has a number of potential benefits for LTC and its residents. Firstly, it focuses discussions and nutritional care decisions on tested strategies for improving residents’ nutritional status rather than on various personal opinions.

Secondly, studies in the literature may be helpful for effectively promoting a philosophy of nutritional care among staff. For example, staff education was a common strategy used by dietitians for promoting their philosophies of care. A variety of studies address can inform this education. For example, some studies highlight that the nutritional care of resident suffers when the focus of nutrition interventions moves away from resident
needs to that of staff workload concerns (6, 13, 14), and others demonstrate an association between resident food intake and functional status (3, 4, 17). Together, these may be helpful in motivating staff to adopt a philosophy of care such as we have described by highlighting that it is in addressing the nutritional needs of residents that staff workloads may be lightened by avoiding complications of malnutrition and dehydration and improving functional status.

Further, while many studies emphasize the need for nutrition education among staff (3, 4, 13), it has also been suggested that “social influence and group norms” (10, pg 230), not education, are the primary influences that shape the attitudes of nurses toward nutritional care (10). Dietitians promoted their philosophy of nutritional care through the modelling of positive interactions with residents and demonstrating how to provide individualized care to residents. These actions sought to establish or reinforce attitudes and norms within their facilities.

The elements of a philosophy of care presented by our participants are not important because dietitians hold them. Our participants always spoke about them in the context of the potential benefit to residents. Further, the literature demonstrates the potential benefits not only to residents, but to staff and facilities. If dietitans’ contributions to the environment within their facilities remain in the domain of dietitians’ personal beliefs their impact is likely to be limited. However, presenting these elements in the context of current literature may promote wider acceptance as facility norms and values for nutritional care. Finally, it is acknowledged that many other players make important
contributions to the environment within LTC facilities, each of which has the potential to impact nutritional care. Our participants repeatedly reported valuing those who promoted care that maintained a clear and uncompromising resident focus.

UNDERSTANDING QUALITY OF LIFE

There are many definitions of the term quality of life (18) and many opinions as to the parameters that contribute to it. Typical QOL measures include components such as life satisfaction, self-esteem, functional status, and socioeconomic conditions. Further, different types of QOL focus on specific measures. For example, psychosocial QOL focuses on reported overall life satisfaction. Health-related quality of life (HRQOL) "focuses on the changes in physical and mental health dimensions that may occur with disease, aging, or alterations in functional status" (17, p. 54).

Our participants spoke about QOL primarily in terms of making residents happy with some reference to helping them to feel better (i.e.: improved functional status). Providing individualized nutritional care was thought to contribute to overall QOL. While it is interesting to note the factors that dietitians thought contributed to residents’ QOL we cannot assume that dietitians were correct in their perceptions. Indeed, West et al (5) found that staff consistently misjudged residents’ rankings with respect to importance and satisfaction of a variety of factors related to QOL. Nevertheless, our participants’ perceptions do concur with a study that looked specifically at psychosocial QOL for LTC residents and identified choice and individuality as two of 11 “outcome domains”
contributing to it (24). Similarly, Kayser-Jones (22) concluded that QOL for LTC residents was improved by the provision of individualized nutritional care.

Our findings suggest that dietitians working in LTC may contrast HRQOL and psychosocial QOL or hold them in tension. Clearly they were aware of the potential benefits of being properly nourished to residents’ functional status and subsequent sense of well being. However, the resident’s right to choose and to establish personal priorities with respect to care were the bottom line when planning nutrition interventions. Thus, even when dietitians knew that specific dietary changes were likely to improve functional status (HRQOL), they gave priority to aspects primarily associated with psychosocial QOL. Sometimes this meant accepting a resident’s refusal to comply with a recommended nutrition intervention. However, our findings suggest that in adopting a philosophy of care such as that described by our participants, HRQOL may be improved through addressing issues related to a psychosocial understanding of QOL. They are not simply opposite ends of a continuum nor do they necessarily have to be held in tension.

In writing about HRQOL, Amarantos et al (17) acknowledge that eating is a multifaceted process. They are careful to point out that HRQOL does not provide a complete picture as to all aspects of food, nutrition and eating that affect overall quality of life. However, their paper encourages dietitians to set a priority for working to improve the HRQOL of LTC residents stating that when HRQOL improves subjective reports of overall QOL improve (17). Other researchers agree (18, 25, 26). But, where they suggest that HRQOL must be considered without ignoring psychosocial aspects of nutrition and
eating and therefore QOL, our findings suggest that it may be more helpful to state that addressing the psychosocial aspects of QOL may be the most effective way to improve HRQOL. The elements of a philosophy of nutritional care identified by our participants are instructive for doing this. For example, in working to increase choice or in addressing individual preferences related to food and dining residents may have improved food intake which in turn improves their general health and functional status. Indeed, the American Dietetic Association asserts that simply getting residents to eat is the easiest way to improve functional status (23). Further, many nutritional issues related to functional status may be addressed as facilities seek to be resident-focused at the population level. For example, participants identified the need to provide appropriate calcium, protein and fibre intakes for all residents through recipe selection and creative menu planning. Measures such as these address HRQOL issues without waiting for medical problems (e.g.: pressure sores, bone fractures, constipation) to occur.

STRENGTHS AND LIMITATIONS

One limitation of this research is a small sample size, although saturation was reached with respect to the question guide. A larger sample would have allowed for more specific exploration of the themes reported in this paper. It is acknowledged that in choosing to hear only from dietitians there remain many unanswered questions, especially with respect to more fully understanding the challenges to implementing a philosophy of nutritional care that participants reported. Nevertheless, this paper does serve as a seminal work in articulating a philosophy of nutritional care for the LTC setting. It also highlights potential benefits to residents, staff and facilities of striving to provide
resident-focused care. As with any qualitative study, the transferability of findings cannot be assumed. Readers are advised to consider these findings in light of their unique situation.

CONCLUSION
Dietitians working in LTC hold a philosophy of nutritional care that is substantiated by recent studies and highlighted in professional literature. Key elements are that nutritional care be resident-focused and, as much as possible, individualized; that residents have choice; and that nutritional care be practical and promote actual consumption of food. In addition, nutritional care must seek to promote quality of life for residents of LTC facilities. Further, the features of the philosophy of care presented in this paper are consistent with factors that reportedly contribute to improved psychosocial QOL for LTC residents. Our findings suggest that addressing these QOL factors, especially those that are more psychosocially oriented, is not just another aspect of nutritional care but a vital component of a holistic approach to it. Indeed, it may be the key to improving nutritional / functional status. As Amarantos et al stated in their article about HRQOL, “This statement may be obvious to nutrition professionals, but still needs to be recognized and made operational in the rest of the health care community” (17, p.60).
REFERENCES


CHAPTER FOUR

Concluding Chapter
PUTTING IT ALL TOGETHER

The original purpose of this study was to hear about and learn from the experiences of clinical dietitians working in Long Term Care (LTC), with a particular interest in aspects of the culture of LTC that affect / influence dietetic practice. Through the analysis process four themes predominated: teams / teamwork, dietitians' roles and philosophy of nutritional care. The preceding papers discuss these themes in pairs. However, it is not difficult to see how the findings in these pairs of themes interact and support each other. In short, teamwork requires clearly identified goals and a shared sense of purpose among team members (1, 2) and a well-articulated philosophy of care informs and guides the development of these. At the same time implementing or applying a philosophy of care in practice requires teamwork. Individual team members must work together to share information and actually provide individualized nutritional care that promotes quality of life for LTC residents. Figure 4-1 illustrates this interaction and the interdependence of these two elements in providing care. When either element is lacking the other suffers. Note that this cyclic relationship between teamwork and a philosophy of care orbits around the resident, indicating resident-focused care. This is not to suggest that the resident “calls all the shots” with respect to his or her care, but rather that this cycle exists to serve / benefit the resident.
Further, although we discussed the roles that dietitians take on to contribute to teamwork and build up the teams in their facilities, it is only in light of the second paper that it becomes evident that a driving force behind these roles is the dietitians' philosophy of care. As we have already heard, it is true that dietitians must perform specific tasks; however, many of the roles that dietitians reported taking on, particularly their roles of being, work to promote a context or culture in which the above cycle can function. They seek to ensure that every member of the team understands the part that they have in providing and promoting optimal nutritional care for and among residents.

The fact that our dietitians' philosophy of care is shared by many nursing researchers suggests that it is possible to decrease the degree of competition within institutions, among various goals, that was suggested by Mason et al (see Figure 1-1) (3). Sharing a

Figure 4-1 Relationship between Philosophy of Nutritional Care and Teamwork in Long Term Care
philosophy of care between dietitians and nurses\(^1\) has the potential to draw members of
the multidisciplinary team together with respect to their purpose. Understanding the
benefits to staff of having well-nourished residents is a vital aspect of this in practice.
Thus these findings, beyond simply explaining the perspective of yet another voice in the
discussion on teams and teamwork in healthcare, or outlining principles that guide
dietitians in their work, illustrate how dietitians are working to implement the very
principles that current nursing research encourages nurses to adopt.

This research also suggests that there is a great deal of literature about teams that is easily
ignored in practice. For example, whereas our participants assumed that they worked
within a team culture, there were often significant aspects of developing a team that were
overlooked, lacking or inconsistently applied in their facilities. This was most notable
with respect to the need for and place of clear team structures and systems. Participants
used language that suggested that they primarily understood teamwork as a collegial,
individually negotiated way of working with staff in their facilities. While this is
undoubtedly an aspect of teamwork, it does not address the structural requirements of
teams. With respect to this research, it cannot be established whether the teams referred
to by participants were actually teams, as described in the how-to literature. This
realization gives pause for thought and critiques other papers that suggest that the
proliferation of how-to literature is premature in light of the fact that the benefits of
teamwork to residents have not been substantiated. In reflecting on the findings
presented in this thesis, in light of the available team literature, it is evident that a review

\(^1\) Note that nursing departments (also called care departments) within LTC are comprised of both
professional nursing staff and care aides. These comments focus on the department as a whole.
of and application of the how-to literature is necessary before a review of potential benefits can be undertaken. Not only would this ensure that true teams (as compared to working groups or pseudoteams) exist within LTC facilities but it would provide a more consistent base for evaluation of the suggested benefits of teamwork. At the present time many of the papers describing the benefits of teamwork only provides a description of the group of people who comprise “our team.” Thus, comparison among and between studies is difficult and drawing conclusions is tenuous.

These findings also come together as they encourage us to reflect on language and the importance of establishing common meanings and definitions for the purpose of comparison within the literature. We have already mentioned the possibility of mislabelling teams and identified how this can hinder our understanding and use of team research. Another phrase in need of consideration as to its usage is quality of life. Certainly many definitions of quality of life are available, as are many scales for measuring it (4) and this study offers only a preliminary glimpse into how one group of dietitians use the term. Nevertheless, participants tended to use “quality of life” to refer to overall life satisfaction, while at the same time acknowledging the link between physical well-being and life satisfaction (health related quality of life). We have heard about the struggle that dietitians experience trying to balance resident food preferences with issues of safety, especially that of swallowing. Understanding these inner battles in greater detail and connecting the competing priorities with resident priorities is essential in order to establish a thorough understanding of quality of life issues in the LTC setting. Certainly nutrition research provides many suggestion as to how health related quality of
life could be improved through nutrition. However, its application can remain theoretical. Further, it often puts the resident in the position of object to be treated, rather than person with the right to direct care and make choices. Our study presents the two sides of this dilemma -- professional ethics and responsibility to provide care alongside residents' personal autonomy and right to choose. These findings highlight that for dietitians it is not always clear as to how to reconcile these sometimes conflicting understandings of quality of life. The need to be clear as to what terms such as quality of life mean is important both in research and in everyday practice.

STRENGTHS AND LIMITATIONS OF THE RESEARCH

The many ways in which this research is significant and unique are unquestionably some of its strengths. Firstly, it illustrates the real-life experiences of dietitians working on teams in LTC who seek to provide resident-focused care. Further, this project holds what is currently happening up to the mirror of the literature that seeks to direct team formation and the establishment of an overall philosophy of nutritional care for this client group. In doing so it gives voice to dietitians who have previously had an absent or minimal voice in discussions of teamwork in LTC. It also provides a critique of the literature. Our findings suggest that at least in speaking about teams in LTC staff may minimize the importance of structural elements of teams and focus on cultural elements. Our findings also suggest that it is both desirable and possible to bring together different professional groups to establish common goals and priorities for teamwork. Further, they highlight the importance of drawing non-professional staff into these discussions and
establishing the unique needs of teams within LTC which seek to fully include non-professionals as team members.

A number of aspects of the method of this research contributed to its rigour. These included peer debriefing, extensive memoing, bracketing by the interviewer and ongoing discussion of the emerging findings between my thesis supervisor and myself. An indicator that a good degree of rigour was achieved was that the results of this research focus on areas not anticipated by the researchers at the outset. This suggests that I was successful in putting aside my own speculations as to what makes dietetic practice successful or unsuccessful and hearing what my participants had to say.

One limitation of my research was its small sample size. While saturation was reached with respect to the question guide used (Table 4-1) the guide did not change significantly through the project to add in the emerging themes. Further interviews could have pursued additional questions that focused on teamwork and a philosophy of nutritional care for LTC in greater detail. Obtaining additional data through participant observation would have added to the depth and richness of the findings, however, doing so would have prohibitively increased the complexity of conducting this project.

Participant and facility characteristics (Table 4-2) and the fact that the findings represent dietitians in one specific geographical area influence the transferability of my findings. Readers are cautioned to consider these factors in relation to their own context when seeking to transfer findings.
# Table 4-1. Interview Guide

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I’m interested in hearing about your work as a clinical dietitian within a LTC facility. Maybe we can start with you telling me what you see your role as within the facility.</td>
</tr>
<tr>
<td>2.</td>
<td>I’m interested in learning about conditions and factors that affect dietitians’ abilities to do their work in LTC settings. To get us thinking in that area, I wonder if you can tell me about a specific example of something you’ve done at work that you’re really proud of – something that made you think, “yes! I’m doing a good job.”</td>
</tr>
<tr>
<td>3.</td>
<td>Now can you tell me about a situation where you felt that you weren’t able to do your job well?</td>
</tr>
<tr>
<td>4.</td>
<td>What needs to be in place for you to do your work?</td>
</tr>
<tr>
<td>5.</td>
<td>Are there any key players who make it easier / possible for you to do your work?</td>
</tr>
<tr>
<td>6.</td>
<td>In what ways does nutrition matter to others working in your facility? How do these perspectives affect you in your work?</td>
</tr>
<tr>
<td>7.</td>
<td>Has your experience of practicing dietetics within LTC changed over time? If so, how? How would you like to see it change in the future?</td>
</tr>
<tr>
<td>8.</td>
<td>Is there anything else that you would like to tell me about your experience of clinical dietetic practice within LTC?</td>
</tr>
</tbody>
</table>
### Table 4-2. Participant and Facility Characteristics

<table>
<thead>
<tr>
<th>Participant Characteristics (n = 11)</th>
<th>Years since completing dietetic internship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;1</td>
</tr>
<tr>
<td></td>
<td>1-4.9</td>
</tr>
<tr>
<td></td>
<td>5-9.9</td>
</tr>
<tr>
<td></td>
<td>10-19.9</td>
</tr>
<tr>
<td></td>
<td>≥20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years working in Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
</tr>
<tr>
<td>1 - 4.9</td>
</tr>
<tr>
<td>5 - 9.9</td>
</tr>
<tr>
<td>10 - 19.9</td>
</tr>
<tr>
<td>≥20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of LTC Facilities Currently Working At</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Characteristics (n = 19)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years at present facility</td>
</tr>
<tr>
<td>&lt;1</td>
</tr>
<tr>
<td>1 - 4.9</td>
</tr>
<tr>
<td>5 - 9.9</td>
</tr>
<tr>
<td>≥10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility size (# residents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15</td>
</tr>
<tr>
<td>15 - 49</td>
</tr>
<tr>
<td>50 - 99</td>
</tr>
<tr>
<td>100 - 149</td>
</tr>
<tr>
<td>≥150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dietitian Time at Facility (hours / week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
</tr>
<tr>
<td>10 - 19.9</td>
</tr>
<tr>
<td>20 - 29.9</td>
</tr>
<tr>
<td>≥30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dietitian Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>contracted</td>
</tr>
<tr>
<td>employee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dietitian’s Area(s) of Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>clinical</td>
</tr>
<tr>
<td>clinical and administrative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>private</td>
</tr>
<tr>
<td>government</td>
</tr>
<tr>
<td>government funded with some private beds</td>
</tr>
</tbody>
</table>

² Because several participants worked at more than one LTC facility, the number of facilities is greater than the number of participants.
Finally, as much as it was important to give dietitians a voice in these discussions, it is acknowledged that hearing from other voices, especially those yet to be heard, is critical to a full understanding of teams and teamwork within LTC.

OVERALL SIGNIFICANCE TO DIETETIC PRACTICE

As participants spoke about their experiences working in LTC, they suggest that the culture of LTC is a culture of teams. This approach to work, even when the parameters of it were not well defined or understood, was considered the best or right approach to caring for residents. The culture within LTC facilities described by participants presented many challenges to dietitians in trying to promote and facilitate teamwork. Further, this culture allowed dietitians to develop their own roles that generally addressed the challenges to teamwork and the implementation of their philosophy of nutritional care. Thus, these findings are significant in that they identify that even at the fundamental level of assigning all team members clearly identified roles, many LTC teams are failing. Assigning roles is a structural element of teamwork. Teamwork must be understood as more than simply a collegial way to work together. It requires structure, and, according to those who claim experience and expertise in establishing teams; its success depends upon it (1, 2).

Related to this is the fact that the LTC community must never think that dietitians can be hired to 'do' or 'look after' nutritional care. The nutritional care of residents requires teamwork. And while the needs of residents must be the primary goal of teamwork, there are other possible benefits to effective teamwork within LTC. These include the
possibility to realize savings in healthcare budgets as the principles of a philosophy of nutritional care presented in Chapter Three are embraced within facilities. The improved nutritional status of residents means savings for LTC facilities as residents experience a higher degree of health. Money can also be saved in acute care due to fewer hospital admissions of LTC residents (5). It is important to note however, that even with the clear benefits of having all staff within a facility understand and embrace basic principles for nutritional care this does not eliminate the need for a dietitian. Indeed, it has been documented that the number of hospitalizations per resident per month were negatively correlated with the number of minutes / resident / week that a consulting dietitian was available at a facility (5). Thus, while nutrition must not be thought of as the ‘domain of the dietitian’ there is clearly an important role for the dietitian in providing leadership and expertise to healthcare teams as they implement a sound philosophy of nutritional care. Our participants sought to do these things through many of the roles that they take on.

My findings are also significant for the education of dietitians, other healthcare professionals and healthcare workers. For dietetic students it is important that discussions on ethics not be limited to topics such as nutrition support or palliative care. Helping students to understand the value and importance of an ethical framework for decision making that is specific to whatever client group they serve has several benefits. Firstly, it would broaden their understanding of ethics as having to do with more than just ‘death and dying’ issues. Secondly, it could sensitize students to specific nutrition-related ethical issues for a variety of settings, even if courses could not devote time to in-depth study of specific frameworks. Thirdly, it would provide insight into the many
people, beyond the dietitian and her client, who play a role in providing nutritional care and who each bring factors that influence how nutritional care is provided in LTC.

Indeed, nutritional care, at least in the LTC setting, is not the domain of just the dietitian. While dietitians do bring knowledge and expertise to their work, other health professionals and healthcare workers have an interest in nutritional care and are important to its provision to residents. Giving students even a basic understanding of the many aspects of teamwork and team building may better equip young professionals to work as team members and promote effective teamwork. Education on teamwork is even more important with respect to LTC in that dietitians are not always in a formal position (i.e.: management) to build the teams at their facilities.

Most of these aspects of education will be of interest to other health professionals and may be best taught in an interprofessional educational context. Of particular benefit could be the co-education of dietitians and nurses particularly with a vision to building a common ethical framework for nutritional care. In addition, education on teamwork must be distinguished from discussions about collaboration. In brief, papers in nursing journals that discuss collaboration between doctors and nurses tend to focus on promoting the nursing profession (6, 7, 8, 9); in contrast, the primary focus in teamwork is resident needs. Certainly these discussions are not mutually exclusive, but they are different.

This research can also inform the education of non-professional healthcare workers. Teaching the features of the philosophy of care presented in Chapter Three along with a basic understanding of the many benefits that can be realized through its implementation
to Food Service Managers and Care Aides may well be the key to ensuring that residents consistently receive individualized nutritional care in the LTC setting.

Above all, these findings are significant for residents living in LTC facilities. Improving the nutritional status and quality of life of LTC residents does not necessarily require more money nor legislative changes. Indeed, in the United States where significant legislative measures were taken to address issues related to quality of care in LTC, follow-up studies almost ten years later indicated that poor nutrition continued to be a concern (10). Improvements in the nutritional status of LTC residents may result from establishing team systems that improve the consistency or skill with which nutritional care is delivered (10, 11). Moreover, getting to know residents and their individual nutritional needs and preferences in order to promote and ensure actual food intake has great potential to improve the health and quality of life of LTC residents (12).

This study shows in a sobering way how relatively simple it is to address nutritional needs within the LTC setting. Simple, and yet the culture (people, attitudes, habits, systems – or lack thereof) can get in the way. My findings suggest that what is needed is not necessarily more legislation, or even more money but a simple and clear affirmation and understanding of resident-focused care and its benefits by the members of well-crafted teams.
FUTURE RESEARCH

My research identifies a number of unanswered questions and suggestions for future studies. Firstly, there is a need for team research within LTC that includes the whole multidisciplinary team, both professional and non-professional staff. Studies must identify significant structural elements and investigate how these affect nutritional care. For example, in Cott’s (13) study non-professional staff were not included in multidisciplinary conferences, whereas in our study they were. Thus transfer of her findings in Ontario (13, 14) to our setting of British Columbia is difficult. How does this difference (and others) affect teamwork, understanding of team and team membership and nutritional care? Also, investigation of what formal team structures promote improved nutritional care is warranted.

Another area for further study has to do with quality of life. What factors do dietitians working in LTC associate with improved quality of life? How do dietitians understand quality of life? What is the place of health related quality of life in a general discussion of quality of life? How do dietitians balance resident risk with their own responsibility to address nutritional needs and residents’ perspectives on quality of life? How do LTC residents understand quality of life and balance potential risks with food preferences and their right to choose food that may bring harm?

And perhaps most importantly, it is worth investigating why principles that are clearly presented in the nursing literature and that are embraced by dietitians working in LTC
often fail to be implemented. How can dietitians and nursing departments come together to achieve these goals and apply these principles that they hold in common. There are benefits for themselves and most importantly benefits for residents of LTC. The failure to consistently apply the principles of the philosophy of care identified by our participants has been noted since the time of Florence Nightingale (11). Almost 150 years later, it’s time we not only figured out why but begin to do something about it.
REFERENCES


APPENDICES
# Summary of Care Levels (1)

<table>
<thead>
<tr>
<th></th>
<th>Personal Care</th>
<th>Intermediate 1</th>
<th>Intermediate 2</th>
<th>Intermediate 3</th>
<th>Extended Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Care</strong></td>
<td>Does not require professional supervision. Medically stable.</td>
<td>Requires daily professional care/supervision for such procedures as wound, catheter, or ostomy care; and/or supervision of medications.</td>
<td>Requires heavier care and assistance; may require a variety of professional services.</td>
<td>Requires increased staff time.</td>
<td>Requires extensive professional care / monitoring.</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>May be fully competent or mildly forgetful or confused.</td>
<td>May have moderately impaired comprehension; difficulty in orientation (person, place, time), mild depression / agitation.</td>
<td>May have impaired comprehension requiring extra staff time. Might occasionally be socially / behaviourally inappropriate.</td>
<td>May have impaired comprehension requiring extra staff time. Might occasionally be socially / behaviourally inappropriate.</td>
<td>May have comprehension.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>Able to express needs.</td>
<td>May have difficulty expressing needs.</td>
<td>May have difficulty expressing needs.</td>
<td>May have difficulty expressing even basic needs.</td>
<td>May have difficulty expressing even basic needs.</td>
</tr>
<tr>
<td><strong>Mobility</strong></td>
<td>Independently mobile with or without aids. May require minor help to bathe, dress or groom.</td>
<td>Independently mobile / transfers. May require moderate personal care assistance.</td>
<td>Independently mobile / transfers but may require more supervision of activities and assistance with personal care.</td>
<td>Mobile but requires greater supervision / assistance for safety.</td>
<td>Unable to walk independently for 15 feet and / or unable to transfer independently. May require major to total assistance with personal care.</td>
</tr>
<tr>
<td><strong>Self Care Capability</strong></td>
<td>May require assistance to maintain independence in some activities of daily living.</td>
<td>May require directional assistance or supervision to keep health appointments. May require programs for social and recreational activities.</td>
<td>May wander or require considerable directional assistance. May be incontinent.</td>
<td>May have severe behaviour problems on an on-going basis.</td>
<td>May not have self care capability.</td>
</tr>
</tbody>
</table>
REFERENCES

1. Province of British Columbia, Ministry of Health and Ministry Responsible for Seniors, Continuing Care Division, Service Provider Policy Handbook.
Appendix 2

Letter of Contact

THE UNIVERSITY OF BRITISH COLUMBIA

Food, Nutrition and Health
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, B.C. Canada V6T 1Z4
Fax: (604) 822-5143

UNDERSTANDING DIETITIANS' EXPERIENCE OF CLINICAL PRACTICE IN
LONG TERM CARE (Masters of Science Thesis)

Dear Dietitian:

We are writing to ask you to participate in a research study. The primary aim of this study is to gain insight into the experience of dietitians as they practice clinical dietetics in the Long Term Care (LTC) setting, with a particular interest in elements of the LTC facilities that help or hinder clinical dietetic practice to the benefit of LTC clients. Through the time that you have been in practice you may have experienced times when you were able to apply your dietetic knowledge easily and thoroughly to the benefit of your clients. At other times this may not have been the case. We are keen to hear your stories and your experiences in order to increase our understanding as to how dietitians can be supported in their work in order that LTC clients can benefit from their dietetic expertise.

We have chosen to conduct qualitative interviews as a means of data collection. If you agree to participate, the co-investigator who has experience in qualitative research will interview you individually. Interviews are expected to last between 60 and 90 minutes. The co-investigator is working under the guidance of Gwen Chapman, Associate Professor in Food, Nutrition and Health, Faculty of Agricultural Sciences at the University of British Columbia and faculty advisor to the co-investigator.

Each interview will be audiotaped and transcribed verbatim. The data from the interview will provide the basis for understanding your views as to what positively and negatively affects your ability to carry out clinical dietetic practice within the