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Building Community through Meals in the Care Home Setting

EXPERIENCE FROM DENMARK

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Abstract

Drawing on an observation of life in Danish care homes for the elderly, this article examines how meals are used to build community among the institutionalized elderly in Denmark. Using qualitative methods, the article follows the transition of sixteen elderly people from own their homes into the care home setting. Elderly people and care home staff share similar expectations about meals, including how "cozy" conversation should create the "cozy" community that is fundamental to Danish social life. Nevertheless, the establishment of a sense of community among meal participants is inhibited by a number of obstacles, including staff discussions of work-related issues, social hierarchy among the elderly residents, lack of basic social competency, and residents' protests against institutional practices. I argue that building community through meals is a useful concept for furthering an understanding of meals as an aspect of care for the institutionalized elderly.

Keywords: family meals, institutionalized care, elderly people

Introduction

Simmel (1993) argues for the importance of the meal as the original form of socializing. In his classic article on the sociology of the meal, Simmel (1993) suggests that a civilized meal is characterized by prohibitions and rules that elevate it above the level of the physiologically primitive and raise the inevitably common to a level of social significance. People who share no common interests can thus create a sense of community through meal sharing. According to Simmel (1993), sharing food and drink is a basic socializing force. Therefore, the meal must be an

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event that in itself has an impact, becoming a medium between the private and the public. Sharing food and drink at a meal "plays an important role in marking closeness" between the people participating in the meal (Mäkelä 1991: 91).

The impact of the meal is traceable in the descriptions of meals at Danish care homes, as I will argue later in this section. Moreover, this impact has also been an important topic in the literature. Several anthropological and sociological studies have indicated the symbolic importance of sharing particular food, thus emphasizing both group solidarity and the attempts of certain groups to distance themselves from other groups. In his analysis of what we can roughly call the cultural phenomena of food and eating, Claude Lévi-Strauss (1986) treats food as a language illuminating a classification that singles out food in terms of elementary oppositions between culture/nature, human/non-human, edible/inedible, etc. In this way, according to James (1997), Lévi-Strauss explains why some groups of people can make symbolic statements and distance themselves through the food they perceive as edible, in contrast to other groups that perceive the same food as inedible. However, categories of food and drink can change, and some see the choices of food and drink as social mobility strategies provoked by social, political and economic changes (Mennell *et al*. 1992; Jenkins 1999).

The family meal is an event that brings together the individual members in a daily ritual (DeVault 1991). As an "icon" of Western food cultures (Bove and Sobal 2006), the family meal defines both the proper meal and cultural standards about appropriate foods, people, time and places (DeVault 1991; Murcott 1997). The proper food items are served in an established order (DeVault 1991; Murcott 1997). The family meals are scheduled at appropriate times, typically in the evenings and typically at home. The family, argues DeVault (1991: 39), is "not a natural occurring collection of individuals; its reality is constructed from day to day through activities like eating together." Conversation about the activities of the day during meals is considered an important part of maintaining the family. According to DeVault (1991), the family is recreated and relationships confirmed daily via conversation during family meals (see also Holm and Iversen 1999; Anving and Sellerberg 2010). In line with DeVault (1991), Murcott (1997: 39–40), argues that the idea of the family meals "continues to be an ideal towards which people should strive, an aspiration."

In the nutritional literature on total institutions, one also finds traces of the family meal as an ideal for community-building. Although this literature focuses on dietary needs and nutritional aspects of the meal that might increase residents' caloric and protein intake,[1] many studies have discussed whether eating alone or eating in the company of other residents improves nutritional status (e.g. see Pearson *et al*. 1998; Pliner *et al*. 2006). More recently, Mathey *et al*. (2001) and Nijs *et al*. (2006) argue that being in the company of other staff and residents has a positive effect on residents' nutritional intake. In addition, other studies strongly indicate that a cozy eating environment has a similar effect (Elmståhl *et al*. 1987; Stroebele and De Castro 2004; Gibbons and Henry 2005). Thus, the literature emphasizes that staff play a significant role in creating a companionable eating environment, moderating the conversation, and establishing a community that can increase residents' intake of food and drink (see also Evans *et al*. 2003).

The ideal of the family meal is also traceable in Denmark at assisted living facilities for the elderly. In Denmark, these facilities (hereafter "care homes") are known as "protective care homes," and their purpose is to provide 24-hour care for elderly residents who can no longer take care of themselves (e.g. who can no longer bathe or dress themselves or who have various degrees of dementia). The ideal is transformed into a state-mandated goal of community-building through meals in Danish care homes (Søndergaard 2008), with the Danish word "*hyggelig*" repeatedly used in descriptions of this meal (Kofod 2008; see also Jenkins 1999). Although *hyggelig* has no exact English translation, "'coziness' and 'cozy' more or less convey the meaning" (Reddy 1993: 138). In Denmark, a cozy situation is linked with a sense of community, subdued lighting or candlelight, and a pleasant atmosphere. Most importantly, it permeates all facets of Danish life, from eating at home to eating at restaurants, with the underlying cultural expectation that if everything is *hyggelig*, then everything will work out, i.e. all problems will be resolved (Reddy 1993: 138). As such, the Danish government's aim of making meals *hyggelig* in institutions for the elderly is not surprising. On the one hand, this goal suggests a continuation of cultural behavioral norms; on the other, it contains the hope that continuing these norms will lead to the easier resolution of any problems that may arise.

According to Goffman's (1961) definition of total institutions, elderly people institutionalized in care homes have very limited influence upon daily activities. A consequence of this limited influence could be that applying the concept of community-building through meals is uncomplicated for staff at care homes to implement. However, the literature on nursing homes and care homes indicates that it is possible for residents to oppose the idea of institutions strongly limiting residents' influence on institutional practices (see e.g. Foner 1995; Paterniti 2003; McColgan 2005; Sterns and Kahana 2007; Yamasaki and Sharf 2011). This literature also identifies how apparent passivity can be understood as a way in which even weak residents such as dementia sufferers manipulate events into opportunities whereby they gain more time with staff and receive care in accordance with their preferences.

The transition from home into care home offers a unique opportunity for examining how staff apply the ideal of community-building through meals among residents and staff at total institutions for the elderly. To examine how this community-building is negotiated, the present study focuses on the expectations of new residents with respect to these meals in addition to the staff's implementation of community-building as an essential part of care provision. In particular, the article analyzes how staff encourage residents to become actively involved in communal activities (with other staff and residents) and whether they succeed in establishing a sense of community through the communal meals on the care home wards.

To further understand the application of the ideals of community-building through meals at total institutions for the elderly, I designed and conducted a qualitative research study to examine how staff and elderly residents engage in meals in Danish care homes. An important focus of the study was to determine the success or failure of these state-mandated goals in practice.

Methods

Interviews and Observation

The study focused on the question of how the food-related practices (e.g. preparation, preferences, dining behavior) of sixteen elderly people changed during their transition from living at home to living in a care home. To answer this question, I developed a longitudinal research design with two stages of data collection, namely before and after each resident's arrival in the care home. As the focus was on the sense of community possibly established during meals, I conducted qualitative interviews with the individuals with whom the elderly people had meals during the transition. The most important individuals were relatives, care home staff and the other residents living on their ward. By interviewing these other people, I was able to contrast the sixteen elderly informants' experiences of everyday life at home and on the wards with the perceptions of relatives, staff and other residents. Furthermore, by observing life within the informants' own homes and in the care homes, I could examine the views they expressed in the interviews and compare them with the situations I observed (Hastrup 2003).

I interviewed the sixteen elderly people eight times during their transition, including three interviews before their move to their care home, with another interview a few days after the move, to record their first impressions. The next interviews were conducted after approximately four weeks, and these interviews continued for another four months, ending when the residents had been in the care home setting for about half a year.

I conducted semi-structured and unstructured interviews with the sixteen informants, their relatives, the staff and other residents on the wards. The semi-structured interviews revealed the sixteen informants' perceptions of everyday life both at home (before the move) and in the care home (after the move), with a particular focus on eating habits, physical impairments and their perceptions of home. Moreover, by conducting additional semi-structured interviews, I investigated whether their perceptions had changed during the transition (Tjørnhøj-Thomsen 2003). In addition, I conducted unstructured life-history interviews with the sixteen informants about their backgrounds, major life events and their perceptions of these events (Steffen 1997), as well as semi-structured interviews about their previous and present food-related practices (e.g. preparation, preferences, dining behavior). The interviews, which took place both in the respondents' homes and in their private apartments in the care home, were all informal.

The semi-structured interviews with staff, other ward residents and relatives focused on how they perceived the transition or observed any changes on the ward with the arrival of a new resident. These interviews also gave staff the opportunity to discuss issues of importance in their care work. One of the two staff members I interviewed was their contact person—the individual who assisted them with personal care and who was thus in closest contact with each of them. The other staff member on the ward would occasionally take care of the resident when, for example, his or her primary caregiver was on vacation.

In the interview I immediately worked to establish an atmosphere of rapport and trust, providing multiple opportunities for going deeply into matters of importance for the sixteen informants, the better to grasp their perspective of the transition. Interviews were terminated once the saturation point had been reached, i.e once the information in the interviews began to be repetitive (Kvale 1996; Hardon 2001).

Observation was an important part of my material. I used the interviews in the residents' homes as observation opportunities (Rubow 2003) during times when the elderly informants needed to take a break, answer the telephone or talk to the home-care assistant. In addition, I conducted observation in each care home from the time I arrived in the institution until I left late in the day or evening. I also conducted a series of focused observations of each resident concerning his or her behavior in the ward during the day, with an intensive focus on the first two days. I observed 64 meal events and different staff meetings and breaks, and participated in many informal coffee breaks.

To analyze the material, I audiotaped all interviews and transcribed them verbatim. I took notes either during the observation or immediately thereafter. Close reading and content analysis (as identified by Hardon 2001) of the interview and observation material led to the development of the major themes in this article.

Participants

In Denmark, some 10 percent of those aged 65 or older (approximately 50,000 people) live in care homes for the elderly (Kommunernes Landsforening 2008). The sixteen participants in the present study came from this group. I followed their transition from home to care home from early June 2004 through November 2005. The subjects were residing in the area of Greater Copenhagen, which covers a diverse array of city, town and suburban populations, as well as a wide range of income and education levels.

All participants were recruited via their respective municipalities, these being the authorities in Denmark responsible for assessing elderly people living in care homes. The participants were between 68 and 94 years of age (mean 87 years), and both men (four) and women (twelve) were included. For me to interview them, they had to be able to understand and respond to my questions. This criterion excluded people suffering from dementia and Alzheimer's disease, as one consequence of dementia is the loss of ability to remember recent events (Swane 1998; Kofod and Birkemose 2004; Kofod 2008).

Prior to their participation, these elderly people received a written description of the project. They were asked to give their informed consent after they had had sufficient time to discuss their participation with their relatives or a home care assistant. None of the elderly people refused to take part, and the sample size was driven by the number of persons being admitted to the nursing homes during the time of my study. Additionally, the research was approved by the heads of the care homes, and the municipal authorities, and the project was registered with the Danish Data Protection Commission. In this article, the names of the residents have been changed to ensure anonymity.

The sixteen elderly people each became a resident at one of four large care homes, each with more than one hundred residents. On each of the sixteen wards, between eight and thirty-two residents were living together, each provided with a private apartment with a full bathroom. On four wards, one apartment was reserved for residents in temporary rehabilitation, with a new resident coming in every two weeks.

Results

The interviews and observation revealed the way in which the staff applied the ideal of community-building through meals on the care home wards, as well as residents' reactions to the communal meals and related staff behavior. I first present the findings relative to the context of the care home meal and staff application of the state-mandated ideals, followed by selected episodes that illustrate the barriers to and the negotiation of these ideals.

Context and Application of the Ideal of Community-building through Meals

The meals were eaten in the dining rooms on the wards. The activities in these rooms were very similar in the four care homes in this study, and the staff conducted their social activities during the ward meals in similar ways. During the day, the dining room hosted a range of different functions, with a constant flow of staff members, residents, relatives and different skilled workers. While this flow continued during lunch, the meals at 6 pm were not affected to the same extent by these distractions. For the evening meals in particular, staff laid the tables not only with plates and cutlery (as they also did at lunch) but also with traditional small candles (tea lights) in appropriately-sized glass candle-holders. Such candle lights are in daily use in most homes, restaurants, cafés and bars in Denmark and are considered part of making the atmosphere "cozy."

The seating arrangements at the dining table were fixed at lunch and dinner, although sometimes the size of certain wheelchairs necessitated increasing the table space, and other residents would need to change seats accordingly.

The meal situation I most often observed in the care home wards was one in which the staff joined the residents at the table for most of the meal. These meals lasted up to 45 minutes. The staff would always decide on a common denominator for residents' physical and mental eating abilities, so residents whose dementia had an aggressive effect sometimes had their meals in their rooms.

The staff invited residents to participate in lunch and dinner, strongly encouraging residents to take part in the conversation because this was viewed as part of the care. Some of them even considered it unhealthy for residents to be left on their own, without participating in any kind of social activity. As staff were very happy to have talkative participants, I was occasionally invited, primarily to enliven the conversation.

Staff explained their invitations to communal ward meals in the following way: "When a new resident moves in, we indeed like to invite him or her out here as soon as possible." Staff thus expressed disappointment when those who might add

to the conversation at the dining table turned down their invitations. For example, when Oda preferred to eat on her own, staff said: "She uses this [the care home] as too much of a hotel … She could be a resource at the table…" About Dorte, a staff member said with frustration: "It is impossible to lure her into the dining room … She is definitely not fond of company."

Despite staff intentions, one or two residents in the smaller wards (eight residents) chose to eat on their own, and in the larger wards (thirty residents) four to six preferred to eat in their apartments. According to the staff, the residents made their choice because of their individual needs and illnesses. These residents also often cited their dislike of the other residents and their inappropriate table manners (for example, their inability to use a knife and fork properly) as their main reason for avoiding the communal meals.

The communal meals that the staff invited the residents to enjoy resembled the ideal of community-building through meals, and staff always underlined the cozy (*hyggelig*) atmosphere created by mutual involvement and the flow of conversation. All staff members used the word *hyggelig* in one way or another when asked to describe the care home meal. For example, one said, "Everyone present must feel like a participant in the meal and add part of themselves to the sense of community [*hygge*] at the table." However, residents often expressed their dislike of other residents; for example, one described another resident as eating "like a threshing machine." Another said that he felt distracted and embarrassed by the bad manners of his table companions. Or, as Lydia expressed it, "They have told us that it is supposed to be cozy. But you can't force people into such an atmosphere."

For most of the meals I observed, the staff adopted host-like behavior at the dining table (although residents did not adopt the behavior of guests). Staff initiated conversation by bringing different issues up for conversation, such as the preparation of traditional dishes, the weather or a television program from the previous evening. Most often, the staff member asked the residents directly for their opinions on a certain topic, in this way trying to produce a flow of conversation. Although the residents readily answered these questions, they remained silent if the staff member did not elaborate further on the issues in the conversation. Residents rarely initiated a new topic of conversation.

Major Observations

Intimate Details and Work Instructions Disrupt "Cozy Conversation"

I use three brief examples from different wards to illustrate the difficulties of applying the ideal of community-building through meals in the care home setting. In this section I present and discuss more results of the study. The results take the form of my most important and consistent observations. To present them in a useful context, I divide them by type and illustrate them with selected episodes. We begin at a ward where eight residents and two staff members formed the group at lunch and dinner.

The transmission of regular instructions between staff members often interrupted "cozy conversation." During one lunch on Lis's ward, a staff member in

the middle of a discussion about the proper spices for sausages appeared suddenly to think of something else and interrupted herself. She said to her colleague at the other end of the dining table, "The diapers you ordered for Lis were the wrong size. Did you remember to change this order in accordance with my instructions?" The colleague replied: "Absolutely." In this case the conversation focused on Lis and her lack of bowel control. Lis was embarrassed, she later told me, and the fact that conversation at the table suddenly stopped was clearly linked to the other residents not wishing to participate (see also Sidenvall *et al*. 1996; Sidenvall 1999).

Observation from another ward showed that residents preferred to keep intimate details (e.g. Lis's absorbent pads) between themselves and the staff, and within the confines of their private apartment. On another occasion, a female resident started to leave the table. A few feet from the table, a staff member called out in a loud voice: "Do you need to go to the toilet, dear?" The resident made no answer. The staff member then left the table and caught up with the female resident further down the corridor, where I heard them discreetly lowering their voices and the resident confirming that, indeed, she needed to use the toilet.

At yet another meal, a staff member serving the residents was asking about their preferences. She then suddenly changed the subject to ask a colleague about additional grocery needs and necessary instructions for the new staff member arriving in the afternoon. It appeared that residents were used to staff changing subjects, because they accepted the interruption and kept quiet until staff asked them questions again.

Sometimes work-related comments also left residents out of the conversation. The following example illustrates how a resident was not only excluded but also talked about as if she were not present. A staff member asked Anna, a resident who had returned from hospital the previous day, "Anna, how many potatoes would you like?" In a low voice Anna said, "Please, I would like three." The staff member replied, "Oh, three, it seems you are well again, I am so happy to hear that." The staff member finished waiting on the other residents and a little later said to her colleague at the other end of the table, while nodding towards Anna: "She's much better today, don't you think?" The colleague agreed by nodding her head.

Hierarchy among Residents

These examples show how the topics that staff choose for conversation determine the flow of "cozy conversation." Moreover, my observation indicates not only a hierarchy among residents, but also that this hierarchy is yet another obstacle to establishing "cozy conversation" among meal participants. This hierarchy is based upon residents' mental and physical abilities. For example, being able to express oneself or to leave the dining table unassisted creates a position at the top of the hierarchy, and vice versa. My observation and interviews show that hierarchies among residents influence the flow of conversation at the dining table, as residents at the top of the hierarchy often choose not to answer the rare questions from residents at the bottom (see Mäkelä 2000). For example, when Ole (who had dementia and was therefore at the low end of the hierarchy) commented that the weather forecast predicted heavy rain, the other residents at the table ignored him.

On Hans´ ward, Karen was one such resident suffering from dementia. She was nearly always present in the dining room, greeting everyone entering or passing through the room and asking their name. Normally one or two other residents would tire of Karen's constant questioning and would tell her in a more or less polite way to be quiet. While Hans normally said nothing in these disputes, on the day that a new resident was introduced, Hans also gave Karen the sharp end of his tongue to show the new resident that he was part of this group and intended to keep Karen at the bottom of the hierarchy.

Lack of Mental Abilities

Another obstacle to establishing "cozy conversation" was the lack of mental abilities among the meal participants. Having temporary residents at the table (i.e. those in rehabilitation care) in some cases completely changed the conversation dynamics, as staff members constantly had to tell them how to behave. A typical example was Hans, who suffered from dementia, and asked staff the questions every five minutes: "Do you work here?" and immediately afterwards, "Do you live here?" After half an hour of such repetition, a staff member harshly told him to remain silent. Such constant instructions also prevented the establishment of "cozy conversation."

An average of 65 percent of the ward residents were suffering from dementia. Consequently, establishing a flow of conversation at the table was difficult. Oda, for example, suffered from mild dementia and often had difficulties recognizing the meal as an occasion for socializing. Although she smiled happily whenever staff asked her questions during meals, she could not and did not reply.

The residents' diminishing senses of taste, smell and sight also made eating together and participating in conversation an unsettling experience (Merleau-Ponty 1994; Ingerslev *et al*. 2002). Moreover, the residents were well aware that their motor abilities were increasingly making them unable to behave according to dining etiquette. For example, Lis needed help cutting up her food, and two of her fellow residents needed staff assistance in the actual act of eating. In this way their civilized bodies, in which etiquette had been inscribed (Lupton 1996), could no longer maintain or remember etiquette. In other words, their less-than-able bodies were partly unable to meet the standards of what they knew was appropriate behavior at meals (e.g. see Merleau-Ponty 1994). Thus, they could no longer easily establish social relationships at meals as they were unable to behave in accordance with the familiar etiquette prescribed for these occasions.

The interviews and observation reveal that both the residents' mental abilities and the topics that staff choose for conversation are important obstacles to establishing the "cozy conversation" that both the state and the staff consider a crucial part of the process of building community through meals.

Discussion

Of the sixty-four meal events I observed, only a few actually appeared to characterize a community-building meal with *hyggelig* (cozy) conversation. In other words, there was no real sense of community among the meal participants in the

majority of the meals I observed at the care homes. The present section begins by discussing why creating the cozy meal is difficult and ends with some suggestions for applying the ideals of the family meal at care homes for the elderly.

Both my observations and the residents' comments about communal meals show that residents often experience embarrassment when participating in such meals. They react either through reluctance to accept staff invitations to attend or by attending but not adding to the flow of conversation. Residents further restrict their eating at communal meals by leaving the table as soon as possible.

The importance of meal etiquette should not be underestimated, particularly as the notion of "proper" behavior at meals is fundamental to commented that the weather forecast predicted Danish culture. To illustrate this point, Emma Gad's guide to meal-related rules and prohibitions in Denmark was first published in 1918 but remains in print (Gad 2006). Further afield, Davidoff (1973), Elias (1978) and Mennell (1985) have comprehensively discussed etiquette manuals and their historical emergence in Europe.

As the flow of conversation was a core element in staff descriptions of the ward meal, adding to this flow is another essential element in "proper manners." Gad (2006), Friedman Hansen (1980) and Knudsen (1996) agree on the need for a continuous flow of conversation at Danish meals. Both when the family eats in private and when other people are invited, the conversation needs to flow and keep developing through cheerful, spontaneous comments and responses. Guests are also to be seated so that they are well matched for conversation, and this arrangement should enable them to add to the conversation with "a breath of fresh air" (Gad 2006: 97). The host should moderate the conversation in such ways that nobody at the table is left with the uncomfortable feeling of being isolated, and that no one interrupts when someone is talking (see also Reddy 1993). In her guide to tactfulness and manners, Gad (2006) emphasizes that the flow must be established without angry comments or remarks that would annoy or upset anyone present. Furthermore, the host is obligated to moderate conversation with kindness and sensitivity, thereby avoiding all mention of private matters (Gad 2006; see also Redlich 1948). Thus, commenting on the peculiar appearances of other guests, who are perfectly aware of their peculiarities, is inappropriate (Gad 2006). More generally, Goffman's (1971) distinction between "front stage" and "back stage" behavior is applicable here. As illustrated in the example of the female resident who needed to use the bathroom, residents expect staff to restrict intimate matters to the apartment, that is, "the back stage." They do not wish to discuss intimate matters on "the front stage," that is, in the dining room.

By discussing Lis's absorbent pads during a meal, the staff member broke these rules of etiquette, as such private matters should have been left out of the conversation. These remarks drew other residents' attention to the embarrassing fact that Lis was unable to control some of her bodily functions (Lupton 1996). Likewise, when Anna was served and later talked about as if she were not present, this was also a breach of etiquette.

Goffman's (1961) important book about total institutions provides additional insights to residents' reactions to staff attempts to build community through meals.

He discusses what he calls "the situational withdrawal," which represents regression, where the resident "withdraws apparent attention from everything except events immediately around his body" (Goffman 1961: 61). This situational withdrawal is apparent when the residents answer staff questions but otherwise remain silent, rarely initiating a new topic of conversation. Moreover, what Goffman defines as "the intransigent line" (Goffman 1961: 62) represents a protest against the practice of total institutions. Such protest was evident when Lydia commented on staff invitations to ward meals, saying that one cannot force a cozy atmosphere, and it was also evident when residents suddenly stopped talking when a staff member mentioned Lis's absorbent pads. In a similar way, both protest and withdrawal manifested when Oda and other residents told me that their reasons for eating alone in their apartments were based on similar (negative) opinions about staff practices at meals.

My observations of the meal events at care homes indicate that, despite the residents' withdrawal and refusal to participate, they were mostly unsuccessful in opposing the basic "processes by which a person's self is mortified … in total institutions" (Goffman 1961: 14). However, their protest also resembled the way in which they insisted on being treated as full persons (see also Solomon 1982; Clark and Bowling 1990; Sterns and Kahana 2007), not just as bodies in need of care.

In conclusion, staff found it difficult to incorporate into their work the ideal of community-building through meals because they found it difficult to play the role of host convincingly. When work-related issues took priority, staff did not follow etiquette, and residents reacted by protest of or withdrawal from institutional practice. Irrespective of what the residents may have intended by their reactions, in most cases staff did not succeed in creating the desired cozy conversation or *hyggelig* atmosphere. Thus, despite staff efforts to respond to the state-mandated goal of using the ward meal as the medium for building community, the observed institutional practice reveals a lack of success in implementing this goal.

This study therefore indicates that when the state-mandated goal of building community through meals is applied in total institutions for the elderly, staff must convincingly play the role of hosts and accept that residents' withdrawal or refusal to participate is an inherent part of institutional life. Moreover, staff not only need to follow etiquette but also most likely need support in doing so, particularly because total institutions for the elderly are facing an increase in the number of residents suffering from dementia.

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Note

1 Studies indicate that care home residents consume only small amounts of food and drink. The nutritional status of 60 percent of nursing home residents in Denmark (Ingerslev *et al*. 2002) and in many other Western countries (Morley and Silver 1995) is poor. A poor nutritional status is associated with an increased loss of ability to manage on one's own, sickness and eventually death. Moreover, a low BMI reduces independence and the quality of life for these elderly people (Ingerslev *et al*. 2002).

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