

Cultural Commentary: Institutionalizing the De-Institutionalization of Food

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I am not a food professional. I am an amateur cook (particularly of Indian food). Obviously, I enjoy my food and I love cooking for others. I love the pleasure we get from eating good food. I think and talk about food a lot. And most of the people I know and work with talk a lot about it too.

From 1997 until 2005, I had been the CEO responsible for the care of more than 500 people with intellectual disabilities living in some large government institutions in western Sydney, Australia. The majority of residents had been in our care since they were little children. The oldest resident was in his early nineties. The youngest resident was in her late teens. We were no longer admitting new residents.

It was government policy that these institutions be closed and the residents move into more "normal" accommodation in the community, usually small group homes. The policy will go a long way towards improving the lives of these residents. Unfortunately, it is going to take some years before these institutions close, and likely, some in other places may never close.

The baby boomers among us do not need to be reminded that the populations of nursing homes and hostels for older people are burgeoning. Although these places are presented as havens, gardens or oases of care, they are, at bottom, institutions too.

So how do we enhance the lives of people in institutions?

I have an abiding memory of my dearest old friend who died in a very posh nursing home in Erina a couple of years ago. She was a large, gregarious, beautiful, and fascinating woman who lived for partying, good times, entertaining, and lots of food and lots of drink. From presiding over her very social and hedonistic world, a stroke took her to the nursing home. She could not read. She could not walk. She had to wear *nappies*. She could not chew. But she could spoon-feed herself (although with dribbles). Her meals were always pureed. (I am not sure exactly what was pureed. We used to search among the colours for clues.) She could also talk a little. So she sure let me know how much she hated all of it. But things were out of her control. Thankfully, this did not last too long. She contracted pneumonia and died in her sleep.

We often hear about pneumonia being the cause of death for people in institutions. This is often what is called "aspiration pneumonia," caused by food that goes down the wrong way (or is not texture-modified to suit the person, or which is fed to a person with insufficient care).

I recall that, at an Adelaide Festival, a group of people specially prepared some "real food" and delivered it to one of the Adelaide Hospitals. This caught my imagination. However, on

reflection, I realized that the people who received those generous offerings were probably sick people on short stays at the hospital. People who *live* in different forms of residential care institutions are, generally, quite well. And they are living there for a very long time. Sometimes, for the rest of their lives.

They might be a bit bewildered. They may have physical and other disabilities. They might just be very old. Their lives are probably regimented. They are usually dependent on others for assistance. Lots of them need personal assistance to have their meals and in most other aspects of daily living. Some people cannot chew or swallow easily. Some cannot always clearly express their wishes or reactions.

But it is important to remember that they are usually pretty healthy for their ages and stages of life. And you can bet that mealtimes are something most take a significant interest in. If nothing else, a meal can break up an otherwise pretty dull day.

Imagine, then, the disappointment of thousands of people living in institutions when mealtimes come around. The smell of the food is probably the same as yesterday. The look of the food is the same as last time — a serve of something white; a serve of something orange; a serve of something green; and a serve of something brown. Whatever it is, it is often served up as a khaki mush stirred up by someone focused on efficiently seeing that the food is consumed as neatly and as quickly as possible.

People probably receive their basic need for calories. The likelihood of choking is minimized by food being reduced to a common puree. But enjoyment? Interest? A desire for more?

All of this is probably something most of us do not want to think about too much. But if we don't, the same fate may await many of us.

Where have we come from?

Let me tell you what it was like when I took up my position back in 1997.

The institution, like the one where I worked, had been set up according to a medical model. This means that they were, essentially, hospitals. They looked like hospitals. They smelled like hospitals. They acted like hospitals. They were usually headed by doctors and staffed by nurses. Residents were treated as though they were patients, or sick people, and could be somehow "rehabilitated." Some were part of large psychiatric hospitals. One had been set up in the late sixties as a hospital for children with "developmental disabilities". Generally, there was some tension between nurses striving to be nurses in the old sense, focusing on the giving of medications, and more modern expectations that staff should concentrate on enhancing the lives of residents.

Many large dormitory-style rooms remained and in others, four people shared a bedroom. Most people did not even have their own cupboards or dressing tables. Day rooms and dining rooms were large spaces shared by 24 people. Privacy was very limited. The environment was pretty grim.

Food was delivered by truck in foam "dixies" from a thirty-year old central kitchen. The equipment was old and outdated. Tiles were cracked. There was not much to inspire

creativity or customer satisfaction in the environment. People with experience in cooking for the (old-fashioned) army would have felt right at home!

In the pantries, Domestic Services Assistants dished food out onto trays where it waited to be served to residents. Sometimes, it was a pretty long wait, depending on the support needs of other residents.

The menu was pretty boring - lots of stew and steamed vegetables (things that would transport easily and keep) or sometimes, for breakfast, just large quantities of baked beans from very large tins, heated up. I do not know how long these menus had been in place - they were "traditional" and only changed from summer to winter.

Although menus were written down, they were often changed from day-to-day, depending on which meat was available. To my horror, I learned that we got meat very cheaply from a technical college - after the apprentice butchers had been practicing on it! For some time I had nightmares! Even though a visit to the Tech was organized for me, it did nothing to allay my concerns! (I also took the opportunity to ban the purchase of some very bright pink Devon [a pressed cooked meat product, similar to Spam] from the same Tech... The Devon fight went on for many months, but I won that battle!).

Having lots of soft stewed food meant that most people could swallow it without too much trouble, and staff did not have to help people cut their food. There were also several people who had their meals pureed. I never saw a pureed meal served in any other way than stirred together into a khaki mush. Desserts were served out from large tin trays. Lots of custards and jellies. Sometimes the jellies had pieces of tinned fruit set in them. They were always in very bright colors.

As often as they could (and probably encouraged by staff), many of our clients — at least those who could speak up for themselves — decided to order "take-out". Others went in small groups to fast food restaurants. The take-out food was often Chinese, rather than fatty Aussie-style (probably a bit of a bonus in terms of nutrition). Some families — often those from cultures other than traditional "Australian" — also brought in favorite dishes from home for their family members.

The dieticians highly disapproved of so much take-out and fast food — generally high in salts and fats, and often in textures hard for our residents to swallow safely. Moreover, new legislation targeting health regulations minimized the amount of food being brought from home — mainly over concerns with storage times and conditions.

What changes were made? Where are we going?

In times of pretty scarce resources — this was an era of "fiscal frugality" — we have had to be pretty opportunistic. Any new funds had to be directed to improving community resources, rather than propping up old institutions.

But when some windfalls have provided money to fix roofs and repair aging buildings or ventilation, we have been able to remodel most accommodation units into "suites" of 6-bedroom "apartments," each with its own living/dining room. So, instead of 24 people crowded together, we have smaller groups of six sharing each apartment. Residents have their

own private rooms. As a result, the environment is radically improved. There is more privacy and dignity for the individual.

In partnership with our parents and friends group, a nutrition report was commissioned. The parents and friends group (The Western Sydney Intellectual Disability Support Group) were ahead of us in their concern and interest about the nutritional well-being of their family members and were keen to work with our staff. In addition to the educational value derived locally from such an exercise, the report had a broader impact on policy and practice. It put nutrition high on a "to-do" list - not only in institutions, but also in group homes, both Government and non-Government.

We hired dietitians and speech pathologists and other therapy and nursing staff interested in improving nutrition and food services. Within budget, we had to create new full-time positions for dietitians, as well as recruiting others on a contractual basis. We also found a speech pathologist, who is one of the acknowledged experts on swallowing difficulties (i.e., dysphagia).

These experts were not universally welcomed. They were seen as threatening the status quo and somehow "critical" of the professionalism of the nursing and other staff. There was a great deal of resistance and mistrust and undermining. Sometimes it was subtle. At other times, it was more like trench warfare. The "old staff" (the nurses and food services staff) saw the dietitians and speech pathologists as people with fancy ideas who did not appreciate the way things had always been. (And they saw me as the Wicked Witch of the West!)

I got puzzled looks when I told the staff that mealtimes were more important than neatly made beds and even cleanliness! But there were endless discussions, lots of meetings. I learned to be more persistent, more tenacious, and more persuasive.

But we were still operating from the antiquated 1960s kitchen. So, when new Food Services legislation was introduced, we saw another opportunity.

We contracted a report from a food services consultant. While it was most helpful, the report unfortunately recommended we use "cook-chill" (i.e., pre-prepared) food, either bought-in or produced in-house. There was a lot of support from the hard-headed accountants and economists in central office for cook-chill, because it made good economic sense! . But we looked around at the cook-chill options and but did not like what we saw. It may have been OK for short-stay sick people, perhaps... but not the longer-staying, healthy individuals we were concerned about.

We then allocated some limited funds to fix up the old kitchen. We had to start renovations while fighting a rear-guard action against the cook-chill approach. Through some devious negotiation and another report, we finally managed to get agreement that freshly cooked would be better for the needs of our residents — and should not cost more.

After more than a year, we ended up with a fantastic kitchen (although it cost about 10 times the original estimate). We also got a new system of trolleys, which can deliver food hot and fresh (or cold and fresh) and safe. That kitchen produces more than 1200 fresh meals each day.

How can we "institutionalize" this process to replicate it elsewhere?

We engaged and challenged our hospitality staff — especially our kitchen staff — in preparing food (rather than producing "x" number of meals). Despite initial scepticism, they developed a new level of interest in cooking. We also encouraged their interest in food by getting them to cook special menus (e.g., "Arabian Nights") for our annual balls and other special occasions. It was terrific to see the pride of the hospitality staff on these occasions!

We trained all staff in using new equipment, new recipes, and food safety procedures. Because of new legislation, we had to update training, to ensure that we are fully compliant with all standards and procedures. While training in safe food handling, and introducing systems of record keeping, we had to maintain a focus on still presenting meals our residents wanted to eat. With a very multicultural workforce, we faced several challenges in communication and reporting.

We hired a Hospitality Services Manager to support the Food Services, Domestic Services and Transport Managers, and to create a Hospitality Services team. This person had experience in international hotels and utilized that experience to make a real difference.

Food safety — legislative requirements and safe food handling — brought other constraints or other challenges in trying to provide fresh-tasting food that also minimized risks. This is particularly important when you have a group of individuals who are at higher risk than many in the community. For example, Listeriosis is always lurking there! This means that we had to accept, sometimes, that a "fresh" fruit salad might carry greater risk than canned fruit salad. Or a fresh green salad must be impeccably handled. We could not usually leave bowls of fresh fruit around for residents to help themselves. We had to remember to frequently offer a variety of drinks because most residents could not help themselves nor ask for them. Staff had to be reminded to do this often — not just at meal and tea breaks, as is the practice in most institutions.

When people are fairly institutionalized in the ways they have always done things, it is harder than you might imagine to "institutionalize" them into different ways of operating.

In addition to training, we produced Manuals and Checklists (an "institutional" approach). We bought new equipment — and then had to issue guides for its use. We made drawings of spoons and their capacities (i.e., "use this one for 1 serving of potatoes!") to ensure residents received the right sized servings. We had photographs of different food textures and ways of serving them. "Keep it attractive!"

I also explored a different form of divided plate as an extra deterrent against mashing up the colors — or at least helping the colors and flavors of food stay separate, especially when pureed. Most divided plates look too institutional, or, at best, like cheap airline meals. We struggled for the "normal" in a not very normal environment.

We introduced individual menus for each resident — all computerized to assist production and (more importantly) to ensure each resident got food tailored to his/her individual need and (limited) preference. Doing this can also ensure residents do not eat food to which they are allergic or is inappropriate for religious reasons. Each resident had his or her own Eating and Drinking Plan. These Plans included the addition of food supplements or additional servings of nutritious snacks.

We made food and mealtimes one of the most important things discussed, thought about, met over, and argued about. We had about three different monthly meetings around food. We had monthly tastings of food — new dishes as well as tried and true favourites.

It was interesting to see the different perspectives that different professionals brought to these discussions and tastings. Dieticians were excellent on the content — but not always on the form the food took. There had been a few times when all the other staff and all the clients rose up in objection to new dishes placed on the menu by their dieticians. One was when the "meat" was removed from the minestrone! Another one was the introduction of a particularly wobbly "egg slice" (which did not travel well and went down less well!) I think there were a lot of "self-determining to eat out" by the residents that night — that is: there were mad rushes down the road to Maccas or Kentucky Fried or the local Chinese Takeaway.

After that, we provided "Emergency Packages" of noodles, tuna, pasta, soups, baked beans etc to each residence in case a particular resident did not like the meal, or the wrong one arrived. These have had to be limited, as most nursing staff did not see it as their duty to cook.

At the last tasting attended, we were served a very good lentil soup with a mild curry flavor (I forgot to mention that our Hospital Services Manager was born in Sri Lanka). The Dietician still was not happy - she wanted to add more bulk to it, by adding rice. We had a lively discussion about nutrition and cultural authenticity. I think we agreed that, for those who needed something extra, they could have rice on the side.

The level of interest and commitment (and, for some, "nuisance value") blossomed. We integrated good food, good nutrition and healthy eating into our daily routines. We essentially "institutionalized" improved food services and nutrition.

In conclusion: Never let up!

Take eating out, for example. Maximizing access to the community was also high on our agenda. Some staff said it was "too hard" or "too dangerous" to take our residents out for a meal. So our cunning and committed group of dieticians and speech pathologists got together and prepared a booklet — a guide for eating out, complete with photographs; they even sampled the texture-modified food themselves! They assured me that a pureed hamburger tastes delicious, and a minced Chinese meal suffers little in the translation. (I did not verify this through a taste test... I did, however, look closely at the pictures!)

I am quite proud of what we have achieved, but there is still a long way to go. We are planning to introduce more choices in our menu as our systems settle in. We anticipate changing the job titles from "Cooks" to "Chefs", to match our expectations. We are planning to introduce a "Chef on the Move" where one of our best chefs will go to a pantry in a residential unit and cook on the spot. Not only will residents get the anticipation and enjoyment of the sounds and smells of cooking, they will be able to enjoy foods such as grills and stir-fries, which travel less well.

I really know that, through the work we have done together, and with the fundamental changes we have introduced, we have established new ways of doing things that will last, set standards which have become second nature, and "institutionalized" a new system which will bring lasting improvements and new levels of enjoyment to residents. These residents were

amongst the least visible in the community. If we could bring these improvements to them, it demonstrates what can be done in other institutions.