Structure and agency attributes of residents' use of dining space during mealtimes in care homes for older people

Dr Adriano Maluf, Professor Francine Cheater, Professor Fiona Poland, Professor Antony Arthur

School of Health Sciences, University of East Anglia, Norwich, United Kingdom

Correspondence: Antony Arthur, antony.arthur@uea.ac.uk

Abstract:

Research stresses that mealtimes in care homes for older people are vital social events in residents' lives. Mealtimes have great importance for residents as they provide a sense of normality, reinforce individuals' identities, and orientate their routines. This ethnographic study aimed to understand residents' use of dining spaces during mealtimes, specifically examining residents' table assignment processes. Data were collected in summer 2015 in three care homes located in England. The research settings looked after residents aged 65+, each having a distinct profile: a nursing home, a residential home for older people, and a residential home for those with advanced dementia. Analyses revealed a two-stage table assignment process: 1. *Allocation* – where staff exert control by determining residents' seating. Allocation is inherently part of the care provided by the homes and reflects the structured element of living in an institution. This study identified three strategies for allocation adopted by the staff: a) personal compatibilities; b) according to gender; and c) 'continual allocation'. 2. *Appropriation* - consists of residents routinely and willingly occupying the same

space in the dining room. Appropriation helps residents to create and maintain their daily routines and it is an expression of their agency. The findings demonstrate the mechanisms of residents' table assignment and its importance for their routines, contributing towards a potentially more self-fulfilling life. These findings have implications for policy and care practices in residential and nursing homes.

Keywords: care homes, older people, dining room, mealtimes, table assignment, agency.

What is known about this topic?

- Mealtimes in care homes for older people are essential social events in residents' lives;
- Space, staff and table companions at mealtimes have great importance for residents' experiences;
- Staff are mostly responsible for residents' table assignment.

What this paper adds?

- Residents' table assignments are essential for their routines and unfold in two stages;
- *Allocation* is exercised by the staff in placing the resident at a table reflecting the structural element of life in care homes;
- *Appropriation* is exercised by residents through routinely using the same space in the dining area. Appropriation reflects residents' agency potentially contributing to a more autonomous and self-fulfilling life.

1. Introduction

Georg Simmel's 1910 essay on 'The Sociology of the Meal' argues that eating together at mealtimes creates invaluable opportunities for socialising while strengthening a group's social norms (Simmel,1997; Symons, 1994) while bridging the public and private spheres of life

(Simmel, 1997). In old age, having companions at mealtimes is associated with increased food intake, whereas those dining alone are at greater risk of malnutrition (Hetherington, et al. 2006; Shahar et al., 2003; Sharkey, 2002).

In care homes for older people, mealtimes have been identified as essential events in the social lives of residents (Bundgaard, 2005; Kofod, 2012; Tsai & Tsai, 2008; Watkins et al., 2017; Wikby & Fagerskiold, 2004; Wright, et al., 2006) which go beyond the act of ingestion (Wikby & Fagerskiold, 2004; Wright, et al. , 2006).

Previous studies identified numerous factors that influence residents' experiences at mealtimes, including the material conditions of the dining room space (Chaudhury, 2013; McDaniel et al., 2001; Passini et al., 2000) and how well-acquainted residents are with this space (Carrier, West, & Ouellet, 2009). Other factors include the presence, attitudes and training of the staff in how they interact and support residents (Bourdel-Marchasson, 2010; Gibbs-Ward & Keller, 2005; Simmons & Levy-Storms, 2006), the quality of interactions between residents (Philpin et al., 2011), and the freedom of choice around food, place, time and companions (Carrier et al., 2009; Crogan et al., 2004; Watkins et al., 2017).

Mealtimes are regarded as social events that foster a sense of community integration, the perception of normality, and reinforce personal identity (Gibbs-Ward & Keller, 2005; Palacios-Ceña et al., 2013; Philpin et al., 2011; Watkins et al., 2017). Mealtimes involve social exchanges between those around the table, including sharing personal feelings, employing humour, displaying affection and appreciation, and perhaps less positively, rebuffing and avoidance (Curle & Keller, 2010). Mealtimes serve as a 'compass' around which residents can orientate their social routines throughout the day (Palacios-Ceña et al., 2013). While several studies reported that residents tend to occupy the same place in the dining room during each

mealtime (Kofod, 2012; Palacios-Ceña et al., 2013), it remains unclear why and how residents do this.

This paper examines how residents exercise agency and how this is affected and sometimes constrained by care home social rules, care practices and space. Agency is a concept that varies according to the field of study (Hitlin & Elder Jr, 2007 : 171). Previous gerontological studies defined agency as acting independently (Baltes & Carstensen, 1996; Rowe & Kahn, 1997). However, the progressive decline of cognitive and physical capacities in advanced age means a loss of agency (Rozanova, 2010; Tulle-Winton, 1999). Agency here is not limited to actions but it is extended to the idea of 'being' (Pirhonen & Pietila, 2018 : 34). This paper aims to explore the mechanisms behind residents' use of spaces in dining areas as communal areas where care is provided (structure) with broad implications for residents' abilities to construct and maintain their daily routines (agency).

2. Methods

This study employed an ethnographic approach that enabled the researcher to explore the cultural context of social groups in their setting (Hammersley & Atkinson, 1995). Constructionist ethnography was used to explore how individuals created, assembled and maintained social meanings through their daily routines and their use of language (Holstein & Gubrium, 2008), focusing on mealtimes.

Participant observations were employed to generate data, enabling AM (the lead author) to experience the settings at first hand and to interact with participants (Hammersley & Atkinson, 1995; Mason, 2002). AM adopted a 'moderate participation' role (Spradley, 1980) working as volunteer in the settings by undertaking simple activities which did not involve residents' direct

care. Ethnographic interviews (Spradley, 2016) were also conducted to explore participants' experiences in the field.

2.1. Settings and data collection

Data were collected from three settings which cared for residents aged 65+: Cedar-Home, a nursing home; Oak-Home, a care home for older age; Beech-Home, a care home for people with dementia (although the other two settings also cared for people with dementia). The settings were located in the South East of England. Table 1 shows the characteristics of the settings.

	CEDAR-HOME (Nursing Home)	OAK-HOME (Residential Care Home)	BEECH-HOME (Residential Care Home)
Type of care	Care for older people with complex needs (i.e. cancer, stroke)	Care for older people in general	Care for people with advanced stages of dementia
Type of building	2 floor building, built for purpose	4 floor refurbished manor house adapted to a care home	6 floor Victorian building adapted to a care home
Characteristic of dining room spaces	A large dining room linked with the kitchen through a hatch	An open and large room which accommodates the dining room and TV lounge	A small and cluttered room with tables and chairs
Number of residents living in the care home	33	21	26
Number of residents frequenting the dining room	13-14	11-14	15-16
Mean residents' age	86.7	90.5	87

Table 1 – Characteristics of the research settings

The data presented here were collected as part of a larger research project comprising 266 hours of observations (40% at mealtimes), and 17 interviews with staff, residents and visitors, which explored different topics including mealtimes. All residents, staff and visitors were invited to take part in the research, including residents with advanced dementia and those experiencing difficulties with communication. The data collection was conducted between August 2015 and July 2016.

2.3. Data analysis

The analysis started in the early stages of the fieldwork (Brewer, 2002 : 107) as AM examined key interactions in how people engaged in their daily routines and the power relations between main actors, i.e. staff/residents. On completion of the data collection, thematic analysis was employed by coding the dataset using NVivo 11 software for data management. 'Open codes' (Bryman, 2016) were created which covered all aspects of mealtimes. Subsequently, 'focused codes' (Emerson, 2011) were developed by selecting the most relevant and meaningful aspects of residents' table assignment. The focused codes were examined in fine detail to ensure the rigour of results. For example, the open codes: staff providing care/support; staff members' decisions; and staff modifying the dining space were clustered under one focused code 'staff's control'. A 'code tree' was created to compare the focused codes (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008). Subsequently, the focused codes were interpreted into concepts, i.e. 'staff's control' code was interpreted as 'allocation'. A final step in the analysis consisted of linking the concept of allocation to the notion of 'structure' of life in care. 'Abductive' reasoning (Mason, 2002) was adopted in the analysis which comprised moving backwards and forwards between interpreting the data and theory.

2.4. Ethical considerations

The study received ethical approval by the Social Care Research Ethics Committee, National Health Service (NHS) Health Research Authority in England and Wales – study reference 15/IEC08/0039.

A member of the staff informally assessed residents' capacity to make the decision about their participation in the study. Residents deemed capable to make such decision provided written consent alongside verbal consent prior to each observation period as residents' capacity might fluctuate during the day. A consultee was appointed if the resident was unable to make an informed decision about their participation who would consider resident's best interest in taking part in the study. Participants were assigned pseudonyms while staff were identified with (S) in the reporting of the findings.

3. Findings

The findings presented in this paper attempt to explain how residents came to occupy the dining room spaces during mealtimes. The analysis revealed that residents' table assignment involved two stages: 'allocation' in which the staff appear to group residents at a specific table/seat in the dining room followed by 'appropriation' in which residents seemed to continually and willingly occupying the same seats as part of their routines.

3.1. Allocation

The dining rooms were treated as communal areas in which a range of activities occurred as well as mealtimes. The decisions and actions of staff in placing residents in specific spaces in the dining room is referred to in this study as *allocation* which occurred when the

resident first arrived and settled down in the care home but usually not after that, as explained:

> ‘When you first come here and you go in the dining room it’s usually the girls [referring to care staff] in the dining room who say ‘oh well, we’ll put you there or we’ll put her there or whatever...’ (Mark’s interview, Cedar-Home)

A similar situation was reported by Mary in Cedar-Home when asked how she chose a seat/table when first accessing the dining room:

> They decided it! I didn’t! Well, it was a vacant seat, so they put me there, sort of. (observation, Cedar-Home)

Residents perceived their first experience of the dining areas as one in which they had no choice regarding where they would sit at mealtimes, the staff made these decisions. Residents’ passive roles in the allocation process is further expressed by Peter:

> AM - Did you have any say in where to sit? [in the dining room]
>
> Peter - They just put you there. They allocated you in that place. It is very much like going to school. Like in the school, in the class somebody new came and had change in the pattern. (interview, Oak-Home)

Peter’s statement reveals that from residents’ perspectives the table assignment can be an institutionalising experience in the sense they did not have control over choosing where to sit from the outset which limited residents’ agency. Their experiences during mealtimes could change over time as table groupings reassembled to accommodate newcomers, as older companions departed, or their health declined. Residents’ lack of control was not restricted to where to sit in the dining room but was widened to having no control over the configuration of the group sharing the same table. The following observation from Oak-Home illustrates how the staff team managed the allocation of new residents:

> Previously I observed Simon having his lunch alone at one of the tables in the dining room. Today I asked the manager why Simon was sitting on his own

> while everybody else was sat in groups. The manager seemed surprised with my question and checked the information with Cornelia(S) who was present in the conversation. Cornelia(S) confirmed the information and the manager replied: 'well, make sure that he sits with other residents next time.' At lunch time I observed the residents' arrival and Cornelia(S) escorted Simon by the arm. As they got into the dining room, Simon tried to walk towards his usual seat. Cornelia(S) held Simon's arm and said: 'you sit here with the ladies!' pointing to a vacant chair between Theresa and Joan, enforcing the command by saying: 'right here!' and pulling out an empty chair for Simon to sit. Simon followed Cornelia's(S) instructions with no protest and had his meal in this seat. (observation, Oak-Home)

The excerpt reveals that care staff actively planned where the residents should sit at mealtimes in Oak-Home. Fig. 1 illustrates Simon's allocation in the dining room:

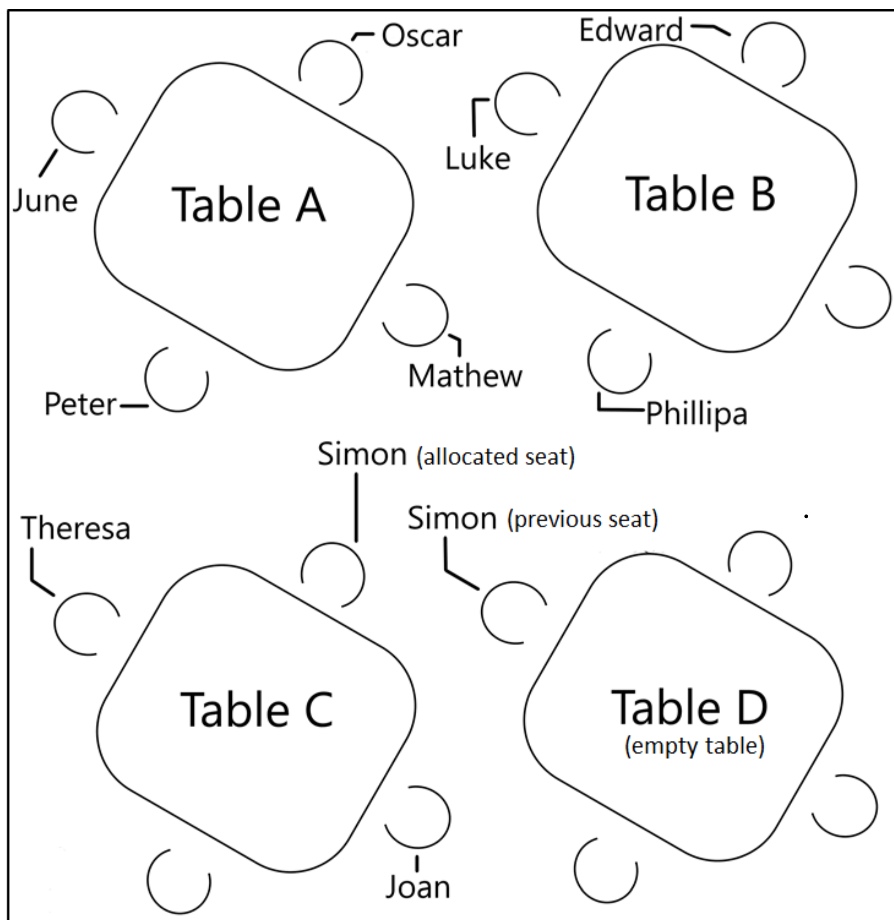

Figure 1 – Residents' table assignment in Oak-Home

The manager explained further the purpose and strategies when allocating residents:

> 'What we try to do, like we've got a lady coming in next week and she's 100 but she's got full capacity and she likes to chat. So straight away I would put

her in the small lounge [for the mealtimes] because they like conversation more... We do think about where we sit them, and we've sat people before and it doesn't work, so we move them around every so often if we find that they're not getting on with those people… Because it's always a good thing if you're sat eating, you've got to enjoy your company, …' (manager's interview, Oak-Home)

The manager's strategy was sensitive to individuals' needs and aimed to encourage social interactions, while diminishing possible confrontations by grouping residents with compatible personalities. Thus, allocation in this context appears to be an intrinsic part of the staff duty of care to the residents. However, other allocation strategies were employed in different care settings:

> Ronald recently arrived in Cedar-Home and today was the first lunch in the dining room. Martha(S), a nurse, supported Ronald to sit at one of the tables before any of the residents had arrived. He sat at the Helen's and Fiona's table. As the room became busier in preparation for the lunch, it appeared that Ella(S) and Mabel(S) were discussing moving Ronald to another table. Mabel(S) helped Ronald to move to Terry's, Mark's and Paul's table. After the lunch, I approached Mabel(S) to ask her why they moved Ronald. Mabel(S) replied: 'because men like to sit with men – it is the men's table'. (observation, Cedar-Home)

Gender is used as the strategy for allocating residents in the dining room. The term 'men's table' was not exclusively used by the staff though.

> 'Somebody else who comes, who comes, may come in and because it's a man they put them at our table because that's always considered the 'men's table'. (Mark's interview, Cedar-Home)

Mark's comments indicate that the term 'men's table' was not restricted to staff; making clear that the dining room in Cedar-Home was divided into gendered areas.

3.2. Appropriation

Following allocation to a specific table, residents seemed to become accustomed to sitting at the table/seat to which they had been assigned during mealtimes. This seemingly trivial behaviour is argued to have real significance for the lives of residents as Mark explains:

> '... but then after that, that's your place, you know, and nobody else goes, I mean if somebody sat in my chair now, I think the roof would go off!' [loud laughter] (Mark's interview, Cedar-Home)

Residents appropriating their seats situated them spatially in the room. This became part of the social rules or etiquette amongst the residents. The following observation and Fig. 2 demonstrate to what extent residents were prepared to keep their space in the dining room:

> The meal service was ending as residents were finishing the dessert course when Lucy arrived in the dining room. Lucy's usual seat at table B was occupied by Betty (see figure 2). Edith(S) came to Lucy's aid and asked:
> Edith(S) - Hi Lucy! Where are you having lunch? There! [pointing to table E] or there! [pointing to the seat at table B]
> Lucy – Here! [holding the back of the chair placed at her table ['optional seat' in table B].
> With certain impatience in her expression, Edith(S) repeated the same question:
> Edith(S) – Where do you want to sit Lucy? Over there? Or there? [making hand gestures towards the two options].
> Lucy - I want to sit here!
> Edith(S) - Yes! You can sit here! [pulling the chair for Lucy to sit]. (observation, Cedar-Home).

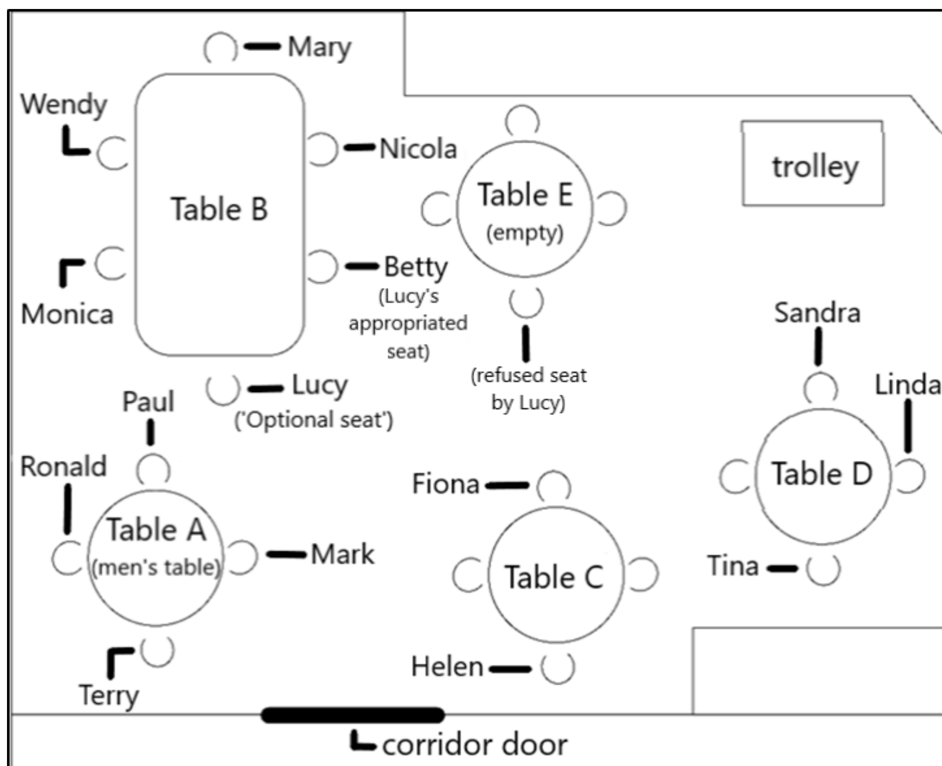

Figure 2 – Residents' table assignment in Cedar-Home

It appeared that Edith(S) not only aimed to support Lucy to settle down for the meal but also wanted to organise the space in a more efficient manner by placing Lucy at table E where she would not obstruct Wendy, Monica, Paul and Ronald from leaving the room after they finished their meals. Edith's(S) repeated questioning about the choice of seat was an indirect suggestion for Lucy to sit somewhere in the diningroom which would result in Lucy's displacement in the wider dining group and isolation from her tablemates. Ultimately, moving Lucy to another table would have undermined her agency in maintaining her usual social routines. Lucy's resolution in sitting in her usual table/space demonstrated that residents also exercised an indirect and parallel control in relation to the staff's power over the communal areas. This habitual use of a particular space in the dining area is defined here as *appropriation* and it is interpreted as a manifestation of residents' agency over the communal area and was an essential part in regulating their

social experiences within the group. Some residents retained appropriation even if they had no affinity with the people whom they shared the table with, as Luke explained:

> 'Mostly on the meals, the worst part about it actually I shouldn't say this but Philippa is a pain in the neck. She's on our table, up and down, up and down! Anyway, I'm not moving so I'm staying where I am! Down there! [referring to the dining room downstairs, raising his voice and gesticulating] I'm quite happy!' (Luke's interview, Oak-Home)

Luke prioritised maintaining ownership of his seat at the dining room over avoiding undesirable company. The idea of changing seats for Luke seemed to threaten his agency by removing him from a familiar and personal space.

By contrast, some of the residents in Beech-Home were not able to appropriate their dining seats, as the assignment system had a different dynamic. The dining room in Beech-Home was not spacious enough to allow the staff and residents to move freely. The space in the dining room was cluttered and crowded when accommodating all diners. The process of moving residents into the dining room was time-consuming and required coordination from the staff as the doors and corridor to the dining room were narrow, allowing only one person to walk through at a time. This seemed to make it harder for staff to support all residents in appropriating their individual seats as residents experienced mobility and cognitive impairments. Fig. 3 shows the group of residents who were unable to retain appropriation.

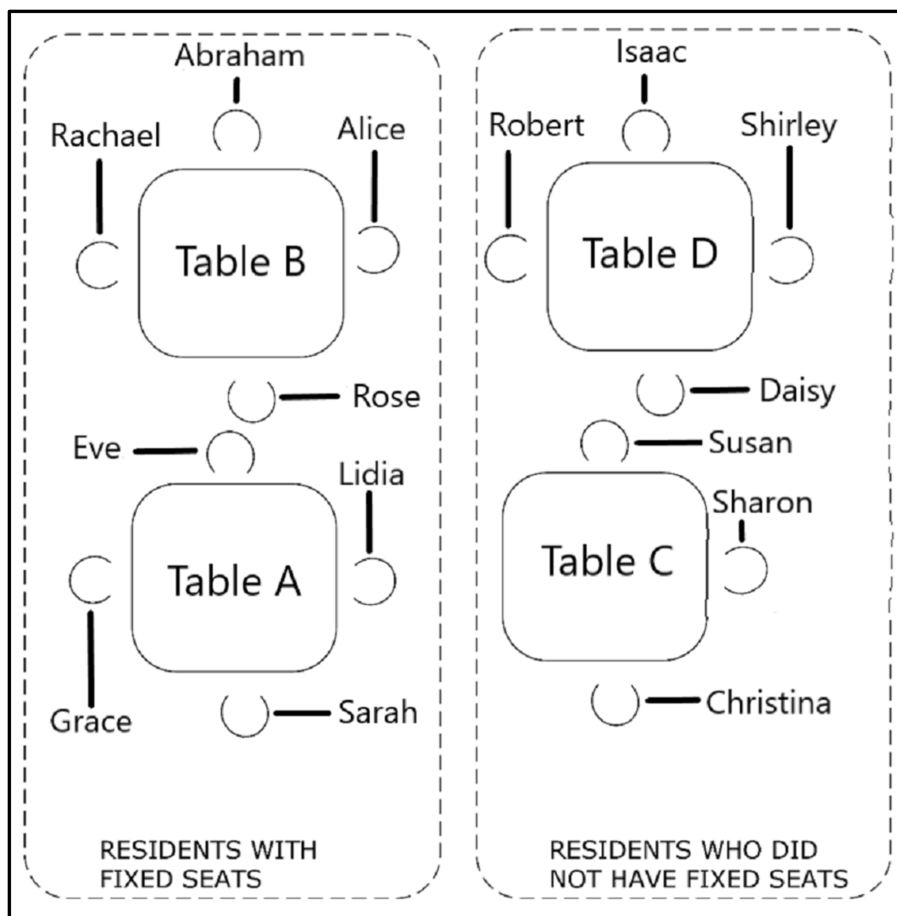

Figure 3 - Residents' table assignment in Beech-Home

Residents who sat at tables A and B were able to appropriate their seats, but the reasons for this varied. Residents at table B were all wheelchair-bound and they were the first residents to be moved in at mealtimes and the last residents to leave afterwards. Members of table A however, had advanced dementia and would not accept a seat somewhere else with different people. Residents at tables C and D were re-allocated rather randomly by staff to a different table and seat every mealtime. These residents were unable to appropriate their seats at the tables, preventing them from creating closer bonds with tablemates and taking ownership of seating spaces. The building layout of Beech-Home and its dining room (see Table 1) might well have an impact on the staff's care practices. The following excerpt illustrates how a resident was supported by the staff to occupy a seat at table C (see Fig. 3):

> I observed Susan walking with difficulty towards the centre of the dining room. She walked with a Zimmer frame by taking small steps, each at a time, while resting her body weight on the frame, pushing it forward with great effort while looking down at the floor. When Susan got closer to Elsa(S) she paused walking and then looked up to the care staff and said with a faint voice: '*where?!'* Elsa(S) looked around and replied to Susan: 'you sit here darling' while pulling a chair that was close Susan. Susan sat at the chair suggested by the care staff. (observation, Beech-Home)

Susan suffered with dementia which prevented her from recollecting and discussing issues regarding the care she received, including the choice where to sit in the dining room, despite AM's efforts to engage with this aspect of her experience. Observation methods were key for the participation of residents with dementia with limited speech. The excerpt demonstrated the nature of power relations between resident and staff as Susan asked 'where?' indicating how she was dependent on staff guidance while the staff replied 'you sit here darling' indicating their control over the communal area.

Residents' persistent lack of control over where to sit in the dining room and the absence of residents' appropriation is conceptualised as 'continuous allocation'. The impact of continual allocation may reduce residents' autonomy to self-regulate their daily lives and may cause uncertainty as residents would sit with less familiar spaces/tablemates. Conversely, residents who were supported to retain appropriation seemed keen to keep their seat in the dining room regardless of their cognitive skills. This seemed to be the case for Helen, a wheelchair bound and long-term resident in Cedar-Home. In the following excerpt, Helen's daughter explained her mother's desire to sit at her usual space in the dining room:

> I approached Helen's daughter to obtain research consent for her mother's participation. The daughter replied to me: '…mum will not be of much help for you…' telling me her mother is in advanced stages of Alzheimer's disease and unable to communicate. I explained that Helen's impairments wouldn't prevent her participation mentioning I could map Helen's location in the

> dining room. Helen's daughter replied with enthusiasm: 'Oh! Good luck if you are moving mum from her seat, nobody makes her to sit somewhere else!' (laughs). I asked what would happen if Helen needs to change seats and the daughter replied: 'she wouldn't have it! I will tell you that! A couple of times we tried to move mum to a different table, but she became so agitated and upset that we had to give up …' [Notes recorded with Helen's daughter consent] (observation, Cedar-Home)

Indeed, Helen sat at the same table (see table C in Fig. 2) throughout the data collection in Cedar-Home.

The findings presented in this study enable three important conclusions about residents' appropriation in the dining room. Firstly, care home staff were key in supporting residents' abilities to acquire appropriation and to some extent this was part of the structure of care; secondly, appropriation remained an important element in residents' lives despite their cognitive decline; and thirdly, appropriation was a direct manifestation of residents' control and an expression of their agency.

4. Discussion

Knowledge of care home residents' use of the dining room space is limited and the findings reported here help address this gap in the literature, revealing the power relations between staff/residents and the importance for residents routines. The findings indicate communal areas such as dining rooms are partially controlled by care staff through the allocation of residents. Allocation appeared to be part of the staff's duties of care towards residents but was an institutionalising experience for residents as they were denied choice in the table assignment. This reveals a structural aspect of life in care.

Three main care strategies were identified for allocation: a) according to residents' personality compatibilities; b) based on residents' gender; and c) 'continual allocation'. Previous research has argued that the assignment of residents to dining tables depends on: '(i) personal

judgment; (ii) resident behaviour; and (iii) the perspectives of the residents about the composition of table groups' (Palacios-Ceña et al., 2013 : 485-6). Those findings were based exclusively on interviews and therefore were limited to residents' and staff's perceptions. Palacios-ceña et al., (2013) suggested that the care staff arranged residents at the same tables as a tactic to reduce tensions between tablemates while Curle & Keller (2010) reported that residents with similar characteristics (social background, language, accent and common interests) tended to socialise better. These findings appear to be closely aligned with the 'personality compatibilities' strategy proposed in this study. However, the discussed studies may over-emphasise the care staff's control and fail to recognise residents' agency through appropriation of their space, as demonstrated in this study. Interestingly, no previous study identified gender as a criterion for allocating residents in the dining area, although there were references to 'all male' and 'all female' tables (Curle & Keller, 2010).

'A*ppropriation'* comprises residents' habits of routinely using the same space in the dining room by sitting at the same table, having the same companions and maintaining their place within the social group of residents. It is a mechanism which enabled residents to have familiarity with their surroundings and people and may create security and reduce anxiety. The willingness of residents to appropriate their seats signify residents' active choice and an exercise of their agency. Thus, appropriation may lead to a more autonomous and self-fulfilling life.

Pearson et al. (2003) argued that staff recognise residents' seating arrangements as an important element of residents' social interactions. While residents' table assignment was identified as being fairly rigid (Kofod, 2012; Pearson et al., 2003) the activities around eating in care homes nonetheless provided opportunities for residents to express their autonomy,

control and agency, which reinforced and maintained their personal identity (Watkins et al., 2017).

No previous studies have explored residents' use of the dining room from an agency perspective. Palacios-Ceña et al., (2013) mainly portrayed the table assignment as residents having a passive role, although there is a tacit recognition of residents' agency as they were able to 'veto' individuals who did not conform with the attitudes and manners shared by others at the same table. The findings presented here are aligned with the conceptualisation of agency as defined by Pirhonen & Pietila (2018) which is not restricted to 'doing' activities but expanded to 'being' as they are supported by the staff and surroundings of the dining area.

Moreover, the appropriation phase was very much connected to creating attachment to spaces, which is essential in experiencing a sense of home in residential care (Falk et al., 2012). Similar studies have recognised that the surroundings and spatial dimensions of the dining area influenced the social interactions of the diners (Curle & Keller, 2010; Philpin et al., 2011).

When residents were unable to appropriate their seats in the dining room, the staff continually allocated residents to seats. Continual allocation may reduce residents' autonomy as they were repeatedly prompted to seek direction from the staff, and perhaps staff approval for residents to use the dining room. Continual allocation emerged from practices other than residents exercising agency.

This study has significant implications for care practices and policies. The process of residents' table assignment presented in this study poses complex issues in relation to person-centred care. In broad terms patient-centred care is conceptualised as 'providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decision' (Institute of Medicine, 2001) while person-centred care for people with dementia is identified as: 'knowing the person; …; being in a personalised

environment; and experiencing flexibility and continuity' (Edvardsson et al., 2010). Allocation of residents by the staff in the dining room appeared to be an alienating experience for residents and contrary to the principles of person-centred care. However, allocation was a mechanism employed by the staff to ensure the care needs of all residents were met as they used the communal area. Appropriation on the other hand enabled continuity of care and the experience of a personalised environment. Appropriation was a subtle but ongoing, active, and real choice made by residents about their daily routines and therefore an expression of residents' agency which can only contribute to best practice in person-centred care. Most importantly, allocation was a relatively uncommon event as it only happened with a resident's arrival and occasional re-allocations when necessary while appropriation was enacted every day at every mealtime; thus, the table assignment process described in this paper is largely aligned with person-centred care.

The regulations in England around the suitability of communal areas to provide the basic care for residents states: 'Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time…' and 'People should be able to easily enter and exit premises and find their way around easily and independently' (Health and Social Care Act, 2008). These regulations lack clarity, leaving the assessor to judge what is 'big enough' for a communal area and make no reference to the procedures for assessing these spaces.

This study has limitations. Firstly, it does not investigate all possible strategies for the allocation of residents in dining areas. Other strategies may exist such as staff allocating residents according to their cognitive and physical abilities. Secondly, it does not explore how the table assignments affect residents' social interactions with their tablemates nor the broader social implications for individual residents in being members of subgroups in the care home, i.e.

groups organised by gender. The findings indicate that future research should focus on the isolating aspects of being part of subgroups of residents such as men and those residents who are most disabled.

5. Conclusion

This study provides detailed insights into specific ways care home residents occupied the dining areas during mealtimes. The initial stage of allocation of residents in the dining area by the staff reflected the organisational structure to meet residents' care needs as a group. Subsequently, the appropriation of the seats by residents was a stage which appeared essential in enabling residents to maintain their daily social routines, creating personalised care and enacting agency which contributed to a more self-fulfilling life in care homes. The findings demonstrate the vital role of the care home workforce in the table assignment process and highlights the implications of care practices of 'continual allocation' which denies appropriation of spaces and therefore restricts residents' agency.

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