

**Negative prompts aimed at maintaining eating independence in nursing home residents:
purposes and implications - A critical analysis**

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Abstract

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Background: Psychological abuse of older people is difficult to recognise; specifically, nursing home (NH) residents have been documented to be at higher risk of psychological abuse during daily care, such as during feeding. Health care professionals (HCPs) adopt positive and negative verbal prompts to maintain residents' eating independence; however, negative prompts' purposes and implications have never been discussed to date.

Research aims: To critically analyse negative verbal prompts given during mealtimes as forms of abuse of older individuals and violation of ethical principles.

Research design: Secondary analysis of three cases of negative prompts that emerged in a large descriptive study based upon focus group methodology and involving 13 NHs and 54 HCPs.

Participants and research context: Three out of 13 NHs caring for residents with moderate/severe functional dependence in self-feeding mainly due to dementia; in these NHs, we conducted three focus groups and 13 HCPs participated.

Ethical considerations: This study was conducted in accordance with the Human Subject Research Ethics Committee guidelines after being approved by the Review Board of the Trust.

Findings: With the intent of maintaining self-feeding independence, negative verbal prompts have been reported as being used by NH teams. By critically analysing these negative prompts, it turned out they could trigger intimidation, depression, and anxiety and thus could be considered as forms of abuse; moreover, negative prompts can threaten the ethical principles of: a) autonomy by using a paternalist approach; b) beneficence and non-maleficence as with the intent to act in the best interests of residents (to maintain self-feeding independence) they are harmed in their dignity; and c) justice, given that residents who received negative prompts are treated differently to those who received positive prompts.

Discussion: Eating should be a pleasant experience with a positive impact on physiological, psychological, and social well-being. However, negative prompting can lead to abuse and violation of basic ethical principles, destroying the HCP-resident and -relative relationships strongly dependant on trust.

Conclusion: Negative verbal prompting should must be avoided.

Keywords: eating independence, feeding difficulties, mealtime assistance, nursing home, qualitative study, verbal prompting, elder abuse, ethical principles

Introduction

Over the past decade, elder abuse has been defined as the mistreatment of older people, which has been recently identified in five types, e.g. physical, psychological, sexual, financial, and neglect.¹ Recognising older abuse may be challenging and psychological abuse is among the subtlest forms to identify: intimidation, humiliation, disregard, or causing fear are only some types of psychological abuse.²

The overall prevalence of elder abuse has been reported at approximately 10%,¹ although it is likely to be underestimated since cognitively impaired individuals can have difficulties in reporting abuse or may not be believed when they report it. For every recognised case, five or more have been estimated as being unreported.³ Specifically, given that most nursing home (NH) residents are admitted due to the consequences of cognitive impairments, in this setting an increased risk of abuse has been reported also during daily basic care, such as support while eating.⁴

The prevalence of eating difficulties has been documented as high, involving > 85% of residents with advanced dementia.^{5,6} When residents' eating performance is initially impaired, health care professionals (HCPs) offer mealtime assistance in the form of verbal prompts and cues, positive reinforcements and appropriate encouragement. These have all been documented as interventions to maintain independence and the residents' active participation at mealtime rather than being a passive recipient of food.⁵ In advanced stages, when self-feeding worsens, partial (e.g. assisting the resident in holding the cup or tools) and total assistance (e.g. feeding the resident) are required.^{7,8}

According to the evidence available, prompts delivered by HCPs aimed at maintaining or increasing eating performance have been categorised as: a) tactile, e.g. offering tactile prompts followed by immediately offering food; b) motivational, e.g. offering positive reinforcements when the resident completes the eating task, by saying "*That's right, good*"; c) role modelling, e.g. positioning the resident with compromised eating abilities between residents who are able to feed themselves to provide examples as role models; d) verbal, e.g. instructing them to eat/drink, or inviting questions as "*Why don't you try a bit of your soup?*"; and e) non-verbal, e.g. opening containers, cutting meat.⁷⁻¹⁰

However, these prompts can assume the features of psychological abuse when they are delivered in a negative manner rather than providing positive reinforcements, e.g. making the patient feel guilty for not being able to eat alone or threatening to withhold the reward at the end of the meal, as coffee or sweets, if all the food has not been eaten.² Humiliation by infantilisation and threatening are examples of psychological abuses violating a resident's dignity and ethical principles.¹¹ Their protection in NH settings relies to an extended degree on the behaviour, compassion and sensitivity of HCPs; therefore they can be threatened when HCPs' authority prevails.¹¹

To our best knowledge, an in-depth analysis of negative prompts offered during mealtimes aimed at stimulating eating independence has never been conducted with regards to their contribution to elder abuse and violation of ethical principles. With this intent, the principal purpose of this study was to contribute to the progression of the debate in this field by critically analysing the use of negative prompts as a form of psychological abuse to maintain self-feeding performance among NH residents with moderately severe to severe cognitive impairment and moderate to high dependence in eating.

Background

The concept of '*prompt*' refers, according to its etymology, to '*incite*' to do something.¹² Prompts are offered before the action. Moreover, all interventions aimed at driving the action by anticipating what can happen if the action is appropriately performed (e.g. receiving a reward), can be considered a reinforcement. Prompts and reinforcements have been considered relevant among learning theories, mainly in the field of behaviourism.^{13, 14}

Negative reinforcements have been documented as aimed at removing, reducing, postponing, or preventing certain stimuli.¹⁵ Negative reinforcers can generate two consequences amongst the residents, "escaping" and "avoiding": while the former refers to the attempt to remove or reduce a stimulus (e.g. when the resident starts to refuse to eat in the dining room during the meal due to his/her attempt to prevent negative prompts), the latter is aimed at preventing the occurrence of the stimulus (e.g., asking to eat in the bedroom and not in the dining room in order to avoid humiliations during meals). Moreover, while negative

reinforcements consist in the attempt to remove something that can be unpleasant to a person, punishment is a process by which a consequence immediately follows a behaviour with the intent to decrease its future occurrence.¹⁶

Negative reinforcement has been considered intrusive as a punishment given that the presentation of the aversive stimulus is contingent on the absence, rather than the occurrence, of behaviour.¹⁶ Both concepts are widely used and debated in primary education, and according to Iwata¹⁶ there is a need to conduct research with great care and under the appropriate conditions to determine how negative reinforcements might be used effectively and humanely, their limitations, and their proper role within the larger realm of currently available educational strategies used to enhance learning.

Negative prompts may appear as psychological abuse when promoting residents' tendency to isolation during social activities as eating (e.g. residents prefer to eat in their room rather than with the others) to avoid punishment; moreover, they may also appear to threaten ethical principles that should guide HCP practice. Specifically, HCPs are required to assess the wishes and desires of each individual aiming at protecting his/her autonomy by avoiding 'paternalistic' patterns (respect for autonomy); moreover, HCPs are required to act in the best interests of patients and their families'/carers' views and to not harm them (non-maleficence); furthermore, HCPs are required to undertake decisions by ensuring fair distribution of scarce resources (distributive justice), by respecting individual rights (rights based justice) and by respecting morally accepted laws (legal justice).³¹

Methods

Study design

This was a secondary analysis of negative cases¹⁷ that emerged in a large descriptive qualitative study¹⁸ based on focus group methodology¹⁹ performed in 2017. The COnsolidated criteria for REporting Qualitative research (COREQ),²⁰ were considered here to report those methodological aspects related to the study design as summarised in Table 1.

Setting and participants

The primary study involved 13 NHs that were regulated by the Regional Health Services and located in a rural area of the North-East of Italy.¹⁸ Residents were admitted to these NHs with moderate/severe functional dependence in need of feeding care due to different health conditions, mainly dementia.²¹

Specifically, a purposeful sample²² of HCPs in each NH (a) involved on a daily basis in assisting residents at meal times, (b) working in the NH for the last six months, and (c) willing to participate, were invited to be part of the focus group formed in each NH. HCPs (n=54) were involved in the primary study¹⁸; in this secondary analysis, findings from 13 HCPs working in three NHs were analysed.

Data collection process

After having observed (AP, KT) the HCPs during mealtime assistance in the dining room of each involved NH and collecting in-the-field notes regarding behaviour and verbal or non-verbal interventions adopted to maintain eating independence, a purposeful sample of HCPs was selected by the NH nurse manager. A focus group methodology²³ was used to collect data; thus, 13 focus group interviews were conducted by following a specific guide (available from Authors) developed by researchers: after collecting some demographic and professional data, a set of open-ended questions were asked aimed at stimulating the detection of interventions performed on a daily basis, aimed at maintaining residents' eating performance. Thus, by reporting some interventions witnessed by researchers during their lunchtime observation, the discussion was further continued with the purpose of collecting all interventions delivered. Furthermore, the interventions that emerged in the previous focus groups were reported with the intent to introduce new insights and data into those already collected.²⁴

A senior researcher (AP) conducted the data collection process with the support of a junior researcher (KT) who collected notes during the interview; the focus groups were all conducted in appropriate NH environments facilitating interactions among participants. The focus groups were on average one hour in length (from 45 to 130 minutes); they were audio-recorded and then verbatim transcribed. Aiming at ensuring data dependability,²⁵ the focus groups were numbered (e.g. focus group Nursing Home 5, NH 5).

Negative case identification

From the verbatim transcriptions, there were three negative cases identified in three different NHs that did not support or contradict the patterns of positive prompts with regards to self-feeding that emerged from the data analysis.¹⁷ These cases were preliminarily categorised as ‘verbal prompts’ but given (a) their negative intention, thus not intended to reward or support the resident,⁷⁻¹⁰ and (b) their potential negative impact on residents (e.g. fear)², they were selected and extracted.

Moreover, in-the-field notes collected during the mealtime observation phase were all also scrutinised by two researchers (AP, SG) to check if the cases emerged in the focus groups were also witnessed as actual interventions; in the field notes, no data was reported. Furthermore, aiming at ensuring data consistency, sessions of focus group member checking²⁵ of extracted data were performed by returning to two NH focus groups, selected casually, out of three.

These agreed with the data extracted, which was then considered valid. Thus, these negative cases were contextualised by describing their profile at the:

- (a) NHs levels, as the number of beds and the number of residents living in each;
- (b) resident levels, by reporting age, gender, the degree of functional dependence as measured by the Barthel index score (from 0 = total dependence to 100 = total independence),²⁶ the degree of the cognitive impairment as measured by the Cognitive Performance Scale (CPS, from 0 = intact to 6 = severe impairment; scores ≥ 4 indicate moderate/severe cognitive impairment),²⁷ and the self-feeding impairments as measured by the Edinburgh Feeding Evaluation in Dementia scale (EdFED),^{28,29} ranging from 0 (any difficulties) to 20 (complete dependence in self-feeding);
- (c) focus group levels, by reporting participants’ ages, gender, professional profiles, and years of clinical experience in the NH.

While at the NHs and at the participants levels, data was collected by the researchers involved, data at the residents’ level was collected through observation, interview or clinical record access, by trained Registered Nurses responsible for the resident’s care in the facilities, by using the abovementioned tools.

Negative case critical analysis

In the preliminary phase, the Lachs & Pillimer's framework was adopted to identify and discuss elderly abuse.¹ According to this framework, elderly abuse can be physical, psychological or verbal, sexual, financial and neglect. Manifestations of abuse change according to the type of abuse: 1) physical abuse should be suspected with abrasions, lacerations, bruises, fractures, burns, pain, depression, or delirium; 2) psychological abuse is suspected when verbal abuse is directly observed or with subtle signs of intimidation, such as deferring questions to some caregivers, producing isolation of the patient from both previously trusted family and/or friends, depression and/or anxiety; 3) sexual abuse is hypothesized in the presence of lacerations in the anogenital area or abdomen, newly acquired sexually transmitted disease or urinary tract infection; 4) nonadherence to medication regimen, malnutrition, weight loss or inability to pay for medicine may be manifestations of financial abuse; while 5) decubitus ulcers, poor hygiene and dehydration may indicate neglect. Thus, according specifically with the manifestations reported in point 2), the negative verbal prompts were considered as a form psychological abuse.

Then, the three cases identified were analysed in-depth according to the ethical principles of autonomy, beneficence/non-maleficence, and justice.³⁰ Furthermore, the feminist ethic of care model based upon relationships, responsibility, trust, loyalty, and sensitivity was also used to analyse the cases.³² According to this framework, HCPs should demonstrate: 1) moral attention, paying attention to the complexity of the situation and get involved; 2) sympathetic understanding; 3) relationship awareness; and 4) harmony, by ensuring balance in the relationship.³²

Negative cases were analysed individually and then collectively by all authors according to the abovementioned frameworks.

Ethical Considerations

The Review Board of the reference Health Care Trust of the NHs approached, approved the study protocol. Participants were informed on the study purpose and they were free to participate and to withdraw from the study at any time. They were asked to sign the consent form before the start of study where they also agreed to be audio-recorded; during the data analysis, researchers anonymised the name of both participants and NHs.

Findings

Negative prompts: cases emerged

With the intent of maintaining or promoting eating independence, in three NHs the staff used three forms of negative prompts reported as follows:

- (1) Case 1: *“If the resident does not eat alone, we tell him/her that we will call his/her daughter.”* (NH n. 7);
- (2) Case 2: *“If the resident does not self-feed, we tell him/her that we will not give them sweets and/or coffee at the end of the lunch.”* (NH n. 5);
- (3) Case 3: *“Sometimes residents are stimulated by saying...It is really a shame to feed you given that you can still be independent...”* (NH n. 1).

As reported in Table 2, these cases emerged in three NHs equipped with a range of beds, from 49 to 102, and reporting bed occupancy rates > 90%.

Residents living in these NHs were on average > 80 years old and mainly female (> 60%). Moreover, in all NHs the degree of dependence as measured with the Barthel Index was < 40 out of 100, thus suggesting a complete or partial functional dependence; with regards to self-feeding difficulties as measured with EdFED, on average residents living in NH 1 had a high dependence for self-feeding while those living in NHs 5 and 7 had a moderate dependence. Furthermore, three quarters of residents were affected by moderately severe to very severe cognitive impairment according to the CPS measures as reported in Table 2.

The focus groups in all NHs were multi-professional based, mainly composed by female Nurse Assistants and RNs with long experience (on average > 10 years) in caring older people in NHs (Table 2).

Negative prompts as a form of elder abuse

According to the Lachs and Pillemer's framework,¹ Case 1 (NH n. 7) expresses a sort of intimidation, and can be considered a form of verbal/psychological abuse. Also, Cases 2 and 3 (NH n. 5 and NH n. 1), where depression and anxiety can be triggered by the negative prompts, can be classified as forms of verbal/psychological elderly abuse.

Negative prompts as a form of violation of ethical principles

According to Beauchamp and Childress³⁰ different ethical principles are threatened in the cases selected. In all cases, a paternalistic approach seems to emerge, thus threatening the principle of autonomy; in the intent of serving the best interests of patients, which is substantially to maintain eating independence (=principle of beneficence), residents are harmed in their dignity by negative prompts. Furthermore, the principle of justice is also threatened given that: (a) residents who received negative prompts are treated differently with respect to those who received positive prompts; (b) residents suffering from dementia have an increased risk of receiving negative prompts as compared to those cognitively unimpaired; and (c) these negative prompts may have been given in order to implicitly apply pressure on the residents to reduce time spent in feeding care, due to rationed nursing care³³ e.g. residents receiving negative prompts can undertake avoidance behaviour, thus becoming more quick in eating.

Discussion

We have selected negative prompts cases used by the staff to enhance eating performance in three NHs out of 13. The health care staff had been already documented to adopt a wide range of strategies to promote independence in eating, including prompting.⁵ Positive prompts have been associated with the retention of eating independence,^{7,9} fluid intake between meals,¹⁰ oral intake during meals,⁸ and weight maintenance.⁹ However, to our best knowledge, negative prompts have never been discussed to date.

Negative prompts as a form of abuse

Resident's independence at mealtime has been reported as an indicator of quality of life,³⁴ with a recently renovated appeal to maintain residents' performance in eating as much as possible.^{5,35} International guidelines and position papers on nutrition in dementia have also recommended to include in the usual care all efforts to enhance oral feeding.³⁶⁻³⁸ Thus, HCPs are used to employing verbal prompts to stimulate the resident to recall movements and their necessary sequences to eat independently; moreover, HCPs are used to adopting motivational prompts congratulating residents when they complete the eating task. However, according to our findings, HCPs also adopt negative prompting. By intimidating and triggering distress, anxiety, and depression,^{1,4} as single or repeated acts occurring within the caring relationship where there is an expectation of trust,³⁹ negative prompting can be considered a form of elderly abuse.

The mechanism involved in the three cases that emerged seems to be different: in Case 1 (*"If the resident does not eat alone, we tell him/her that we will call his/her daughter"*) there is subtle mistreatment in the form of intimidation;² in Case 2 (*"If the resident does not self-feed, we tell him/her that we will not give them sweets and/or coffee at the end of lunch"*) NH residents are threatened by something pleasant that is not offered as a reward, but as a deprivation that can become a punishment;⁴ while in Case 3 (*"Sometimes residents are stimulated by saying...It is really a shame to feed you given that you can still be independent."*) residents are made to feel guilty for not being able to eat alone, thus causing them anguish and distress.²

NHs have already been recognised as places at greater risk of abuse due to the increasing number of cognitively impaired older adults that spend parts of their remaining life there.⁴⁰ As with other forms of abuse, negative prompts should be prevented and avoided; they can be difficult to discover because they occur inside of the dyad (resident and HCP) and should be taken into consideration in those studies aimed at measuring the occurrence of the phenomenon of verbal/psychological abuse as well as in educational strategies enacted to prevent all forms of abuse.

Negative prompts as a form of violation of ethical principles

Eating should be a pleasurable experience with a positive impact on physiological, psychological, and social well-being.³⁴ Therefore, establishing clear boundaries between positive (e.g., encouraging or rewarding) and negative prompting (e.g., punishing) is essential to identify the ethical nature of eating interventions beyond the beneficent scope of increasing residents' nutritional intake.

In the three cases emerged, HCPs were likely guided by the ethical principle of beneficence, thus believing to act in the resident's interest.³⁰ Their scope of practice implies a set of tasks as ensuring nutrition: thus, they can have adopted negative prompts to fulfil their task obligations. However, the principle of beneficence means that unless there is a sufficient reason not to, the obligation is to guarantee interventions that are likely to provide more good than harm;⁴¹ differently, by adopting negative prompting, residents may feel humiliated, intimidated, or guilty, or experience forms of psychological distress such as fear, anxiety, or depression.¹ Thus, HCPs have several good reasons not to adopt negative prompts (e.g., avoiding resident's distress).

Caring with reference to the ethics of duty has to prevent all forms of compromise of a resident's psychological well-being according to the principle of non-maleficence defined as the obligation not to perform interventions that are likely to produce more harm than good.⁴¹ Therefore, the principle of non-maleficence suggests that negative prompts have to be avoided as they place residents at higher risk of distress.

Furthermore, according to the principle of justice, patients with the same needs should not be treated differently;³⁰ thus, it should not be tolerable that some individuals (such as those with dementia) are exposed to positive and others to negative reinforcement(s) to reach the same goal, namely maintaining independence in eating. Discovering the reasons of these different treatments is strongly recommended with the aim of preventing their occurrence, e.g. increased paternalistic approaches with those who cannot be independent such as older people with dementia; or accelerating mealtime processes due to implicit rationing of NH nursing care because of economical restraints.

It has been already documented that ensuring care to older adults affected by cognitive impairments by respecting all ethical principles can be challenging.⁴² As dementia progresses, the person provides minimal contributions; they become progressively incapable of making decisions concerning their care and health, and to express their needs;⁴³ symptoms such as resistance, restlessness, and aggression have been documented as being common during nursing care, as eating

assistance leaves HCPs in an ethically challenging situation between respecting resident's self-determination that leads to consequent malnutrition and forcing them to eat.⁴⁴ However, the principle of autonomy translates into the principle of informed consent and to affirm autonomy treatment preferences needs to be discussed with residents and their relatives, and documented in their records;³⁰ thus, HCPs assume a greater responsibility. HCPs may adopt different strategies to promote the patient's right to self-determination despite cognitive decline – e.g. assessing the patient's wishes by using close questions, involving relatives in the discussion making sure that their preferences were in accordance with the resident's preferences or by allowing relatives to remind them about past preferences.⁴⁵

Furthermore, according to the ethics of care,³² in the three cases that emerged, HCPs did not pay moral attention to the complexity of the situation and the adoption of negative prompts suggests that eating assistance was perceived as a routine task among others. Similarly, in accordance with previous studies,⁴⁶ HCPs failed to recognise the importance of the psychosocial aspects of mealtimes and, given that all cases emerged from focus groups and not from singular interviews, factors at the NH levels could have played a strong influence in shaping mealtime interventions, e.g. NH policies are often task-oriented aimed at guaranteeing adequate caloric intake,⁴⁷ thus threatening other dimensions of mealtime.

Moreover, the three cases suggest that HCPs lacked sympathetic understanding since they did not reflect upon the unpleasant feelings that the negative prompting could induce, making the residents feel guilty for not being able to eat alone or fear their relatives' disappointed reactions when informed about their refusal of food. All interactions between human beings involve a basic trust; having trust means having power.⁴⁸ In all cases, HCPs emerged as powerful over the residents, thus leading to disruption of the relationship. Simultaneously, HCPs misused their power over family caregivers by threatening to call the relative if the resident does not eat independently, an act that infantilises the person and interferes in the familiar relationship. Thus, the balance between the HCP and the care recipient and their relatives is disrupted with a loss of harmony.

Study strengthens and limitations

We analysed three deviant cases that freely emerged during focus group sessions, during which there was the development of a great sense of trust between participants and researchers and the latter never expressed any judgments or personal opinions during data collection. However, according to the in-the-field notes collected in the first stage of the study, these cases were not witnessed in the real world during the lunch time observation performed before the focus groups in each NH. Therefore, their tonality and volume (e.g. shout) as well as their actual implementation, have not been evaluated and scrutinised.

By conducting an interview via focus group, we have documented events through the knowledge of HCPs that drives them in daily practice;⁴⁹ however, more studies aimed at detecting different forms of negative prompts as adopted at the bedside are required to understand in depth their implications both in elderly abuse and in the violation of ethical principles.

Only three cases were analysed that emerged in three focus group out of 13 conducted across different NHs. Therefore, the cases under study were limited and more studies are needed to discover the variability of negative prompts used in NHs as well as their frequency of use.

Conclusion and implications

Verbal reinforcements have been promoted for their positive effects in maintaining eating independence; however, some prompts that are negatively-directed (e.g. punishing or increasing stress and anxiety) instead of positively-directed (based upon rewards) are used during mealtimes. According to their manifestation, negative prompts can be considered a verbal/psychological abuses that must be prevented and avoided; moreover, negative prompts can violate ethical principles of care. It's undeniable that pursuing resident's self-feeding independence has a beneficence scope; however, threatening the trust of residents and their relatives, e.g. by adopting negative prompts, can disrupt the relationship with both of them, thus violating the respect of ethical responsibilities towards older people who are in need. Therefore, verbal prompting should always be positively directed, and negative prompts avoided to prevent abuse and violation of ethical principles.

Since the negative prompts emerged only within focus groups, further investigation of the role of the NH environment (i.e., culture) in shaping mealtime interventions is suggested, with a greater attention for reaching adequate nutritional intake rather than ensuring that the pleasure for a social activity as eating is maintained. Therefore, this analysis provides a basis for discussions among HCPs about aspects of their work of which they might not have previously been aware. In turn, such discussions may result in a change in the attitudes and behaviours of HCPs in promoting independence in eating among NH residents and the adoption of other strategies in place of negative prompts to overcome self-feeding difficulties, particularly in those residents with cognitive impairment. Improvements in awareness, collaboration, and open discussion of concerns, difficulties, and values, beliefs are necessary for improvement. However, an in-depth understanding of why negative prompts are offered, as well as when and under what mechanisms they are originated and included as a part of the usual care is strongly recommended. Furthermore, negative prompts should be taken into consideration in studies aimed at measuring the occurrence of verbal/psychological abuse.

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Table 1.Analysis of the study conduction according to the COnsolidated criteria for REporting Qualitative research²⁰

No. Item	Guide questions/description	Strategies
Domain 1: Research team and reflexivity		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the interview or focus group?	AP (see authors) conducted the interviews; KT (see authors) participated by taking notes during the focus group conduction
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	AP was a PhD student, and experienced in conducting qualitative studies KT was a clinical nurse, educated at the university level
3. Occupation	What was their occupation at the time of the study?	AP was Associate Professor in Nursing Science, KT was a student
4. Gender	Was the researcher male or female?	They were both female
5. Experience and training	What experience or training did the researcher have?	They were trained in conducting interviews; specifically, AP was also supervised in interview conduction in previous research projects
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	They met each other the first time in the day of the focus groups
7. Participant knowledge of the interviewer	What did the participants know about the researcher?	They were informed on the study aims and on the role of the interviewer; no other data was shared
8. Interviewer characteristics	What characteristics were reported about the interviewer or facilitator?	There were reported only their work position and their research lines No other data was shared
Domain 2: Study design		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study?	There were undertaken a case study of negative cases according to Creswell ¹⁷
<i>Participant selection</i>		
10. Sampling	How were participants selected?	A purposeful sample was used
11. Method of approach	How were participants approached?	Participants were approached face-to-face by their NH Nurse Manager and invited to participate in the focus group
12. Sample size	How many participants were in the study?	In the primary study there were 54 participants; in the focus groups where the negative cases emerged, 13 participants were involved
13. Non-participation	How many people refused to participate and why?	None
<i>Setting</i>		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	The data were collected in the NHs, in appropriate environment protected by interruptions and/or sources of disturb
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	None
16. Description of sample	What are the important characteristics of the sample?	Characteristic of the participants has been collected and reported in Table 2

<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	The questions were defined by authors and pilot tested in a NH not involved in the final study
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	No repeated interviews were performed
19. Audio/visual recording	Did researchers use audio/visual recording to collect the data?	The focus groups were all audio-recorded
20. Field notes	Were field notes made during and/or after the focus group?	There were collected in-the-field notes
21. Duration	What was the duration of the inter views or focus group?	In those focus groups were the negative cases emerged, the duration was from 55 to 65 minutes
22. Data saturation	Was data saturation discussed?	NA
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Sessions of member checking ²⁵ of data extracted have been performed by returning to two NH focus groups out three

Domain 3: Analysis and findings

<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	NA
25. Coding tree description	Did authors provide a description of the coding tree?	NA
26. Derivation of themes	Were themes identified in advance or derived from the data?	NA
27. Software	What software, if applicable, was used to manage the data?	NA
28. Participant checking	Did participants provide feedback on the findings?	Sessions of member checking ²⁵ of data extracted have been performed by returning to two NH focus groups out three

<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings?	Quotations were reported at the NH level (e.g. NH 1)
30. Data and findings consistent	Was there consistency between the data presented and the findings?	NA
31. Clarity of major themes	Were major themes clearly presented in the findings?	NA
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	NA

Legend. NH, Nursing Homes; HCP, Health Care Professionals, NA, Not applicable for the purpose of this case study.

Table 2.

Nursing Homes, residents, and focus groups participants' profiles

NH	NH n. 1	NH n. 5	NH n. 7
NH profile			
Bedsides, <i>n</i>	49	102	87
Residents living in the NH at the moment of the study, <i>n</i>	46	95	80
Resident profile			
Age, in years (SD)	88.6 (8.5)	81.3 (11.8)	86.0 (8.8)
F/M	36/10	70/21a	57/23
Barthel Index (0-100), (CI 95%) ^b	22.86 (14.35-31.37)	27.06 (20.54-33.58)	37.96 (29.67-46.25)
CPS (0-6), (CI 95%)	3.02 (2.38-3.67)	3.13 (2.71-3.54)	2.59 (2.09-3.09)
CPS >4 ^c (%)	15 (35.7)	32 (39.5)	28 (34.1)
EdFED (0-20), (CI 95%) ^d	7.29 (4.70-9.87)	1.95 (1.38-2.52)	1.99 (1.17-2.81)
Focus group participants profile			
Participants role, <i>n</i>	2 NAs, 1 PHYS	3 NAs, 2 RNs, 1 ED	2 RNs, 2 NAs
F/M	3/0	6/1	3/1
Age, in years (SD)	39.3 (10.0)	50.1 (5.2)	37.0 (16.7)
Experience, in years (SD)	10.0 (8.0)	22.8 (9.1)	10.3 (3.4)

CI, Confidence Interval; CPS: Cognitive Performance Scale; ED: Professional Educator; EdFED: Edinburgh Feeding Evaluation in Dementia scale; F, Female; M, Male; NH: Nursing Home, NA: Nurse Assistant, PHYS: Physiotherapists, RN: Registered Nurse; SD, Standard Deviation.

^a4 missing data.

^bLower scores indicate higher dependence in activity of daily living.

^cModerately severe to very severe cognitive impairment.

^dHigher scores indicate higher dependence in self-feeding.