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Motivation and performance of nutritional care for people with intellectual disabilities:

A qualitative interview study on the perspectives of supporting staff in municipal health and care services

Master's Thesis by
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Abstract

Background: Overall, persons with intellectual disability (ID) are nutritionally vulnerable and experience a higher burden of associated health risks than the general population. Supporting staff working in municipal health and care services, play an important role for people living in community residential homes with ID. The knowledge, skills, and attitudes of supporting staff are often crucial in facilitating a healthy diet and behavior for this group of people. Their attitudes and behavior are influenced by internal and external contributors of motivation and performance at their workplace. To date, no studies have explored the role of motivation and performance on nutritional care provided by supporting staff for persons with ID.

Aim: The aim of this study was to explore internal factors of motivation and performance towards nutritional care for people with mild to moderate ID by supporting staff working in community residences in municipal health and care services.

Method: In August and September 2021, semi-structured qualitative interviews were conducted individually with 11 supporting staff working with adults with ID, receiving municipal health and care services in the southeastern part of Norway. Questions were based on systematic nutritional care, structured according to factors affecting motivation and performance of staff. Interviews were transcribed and analyzed using systematic text condensation (STC), inspired by the phenomenological methodological approach.

Findings: The main findings from analyses resulted in six themes: *personal drive, barriers to health promoting care, nutritional care, competency,* and *system and structure*. Despite many supporting staff being able to identify the need for nutritional care, they experience difficulties with prioritizing and adapting nutritional care for individualized and complex needs that supports fundamental rights of self-determination and health. Different attitudes, knowledge, and interests in nutrition among staff manifest in different guidance and goal setting, also resulting from lacking system, structure, and routines of nutritional care.

Conclusion: Motivation and performance of nutritional care provided by supporting staff are determined by a complex set of factors that vary in their relative contribution across nutritional care. The essential factors provided in this study emphasize the importance of systematic nutritional care, not only for the purpose of good nutritional practice, but to also maintain motivation of supporting staff in municipal health and care services.

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Abbreviations

ID	Intellectual disability
IQ	Intelligence quotient
NCP	Nutritional Care Process
NSD	Norsk senter for forskningsdata/ Norwegian Centre for Research Data
RCT	Randomized controlled trial
REK	Regionale komiteer for medisinsk og helsefaglig forskningsetikk/ Regional Committee for Medical and Health Research Ethics
STC	Systematic text condensation
TSD	Tjenester for sensitive sata/ Services for Sensitive Data
UiO	Universitetet i Oslo/ University of Oslo

1 Introduction

1.1 Intellectual disability

Intellectual disability (ID) is characterized by limitations in intellectual capacity and adaptive behavior caused by delayed or impaired development (1). Approximately 1% of the population worldwide are diagnosed with an ID, with onset during the developmental period (2). An intellectual or developmental disability as such affect communication, social, and motor skills. It might also impact an individual's ability to understand new and complex information, learning new skills, and cope independently (3, 4). Hence, many encounter challenges of daily living and depend on others for support to perform tasks and make strategic and everyday life choices (5). Persons with ID receiving care and assistance from supporting staff will throughout this thesis be referred to as residents, although care receivers, patients, and users are commonly used elsewhere (6, 7).

People with ID are nutritionally vulnerable and experience a higher burden of associated health risks compared to the general population, in particular obesity, where type 2 diabetes, cardiovascular disease, and certain cancers are attributable diseases (8). Increasing prevalence rates of iron deficiency anemia, electrolyte and fluid disturbances, as well as altered gastrointestinal function have also been documented within this group (9). Additionally, deficits in cognitive and intellectual functioning, may compromise their ability to make rational decisions related to a healthy diet and lifestyle, and many may depend on assistance for decision-making and activities of daily living to ensure good health and quality of life (10-12).

Diagnosis of ID is classified into subgroups based on severity of mild, moderate, severe, and profound according to the Tenth Revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) (2). The condition is defined by the presence of an intelligence quotient (IQ) below 70, where mild ID is defined by IQ 50-69, moderate ID is defined by IQ 35-49, whereas severe ID is defined by 20-34, and profound ID is defined by IQ below 20. Intellectual and adaptive functioning may also vary greatly within each classification and even more between two classifications (11).

Although many causes of ID are unknown, the etiology of ID are primarily genetic or external (13). Genetically caused ID include chromosomal or hereditary disorders, while exposure to infections, trauma, or toxins, including alcohol consumption, iodine, or folic acid

deficiency during pregnancy may also generate disability of the fetus (13). The great independent variations between etiology, diagnosis, complexity, and presence of comorbidities are associated with a wide range of nutritional considerations within this group (14). Obesity is most frequent in mild and moderate ID, Prader-Willi syndrome, Williams syndrome, and Down syndrome (15, 16). The latter condition also have an increased incidence of developing autoimmune conditions, such as coeliac disease and type 1 diabetes (17, 18). In contrast, people with severe or profound ID are more likely to be undernourished (19), a common consequence of dysphagia and cerebral palsy (20). Moreover, persons with autism spectrum disorder are at higher risk of malnutrition resulting from selective eating habits (21, 22).

The level of help and support needed depends on the complexity and personalized care needs, and may change over time (23). Some live independent lives with minimal assistance from health and care services, while others may require significant resources and lifelong support. Regardless, the arrangement, development, and provision of services should be based on an individual's current needs, wishes, and abilities, and should most importantly, be of good quality initially (11, 24). Among services that individuals with ID receive are personal and individualized care, training, and practical support including medical, social, and psychosocial habilitation (25). These services are, due to shift work and staff turnover, performed by numerous different staff members, challenging continuity and overview of nutritional care (26).

Irrespective of cognitive and intellectual ability, individuals with ID are entitled to live in community-based settings, supported by municipal health and care services (27). In Norway, approximately 20,000 people above 16 years of age with ID receive municipal health and care services (28). These services are mostly organized and provided by supporting staff in relation to the accommodation, described in more detail below. Most adults with ID live in rented community apartments, while a minority either live in bought apartments or with their relatives. Municipal community-based living arrangements for adults with ID mainly consist of shared dwellings with individual apartments and common areas within the same building, or co-located dwellings with separate apartments that lie nearby each other and are connected to the same care unit (11, 29).

1.2 Health promotion in municipal health and care services

Municipal health and care services provide care, assistance, and habilitation for adults with ID living in community residential settings (11, 30). Throughout this thesis, supporting staff will be the used term for the municipally employed health and caregivers providing services for individuals with ID. They comprise a wide range of health and social care workers, including social educators, social workers, nurses, child welfare educators, and occupational therapists. However, a high proportion of municipal health and care services are formally untrained personnel without relevant professional and educational background (31, 32). In municipal services for persons with ID, over 30% of supporting staff lack relevant health-related background (33), compared to 25% in municipal health and care services in general (34).

Supporting staff represent an important environmental factor in enabling people with ID to live as independently as possible in their own homes (23, 35). It is necessary that staff possess great interpersonal and relationship skills to aid empowerment and promote residents life skill development (36). Such attributes must be built over time. Even so, supporting staff are expected to provide health-promoting care and ensure preventive measures according to individual needs (6, 37). Residents should be guided and made aware of healthy choices while their right to self-determination is maintained. In practice, supporting staff are often faced with ethical dilemmas related to their role as health care workers committed both to support a healthy lifestyle meanwhile respecting residents' autonomy (38).

A Swedish qualitative study found that supporting staff providing services to persons with ID define their role differently and have varying attitudes to health-promoting work (39). The study identified five different roles among supporting staff: the parent, the manipulator, the coach, the educator, and the libertarian. The different roles may be conflicting, particularly where the role at one side of the spectrum is significantly more controlling than the other, such as the strict parent-role versus the libertarian emphasizing free choice. This is problematic as individuals with ID depend on coordinated and structured health and care services that comply with statutory requirements and norms (37).

Factors affecting the opportunity of supporting staff to promote a healthy diet among adults with ID living in community residential homes, have also been assessed in previous studies (40, 41). Availability and accessibility of healthy foods as well as sufficient time and competency among supporting staff were found to be important facilitators (41). A more

recent study emphasized that the most integral prerequisite to promote and facilitate a healthy diet were common attitudes among staff, skills in facilitating a healthy diet, practical cooking skills, and applied dietary knowledge (40). The study also highlighted the importance of motivated staff and positive attitudes in promoting healthy behavior for people with ID.

As many persons with ID have reduced health literacy and might not be able to communicate their own needs to the same extent as other people in society, shortcomings in health and care services delivered to this group of people can be difficult to detect and can potentially have serious consequences (11). A nationwide inspection carried out by the Norwegian Board of Health Supervision in 2016 found serious weaknesses in municipal health and care services for people with ID across most health authorities (42). Lack of systematic care provision and documentation resulted in poorly informed staff on the residents, their work duties, and responsibilities.

To improve support provided for persons with ID, the Norwegian Directorate of Health has recently published a new national guideline on "Good health and care services for people with intellectual disabilities" (37). The guideline aims to enhance persons with ID life quality according to their capabilities, needs, and wishes. It also describes statutory requirements and recommendations for service providers and practitioners working in municipal health and care services to contribute to knowledge-based practice, improve collaboration, and to ensure optimal priorities are made.

According to the guideline, the municipality shall facilitate good nutrition and a health promoting diet. To maintain good routines for prevention and nutritional management, supporting staff must receive adequate training in identifying nutrition-related health challenges. Prevention and implementation of actions to take regarding malnutrition also involves collaboration with the residents on targeted measures to prevent health-related challenges for those at nutritional risk (37).

To date, most studies assessing supporting staff working with individuals with ID have carried out focus group interviews (39, 43) or concept-mapping methods (40, 43). This study aimed to gain a deeper insight into supporting staffs' personal motivation and considerations in how they experience nutritional care at their workplace. A deeper understanding of their attitudes and perspectives can contribute to strengthening the knowledge base on how to implement measures to improve nutritional care in municipal health and care services for persons with ID and by this reduce social health inequalities.

2 Theoretical framework

2.1 Systematic nutritional care

Nutrition and dietetic professionals utilize the Nutrition Care Process (NCP) model to implement systematic and high-quality individualized care. The framework involves four steps: nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation (44). Although the NCP-model is profession-specific, a similar systematic approach can be applied to municipal health and care services and is essential to deliver individualized optimal nutritional care.

Good nutritional practice provided by municipal health and care services should also follow a systematic approach to detect individuals at risk of nutrition-related health problems (Figure 1) (45, 46). Supporting staff are expected to evaluate nutritional status according to the Norwegian Directorate of Health's guidelines on "Good health and care services for people with intellectual disabilities" and offer health promoting nutritional care in accordance with dietary guidelines, individual preferences, and needs (37). This should be performed through offering people with ID individual services, advice, and guidance on diet and nutrition. The care manager is responsible for establishing systems to ensure that basic nutritional needs are met, considering the service and any additional needs that may be relevant are provided. They are also responsible for establishing systems for nutritional work and ensure that these are followed by supporting staff in practice.

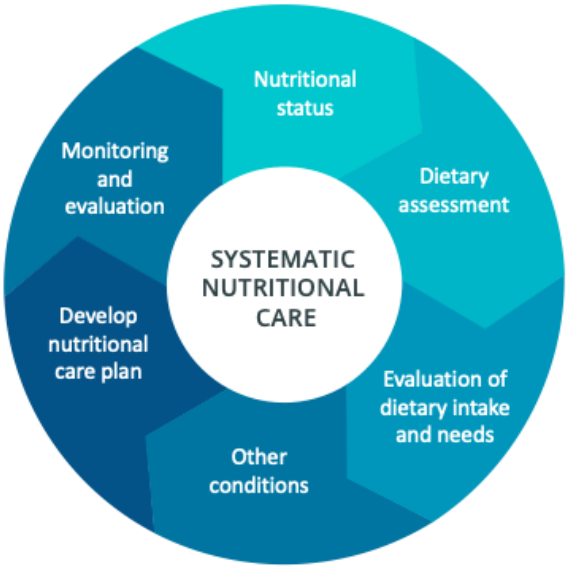

Figure 1 Systematic nutritional care adapted from Nordstrøm (45).

Recognizing individuals at nutritional risk is essential before malnutrition impacts their health and wellbeing (47). Regular nutritional screening can effectively identify individuals who may be at nutritional risk using screening tools and/or observation of weight changes over time in combination with body mass index and weight circumference (48). Systematic monitoring of anthropometric parameters are especially important for persons with ID as there are currently no validated nutritional screening tool adapted for this group (10, 49), or a screening tool addressing the challenges associated with overweight or obesity (50).

Preventive nutritional care and dietary guidance should be based on national dietary advice, also recommended for the general population (37, 51, 52). Residents needing further health assessment and treatment should be referred as appropriate to relevant health care professionals (e.g. doctor, nurse, health care support worker, dietitian) (46). Good communication and cooperation with qualified health care professionals throughout the process is therefore central to establish individualized measures or treatments. Biochemical investigations and clinical tests, dietary intake, comorbidities, environmental, and social factors are also relevant indicators to assess when food and nutrition-related needs are evaluated (53). Dietary intake related to requirements can be assessed by obtaining diet histories or food record charts and observing significant changes regarding appetite and dietary habits.

Based on any identified nutritional needs, clear goals and outcomes as part of an individualized care plan should be made in collaboration with the person with ID and qualified health care professionals (54). Key people in the resident's life should also be involved in these processes. The care plan should address the identified needs and how to meet the selected goals and outcomes. To update nutritional status and health needs, appropriate follow-up through regular monitoring and evaluation are necessary (55). This is done by systematic documentation of the nutritional care carried out, including observations, results of screening, monitoring, and effect of intervention (53, 56). It is of vital importance that documentation is standardized, clear, and consistent for safe and effective nutritional care.

Residents, patients, and users in need of long-term health and care services are assigned a staff member with the main responsibility for individual care plans including essential planning, progress, and follow-up (30, 57). They are often the main point of contact between the resident, their next of kin, and the specialist health service (58). Moreover, they may also be responsible for ensuring that nutritional status and needs are assessed for the resident they are responsible for, but this may vary between community residences (59).

Community residences in municipalities without a dietitian are encouraged to designate a member of staff the role as a "nutritional contact" with the overall responsibility for good nutrition practice and provide training to other staff (37, 46). The nutritional contact should ideally be a health care worker, social educator, or nurse with the relevant education, skills, and competency to ensure professional nutritional care is provided and updated according to

current guidelines (37). All nutritional contacts from residential homes in the municipality should also attend regular meetings to exchange experiences related to nutritional care at their workplace (26). To ensure provision of good quality and professional nutritional care, nutritional contacts should have the opportunity to consult a dietitian. This is particularly important in the management of complex nutritional challenges.

2.2 Model of motivation and performance

According to a motivation-performance model from *People in Organization* by Mitchell and Larson (60), attitudes of staff will be influenced by inner and outer contributors at their workplace. The model describes six components that may affect motivation and performance of staff, which are further divided into internal and external factors (Figure 2). Although both factors often exist simultaneously, they relate to different levels of motivation (60). The present study will focus on the relationship between the supporting staff and nutritional care, using parts of the model to explore internal factors contributing to their motivation and performance when providing nutritional care for adults with ID.

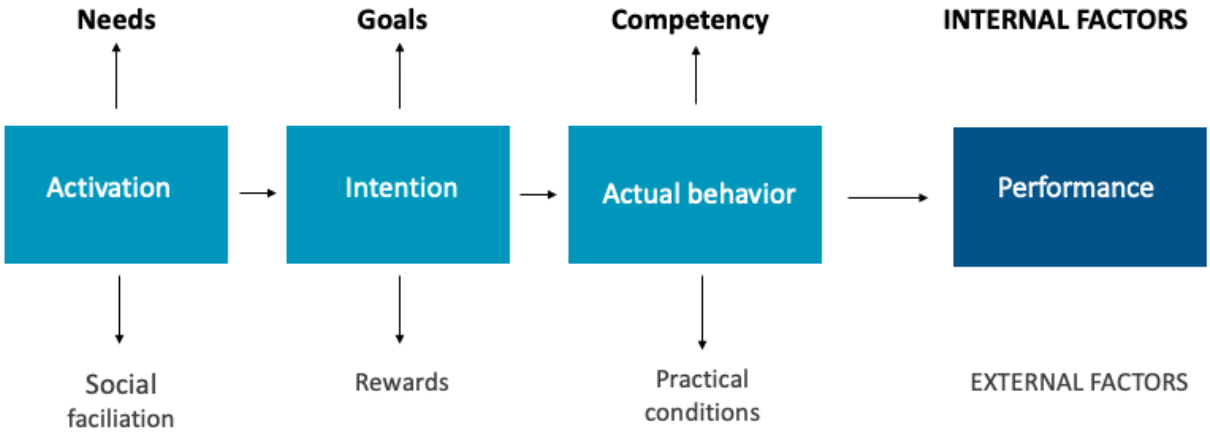

Figure 2 Model of motivation and performance adapted from Mitchell and Larson (60, p. 153).

Internal factors encompass an individual's drive of persistent behavior based on their desire of accomplishing something that has not yet been achieved (60). This can be driven by needs, goals, and competency. A staff member's internal factors of motivation may be affected by their awareness of needs. Needs develop if the supporting staff experience a mismatch between how the nutritional care is from their point of view and how they would like it to be for the individual with ID that they work with. To recognize needs for nutritional care, it is necessary to have knowledge of recommended and adequate nutrition.

Essential principles for goal setting should follow the SMART-criteria (61). A goal should therefore be specific, measurable, ambitious although not too ambitious, realistic, and timely. For many, imprecise goals may be difficult to follow through. Evaluating planned goals and measures to potentially identify new nutritional needs are also important elements of nutritional care planning.

Ability and knowledge in nutrition are known to influence actual behavior of nutritional care combined with intentions (60). It also requires the set of skills to motivate others including communication, empathy, and engaging with the individuals with ID. Michell and Larson (60) describes how the role of motivation in our work is less important where the work depends on skills or ability. Thus, the provision of nutritional care is likely to be determined by a complex set of factors that vary in supporting staffs' contribution across responsibilities and tasks.

External factors consist of outer motivating factors that influence awareness and the actual behavior of a particular task. These include social facilitation, rewards, and practical conditions within the workplace (60). Of these, social facilitation is likely the major factor contributing to activation of performance. The presence of others, a positive work environment, and support from colleagues, the care manager, or key people in the life of the resident are relevant examples of how social facilitation can be driving forces of nutritional care.

Rewards in terms of follow-up of staff and feedback requires observability, meaning that the care managers are involved in what the supporting staff are doing with regards to nutritional care. Also, implementation of rewards may be difficult in settings with heterogeneous groups as different people are motivated by different rewards and types of feedback. In that case, individual rewards and feedback are likely ideal. Practical conditions involve how the workplace facilitates for nutritional care, as poor conditions can be a barrier for staff to carry out their duties.

3 Aim and research questions

Aim

The aim of this study was to explore internal factors contributing to motivation and performance of nutritional care for people with mild to moderate ID by supporting staff working in community residences in municipal health and care services.

Research questions

How does internal factors affect motivation and performance of supporting staff delivering nutritional care for people with mild to moderate ID living in community residences in municipal health and care services?

To delimit and answer the research question, the following objectives will be explored:

1. How does need deprivation affect motivation and performance of nutritional care?
2. How do goals set in the workplace affect motivation and the performance of nutritional care?
3. How does the supporting staff's competency affect motivation and performance of nutritional care?

4 Methodology

4.1 Study design

4.1.1 Qualitative approach

Semi-structured qualitative interviews of supporting staff working with adults with mild to moderate ID living in community residences were conducted from August 2021 to September 2021. Analysis was performed using Malterud's systematic text condensation (STC), an approach inspired by the phenomenology (62-64).

Qualitative research methods are suitable to acquire in-depth knowledge and understanding of a particular concept or phenomenon from personal perspectives of individuals or groups (65, 66). The main focus is to obtain information on people's attitudes, thoughts, and experiences achieved through interviews, observations, or group discussions (64, 66). Therefore, a qualitative approach is suitable for exploring supporting staff's personal perspectives and considerations on nutritional care for adults with mild to moderate ID to improve municipal health and care services.

4.1.2 Recruitment

The current study is affiliated with a cluster randomized controlled trial (RCT) study conducted by a PhD candidate at the University of Oslo (UiO). Participants were purposively sampled, inviting all accessible supporting staff who had followed and assisted participants with mild to moderate ID in the intervention group of the seven-month cluster RCT study with the aim of weight reduction and dietary improvements. As part of the intervention, supporting staff were invited to attend monthly nutrition courses. The recent participation in the RCT study implied new experiences and knowledge for the supporting staff with providing nutritional care to adults with ID. Therefore, the recruited participants were considered suitable for the purpose of the study.

Participants were recruited from five different community residential homes for adults with ID in a municipality in the southeastern part of Norway. A written letter was sent by e-mail to the department managers of the community residential homes informing that selected supporting staff would receive an invitation letter to join the study. An electronic invitation letter including an informed consent form was subsequently e-mailed to 14 supporting staff

eligible for the study (Appendix 1). Of these, one person did not wish to participate and two people could not be reached as they worked elsewhere at the point of recruitment. In total, 11 supporting staff from four different community residential homes took part in the study.

4.1.3 Participants and setting

Socio-demographic data of participants are summarized in Table 1. The present study interviewed 11 participants whom all worked with adults with mild to moderate ID living in community-based residential homes. The interviewees were nine women and two men ranging from 30 to more than 60 years of age. The majority were ethnic Norwegians and had a higher level of education attained (college and/or university degree).

Table 1 Socio-demographic data of participants (n=11)

Variable	Category	n
Gender	Women	9
	Men	2
Age, *years*	30-39	4
	40-49	2
	50-59	3
	Over 60	2
Ethnicity	Norwegian	7
	Other	4
Education level attained	Primary and lower secondary school*	1
	Upper secondary school*	4
	College/university (3 years or more)	6
Work experience	0-5 years	2
	6-10 years	5
	Over 10 years	4

*Primary and lower secondary (1-10 years) and upper secondary school (13 years)

4.2 Data collection

4.2.1 Semi-structured interview guide

Semi-structured interviews were used to collect data and capture the interviewees' internal motivation factors and performance of delivering nutritional care in community residences for adults with ID. The interview guide (Appendix 2) was developed based on current knowledge regarding systematic nutritional care in municipal health and care services, and the guideline on nutritional care in "Good health and care services for people with intellectual disabilities" (37, 46). Questions in the interview guide were structured according to Mitchell and Larson's (60) model of motivation and performance (Figure 2).

To explore inner motivation and performance contribution factors, questions regarding needs were generated. The first question was particularly broad and open-ended to encourage a deeper and more personal insight on nutritional care at their workplace i.e., *What are your thoughts on food and nutrition for the resident in the community residential house?* To examine goal setting within the workplace, questions regarding goals and routines in relation to nutritional care and how these are made were developed. Questions on competency or ability in food and nutrition were developed in relation to the supporting staff's professional background, including formal and perceived competencies as well as their interest within the field.

Of the external contributors to motivation and performance, social facilitation derived from how supporting staff experienced that the workplace culture and environment affected nutrition for the residents at their workplace. Social facilitation also involved whether colleagues, residents, and residents' next of kin support initiatives to improve nutrition. Rewards developed from how supporting staff experienced that their attempts to improve nutritional care is rewarded through feedback, acknowledgement, or incentives. Practical conditions were derived from what the supporting staff thought about the practical arrangements for optimal nutrition such as kitchen and dining facilities, economy, and time available for cooking and preparing meals. Any facilitators and barriers to optimal nutrition in the residence were also considered.

4.2.2 Pilot interviews

Pilot interviews were carried out with two healthcare workers from two different community residential homes that were not included in the current study. These interviews were used to prepare the interviewer and improve the interview guide. The master student was observed by the PhD candidate who provided feedback on the interview technique. The interview guide was revised according to feedback and how questions seemed to be understood by the interviewees. Questions generated were simplified and open-ended to allow the interviewees to elaborate on their perspectives on the topics from the interview guide.

4.2.2 Qualitative interviews

In total, 11 interviews were conducted in-person by the master student at the supporting staffs' workplace during working hours to encourage participation. The interviews were recorded with two digital audio recorders (Olympus VN-541) to secure backup in case of malfunctions. The use of audio recorders enabled the interviewer to fully concentrate on the conversation and non-verbal communication. The interviews lasted from 1 to 1½ hours. Before the recorders were turned on, the interviewer emphasized the purpose of the study, that participation was voluntary and confidential, and that the interviewees were free to withdraw at any time. Participants were also asked to provide their sosio-demographic characteristics in a questionnaire (Appendix 3).

4.3 Ethical considerations

Ethical approval was granted by the Regional Committees for Medical and Health Research Ethics (REK) as part of the research project south-east 2019/362 (Appendix 4). The study was also approved by the Norwegian Centre for Research Data (NSD) to manage data in accordance with the privacy regulations (Appendix 5). The written consent form (Appendix 1) was explained and signed prior to conducting the interviews.

Each interview was anonymized with an identification number for coding audio files and transcripts after the interviews. The audio files were transferred via a computer and saved on an encrypted password protected memory stick (Kingston DataTraveler 2000). All audio files were transcribed consecutively and deleted from the recorder. Participants' socio-demographic data were categorized and stored on a separate memory stick. The physical

copies of the obtained data were subsequently shredded. A list of the codes (code-key) was temporarily stored on a memory stick and saved separately on Services for Sensitive Data (TSD) at UiO. Only the supervisors, the PhD candidate, and the master student had access to the deidentified data and code-key. All identifiable information or descriptions regarding participants or others was anonymized or modified during transcription to ensure confidentiality.

4.4 Data analysis

STC is a descriptive approach, allowing experiences to be presented as they are expressed by the participants as opposed to exploring the underlying meanings (63). This analytical strategy elaborates on Giorgi's four-step procedure for analysis: 1) obtain an impression, 2) identify meaning units, 3) abstract the content of the meaning units, 4) summarize the content of the meaning units. Although STC provides a systematic approach, it allows for flexibility and does not require extensive knowledge on philosophy or experience within qualitative research (64).

The master student and the PhD candidate had a shared agenda for analysis. The master student focused on internal factors of the model of motivation and performance (Figure 2) at an individual level associated with supporting staffs' motivation, work, and responsibilities. The PhD candidate focused on external factors of the model, involving the system level of nutritional care in municipal health and care services for adults with ID. The master student, the PhD candidate, and the supervisors had thorough discussions prior to data analysis.

4.4.1 Transcription

Interviews were initially listened to and transcribed consecutively using f4transkript. The first interview was transcribed by both the master student and the PhD candidate. By comparing the transcribed interviews, an agreement on the inconsistencies for future transcriptions were made. All following interviews were subsequently transcribed by the master student, but listened to multiple times by both the master student and PhD candidate for verifications. When possible, interviews were transcribed prior to conducting the next scheduled interview to ensure new aspects would be included or looked for in the following interviews.

4.4.2 Overall impression

The transcribed interviews were read from a bird's-eye perspective to obtain an overall impression and to get familiar with the material. Preliminary themes considering the research question were noted while setting aside any preconceptions.

4.4.3 Identifying and sorting meaning units

The transcripts were in this step read systematically line-by-line to identify meaning units from the material. Each internal factor of the model *needs*, *goals*, and *competency* (Figure 2) were color-coded. These were eventually changed to themes that emerged from the text reflecting the content of the interview. Meaning units, sections of quotations describing the internal components of the model, were color-coded accordingly. For example, meaning units providing information about competency, skills, and professional attributes required for performing nutritional care were highlighted and abstracted from the original material. The meaning units were sorted and coded in a matrix in Microsoft Word, using a navigation pane to obtain an overview of all themes and code groups. Timestamps created automatically during transcription in f4transkripts were included with each selected meaning unit for quick reference and orientation to the original material when necessary.

Several subgroups within each code group were created to further systematize and sort the data material. A map for the generated themes was developed to visually organize the meaning units into code groups and subgroups. For example, in the code group *competency*, the subgroups presenting similar phenomena were merged, such as *knowledge* and *training in nutritional care* referring to competence development and *unified practice*, *evidence-based practice*, and *insisting practice*, referring to the professional approach taken when performing nutritional care (Figure 3).

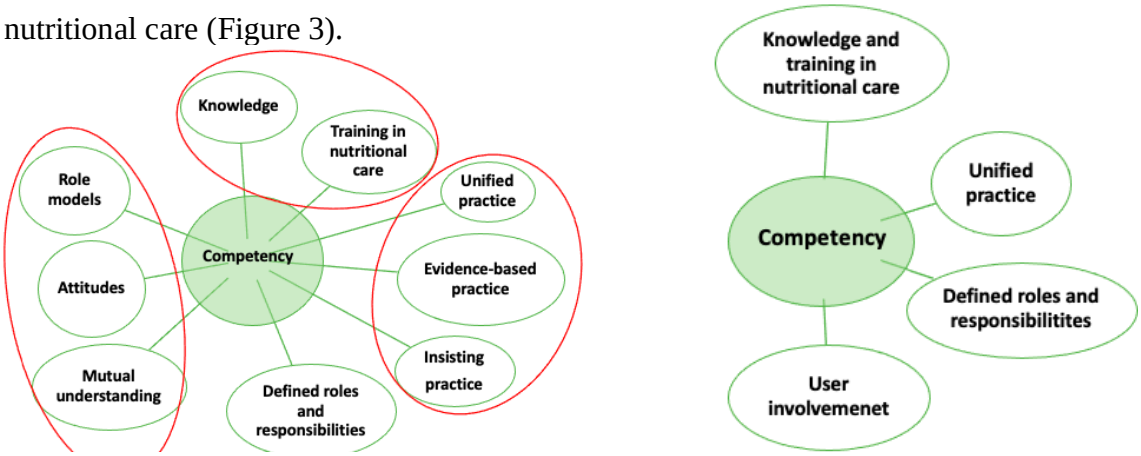

Figure 3 Example of coding, merging, and recoding of subgroups in competency

Another example includes development of the code group referring to nutritional care (Figure 4). The subgroups *individual adaptation*, *evaluation of individual needs*, and *individual goals* are all about individual assessment. These were therefore combined and labelled *individual needs*, which were subsequently relabeled *nutritional status and identified needs* under the code group *nutritional care*.

Figure 4 Example of coding, merging, and recoding of subgroups in nutritional care

4.4.4 Condensation

After delimiting relevant meaning units, the master student went through all the meaning units one more time for summarizing and clarification to reflect the provided insight. This was especially important for the most relevant meaning units for the research questions. The content of the meaning units within the most relevant subgroups was condensed to elaborate on the results of the discovered themes. It was desirable to illustrate contradictive views to show variation in the data, reflecting perspectives of supporting staff in this study. The matrix and map of generated themes (was also used actively in this step and adjusted consecutively.

4.4.5 Synthesizing

Finally, analytic texts were developed by synthesizing the contents of the chosen quotations and descriptions to substantiate and illustrate the presented themes. The original version of the transcripts was maintained for recontextualizing; the transcribed interviews were read through again to ensure that quotes were not withdrawn from their meaning and context. Supporting quotes were translated to English, maintaining the original terminology used by the interviewees including the meaning and context as far as possible. The Norwegian version was read by the supervisors for validation.

5 Findings

Analysis of the eleven interviews resulted in five main themes that were relevant for the research questions: *personal drive*, *barriers to health promoting care*, *nutritional care*, *competency*, and *system and structure.* The main findings within each theme are presented and highlighted in bold, as illustrated in Appendix 6. Attempts have been made to divide the main findings according to these themes despite some of the empirical material overlapping the research questions.

Observations made by the researcher while conducting the interviews showed quite dissimilar community residences as all were organized differently and therefore seemed to encounter individual challenges regarding nutritional care. Despite this, several had diverse experiences and perspectives on the topic researched, even within the same workplace.

5.1 Personal drive

5.1.1 Attitudes

All interviewees stated that staff had different attitudes towards food and nutrition. Staff explained how attitudes to healthy eating, portion sizes, and interest in food could vary due to personality traits, perceptions, and personal food preferences. The multidisciplinary professions would also affect their ways of approaching a certain case, which some experienced as beneficial to gain diverse input.

> *I think it's totally fine that we have an opportunity to discuss it. It's fine that I have my own [opinions], you know, but it's fine to hear others' opinions too. It's okay to hear what others think. Although we make the routines, it's okay… Because we are all working with the resident, you know, so it's good that all of us can discuss it.*
>
> Supporting staff nr. 7

> *There are social educators, social workers, child welfare educators, health professionals, occupational therapists… You know, so… The fact that we think differently about things has to do with the multidisciplinarity too.*
>
> Supporting staff nr. 2

Different attitudes among staff could also be frustrating for some when staff had different attitudes towards the importance of nutrition.

> *I don't feel it is full of conflict, but I probably feel that I am the one who [laughs] is going to say something about it! I will think about it for a bit. Then I think, 'No, when they [supporting staff] have chosen sausages and mashed potatoes, I won't say anything,' because I feel… They are adults, they should know. I can't go after them saying, 'We need to make something that they don't make at home.'*
>
> Supporting staff nr. 6

Many acknowledged the value of staff as role models and explained how they actively promoted healthy behavior in the presence of the residents for them to imitate and learn from their behavior.

> *I see that they notice very easily if I'm going to drink water or if they see me drink water. There are many who have great difficulties with drinking water for example. If they see me during the day with a bottle of water then they will easily talk about it and say 'I want one too. Why do you drink water?'*
>
> Supporting staff nr. 10

Following dietary guidelines and having conversations that create engagement around food through involvement and tasting new flavors, were examples of how staff would guide them in practical situations.

> *If I'm at work, I'm at work. If I want like a chocolate bar or something like that then I must have it at home. It applies to cleaning, it applies to attitude… The professionalism and attitude at work and to the work I do towards helping and motivating the residents, so if there are things I don't like doing at home, then I don't have to mention it here.*
>
> Supporting staff nr. 8

Several supporting staff mentioned food as a major part of the residents' life that is included in every aspect of their life. Many valued a positive approach towards healthy food and nutrition when promoting healthy eating and behavior. They attempt to encourage healthier

options for meals, snacks, and drinks that is pleasurable and enjoyable. Making the activity of shopping and ordering healthy food a positive experience was particularly emphasized as encouraging for both residents and the supporting staff assisting.

> *Well, as I said if you make the shopping exciting when looking after the keyhole on the food items they order. Then it becomes a focus to look for it. And it actually exists on some of the regular items that they buy. Then it becomes fun. Yes, then it becomes positive. And if we get them to, it's not always easy, but if we get them to try something new and they actually like it, and they want to try more of it in the future, and they see that the food does something positive and is not just something that is forced and becomes negative, because then… Then I think one is destined to fail with this user group.*
>
> Supporting staff nr. 11

5.1.2 Interaction and cooperation

Good interaction and cooperation between the resident and the supporting staff are important for developing a harmonious relationship. Many find motivation in interested and motivated residents that accomplish and succeed their set goals. Engaging key people in the resident's life was also mentioned as fundamental to prevent conflicting dietary advice and to collaborate on realistic and achievable goals within their care plan.

> *I actually find it a bit motivating now. With the resident I follow up, I kind of try to work with and collaborate with their next of kin and follow-up from the nutrition courses. Meet the resident where that person is with their motivation, skills, and ability to somehow achieve something. I like that. I like that. And I think it's nice.*
>
> Supporting staff nr. 5

Although relatives could be a positive force in nutritional care, problems could arise as they may have other approaches and set different boundaries than supporting staff.

Everything. Soft drinks. Chocolate. Yes. So it's not always easy with relatives either, you know. They are out with their relatives and then they go shopping and return with large quantities and a lot of sweets. It is not always easy for us. It really isn't.

Supporting staff nr. 11

Supporting staff nr. 10: *Well… I think mostly relatives are the challenge. Because... When we have… An involved group of relatives, it's like a barrier. Yes, they have the right to follow up their children, but at the same time we feel that we have to fulfill their wishes and not always the residents.*

Interviewer: *Is that balance somewhat difficult?*

Supporting staff nr. 10: *Yes.*

Interviewer: *How does it affect your work?*

Supporting staff nr. 10: *It can be stressful sometimes especially those who have very strict relatives, but I always try to follow the care plan... Care plan and routines and if a resident refuse something then I can't do anything more. So I tell them and they just have to accept it, but... Yeah. One knows it's just part of the job. The relatives will be there.*

5.1.3 Disease burden

Incorporating healthy dietary habits were important to supporting staff as individuals with ID have an increased risk of disease compared to the general population. Common consequences of overweight and obesity reported from the residences included social isolation, reduced mobility, and development of type 2 diabetes. Supporting staff found their work meaningful as the burden of disease largely affected residents' quality of life.

[…] you see it all the time, that they have a higher risk of obesity and lifestyle diseases, right? And it's not everything you can avoid or everything you can do something about, but if there are any small changes we can do to improve quality of life in terms of health, then I think that is really important.

Supporting staff nr. 2

5.2 Barriers to health promoting work

5.2.1 Self-determination

The main barrier to promoting healthy eating in the community residences was reported to be the residents' right to self-determination. Several supporting staff expressed how the residents right to self-determination could prevent them from performing health promoting work. Many experienced certain situations as challenging and frustrating when dealing with residents who declines guidance or proposed suggestions from staff.

> *We can't really refuse them and we can't say no, but it would probably be optimal if we were able to stop them from eating that much chocolate and candy. But there's something about that self-determination.*
>
> Supporting staff nr. 8

When questioned on how they promote healthy eating, nearly all explained how they continuously attempted to motivate and guide residents. Some specified that they would suggest healthy options when preparing meals, creating weekly menus, and grocery shopping lists in collaboration with the residents. However, the effort invested in the work often felt useless as residents were economically self-determined and preferred snacks, candy, and soft drinks even between meals.

> *Every community residence says, 'Yes, diet plans or menus does work, and they are actually followed, and the food is healthy and tasty but when dinner is over, they run down to the shop and buy a bag of buns.' So, if you think about it holistically then... It is too much.*
>
> Supporting staff nr. 3

In some interviews, the supporting staff would reflect on how they could perform the role as health care workers and support decision-making while they maintained the residents' self-determination.

> *If they [supporting staff] say, 'No, but they have the self-determination,' then I ask the question, 'What is our role here then? If they had managed everything themselves, what would our role be? Why do we come to work if they can follow a healthy diet? […] Do you not think that it is your role here to motivate and guide in the best way possible?'* Supporting staff nr. 10

5.2.2 Level of ID and assistance needed

Assistance and support needed from staff in community residences declines with increasing independence of the individual with ID. Level of independence affected how involved supporting staff were in nutritional management and how they could influence dietary choices. Some supporting staff explained how they were not permitted to interfere with resident's dietary intake or weight changes unless they consent. Staff members found it difficult to maintain a supportive role when they have limited overview and control of the resident's dietary intake.

> *If it's in a residence where more people live and eat, it's much easier to work with nutrition. That is my experience at least when I used to work in a residence where they live, and you would be in their kitchen several times during a shift. We see our residents maybe once or twice a week so it's very different. […] I received a picture of someone's dinner on my phone, but other than that I don't know what they eat unless they tell me. Some don't tell us anything. We can only imagine if we help them with the trash or cardboard or something.*
>
> Supporting staff nr. 6

5.2.3 Health literacy

According to the interviewees, individuals with ID present challenges in understanding and interpreting dietary advice. Hence, converting dietary knowledge into practice may become very difficult for them. Difficulties in understanding the consequences of their behavior could result in challenges with maintaining their own health. Many supporting staff were therefore concerned about some of the resident's nutritional status as they tend to make unhealthy dietary choices for themselves.

> *They have reduced cognitive functioning, an intellectual disability, most of them so they have limited understanding for what is best for their own health and diet. So I think it can be challenging to guide them because they don't always have a good understanding and they make their own choices and the self-determination is so strong, so they decide what they want to eat.*
>
> Supporting staff nr. 5

5.2.4 Ethical dilemma

Supporting staff experience contradictions between the two legislations, the right to self-determination and the right to health, making them feel insecure on guiding residents in relation to this. Some explained how they frequently experience difficulties in adapting guidance so that it does not go against the residents' self-determination. As staff find the two legislations conflicting, they strive to balance between their role as health care workers and respecting the residents' right to self-determination.

> *Residents may cry and become upset because they don't understand why they can't buy the same amount of chips and pizza as they used to because they have gained so much weight. […] We are kind of standing in between our duty as healthcare workers and their right to self-determination and autonomy. It is a huge dilemma.*
>
> Supporting staff nr. 5

5.3 Nutritional care

5.3.1 Systematic approach

A stronger focus on nutritional care was wanted by most interviewees. Several mentioned issues were related to this theme as many expressed concerns around the existing focus on diet and nutrition being inadequate and ineffective. One mentioned issue was how action seldom was taken to solve problems raised since staff felt unsure of how to deal with the ethical dilemma surrounding health care and self-determination.

> *In many ways we focus on it, but it kind of ends up as what do we do? What shall we do? And then we can't figure out what to do.*
>
> Supporting staff nr. 3

Some supporting staff explained that they wanted nutritional care incorporated on the agenda with a clarification of their role. Where nutritional care was not prioritized or focused on by the workplace, the initiated work tended to fade out over time as other tasks or pressing events would interfere with the time available.

Nutritional care is not enough on the agenda, and we have too few solutions on the problems raised. What do we do with it then? How are we going to help her or him? And it could be the other way; some may not eat or eat too little, or the small amount eaten may be very unhealthy. And they could be hard to reach too. […] I feel we can talk about it, but not to find a solution or do something about their diet.

Supporting staff nr. 6

Time was mentioned as a major limiting factor for planning, organizing, and structuring nutritional work in the residential homes. More time was also warranted to establish individualized care plans, goals, and routines for the residents. Lacking plans on how to solve practical aspects when they are understaffed caused significant time constraints affecting the current nutritional work, particularly preparing meals and dining in the common area. Limited time, poor practical cooking skills, or less interest in food among some staff members could result in cooking food with the residents that was not considered nutritionally balanced by their colleagues.

According to some of the interviewees, meals in the common area are opportunities for the residents to cook, taste, and learn about healthy meals in collaboration with supporting staff. As individuals with ID often require more time than others on practical tasks, enough time for cooking is ideal. However, sudden events, shortness of staff, or other priorities would often lead to staff resorting to ready meals such as fish fingers, sausages with mashed potatoes, or pizza.

The intention may be that we have time but then there's this and there's that, then someone calls in sick, then you have to run there, and then… There are those things all the time, right? Then you're suddenly alone and you don't have time to make what you planned so you look in the freezer if there's any pizza. Okay fine. That's what it will be.

Supporting staff nr. 6

The community residences that had a greater focus on nutritional care, held regular staff meetings to discuss residents' diets. Residents and relatives were actively involved in separate meetings to establish routines and goals in care plans. Meetings also involved follow-ups, evaluations, and feedback on care plans. Those with a delegated role as a

nutrition contact were responsible for leading nutritional care in the residential homes, sharing dietary knowledge, and skills with staff and residents according to current guidelines.

> *As a nutrition contact, I have set it on the agenda for staff meetings so these things can be raised and remind us that we need to improve. […] We have these meetings to make room for discussions.*
>
> Supporting staff nr. 7

These discussions would potentially involve actions to take to expand residents' food repertoire and limiting high calorie and sugar intake from sweets, pastries, and soft drinks. Supporting staff appreciated these meetings as they were important to increase nutrition awareness among staff and improve knowledge on how to carry out nutritional work in practice with each resident.

5.3.2 Nutritional status and identified needs

When asked how the supporting staff would assess nutritional status for the residents they worked with, many reported that several were overweight and at risk of developing type 2 diabetes. The interviewees suggested that the rapid weight gain was primarily due to diagnosis, i.e., Down syndrome or Prader-Willi syndrome, poor dietary habits, and limited understanding of the relationship between dietary intake and health outcomes.

> *Many here are overweight. More people are becoming diabetic, so it is starting to get a bit serious, but their self-determination is so strong.*
>
> Supporting staff nr. 3

Each resident has a supporting staff with the overall responsibility for developing individual care plans and assessing nutritional status such as obtaining weight measurements and assessing dietary intake for those at nutritional risk. Many residents would also be assessed during annual health checks at their general practice. Supporting staff accompanying residents would use this as an opportunity to address dietary issues and receive advice for nutritional management. Routines for assessing and documenting nutritional status in the residences were otherwise limited. One supporting staff acknowledged the need to systematize weight records and establish a plan with a set timeframe for follow-up in case of significant weight changes:

We very much agree that we register that most of them just gain. So we must become more systematic in that sense. And have a plan of action because there is no use of just registering that they go up up up.

Supporting staff nr. 8

Some of the supporting staff had created individualized diet plans together with the residents and their relatives. They explained how clear and specific diet plans were beneficial to alleviate stress, confusion, and social isolation in residents from conflicting information from supporting staff and relatives.

We write down, 'I can attend birthdays. I can eat two hot dogs. I can eat two pizza slices. I can eat one piece of cake or a dessert at birthdays.' Many of the residents need very specific and concretized instructions. […] For example, for the resident I am responsible for I have hung on the inside of the cupboard door that 'everyone cooking dinner are going to follow that this resident would like one potato or two small ones. Two spoons rice. Three spoons pasta, for example. Wishes to maintain their weight.'

Supporting staff nr. 5

5.3.3 Guidance of persons with ID

Guiding the residents towards a healthy diet and lifestyle was mentioned by all supporting staff as their main role in nutritional care. Guidance involved advising, assisting, and facilitating residents in making healthy choices when creating meal plans, planning weekly menus, shopping, or ordering groceries, and cooking and preparing meals. Supporting staff aim at helping the residents acquire the skills needed to achieve and maintain healthy eating principles.

Some supporting staff said they used the national dietary guidelines as a basis to encourage healthy eating. The keyhole label was particularly mentioned as a helpful visual aid, indicating food products lower in fat, sugar, and salt and a higher content of dietary fibre. The keyhole was commonly used in conversations about food and during grocery shopping.

When we buy groceries, the resident asks me, 'Which one should I pick? This or this?' Then I ask, 'What do you think? Why have you chosen these two?'

Then she says, 'Yes, I know about the keyhole.' 'Yes, what does the keyhole mean?' I say, 'It's healthier.' The keyhole makes it easier for everyone to know what is healthier. That's how they learn.

Supporting staff nr. 9

According to the interviewees, diet and nutrition are for many a sensitive subject, and some persons with ID in the community residences are unwilling and uncomfortable talking about diet or body weight. Supporting staff found this challenging as those who may require most guidance and assistance might be the most reluctant to the guidance offered.

Even though you give knowledge and try to guide them, it's not easy to make them accept the guidance you give them, and it very easily becomes nagging from our side.

Supporting staff nr. 3

When asked how such problems were solved at their workplace, a supporting staff answered:

You always need to discuss with them [residents] a little more. Some [supporting staff] always blame the self-determination every time they [residents] say no to something even though they [supporting staff] haven't explained to them why. I don't like to say, 'Because it's healthy' but I say, 'It's because you bought it and you have used your own money on it, and you decide what to buy every week. Then it's a good idea to use it.'

Supporting staff nr. 10

Being constructive and aware of their role when guiding residents appear to be essential if residents deny guidance or advice from staff. Supporting staff focused on engaging the residents to set their own goals and develop care plans and routines. They encourage and optimize participation of the residents in decision-making to make them responsible for their own choices. If the resident does not want to follow their set care plan, the supporting staff expressed how they would use this as an argument:

If every time you hear 'no' or that they don't follow a diet plan… It is not the staff who makes it. They always join staff and make it with us. So you always try to remind them 'you decided this and you have been involved in making your diet plan. Supporting staff nr. 10

5.3.4 Dietary goals

Dietary goals as part of the residents' individualized care plans varied. In some residences, dietary goals were made in collaboration with the resident and their relatives based on national dietary guidelines, dietary needs, and individual preferences. Supporting staff explained how they aimed to support residents' independence in adopting a healthy balanced diet. Individual goals in their care plans were continuously documented and evaluated to establish whether outcomes had been met or whether further action was required.

> *We evaluate things all the time, like their care plan and if we see that they have learned that, 'okay, now it's breakfast, then I'll make that' then we remove it from the care plan. Our aim is that we remove as much as possible from their care plan that they become independent because they are a quite functionable group. And our goal for all of them is that they can shop groceries by themselves. […] Our goal is that they become more independent and what they learn becomes a habit. For example, knowing how many meals to have per day.*
>
> Supporting staff nr. 10

Some supporting staff were not aware of any specific goals in their workplace; however, everyone was aware of the overarching aim of promoting healthier diets for all residents. Some thought this aim was too broad, emphasizing the need for individualized goal setting for each person with ID as they all had different dietary needs. National dietary guidelines were used by some, but many were certain these were not actively used by their colleagues due to different attitudes towards use of the national dietary guidelines.

> ***Interviewer:*** *Do you set any goals for the resident's diet?*
>
> ***Supporting staff nr. 8:*** *Yes, a bit too general. Everything should be healthier after the nutrition course and less sweet and less soft drinks but… We motivate but they make the decision. But we don't have any like… Now we don't have the posters anymore either from the nutrition course, but we don't have any clear goals. They are based on… What are they called? Dietary… Guidelines. But perhaps we're not good at using them… Together.*

When asked how these guidelines were used, some were not aware how this was done at their workplace. However, most supporting staff were positive towards the dietary guidelines to standardize practice. One supporting staff explained how they actively used dietary guidelines to set dietary goals:

> *We try to have four to five meals per day and that they include fruit and vegetables to almost all meals. For example, I am responsible for some of them, and I set goals and diet plans for the whole week and then we try to for example limit soda and all that… Comfort food and such are for the weekends. And of course, that all that they buy are either low fat or sugar free and that bread and such is brown.*
>
> Supporting staff nr. 10

Moreover, the supporting staff also pointed out a list of the national dietary guidelines available in the kitchen and common area. Visual aids were used to reinforce dietary guidelines such as photographs and symbols available for all residents to see when eating or cooking with staff. Posters were also positioned in appropriate height for wheelchair users. These symbols and tools were used in communication, training, and cooking with residents.

5.4 Competency

5.4.1 Knowledge and training in nutritional care

Self-reported knowledge was considered adequate by most supporting staff as many described themselves as having basic nutritional knowledge that enabled them to carry out simple nutritional care for most of the residents. However, some described their knowledge in food and nutrition beyond the dietary guidelines as limited:

> *Another thing is that we think there should be clear expectations and standards on how we should relate to nutrition, and by that we have talked a lot about maybe there is a need for training staff about the most basic. And we have, not all the time, but sometimes we have someone who needs something specially adapted, you know, and one cannot always assume that everyone working here knows what you need to know.*
>
> Supporting staff nr. 2

As illustrated above, regular training and guidance of supporting staff in how to perform nutritional care in the community residences were suggested. Currently, all community residences have one or two nutrition contacts who are responsible for nutrition in the residences. The representatives from each residence attend meetings on a regular basis and are responsible for follow-up and updating nutritional care at their workplace. However, the interviewees who do not attend these meetings, suggested nutrition courses for all staff members to gather staff towards unified practice. Their idea was that nutrition courses for all staff members could contribute to increased mutual understanding, knowledge, and attitudes among staff.

In some cases, supporting staff felt they were expected to have more knowledge than what was within their scope of practice. A member of staff described the gap between the expectations and responsibility given from the care manager, residents' next of kin, and the municipality on how nutritional tasks are carried out and the knowledge that is expected from them. The supporting staff highlighted their lack of skills and knowledge related to nutritional care.

When asked if they would attend nutrition courses in the future if offered, a member of staff explained that supporting staffs' nutritional knowledge was not the root of the problem. Instead, they specified that clearer guidelines and guidance from the municipality in how to assist and facilitate a healthier diet for the residents is needed.

> *I do not think I would have bothered unless I was given a role where we would put it in some kind of system or see what room for maneuver we have. How we can work in multidisciplinary teams with nutrition for example. […] If I wasn't given a role to research and try out how to achieve this, I would not have bothered to go and learn about nutrition. I know enough about nutrition. I really do, but it needs to be put in a system in a different way. And not only from the management in the municipality but also the dilemmas we face.*
>
> Supporting staff nr. 5

5.4.2 Unified practice

Unified practice and similar staff behavior were reported as essential for supporting staff in delivering nutritional care. A common and coherent approach provide predictability for the residents and make them feel more secure. Different attitudes and approaches could potentially limit the residents benefit of care plans as it becomes difficult to evaluate the effect.

> *It's the importance that everyone does it as similar as possible. So yes, we are different, but how we proceed to carry out the duty is important. And it's as I say, about daring to be a little firm.*
>
> Supporting staff nr. 11

Supporting staff explained how staff emphasized different aspects of life and how this affected unified practice:

> *Some people may emphasize quality of life, while others probably think that one should make an attempt anyway, right? […] Some are a bit more in the middle and are like, 'Okay, we can do it a few days a week' while others are like, 'that is not a breakfast. Can we do bread for breakfast and burger for lunch?' Some just make and make and make and make, you know.*
>
> Supporting staff nr. 2

5.4.3 Defined roles and responsibilities

Several of those interviewed were delegated the role as a nutrition contact in the residences they worked at. The understanding of the responsibilities related to this role varied among the interviewees. Many considered the role as important for nutritional awareness, structure, and coordination of nutritional care at their workplace. Some thought that people with designated roles should have a mandate to improve nutritional routines and follow this up in the community residences.

> *The social educators are responsible for the dinners in the common area, but I think it requires that someone is given a role and a mandate for example so there can be much more structure on the guidance here in the common kitchen.*

Supporting staff nr. 5

Nutritional contacts were not always aware of the tasks related to their role. The interviewees explained how many different roles were delegated to distribute responsibility for different things, but few were truly followed up. Consequently, several roles delegated at their workplace would not have any purpose. In other residences, some would take responsibility for all tasks involving food and nutrition regarding the residents and training of staff.

5.4.4 User involvement

Engaging the residents in the care they receive through involvement when establishing their own care plan, goals, and routines are important in person-centered planning. Several supporting staff expressed that user involvement facilitated their role in nutritional care. Examples of common scenarios where user involvement was applied involved choosing menus for meals in the common area. Supporting staff are aware that most residents are not able to make decisions solely on their own. They still want residents to experience that they have self-determination and make their own decisions and find ways in the middle by limiting the number of choices the residents can make.

When residents have their choice fulfilled, they become satisfied and willing to cooperate because they have been involved in decision-making. In the community residences where they focus on engaging the residents in decision-making, the residents are satisfied with the dinner they are served during weekdays. Residents may come up with their own suggestions for dinner, and staff usually suggest or make appropriate changes to improve the diet quality, for example choosing foods with whole grain instead of refined grains.

> *It's a bit like balancing between user involvement and the use of force. If someone says, 'I am going to have four potatoes' then they will get four potatoes, because we can't deny them that, just so that's said. But here we try to include them, and we try to get them to talk about what we can eat. So, if someone would like chicken and rice for example, then we will make a choice on the type of rice we buy, right?*

Supporting staff nr. 2

Some even described how user involvement in nutritional care was not a common practice regarding the residents' common meals at their workplace. Whether user involvement was applied depended on the person carrying out the task.

> *They have little say in what is actually made. We sometimes try to ask and we keep a list and try to distribute it and then it goes a bit into oblivion [laughs] no, but it's probably because it's very much up to the person working. Very much up to each and every one and what we do.*
>
> Supporting staff nr. 6

5.5 System and structure

5.5.1 Guidelines and recommendations

Guidelines and recommendations regarding nutritional care were warranted by several of the interviewees. Many emphasized the need for guidelines on nutritional management for adults with ID, specifying which nutritional tasks should be carried out and how these should be performed. Most importantly, clearer guidelines when nutritional status deteriorates to guide supporting staff in nutritional management of their residents. Supporting staff explained how nutritional care becomes coincidental and mainly up to the person working. Clarity on the current guidelines that apply would facilitate their work, create predictability for both staff and residents, and reduce disparities between staff.

> *We are just here thinking, 'What shall we do? How are we going to start this? What should be the basis?' So, we have tried to figure out if there's any information out there. Does the municipality have guidelines for this? Should we try to figure it out ourselves instead of just receiving a guideline?*
>
> Supporting staff nr. 6

5.5.2 Routines

Clear and structured routines for the residents were appreciated by the interviewees. Persons with ID often have many established routines as it creates an organized and predictable environment and provides stability. Having routines is commonly a way of structuring their

daily life, making it easier for them to keep an overview of their day-to-day and incorporate positive daily habits.

> *They have an intellectual disability, and they are very used to routines and even though most of us like to have a lot of variation in our lives, one day we shop this and another day we shop something else. It is not that easy when you're with people with intellectual disabilities. If you open up one week, then they learn that, 'Okay, I was allowed to buy that' so then it may be that the following week that becomes sort of a habit, so we try to avoid it.*
>
> Supporting staff nr. 10

Dietary routines established in the community residences contributed to facilitate supporting staffs' role in nutritional care. Some supporting staff explained that they had well established routines with nutritious meals according to national dietary guidelines in the common area in the weekdays and free meal choices in the weekends unless they had an individual diet plan. According to staff working in these community residences, residents were happy to follow their diet plans because they were involved in decision-making. Meals in the common area were also a social and enjoyable happening for the residents and a positive influence on their dietary intake as opposed to eating alone.

A couple of supporting staff talked about the importance of staff following routines in the residents' care plans. New or unexperienced staff who are inadequately informed of established routines for every resident could make it complicated for the residents. It seemed like some supporting staff found it particularly difficult to set boundaries and facilitate healthy behavior in the residences they worked at, and many had similar experiences as illustrated by a staff member:

> *I read in a research paper when they move for themselves, many gain several kilos. They have pizza several times a week instead of maybe on a Friday or Saturday evening occasionally, and then suddenly, 'Yes! I have moved for myself so now I can have hot dogs three times a week and pizza on the remaining days.'*
>
> Supporting staff nr. 3

5.5.3 Continuity

According to staff, continuity was important for effective nutritional care as it creates conditions that enables coordination among colleagues. Being consistent over time and adhering to the same care plan, routines, and guidelines were of vital importance for several staff members as it forms the basis of delivering similar practice. A member of staff explained the importance of continuity in nutritional practice and guidance and potential consequences of staff breaking a pattern:

> *It is very important because it's all unified practice here. If a supporting staff don't bother and the resident refuse for example, and you don't spend some time to talk to them and guide them, then you can create a big problem because we build on it and if there are one or two people who do not follow the routines or goals, it can lead to… The users thinking that 'okay, it's not that important to follow a diet plan.'*
>
> Supporting staff nr. 10

Supporting staff felt that continuity of care was difficult to maintain with residents who required minimal assistance. As they became more independent, they also required limited support and time with supporting staff. Supporting staff tend to feel like they deliver more sporadic nutritional care as it could go longer periods of time between their visits.

> *We are there for maybe an hour and then we go, right? And then they eat alone for the next three days, you know? So it's like… Continuity in the work is one of the challenges we have felt a little when we have been working with this.*
>
> Supporting staff nr. 2

The continuity of care could also be challenged when unexperienced staff found it difficult to set boundaries for residents' dietary intake. Lack of communication between the permanent and part time staff was mentioned as a contributing factor to this.

6 Discussion

6.1 Discussion of methodology

6.1.1 Data collection

Preconception

Researchers of qualitative research needs to consider how they might have implicated the findings with their own pre-understanding, prior knowledge, and relationship with the interviewees (67). In this case, the master student's preconception derived from an educational background in clinical nutrition, experience with delivering practical nutritional courses for adults with ID, and work experience with older adults in the municipal health and care service. However, the master student had no former relationship or acquaintances with the participants in this study, and they did not meet before or after the interviews were conducted.

The master student's prior knowledge, work experience, and familiarity with the municipal health and care service may have been an advantage, in that it may have enhanced her understanding of the topic studied and the interviewees' experiences. It may also have been a disadvantage by failing to explore certain topics taken for granted. Additionally, the master student had no experience with conducting qualitative interviews, which may have limited her ability to follow thoroughly up on all relevant topics. To address this issue, the master student strived to bracket any preconceptions and focus on participants' perspectives and views (66). Thus, the master student adopted a consciously naïve attitude during the interviews, analyses, and interpretation of the data.

Study sample

The interviewees in this study had recently participated in nutrition courses as part of the intervention of the RCT, where they received additional training in nutritional care prior to the interviews. They likely have more knowledge and experience with working with nutrition-related issues, providing them with a solid knowledge base for the interviews. Hence, they may have been particularly well qualified for the interviews with more insight and understanding than other supporting staff who were not offered both nutrition courses and follow-up by professionals on this topic. It would have been interesting to include supporting staff from a different municipality, area, or community residences without the similar experience to compare the findings. Care managers, residents, or residents next of kin

likely have different perspectives than supporting staff on the topic studied, which would have been interesting to explore as well. Although the short time frame did not allow for this in the current study, it is possible for future research projects.

The sample size for qualitative interview studies should ideally be continuously assessed throughout the process of data collection to ensure data saturation; the concept where no further empirical data add valuable information compared with previous data (66). However, the purposive sampling from the RCT limited the ability to evaluate saturation beyond the recruited sample. While 15 ± 10 interviewees (66) are common in qualitative research, a purposive sample of six to ten participants with diverse experience is often sufficient to achieve information power, as the aim is to study selected patterns relevant to the research questions and not the entire concept (68).

The intention was to recruit supporting staff from one more community residence, which could have enriched the material with new aspects and experiences from their workplace. It was also desirable to recruit more men, as gender variation may provide different perspectives and opinions on nutritional care. Nonetheless, the final sample represented a diverse group of supporting staff in terms of educational background and years of work experience, reflecting staff in municipal health and care services where women predominate (69). The final sample was considered adequate and satisfactory based on the large variety in the data, providing an abundant basis for analyses.

Semi-structured interview guide

Data collection through semi-structured qualitative interviews was considered a suitable method to explore personal motivation. The interview guide allows for flexibility while providing a schematic presentation of questions on nutritional care, arranged according to factors from the motivation and performance model (Figure 2). This was beneficial to guide questioning and analysis, permitting a comprehensive understanding of how the internal factors affect motivation and performance of supporting staff delivering nutritional care (70). As the master student gained more experience with conducting interviews, the interview guide was followed less rigidly, creating a natural flow and dialogue in the interviews.

Individual qualitative interviews

Individual interviews were chosen instead of focus groups to explore perspectives of the supporting staff where they could express themselves freely. Although focus group interviews can be less resource-consuming with fewer interviews, the group dynamic and

others viewpoints can prevent some participants from revealing their personal thoughts related to the topic (66). An observational approach to a greater extent could study how nutritional care is carried out in practice, and be useful for a more thorough investigation of supporting staffs' experiences (66). On the other hand, the current study particularly sought to explore subjective meanings, and an observational method in addition to interviews would likely shift focus from the current research questions. Instead, detailed field notes were taken after each interview to support data material, reflecting the impression of the interviews, setting, and non-verbal communication.

One may question whether the interviewees expressed their true perspectives during the interviews. As supporting staff were asked about their experiences on nutritional care at their workplace, some may have felt uncomfortable or reluctant about revealing possible weaknesses in their professional conduct. Others may have appreciated the opportunity to share their thoughts about certain situations at their workplace. To encourage the interviewees to elaborate on their true thoughts and opinions, they were assured that their statements would remain confidential and anonymous throughout. They were also informed that their experiences and thoughts were relevant to improve health and social care services for adults with ID.

6.1.2 Data analysis

Transcription

The initial part of analysis starts with transcribing (66), beneficial to become familiar with the material, particularly details and aspects of the material that were not detected during the interviews (64, 66). The software f4transkript used for transcription was helpful during this phase to control the playback speed and produce a document. Researcher triangulation was applied in the transcription phase where the master student and the PhD candidate transcribed the same interview to compare and discuss the form of transcription (63).

Identifying, sorting, and coding data

The matrix created in Microsoft Word provided a systematic overview of themes, code groups, and subgroups. Meaning units, relevant sections of statements, were extracted from the transcribed interviews using copy and paste to the corresponding code groups and subgroups. Text searches in Word were used for quick orientation in the raw data,

particularly useful during the process of recontextualization. This is an important step of STC; validating the findings against original material to ensure it has not been extrapolated from its context (63). Comments for tagging text-based data allowed for notes to be made, valuable during the process of developing codes, relabeling codes, and subgroups (67). Throughout the analysis, the master student and the supervisors had thorough discussions on the themes, code groups, and subgroups. The easy access and familiarity with Word for qualitative research analysis also became an advantage when sharing progress and involving the supervisors in the data analysis, an important aspect of researcher triangulation to strengthen the study (67, 71).

6.1.3 Trustworthiness

In literature, qualitative research is evaluated using different terminology and strategies. Lincoln and Guba (71) propose evaluating credibility, transferability, dependability, and confirmability. These are rather comparable to internal validity, external validity, reliability, and objectivity in quantitative research (72). Several qualitative researchers have also applied similar concepts (64, 66, 73), and Malterud (74) suggests validity, relevance, and reflexivity as key standards to appraise qualitative research. While some strengths and weaknesses of the data collection and analysis have already been accounted for, the qualitative criteria for establishing trustworthiness, most widely used in qualitative research, will otherwise be discussed here.

Credibility

Similar to internal validity in quantitative research is credibility, referring to the accuracy of the findings according to interviewees' perspectives (71). A threat to credibility of qualitative research is the potential misunderstanding or misinterpretation of interviewees' statements. This was avoided during the interviews by asking probing questions if the response was unclear or too vague (71). To ensure a mutual understanding of the themes discussed, statements were paraphrased to mirror what they sounded like to the interviewer to clarify and confirm their statements (66).

Furthermore, all participants were aware that the interviewer was a master student in clinical nutrition. It is likely that this influenced some of their answers, by providing information they thought the interviewer wanted to hear (66). This was evident when interviewees sought

confirmation on the dietary information they provided. To encourage interviewees' own experiences and perspectives, as opposed to general statements, they were asked to support their statements with examples (64). In a few cases, the statements by the interviewees did not correspond with observations made by the interviewer. For instance, there was a piece of old fruit in the common area instead of the fresh fruit that was stated to be available for the residents. As the researcher's presence during data collection may be a limitation in qualitative research (75), data triangulation was applied by interviewing more than one staff member per community residence.

Credibility could have been strengthened further by requesting feedback, comments, or additional thoughts from the interviewees on the transcriptions, analysis, or interpretations (71, 76). This concept of member checking intends to ensure that the accurate representation of perspectives and views are represented and not altered by the researcher (76). However, Malterud (64) argues that interpretation is a central part of research, which is mostly the researchers' responsibility. Member checking may even provide a false assumption that both parts share the same critical ability (77), and it enables participants to reconstruct their narrative or experience (78). A member check was therefore not carried out in this study.

Transferability

Transferability refers to whether the findings of the study can be transferred and applied to other settings of the population it represents (64, 66). The findings cannot be generalized given the recruitment from one municipality in Norway and the non-random sampling. However, the findings may give an indication of the current situation to other settings or institutions within the municipal health and care service. Several of the findings are supported by previous theoretical and empirical research (42, 60, 79, 80), implying that the results are transferable to other supporting staff under the same circumstances.

Dependability

The aspect of consistency and continuity of the approach and interpretation over time refers to dependability (71). The researcher must be aware of the changes that occur in the research process, and how these affect the research findings. To ensure dependability in this study, the master student conducted all the interviews, transcribing, and analyses. The interviews were likely inconsistent, as the technique developed throughout the interviewing process, apparent when comparing the first few interviews with later ones.

Confirmability

Whether the findings of the study could be confirmed by other researchers is known as confirmability (71). It is important that the interpretation of qualitative research is based on the data, instead of personal preferences or perspectives. An audit trail was made for the complete research process, from research team meetings, and reflective thoughts. Although the audit trail was not shared, the supervisors followed the entire process, discussed decisions, and findings of analyses throughout. A possible weakness of this study is that data analyses was mainly performed by the master student alone. However, an additional researcher with experience in qualitative research reviewed the process of data analysis.

6.2 Discussion of findings

The present qualitative study provides perceptions from supporting staff on internal factors affecting motivation and performance of nutritional care for persons with mild to moderate ID receiving municipal health and care services. Several themes emerged through analyses describing how personal attributes, competency, structure, and clear leadership are important factors for supporting staff to provide nutritional care for residents in municipal health and care services. How these internal factors affect motivation and performance of supporting staff delivering nutritional care, will be discussed in light of theory and existing literature.

6.2.1 Needs

Personal drive

According to Mitchell and Larson's theory model of motivation (Figure 2), the starting point of a motivational process is most frequently caused by an individual's need deficiencies (60). One may therefore attempt to reduce the discrepancy between what they are getting and what they want. A positive attitude and approach to healthy eating and behaviors were perceived by several to be fundamental to communicate and guide the residents. Sustaining a positive approach towards healthy choices made the tasks and duties a positive and enjoyable experience for both the residents and the supporting staff carrying out the activity. This was consistent with the findings of a recent study looking at supporting staffs' perceptions on

factors facilitating health promoting care indicating that attitudes of staff were important cornerstones of good role models for people with ID (40).

It is well known that supporting staff have a unique opportunity to influence individuals with ID, as they serve as highly credible role models for individuals with ID (81). The supporting staff in this study expressed that they were aware of this and used this actively to promote healthy eating and behavior. This is supported by previous studies suggesting that access to role models and acting as role models seemed to be important for successful behavior change in adults with mild to moderate ID (82).

Nevertheless, all supporting staff stated that they had different attitudes to nutrition due to personal preferences and professional attributes. However, it is important that staff have a mutual understanding of which attitudes apply at their workplace to better facilitate nutritional care for persons with ID. According to current guidelines, care managers are responsible for ensuring that supporting staff have attitudes and knowledge that promote residents' health competency (37). As health and quality of life can be perceived differently, supporting staff may act based upon their own beliefs (80, 83). The findings of this study suggest that more clarity from the municipality via their care managers on professional attitudes at their workplace is desired to reinforce targeted nutritional care, positive work culture, and routines.

Good interaction and cooperation between staff and residents were important factors that could facilitate nutritional care and motivate the residents through empowerment and making them responsible for their own choices. Additionally, establishing relationship grounded in trust is central to facilitate a health promoting diet without being directly involved in day-to-day food preparation, shopping, or during mealtimes, which was a raised concern among several interviewees. Working and facilitating towards trust by ensuring a good relationship between supporting staff and residents is therefore important to increase cooperation in nutritional care (84).

Individuals with ID have a higher disease burden (8, 9, 19), and many of the supporting staff interviewed mentioned the importance of healthy dietary habits due to their increased risk of developing obesity and associated diseases. Staff in this study seemed to understand there is a need for improving health outcomes for some of their residents. However, many expressed frustration and disengagement in nutritional practices as they infrequently experience any progress of the work they invested.

This was different from what Elinder et al. (85) found in their study where care coordinators of municipal community residences were interviewed about facilitators and barriers to implementing health promotion of diet and physical activity. Motivation to engage in the work increased where the need and demand for health promoting care was greater, but reduced where the staff did not perceive the same need.

Barriers to health promoting care

Internal factors causing poor task performance is a lack of motivation from within themselves arising if one does not believe that their effort improves performance of a task (86). This might be a possible explanation to why supporting staff from this study find it challenging to balance their role as healthcare workers while maintaining the residents' right to self-determination and autonomy. Self-determination of individuals with ID and their health are frequently set against each other, but these contradictions are unfortunate if this means that one has a health promoting diet or their self-determination was maintained. Similarly, Bergström and Wihlman (39) reported that several supporting staff in their study experienced challenges with performing health-promoting work without taking control of the person they assisted. Moreover, they argue that the concept of self-determination is used as an excuse to not intervene if residents make choices that negatively affect their own health.

Both perspectives are fundamental human rights, and it is therefore of vital importance to seek solutions to ensure that both are preserved (87). Persons with ID should be involved in their care, be motivated to make good choices for their health in a way that also supports the basic principle in health promoting work. Supporting staff have a duty of care to ensure individuals with ID health needs are met and should facilitate informed choices (53). This requires adequate competency among staff regarding nutritional conditions related to the various diagnostic groups associated with ID, including knowledge of each resident and their individual challenges (88).

A resident's level of assistance needed has also been associated with their self-determination (89). Supporting staff in this study found it easier to facilitate a healthy diet when they were frequently able to participate in meal preparation and grocery shopping with the residents. Correspondingly, Adolfsson et al. (79) found in their study that the participation of supporting staff influenced residents' food choices positively. Although supporting staff have good intentions by preventing the resident from making poor choices for their health through seeking control, people with ID should be empowered and develop the skills necessary to

make decisions, problem-solve, and determine their own choices independently (84). These findings suggest that supporting staff lack knowledge of how to assess and facilitate a health-promoting diet without being present or directly involved in food preparation or shopping.

The feeling of not having control over residents' dietary intake might also be a consequence of them not being able to see the result of the nutritional care they deliver due to unclear goal setting. Hackman and Oldham's (90) job characteristics model of job enrichment, illustrate that some people become motivated by the knowledge of their results as they experience responsibility for the outcomes of their work. By providing constructive and specific feedback, staff can develop an understanding of how well they have performed, which likely improve effectiveness.

Limited health literacy has frequently been recognized as a barrier to health promotion for this group of people (80, 91). People with ID often have impulsive behavior, reduced short-term memory, and reduced ability to reflect on health implications, which may give rise to health challenges (14). Several supporting staff in this study emphasized residents' need of clear and concise guidance for information to be comprehensible. Moreover, their role often involves reinforcing the agreed individualized goals, planned menus, and purchased groceries. This was also proposed as a successful motivational strategy by Spanos et al. (80), highlighting the importance of relevant individualized goals related to daily priorities, rather than overwhelming residents with information on health benefits of a healthy diet and lifestyle.

Based on what has been expressed from supporting staffs' perspectives, many are able to identify and recognize the need for nutritional care. However, their main challenge is how to emphasize and prioritize nutritional needs against different legislations and other health needs and wishes. Some are unsure of how to address nutritional needs at their workplace, which seems to provide different prioritization among supporting staff. Others lack motivation, and consequently, may not perform the nutritional care as required.

6.2.2 Goals

Nutritional care

Research evidence has demonstrated that goal setting is an essential source of work motivation (60). Particularly explicit goals that are specific and well-defined have greater

impact on motivation (92). With clear goal setting, supporting staff are given expectations, will know what to achieve, and have the chance and opportunity to perform. It is important that they have an opportunity to see their own role and work tasks for them to attain the set goals with reasonable effort. This seems to be a major contributing factor to why some supporting staff in the present study does not appear motivated to deliver nutritional care. The findings in this study imply lacking goal setting and direction regarding nutritional care for persons with ID.

Latham and Locke (93) argue that the first principle of successful goal setting is commitment, and performance is strongest when people are determined to reach it. Some supporting staff worked systematically according to defined dietary goals incorporated in residents' care plans. Outcomes were documented and routinely addressed in meetings to effectively overcome barriers as they arise. Conversely, when someone is less committed to the set goals, they increase the likelihood of giving up because they may not believe that their efforts will improve performance (93). This may explain why some of the supporting staff in this study seem to lack determination and engagement in the nutritional care, as they tend to believe that they will fail to adequately deal with the tasks. Such attitudes and beliefs are unfortunate within a workplace as they may create low self-efficacy among staff and a working environment not striving for improvement (94).

Self-efficacy has important effects on staffs' ability to cope with challenges and performance at their workplace (94). Besides, an individual lacking confidence generated by self-efficacy will likely face difficulties leading and motivating others, problematic for supporting staff where training, guidance, and motivational work are essential parts of nutritional practice for people with ID (37). According to Bandura (95), the most effective way to strengthen self-efficacy is by mastery experiences through achieving set goals where one learns from failure and from documented success, instead of being discouraged by negative outcomes.

Several goal setting theories emphasize that people should be given specific and challenging goals to strive towards to improve performance (60, 96). In contrast, non-specific and simple goals are often too vague, even those where one aims to try their best. This is consistent with the findings in this study where supporting staff mentioned that all they could do was "continue to try to guide the residents as good as they can." Yet most supporting staff in this study experience nutritional care as a major challenge as they do not know how to deal with barriers they encounter.

The findings in this study calls for nutritional care to be systematized. If nutritional needs are recognized, targeted dietary measures, corresponding with the residents' needs and wishes, must be initiated (14). Supporting staff believe that targeted dietary measures for the residents and goal setting among staff in the workplace, can help them to progress from the ethical dilemma they face when guiding residents toward healthy eating and behavior. Additionally, clear and well-defined dietary goals incorporated in a personalized care plan can also prevent dissimilar practice. For goals to be effective, supporting staff must be provided with feedback from their care manager on their progress and performance, and their set goals must be reviewed and evaluated regularly (96). This involves addressing and reflecting on challenges and obstacles in the community residences to find solutions and coping strategies. Providing constructive feedback is also beneficial to clarify expectancies so staff become informed of what is appropriate and what is not (60).

Motivation seemed to be higher in supporting staff who developed personalized goals for the residents, collaborated with their relatives, and had a more comprehensive understanding of what is required to achieve it. Individual goal setting enables supporting staff to focus on the nutrition-related health outcomes that are most important to the individual resident, which is a central part of systematic nutritional care (97). To evaluate the set nutritional goals within the care plan, regular documentation of residents' nutritional status in their healthcare records is a key issue (55).

Inadequate focus on documentation of nutritional care implies that there is little attention drawn to the importance of documentation in most community residences in this study. This is in accordance with the failings reported by the health inspectorate's national inspection of residential properties for people with ID (42). It is also supported by a Danish cross-sectional study by Håkonsen et al. (98) reporting that many participating healthcare professionals did not know where nutritional problems are documented or how to develop nutritional care plans in healthcare records. This is concerning, as documentation provides an account of the nutritional care delivered to the resident, provides continuity of care, and ensures good nutritional practice (53).

Appropriate documentation can contribute to sound and systematic nutritional care through documentation of actions taken, established routines, the guidance provided, and agreements between supporting staff, the resident, and, when relevant, their next of kin (99). It ensures that targeted measures are followed up and adjusted, when necessary, which in practice

should occur through discussions and staff meetings. Lack of appropriate documentation of nutritional care can lead to actions not being taken and result in residents' nutritional needs not being met. Documentation within healthcare has been discussed for several years, and the main causes of poor documentation has been described due to lack of structure and routines (100), which will be discussed in greater depth in 6.2.3 Competency.

6.2.3 Competency

Competency

Motivation and performance of nutritional care also require adequate competency among supporting staff as motivation of behavior is directly affected by skills and knowledge (60). One is likely to become demotivated if the knowledge, skills, or abilities necessary for the task exceeds their actual competency. Nevertheless, Hackman and Oldman (90) describe the importance of growth and development where staff are challenged by learning new skills in a job that is meaningful to them. However, the theory is mostly relevant for those who appreciate responsibility, development, and autonomy within their job (60).

Lack of competency may explain why some of the supporting staff in this study have different approaches to nutritional care. More importantly, competency also involves the supporting staff's relevant professional and educational background. In the present study, almost all interviewees were highly educated and formally trained and are per definition skilled health and social care workers (Table 1) (101). Of these, the most relevant educational background include social educators who are both skilled in behavioral analytics and trained to assess nutritional status (46). The remaining professions of participants, e.g., social workers, are also relevant and skilled health and social care workers, yet they lack relevant nutritional training.

This reflects the expressed concerns brought up by some of the interviewees in this study, that do not have the specialized knowledge or competency regarding nutrition and health needs of the residents. These statements corresponded with the findings in previous studies, where competence among staff were identified as barriers to achieving a healthy diet among residents in community residences (32, 41). Supporting staffs' nutritional knowledge is vital to promote good dietary habits for the residents. Without sufficient nutritional education of staff, research illustrate how this negatively influence the establishment of common attitudes and unified practice of supporting staff in nutritional care (32, 81, 102).

Addressing nutritional challenges in residents with complex needs requires coordinated interdisciplinary collaboration (103, 104). The diverse disciplines among supporting staff can therefore be a strength when discussing nutritional care, targeted dietary measures, and follow-up of an individual (105). For this to be successful, systems must be established through routines on how to collaborate on targeted nutritional care with clearly defined roles and shared responsibilities of the different nutritional tasks with appropriate follow-up (104).

Supporting staff working in municipal health and social care services are already expected to have the appropriate competency of persons with ID in general (11, 33). As many supporting staff in this study feel at loss for what to do when residents are not willing to follow their advice or guidance, training staff could increase their confidence, skills, and abilities in delivering safe and effective nutritional care tailored for each resident. Supporting staff themselves suggest regular training for all staff in nutritional care to establish a common knowledge base, understanding, and professional attitudes to deliver unified practice. In this way, it is easier to practice consistent nutritional care and maintain good nutritional routines in the residential homes. Nevertheless, the findings call for clearer structure on who supporting staff can contact when necessary to develop clear goals, targeted measures, and procedures. Thus, there is currently a need for more dietitians in the municipal health and care services to assist with professional nutritional guidance in the management of increasingly complex nutritional challenges.

System and structure

According to several interviewees in this study, there is a need for enhanced clarity on which guidelines and recommendations that apply in the community residences to better support staff in providing nutritional care for persons with ID. In this also lie clarity on which nutritional tasks are to be carried out. Based on current guidelines on nutritional care for people with ID, there should be established staff requirements and expectations in relation to the nutritional care. As described by Mitchell and Larson (60), organizations must clearly describe what is expected from staff to increase desired behavior. This requires a thorough job description of the relevant expectations. In most community residences in the current study, supporting staff reported that there are lacking clear expectations related to nutritional care for the residents. Besides, they are rarely followed up in what they do related to nutritional care. When nutritional care is not prioritized, set aside time for, or focused on

through established routines, supporting staff are unsure whether it is part of their responsibility.

For many individuals with ID, a structured environment with clear routines and structure are beneficial as it provides predictability and make it easier for them to carry out daily tasks independently (53). This especially applies for routines related to diet and nutrition in health promotion care achieved through routines for prevention of malnutrition. As illustrated in the results, the implementation of well-established routines played an important role in job satisfaction and motivation of supporting staff where this was applicable. Based on statements by the relevant supporting staff, residents had learned to accept the boundaries and felt comfortable with dietary routines.

As exemplified by some interviewees in this study, nutritional care was more organized and systematized by the established written procedures and routines that were concretized and clarified for effective communication to supporting staff and residents. Diet plans, menus, and dietary goals as part of the residents' individualized care plan provided predictability and comfort for the residents. These routines allegedly enabled healthy habits for the residents that were based on current national dietary guidelines. Well-defined roles and tasks, regular meetings, and follow up also improved the interdisciplinary collaboration, a prerequisite for functionable system and structure of nutritional care.

In contrast, some interviewees explained that the provision of nutritional care appears to be random and arbitrary, indicating lack of routines and structure of nutritional care. Unfortunately, this was compatible with the findings by the Norwegian health inspectorate demonstrating that the provision of municipal health and care services for people with ID seemed random, which may originate in missing or deficient routines or because routines are not known or incorporated (42). However, establishing system, structure, and routines is likely easier in newly established community residences as opposed to changing structure and routines for older residents who are more embedded in their habits (106).

7 Conclusion

Supporting staff working in municipal health and care services for adults with ID comprise a diverse group of health and social care workers, and this study aimed to document their perspectives towards nutritional care. Their motivation and performance are determined by a complex set of factors that vary in their relative contribution across nutritional care. The internal factors needs, goals, and competency all seem to affect motivation and work performance of nutritional care. Although attitudes, beliefs, and knowledge have important impact on provision of nutritional care, there is also a need for clear goal setting, structure, and established routines in place for effective health promoting care and a sense of achievement. The findings also indicate that action must be taken to support and guide staff in prioritizing and performing nutritional care for adults with ID in compliance with legislations and individual needs. Considering the findings of this study, future research should focus on implementation systems and strategies in the municipal health and care service for effective provision of nutritional care for persons with ID.

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Appendices

Appendix 1 Informed consent form

Vedlegg 3. 9.3.2021

UiO : Universitetet i Oslo

BÆRUM KOMMUNE

VIL DU DELTA I STUDIEN:
ANSATTE I KOMMUNALE HELSE- OG OMSORSGTJENESTERS MOTIVASJON OG UTFØRING AV ERNÆRINGSARBEID FOR PERSONER MED UTVIKLINGSHEMMING

FORMÅLET MED PROSJEKTET OG HVORFOR DU BLIR SPURT

Dette er en forespørsel til deg som er tjenesteyter i samlokaliserte boliger i Bærum kommune og som har vært med på intervensjonsdelen av forskningsstudiet: «Kosthold for bedre helse for mennesker med utviklingshemming i omsorgsboliger».

Vi ønsker å få mer innsikt i din motivasjon og faktorer som påvirker din utføring av ernæringsarbeid i omsorgsboligen hvor du arbeider. Vi ønsker også å få vite hvordan du har opplevd å være med på intervensjonsstudien. Du får denne forespørselen på vegne av prosjektleder og medarbeidere ved Universitetet i Oslo.

HVA INNEBÆRER PROSJEKTET FOR DEG?

Deltakelse i studien innebærer at du skal svare på spørsmål om din motivasjon, dine ernæringsfaglige arbeidsoppgaver og faktorer som påvirker disse i omsorgsboligen hvor du arbeider. Du vil også bli spurt om hvordan du har opplevd å følge opp en deltaker som har være med på intervensjonsstudien

Du skal i tillegg fylle ut et skjema med spørsmål om alder, kjønn, nasjonalitet, utdanning, stilling og antall år du har arbeidet i samlokaliserte boliger. Intervjuet vil ta cirka 1 ½ time.

Intervjuene vil avholdes i arbeidstiden i boligen du arbeider, eventuelt foregå via Teams om det ikke lar seg gjennomføre som et fysisk møte. Dato og tidspunkt vil avklares nærmere med deg og din leder, men vil skje i tidsperioden fra juni til desember 2021.

MULIGE FORDELER OG ULEMPER

Du vil gjennom intervjuet fortelle om hvordan du opplever ernæringsarbeidet der du jobber og får mulighet for å sette ord på hva som er bra og hva som eventuelt kan forbedres. Det kan oppleves fint, men kan også være ubehagelig å snakke om i en samtale med andre.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE DITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Det vil ikke ha noen negative konsekvenser for deg eller ditt arbeid hvis du ikke vil delta, eller senere velger å trekke deg. Dersom du trekker tilbake samtykket, vil det ikke forskes videre på informasjonen du ga. Adgangen til å kreve sletting eller utlevering gjelder ikke dersom materialet eller opplysningene er anonymisert. Denne adgangen kan også begrenses dersom opplysningene inngår i utførte analyser.

Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte prosjektleder eller prosjektmedarbeiderne (se kontaktinformasjon på siste side).

HVA SKJER MED OPPLYSNINGENE OM DEG?

Opplysningene som registreres om deg skal kun brukes slik som beskrevet under formålet med prosjektet, og planlegges brukt til 31.12.2022. Eventuelle utvidelser i bruk og oppbevaringstid kan kun skje etter godkjenning fra Regional Etisk Komite (REK) og andre relevante myndigheter. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Du har også rett til å få innsyn i sikkerhetstiltakene ved behandling av opplysningene. Du kan klage på behandlingen av dine opplysninger til Datatilsynet og institusjonen sitt personvernombud.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger (=kodede opplysninger). En kodenøkkel knytter deg til dine opplysninger gjennom en navneliste. Det er kun prosjektleder professor Svein Olav Kolset, og prosjektmedarbeiderne Marianne Nordstrøm, Helen K. Røstad-Tollefsen og Benedicte Hagen Venås, som har tilgang til denne kodelisten. Koblingsnøkkel oppbevares i 5 år og vil deretter destrueres.

Av kontrollhensyn vil anonyme opplysningene om deg bli oppbevart til 31.12.2033.

GODKJENNINGER

Regionale komité for medisinsk og helsefaglig forskningsetikk (REK) har gjort en forskningsetisk vurdering av prosjektet, saksnr 2019/362 B.

Universitetet i Oslo, Institutt for medisinske basalfag og prosjektleder Svein Olav Kolset er ansvarlig for personvernet i prosjektet.

Vi behandler opplysningene basert på ditt samtykke.

KONTAKTOPPLYSNINGER

Dersom du har spørsmål til prosjektet eller ønsker å trekke deg fra deltakelse, kan du kontakte:

- Prosjektleder professor Svein Olav Kolset, e-post: s.o.kolset@medisin.uio.no eller på telefon: 22851383.
- Prosjektmedarbeider Ph.D. klinisk ernæringsfysiolog Marianne Nordstrøm, e-post: marianne.nordstrom@frambu.no eller telefon 64856000.
- Prosjektmedarbeider Helen K. Røstad-Tollefsen, e-post: helen.tollefsen@baerum.kommune.no eller telefon 99011566.

Dersom du har spørsmål om personvernet i prosjektet, kan du kontakte personvernombudet ved institusjonen, Roger Margraf-Bye, e-post: personvernombudet@uio.no, eller datatilsynet på deres veiledningstelefon: 22396900.

JEG SAMTYKKER TIL Å DELTA I PROSJEKTET OG TIL AT MINE PERSONOPPLYSNINGER BRUKES SLIK DET ER BESKREVET

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

Appendix 2 Interview guide

INTERVJUGUIDE TIL DELTSTUDIEN:

«Ansatte i kommunale helse- og omsorgstjenesters motivasjon og utføring av ernæringsarbeid for personer med utviklingshemming».

Før båndopptaker blir slått på, stiller jeg spørsmål om sosio-demografisk informasjon, ut ifra vedlegg 2.

Tema og rammebetingelser	**Hovedspørsmål**	**Tilleggsspørsmål**
Introduksjon (ca. 5 min) Takke deltager for at vedkommende vil delta. Presentasjon av meg selv. Forklare hva intervjuet går ut på og hva det skal brukes til: I intervjuet vil vi snakke om dine tanker rundt mat, ernæring og hvordan ernæringsarbeidet utføres i boligen du jobber. Du vil også bli spurt om hvordan du har opplevd å være med i intervensjonsdelen av forskningsstudien «Kosthold for bedre helse».		Praktiske opplysninger: Tid – 60-90 min. All informasjon vil avidentifiseres og deltagerne vil ikke kunne gjenkjennes. Taushetsplikt – med mindre det går utover liv og helse. Deltagernes rett til å trekke seg når som helst.
INDRE FAKTORER **BEHOV**	Kan du fortelle meg om dine tanker rundt mat og ernæring til den enkelte beboer i boligen? Hvordan mener du at kostholdet til beboerne du jobber med **er**? Hvordan synes du det **burde** være? Hva gjør du av **oppgaver** i jobben din for at beboerne i boligen skal ha et sunt kosthold?	

	Hvem har laget disse oppgavene? Hvis det er på egent initiativ- Opplever du dette som **konfliktfylt**? Forklar.	
MÅL	Kan du fortelle meg hvordan dere jobber **administrativt** med ernæringsarbeidet i boligen du jobber?	F.eks. samtaler- pårørende, kollegaer, utviklingssamtaler, personalmøter.
	Hvordan vurderer dere **ernæringssituasjonen** for beboeren du jobber med i boligen? Hva slags **rutiner** er det for dette? Settes det noen mål om hvordan kostholdet til beboerne skal være? Hvordan **lages** de? Kan du gi eksempler? Hvordan **følges** disse målene **opp**? Hvis dere **ikke** har slike mål- Hva kunne slike mål ha hjulpet dere med i boligen der du jobber tenker du?	KMI, vekt, vektutvikling, matlyst? handlelister?, menyer?, innkjøp?, fellesmiddager?

KUNNSKAP *Kunnskap om mat og ernæring*	Hvordan opplever du din **egen kunnskap** om mat og ernæring er? Forklar. Hvordan har du **tilegnet** deg denne kunnskapen? Hvordan opplever du kunnskapen om mat og ernæring hos **de andre** ansatte i boligen er? På hvilken måte- kan du gi eksempler? Tilbys det – eller har du deltatt på **ernæringskurs** i kommunen? Ønsker du eventuelt å ha mulighet til å delta på slike ernæringskurs? Følger dere noen **kostråd** i boligen der du jobber? Hvilke? **Hvordan** følges disse opp? **Hvis ikke**, har du noen tanker om slike kostråd?	Hvilke? Offisielle? 5 om dagen? Nøkkelhullet?
<u>YTRE FAKTORER</u> **SOSIAL FASILITERING**	Hvordan jobber **andre ansatte** for at kostholdet til beboerne der du jobber skal bli bedre? Dersom du ønsker å tilrettelegge for et sunnere kosthold til beboerne der du jobber, **hvordan stiller** kollegaer eller lederen din seg til dette? Hvordan ser dine kollegaer og din leder på **betydningen** av at beboerne har et sunt kosthold? Har dere samme holdninger til dette?	Har du eksempler? Hvis negativt svar, kan du utdype? Støtte? Konflikt? Motarbeidelse?

BELØNNING	Hvordan blir du **fulgt opp** på ernæringsoppgaver du gjør?	Eventuelt av hvem?
	Hvordan opplever du **balansen** mellom hvor mye du bruker av tid til å fremme et sunt kosthold og hvor mye støtte og feedback du får i dette arbeidet?	
	Hvordan vil du beskrive din avdelingsleders **holdning** til kosthold og ernæring for beboerne i boligen?	Engasjert? Opptatt av sunt kosthold og riktig ernæring?
	Hvordan arbeider lederen din med dette **ernæringsarbeidet?**	Settes det krav til deg i forbindelse med ernæringsarbeidet?
	Hvordan **påvirker** dette din arbeidshverdag?	
PRAKTISKE FORHOLD	Opplever du at det er faktorer som gjør det **enklere** å gjennomføre ernæringsarbeidet, eventuelt **vanskeligere** -og kan du beskrive disse?	F.eks. fasiliteter, tid, bemanning, andre prioriteringer? Hvordan løser dere dette?
	Har dere utpekt en ernæringskontakt i boligen? Hva tenker du evt. om dette?	
	Inngår ernæringsfaglig arbeid i - planer? - arbeidsbeskrivelser? - utviklingssamtaler?	Kjøkkenservice/ maskiner? Hyggelige spiselokaler?
	Kan du fortelle meg litt om kjøkkenet i boligen (fellesareal og beboerne)? - tilrettelagt for å oppbevare, tilberede og innta mat? - Er det hygienisk og rent for å lage mat?	Hva tenker **beboerne** om maten?

	Hvordan opplever du balansen mellom **økonomien** til den enkelte beboer og kostholdet som anbefales i boligen?	
SWOT-SPØRSMÅL *Hvordan ansatte oppfatter intervensjonen*	Kan du fortelle om: ○ Styrkene du oppfatter ved forskningsstudien «Kosthold for bedre helse»? ○ Svakheter du oppfatter ved forskningsstudien «Kosthold for bedre helse»? ○ Muligheter du oppfatter ved forskningsstudien «Kosthold for bedre helse»? ○ Trusler/utfordringer du oppfatter ved forskningsstudien «Kosthold for bedre helse»? ○ Har du noen råd for hvordan studien kunne ha vært utført på en bedre måte?	
AVSLUTNING (ca. 5 min) *Liten oppsummering av hovedpunkter*	Er det noe mer du kommer på eller ønsker å supplere? Takke for at de stilte opp. Gjenta at informasjonen blir avidentifisert og at de ikke vil bli gjenkjent.	

Appendix 3 Sosio-demographic information questionnaire

UiO : Universitetet i Oslo

BÆRUM KOMMUNE

Spørreskjema for sosio-demografisk data til semi-strukturerte intervjuer av ansatte i samlokaliserte boliger til delstudien: «Ansatte i kommunale helse- og omsorgstjenesters motivasjon og utføring av ernæringsarbeid for personer med utviklingshemming».

Bakgrunnsinformasjon om deg:

1. Er du
   - Kvinne ◯
   - Mann ◯

2. Hva er din alder?
   - Under 20 ◯
   - 20-29 ◯
   - 30-39 ◯
   - 40-49 ◯
   - 50-59 ◯
   - Over 60 ◯

3. Hvilken landbakgrunn har du?
   - Norge ◯
   - Øvrige Europa ◯
   - Utenfor Europa ◯

4. Hvilken utdannelse har du? *Sett kryss for høyeste fullførte utdanning.*
   - Utdanning på grunnskolenivå eller lavere ◯
   - Utdanning på videregående nivå (gymnas/ fagbrev) ◯
   - Utdanning på universitets- og høgskolenivå (3 år eller mindre) ◯
   - Utdanning på universitets- høgskolenivå (mer enn 3 år) ◯

5. Arbeidserfaring i omsorgsboliger for mennesker med utviklingshemming?
   - 0-5 år ◯
   - 6-10 år ◯
   - Over 10 år ◯

Appendix 4 REK approval

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst B	Elin Evju Sagbakken	22845502	16.03.2021	10918
			Deres referanse:	

Svein Olav Kolset

10918 Kosthold for bedre helse for mennesker med utviklingshemming i omsorgsboliger

Forskningsansvarlig: Universitetet i Oslo

Søker: Svein Olav Kolset

REKs vurdering

REK viser til endringsmelding innsendt 09.03.2021 for prosjekt 10918 (2019/362). Søknaden er behandlet av sekretariatet REK sør-øst på fullmakt fra REK sør-øst B, med hjemmel i helseforskningsloven § 11.

REK har vurdert følgende endringer:

1) En ny prosjektmedarbeider, Marianne Nordstrøm, PhD-kandidat, Frambu Senter for sjeldne funksjonshemninger.

2. Nytt delprosjekt med tittel «Ansatte i kommunale helse- og omsorgstjenesters motivasjon og utføring av ernæringsarbeid for personer med utviklingshemming». Prosjektet vil inkludere tjenesteytere i kommunale helse- og omsorgstjenester i Bærum kommune.

15 ansatte i Bærum kommune, som har vært med på intervensjonsdelen av forskningsstudien: «Kosthold for bedre helse for mennesker med utviklingshemming i omsorgsboliger», vil inviteres til å delta i disse semistrukturerte intervjuene. De vil underveis i intervjuet også bli spurt om hvordan de har opplevd å være med på kostholdsintervensjonen.

Det vil innhentet sosio- demografisk informasjon om de 15 intervjuobjektene (vedlegg 2). Det er utarbeidet et samtykkeskjema for de 15 ansatte som blir forespurt om å delta (vedlegg 3).

REK har vurdert den omsøkte endringen og har ingen forskningsetiske innvendinger til de endringer som er beskrevet i skjema for prosjektendring.

REK sør-øst B
Besøksadresse: Gullhaugveien 1-3, 0484 Oslo
Telefon:22 84 55 11 | **E-post**:rek-sorost@medisin.uio.no
Web:https://rekportalen.no

Vedtak

Godkjent

REK godkjenner med hjemmel i helseforskningsloven § 11 annet ledd at prosjektet videreføres i samsvar med det som fremgår av søknaden om prosjektendring og i samsvar med de bestemmelser som følger av helseforskningsloven med forskrifter.
Vi gjør samtidig oppmerksom på at etter ny personopplysningslov må det også foreligge et behandlingsgrunnlag etter personvernforordningen. Det må forankres i egen institusjon.

Dersom det skal gjøres ytterligere endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende ny endringsmelding til REK.

Av dokumentasjonshensyn skal opplysningene oppbevares i 5 år etter prosjektslutt. Opplysningene skal deretter slettes eller anonymiseres. Opplysningene skal oppbevares avidentifisert, dvs. atskilt i en nøkkel- og en datafil.
Prosjektet skal sende sluttmelding til REK, se helseforskningsloven § 12, senest 6 måneder etter at prosjektet er avsluttet.
Vi ber om at alle henvendelser sendes inn via vår saksportal: : https://rekportalen.no
Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen

Jacob C. Hølen
Sekretariatsleder REK sør-øst

Elin Evju Sagbakken
Seniorrådgiver
REK sør-øst B

Kopi sendes forskningsansvarlig institusjon og eventuelle medbrukere som er gitt tilgang til prosjektet i REK-portalen.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK sør-øst B. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering.

Appendix 5 NSD approval

NSD Godkjenning

Melding11.06.2021 12:10

Behandlingen av personopplysninger er vurdert av NSD. Vurderingen er: BAKGRUNN Prosjektet er tilknyttet et større prosjekt som er vurdert og godkjent av Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK) etter helseforskningsloven (hfl.) § 10 (REK sin ref: 10918). Det aktuelle meldeskjema gjelder et delprosjekt i dette prosjektet der ansatte i kommunale helse- og omsorgstjenester skal intervjues om ernæringsarbeid. Delprosjektet er godkjent som en endring helseforskningsloven (hfl.) § 11. Det er NSD sin vurdering at behandlingen også vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet datert 11.06.2021 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte. MELD VESENTLIGE ENDRINGER Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde: nsd.no/personverntjenester/fylle-ut-meldeskjema-for-personopplysninger/melde-endringer-i-meldeskjema Du må vente på svar fra NSD før endringen gjennomføres. TYPE OPPLYSNINGER OG VARIGHET Prosjektet vil behandle alminnelige kategorier av personopplysninger frem til 31.12.2022. Opplysningene skal deretter oppbevares i fem år (til 31.12.2027) for dokumentasjonshensyn eller vilkår fra Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK). LOVLIG GRUNNLAG FOR UTVALGET Prosjektet vil innhente samtykke fra de registrerte i utvalget til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a. LOVLIG GRUNNLAG FOR TREDJEPERSON Under datainnsamlingen kan det fremkomme personopplysninger om ledere og andre ansatte. I intervjuene vil ansatte bli spurt om arbeidsoppgaver og ledelse på arbeidsplassen. Informasjonen vil inneholde indirekte identifiserende opplysninger om deres ledere og andre ansatte på arbeidsplassen. Det skal bare registreres alminnelige kategorier av personopplysninger om tredjeperson og de vil ikke direkte identifiseres. Prosjektet vil i tråd med formålet trenge opplysninger om rutiner tilknyttet ernæring på bofellesskapet. Det samles lite opplysninger om tredjepersoner og nytten av å behandles opplysningene anses derfor som høyere enn ulempen for tredjepersoner. Prosjektet vil behandle personopplysninger om tredjeperson med grunnlag i en oppgave av allmenn interesse. Vår vurdering er at

behandlingen oppfyller vilkåret om vitenskapelig forskning, jf. personopplysningsloven § 8, og dermed utfører en oppgave i allmenhetens interesse. Lovlig grunnlag for behandlingen vil dermed være utførelse av en oppgave i allmenhetens interesse, jf. personvernforordningen art. 6 nr. 1 bokstav e), jf. art. 6 nr. 3 bokstav b), jf. personopplysningsloven § 8. PERSONVERNPRINSIPPER NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om: - lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at utvalget får tilfredsstillende informasjon om og samtykker til behandlingen - formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke behandles til nye, uforenlige formål - dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet - lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet DE REGISTRERTES RETTIGHETER - UTVALGET NSD vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13. Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20). I utgangspunktet har alle som registreres i forskningsprosjektet rett til å få slettet opplysninger som er registrert om dem. Etter helseforskningsloven § 16 tredje ledd vil imidlertid adgangen til å kreve sletting av sine helseopplysninger ikke gjelde dersom materialet eller opplysningene er anonymisert, dersom materialet etter bearbeidelse inngår i et annet biologisk produkt, eller dersom opplysningene allerede er inngått i utførte analyser. Regelen henviser til at sletting i slike situasjoner vil være svært vanskelig og/eller ødeleggende for forskningen, og dermed forhindre at formålet med forskningen oppnås. Etter personvernforordningen art 17 nr. 3 d kan man unnta fra retten til sletting dersom behandlingen er nødvendig for formål knyttet til vitenskapelig eller historisk forskning eller for statistiske formål i samsvar med artikkel 89 nr. 1 i den grad sletting sannsynligvis vil gjøre det umulig eller i alvorlig grad vil hindre at målene med nevnte behandling nås. NSD vurderer dermed at det kan gjøres unntak fra retten til sletting av helseopplysninger etter helseforskningslovens § 16 tredje ledd og personvernforordningen art 17 nr. 3 d, når materialet er bearbeidet slik at det inngår i et annet biologisk produkt, eller dersom opplysningene allerede er inngått i utførte analyser. Vi presiserer at helseopplysninger inngår i utførte analyser dersom de er sammenstilt eller koblet med andre opplysninger eller prøvesvar. Vi gjør oppmerksom på at øvrige opplysninger må slettes og det kan ikke innhentes ytterligere opplysninger fra deltakeren. Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned. DE REGISTRERTES RETTIGHETER - TREDJEPERSONER Så lenge tredjepersoner kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15),

retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), protest (art 21). Det kan også unntas fra informasjonsplikt etter art. 14 nr. 5 b), der personopplysninger ikke har blitt samlet inn fra den registrerte. Det samles inn få opplysninger om tredjepersoner, og de vil kun være indirekte identifiserbare. Ettersom prosjektet ikke kjenner tredjepersoners identitet vil det kreve en uforholdsmessig innsats å informere tredjepersoner sett opp mot nytten de vil ha av informasjonen. Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned. FØLG DIN INSTITUSJONS RETNINGSLINJER NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32). Microsoft Teams er databehandler i prosjektet. NSD legger til grunn at behandlingen oppfyller kravene til bruk av databehandler, jf. art 28 og 29. For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og/eller rådføre dere med behandlingsansvarlig institusjon. OPPFØLGING AV PROSJEKTET NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/ pågår i tråd med den behandlingen som er dokumentert. Lykke til med prosjektet! Kontaktperson hos NSD: Jørgen Wincentsen Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Appendix 6 Map of generated themes