Teaching kitchens in medical rehabilitation – an inventory

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Abstract

Concrete guidelines for the equipment and implementation of the therapeutic teaching kitchen event (German: *Lehrküchenveranstaltung* [LKV]) are still lacking. One aim of the mixed-methods study LeKER is to analyze the current situation by means of a quantitative online survey of nutrition therapy specialists (n = 116).

Space and equipment are mostly rated as good. Structures and processes are heterogeneous. Around half of the respondents formulated concrete goals for the LKV. Evaluation and documentation rarely take place due to a lack of target formulation and time limitations. It is difficult to formulate objectives due to the predominantly cross-indication nature of LKV and the lack of integration into a nutritional therapy concept.

The development of structured, goal-orientated concepts for the further development and quality assurance of LKV is urgently required. The recommendations of the LeKER framework concept for the structured conceptualisation, formulation of objectives, evaluation and documentation can make an important contribution here.

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Introduction

Alongside statutory health insurance (German: *gesetzliche Krankenversicherung* (GKV)), the *Deutsche Rentenversicherung* (DRV Bund)[1] is the most important funding organization for medical rehabilitation in Germany. In contrast to GKV, which does not stipulate any requirements for nutritional therapy, the DRV defines nutritional therapy measures as an integral part of rehabilitation services. These nutritional therapy measures include teaching kitchen events (German: *Lehrküchenveranstaltung* [LKV]).[1] However, the aims of the LKV are only outlined in very general terms [1].

The LKV helps to deepen acquired knowledge about healthy eating and to put it into practice by improving cooking and everyday skills. The focus is on strengthening motivation for sustainable lifestyle change, which can stabilize health in the long term. However, specific guidelines and targets for LKV are still lacking. According to the current state, there are hardly any scientific studies or publications on the "teaching kitchen" intervention as part of nutrition therapy.

The DRV Bund is therefore supporting the mixed-methods study "Teaching kitchens – inventory and recommendations for standardized concepts in medical rehabilitation" (LeKER) as part of a research grant. The aim of the study is to develop a framework concept for the structures and implementation of LKV. The basis for this is a written online survey to answer the following research questions:

1. How is the nutritional therapy service of the teaching kitchen event carried out in medical rehabilitation?
2. What is the minimum equipment and what is the need for further development in the area of teaching kitchen (events)?

This publication focusses on the current status of processes and equipment in the teaching kitchens and the implementation of teaching kitchen events (LKV).

Background

International studies point to the potential effectiveness of cookery classes/LKV in therapy and prevention. The reported results range from general positive to specific effects (e. g. improvement in dietary behaviour [2], normalization of HbA1c levels in subjects with type 2 diabetes mellitus [3]). However, these

[1] The *Deutsche Rentenversicherung* (German Pension Insurance) is Germany's public retirement insurance system. It is a mandatory social insurance program for the majority of employees.

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are often multi-component studies (e. g. combination with theoretical nutritional units, sport, mindfulness training, etc.), which makes it difficult to analyze the LKV in isolation. The assessment of effectiveness is also limited due to heterogeneous study designs and results [4]. In addition, there is a lack of descriptions of conceptual approaches for the implementation of cookery courses/LKV. Various LKV concepts are available for the training of multipliers, e. g. Culinary Medicine [5], training of nutritionists (e. g. ISB [6]). Only a few, mostly incomplete, approaches are available for the intervention itself. Furthermore, internationally divergent healthcare systems and structures as well as cultural differences limit the transferability of the results to Germany. All concepts focus on the acquisition of technical cooking skills [5, 7]. The use of behavior-modifying techniques is not consistently described. Evidence of successful behavior modification has already been provided in nutritional counselling and therapy [e. g. 8–12]. There are no empirically tested concepts of nutritional therapy using LKV and the behavior modification techniques used in it – especially in the context of medical rehabilitation.

The functional room "teaching kitchen" is considered structurally relevant for all medical rehabilitation facilities under contract with the DRV – in other words, it is a requirement for occupancy by the DRV. Apart from the general requirement of "functionality" and the recommendation of accessibility, there are no instructions or recommendations [13].

The DRV defines evidence-based rehabilitation therapy standards (German: *Reha-Therapiestandards* [RTS]) to ensure the quality of care and processes [14]. The evidence-based therapy modules (German: *Evidenzbasierte Therapiemodule* [ETM]) define minimum requirements for therapeutic care and are based on the classification of therapeutic services (German: *Klassifikation therapeutischer Leistungen* [KTL]) [1, 15]. Nutritional therapy measures have been anchored as a separate chapter M in the KTL since 2015, while the KTL was first published in 1997 [1]. Nutritional therapy measures are required as ETM in all RTS, to varying degrees depending on the indication. LKV is always listed there as one of the possible nutritional therapy interventions [14] and has the same quality characteristics for both indication-specific and cross-indication implementation in the group [1] (◆ table 1). In particular, the objectives of the LKV are outlined in very general terms as "practical implementation of the content of nutritional counselling, imparting knowledge about nutrition, motivation to change behavior[2]" [1].

Occupational group:	dietician, ecotrophologist (BA, MA, diploma)
Additional qualification:	
Speciality:	interdisciplinary
Indication:	nutrition-associated risks and diseases
Therapy objective:	practical implementation of the contents of nutritional counselling, imparting knowledge about nutrition, motivation to change behavior
Minimum duration:	90 minutes
Frequency:	at least 1 time per rehabilitation programme
Number of rehabilitants:	maximum of 9 rehabilitants
Further information:	including teaching kitchen for parents, children, adolescents

Tab. 1: **Quality characteristics of the KTL 2015 "M62 Teaching kitchen in the group" [1]**

The current data do not provide an insight into the current practice of the LKV, nor do they provide any indication of the basic orientation or the need for further development of teaching kitchens and teaching kitchen events. Their collection is a prerequisite for the conceptual development of a best-practice model for the LKV.

Methodology

A standardized survey questionnaire was developed to assess the current situation and needs of the LKV practice. Extensive literature research and a qualitative survey of teaching kitchens [16] served as the methodological and content-related basis for the survey concept. The development of the questionnaire was supported by an external control group in order to ensure intra- and interdisciplinarity and a high level of practical relevance. Prior to field access, the questionnaire underwent both an internal and external pre-test (n = 9). The final online questionnaire comprised 79 closed and open questions[3] from eight subject areas (general information and structural features; space and equipment; quality features of the LKV; preparation, implementation and follow-up of the LKV; final assessments; socio-demographic information).

The link to the survey was sent to approx. 1480 medical rehabilitation facilities via a mailing list of the DRV Bund and they were asked to forward it to their specialist nutritional therapy department. The survey was aimed at nutritional therapy specialists at all medical rehabilitation centres. Due to special therapeutic features, clinics focusing exclusively on children and adolescents

[2] Original quote: *„praktische Umsetzung der Inhalte der Ernährungsberatung, Vermittlung von Wissen über Ernährung, Motivation zur Verhaltensänderung"* [1].

[3] Depending on the filter, min. 10 and max. 75 questions

as well as addiction disorders were excluded. In order to ensure a high level of participation, the research project was promoted via various channels, in particular professional associations, in parallel to the development of the questionnaire. Attention was primarily drawn to the online survey and access to it. The survey ran in September/October 2023 (39 days). The data was analysed using the Statistical Package for Social Sciences (SPSS; version: SPSS Statistics 28) analyzis software.

Results

Description of the sample

Of the approximately 1480 organizations contacted, the link was accessed 412 times. A total of 127 questionnaires were completed (response rate 9%), eleven of which met the above exclusion criteria. The size of the random sample is therefore $n = 116$[4].

Over half of the participating facilities (56%) offer both inpatient and outpatient care. The most frequently cited indications are: Orthopaedics (29%), psychosomatics (19%), oncology (13%) and cardiology (12%). With the exception of one case (trainee), the questionnaire was completed by nutrition professionals.

General conditions and therapeutic concept

In 89% of the participating facilities, nutritional therapy is a separate therapeutic department. In 6% of cases, it is assigned to the kitchen and in 5% to other therapeutic departments (e. g. occupational therapy, physiotherapy). If nutritional therapy measures are prescribed, rehabilitants predominantly receive 1–< 3 hours of nutritional therapy (68%). A shorter duration was mentioned by 10% and a longer duration by 23% of respondents. The facilities surveyed stated that they tended to carry out cross-indication LKV (78%) rather than indication-specific (22%). The main focus of the LKV is predominantly on general topics (64%) and less frequently on disease-specific content (36%).

On average, participation in a LKV is based on 2.72 ($SD = 1.04$) factors, but according to the respondents, most often at the request of the rehabilitants (84%; multiple response question [MR]). 72% of rehabilitants take part in the LKV as a result of referral by doctors and 68% initiated by nutritional therapy specialists (MR). For 48%, participation in LKV is firmly anchored in the therapy concept (MR). The respondents named group nutritional counselling (76%) or individual counselling (73%) and the coordination of an energy-defined diet (45%) as the most common links between LKV and other nutritional therapy measures (MR). According to 46% of respondents, participation in LKV is not necessarily linked to participation in other nutritional therapy measures.

Didactics and methods

With regard to the didactic approach during the LKV, almost all respondents stated that they provide practical assistance (97%) or instruct the preparation (93%). Less frequently, the instructors (39%) are actively involved in the cooking process. Communicative-motivational aspects such as sufficient time to answer questions (89%), motivating the rehabilitants to achieve their goals (78%) and using strategies of motivational interviewing (74%) are further key elements.

The prepared meals are eaten together by 93% of those surveyed in the LKV. The instructors take part in 17% of the meals in part and 75% in full ($n = 111$). The participation of the instructors in the communal meal is considered important for several reasons: Firstly, it strengthens the therapeutic relationship (86%) and is also part of the LKV concept (83%) ($n = 102$; MR). Secondly, the instructors serve as role models for eating behavior (68%) and 52% carry out a sensory evaluation of the food during the meal ($n = 102$; MR). If the instructors are not involved in eating together (8%; $n = 111$), this is due to various factors. In 56% of these cases, the food is not allocated to therapy/work time or the instructors tidy up the training kitchen while the rehabilitants are eating ($n = 9$; MR). Refund of meal costs by the instructors and an insufficient amount of food for cost reasons were each cited by 22% of respondents as reasons for not participating in the communal meal ($n = 9$; MR).

Processes

In order to record the processes of an LKV, respondents were asked, among other things, whether standards exist for the preparation, implementation and/or follow-up of LKV (◆ figure 2). Overall, complete standards are available for cross-indication rather than indication-specific LKV. The highest level of agreement relates to the performance of a cross-indication LKV (35%). Standards for the preparation of indication-specific LKV are the least common (22%).

Around half (52%) of those surveyed formulate specific objectives before carrying out an LKV. Evaluating the achievement of objectives at the end of the LKV is affirmed by 32% of respondents and denied by 30%.

The evaluation of the LKV can be carried out by the rehabilitants on the one hand and by the instructors on the other. An evaluation of the LKV as an overall event is more likely to be carried out by rehabilitants (20%; modal value = "partly" [42%]) than by instructors (12%; modal value = "never" [33%]). Both evaluation dimensions are considered by 47%[5]

4 Unless otherwise stated, the results always refer to n = 116 than 100 %.

5 At least "partly" (rehabilitants) and at least "rarely" (instructors)

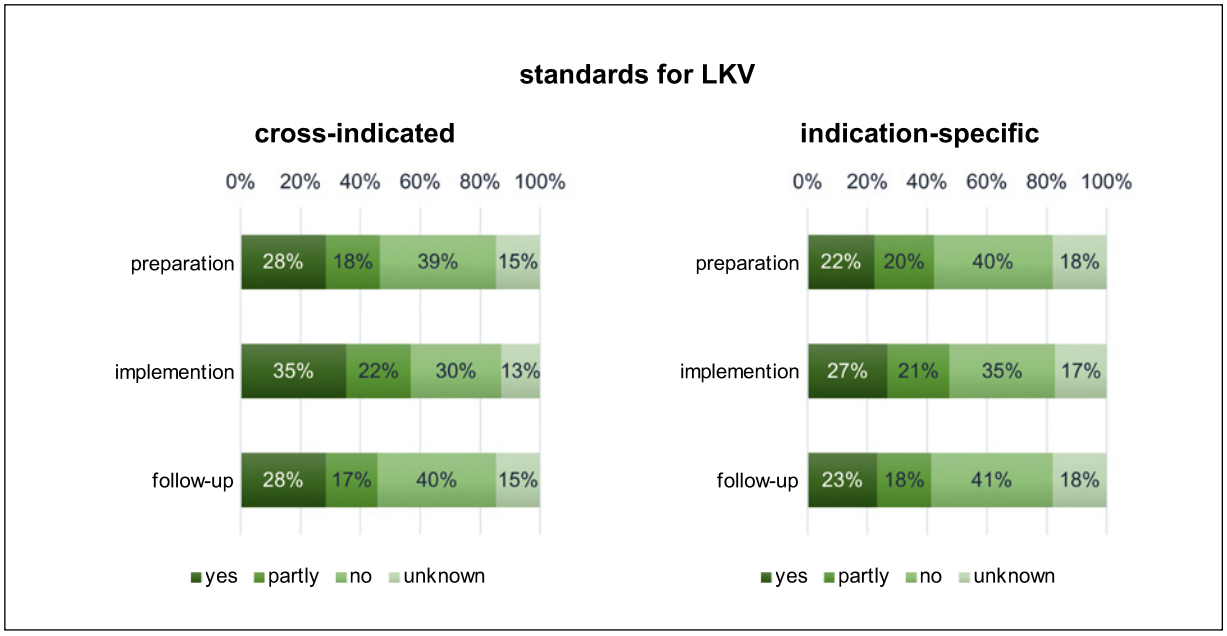

Fig. 1: **Standards for cross-indication and indication-specific LKV** (n = 116)

of the sample and neither evaluation takes place for 17 %.

If one of the two evaluation modes is at least partially (rehabilitants) or rarely (instructors) carried out by the respondents in the sample (83%), then 34% of respondents never document the evaluation results and 28% always do so (n = 96). Rare (22%) and frequent (16%) documentation of the evaluation results lie between these endpoints (n = 96). The time available for the individual process steps is described as insufficient, particularly in the area of evaluation and documentation.

Structures

Most participating facilities named four to five rehabilitants (41%) as the regular group size per LKV. In 34% of the participating facilities, LKV are carried out with six to seven and in 22% of the participating facilities with more than eight rehabilitants. Six to seven participants were rated as the optimum group size by 41% of respondents. 36% stated that four to five participants in the LKV were considered optimal.

In the facilities surveyed, LKV almost always take place in their own teaching kitchen (95%). Other venues, named by 5% of respondents, were the canteen kitchen (3%), other premises (2%) or a third-party teaching kitchen (1%). Most facilities have a single teaching kitchen room (90%). Two (9%) or three (2%) teaching kitchen rooms are less common.

In the following, all 130 existing teaching kitchen rooms are considered together. Half of the teaching kitchens are between 2 –40 m² in size (modal value = 21–30 m²; 36%). Around one fifth of the teaching kitchens are smaller (21% ≤ 20 m²) and one fifth larger (15% 4 –50 m²; 4% ≥ 51 m²). The teaching kitchens usually have six to eight work and dining areas (50% respectively 51%). Most frequently (30%), the teaching kitchens have a single workstation for people with physical disabilities. Two such workstations are offered by 26% of the facilities, 25% none, 6% three and 12% four or more.

The respondents predominantly rated both the size (60%) and the respective number of workstations (60%) and eating places (84%) as good to very good.The availability of workstations for people with physical and/or motor impairments was described as inadequate by 17% of respondents. Having very good equipment was confirmed by 43%, while half of the respondents only partially agreed with this assessment.

Importance of LKV and wishes from the respondents' perspective

Almost all respondents (94%) do not want to do without LKV in nutritional therapy and over half (62%) were of the opinion that rehabilitants would benefit from more frequent LKV from a therapeutic perspective. For the majority of those surveyed, the therapeutic benefits of LKV are the main focus (86%). 70% stated that teaching cooking must first and foremost be fun for the rehabilitants. 91% of respondents emphazised the promotion of self-efficacy by carrying out LKV. The freedom to organize the LKV is particularly valued (93%), 97% consciously design the LKV as a positive experience for the rehabilitants.

With regard to practice-oriented training concepts or modules, most of the respondents (69%) favoured individual training modules for the LKV. Respondents would rather have specific guidelines for equipping teaching kitchens (61%) than for organizing

a LKV (36%). However, further training (78%) and practical exchanges (77%) on the conception and implementation of the LKV are considered useful. Clear information posters, e. g. on cooking methods, seasoning with herbs (77%) or hygiene and safety regulations in the teaching kitchen (74%) as well as documentation aids for the LKV (59%) were also rated as useful.

Discussion

As the contact details of the nutrition teams were not available for data protection reasons, the questionnaire link was sent via a mailing list of the DRV Bund. The recipients of the mailing list were potentially the administrations of the facilities. Forwarding to the nutrition therapy specialists was not guaranteed. An attempt was made to address interested nutrition therapy specialists directly via the websites of the professional associations, Fulda University of Applied Sciences and the DRV. This proved to be insufficient, as the survey link had to be actively requested. This explains the relatively low response rate of 9%. Compared to the Rehab Report 2024 [17], the frequency distribution of the indications among the participating facilities is nevertheless mostly representative.

Possible reasons for the high cancellation rate (69%; n = 412) are in particular the processing time of approx. 40–50 minutes announced on the start page and the high security standard of the facilities, which restricts internet access. This assumption is based on the observation that 75% of cancellations occurred on the start page and 18% in the first topic area (n = 285). The relatively long processing time may have led to non-completion, cancellations or participation in the survey in a private setting due to the stress of everyday working life.

The dining and workstations available in the teaching kitchens are congruent with the usual group sizes indicated. Both the current group size and the group size in the LKV that is perceived as optimal is below the maximum target of 9 rehabilitants according to KTL 2015 [1]. This ensures parallel and independent work in small cooking groups, social-communicative exchange and individual support during joint food preparation. In existing kitchens in particular, the group size is usually limited by the size of the teaching kitchen or the number of workstations. The square metre figures for the teaching kitchens are based on estimates. Space and equipment are predominantly rated as good. According to the interviewees, the availability of workstations and work materials for people with special needs (e. g. motor impairments) does not meet the requirements. However, these conditions are necessary in order to enable the target group to acquire skills in line with their needs and requirements.

Rehabilitation services are participation-orientated and serve in particular to restore the ability to work. Clear goals must be defined for a rehabilitation programme in this context. These goals can be derived from the indication of the rehabilitants (e. g. weight stabilization in the case of malnutrition, food intolerances, etc.) or from the reality of their lives (e. g. needs-based nutrition for shift work or on a low income, eating at the workplace, single-person household, etc.). The competences to be taught in the LKV and the basis for evaluating the event are derived from the objectives to be defined. Without objectives, systematic evaluation and documentation are not possible.

The results show that nutritional therapy, including LKV, is firmly established in the facilities surveyed. Although it often makes sense to combine LKV with nutritional counselling (group and individual) and the coordination of an energy-defined diet, almost half of the respondents stated that this is not necessarily the case. The desire of the rehabilitants is usually a decisive factor for participation in LKV. On the one hand, this speaks in favour of a high level of intrinsic motivation on the part of the participants and a needs-oriented approach to the rehabilitation offer. On the other hand, this approach does not make sense, as needs do not automatically correspond to a therapeutic need. For example, rehabilitants who already have cooking and nutritional skills are much more likely to participate. Furthermore, self-enrolment (especially through open notices) makes it impossible to plan which and how many rehabilitants with which indications, knowledge and/or skills will attend the LKV. Possible consequences include over- or under-challenging the rehabilitants and heterogeneous groups that do not correspond to the LKV concept. Due to the heterogeneity of the groups, cross-indication LKV clearly predominate and general content, such as healthy eating in everyday life and at work, is emphazised more than indication-specific content. The broad content of the LKV and the partial lack of links with other nutritional therapy measures make it difficult to formulate clear objectives and evaluate them.

Although doctors are responsible for prescribing therapy [18], the recommendation and organization of nutritional therapy measures should ideally be carried out by nutritional therapy specialists. They have the expertise to recognize client-specific nutritional therapy needs and initiate measures. In addition to indication- and participation-specific goals, anamnestic goals within the LKV are also relevant to supplement the assessment. These include, for example, the observation and assessment of the rehabilitants' cooking and food skills, including their behavior in the kitchen or with (previously unknown) foods. Motivation to change behavior can be initiated with one to three hours of nutrition therapy per rehabilitation measure and rehabilitant, but it is not possible to apply and practice the behavior sufficiently in the time available

[19]. To summarize, it can be concluded that cross-indication implementations, self-enrolment of rehabilitants in LKV and the lack of integration into a larger nutritional therapy concept make it difficult to formulate goals. The consistent, structured and transparent embedding of LKV in the nutritional therapy concept along the German-Nutrition Care Prozess (G-NCP) is therefore of great importance.

The interviewees see eating together with the rehabilitants as an integral and important therapeutic component of the LKV. The organization of the LKV thus goes beyond the mere preparation of food according to KTL 2015. Eating the prepared meals together is relevant to the therapeutic benefits of the LKV. It enables an evaluation in the form of verbal feedback, getting to know the rehabilitants better with their individual likes and dislikes (assessment character) and strengthening the group dynamics. The minimum time requirement for a LKV of 90 minutes (according to KTL 2015 only cooking [1]) does not cover this additional requirement. This can result in time restrictions at various points (e. g. preparation time, evaluation of the LKV) and a general overload for nutrition therapy specialists. The infrequent and non-standardized evaluation and documentation of the LKV due to a lack of target formulation and time limitations should be discussed critically. According to the G-NCP, structured work with transparent and comprehensible evaluation and documentation is essential for quality assurance in nutritional therapy. The development of structured, teaching goal-orientated concepts is urgently required for the further development and quality assurance of LKV and strengthens the role of nutritional therapy specialists in the medical rehabilitation process.

Conclusion

LKV is an action-orientated and regularly implemented nutritional therapy approach in medical rehabilitation facilities. However, the review presented here makes it clear that there often is a lack of a structured, goal-orientated nutritional therapy concept that is integrated into nutritional therapy. Corresponding concepts for medical rehabilitation are also not to be found in the international literature. The results of the survey therefore served as the basis for the development of a framework concept, which was created together with an expert advisory board. This can support the development and implementation of institution-specific concepts for teaching kitchen events. The framework concept is expected to be available on the DRV Bund website in 2026.

Conflict of interest
The LeKER study is funded by the DRV Bund. The authors declare that there are no other conflicts of interest. AI was used to create/check translations.

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