



Queen Margaret University College



**RECIPE FOR LIFE:  
HELPING OLDER PEOPLE TO EAT WELL**

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**FINAL REPORT OF RESEARCH  
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UNIVERSITY OF  
STIRLING

Dementia Services Development Centre



## **Roles of the authors**

Chris Jones is the principal investigator. She has taken the lead on developing research tools and analysing data and had primary responsibility for producing the report. She has undertaken fieldwork with older people and professionals.

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# **1 EXECUTIVE SUMMARY**

## **1.1 INTRODUCTION**

Recipe for Life is a three year project which aims to find better ways to support older people to eat well. The project is being undertaken in two phases, a research phase and a practice development phase. This is the report of the research phase that ran from April 2003 to September 2005. In this period, the project has worked with two Scottish local authorities to gather data on people's views and experiences about factors that help and hinder older people's ability to eat well. Below is a summary of the aims and objectives of the project as a whole, the way we have approached the research element of the project and some key messages that have emerged from this research.

## **1.2 AIMS AND OBJECTIVES**

### **The primary aim of the project is:**

to identify action that can be taken to improve the physical and social well being of older people who live alone and have difficulty leaving home, in relation to their nutritional and food-related needs, from the perspective of older people, family members, friends and social work staff.

### **The objectives of the project are:**

- to establish the nutritional status of older people participating in the project, obtain information about their food and drink intake and identify those at greatest risk of malnutrition;
- to explore the social, emotional, physical and practical factors that support or hinder good nutrition and eating well for older people who live alone and have difficulty leaving their home;
- to seek the views of this group of older people about their expectations of people providing services relating to food and nutrition;
- to explore the problems facing organisations when providing services for older people to ensure that food and nutrition are provided using person-centred principles;
- to explore issues facing front-line staff when providing food-related services and their needs for training support and development in this area of their work; and
- to develop and explore possible interventions to optimise the nutrition and food related social well-being of this group of people.

A number of interventions are being identified which can be implemented and evaluated in the final phase of the project. The final phase of the project will run from October 2005 to June 2006

## **1.3 OUR APPROACH**

The research element of the project has adopted a qualitative approach to explore the views and experiences of older people, family members, friends and social work staff in order to better understand the factors that help or hinder older people's ability to eat well. Two local

authorities participated in the study and within each local authority the following fieldwork was undertaken:

- multiple in-depth semi structured interviews with ten older people who live alone and have difficulty leaving home;
- collection of food and eating information from older participants using a food diary;
- a nutritional assessment of older participants;
- semi-structured interviews with family members or friends of older participants where these existed and older people consented to their involvement;
- a focus group with home care workers;
- a focus group with home care managers;
- a focus group with those responsible for the assessment of older people's community care needs;
- a semi structured interview with a senior manager with responsibility for food related services for older people.

Following data collection within each local authority a workshop was organised to feed back the main findings and to generate new data relating to possible solutions to the issues raised by participants.

The key findings from workshops, interviews, diaries and focus groups are summarised below.

## **1.4 KEY MESSAGES**

Below is a short summary of the main findings that have emerged during the project.

### **1.4.1 Difficulties experienced by frail older people**

It is evident that very frail older people with significant impairments and health problems are being supported to remain at home. This group of older people appear to experience multiple difficulties, which can impact on their day-to-day ability to eat well. These include difficulties such as sensory, physical and cognitive impairment, long term medical conditions and polypharmacy as well as psychological and social barriers to eating well. These individuals may, in the past, have been expected to enter residential care. They provide a challenge to home care services, which are continuing to shift from a domestic support model to a personal care role. Because of the increasing complexity of the needs of frail older people, it is likely that an increasingly complex assessment process and range of solutions will be needed to identify and meet their needs.

### **1.4.2 Assessing older people's food related needs**

It became apparent when talking to assessors and home care managers that the assessment of older people's needs generally, and in relation to food and eating more specifically, is a highly complex task requiring consideration of a wide range of factors and considerable skill on the part of the person carrying out the assessment.

In both areas, there did not appear to be a satisfactory assessment tool that could provide some structure to any investigation of food and nutrition related problems to ensure that issues are assessed thoroughly and at the same time ensure that the process is not overburdensome. Three main purposes of assessment emerged. These were:

- to ensure that a good match is made between services put in place and the needs of the individual;

- to identify those who are not eating well and may be at risk of malnutrition who require their situation to be monitored; and,
- to decide whether a person should be referred on to specialist services such as a community dietician.

It is possible that different assessment tools will be needed for these different purposes.

As stated in the previous section, the factors requiring consideration during the assessment process include physical, psychological, social and cultural issues. It is important that workers have specific knowledge of the nutrition needs of frail older people as well as skills in eliciting the preferences of older people and the social, psychological and cultural meaning of food in older people's lives. It was felt that all staff members could benefit from having more knowledge and skills in the area of food and nutrition. There is a need for specialist courses for all workers to enable them to identify risk factors and helpful interventions for older people who have problems with food and nutrition. There is also a need for an established induction programme and training course for home care workers to address these issues. This will become even more important as the level of frailty and impairment of older people living in the community, and therefore the level of specialist knowledge needed, increases. There may be scope to develop opportunities for older people to contribute to some food-related training. There would also be value in providing information to 'well' older people and family members about the nutritional needs of frail older people so that they are empowered to take responsibility for their own health before the need for intervention arises.

There is a danger that, if all of these factors are not taken into account, those at risk will go undetected, unsuitable services will be provided and appropriate referrals to specialist services will not be made. There is also clearly a need for close co-operation between health and social work colleagues about the food and nutrition of older people. The Joint Futures Agenda (Scottish Executive 2000) may provide opportunities to improve co-operation between health and social work services on this specific issue. The initiative aims to promote better joint working between local authorities, NHSScotland and other organisations through new arrangements for local joint management and resourcing of relevant health, social work and housing services and for 'single shared assessments' of individual needs (<http://www.scotland.gov.uk/Topics/Health/care/17673/9471>). More joint work specifically on food and nutrition issues at a local level would be welcomed by home care services.

### **1.4.3 The meaning of 'eating well'**

Emphasis was placed on older people having a 'proper meal' once a day. This was defined as a hot meal, a cooked meal or a meal of meat, potatoes and vegetables. These definitions of a 'proper meal' are consistent with earlier work undertaken with older women (Howarth 1993).

There was agreement that freshly prepared food is preferable to ready prepared meals. The latter can have a positive role to play in helping someone maintain some independence and introducing people to new meal ideas other than their generally favoured traditional meals. However, many participants would like there to be less reliance on these in older people's diets. Many older people are eating bland and unexciting diets. This may be because of a lack of motivation on the part of the older person, a lack of imagination on their part or that of the service provider, or maybe because changes in older people's tastes and digestion have led them to reduce the range of foods that they are willing to eat and find acceptable.

It appears that there would be value in providing:

- guidance for both older people and workers about what constitutes an adequate meal or a good diet for a frail older person to support older people to make good nutrition choices;
- meal ideas which suit an older person's needs and tastes; and
- signposts to better identify when a client's diet may be putting them at risk of malnutrition.

Older people and workers could valuably work together to develop ways that older people can be better supported to eat well that are acceptable to older people and achievable within service limitations.

There may also be a role for older people to teach younger home care workers about traditional meals and perhaps to develop recipe cards for quick and easy hot meals made from fresh ingredients, or traditional foods such as porridge.

#### **1.4.4 The importance of appetite or motivation to eat**

Low appetite was common among frail older participants, putting them at risk of malnutrition. The effects of the ageing process on older people's appetite are well known, and the need to provide nutritionally balanced meals is recognised by service providers. However, less attention has been paid to the social and psychological factors that need to be addressed in order to support older people to eat well. The main social and psychological factors that emerged from this study were:

- eating with others,
- cooking for others,
- having a good quality meal cooked by someone else,
- eating food that looks appetising,
- smelling food as it is being cooked,
- getting out of the house,
- being active,
- having exposure to foods and food ideas,
- having a varied and suitable diet,
- being supported to be spontaneous with food, and
- support to address losses, low mood or depression.

It appears that while services may at present be well set up to provide for people's basic needs for food and cooking, they are less well set up to address some of the social and psychological components that contribute to older people's ability to eat well and to quality of life. As there is a large psychological and social component to appetite and ability to eat well, it is particularly important that these issues are addressed wherever possible. Where these issues are not addressed they can provide significant barriers to older people's ability to eat well.

Further work needs to be undertaken to explore the role that services and communities can take to address these social and psychological factors more systematically. For example, research has shown that eating with familiar others can increase food intake by 60% in healthy older adults (McAlpine et al 2003), however, opportunities for social eating often decrease with age. The current mindset that physical needs are of primary importance and social and psychological needs are of secondary importance does not appear to be helpful, and may lead to inappropriate targeting of resources with little positive benefit. The neglect

of social and psychological needs in home care services has been noted in work undertaken by University of York (see Patmore and McNulty 2005). It appears to be just as essential to older people's ability to eat and, therefore, to their health and survival, that social and psychological aspects of food and eating are given attention.

One area that appears to be particularly lacking attention in services for older people is the provision of support to deal with the multiple losses experienced as we age. Howarth (1993) has written about the way bereavement in later life necessitates a reappraisal of behaviour, meaning and social identity. She quotes Marris (1986, p.33) who suggested the "fundamental crisis of bereavement arises not from loss of others, but the loss of self". This requires further attention if the wellbeing of older people is to be addressed adequately.

#### **1.4.5 Ways in which older people are supported to eat well**

Older people expressed high levels of satisfaction with the service they receive and gratitude to those providing support. Home care workers play an important role in encouraging older people to eat well. They fulfil this role by developing trusting relationships with clients, suggesting new foods or recipes to them, bringing new or favourite foods into the person's home, cooking foods in their own home and bringing them to the older person, providing opportunities for social eating with the home care worker or others. Some of these activities, such as cooking at home and shopping, are done on a voluntary basis outwith the home care workers normal role or hours.

The quality of the relationship between the older person and the home care workers is very important and can have an impact on the ability of older people to eat well. This relies on continuity and the worker and client feeling they develop an understanding over time. There may be a case for more careful matching of clients and workers to ensure that relationships are positive where this is possible. MacDonald (2004) highlights the lack of research exploring the impact of recruitment and retention policies on the quality and person-centred nature of service provision.

Creative individual arrangements to support older people to eat well have been successful, particularly for people with dementia. Further work is needed to explore opportunities for further funding of these individual arrangements through programmes such as 'Supporting People'.

Families and friends also play a very important role in supporting older people to eat well. Often they have an overview of the person's service and take on a co-ordination and monitoring role. This is consistent with findings of a recent study of intensive domiciliary support in Scotland (Curtice et al. 2002). However, the stress of caring results in these 'informal carers' setting boundaries around what they can and cannot do in order to make caring manageable. Older people are very aware of this stress and often try to minimise it if possible. This may lead to needs going unmet. Where families and friends are involved, there is a need to consider their support needs as well as the older person's support and their rights under the Carers (Recognition and Services) Act (1995). Where families and services both have a role in supporting the person to eat well, it is important that their efforts are co-ordinated and complementary.

Finally, local community facilities have an important role to play in supporting older people to eat well and maintain independence for as long as possible. Older people appreciated local

shops and cafes that offer a personalised service and accessible and older person friendly shopping facilities.

#### **1.4.6 Barriers to older people eating well**

A number of factors emerged which older people, family members and workers associated with quality when supporting older people to eat well. These included: recognising individuality, providing choice, accommodating personal tastes and preferences, appropriate timing of support, addressing cultural issues, supporting people to feel connected to food, allocating adequate time for support, helping people stay in control, providing continuity, co-ordination and good communication, proactive monitoring and reviewing of services and ensuring workers have appropriate knowledge and skills to meet older people's food related needs. Some of these issues have been raised in previous studies of home care (Henwood et al 1998, Accounts Commission for Scotland 2001, Raynes et al 2001). What has not been explored previously is the impact on older people's ability to eat well and their related physical, psychological and social wellbeing if these quality indicators are not addressed.

From the data gathered it has emerged that the consequences of not addressing these aspects of quality could include:

- older people feeling a lack of interest or motivation in relation to food and eating;
- older people not expressing their food related needs or preferences;
- food related needs going unmet or being poorly met;
- older people not being aware of their rights and not feeling able to make a complaint;
- an over-reliance on pre-prepared meals;
- workers providing support with food outwith their hours and job description;
- no-one having an overview of the older person's diet and any risk of malnutrition;
- the wellbeing of older people being negatively affected.

There is a need to re-examine the aims of food related services and for there to be a shift away from services providing 'food as fuel' to 'food as a route to wellbeing'. Monitoring and review systems are also needed which place less emphasis on assessing the time given and tasks undertaken and instead, the outcomes of home care interventions should be the focus. The scope for increased independent advocacy should also be explored. The recognition of individuality when providing service emerged as a key consideration. Research by the Social Policy Research Unit at York University is investigating the ways that home care services can become more flexible and person-centred through, for example smaller support teams and arrangements similar to Direct Payments but without the burden of the employer role (Patmore and McNulty 2005). Direct Payments have the potential to change the relationship between older people and service providers and create innovative solutions to older people's care needs but remain relatively new and under-researched.

Finally, there is a need to ensure that communities and community facilities are inclusive, with the development of, for example, human scale supermarkets and other community services that are older person friendly and cater for the needs of older people who live alone.

#### **1.4.7 Future directions**

A range of creative solutions and ideas were suggested by participants in order to improve the ability of older people to eat well. These included extending existing service to make them more accessible and appropriate for frail older people and making greater use of the potential for community facilities to meet the needs of frail older people, given the right guidance and support. There were very practical suggestions to improve the systems for communication

within the service and between the service and older people and family members and to develop independent monitoring arrangements. Better procedures to identify risk and link with specialist services were identified. Finally, co-operative arrangements between older people in a neighbourhood, such as taking turns to cook for each other, were seen to have advantages for older people. These may also require some facilitation or support.

#### **1.4.8 Conclusions**

Many of the frail older people who participated in the study experienced reduced appetite or lack of motivation to eat. Food is essential to our wellbeing. The importance of food to our physical wellbeing is well recognised by services. Its importance to our psychological and social wellbeing is less widely acknowledged. Food can provide punctuation and structure to our day, our week and even our year. It can help to shape and reinforce our identity. It provides opportunities for social interaction and shared experiences and plays a role in celebrations. For older people who rely on services, some of these positive social and psychological benefits associated with food can be lost along with independence, unless services pay particular attention to maintaining these. The social and psychological factors that can improve or reduce appetite appear to be poorly understood or addressed within social work services.

There is a need to re-examine the aims of food related services and for there to be a shift away from services providing 'food as fuel' to 'food as a route to wellbeing'. Monitoring and review systems are needed which place less emphasis on assessing the time given and tasks undertaken and instead the outcomes of home care interventions should be the focus.

There is also a need to recognise the important role that those outside of services can play and for there to be a co-operative effort between social work services, older people, their family members and friends as well as communities more broadly to work together to enable older people to eat well.

## **2 BACKGROUND TO THE PROJECT**

### **2.1 INTRODUCTION**

The 'Recipe for Life' project aims to help older people who live alone to eat well by developing and piloting new and innovative ways of providing support with food and eating. The project is being undertaken by the Royal Bank of Scotland Centre for the Older Person's Agenda at Queen Margaret University College in partnership with the Dementia Services Development Centre at University of Stirling and Age Concern Scotland. It is funded by Zurich Financial Services Community Trust under their 'Zurich Cares Older People Programme'.

The project runs from April 2002 to June 2006 and is organised into two phases, a research phase and a practice development phase. This is the report of the research phase that ran from April 2002 to September 2005. In this time, the project worked with two Scottish local authorities to gather data on people's views and experiences about factors that help and hinder older people's ability to eat well. The aims and objectives of the project, and the approach taken for the research, are explained in more detail in chapter 3. The rationale for the project is described below.

A number of interventions are being identified which can be implemented and evaluated in the final phase of the project. The final phase of the project will run from October 2005 to June 2006

### **2.2 WHY THE PROJECT IS NEEDED AND THE FOCUS OF THE PROJECT**

#### **2.2.1 Changing nutritional needs as we age**

As we get older, a number of things can lead to individuals not eating well. In some cases, people may have developed an illness or disability which makes it difficult for them to cook or enjoy food. For others, it may not be easy to get to the shops. If living alone, an individual may not feel it is worth cooking a meal for one. In addition, the normal ageing process can affect older people's enjoyment of food. Taste becomes impaired as we age and this may contribute to poorer appetite. Although older people may require fewer calories and may eat less as they grow older, they still require the same nutrients as younger people, such as essential vitamins and minerals, and they require slightly higher levels of protein. It may be difficult to consume the required levels of these nutrients, and eating less and being underweight represents a far greater risk to health for older people than being overweight (Ogilvie et al. 2003). The health risks associated with undernutrition include an increased risk of infection and poor mobility. Inadequate fluid intake is also a concern in some older people and can lead to constipation and mild confusion. Therefore, a poor diet can have a major impact on an older person's ability to stay well and in control of their own life.

#### **2.2.2 Prevalence of malnutrition among frail older people living in their own home**

Estimates of the prevalence of malnutrition among older people vary between 1% and 65% (Olde Rikkert and Rigaud 2003). A major survey of more than 1000 people aged 65 and over estimated that more than 60% of the older people living in the community are overweight or obese and one in six of the older people living in institutions are underweight (Finch et al. 1998). While many of the higher published estimates of malnutrition are associated with frail older people living in institutional settings, it appears that little is known specifically about the nutritional status of older people who live alone and have difficulty leaving home (Krassie et al. 2000). However, there is evidence to suggest that frail older people living in

the community may be at risk because of the impact of socio-economic factors (Wells 1992) and that the majority of 'home-bound' older people have poor diets (Stevens et al 1992). It is also the case that increasingly frail older people are being cared for in their own home when previously they may have entered residential care homes. A recent study by Soini et al (2005) which used the mini nutritional assessment to assess levels of malnutrition among older people living at home and receiving home health care services, estimated that almost half of older adults living at home and receiving these services are at high risk of malnutrition. In addition, people with dementia may face particular difficulties such as forgetting to eat, chewing or swallowing problems and increased levels of activity requiring increased calorie intake (Copeman 1999). As individuals age, they become increasingly vulnerable to physiological and psychosocial effects of inadequate nutrition (Betts 1988). Under-nourishment can, therefore, have major consequences for older people, affecting their ability to maintain their quality of life and independence.

### **2.2.3 The role of food related services in community care for older people**

Since the early 1980s there has been a policy drive towards caring for older people in the community, a shift from hospital based and institutional continuing care and an emphasis on early hospital discharge and preventative services to avoid hospital admission (see, for example, Caring for People 1989 and Modernising Community Care 1998). There are now significant numbers of older people living in their own homes with high levels of support.

A number of food related social care and health services contribute to supporting older people to remain at home including:

- home care services;
- shopping services;
- meal-on wheels;
- frozen meals services;
- lunch clubs;
- day care;
- community dietetics services;
- community dental services;
- community occupational therapy services which provides advice, equipment and adaptations and rehabilitation; and
- speech and language therapy services which provide feeding and swallowing advice;

Eating well for older people has been given much attention in health related research with an emphasis on measuring nutrition status and improving the nutritional care given to hospitalised and institutionalised older people. However, less attention has been paid to the nutritional and food related support needs of frail older people living in their own home and the role of social care services in supporting older people to eat well. The specific focus of this project is, therefore, the role of social work services, particularly home care services, in helping older people to eat well.

Home care services play a vital role in supporting older people to remain in their own home. Home care was originally set up as a service for mothers and children and only later was extended to meet the needs of the 'elderly and infirm' (Curtice et al 2002). It now provides essential support to disabled and frail older people who require support.

In Scotland, an estimated 548,588 hours of Home Care were provided or purchased by Local Authorities in 2004 for 70,014 people (Scottish Executive 2004a). Of these 70,014 people, 57,789 were aged 65 or over, with the vast majority being older people with physical disability or frailty (see table 1 below). The estimated number of older people receiving intensive home care (more than 10 hours per week) has increased significantly from 9.5 clients per 1,000 of the population aged 65 in 1998 to 16.9 clients per 1,000 of the population aged 65 in 2004. Older people who live alone and have difficulty leaving home are the focus of this study and, therefore, perhaps inevitably the majority fall within the category of requiring intensive home care.

**Table 1: Age, client group and gender of clients aged 65 and over receiving home care services 2004.**

| Client group   | Age group     |               |               |               |
|--|---------------|---------------|---------------|---------------|
|  | 65-74         | 75-84         | 85+           | Total clients |
| People with dementia   | 450           | 1,550         | 974           | 2,974         |
| People with mental health problems                                     | 503           | 716           | 396           | 1,615         |
| People with learning difficulties                                      | 220           | 92            | 30            | 342           |
| People with physical disabilities<br>(includes frailty due to old age) | 9,333         | 23,100        | 18,557        | 50,990        |
| People with HIV or AIDS, alcohol or drug problems                      | 142           | 94            | 25            | 261           |
| Carers of dependent people in groups above                             | 45            | 44            | 19            | 108           |
| Carers not in groups above   | 12            | 6             | 6             | 24            |
| People in other vulnerable groups                                      | 399           | 596           | 480           | 1,475         |
| <b>Male</b>  | 4,064         | 7,089         | 4,280         | 15,433        |
| <b>Female</b>  | 7,040         | 19,109        | 16,207        | 42,356        |
| <b>Total clients</b>   | <b>11,104</b> | <b>26,198</b> | <b>20,487</b> | <b>57,789</b> |

**Source: Scottish Executive, (2004), *Statistics release. Home Care Services Scotland 2004.***

Another change that has taken place in home care services is the shift from providing support with domestic tasks to also providing personal and sometimes intimate care. A significant proportion of the tasks undertaken by Home Care Workers relate to food and eating. A review by the Accounts Commission for Scotland (2001) reports that approximately 15% of the time spent by Home Care services doing domestic tasks is spent cooking and 22% shopping. Five percent of personal care tasks are related to food, namely, assisting people with eating.

The contribution made by family members, neighbours and friends to the care of frail older people in the community is substantial and was formerly recognised in the Carers (Recognition and Services) Act (1995). Their role in relation to helping older people, who live alone in their own home, to eat well has also been relatively neglected in the research literature. Attention is also paid in the study, therefore, to the essential food related support provided by family, friends, neighbours and the wider community.

#### **2.2.4 An holistic approach to food service provision**

The provision and delivery of nutritious meals for older people who live alone is complex and varied, ranging from home care staff buying and preparing meals, to delivery of two weeks' supply of frozen meals for re-heating by microwave or other types of equipment. There is evidence that the systems approaches to bulk meal delivery, while economically

efficient in management terms and scientifically based in nutritional terms, may fail to identify and respond to individual needs and preferences. These approaches may also place limited emphasis on the social aspects of eating and drinking which are important to most of us in helping us to enjoy mealtimes and promoting a sense of well-being. For example, a report by Bromley London Borough Council (2001) reviewing meals service in the borough identified a number of people receiving meal services who throw most of their meal away but continue with the service for the social contact. The review recommended that the Council identify and evaluate alternative options to reduce social isolation and deliver 'non-nutritional service benefits'. This study, therefore, focuses on the wider social and psychological functions of food in the lives of older people as well as the physical benefits.

## **2.3 ASPECTS OF SERVICE QUALITY RELEVANT TO THE STUDY**

### **2.3.1 Measuring quality in home care services**

The expectations of service users in terms of the quality of care provided by home care services are now well established. Henshaw et al (1998) reported the following aspects of service that were particularly important to users:

- Staff reliability
- Continuity of care and staff
- Kindness and understanding shown by care workers
- Competence in undertaking certain tasks
- Flexibility to respond to changing needs and requirements
- Knowledge and experience of the needs and wishes of the user and/or carer
- Information about the services to be provided.

Raynes et al (2001) identified the following dimensions of quality in home care services of importance to older people:

- continuation of their existing array of personal care, domestic help, aids and adaptations to enable them to maintain their independence;
- carers doing tasks that older people identify as necessary, with a clear emphasis on more help with domestic tasks;
- provision of amenities, aids and adaptations;
- continuity of service;
- provision of information about the service;
- reliability and dependability of the service;
- monitoring the quality of the services provided;
- a responsive and sensitive quantity of provision;
- an increase in the quantity of provision;
- training carers;
- improvements in the care planning process.

Raynes and colleagues also emphasised that older people defined home care more broadly than service providers, extending the definition beyond 'care in the home' to support that enables them to get out of the home.

### **2.3.2 National Care Standards for Care at Home**

National Care Standards for Care at Home (Scottish Executive 2004b) have now been developed in order to enable the Scottish Commission for the Regulation of Care to fulfil its legal duty to register and inspect home care services. Standard six relates specifically to

‘eating well’ (see figure 1). As these standards are in the early stages of being implemented, the ways in which they are interpreted and the impact on practice remains to be seen.

#### **Figure 1 - National care standards - care at home**

Eating well - Standard 6

**If shopping for food or preparing meals is part of the service, you know that the food will be handled safely and meals will reflect your choices and special dietary needs (if any).**

1. Your home care worker gets to know your food choices and any ethnic, cultural, faith or other preferences you have. Any special diet (for example, vegetarian, low-fat or high-protein) is recorded in your personal plan.

2. Unless you ask for it to be otherwise, the food that is bought and prepared for you will reflect your known choices and preferences and any special dietary needs.

3. All food handling follows good food hygiene practices. Your meals are well prepared and well presented.

4. You must be able to eat and enjoy your food. If you need any help to do so, for example, adapted cutlery or crockery or a liquidised diet, your home care worker will arrange this for you.

5. You can expect your home care worker to notice anything that affects your ability to eat or drink, such as dental health or loss of appetite. If so, she or he will discuss these with you and help you to get professional help if you want.

Source: Scottish Executive, 2004, National Care Standards. Care at Home. Edinburgh, Scottish Executive.

### **2.3.3 Good practice guides**

There do not appear to be any good practice guides that specifically relate to the provision of nutritional meals by home care workers to frail older people living in their own home. However, there are some guidance documents aimed at other populations of older people that are of interest. These are briefly described below.

The Nursing & Midwifery Practice Development Unit NHSScotland (2002) has produced a document as part of a series of best practice statements, that offers guidance on meeting the nutritional needs of physically frail people within continuing care facilities such as hospitals and residential care homes and covers: assessment and care planning; promoting a nutritious diet; the environment of care; the managerial role of the nurse and education and training of staff.

The Caroline Walker Trust has produced two comprehensive guides, one offering practical guidance on providing food to older people in residential and nursing homes and through community meals such as meals on wheels and frozen meals services (Caroline Walker Trust 2004) and the other advising on supporting older people with dementia living in residential and nursing homes to eat well (Caroline Walker Trust 1998).

Age Concern has also produced a useful guide aimed at providers of residential care, day care and community meals (Copeman 1999). It explores the wider social, psychological and cultural significance of food and offers advice on nutritional assessment, tackling eating problems and supporting people with dementia.

While the purpose of this study is not to evaluate services against the criteria described above, these quality indicators, standards and guidance documents provide a valuable context to the study.

### **3 HOW WE WENT ABOUT THE PROJECT**

In this section of the report, the aims and objectives of the project are described, as well as the approach taken for the research element of the project. The ethical issues that were given consideration are discussed, as well as the procedures that were put in place to ensure the quality of the study. The involvement of older people in the study is outlined. Finally, the terms used to describe workers throughout the report are defined.

#### **3.1 PROJECT AIMS AND OBJECTIVES**

**The primary aim of the project is:**

to identify action that can be taken to improve the physical and social well being of older people who live alone and have difficulty leaving home, in relation to their nutritional and food-related needs, from the perspective of older people, family members and social care staff.

**The objectives of the project are:**

- to establish the nutritional status of older people participating in the project, obtain information about their food and drink intake and identify those at greatest risk of malnutrition;
- to explore the social, emotional, physical and practical factors that support or hinder good nutrition and eating well for older people who live alone and have difficulty leaving their home;
- to seek the views of this group of older people about their expectations of service providers and social care workers delivering services relating to food and nutrition;
- to explore the problems facing organisations when providing services for older people to ensure that food and nutrition are provided using person-centred principles;
- to explore issues facing front-line staff when providing food-related services and their needs for training support and development in this area of their work; and
- to develop and explore possible intervention(s) to optimise the nutrition and food related social well-being of this group of people.

#### **3.2 OUR APPROACH**

The research element of the project adopted a qualitative approach to explore the views and experiences of older people, their family members and friends and social work staff in order to better understand the factors that help or hinder older people's ability to eat well.

In order to recruit participants to the study two local authorities were invited to participate. These are referred to as site A and site B throughout the report. Both sites were in Scotland. They were chosen because of their interest in improving food-related services for older people. Site A was a large industrial town and site B a city. Within each Council access was negotiated through the Director of Social Work or a Senior Manager with responsibility for home care services. Formal applications were made to each authority to get approval for access arrangements and the ethical conduct of the research.

Within each site data was gathered from the following stakeholders:

- older people who live alone and have difficulty leaving home;
- family members and friends of older participants;
- home care workers providing direct support to older people in their own home;
- home care managers with responsibility for the day to day co-ordination and supervision of these home care workers
- community care team members with responsibility for the assessment of older people's needs
- senior managers with overall responsibility for home care and other food related services.

### **3.2.1 Recruitment of older participants and family and friends**

Older people who live alone and have difficulty leaving the house and their family members and friends were recruited to the study via home care managers and community care team members (see access protocol at appendix B).

For the purposes of the study, 'older person' was defined as anyone aged 65 or over. This definition reflected that used by social work services. The main criteria for inclusion of older people in the project sample were:

- the older person lives alone;
- the older person has difficulty leaving home; and
- the older person faces difficulties with food and eating.

People who identify themselves as having terminal illness were excluded from the project because of the particular nutritional issues resulting from their illness. Only one potential participant declined to take part in the study due to family circumstances. However, it became apparent in the course of the study that it was necessary to recruit greater numbers of potential participants than actual older participants because of the circumstances of the population being targeted. For example, in area A in the gap between identification of potential older participants and contacting them, some people had moved to care homes or had become more confused and one had even, sadly, died. In addition, of those who did participate in the study, two were admitted to hospital and were unable to complete the second interview.

All of the older people who participated in the study were in receipt of home care services. Attempts were made to include older people who were not in receipt of services. Unfortunately this proved to be difficult as the reasons for not receiving services included chaotic lifestyles and dissatisfaction with social work services.

A total of twenty older people participated in the study. These participants were aged between 65 and 101. Four of the older participants reported that they never leave the house and a further two of the participants did not leave the house except in exceptional circumstances such as Christmas visits to relatives. Another two participants got out once or twice a month. The remaining twelve participants did leave the house at least on a weekly basis, however, just under half of these twelve were reliant on special transport and the only regular place visited was a day centre or day hospital. Participants who arranged social activities outside the home and outwith services, tended to be less frail older people who relied on support from friends and relatives to go out.

### **3.2.2 Fieldwork undertaken**

Within each local authority, the following fieldwork was undertaken:

- multiple in-depth semi structured interviews with ten older people who live alone and have difficulty leaving home;
- collection of food and eating information from older participants using a food diary;
- a nutritional assessment of older participants;
- semi-structured interviews with family members or friends of older participants where these existed and older people consented to their involvement;
- a focus group with home care workers;
- a focus group with home care managers;
- a focus group with those responsible for the assessment of older people's community care needs;
- a semi structured interview with a senior manager with responsibility for food related services for older people.

Following data collection within each local authority a workshop was organised to feed back the main findings and to generate new data relating to possible solutions to the issues raised by participants.

#### ***Interviews with older participants***

Each older person taking part in the study was interviewed on two occasions within a period of two weeks. The short gap between interview one and two gave participants an opportunity to reflect on some of the issues raised in the first interview and to fill in a food diary for discussion at the second interview. Participants were asked about: their needs in relation to eating well; the informal supports and formal services that are currently available to them; social, emotional, physical and practical factors that support or hinder their eating well; ways that supports and services can be improved. Prior to the first interview, basic information about the person's support needs was sought from their social worker or key worker.

As the study progressed, a number of additional aids to the interview were developed, such as photographs of food and vignettes to stimulate discussion. The vignettes enabled older participants to talk about difficulties in the third person and therefore to make less positive comments about support and practices without having to make complaints about their specific service. The interview guides and other aids can be found at appendix C. The vignettes and photographs were also used to make the interview process accessible to people with cognitive impairments. In addition, participatory observation and guided conversations or unstructured interviews were used as appropriate with people with dementia.

#### ***Diaries***

Each older participant was asked to keep a food diary for three consecutive days in the period between interview one and two. The purpose of the diary was to identify older people at risk of malnutrition and to gain an insight into the types and variety of food eaten by older participants. The information supplied in the diary also allowed questions in interview two, based on real life examples, about routines, likes, dislikes and satisfaction with support.

Where older participants required assistance to fill in the diaries, arrangements were made, with the permission of the older person, for family members or home care workers to provide this. The researcher talked through an example in order to show the older person and helper the information that was required, and as the study progressed it was decided that the

researcher should fill in a page of the diary with the person at the end of the first interview to record the previous day's intake in order to demonstrate what was required.

### ***Taking nutritional measurements***

Some nutritional measurements and information were collected from each older participant, similar to those used for the MUST assessment tool in order to get a snapshot of each older person's nutritional status (see <http://www.bapen.org.uk/pdfs/Must/MUST-Complete.pdf> ).

Firstly, the older person's height and weight were measured. Where it was not possible to take these measurements older people were asked to estimate height and weight. Estimates were often necessary as many of the older people participating had mobility problems, difficulty standing and were frail. Secondly, some questions were also asked to determine whether the person was aware of any indication of unplanned weight loss such as clothes and/or jewelry becoming loose fitting, whether they had experienced reduced appetite or had noticed they were eating less. Because it was difficult to obtain accurate information from older participants, no firm conclusions about participants' nutritional status could be reached. However, the information was used, along with diary data, to establish if any participants were at immediate risk of malnutrition. One such person was identified and she and her social worker were informed. Her social worker was advised to refer her for a specialist assessment.

### ***Interviews with friends or relatives***

A total of seven family members or friends of older participants were interviewed. One older participant requested that we did not interview his daughter as he was concerned that she was already overburdened and another made the same request as her relationship with her daughter was poor. A large majority of the remaining eleven older people either do not receive support from family or did not have any family members or friends in their lives.

Friends or relatives taking part were interviewed on one occasion (see interview guide at appendix C). They were asked about: the support needed by the older person; the support they provide; their views about the services received by the older person and ideas about possible service improvements.

### ***Focus groups with workers***

Three focus groups were held in each area, one with a group of community care team members who undertake assessments, one with a group of home care workers and one with a group of home care managers(see focus group guide at appendix C).

Appropriate managers, assessors and workers were identified with the help of key contacts within the home care service. All people taking part in the study were given verbal information about the purpose of the project, the nature of their involvement and how the findings will be used. Written information was provided for older people and their friends and family members. It was explained to people that they were free to withdraw from the project at any time and that any services they are receiving would not be adversely affected if they declined to take part.

Home care workers were asked about: factors that help or hinder older people's ability to eat well; their role in relation to eating and food and any practical difficulties they experience delivering the service. Home care and social work managers were asked about: the assessment procedures in use; their interface with health and voluntary services; their perception of who is at most risk of under-nutrition; the strengths and limitations of the

current service; the support and training needs of workers and any organisational difficulties they face.

### ***Interview with senior manager with responsibility for home care services***

An interview was also conducted with a senior manager with responsibility for home care services in each area. The manager was asked about the range of food related services available to older people; aspects of services that are working well; any gaps identified or improvements required and organisational barriers to change.

### **3.2.3 Analysis of findings**

The collection of qualitative data in the form of interview and focus group records, diaries, observation notes, formal and informal discussions with staff, family members or friends and older people and the analyses of those data were done in tandem.

The method of analysis used was constant comparative analysis (Strauss & Corbin 1998) in which sections of data (whether they be interview, documentary or observation) are compared to identify salient categories and themes and to clarify characteristics. As data were collected they were analysed to identify key themes. These themes, although guided by the main questions being explored in the evaluation, derived from participants' experience expressed during interviews and focus groups.

These key themes then became the main focus of subsequent data collection and analysis and, through this process they gradually crystallised. A major advantage of analysing data as they are collected is that it benefits subsequent data collection.

## **3.3 ETHICAL ISSUES**

Below are outlined the main ethical issues that have been given attention within the study.

### **3.3.1 Informed consent**

All people taking part in the study were given verbal and written information about the purpose of the project, the nature of their involvement and how the findings would be used. It was explained to people that they were free to withdraw from the project at any time and that any services they are receiving would be adversely affected if they decline to take part.

Staff member participants were recruited via key contacts within the home care service (see access protocol in appendix B). Potential older participants and family members were approached initially by a professional whom they know and trust, and were given written and verbal information about the project. The older person was approached first and their verbal consent to the participation of their family member was sought. If they were not happy to consent to the participation of their family member, they were still able to participate in the study. Older people and family members were only contacted by the researcher if they expressed an interest in taking part. They were given the researcher's name and telephone contact if they required further information. The researcher met the older person and, if appropriate, the family member, to go through the information again, giving people an opportunity to ask questions.

Written consent was sought from older participants and family members (see appendix B). The consent form contained information about the project together with a photograph of the researcher who would be visiting them. A copy of the signed form was kept by the researcher and the participant. Ongoing consent was checked out as the project progresses – this was

considered particularly important if the older person was showing early signs of dementia or memory loss. The protocols used with people with dementia are described in more detail below.

Older participants were asked if they would consent to some nutritional screening measurements. This involved measuring the person's weight and height and answering some questions about appetite and weight loss. Participants were given a choice to decline to take part in this part of the study if they wished, whilst still being able to be part of the interviewing process. None did. These areas were differentiated on the consent form for the older people.

### **3.3.2 Inclusion of people with dementia**

The ethical framework used for collecting data from people with cognitive impairments derives from the work of Jan Dewing (Dewing 2002). Central to this approach is the concept of personhood, and the principles of direct interest, equality, and social justice. A core value for the research team was the ethical principle of personhood, which acknowledges changes to cognition and demands that consent is sought from the person directly and not through the mechanisms of proxy consent (see appendix D for more information).

This approach offers an alternative method for gaining consent for use with people with a cognitive impairment. Unlike traditional competency-based consent, which places an emphasis on the person's intellectual capacity, this is a process of continual verbal consent with an emphasis on the person's well being/ill being, and requires the process to be repeated at each point of contact with the participant. The researcher is required to gather information from key informants regarding the prospective participant's usual communication, both verbal and non verbal, which might convey consent or non-consent. A conversation is then held with the prospective participant to convey the aim of the research and what their involvement with the study will entail, if they agree to participate. This information is conveyed through the use of uncomplicated language, whilst monitoring the verbal and non-verbal cues of well-being or distress. If agreement to participate is granted, this process is repeated for each return visit the researcher makes to the participant. A detailed record of the process is kept by the researcher regarding the inclusionary consent process and the behavioural and verbal indicators that indicate consent or non consent.

Examples from the participants of agreement to consent:

*'You're welcome anytime; I don't mind speaking to you'*

*'I don't mind, I used to be a professional cook'*

*'Yes that will be alright, when will you come back?'*

### **3.3.3 Confidentiality and anonymity**

A coding system was used in order to anonymise audio tapes and any written information relating to clients, staff or sites. Although the characteristics of service users, staff and premises are described in general terms in order to contextualise findings, names do not appear at any time in dissemination materials. Instead, pseudonyms are used. Anonymity becomes more difficult to assure when the sample size is small. If there were any doubts about anonymity being maintained, reports of findings would have been shown to the individuals concerned to check for accuracy and to gain their permission to publish the material. This did not arise.

### **3.3.4 Personal safety of the older person and family member**

Interviews were typically conducted in the older person's home as the people taking part have difficulty leaving home. However, some participants with dementia or memory loss were interviewed in the day centre that they attend in order to provide them with a safe and familiar context to give their views about food and eating and the support they receive. Where this was the case, a private room was used for interviews. Family members were given the choice about where their interview took place. All chose to either be interviewed in their own or the older person's home. Both older people and carers were given a written record of the researcher's name and contact details and a business card. Older people were also provided with a photograph of the researcher. The researcher did not visit the person's home at any times other than those booked for interviews.

### **3.3.5 Responsibilities of the project team to the participants**

It was important to avoid raising expectations about the likely outcome of the project. It was, therefore, explained carefully to participants that it is hoped that the project will influence policy and practice, but no guarantees could be given that this will happen generally or specifically in relation to their services. It was also explained to the older people that they could not be given individualised advice about their diet and nutrition. That said, in the course of the project, it became apparent that some older people had unmet needs. The research team ensured that they had information about local services and supports so that they could pass this information on to the older person and their carers. On one occasion a service was contacted on the person's behalf to inform it that the person needed to see a dentist and on another occasion it was alerted that a participant was expressing suicidal thoughts.

Nutritional status information was analysed by a project adviser with expertise in nutrition and diet, who was able to make a judgement about whether any particular action needs to be taken, such as advising the person to seek advice from their GP or NHS dietician. This happened on one occasion.

## **3.4 MAINTAINING QUALITY THROUGHOUT THE PROJECT**

The quality of the project was maintained in the following ways:

Firstly, a range of methods enabled us to triangulate data, thus enhancing the validity of analyses.

Secondly, as questions and issues arose from the study these were raised with participants so that the research team could clarify and validate their analyses as they went along.

Thirdly, by providing feedback of emergent findings to a range of service providers and older people we were able to get a sense of the accuracy of the findings.

Fourthly, by involving several experienced researchers from a range of backgrounds and a team of older people themselves in various stages of the research the process we were able to widen our understanding of emergent issues.

Finally, an external steering group provided an opportunity to discuss issues arising from the study.

### **3.5 INVOLVEMENT OF OLDER PEOPLE IN THE PROJECT**

Crucial to the design of the project is the involvement of older people. Originally, the intention of the project was to involve one or two older people in the advisory group. The project approached four people who had attended the 'Education for Participation' course organised by the Royal Bank of Scotland Centre for the Older Person's Agenda and had expressed an interest in working on projects relating to food and nutrition. All of the people were willing to become part of the Recipe for Life advisory group and a decision was made that funds would be found to make this possible.

Individual learning plans were completed with each lay member in order to identify the wide range of skills and experiences that they brought to the project and to agree their support and training needs (see appendix E). Training was undertaken to enable the older steering group members to take on a wider role within the project as co-interviewers. They also assisted with feedback and discussion sessions with sites. Older steering group members were paid for the contribution that they made to the project.

### **3.6 TERMS WE USE**

Throughout the report reference is made to a number of different personnel responsible for organising or delivering services to older people who live in their own homes. The terms used to distinguish these personnel are described below.

'Home care worker' has been adopted as a generic term to include all workers employed in home care or domiciliary care services providing direct support with domestic and care tasks to older people in their own home. The term includes personnel such as home helps, domestic home helps, traditional home helps and extended personal carers. The term also includes senior home helps who provide direct support to clients and also have a role in the day-to-day supervision of home care workers.

'Shopping assistant' is the term used to describe home care staff members with specific responsibility for collecting a shopping list from a client, purchasing the items in a shop and returning them to the client's home.

The term 'home care manager' is used to include those responsible for organising and managing home care workers, senior home helps, and shopping assistants as well as Emergency or On-call Managers.

The 'senior manager of home care services' is the overall manager of home care and some additional food related services such as the shopping service, frozen meals or Meals on Wheels service and Lunch Clubs either across the whole authority or within the area of the Council participating in the study.

The term 'assessor' is used to include any member of the Community Care Team who is responsible for undertaking needs assessments of older people referred to the Social Work Office. This includes a Community Care Team Manager, Community Care Manager, Occupational Therapists, Social Care Officers, and Social Workers.

## **4 WHAT WE FOUND**

In this chapter of the report we describe and discuss some of the key issues that emerged from interviews, focus groups and workshops with participants. The section begins by outlining the main food related services that were in place in the two areas taking part in the study. The main difficulties with eating well that frail older people who live alone and have difficulty living alone are then outlined. Issues related to assessment of frail older people's needs in relation to eating well are then described and the definitions of 'eating well' used by various stakeholder groups are explored. The factors that are believed to affect frail older people's appetite or motivation to eat are then discussed. The following two sections look at the ways that social work services and communities currently help or hinder frail older people's ability to eat well. Finally the chapter ends with some suggestions made by participants about things that could be put in place to improve the support available to older people to eat well.

### **4.1 THE RANGE OF FOOD RELATED SERVICES AVAILABLE**

There were a range of food related services provided for older people by Social Work Departments in the two participating local authority areas. In both areas there was a home care service, a shopping service, lunch clubs and day services. There was a meals-on-wheels service in site A and not site B but unlike site A, site B had a frozen meals service. There were also concessionary travel or special transport schemes, such as taxi-cards and Dial a Ride, available for frail and disabled people. These could potentially help some people with travel to and from shops and restaurants.

#### **4.1.1 Home care services**

The home care services provide support to people living in their own homes with domestic tasks such as cleaning and cooking, and personal tasks such as eating, washing and dressing. They provide a range of food-related services including preparing cooking and reheating food, ensuring food is safely stored, preparing special diets or liquidised food and supporting people with eating. Some home care workers buy fresh food items for clients and some also do a weekly shop.

#### **4.1.2 Shopping service**

The two sites also have a shopping service. The service involves shopping assistants visiting a number of older people in their own home, collecting each person's shopping list and money and going to a supermarket to purchase the goods requested. At the supermarket, the shopping assistants buy items for several clients and then return these to the client. Where necessary, the shopping assistants put shopping away in the person's fridge, freezer or cupboards. They return any change and shopping receipts. Clients have to choose one supermarket and always get their shopping from this shop on the same day each week. The reasons given for providing a shopping service included freeing up home care workers to spend more time doing personal care tasks, reducing costs, ensuring the health and safety of Home Helps by avoiding them carrying heavy shopping bags over long distances and ensuring the personal safety of Home Helps by avoiding individuals carrying large sums of money. Where appropriate, a charge is made for the service of £5 per week in both sites. The shopping service replaced the service whereby the older person's home help does weekly or daily shopping.

#### **4.1.3 Meals on Wheels**

The Meals on Wheels service in site A provides a hot meal at lunchtime to people in their own homes. The meals are produced by local school kitchens and delivered in vans. They are

provided five days per week in one part of the Council and less in other areas. They are not provided at weekends, Christmas or New Year. People can order either a soup and a main course or a main course and a dessert. These meals are designed to be nutritionally balanced. Clients order meals two weeks in advance. The cost of these is £1.30 per meal and they are subsidised by the Council. This service is not available in site B

#### **4.1.4 Frozen meals services**

A frozen meals service is provided in site B by a private company. They deliver a supply of meals chosen by the client on a two weekly basis. The service assesses the client's suitability for frozen meals and where necessary can supply a freezer and heating device for the meals.

#### **4.1.5 Lunch clubs**

There were a number of lunch clubs for older and disabled people in both sites. These provide people with a two-course lunch and the opportunity to socialise with others.

#### **4.1.6 Day services**

Some older participants attended day services. These services typically provide a two or three-course meal at lunchtime for those attending.

#### **4.1.7 Private providers**

There were a number of private companies providing support to older people with food and eating. These services can be purchased directly by the service user or can be arranged by Community Care services if a Social Work Department's services are oversubscribed.

#### **4.1.8 The ongoing development of services**

In both areas there were a number of changes taking place in the organisation of services and the services provided were under review. Therefore, the descriptions of services provide only a snapshot of what was available at the time of data collection. Managers highlighted a number of areas undergoing review, and reform included the introduction of new shift systems, new pay structures and job descriptions for home care workers and managers, extension of weekday services into seven days per week services and changing the criteria for access to services so that greater levels of support are offered to those with higher support needs. Recruitment and retention of staff was highlighted as a major challenge for home care services.

## **4.2 DIFFICULTIES EXPERIENCED BY FRAIL OLDER PEOPLE**

Assessors and home care managers explained that older people can have a range of impairments which make food and eating a problem for them. These can include: sensory impairment such as visual or hearing loss; physical impairment such as mobility difficulties; standing problems; and cognitive impairment such as sequencing problems, for example following a stroke; or memory loss.

These difficulties can affect an older person's functional abilities in relation to food in a number of ways including making it difficult to:

- make a shopping list,
- get to the shops,
- negotiate supermarket aisles and collect goods in a basket,
- carry foods home from the shops,
- move around the kitchen,
- operate a cooker or electrical appliances such as kettles, microwaves,

- carry food from room to room,
- lift and pour hot liquids,
- stand at the cooker,
- bend and reach into cupboards,
- peel, chop and prepare food,
- remember to eat, and at appropriate times of the day,
- plan meals and organise menus.

Older people may also experience health-related problems that can severely affect their quality of life such as: badly fitting dentures; medical problems such as hernia; mental health problems such as depression or anxiety, general frailty and the effects of polypharmacy.

In addition, professionals reported a number of other psychological and social issues that can affect older people's ability to eat well. In order to better describe the range of difficulties experienced by frail older people, a pen picture of one older participant is included below (figure 2).

Figure 2 - Pen picture of Mrs Morris (pseudonym)

Mrs Morris is aged 81. Since her husband's death three years ago, she has lived alone in a second floor flat in a Victorian tenement building in a large Scottish city. She and her husband lived there together for most of their 55 years of married life.

Mrs Morris was discharged from hospital two years ago having sustained multiple fractures following a fall. She is still very nervous about walking and uses a walking frame to move around her house. She cannot stand for long periods and so cannot use her cooker or prepare foods at her worktop. She cannot safely reach down into her fridge or up into her kitchen cupboards and relies on others to tell her what foods are available for meals and when use-by-dates have expired. She very rarely goes into her kitchen.

Mrs Morris's son and grandchildren live in England. She speaks on the telephone to her son at least once a week and he visits once or twice a year. She is visited once every two weeks by a longstanding friend. Both her friend and her son are finding it increasingly difficult to visit as they too have poor health.

Mrs Morris gets support from the local social work department's home care service three times a day, seven days per week. A home help visits between 9 and 10 o'clock each morning to help her with dressing and breakfast. They also make her a sandwich to eat at lunchtime. They visit again at 4.30 p.m. for an hour to provide an evening meal and do some housework. They then call at 9 p.m. for half an hour to help her with medication and getting into bed. She also uses the local shopping service provided by the social work department. As she has arthritis in her hands, her home help writes out a list for her and it is collected each Tuesday morning by the Shopping Service. They deliver her shopping that afternoon.

Mrs Morris' health is poor and she takes several tablets every day. She has been finding that her dentures are not fitting well and has been using a nail file to try to adjust them herself. She does not want to bother her home help by asking her for help with this.

Mrs Morris used to be very active in her community, volunteering for her local church. However, now she cannot leave her flat unless she is carried down the stairs. She last left her flat when attending a local day hospital two years ago. Mrs Morris spends most of her day watching television. She used to read and do needlework but now finds that poor eyesight makes this difficult. Mrs Morris is always sitting in her armchair in the living room when the home help arrives. Mrs Morris explained that she often feels low and that she still misses her husband every day.

Mrs Morris always did the cooking for her family, providing them with a hot meal every day. She was particularly known for her homemade stews and soups. She now mainly eats reheated pre-prepared foods as these are easy and quick for the home help to prepare.

Many of the features of Mrs Morris's situation were common to other older participants in the study. The majority of the older people who took part in the pilot study had multiple health problems or impairments and faced social and psychological barriers to eating well. Many reported having a poor or reduced appetite and some were concerned that their diet was monotonous. Many had become disengaged or distanced from food and food production either because of physical barriers such as lack of access to a supermarket or the kitchen or psychological barriers such as low mood or motivation. Older participants were socially isolated, some relying on visits from service personnel for their only social contact and many lacked any daily activity even within the home, spending large periods of time watching television. Finally, it was common for people to have experienced multiple losses such as the death of a spouse, other family members or friends; the loss of role within the family as the provider of food and nourishment and the loss of a previous lifestyle outside the home. The effect of these on appetite is discussed in more depth in section 4.5.

Workers also described the particular difficulties faced by people with dementia. One worker described the situation of one woman with dementia who was buying tuna sandwiches every day at a local baker. She would not eat them, then would forget she had bought them and buy more. They did not have sell-by dates printed on them and so it was not clear which were safe to eat and which were not. Professionals also reported instances of people with dementia eating food that was not defrosted properly or reheating Meals on Wheels and this can also present a risk.

#### **4.2.1 Conclusions**

It is evident that very frail older people with significant impairments and health problems are being supported to remain at home. This group of older people appear to experience multiple difficulties that can impact on their day-to-day ability to eat well. These include difficulties such as sensory, physical and cognitive impairment, long term medical conditions and polypharmacy, as well as psychological and social barriers to eating well. These individuals may have previously been expected to enter residential care, and provide a challenge to home care services which are continuing to shift from a domestic support model to a personal care role. Because of the increasing complexity of the needs of frail older people, it is likely that an increasingly complex assessment process and range of solutions will be needed to identify and meet their needs. Issues relating to the assessment of older people's needs in relation to food are discussed below.

#### **Key points**

- very frail older people with significant impairments and health problems are being supported to remain at home
- very frail older people may have psychological and social barriers to eating well
- because of the increasing complexity of the needs of frail older people, it is likely that an increasingly complex assessment process and range of solutions will be needed to identify and meet their needs

### **4.3 ASSESSING OLDER PEOPLE'S FOOD RELATED NEEDS**

All staff members who took part in the study felt that they had a role to play in identifying any problems that older people experience with eating or having a healthy diet. This may be done at the stage of initial assessment and as part of the ongoing monitoring process. In area A, at the time of data collection, the standard form in use for assessment purposes did not have a detailed set of questions relating to food and nutrition. The workers identified this as a gap.

The assessors and home care managers in this area gave examples of some of the food-related questions they explore during assessment such as:

- what does the person eat?;
- do they have snacks or meals?;
- are there are certain foods they will or will not eat or drink?;
- when do they have their main meal of the day?;
- do they use the microwave or cooker?;
- if a person will not eat, is this a long standing issue or a new one?;
- does the person have any memory problems?; and
- are there any safety considerations?

It was reported that there used to be a structured guide for the assessment of people moving into residential care produced by the National Institute of Social Work but this was withdrawn. This form was also general rather than being specifically related to food and nutrition. Assessors in this area saw value in developing a similar checklist in relation to food and diet.

In area B, there were specific food related questions on the form used for the single shared assessment. However, assessors explained that they tend to use the headings as a guide rather than follow the form rigidly as to do so could be very time consuming. One assessor explained “*you fit your own assessment into the tool, rather than the other way round.*” (assessor area A). Assessors saw value in using diaries and observation as a routine part of assessment but said that they and other workers were often too busy to undertake such assessments.

Assessors explained that the answers to the questions they ask about food and eating “*can give clues to problems*” (assessor area A). For example, people may be eating soft foods because they are having problems with dentures. They said that it is important to check out whether someone's eating patterns have changed due to infirmity or personal choice. For example, some older people may say that they eat toast for a meal but this is because they cannot manage to make mince and other favourite foods any more rather than it being a preference. Assessors have also found that some older people do not drink after eight in the evening as they do not want to have to get up in the night to use the toilet.

#### **4.3.1 The sensitivities of assessment and monitoring**

Both home care managers and assessors explained that getting the relevant information about food and eating difficulties can be a sensitive task. They reported that *“people are proud and like to feel they can manage”* (assessor area A) making it difficult to admit difficulties. In their experience, older people often present themselves very well when visited by a worker making it difficult to determine the extent of their needs. It was said *“in this job you have to be a bit like Sherlock Holmes as well”* (Home Care Manger area B). It was felt that the majority of older people do not want workers coming in and doing things for them and that older people frequently say to workers *“I never thought I would come to this, hen”* (Home Care Manger area B). It was also said that reluctance to accept help or, as older people see it, intrusions into their home, lead them and family members to choose less intrusive service options. For example, some may tolerate having a meal delivered to the house more than someone coming in to cook.

Workers reported particular problems faced when assessing the needs of people with dementia. The main problem described by assessors is the lack of insight of people with dementia to the fact that there is a problem, making it very difficult to negotiate support. Assessors explained that the person may tell them that they have just made themselves a meal but there is no evidence of cooking in the kitchen.

#### **4.3.2 Knowledge required to assess and monitor ability to eat well**

In order to effectively assess and monitor the needs of older people in relation to food, it was felt that workers need to have some basic knowledge of food and nutrition issues experienced by older people.

Knowledge of food and nutrition issues among all workers appeared to be patchy. Some were able to identify areas that they would give consideration to when identifying those at risk of malnutrition. However, this knowledge was not consistent across all staff and many workers admitted to feeling uncertain about identifying those at risk. It appears that knowledge often relies on information gained through the media or from personal or work experience that is shared between colleagues. For example, one assessor explained that she gained knowledge when her aunt lost her sense of smell, and as a result her appetite, when she was ill and had to be tube fed. While gaining knowledge in these ways can be beneficial, there were also examples of healthy eating messages aimed at the general population, such as a low fat diet, being inappropriately applied to frail older people.

Home care managers said:

*“we’ve all got mothers and things like that, you know. I think we’re all in touch with older people outwith our jobs.”* (Home Care Manger area B)

*“There are no hard and fast rules. Just common knowledge, and what you think would be good”* (Home Care Manger area B)

*“There is so much on TV, and in newspapers and magazines etc., and we’re all a lot more aware about diet, and I think that’s where most of the workers get their information - from media sources.”* (Home Care Manger area B)

While formal training courses are being developed for home care workers, there are currently no established courses related specifically to food, nutrition, healthy eating and identifying

risk of malnutrition for home care workers, organisers or assessors. In area A it was pointed out that there is a section in the home care workers' induction handbook regarding dietary information, but only new staff get this, at induction.

The majority of workers felt they would benefit from having more knowledge and skills about food and dietary issues as they feel this is a highly specialised area and they are not necessarily knowledgeable enough to deal with it. They are aware that not eating and drinking can have serious consequences such as dehydration and hospital admission and described this as a weighty responsibility as “*if you don't eat you die*” (Assessor area A). One participant said that he finished his Social Work degree two years ago and at that point nothing was covered about nutrition. He explained that it may be covered on some practice placements during training but is not deliberately built into fieldwork experience. Assessors said that food can be a big part of assessments and they felt there might be a need to cover more on this subject on their professional courses. There was also some concern that, without specific training, their advice may be seen as less authoritative than, for example, a doctor's advice, and therefore will be ignored.

#### **Some of the areas about which workers would like to know more.**

What is a reasonable diet for someone who is inactive?

Is full fat milk better for older people than semi-skimmed?

Are the TV messages that are seen by older people applicable to them (e.g. low fat diet) and, if not, what information do they need?

What effect can medication have on diet?

How long can someone go without food before they are in danger?

What is the maximum gap that people should be expected to wait between their last meal at night and their breakfast the next morning?

#### **4.3.3 Referring on to specialist services**

All staff members acknowledged that there are certain circumstances in which they have to refer an older person on for more specialist services. Both home care managers and home care workers said that they inform the family or GP if they are concerned about a client's wellbeing. People may then be referred on for further assessment.

Within the community care teams, the role of the team varies in relation to referrals to other services. If older people can do this themselves, they are encouraged to do so. If they cannot or they live alone, the worker may do it. If the person has weight loss but they are still eating, the worker will usually speak to their family and/or the home care worker and see if it is appropriate to refer the person on to their General Practitioner. They may also arrange some visits around meal times to see if any problems can be observed.

If a person is not eating because they are lonely or depressed the community care team can refer them directly to a Community Psychiatric Nurse or psychological services. Workers

have also referred people to Cruise if they need bereavement counselling. However, it was also said that “*sometimes day care is just enough to lift people*” (Assessors area A) and that a specialist referral is not always necessary.

A significant problem described by assessors in area A was the perceived difficulty associated with referring older people to Dietetic services, particularly community dieticians. Some assessors were unsure whether they can refer on directly to dieticians. It was assessors’ experience that it is easier to refer a younger disabled person or a person with learning difficulties to a dietician than an older people. There were also issues raised relating to discharge from hospital to community dietetic services, inadequate communication between health and social work agencies in some instances and the relative newness of single shared assessment.

#### **4.3.4 Conclusions**

It became apparent when talking to assessors and home care managers that the assessment of older people’s needs generally, and in relation to food and eating more specifically, is a highly complex task requiring consideration of a wide range of factors and considerable skill on the part of the person carrying out the assessment.

In both areas, there did not appear to be a satisfactory assessment tool which could provide some structure to any investigation of food and nutrition related problems to ensure that issues are assessed thoroughly and at the same time ensure that the process is not overburdensome. Three main purposes of assessment emerged. These were:

- to ensure that a good match is made between services put in place and the needs of the individual;
- to identify those who are not eating well and may be at risk of malnutrition who require their situation to be monitored; and
- to decide whether a person should be referred on to specialist services such as a community dietician.

It is possible that different assessment tools will be needed for these different purposes.

As stated in the previous section, the factors requiring consideration during the assessment process include physical, psychological, social and cultural issues. It is important that workers have specific knowledge of the nutritional needs of frail older people, as well as skills in eliciting the preferences of older people and the social, psychological and cultural meaning of food in older people’s lives. It was felt that all staff members could benefit from having more knowledge and skills in the area of food and nutrition. There is a need for specialist courses for all workers to enable them to identify risk factors and helpful interventions for older people who have problems with food and nutrition. There is also a need for an established induction programme and training course for home care workers to address these issues. This will become even more important as the level of frailty and impairment of older people living in the community, and therefore the level of specialist knowledge needed, increases. There may be scope to develop opportunities for older people to contribute to some food-related training. There would also be value in providing information to ‘well’ older people and family members about the nutritional needs of frail older people so that they are empowered to take responsibility for their own health before the need for intervention arises.

There is a danger that, if all of these factors are not taken into account, those at risk will go undetected, unsuitable services will be provided and appropriate referrals to specialist

services will not be made. There is also clearly a need for close co-operation between health and social work colleagues about the food and nutrition of older people. The Joint Futures Agenda (Scottish Executive 2000) may provide opportunities to improve co-operation between health and social work services on this specific issue. The initiative aims to promote better joint working between local authorities, NHSScotland and other organisations through new arrangements for local joint management and resourcing of relevant health, social work and housing services and for ‘single shared assessments’ of individual needs. (<http://www.scotland.gov.uk/Topics/Health/care/17673/9471>). More joint work specifically on food and nutrition issues at a local level would be welcomed by home care services.

#### **Key points**

- assessment of older people’s needs generally, and in relation to food and eating more specifically, is a highly complex task requiring consideration of a wide range of factors and considerable skill on the part of the person carrying out the assessment
- there did not appear to be a satisfactory assessment tool in either area which could provide some structure to any investigation of food and nutrition related problems
- it is important that workers have specific knowledge of the nutritional needs of frail older people, as well as skills in eliciting the preferences of older people and the social, psychological and cultural meaning of food in older people’s lives
- all staff members could benefit from having more knowledge and skills in the area of food and nutrition
- there may be scope to develop opportunities for older people to contribute to some food-related training
- there would also be value in providing information to ‘well’ older people and family members about the nutritional needs of frail older people so that they are empowered to take responsibility for their own health before the need for intervention arises
- there is a need for close co-operation between health and social work colleagues about the food and nutrition of older people, and more joint work specifically on food and nutrition issues at a local level would be welcomed by home care services

#### **4.4 THE MEANING OF ‘EATING WELL’**

A range of criteria were used by workers, family members and older people about what constitutes a ‘proper meal’, ‘good diet’ or ‘eating well’. Sometimes the criteria were about the size of the meal, the content of the meal, whether the meal was hot or cold or the variety of the food available. It was felt important that older people have a ‘proper meal’ or as assessors put it “*a full meal*” (Assessors area A) once day. This was defined as a hot meal, a cooked meal or a meal of meat, potatoes and vegetables.

Older people were concerned to eat fresh foods, particularly fruit and vegetables, in order to eat well. However, a number of other elements emerged that were important including:

- freshly prepared home cooked food
- access to favourite foods including traditional dishes such as stews and porridge
- routine or predictability
- variety, choice and spontaneity
- good presentation and small portions.

These definitions of a 'proper meal' are consistent with earlier work undertaken with older women (Howarth 1993).

#### **4.3.5 Access to fresh foods**

The most widely discussed aspect of 'eating well' across all groups of participants was the availability of freshly prepared and cooked food. It was considered particularly important that people get fresh food, for example, boiled potatoes rather than Smash, or similar dried foods, and freshly prepared food rather than ready prepared meals. It was evident that older people valued having freshly prepared and cooked food.

*"I don't like ready meals. They're not the same as your own"* (A4)

*"there's not a lot of goodness in tinned soup...it's just hot"* (A3).

*"take the modern packets, ah mean, I cooked them right from ma fingers... it tasted real. But out o' they packets it's no my way of working"* (A8)

The concern was expressed by some home care managers that the service cannot always provide fresh fruit and vegetables every day and instead people receive microwavable meals. One home care worker said *"We used to prepare and make food, mince, stews etc., but now don't have time to make real food."* (Home care worker area B) and another suggested that the service should aspire to providing *"food that doesn't go 'ping'!"* (Home care worker area B). Home care workers reported that a high number of clients regularly eat 'Cuppa soup' because it is easy to prepare. Also it was reported that a weekly shopping service does not necessarily ensure that fresh produce is available as some fruit and vegetables become inedible in less than a week. Assessors shared the manager's concern about the over-reliance on frozen or pre-prepared foods as opposed to fresh foods. It was the expectation of some managers that family members would provide fresh items in-between weekly deliveries by the shopping service. Where clients did not have family members this was more problematic.

However, some more positive aspects of frozen or pre-prepared foods were also noted. Some older people and families felt that convenience foods allowed people to maintain some independence with food. Some workers also reported that introducing older people to ready meals had led them to try foods that they would not have previously eaten, such as curries, and they had enjoyed them. There was a discussion about the vitamin content of frozen, fresh or canned vegetables and again some uncertainty about the 'rights and wrongs' of these alternatives. Several managers said that while it is possible to provide healthy freshly prepared food to older people, this relies on home care workers being well organised and thinking ahead and *"some are better at this than others"* (Home care manager area A).

#### **4.3.6 Access to favourite foods and traditional meals**

Older people's favourite foods included homemade soups and broths, meat pies, and roast dinners. Apple pie and custard was a favourite of many. In site A, a number of surveys of Meals on Wheels users have been undertaken and recently 425 service users were asked about the kind of food they would like. It showed that traditional meals such as fish and chips and mince were favoured. There is an issue, however, about the service's ability to cook such meals from scratch in the short time allocated for each visit.

#### **4.3.7 Routine and predictability**

For some older participants, having a familiar routine with foods was important such as having a special meal on Sunday.

*“I make myself a wee roasty dinner on a Sunday which is different to during the week [when] it’s just corned beef hash” (A3).*

These routines were often long established .

*“Roast on a Sunday, washing day on Monday so stovies made with roast beef and gravy...” (A9)*

*“I wouldn’t have a cooked meal at that time. I’m used to that as well. I used to go to the canteen [at work]”(A6)*

Having family meals at the weekend or wine with meals at the weekend was also important to some.

*“Used to be like that, a crowd of them all in every Sunday”(A7)*

Some routines had been lost when a spouse died or an older person became more frail. This was a source of sadness and regret for older participants.

*“Saturdays especially, used to have our wine on the table.... I miss him that way tae. Oh dear aye it’s a sair fecht eh?” (A7)*

#### **4.3.8 Facilitating variety, choice and spontaneity**

When discussing the importance of variety, choice and spontaneity, participants highlighted to role of snacks in a good diet. The family of one participant with dementia ensured that she had a range of snacks available that she can get independently throughout the day such as Cuppa soup, low fat desserts, small apple pies, scones, pancakes, fruit loaf and breakfast cereals. It was pointed out that it is important that these snacks provide additional opportunities to eat rather than replacing meals. For example, one older participant ate frequent snacks such as sweets but as a result did not feel hungry when a nutritious meal was presented to her.

Concerns were expressed by participants that many older people have very bland and repetitive diets and this view was confirmed in the diary information collected. This appeared to be due to a range of factors including a lack of meal ideas, changing tastes and intolerance for previously eaten and familiar foods.

#### **4.3.9 The role of home care workers in helping older people to eat well**

Home care workers saw it as part of their role to help older people to eat well saying *“we try to get things that are better to eat ...better things in the diet”* (Home care worker area A). However, many workers were unsure what is an older person’s minimal or optimal requirements in terms of the nutrient content and variety of foods. Some workers were also unsure how to or whether to intervene when older people made nutritionally poor choices. One said:

*“They’re eating too much chocolate, crisps and sweeties, I personally believe. Not all of them, obviously, but a lot of my clients they eat sweeties etc., then you make a meal and they don’t want it, they won’t eat it, so you throw it in the bucket....Because they’ve filled up on crisps etc. .... It’s hard, but it’s their choice.”* (Home care worker area B)

#### 4.3.10 Conclusions

Emphasis was placed on older people having a ‘proper meal’ once a day. This was defined as a hot meal, a cooked meal or a meal of meat, potatoes and vegetables. These definitions of a ‘proper meal’ are consistent with earlier work undertaken with older women (Howarth 1993).

There was agreement that freshly prepared food is preferable to ready prepared meals. The latter can have a positive role to play in helping someone maintain some independence and introducing people to new meal ideas other than their generally favoured traditional meals. However, many participants would like there to be less reliance on these in older people’s diets. Many older people were eating bland and unexciting diets. This may be because of a lack of motivation on the part of the older person, a lack of imagination on their part or that of the service provider or may be because changes in older people’s tastes and digestion have led them reduce the range of foods that they are willing to eat and find acceptable.

It appears that there would be value in providing:

- guidance for both older people and workers about what constitutes an adequate meal or a good diet for a frail older person to support older people to make good nutrition choices;
- meal ideas which suit an older person’s needs and tastes; and
- signposts to better identify when a client’s diet may be putting them at risk of malnutrition.

Older people and workers could valuably work together to develop ways that older people can be better supported to eat well that are acceptable to older people and achievable within service limitations.

There may also be a role for older people to teach younger home care workers about traditional meals and perhaps to develop recipe cards for quick and easy hot meals made from fresh ingredients or traditional foods such as porridge.

#### **Key points**

- emphasis was placed on older people having a ‘proper meal’ once a day: a hot meal, a cooked meal or a meal of meat, potatoes and vegetables
- freshly prepared food is preferable to ready prepared meals, however, the latter can have a positive role to play in helping someone maintain some independence and introducing people to new meal ideas other than their generally favoured traditional meals
- many older people were eating bland and unexciting diets, perhaps because of a lack of motivation on the part of the older person, a lack of imagination on their part or that of the service provider or may be because changes in older people’s tastes and digestion have led them reduce the range of foods that they are willing to eat and find acceptable
- older people and workers could valuably work together to develop ways that older people can be better supported to eat well that are acceptable to older people and achievable within service limitations

## 4.4 FACTORS AFFECTING APPETITE OR MOTIVATION TO EAT

### 4.4.1 The problem of low appetite or lack of motivation to eat

One of the major difficulties faced by older people in relation to eating well which has been highlighted by the study is the presence of low appetite, lack of interest in food or lack of motivation to eat. One older participant said:

*“[My Home Help] keeps on saying ‘what can I make for you, anything you fancy’. I say oh I dinnae fancy anything. She says ‘I’ll leave it for two or three minutes, I’ll go and do something else and think about what you’d like to eat’. I cannae. It’s not her fault, it’s mine.”* (B1)

Older people were often not able to identify particular causes of loss of appetite, unless specific conditions such as Irritable Bowel Syndrome were present. However, it was their experience that factors contributing to a poor appetite included needing fewer calories as they have got older, illness, hospital admission, constipation, lack of contact with raw ingredients or food items through shopping and cooking and poor quality foods available from retailers. People with dementia had the additional problem that they did not necessarily remember to eat at appropriate times, if at all. Things believed by participants to increase appetite were improved health and well being, medication, eating with friends and loved ones, doing activities such as shopping with friends and combining this with eating, walking, having nice meals cooked for you and being exposed to appealing food smells such as passing the fish and chip shop. Some of the major factors believed to affect appetite are described more fully below.

### 4.4.2 The importance of social contact

The major factor impacting negatively on appetite that was identified was that older people who have difficulty leaving home are socially isolated and lonely and as a result are low in mood and motivation to eat. One older woman said

*“You’ve no idea what it’s like sitting here all day long with no one to talk to ... [I feel] dilapidated by the hours and hours on my own”* (A2).

Her loneliness is compounded by the fact that she cannot easily use the phone due to severe arthritis. Others said:

*“I’m very, very lonely”* (A4)

*“it gets awfy boring on your own”* (A7)

*“I have nobody here to talk to”*(A1),

When asked what single thing could be done to improve her quality of life one woman said:

*“[my home care worker] staying for a blether ....it doesn’t need to be longer than ten minutes”*(A1).

A family member felt:

*“it’s like a prison.. I don’t know how she thinks at the present moment”* (BF1)

Assessors reported that some older people rely on workers for their only social contact. One said:

*“The years I’ve worked, they don’t ask for ID. I remember this woman who said ‘come in, I don’t care who you are I just want someone to talk to’. It was just so sad because they haven’t seen anyone for about a week”* (Assessor area B)

A small but significant number of the older participants had no friends or family who can visit them and their only visitors were workers.

Living alone and, therefore, often eating alone, were also cited as reasons for low motivation to cook and eat food. Cooking for one was also seen as a big disincentive.

*“Well ah can eat if ah want to but it’s not the same on your own you know”* (A6)

*“I don’t think I’ll ever get used to [eating alone]”* (A3).

*“sometimes I cannae be bothered [to cook for one]”*(A4).

*“Probably a lot of them are on their own, they can’t be bothered [to cook].”* (Home care worker area B)

*“Home Helps can be in and out in half an hour, prepare the meal and then go. The person’s then left to sit and eat the meal by themselves”* (Assessor area B)

Cooking for one was also seen as potentially leading to waste.

*“Ah used to make a lot of porridge when the family were in, but just for yourself and that you know, ah dinnae make it the same (laughs) ... ye dinnae want to make a big plateful ‘cause ye say to yourself, well if ye dinnae eat it you just need to put it in the bucket”* (A6)

*“Ye cannae, you say to yourself to go and make soup and that. It’s for one person and ah mean you cannae keep it too long”* (A6)

*“Oh you’re no’ going to put a big pan on the range like that because you’re just yourself, it’s such a lot of waste”* (A7)

Eating with others was believed to have a positive impact on appetite.

*“There’s quite a few clients I’ve went to that say, ‘help yourself as well, get yourself something!’ ... I’ll maybe sit down and have a cup of tea. You can’t sit down and say, ‘I’ll have the same as you’ but it’s the company as well.”* Home care worker

*“Having the company certainly does make them eat more”* (BF2)

*“When we go on holiday.....the meals they serve up...well she keeps saying just a small portion but she eats 3 meals a day there, which she wouldn’t do at home...so the appetite is there albeit for smaller portions but who bothers when it’s only for themselves”* (BF2)

*“they’re eating, so you eat ... you see them doing it and you say oh I must do it ... I eat more in company”* (A1)

*“she does eat well, especially when she’s with us[her family]”* (A9’s relative)

Eating out as a social activity had been lost as a regular event for participants following the death of a spouse or increasing frailty.

Day care was seen to offer a potential solution for some people in order to relieve loneliness and provide an opportunity for social eating. Assessors said that they have experience to suggest that people eat better when going out and eating with others, for example, at a day centre. However, it was recognised that this does not suit everyone. Only eight of the older participants (n=20) attend a day centre or day hospital. Some older people felt that they do not have anything in common with people attending day centres and some felt they would rather eat with family and friends.

*“I’ve nothing at all in common with them, except for the fact that we’re all sick” (B2)*

Even where people had active support from their family they wanted to minimise the burden placed on them.

*“Oh no, I couldnae be bothered with that... it doesn’t bother me [having no company at mealtimes], I know I’m quite happy when [granddaughter] comes in right enough but I wouldn’t expect her to come up everyday”. (B3)*

#### **4.4.3 The effect of low mood and depression**

Related to the problem of social isolation, depression was described by professionals as very common. It was reported that this results in people not eating, throwing away food and often snacking on biscuits and sweets. Several older participants had lost their spouse less than three years ago. All said, unsurprisingly, that their appetite had been affected by their grief. However, some have also found that the death of a spouse has had longer-term effects on appetite. For example, one woman said that she still feels she has no appetite at least once a day more than two years after her husband’s death.

Other losses experienced by older participants included loss of friends and family members through death or moving to other geographical areas to seek employment, loss of good health or functional abilities. These losses, in turn, led to greater social isolation, loss of activities or structure to the week, loss of role as care giver or provider in the family and ultimately, in some cases, a lack of motivation.

Professionals were also concerned about the high numbers of people being referred to the service with alcohol problems related to isolation and depression and the negative impact this has on people’s ability to eat well. Only one of the ten older participants at this site had an issue with alcohol. The participant’s friend confirmed that use of alcohol reduced his friend’s appetite.

#### **4.4.4 The importance of activity**

Older participants were asked to describe a typical day and week. It was evident that many had very repetitive days and weeks that mainly consisted of watching television and waiting for home care workers to arrive.

*“ah dinnae ken what ah would dae if we hadnae the telly. At least when I go home I have ma tea and ah put the telly on and ah sit and at least it’s somebody to talk, you know. Sometimes it’s a load of rubbish but ah just sit back and say oh well ah may as well watch it that sit and not do anything.” (A6)*

*“You get bored sitting here. I’m terrible at times, all you’re doing is sitting watching four walls” (A10)*

*“I’m fed up looking at four walls ...I never can get no-one to take me any place” (B1)*

Another older participant who has recently become unable to leave his flat described it as *“mildly frustrating, I quite enjoyed going out, you know”* ...and said with irony *“I’ve got daytime television haven’t I?” (B2)*

Family members were of the view that inactivity affects appetite negatively. One said of her relative *“she says she is not hungry ... she just sits all day watching television doing nothing” (AF1).*

Workers also felt that people are more likely to eat when going out, as activities such as getting ready to go out can provide exercise. They suggested that other forms of exercise such as walking groups could help to increase older people's appetite. One older participant said *"I feel better when I'm out. I eat more than I seem to do when I'm in"* (A3).

Shopping was important or had been important in the past to some older participants providing them with a regular activity and opportunities for social contact.

*"If I could do it I would, I used to like going to the shops."* (B3)

*"That's where you old ladies used to meet up for a gab at the seats at the bottom of the till!"* (BF3)

*"We go for a coffee and something to eat and then do the shops and she really enjoys it"* (BF2)

Therefore, everyday activities such as shopping were seen to be beneficial to appetite and lack of activity perceived as reducing appetite.

#### **4.4.5 The importance of presentation of food**

The importance of good presentation of food also emerged in relation to increasing appetite. Assessors' experience was that older people feel less motivated to eat because of poor presentation of food on the plate and within the setting it is being served.

*"Often there's no-one around to make that nice tempting meal, you know. It's a frozen meal out the freezer, or it's a home help rushing to do something in half an hour, forty five minutes."* (Assessor area B)

Assessors suggested that boredom with their surroundings, especially those who *'sit with the same plate looking at the same walls every mealtime'* (Assessor area A) reduced appetite saying *"no wonder people stop eating"* (Assessor area A). They also speculated that older people may eat more if meals are presented well. This was confirmed by some older participants. One older people stressed the value of having *"a nice meal cooked by someone else"* (A3)

Assessors suggested taking Meals on Wheels out of the tin and putting the meal onto a plate, varying the crockery, cutlery and surroundings at meal times or serving some frozen peas and bread and butter with the fish supper to make the meal more special. Workers said that Meals on Wheels deliverers are *"quite flexible"* (Home care manager area A) and if asked to take the meal from the tin and put on a plate most will do this, although it does rely on helpful individuals rather than this being part of the service and so is inconsistent. It was felt that this would also help the appetite and memory of people who are confused. There were some problems with food being prepared earlier in the day for later consumption.

*"They don't want the sandwich drying up underneath a plate"* (Assessor area B)

*"That's right. They cook their lunch and leave a corned beef sandwich for tea and it's not very appetising is it?"* (Assessor area B)

Older participants and home care workers said that older people do not like to be presented with a large meal as this can be off putting.

*"I dinnae like a big plate. I just like a small portion"* (B1)

*"If I see a big plate in front of me, that's it finished"* (B9).

#### 4.4.6 The importance of choice and variety

Variety and choice of foods were seen as important appetite stimulators.

One older participant said: *“If you get the same thing all the time then it’s no the same, you know, oh I’m not wanting that again!”* (B7)

Home care workers reported that some older people get *“into a rut”* with food and their appetite is affected by this.

*“They must get fed up of the food.”*

*“Sometimes they say, oh, not this again, not that again, and it depends what they have in as well, what’s in their freezer of their fridge. 9 times out of 10 it’s always the same thing.”*

*“Week in, week out, the same thing.”*

*“You try give them a choice, like you’re meant to do, and they say “oh, I don’t know”!*

*“I go to one now and she tells me to decide for her, ‘you pick, you decide’!”* (Home care workers area B)

This appears to be a particular problem when people were not able to look in their fridge or cupboards to see what is available or look around the supermarket to get new meal ideas. There was a sense of people feeling disconnected from food and food production.

*“I dinnae ken what’s in the cupboards.”* (B1)

*“when you don’t deal with food or go to the shops or anything, trying to think of something ... it’s difficult ... you miss seeing all the new things [at the supermarket]”* (A1).

*“If they can’t get out to go around the shops themselves, they rely on other people to bring in things that they remember about on a day to day basis and people might not get the range of choice if they did the shopping themselves”* (Assessor area B)

Assessors were concerned that older people who live alone do not have the same opportunities to even talk about food. For example, they often chat with colleagues or friends about what you have eaten and this leads to *“that sounds nice, what’s the recipe?”* (Assessor area B).

Home care workers speculated that a vicious circle can develop if a shopping assistant gets to know a client’s preferences and so buys the same foods for a client each week, which means that people are not exposed to new food ideas and do not suggest alternatives. It appears that some home care workers give clients ideas for meals or items on shopping lists but others do not see it as a key aspect of their job. One older participant reported that she get ideas for meals from home delivered supermarket leaflets. However, many admitted to struggling to write a shopping list. Workers suggested that a hamper of a supermarket’s new ranges could be taken to client’s houses to give them new ideas.

Some older people appear to stick with the same foods as it is safe or easy for them to prepare or digest. Several people reported regularly having ‘cuppa soups’ and one lady said *“I eat an awful lot of toast”* (B1). It was also reported that a bland diet can also result from older peoples’ concern to make things last and avoid waste. Home care workers reported that even financially secure older people worry about this.

*“I know that they’re maybe a wee bit dearer and that but I feel that I’m not wasting any so I buy frozen vegetables like sprouts and ...”* (B9)

*“the sameness ...the boredom...even cookin’ a half pound of mince, that’s got to do 2 days ...you have it one day and maybe the next day you’re no feelin’ like it”* (Home care workers area B)

*“I hate stuff going out of date”* (A10)

One man who lives in a hotel said that he keeps pieces of toast which he does not eat at breakfast time to have as a snack in the evening. Home care workers reported that some older people are prepared to risk food poisoning by, for example, cutting mould off cheese, to avoid waste or keeping and reheating Meals On Wheels.

*“Oh I hate to throw things away, especially if they’re for eating. I never destroy anything that can be kept... I got a row yesterday about the bacon.”* (B6)

Several participants mentioned that even single portion sized food items in supermarkets are often too big for older people. In order to avoid waste some older people tend to eat the same foods to use up items leading to a repetitive diet.

*“Big shops don’t cater for single people everything is in 2, 3 or 4 packs which makes eating very repetitive....so when you buy something you have to have it 2 days running even if you dinnae want to”* (BF2)

One man who finds it difficult to keep fruit fresh and often it is past its best before he can eat it all. Grapes have provided a solution as he can graze on these throughout the day as he goes to and from the kitchen:

*“Well fruit, I usually buy grapes, I used to buy apples but they were starting to catch up on me, they were starting to go off before I got them eaten, but I get grapes now and I’m always picking a grape...when ever I’m passing in the kitchen. I have them every day but I just pick and choose when I like, no set time for that”* (B5)

#### **4.4.7 Opportunities for spontaneity with food**

The lack of ability or opportunity to be spontaneous with food was also raised as an issue. For example, an older person who cannot leave home without support cannot take full advantage of a sudden appetite, hunger or even craving by popping out to a local shop. One woman said *“you can’t do anything on the spur of the moment as far as food’s concerned”*(G-1) and felt *“there’s not much I can do”* (G-1). This woman’s last home care worker used to bring her a bridie or sausage roll at lunchtime if she asked her to do this at breakfast time or a fish supper on a weekend, which was *“a big treat”* for her. She does not ask her current home care worker as she is unsure whether this was a legitimate part of the home care worker’s role. She said *“they’ve all changed recently. I don’t know where she lives and whether she passes a shop on her way here ... and I’m the type of person who won’t ask them to go out of their way”* (G-1). Another older participants with dementia said *“I’ve always got a thought in my mind that I’d go down to the chippie for chips, I love chips (laughs)... [The smell] gives me an appetite!”* (B7) but again is unable to met this craving. Older people felt that meals that are generally available for delivery, such as pizza and curries, are less popular with older people.

This highlights the importance of the timeliness of support. Lack of ability to respond to food cravings, fancies or notions also led to missed opportunities to satisfy episodes of increased appetite in a timely way.

#### **4.4.8 Maximising opportunities to improve appetite and eating**

There also appeared to be key events that could provide opportunities to establish better eating patterns. For example, one woman who has a poor appetite was encouraged to have porridge when in hospital. Her friend commented on her increased appetite recently and felt that it was a result of the change in her breakfast choice.

*“she’s been no’ bad lately I think its since she went on the porridge...she was in hospital no long ago and they gave it to her there so I wrote a note up please give porridge...if you have porridge in the morning it gives you an appetite for later.....”* (BF4)

The home care service has maintained this new routine.

#### **4.4.9 Conclusions**

Low appetite was common among frail older participants, putting them at risk of malnutrition. The effects of the ageing process on older people’s appetite is well known and the need to provide nutritionally balanced meals is recognised by service providers. However, less attention has been paid to the social and psychological factors that need to be addressed in order to support older people to eat well. The main social and psychological factors which emerged from this study were:

- eating with others,
- cooking for others,
- having a good quality meal cooked by someone else,
- eating food that looks appetising,
- smelling food as it is being cooked,
- getting out of the house,
- being active,
- having exposure to foods and food ideas,
- having a varied and suitable diet,
- being supported to be spontaneous with food, and
- support to address losses, low mood or depression.

It appears that while services may at present be well set up to provide for people’s basic needs for food and cooking, they are less well set up to address some of the social and psychological components that contribute to older people’s ability to eat well and quality of life. As there is a large psychological and social component to appetite and ability to eat well, it is particularly important that these issues are addressed wherever possible. Where these issues are not addressed they can provide significant barriers to older people’s ability to eat well.

Further work needs to be undertaken to explore the role that services and communities can take to address these social and psychological factors more systematically. For example, research has shown that eating with familiar others can increase food intake by 60% in healthy older adults (McAlpine et al 2003), however, opportunities for social eating often decrease with age. The current mindset that physical needs are of primary importance and social and psychological needs are of secondary importance does not appear to be helpful,

and may lead to inappropriate targeting of resources with little positive benefit. The neglect of social and psychological needs in home care services has been noted in work undertaken by the University of York (see Patmore and McNulty 2005). It appears to be just as essential to older people's ability to eat and, therefore, their health and survival that social and psychological aspects of food and eating are given attention.

One area which appears to be particularly lacking attention in services for older people is the provision of support to deal with the multiple losses experienced as we age. Howarth (1993) has written about the way bereavement in later life necessitates a reappraisal of behaviour, meaning and social identity. She quotes Marris (1986, p.33) who suggested the "fundamental crisis of bereavement arises not from loss of others, but the loss of self". This requires further attention if the wellbeing of older people is to be addressed adequately.

Some of the ways that older people are currently supported to eat well by social work services and communities more generally are explored below in section 4.5.

#### **Key points**

- low appetite was common among frail older participants, putting them at risk of malnutrition
- the effects of the ageing process on older people's appetite is well known and the need to provide nutritionally balanced meals is recognised by service providers
- it appears that while services may at present be well set up to provide for people's basic needs for food and cooking, they are less well set up to address some of the social and psychological components that contribute to older people's ability to eat well and quality of life
- the main social and psychological factors which emerged from this study were: eating with others, cooking for others, having a good quality meal cooked by someone else, eating food that looks appetising, smelling food as it is being cooked, getting out of the house, being active, having exposure to foods and food ideas, having a varied and suitable diet, being supported to be spontaneous with food, and support to address losses, low mood or depression.
- further work needs to be undertaken to explore the role that services and communities can take to address these social and psychological factors more systematically
- one area which appears to be particularly lacking attention in services for older people is the provision of support to deal with the multiple losses experienced as we age

## **4.5 WAYS IN WHICH OLDER PEOPLE ARE SUPPORTED TO EAT WELL**

### **4.5.1 Satisfaction with the service**

Although older participants did make some criticisms of the home care service, they overwhelmingly expressed high levels of satisfaction and gratitude to those delivering the service.

*"My service I get is brilliant. The two I've got are brilliant"*

*"They'll do anything you ask them" (A5)*

*'She's so good I cannae even fault her.'* (B5)

*“the girls are very good. I have no bother with them... you’re never lonely.. they all have a wee story to tell you”.* (B6)

*“They’re all very, very helpful. They sent me a resume of the care conference that they had and it said that I was more than satisfied with the service, which is true. It’s excellent”* (B2)

*“she’s efficient, she knows what she’s doing”.* (B4)

#### **4.5.2 The role of home care workers in encouraging older people to eat well**

All participants highlighted the important role that home care workers can play in motivating older people to eat, monitoring food intake and raising concerns about appetite or problems with eating. Home care workers said:

*“Most people who receive support, need to be encouraged [to eat].”* (Home care worker area B)

*“Sometimes they put their food in the bin when you’ve gone. And the home help would check as part of their routine.”* (Home care worker area A)

*“you find a lot of the older people who maybe are not that keen on eating. You’ve got to encourage them. You’ve got to say ‘come on now’... That’s right I always got told prompt to eat and drink.”* (Home care worker area B)

*“It is just a habit they’ve got and if they haven’t eaten for such a long time I’ll say to them, ‘if you eat a wee bit more the day, you can have a wee bit more tomorrow’”* (Home care worker area B)

An older participant appreciated his home helps efforts to introduce him to new foods in order to encourage him to eat.

*“[my Home Help] brings me in a lot of things that I didn’t have before like tins of sardines.”* (B10)

Home care workers said that they get job satisfaction when someone has a good appetite and eats the food presented to them.

*“She always eats everything that I put down to her, and it’s such a good feeling ...”* (Home care worker area B)

#### **4.5.3 Home care workers providing social contact**

Assessors suggested that home care workers could usefully provide company for older people in order to stimulate appetite as they believed that *“eating is a social activity – sharing a meal”*. (Assessor area B)

Home care workers gave examples of where this had been successful.

*“We had a lady that didn’t want her meals at night, but if you sat down and had a cup of tea with her and ate, she ate.”*

*“Aye, we used to have our break in there, used to take our sandwiches, so if we were eating our sandwiches, she would eat her tea.”*

*“So just having someone to sit down with you while you’re eating, and have a little chat, that makes a difference?”* (Home care workers area B)

However, this is not always possible within the time allocated to provide care. A friend of an older participant also reported that the home care worker cooks lunch for the older person and the friend once a week to encourage social eating and this appears to increase the older person's appetite.

#### **4.5.4 The importance of good relationships**

The great value of there being a good relationship between the older person and the home care worker was highlighted on several occasions. The researchers observed positive relationships between home care workers and clients. Home care managers also saw the value of the client and worker having a good relationship. They said they try wherever possible to match the client and worker when allocating a home care worker. However, this is not possible as a matter of standard practice.

Older people were very appreciative when home helps took time to get to know them and their preferences and give them gentle encouragement.

One older participant spoke very highly of the home help who supported her when she had just returned from hospital saying:

*“She was awfully good to me.. she was absolutely marvellous... Something in her nature .. she made you feel as if you werenae getting help. She made you feel right”*(B 6)

She explained that she was *“not good at eating”* at this time (B6). The worker encouraged the participant to eat by bringing in things that the worker had made at home and buying the older participant meals from Marks and Spencer. These were introduced to give the participant a break from the home cooked meals that were prepared by a relative. The worker also successfully encouraged the participant to try bacon and eggs for breakfast at weekends. The older participant felt that the success of the workers' efforts was related to the close and trusting relationship that they developed and also the workers empathy for the participant's situation as she too had had health problems in the past.

Other participants talked about the things that contributed to good relationships with workers. For some it was important that they were able to have a joke with workers. Others appreciate it when workers *“take a person as a person”* (A5) and *“treat them like normal”* (A5). Having someone you can talk to and feel comfortable with was important:

*“well she's very nice to talk to... you like somebody to talk to, you know, someone who'll do something for ye, be sympathetic. (B1)*

*“ah can talk to her like that... She's clear and she's plain talking... She's nice.”* (A8)

Knowing the older person and *“their ways”* (AF1) was seen as an important part of providing a good service. Where relationships were particularly well established and workers attuned to the needs of clients, home care managers described a situation where *“the home help thought for [the client]”* ((Home care manager area A) and older participants said:

*“The team I've got at the moment are tremendous and they all know my habits and blah blah blah. They even, they essentially read my mind.”* (B2)

*“she's my favourite....you don't have to tell her what to do, she just does it”. (B8)*

Some older participants appreciated the way they could work as 'a team'. For example, one man starts to prepare his meal and his home care worker cooks it when she arrives. One woman said she was willing to do this but the opportunity had not presented itself and she did not feel able to suggest it.

Continuity of worker and consistency were also viewed positively by clients as contributing to good relationships and to a good service.

*"they've started a new system with two home helps and it's much better now ... I know they're coming at half seven for my breakfast... and that's a big difference"* (A5).

*"In the morning, for breakfast it's usually the same person, well for the last three days so that's good, very good. Having the same person for the same thing is very good. And they're here tomorrow too so. It means I know that it's the same person and I know that they're quite efficient"* (B2)

*"It was the same person who came here today who comes tomorrow, as it happens... they're coming for breakfast tomorrow, so they know what to make, you know. I don't have to tell them, you know."* (B2)

Managers also saw the value of having a consistent home care worker who gets to know the older person in order to plan menus for the week and provide foods that the person likes to eat. One said:

*"She'll maybe order mince, and cook it, freeze some of it for the end of the week, and use some of it for the beginning of the week..... the majority of them can organise what they're going to be cooking, and what the person likes. That's if they know the person."* (Home care manager area B)

Diaries were being used to increase consistency and planning with most clients although the success of these was variable.

Perhaps unsurprisingly, as we are all individuals, most older people reported having better relationships with some home care workers than others.

#### **4.5.5 Additional support provided by home care workers**

There were a number of examples given of home care workers 'going the extra mile', that is, providing support with food to older people in their own time and doing tasks outwith their job description. One home care worker agreed to accompany a client to a charity dinner and another worker's family members provide regular lifts and help with shopping for one client. Some workers also buy extra food shopping for clients when they are doing their own shopping or bring food from home as a gift. One man said:

*"That's what my home help brings in, Haggis, cause I said to her one day, the only thing missing from the frozen meal service ... haggis and turnip and potatoes ... before I knew it, I went in the cupboard one day and here was haggis, neeps and potatoes, ...She'd been in Marks and Spencer's food hall and she thought well '[name] likes haggis, cause I tell her about the haggis.. she's bought it once or twice for me, it's great, goes down well."* (B5)

Two older participants described occasions when home care workers had taken ingredients to their own home to cook a casserole for the client and returned with it the next day, and two clients had been given a gift of home made soup cooked by the home care worker. This

appears to be relatively common practice from the reports given by home care workers and in one area home care managers were aware of this practice. They stated:

*“it would actually surprise you how many [home care workers] take food in ... food from their houses .... that’s quite a regular thing”.* (Home care manager area A)

Home care workers confirmed that this does happen explaining:

*“Homemade soup – nice in the winter. Several home helps take a container in with them. They feel sorry for them. Nice for clients to have homemade soup.”* (Home care worker area B)

*“I know you’re not supposed to let your emotions and feelings get involved, but you do feel for them sometimes, especially in the winter months. Some have no family or support. So it’s hard.”* (Home care worker area B)

Home care workers may also go out to the fish and chip shop to buy someone’s meal if asked to do so even though *“you’re not supposed to do it”* (Home care worker area B)

Home care managers stated that they believed that workers did this with the best intentions. However they also recognised that this can be problematic. The managers’ main concerns were, firstly, that someone could get food poisoning and, secondly, that people’s expectations of the service were raised and these expectations cannot necessarily be met if a different worker is appointed.

*“Most people, if they are doing it, think they are helping the client, but our concerns with that would be infection in some way, would the food be stored at the right temperature, etc. How many clients have they visited before they bring the food? Certainly they shouldn’t be doing it.”* (Home care manager area B)

The concern was expressed that this happens because workers are not allocated enough time to cook a meal for clients. Home care managers said:

*“Yes, time is a factor, so maybe it’s ready meals, frozen meals that they’ve bought.”*

*“ I suppose that’s another reason why some of them see taking in soup as a favour, as otherwise wouldn’t have time to prepare food.”*

*“Yes, it’s all convenience foods maybe.”*

One manager suggested that home care workers need to find other ways to meet people’s needs such as preparing and slow cooking casseroles when they visit in the morning. Home care managers reported that some workers are more capable of this sort of creative approach than others.

#### **4.5.6 Creative solutions and individual support arrangements**

There were some examples of individual arrangements being put in place to meet older people’s needs. One social worker described an arrangement whereby an older disabled woman who had not been eating food cooked by her husband is now going with her husband to a nearby respite service so they can eat together. The respite home manager personally wheels the lady along in her wheelchair to have lunch there. Her appetite has improved with this new arrangement. The social workers explained that this is an unusual arrangement that required some creativity and flexibility on the part of the service provider but that it was very rewarding for her as a practitioner.

*“ [The manager] is particularly creative and flexible. I knew that so I could approach him.”*  
*“We have to try to find solutions on a case-by-case basis”.* (Assessor area B)

There were also some positive examples of flexible services being put in place to meet the needs of people with dementia. People with dementia were seen to have particular needs and, therefore, to require more time. It was reported that often people with dementia need encouragement to eat and will not do so unless the home care worker stays with them. In one case an arrangement whereby the home care workers sits with the person while they have their meal is made possible as the lady does not have breakfast until after 10 a.m. At this time the home care workers are less rushed and so can accommodate the woman’s needs.

A new type of ‘lunch service’ has also been put in place whereby, instead of going to a lunch club, a small group of people with dementia go out for a meal with support. Assessors have negotiated money from the budget to provide this new service allowing two carers to support four or five older people at a cost equivalent to two hours home care. The older people pay for their lunch. Assessors explained that while it is not a cheaper option than home care it is more effective as it has been very successful in increasing the amount of food eaten by people with dementia. This option also provides a shorter period of support for people who do not necessarily want day care for a whole day.

Home care workers also gave some examples of ways of working they have adopted to try to accommodate individual preferences. They said:

*“We ...used to do the vegetables, put them on in the morning, while we were getting her washed and dressed, and switch it off. She liked her carrot and her turnip with potatoes every day and that was the only way we could do it.”* (Home care worker area A)

*“We would cook enough for two days and put the other half in the fridge”* (Home care worker area B)

They explained that often these arrangements rely on careful planning and close co-operation between home care workers saying *“That’s all down to your home help, if you are working together. No’ all home helps.....and that is the same all over. It is good if you can do that, we had that person down to a fine art”.* (Home care manager area A)

An example was given by one older woman, of a simple change made by a home care worker that increased her appetite. She found that rice tastes better if boiled in the bag instead of being microwaved. In order to accommodate this preference one worker puts her rice in the pan then goes to see another client, returning later to serve her meal. The woman said *“it was a good idea and it was the way I like it”* (A2)

In area A, the ‘Supporting People’ programme was raised as a potential route to providing creative and individualised services. It was stated that the programme had been promoted for people with learning difficulties or mental health problems to provide one-to-one support but had not been opened up to older people. Funding from this source was being used in area B to develop a new ‘person-centred’ service for people with dementia.

#### 4.5.7 The role of families and friends

It was reported that families and friends can play a very important role in supporting older people to eat well.

The types of support offered with food and eating included helping with shopping lists, shopping, and putting away items, cooking at the person's home, supplying food cooked in the relative or friend's home, providing a meal in the relative's home, bringing in take-away foods, eating with the person, doing washing up, and helping with budgeting. More general support such as regular phone calls or visits to check that the person was well, were also common. Often friends and family played a key role in co-ordinating, monitoring and directing services to ensure that the older person gets what they need. Families and friends also play a very important role in supporting older people to eat well. Often they have an overview of the person's service and take on a co-ordination and monitoring role. This is consistent with findings of a recent study of intensive domiciliary support in Scotland (Curtice et al 2002). One friend described himself as the "*chief overseer*" of his friend's life (BF5). A common way of making suggestions or giving direction to the service was through the communication diaries held in people's homes. While this worked well for some, others expressed frustration that suggestions were not always followed up.

*'The Home Helps, they write everything they do...the books open.. anybody can write in this book...'* (BF1)

*"I put 'post its' in their log book but they totally ignore it."* (BF5)

The support offered by family and friends was highly valued by older people.

*"it's the family that look after me, it's agreed with the hospital that the family would cover me. They used to pop down whenever to see me, but now they come down and help me with my tea. My son in law is good, he brings a Birdseye roast beef dinner, with roast potatoes carrots and sausages, it's lovely"* (B5)

*"I appreciate everything that [relative] does. She's marvellous. But then I couldnae do without [another relative]. So the pair of them are in the same area".* (B6)

*"[my granddaughter] gets ma messages, she does everything for me. She's a gem"* (A8)

This support sometimes filled gaps left by services. For example, bringing in shopping from individual shops that the shopping service does not visit.

The majority of family and friends interviewed were offering high levels of support, typically visiting at least two or three time per week and often speaking daily on the phone to the older person. Some friends and family member explained that there are limits to what they can offer and described ways in which they try to keep the task of caring manageable.

*"I take her out once a week ... it used to be more often but she makes me feel bad ... it's depressing she talks about her illness all the time ... I tend to cut her back but she's on the phone at least 3 times a day ... she phones me when she's going to her bed, she phones me when she gets up"* (AF1).

*“I have to draw a wee bit of a line on this for my own sanity.....someone else has got to take over I have a life, another home, a wife and a business to run.,I sorted out his new glasses...I need someone to cut his toenails. I am sorry there is only so much I can do.....I have come in tonight the place is a tip and his trousers are on back to front..I have to draw a line I can't keep barking at them” (BF5)*

Another said: *“I've spent the last 5 years looking after somebody and I don't want to look after anybody- I don't want to look after my mum because I have to...I want a year out of my life for me.” (BF2)*

Older people were also concerned not to overburden relatives. One said: *“they've got their own husbands and bairns to look after so that's them tied up, so I just have my tea here myself.” (B5)*

Relatives were aware of this worry. One said *“she tends not to ask for help – she says to me I didn't want to bother you, you've got your work in the morning” (BF2)*

An anxiety to not “bother” relatives can therefore lead to a danger that older people's needs go unmet. Where families and friends are involved, there is a need to consider their support needs as well as the older person's support and their rights under the Carers (Recognition and Services) Act (1995). Where families and services both have a role in supporting the person to eat well, it is important that their efforts are co-ordinated and complementary

#### **4.5.8 Role of the wider community in maintaining older people's ability to eat well**

Community facilities can play an important role in helping older people to eat well. Older people spoke of the value of small local retailers, human scale user-friendly supermarkets, accessible shopping malls, take-away restaurants and access to local cafes and pubs.

Some of the older participants reported that small local shops have helped them to maintain some independence. One woman with a visual impairment who was particularly fond of haggis, neeps and tatties reported that her local greengrocer would peel and chop her turnip as her frailty and poor eyesight no longer allowed her to do this herself. Unfortunately this shop has closed since the opening of a new large supermarket in the neighbourhood. She also shops at her local general store. She is well known in the shop and feels very comfortable about asking the shopkeeper for help with locating and selecting products. Her experience of getting assistance at the supermarket has been less positive. She reported that she had been sold incorrect items such as the wrong type of milk without being informed by the assistant.

One man with agoraphobia explained that his local shop, which he visits every day very early in the morning when it is quiet, offers him an opportunity to shop for essential items without facing the high levels of stress that he experiences when using supermarkets. He said that he is prepared to pay higher prices for this convenience. Some other older people who did not have mental health issues also found supermarkets intimidating or not user friendly. Some are very large to walk around and supposedly accessible features such as automatic doors can be problematic for people with visual or perceptual difficulties. Assessors reported that some clients find the free delivery available at some supermarkets very helpful.

Two of the older participants who are able to get out of the house with support like to visit new shopping malls as these are wheelchair accessible. This opens up opportunities for them to choose purchases first hand.

Assessors reported that several older clients use take-away restaurants such as fish and chip shops and Chinese and Indian take-aways and that local pubs and cafes are well used especially when they provide a special meal for pensioners. Some older clients reported that take-aways that deliver food tend to provide pizza, Chinese or Indian food, however, they would be more likely to use such a service if it was available from the local fish and chip shop.

One older participant is able to go to a local café for afternoon tea once a week. This has brought her a number of benefits. She meets two other women there regularly and has an opportunity to socialise. It also frees her from cooking and washing up once a week. Finally, she is known by the café staff and they now offer to cook her particular meals that suit her better than some other choices on the menu. One man spoke about how much he missed getting to his local café and how helpful they were:

*'When I used t go to the [Café], I cannae walk that far now, but when I used to every Friday for my bacon roll, I did it for the company, [the owner] and various people I used to meet, used to meet one to two people that stayed in sheltered housing, I used to meet them up there, [friend's name] but I haven't seen him for ages, and I used to meet them and have a wee blether with them and I have a blether with [name] the waitress she used to look after me, and she looked after me well, as soon as I came in she would have my tea right there, if I wanted to draw money out the bank first I used to go past the window, signal [through the window] 5 minutes and when I came back there was my cup of tea just poured still boiling hot and my cake and my bacon roll and everything... my home help does it now, she knows that I miss a Friday walking up there and she knows that I cannae make it, she makes me a bacon roll.... so to keep myself going and get some fresh air I go out and walk down the street and back up to give myself a wee walk, but now in this cold weather I hardly go out'*  
(B5)

There may be more scope to offer additional support to older people in ordinary places. In one area, assessors had heard of a local nightclub that was providing a meal and tea-dance to older people being supported by the social work department. This allowed the nightclub to make use of its premises and cooking facilities at a time when it would normally be closed.

#### **4.5.9 Conclusions**

Older people expressed high levels of satisfaction with the service they receive and gratitude to those providing support. Home care workers play an important role in encouraging older people to eat well. They fulfil this role by developing trusting relationships with clients, suggesting new foods or recipes to them, bringing new or favourite foods into the person's home, cooking foods in their own home and bringing them to the older person, providing opportunities for social eating with the home care worker or others. Some of these activities such as cooking at home and shopping are done on a voluntary basis outwith the home care workers' normal role or hours.

The quality of the relationship between the older person and the home care workers is very important and can have an impact on the ability of older people to eat well. This relies on continuity and the worker and client feeling they develop an understanding over time. There

may be a case for more careful matching of clients and workers to ensure that relationships are positive where this is possible. MacDonald (2004) highlights the lack of research exploring the impact of recruitment and retention policies on the quality and person-centred nature of service provision.

Creative individual arrangements to support older people to eat well have been successful, particularly for people with dementia. Further work is needed to explore opportunities for further funding of these individual arrangements through programmes such as ‘Supporting People’.

Families and friends also play a very important role in supporting older people to eat well. Often they have an overview of the person’s service and take on a co-ordination and monitoring role. This is consistent with findings of a recent study of intensive domiciliary support in Scotland (Curtice et al. 2002). However, the stress of caring results in these ‘informal carers’ setting boundaries around what they can and cannot do in order to make caring manageable. Older people are very aware of this stress and often try to minimise it if possible. This may lead to needs going unmet. Where families and friends are involved, there is a need to consider their support needs as well as the older person’s support and their rights under the Carers (Recognition and Services) Act (1995). Where families and services both have a role in supporting the person to eat well, it is important that their efforts are co-ordinated and complementary.

Finally, local community facilities have an important role to play in supporting older people to eat well and maintain independence for as long as possible. Older people appreciated local shops and cafes that offer a personalised service and accessible and older person friendly shopping facilities.

**Key points**

- home care workers play an important role in encouraging older people to eat well
- home care workers are in a position to develop trusting relationships with clients, suggesting new foods or recipes to them, bringing new or favourite foods into the person’s home, cooking foods in their own home and bringing them to the older person, providing opportunities for social eating with the home care worker or others
- creative individual arrangements to support older people to eat well have been successful, particularly for people with dementia
- families and friends also play a very important role in supporting older people to eat well, often having an overview of the person’s service and taking on a co-ordination and monitoring role
- local community facilities have an important role to play in supporting older people to eat well and maintain independence for as long as possible

**4.6 BARRIERS TO OLDER PEOPLE EATING WELL**

Older participants expressed high levels of satisfaction with the services they receive and were able to give examples of ways in which community facilities had enabled them to eat well. However, a range of barriers to older people eating well, within services and community facilities, were also identified by the study. Some of the difficulties associated with the provision of high quality home care services have been described in previous work (see Accounts Commission for Scotland (2001)). However, their impact on eating well for

older people is less well known. These difficulties are discussed below, along with barriers within the wider community.

#### **4.6.1 Difficulties accommodating individuality and choice**

Individuality and choice were seen as important dimensions of quality within services. Assessors and home care managers both stated that they try as far as possible to provide solutions tailored to the individual. However, they also reported that this is not always possible. Assessors reported that options are often limited by the range of services that happen to be available. Home care managers in one area expressed concerns that “*we’re getting away from a needs-led assessment to a service-led assessment*” (Home care managers area A). Some older people also felt that individuality was not always recognised. One said:

“*when you get old, you’re only a number*” (A9)

There were four main areas relating to choice and individuality which participants discussed with specific reference to food and eating. These were:

- accommodating individual needs and preferences
- accommodating personal tastes
- appropriate timing of meals
- meeting the needs of people from minority ethnic communities.

#### ***Accommodating individual needs and preferences***

Shopping services provided several examples of the difficulties services face in trying to meet people’s individual needs and accommodate preferences. Previously, home care workers had prepared shopping lists with clients and then bought and returned the shopping to the client’s home. Now it is common for a specific shopping service to be provided. This involves a shopping assistant collecting an older people’s shopping list and purchasing and delivering the shopping to the person’s home. It generally remains the role of home care workers to help older people prepare shopping lists. The shopping service requires that a client does all their shopping in one store and this is done on a set day of the week. There is usually a choice of store but this cannot be altered from week to week. Assessors, home care managers and older people identified a number of problems this can potentially create for older people in relation to having their individual needs and preferences met:

- in area A, it was said that this style of service is incompatible with the culture of the local community. It was said by assessors, “*the people of [our town] like to go to different shops every day or every other day*” (assessors area A). Many older participants in both sites confirmed that this was their preferred way of shopping before they became reliant on services;
- it was felt that shopping at one shop results in people having less choice of products and not being able to get everything they need. This in turn can lead to them relying on friends or family to pick up items that the shopping service could not purchase in their allocated store, where family and friends exist;
- many older people have a tight budget. They receive mail shots advertising special offers in supermarkets but if the advert is for a supermarket other than their allocated store, they are not able to take advantage of these offers;

A particular concern of older participants were instances where shopping assistants have had to substitute items on the list when an item has been out of stock. On occasions inappropriate substitutions have been made. Some older people felt that when a worker makes substitutions because an item is unavailable “*it’s [the worker’s] choice*” (A1) and not based on what the

client would choose or could manage. One said "... *they just grab anything*". (B1) A relative sympathised with the service saying "... *but it must be hard for them ... some of them have to shop for 6 people at a time... I would find that hard*" (AF1).

Older people also felt that some shopping assistants are not aware of the needs of older people living alone, buying family size items which are difficult for older people to lift or too large to use before they perish.

*"[the shopping service buys] the biggest loaves they could get and the cheapest yoghurts ..... what's the use of getting something that I'll have to throw out?"* (A4).

*"I've always got my home help to put two by one litre (2x1 litre), green cap or semi skimmed milk but if I hadn't have done that they bring what ever they've picked up off the shelf. .There was one day I didn't [specify 2 x 1 litre]. I could feel the handle of the milk container, I went to lift it, I couldn't get it out the box, it was a two litre one. Oh what a weight it was".* (B5)

*"every time I put a small tin, a small portion, they'll bring out the biggest one they can get. You ken you dinnae use it all. I said a very small bit of turnip cause I was having a wee bit of haggis. God they brought a great big turnip like this... you couldnae carry it. .. and you ask them to bring bacon and a small portion of cheese. They bring a big lump of cheese and you dinnae eat it all. .... they dinnae tell me what they dinnae bring".* (B6)

There appear to be a number of conditions that need to be in place in order to ensure that people's needs are more likely to be met. It requires that:

- the older person is as specific as possible about their requirements – size, brand, flavour, type, second or third choices;
- the older person and worker prepare the list together so that preferences, as well as what is possible for the worker to cook in the time available, are taken into account;
- the shopping assistant has knowledge about the person, their lifestyle, their difficulties, the support they receive and their personal tastes so that any substitutions are appropriate and special offers can be taken advantage of.

There are a number of problems associated with this. For example, it requires that the older person has a wide knowledge of the food items available in the store visited. This is unlikely in the case of older people who have difficulty leaving home and appears to be a problem for clients who have previously shopped in small local shops rather than the larger stores. One family member explained that the introduction of the shopping service has been a difficult change for her mother-in-law as "*they don't get the things she wants .... she did have a home help that did get her the things she wanted ... she would go to Gregg's the bakers ... then they decided the home helps weren't to go the messages at local shops- they had to go to the supermarkets like Tesco .... she knew what she wanted out of the local shops*" (AF1).

An assessor also described some of the difficulties experienced by one client requiring a special diet who had to stop shopping at Marks and Spencer and use a large supermarket when she was referred to the shopping service. Her daughter had to go around the new store making a list of items that her mother might enjoy and be able to eat, discuss these with her mother and then the shopping service.

An additional negative consequence of the introduction of the shopping service is that fresh foods are only purchased once per week rather than when needed. Home care managers were concerned that this leads to older people buying and eating less fresh fruit and vegetables.

*“I don’t think when you buy fresh food now that it lasts as long once you take it home to a warm environment. The shopping service is only once per week, and quite often, by the end of the week, the bananas are black. Previously, workers were buying food more frequently, might be buying a couple of bananas or apples or peppers. I certainly know that with some fruit, as soon as you take it into a warm house, it just goes. So I would think that probably a few older people don’t buy as much fresh fruit and veg as they would maybe like, because of having to throw it out.”* (Home care managers area B)

One man had adapted his eating habits to get around this problem, choosing to graze on grapes rather than eating larger fruit such as apples.

There was some evidence of the shopping services trying to improve by putting in place procedures to avoid people getting shopping items that do not suit them. When the shopping assistants pick up the shopping list, they go over the list with the client. In one area a pre-drawn up list of items was in use to help the process of making a list. In the other area this had been abandoned as people *“prefer to write their own”* (Home care managers area A). There appears to be a need to develop a tool which facilitates the writing of shopping lists without making people feel their choices or their opportunity to try something new are being restricted.

Previously, home care workers were responsible for collecting individuals’ shopping. It was felt by some that the previous system allowed individual needs and preferences to be taken into account more and this appeared to be favoured by some of the older participants in the project.

### ***Difficulties accommodating personal tastes***

Older people were highly appreciative when individual workers went out of their way to get favourite foods. There were numerous examples of home care workers buying favourite foods for older clients when doing their own shopping. However, there was also some dissatisfaction among older people and family members with the inability of the service to meet individual tastes and preferences. Often older people who were expressing a preference about foods did so very tentatively, one saying *“maybe it’s alright for other people. Maybe it’s me, I don’t know”* (A4). Several older participants expressed concerns that their individual requests or preferences may be unreasonable or may be perceived negatively by the service. One said *“a lot of people may like it. I’m maybe fussy”* (A1). Family members were aware that older relatives find it difficult to express preferences or suggest changes to home care workers even when they have a good relationship. One family member said:

*“She’s maybe too friendly with them to say anything to them”* (BF2)

This was also observed during interviews with older people. One said of her home help:

*“Ah never thought to [ask for cheese on bread], see ah dinnae want to annoy her”* (A8) and *“Ah dinnae want to hurt her feelings”* (A8)

In many cases it seems that older people accept this problem of not having their preferences met as inevitable. One man who was provided with a cheese omelette instead of a Spanish omelette by the frozen meals service said:

*“It’s a case of beggars can’t be choosers... I had to learn to like cheese, didn’t like it before”* (B5)

### ***Difficulties arranging appropriate timing of meals***

Concerns were expressed about the inability of the services to provide support at the times preferred by older people and at appropriate intervals throughout the day. Assessors explained that the home care service is in greatest demand at key times of the day such as morning, lunchtime, tea time and bedtime and it is not unknown for some people to have long gaps between breakfast and lunch and others shorter gaps.

*“We would want to fit into person’s own schedule but it is really difficult. Everyone wants [home care] at the same time which is not possible.”*

*“Often we cannot get carers to go in at the time people want to eat. Maybe someone gets up and wants their breakfast at about 9 o’clock. Sometimes we can’t get them there ‘til 11”*

*“which is nearly lunchtime”*

*“and then they’re maybe having their lunch at two o’clock.”* (Assessor area B)

Assessors were concerned that some people may feel hungry mid-morning and wondered if there was any advice that could be given about the nutritional content of breakfast if having to wait from 7.30 a.m. to 12 p.m. between meals. They also speculated that some older people who have a short gap between breakfast and lunch may not feel hungry and so may miss lunch then get hungry in the early afternoon but have to wait until teatime for more food.

The timing of delivery of hot meals was also raised as an issue. Meals on Wheels are delivered hot at lunchtime for immediate consumption. Both home care managers and assessors reported that people frequently reheat Meals on Wheels and eat them in the evening despite being told of the dangers of food poisoning associated with reheating them. This is because they prefer their main meal in the evening. Some also freeze meals for later consumption. This delay in eating the meal was also observed in the course of the project.

### ***Difficulties meeting the needs of minority ethnic communities***

The study did not systematically collect data relating to the needs of minority ethnic communities and did not interview anyone from a minority ethnic community. However, the professionals participating in the study raised some issues. They felt that the needs of minority ethnic communities should be specifically addressed by a service. One issue raised was the importance of matching workers and clients. Assessors felt that there was a lack of home care workers from minority ethnic backgrounds leading to a lack of understanding about appropriate food practices and festivals. They were aware of some clients who had chosen not to have a service because of this issue.

The consequences of not being able to accommodate individual needs and preferences, personal tastes, preferences about timing of meals or the needs of people from minority ethnic communities may vary from individual to individual but are likely to have a negative impact on an older person’s ability to eat well.

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#### **4.6.2 Difficulties associated with older people being disconnected from food**

Many of the older participants gave examples of ways in which they had become less involved with certain aspects of food and food production as they had become more frail or disabled. Many said that they had previously enjoyed eating out but were no longer able to do this. The majority of participants were no longer able to do shopping either in local shops or larger stores. In addition, several older participants described ways in which they were disconnected from food and food production within their own home. For example, an older participant who was a wheelchair user was not able to enter her kitchen as the doorway was

too narrow. Other participants were able to enter the kitchen but rarely chose to do so as once in the room, they were unable to reach up or down into cupboards or appliances, to stand to prepare food or to lift pans. This meant that they were reliant on others to tell them what was in the cupboards or fridge, what was available to eat and what items were needed from the shops.

*“I dinnae ken what’s in the cupboards.” (B1)*

*“when you don’t deal with food or go to the shops or anything, trying to think of something ... it’s difficult ... you miss seeing all the new things [at the supermarket]” (A1).*

*“If they can’t get out to go around the shops themselves, they rely on other people to bring in things that they remember about on a day to day basis and people might not get the range of choice if they did the shopping themselves” (Assessor area B)*

Many of the older participants spent long periods of time in armchairs in their living room and few would be in the kitchen with the home help while they were preparing a meal. Taken together, these things resulted in older people being ‘estranged’ from food and food production. The result of this seems to be that people find it difficult to feel motivated or even excited by food and they struggle to have meal or menu ideas.

#### **4.6.3 Difficulties associated with the service feeling rushed**

The most common problem faced by home care services, cited by all participating groups, was the lack of time for direct support. Older people and family members said:

*“oh it’s time again. They never have time” (A1)*

*“they’re in, do what they have to do then off again” (A1)*

*“She’s only in half an hour. I’ll say’ is that you away already. I never even get time to talk to you’. Just rush back and forth.... They get that many to do. It’s just one mad rush.” (B1)*

*“Night time they come in and they have 10 minutes to make her something. It is not long enough. One time she asked for chips and they burnt them” (AF1)*

*“that’s ridiculous, 10 minutes, what can you do in 10 minutes” (A4)*

*“Give the girls more time. I don’t think the girls get enough time to do their jobs” (A3)*

*“I don’t know what they do when they are a fussy eater as it all takes time and they haven’t got the time” (A1)*

Home care workers also referred to this problem many times saying for example:

*“The biggest problem is time. We don’t have time to cook..... Like we haven’t time to stand and cook. A lot of it is microwave meals”. (Home care worker area A)*

*They said that they feel like they “leave [the meal] and run”(Home care worker area B)*

Home care workers reported that time allocated to make meals for clients has been reduced over the years.

*“We used to prepare and make food, mince, stews etc., but now don’t have time to make real food. We used to have 1-2 hours, 2 or 3 days a week, but we only get half an hour now. And the person who is in before, they don’t have the time to make real food.” (Home care worker area B)*

They expressed concern that it is difficult to meet the person’s needs in this short time.

*“If you have a client to feed, you don’t have time to cook it, and feed the client as well.... even an hour isn’t long enough because you’re just rushing all the time.”* Home care worker.  
*“I get the hour, but he is slowing down, he gets soup, and he gets his pudding after that as well, and that will take him about 45 minutes to eat it, and you’ve got everything else on top of that – dishes etc. It’s tight.”* (Home care worker area B).

Home care managers said:

*“Time is a major factor as well.”*

*“...each client’s care package is down to time ... and that’s related to budgets”*

*“..you’re governed by a lack of resources”* (Home care manager area B)

*“We’re always chasing our tails. We’re always looking for that extra minute.”* (Home care manager area A)

### ***Factors contributing to this lack of time***

There were a number of factors that appeared to contribute to the problem of lack of time. These included a shortage of resources, inadequate kitchen equipment and home care workers’ travelling time eating into the time allocated to provide care.

Assessors explained that financial pressures lead workers to reduce care packages to the minimum making it possible to meet people’s basic needs only.

*“Because of the financial situation in the department, all of the care packages are being really trimmed to a minimum. Whereas an OT or Social Worker might assess for an hour for meals, we’re saying well can it be done in half an hour. And we’ve got two hours here. Can we take one of the hours and move it. So everything’s really being trimmed to the bone at the minute ”* (Assessor area B)

The kitchen equipment available to the worker affects what can be achieved within the time available. It was reported that some older people’s appliances are old and an oven may take 10 or 15 minutes to heat up before any cooking can start. As a result, a client’s dishes may be left and the older person left alone to eat their meal as the whole of the time allocated for the meal has been taken up with the cooking tasks. The dishes being left then has an impact on the time available to the worker who arrives next. Managers estimated that between 25 and 30 per cent of clients have microwaves. This offers a quicker option but may still lead to older people eating high numbers of convenience meals.

An additional factor limiting time is the need to travel to the client within their allocated care time.

*“On a back shift, between 16.00 and 22.00, you have 9 clients to visit. After 7 o’clock, it’s half-hours. But they’re forgetting that you still have to get to them”.* (Home care worker area B)

Home care managers reported that this becomes increasingly difficult to manage as the time allocated reduced to 30 minute or 15minute slots. This is easier when two or more clients live very close to each other.

*“It’s okay if you’ve people who live very close to each other, like in the sheltered housing complexes, it’s fairly easy. I know on the weekend, I’ve got 2 clients in one block, and it’s a*

*matter of up and down, leaving one eating, while you're away cooking for the other one. So they're getting their time that they're limited to. And it means that the two of them are eating roughly about the same time. It is handy if you've got them in the same building, but if they've got a good 5-10 minute walk, then it's not so easy.*" (Home care worker area B)

Time is additionally reduced when a worker is going to a new client and having to find their way around an unfamiliar neighbourhood or home.

*"I've been at a [new] client for an hour, and have only been able to give them 20 minutes. Because I was late, and I had to get back"* (Home care worker area B)

### ***Consequences of a rushed service***

There were a number of possible consequences to the service lacking time and feeling rushed which had an impact on older people's ability to eat well. Firstly, lack of time made it difficult for workers to cook fresh foods and the traditional meals such as stews and mince, which older people favoured, in the time allocated for a 'meal visit' and people may be given ready prepared meals or vegetables instead of fresh foods, for example, 'Smash' instead of boiled potatoes. All workers were concerned that there is an over reliance on convenience and processed foods. When asked what options are open to older people who do not want processed food and do not own a microwave, Managers said:

*"That depends on what people are making."*

*"If it's eggs and sausages, or if it's mince and potatoes, or sometimes if it's stew, they're precooked/half-cooked in the morning, and finished off at lunch time."* (Home care manager area A)

This, therefore, relies more heavily on co-operation between teams of workers.

It was home care managers' expectation that home care workers use their limited time efficiently by, for example, making a stew and putting it in the oven and, if the client is able, they switch the cooker off at a certain time. It was also suggested that home care workers could prepare the meal for the next day or the evening while they wait for the client's potatoes to boil. However, they also stated that some workers may feel too pressured to think in this way. It was said *"because of the volume of work you've got, sometimes you don't think like that"* (Home care manager area A), and if something unexpected comes up then planning ahead becomes impossible.

Secondly, assessors believed that time pressures lead clients to make fewer demands on workers such as not asking for a hot meal or *"a full meal"* (Assessor area A), despite this being their preference, as they do not want to inconvenience the home care workers. As a result, some people *"eat the same thing day in and day out"* (Home care manager area A). Another explained that she will ask for a sandwich at teatime and the worker will give her this and leave. However, she may decide after the sandwich that she would like another, but as the worker has already gone she cannot have more food. She said *"I thoroughly enjoyed it but I could have eaten the two"* (A2). Assessors expressed concern that turning down the offer of a meal can be interpreted as the client expressing choice if the older person says that they do not want anything when asked what they would like to eat, when in fact it is the result of inappropriate or hurried support.

Thirdly, it was felt by some home care managers that lack of time leads to people not getting adequate support to eat well. For example, One woman said that she was bored with her meals but when asked why she does not ask for different foods she said *“probably I just cannae think of anything. They come in that quick and go out”* (A1). Others said that they would appreciate more help to write shopping lists.

Finally, home care workers described some ways that they adapt their ways of working to make their job manageable. One way is to ‘break the rules’ and bring food cooked at their own home in to the older person’s home. It was stated that it was not uncommon for home care workers to make food, such as soup or a stew, at home and take it to the client the following day. Another way that workers make their job more manageable is by taking the decision to adjust the time allocated to clients

*“it varies, depends how long people like to have their meals. One client, a lady, was half an hour to eat her soup, and even longer for the main meal, and also a pudding. And we were only allocated an hour, but because you could make space, you knew you had to give this lady more time.”*

*“it varies according to the client. If you have a client who’s got an hour before the lady who takes longer, then obviously you can make some time to spare. But that can’t always happen.”*

*“Juggling all the time.”* (Home care workers area B)

In one area, assessors explained that if people need more time for support with cooking they can be referred to private services but they may have to pay for these. Workers can make a case for longer care hours if the purpose is to retain people’s skills. An example was given of one client who gets three hours twice a week for a carer to accompany her to the shops and then help her prepare a meal. It was unclear how much scope there is to extend this type of service. One older participant suggested she could help out and save time for the home care worker saying *“I could do potatoes ready to put on but nobody ever bothers with it”* (A1).

Increasing time was felt by home care workers to be the key area for improving the service. There is a need to think more creatively about how time and the abilities of clients are used. Home care managers suggested that it would be more beneficial if workers spent blocks of time with people.

#### **4.6.4 Problems associated with older people feeling a lack of control**

Many clients with high support needs may receive a service from a large number of workers. This appeared to cause some difficulties for some older people who did not appear to feel in control of who was coming into their home and when. One woman said of her home care worker *“she could come anytime at the moment because I haven’t got a special home help like I had”* and *“there’s always someone different appearing ... they change so often”* (A1). She felt *“... you never know who’s going to walk in ... you just never know. You’re just so glad that someone is coming in to make tea”* and joked *“I’m trying to remember all of their names”* (A1). Another said *“every time it’s a different woman... Tom, Dick and Harry. I never thought I’d finish that way with every Tom, Dick and Harry coming into my house”* (A4). Sometimes as many as eight people provided home care to one person. Another said *“I’m getting muddled up with them”* and *“said “oh the others, I didnae ken all their names. I get fed up”* (B1). There was some apprehension when there was uncertainty about which home care worker was coming to the person’s home later in the day and this appeared to have an impact on the person’s ability to enjoy their food. One said *“it’s just all of the different*

*home helps coming in. There's always someone different and you wonder what on earth they're gonnae make for you. Some are good, some are bad"* (A1).

Older people also reported that home care workers may be moved without notice or consultation. There was a sense of people coming and going in older persons' lives without clients having much of a say. One woman's experience is *"they just mix ... she'd maybe be here for a while and they they'd say 'oh you must go to [somewhere else]'"* (A1). As a result, older people do not always know whether a home care worker has left her job or is just on holiday. One older woman said of her favourite home care worker *"I haven't seen her for a wee while"* (A1) and did not know whether she is returning or not. This raised issues about the vulnerability of older people if visited by ex-workers.

Holiday time when cover is provided seemed to lead to particular difficulties and anxieties *"when they're off you'll get some hassle sometimes"* (A5)

Some older people described situations in which they had to direct or negotiate elements of the service, for example, asking a worker to come back at a later time. Some older participants felt able to do this, one woman telling her worker clearly *"no, you're not coming here at this time"* (A2) and another saying of his two home care workers *"I let them work it out between their two selves"* (A5). Others, however, felt less able to direct or negotiate with the worker saying *"I don't like arguing with them... stop them doing what they're doing ... in case you make it worse"* (A1). Often older people were unclear about the services they were entitled to receive and what tasks were within and outwith the remit of the home care service and therefore legitimate or not to request. It appears that discomfort with making adjustments or sorting out problems can, in some cases, either lead to older people cancelling services or a resigned acceptance that services will not come up to standard. One woman said *"I'm fed up, I really am. I wish I could get rid of the lot of them"* (A4) and another said *"well I cannae do anything about it"* (A1).

Paying for a service did not necessarily guarantee that the person has control over the quality of the service received. One older participant has a private arrangement with two neighbours to offer her support, but expressed some dissatisfaction with one of these arrangements. However, she did not feel able to address this with the neighbour due to her reliance on her help.

A number of issues relating to the control of older people over their day to day services were raised. These included:

- older people do not necessarily know who's coming to their home each day to provide their service or at what time;
- this led to some apprehension when there was uncertainty about which home care worker was coming to the person's home;
- older people reported that home care workers may be moved without warning or consultation;
- only some older participants felt able to do this; and
- paying for a service did not necessarily guarantee that the person has control over the quality of the service received.

There was a sense of things happening around people rather than being directed by the older people. There was uncertainty about who comes when. The clients were not involved in choosing workers at the point of recruitment or allocation to particular tasks and clients. Also

older people are often not clear about the role of a home care worker, the tasks they have been assessed as requiring, the degree flexibility that is possible within the service and their rights. They, therefore, feel uncomfortable when they have to ask a worker to do something or direct them to do a task in a particular way. There were some instances where individuals did feel confident about doing this, for example, asking a worker to come back at a later time. The majority of individuals, however, tend to accept the service the way it is and are unsure about how and where to voice their needs and opinions. There would be value in developing an induction pack for clients as well as putting in place a process for regular monitoring of the service. Where workers are with older people for long periods, they tend to work out a way of working together. It takes a while for both parties to settle into a routine that suits them both.

#### **4.6.5 Difficulties related to lack of continuity or co-ordination**

Continuity of worker and co-ordination and communication between workers were identified as key contributors to a quality service. It appears that home care services are increasingly being delivered to frailer older people by ever larger numbers of workers making continuity and co-ordination even more vital. In the past clients would have had lower support needs and require fewer hours of support. This made it possible to provide the person's service through a small number of workers. As the clients' levels of support need have increased, the number of people going into the clients' homes to provide this support has also increased. Home care managers explained:

*"It might be, by chance, you have a worker that has every morning at 9 o'clock, and then she's also free at 12 o'clock to go back again, for a meal. That's highly unlikely, that's the ideal."*

*"But you find that very seldom happens, unless you've got a new home help who's just started off that has quite a bit of free time."*

*"Yes, or it could be that you've got one person does Monday, Wednesday and Friday, in the morning, and you've got another worker that goes in Tuesday and Thursday in the morning, for breakfast, and it might be the same at lunchtime if you've got somebody free at 12 o'clock. You might have to change the time slightly to 1 o'clock, or 11 o'clock, depending on what worker you've got available. It could be that you've got about 4 or 5 workers going into one person, especially if they get 3 or 4 times a day."*

*"We do try our best not to have a lot of different workers in, because it causes more problems with the feedback and communicating with each other."* (Home care managers area B)

This can be a particular problem at holiday times.

*"[Holiday cover] can sometimes be difficult, because they prefer the same person going in, or somebody that they know .... you've not always got the same person with free time."* (Home care manager area A)

*"if it is a stranger that's going in, they've just got to use their initiative, see what's there, see what they've got time to cook"* (Home care manager area B)

Home care workers also found this difficult. They said

*"if you get sent somewhere where you don't know, you've never been to, first of all, they've got to get used to you, you've got to get used to them, you don't know where the plates are, where's this, where's this ...."* (Home care worker area B)

In addition, specific support with shopping is no longer within the remit of the home care worker, with the result that two teams of workers are providing a service previously provided by one, increasing the number of workers involved with each client. In area A, Managers speculated that a change in shift patterns for home care workers was resisted by some older people as it meant that they would be receiving a service from double the number of workers, in some cases up to eight workers.

Having small teams of workers and one consistent home care worker with whom the older person has a good relationship appears to improve co-ordination. The small teams of three workers that operate as a social care team appear to offer greater continuity than single workers providing consistency particularly at holiday times.

Continuity of manager was identified by home care managers as a key element of quality allowing them to offer a personal approach. They felt that the older people value the fact that they have a named person whom they can phone rather than be dealt with by a 'call centre' type approach. They spoke of the importance of:

- the approachability of managers;
- speaking to a named person;
- being listened to and heard; and
- the service knowing who you are when you phone the office.

#### ***Negative consequences of lack of continuity or co-ordination***

Where the service was unable to offer continuity of staffing or smaller staff teams, this too can have negative consequences for older people's ability to eat well. A number of examples were given.

Firstly, the ability of workers and older people to develop a good working relationship could be affected. The concern was expressed that the quality of the shopping service had been affected by the change from home care workers doing shopping to shopping assistants undertaking this role. Home care managers said:

*"It was easier when home helps did shopping themselves, because they ... knew the person"*  
(Home care manager area B).

*"It used to be the same workers that were going in, and occasionally, if they saw a special offer, or if they saw something that they knew that Miss Smith liked, they would maybe get that, but that's not happening so much now. They really are sticking to what's on their list."*  
(Home care manager area B)

The importance of having continuity to develop a trusting relationship in order to encourage eating well was highlighted by family members.

*"She has no appetite. If she got the same person every week... someone who got to know her and her funny ways and could coax her into eating" (AF1).*

Secondly, lack of continuity or co-ordination can result in no-one within the service having an overview of the person's diet. The greater the number of workers going into an older person's home, the greater the need for co-ordination and co-operation between the service, the individual and any family members.

Home care workers explained:

*“If you’re going there all the time, you tend to know what’s in the house, what’s in the cupboards, what’s been eaten and what hasn’t. But obviously if it’s not a regular client, then you don’t know.”*

*“But if you’ve got like myself, and say somebody else is away on holiday, and your other team member is away on holiday as well, and you’re the only one, you have two other people going in, but maybe not knowing when that food was bought, how long it’s been lying there.”*  
(Home care workers area B)

Family members and friends also had concerns about the lack of leadership evident to co-ordinate the many people providing a service.

*“There are too many people involved and they have their shifts and rotas. The hospital discharge team were different...there was clearly a leader”* (BF5)  
*‘there is no co-ordination...I don’t know how many times I have explained to everybody’*  
(BF5)

Home care workers said *“Having regular clients would help.”* (Home care workers area A)  
Continuity allows a worker to have an overview of the clients’ meals for the week and to organise shopping and cooking accordingly. However, this also relies on the worker knowing the older person well.

*“[The home care worker will] order mince, and cook it, freeze some of it for the end of the week, and use some of it for the beginning of the week. These kind of things. Most of the home helps have brought up families themselves, and the majority of them can organise what they’re going to be cooking, and what the person likes. That’s if they know the person.”*  
(Home care manager area B)

Thirdly, it was felt that a lack of continuity can have an impact on people’s wellbeing.

*“They get used to their home help, they know where everything is, and sometimes they find it a bother to have to explain to a new home help what to do, where everything is.”* (Home care worker area A)

*“I was with a lady on Friday, and she says I was the sixth different person she had that that week, she never had the same face twice. That can be unsettling, they get upset about things like that.”* (Home care worker area B)

*“Same with caring, you’ve got a different one every time they come. And they ask you all the daft questions, ‘what do you want in your tea, how do you take your tea, do you take butter or marmalade on your toast’. Oh I say for goodness sake just give me a bit of toast and butter... Oh god it drives you up the bend.”* (B1)

This lack of continuity was seen as a particular problem for people with dementia saying *“it is a lot of change for them, especially dementia people”* (Home care worker area A).

### **Systems to aid co-ordination and communication.**

In both areas, examples were given of systems that are in place to aid communication, The most frequent method of communication used is a household diary or communication book. This is kept in the older person’s home. It is mainly used by the workers to communicate with

each other but is also sometimes used by friends and relatives to pass on information or make requests of the service. The main purposes of the diary described by professionals were:

- so that workers know they're doing the same tasks
- to keep home care managers and families informed about medication, monitoring food intake etc.
- to pass on tasks from worker to worker.
- if it's a weekly diary, to ensure variety in the diet
- occasionally workers used it to pick up recipes/ways of cooking.

While this system was viewed positively by most, there were some areas for improvement identified.

The researchers read some of the diary entries and it was evident that diaries are used in different ways by different people. Often the entries were very descriptive confirming that the required tasks had been completed with statements such as "all's well, tidied up, washed ashtrays, eaten black pudding roll".

One friend was concerned that diary information may not be accurate.

*"Meds taken, meds taken it will say in the book...but he has not actually taken them ..they are lying on the table"* (BF5)

It would have been more accurate to write "meds given - to be taken later" Some friends and relatives felt that requests they made in diaries were not consistently followed up or acted upon.

*"I put 'post-its' in their log book but they totally ignore it."* (BF5)

There would be value in exploring all of the current and possible uses of diaries to ensure that they are being used to their maximum potential and that information is appropriate and accurate.

In both areas, at the time of data collection, personal plans were not in use but were being developed. In one area they were being piloted. It was hoped that the personal plans will allow for preferences such as foods eaten, foods disliked and ways that client likes food to be presented, to be noted. For example, some people do not like a runny egg yolk. It was hoped that this will be of particular help to relief staff.

Workers had views about the information that they would like to have and the way this should be presented. Before visiting the person, workers would like basic information such as the person's full name, address, age, any special needs or health issues, alcohol issues, and tasks that have to be done. This is not always available when workers are called in at short notice to fill a gap. They felt the plan should be detailed but clearly organised under headings in a folder to make it easy to find your way around the information. They also felt that the personal plan should have a summary page at the front that could be read very quickly by someone visiting a person as a relief member of staff or at short notice. One worker reported that the ambulance service have such a system as do nursing records. It was felt that this should include information about what the person likes to eat if cooking is one of the main tasks that workers are going in to provide. It should also include emergency contacts such as doctor and next of kin. Finally, they felt it was important to have more space than is currently available to update care plan records.

As well as formal systems which aid communication, workers also spoke of the value of informal systems. One such system described by home care workers was the use of stickers on food items.

*“We put wee stickers on [foods] with the dates, or write it in the book, say when things were opened, then you know after 2 or 3 days to put it in the bucket.”* (Home care worker area B)

Workers also spoke of the value of bumping into colleagues when between visits. This usually results in a quick update of how a client was when last visited. Workers reported that these chance encounters are less likely to happen now that home care workers do not do people’s shopping. Workers in one area also reported using their personal mobile phones to quickly pass important information to colleagues.

#### **4.6.6 Difficulties related to review and monitoring**

In both areas it was reported that it is policy to review the implementation of a package of care after six weeks and then in one area the case would be closed and in another a six monthly review would be planned, or more if required. However, time pressures meant that often reviews are not undertaken in this planned way. It was, therefore, the expectation in both areas that the home care service provider would undertake day to day monitoring and review of the service and make a referral back to the community care team if necessary. In practice, however, there does not appear to be a systematic approach to reviewing and monitoring within the home care services participating in the study. Monitoring and review are mainly done on an ad hoc basis as required.

Most of the Home care managers’ contact with clients is via the telephone. While some home visits are conducted, these visits are not made to all clients.

*“you get to know people quite well on the phone, but have not necessarily met all of them.”*

*“[we] try to get out once a week.”*

*“In an ideal world, clients should be visited twice a year. This is a Care Commission expectation.”* (Home care manager area B)

Instead, home care managers rely on home care workers, social workers, family and friends or the older people themselves, to alert them to problems or changes in the person’s situation. Even neighbours have alerted the service to problems.

*“Neighbours occasionally will contact us, e.g., I can think of a few clients, who used to get meals on wheels, and they were seen outside the window or door, feeding the birds with the food provided, and neighbours have come and told us that.”* (Home care manager area B)

Home care workers play a key role in monitoring the effectiveness of the service offered and are expected to routinely look out for signs of the service being ineffective. Home care managers referred to this as *“keeping an eye open”* (Home care manager area A) and said:

*“we’re relying on the workers to tell organisers if there is a problem.”*

*“If the home helps encounter a problem, then they phone us.”*

*“Sometimes [clients] put their food in the bin when you’ve gone. And the home help would check as part of their routine.”* (Home care manager area A)

Home care workers feed back issues either by phoning the office or, in one area, putting in a letter with their time sheet. Generally, it was felt by home care managers that home care workers are in a good position to spot potential problems, such as an older person not eating,

as they do tasks such as emptying the person's kitchen bin or washing their dishes, and see clients daily. If a client has specific needs in relation to monitoring their food intake or appetite, this would be recorded on the computerised client records and the information passed on to home care workers. Home care managers said that they feel confident that the majority of needs that arise are identified by home care workers and are fed back and dealt with by the service.

However, there are some difficulties with this reliance on workers, friends and family. Firstly, home care managers reported that this is not always consistently done saying "*we're dependent on home helps coming back and saying, and a lot of home helps, they go with the flow*" (Home care manager area A). They have had incidents in which they have had to challenge home care workers who have not fed back important information. It was also suggested that, because of their daily contact with clients, home care workers might not spot problematic changes that happen gradually over an extended period of time. Home care managers saw the value of a new person, such as a relief home care worker, going to see a client as "*a stranger going in sees things with new eyes*". (Home care manager area A)

There did not appear to be clear guidance in place for home care workers to assess and alert managers to a potential problem with eating and nutrition experienced by current clients living alone at home, or any agreement about how this should best be done. Instead, the emphasis appears to be on individual workers being vigilant to changes in clients' wellbeing. Workers said that it could be hard to judge whether someone has lost weight unless their clothes are very loose. Sometimes a home care worker will only notice weight loss when bathing a person.

Reliance on others in the person's life to alert the service to problems is also problematic among this group of older people, as many of the older participants in the study had no friends or relatives involved in their lives who could raise issues on their behalf.

In addition, the reviews undertaken by home care managers appeared to be reactive rather than proactive.

*"Most of clients who have concerns or moans and groans are seen."*

*"The ones that you're hearing about."*

*"But others we never hear from, and you never keep in contact with them until there is a problem."* (Home care managers area A)

This reactive approach could mean that efforts are targeted at people in immediate need but there is a danger that it could also result in a small number of more vociferous older people who complain receiving a disproportionate amount of home care managers' time while the majority of older people remain invisible to the service. This creates a risk of some older people's needs being unrecognised and unmet and, therefore, their wellbeing being put at risk. While older people were aware of how to make a complaint about the service they receive, some expressed reluctance to do so or to make any negative comments about their service.

*"Ah but that's complaining you see. I'm not complaining because as I say, a lot of people may like it ... a lot of people might like it. I'm maybe fussy ... I'm not bothered as I take other things"* (A3).

*"That's the way I feel about it, but yae cannae complain"* (B5)

*“You don’t bite the hand that helps you”* (B4)

This may be particularly difficult if the complaint is about the home care worker. It was notable that none of the older people who participated in the study, including the most vulnerable older people such as those with a cognitive impairment and those with no family and friends involved in their life, had an independent advocate.

It was felt that the lack of time for review could have a detrimental impact on the operation of the service as well as its effectiveness. For example, some people are referred from the hospital for short term support with meals. After a period of time, they may no longer need help with meals but may receive support for longer than necessary, as their situation is not reviewed. They may continue with the service as they like the social contact the home care worker provides. The service may not be aware of this change of function.

A new computer system that is being introduced in one area to review and monitor home care services was seen as unhelpful. The system records the movements of home care workers in blocks of time. Home care managers feared that they would *“not get out the door”* and their job would *“be like telesales”* if this system is introduced in their area. It was suggested it would not be *“person centred, needs-led or anything like that. It’s going to be machine-led as everything has to fit into every slot, every minute of a person’s day”* (Home care manager area B).

This raises some questions about what should be reviewed and monitored. It appears that great emphasis is placed on assessing the time spent with clients or whether certain tasks have been completed. There is less emphasis on the desirable outcomes of interventions and monitoring and reviewing progress towards meeting these.

In one area, it was felt though that feedback had been improved since the introduction of senior home helps who do 28 hours of hands-on work as well as spending seven hours in the office each week. They can use these hours, among other things, as an opportunity to feed back issues to home care managers. In the other area the service was being re-organised to create two levels of home care organiser; one would be office based and the other would visit workers and clients at home to offer support, guidance and opportunities.

#### ***Unmet needs identified by the study***

As stated earlier, without good monitoring there is a danger that some of the older people’s needs will go unmet. Some unmet needs became apparent in the course of this study. These included needs for dental services, transport, help to maintain independence, advice about swallowing and choking on food, dietary advice and most frequently support to tackle the social isolation faced by older people who live alone and have difficulty leaving home. The consequences of needs going unmet can be significant. For example, there is research to suggest that frail older people who have dental problems do less well than those with functioning natural dentition (Soini et al 2005)

Assessors in one area explained that there is currently no system for logging unmet need. There is scope for this to be recorded as part of the computerised single shared assessment but this has not yet been established. One assessor suggested that the most effective way to flag up unmet need presently is through a client making a formal written complaint.

In conclusion, there are a number of issues relating to the monitoring and review of home care services. These include:

- a recognised need to monitor and review home care services and an individual's wellbeing in order to ensure that problems are identified and service levels are appropriate;
- as the population of older people cared for in their own home becomes increasingly frail, there will be a need to consider the best approach to monitoring and the timing of reviews. These may need to be more frequent for more frail individuals whose circumstances may change considerably in a short space of time;
- a lack of regular reviews of clients of the home care service currently due to time constraints may be leading to an over reliance on home care workers to identify issues and changes in need;
- there is a lack of consistency with which issues are identified by home care workers;
- there is a need for home care workers to have training to be able to identify food and nutrition related problems more consistently;
- there is a need to develop a monitoring and review system that is person-centred and outcome focussed;
- the role of independent advocacy for the most vulnerable older people needs to be explored;
- home care managers face a significant challenge assessing the quality of the service when managing workers at a distance. There would be value in exploring models of good practice in relation to this;
- there is a need to systematically record and address unmet need.

Monitoring and review is, therefore, an area requiring further development. The introduction of Personal Plans will, at least, give older people information about the minimum level of service that they should expect, although an induction pack for clients may also prove to be helpful. There is a need, though, to develop a monitoring and review system which takes account of the qualitative aspects of the service and outcomes as well as quantifiable elements such as time given and tasks undertaken. Previous research has identified the use of outcomes as an underdeveloped area in the care management process (MacDonald 2004). There would be value in exploring the application of work undertaken at the Social Policy Research Unit at University of York on outcomes in care management to the home care service (Nicholas et al 2003, Qureshi 2000).

#### **4.6.7 Difficulties associated with a lack of knowledge or skill among home care workers**

##### ***Skills of home care workers when preparing, cooking and presenting food***

From the older people's perspective, the level of knowledge and skills of home care workers is closely related to the quality of service they receive. For example, one woman noted that her meals are much more nicely presented, and therefore more appealing, when served by a particular home care worker who has a catering qualification. Another woman said that she mainly asks the home care workers to make her toast as she considers that they cannot cook. She reported that one home care worker had asked her how to turn fish in the frying pan. Poor hygiene of home care workers was also identified as a factor affecting the appetite of two participants. Both complained that workers do not wash their hands before handling food and one has complained in the past about workers not having their hair tied back.

Home care managers drew attention to the range of skills that a home care worker needs such as being able to organise a kitchen, design menus, plan ahead, prepare food and cook a meal from scratch in a short time. They expressed concerns that some home care workers lacked skills in these areas saying “*some home helps are better than others to be quite honest*” (Home care manager area A). One gap in knowledge and skills identified by assessors was some home care workers being experienced cooks while others “*don’t know how to cook scrambled eggs*” (Home care manager area A). This obviously has an impact on the consistency of the service received.

It was explained by assessors and home care managers that traditionally young mothers were employed as home helps and they mainly undertook domestic support tasks. The workforce came, therefore, ready skilled. As the service has diversified into providing help with cooking, and now personal care, this is less so and many young women applying for home care worker posts now have less experience of ‘cooking’ and instead are, like many other sections of society, more familiar with reheating convenience foods. They are also less familiar with some of the traditional meals favoured by older people such as mince or liver and onions.

All groups that participated in the study reported that while all home care workers are able to reheat food some are not able to cook a meal from scratch and even those with cooking skills struggle to prepare and cook fresh food due to time limitations. Senior managers described the difficulties associated with assessing whether someone can cook at interview without asking them to undertake a practical test. Assessors felt that a basic course and test of competency was needed in order for home care workers to practice.

Home care managers felt that skills should be much more clearly ascertained at interview.

*“being able to talk about food preparation/cooking in an interview – it is a basic requirement for the job, becoming such a big part of the job – to be able to ask specific questions [at interview].”*

*“ At least if you can, can you make porridge, mince and tatties, and how would you make mince and potatoes, because if you say can you, they would just say yes.”*

*“ Or if a prospective worker is a vegetarian, how do they feel about preparing meat dishes? It’s difficult, because she can’t bring her own personal parts into the job.”*

*“ If you can’t do the job, you shouldn’t be in it, whereas they get away with it. Home helps that can’t cook, and it’s part of the job, but we’re not allowed to say – it’s discriminating.”*

(Home care managers area B)

Home care managers felt that additional training courses would be helpful for home care workers to learn about cooking and the preferences of older people in relation to food preparation, cooking and presentation. One said:

*“We have quite a lot of workers [who are] not always familiar with how older people like food to be prepared. A course would help. Sometimes you get people phoning up saying ‘don’t send so and so, she didn’t understand it, I like this and she doesn’t understand’ – if there was a course, a person would understand.”* (Home care manager area A)

### ***Training currently available***

Managers reported that efforts are being made to increase the training available for home care workers and Scottish Vocational Qualifications (SVQs) are becoming more common.

However, the most frequently cited training course relating to food that is offered is a health and safety course and this is not yet available universally. In one area it was reported that a three year plan to roll out health and hygiene training to home care workers is beginning this year. There is no regular and established training related specifically to food, nutrition and healthy eating available to home care staff.

There are also some developments being introduced to offer a more detailed induction to new staff. In one area a new induction pack has been prepared in the form of a folder containing various policies and documents. Included in this pack are food hygiene guidelines. The manager in this area explained that there is a significant challenge to meet the training needs of existing staff as well as well as new workers joining the service.

### ***Using the knowledge and skills of older people***

The project came across examples where some older participants' knowledge and skills were greater than that of the workers in some areas. For example, three older people had worked in the catering industry and therefore had skills and were aware of health and safety issues. Also, several of the older people had raised a family and looked after a home for many years, and dealing with food had been a key role which they had in their household. In some cases this knowledge was used to great effect by the service. For example, one man who required a special diet related how he had trained up his staff to be able to meet his needs. He said "*I stood over them for the first couple of weeks and told them how to cook it ... I could even send [my home care worker] to the shops herself now*" (A5). In other instances there may be scope to make better use of older people's knowledge and skills to train home care workers.

In conclusion, it appears that the quality of the service received by older people can be dependent on the knowledge and skills of individual workers and it was felt that all staff members could benefit from having more knowledge and skills in the area of food and nutrition. There is a need for specialist courses for all workers to enable them to identify risk factors and helpful interventions for older people who have problems with food and nutrition. There is also a need for an established induction programme and training course for home care workers to develop basic skills such as meal preparation and presentation, and time management. This will become even more important as the level of frailty and impairment of older people living in the community, and therefore the level of specialist knowledge needed, increases. There may be scope to develop opportunities for older people to contribute to some food-related training. There would also be value in providing information to 'well' older people and family members about the nutritional needs of frail older people so that they are empowered to take responsibility for their own health before the need for services arises.

#### **4.6.8 Barriers presented by the wider community**

Community facilities can also present barriers to older people eating well. Some participants felt that supermarkets are becoming less accessible to older people despite services such as shopping assistants being available in store. Some of the criticisms made are described below.

Participants felt that large supermarkets do not cater for single older people. Items are sold in large packs. This is particularly a problem when fresh items are being sold.

*"Big shops don't cater for single people everything is in 2,3, or 4 packs which makes eating very repetitive....so when you buy something you have to have it 2 days running even if you dinnae want to"* (BF2)

*“a lot of the places you go everything is made up in packs...you can have 6 tomatoes, 3 pounds of potatoes...I use it once and I throw it in the bucket...when I retire I’m going to have to make it do 3 days. The thought of having to eat something that you don’t really want.... I can see why eating can be a problem for older people” (BF2)*

*“And they don’t want to buy a big bag of potatoes either. Maybe just want to buy a few individual ones.”*

*“Waste – there’s a lot of waste. Again, because lots come in big packages, and they go off, so by the time they get to eat it, a lot gets wasted and thrown out.” (Home care worker area B)*

‘Two for one’ offers also tend to be fresh items and so cannot be used by a single person in a short time.

*“The worst one was the two for the price of one .....they’ve stopped that now....but .in some areas the rotary clubs were taking the extra one and giving it to the needy...that was a good idea....she doesn’t need two loaves of bread and she doesn’t need four apples she only needs two. It is alright for big families. The home helps were getting litres of things...even at Christmas they got her a litre of sherry and nobody drinks it...it’s still in there...she likes to have it but no a litre” (BF1)*

This can also be a problem with frozen items.

*“Even the frozen vegetables – some of them have just got a wee freezer, you can’t store the big bags, and sometimes that’s all they’ve got.” (Home care worker area B)*

Participants expressed concerns that supermarkets are getting bigger and as a result are less accessible for older people. The example was given of one local supermarket which had recently opened. It has replaced a smaller supermarket, and in doing so has also replaced an in-store café, both of which were previously used well by older people, with a MacDonalD’s restaurant which is more aimed at children and families. It was felt that this supermarket is so large that older people find it tiring to move around. Technology such as automatic doors can also provide challenges for people with visual or perceptual difficulties, perhaps following a stroke.

Some older people felt less comfortable seeking help in a supermarket than they did in their local store despite this service being available. They appear to prefer to shop where they are known by the shop assistants and know them.

It was also some older people’s experience that smaller retailers are not as helpful as they were in previous times. One said:

*“the shops are no’ the same when you go in.... you’re maybe looking for this and that, and they don’t care. They don’t come over and say ‘can I help you? Are you looking for something?’. You’ve just got to get on with it yourself” (A9)*

Some older people would welcome home delivery services of traditional foods such as fish and chips rather than curries or pizzas. Some professionals were concerned that meeting places previously used by older people such as post offices and corner shops are closing and these need to be replaced if older people are not to become more isolated.

Community planning has a role in developing community facilities that meet the needs of all community members. There is evidence that some developments are creating barriers to older people's participation in their community.

#### **4.6.9 Conclusions**

A number of factors emerged which older people, family members and workers associated with quality when supporting older people to eat well. These included recognising individuality, providing choice, accommodating personal tastes and preferences, appropriate timing of support, addressing cultural issues, supporting people to feel connected to food, allocating adequate time for support, helping people stay in control, providing continuity, co-ordination and good communication, proactive monitoring and reviewing of services and ensuring workers have appropriate knowledge and skills to meet older people's food related needs. Some of these issues have been raised in previous studies of home care (Henwood et al 1998, Accounts Commission for Scotland 2001, Raynes et al 2001). What has not been explored previously is the impact on older people's ability to eat well and their related physical, psychological and social wellbeing if these quality indicators are not addressed.

From the data gathered it has emerged that the consequences of not addressing these aspects of quality could include:

- older people feeling lack of interest or motivation in relation to food and eating;
- older people not expressing their food related needs or preferences;
- food related needs going unmet or poorly met;
- older people not being aware of their rights and not feeling able to make a complaint;
- an over-reliance on pre-prepared meals;
- workers providing support with food outwith their hours and job description;
- no-one having an overview of the older person's diet and any risk of malnutrition;
- the wellbeing of older people being negatively affected.

There is a need to re-examine the aims of food related services and for there to be a shift away from services providing 'food as fuel' to 'food as a route to wellbeing'. Monitoring and review systems are also needed which place less emphasis on assessing the time given and tasks undertaken and instead the outcomes of home care interventions should be the focus. The scope for increased independent advocacy should also be explored. The recognition of individuality when providing a service emerged as a key consideration. Interesting research by the Social Policy Research Unit at York University is investigating the ways that home cares services can become more flexible and person-centred through, for example smaller support teams and arrangements similar to Direct Payments, but without the burden of the employer role (Patmore and McNulty 2005).

Access to Direct Payments for older people was introduced in 2000. Direct Payments are made to those assessed as requiring a community care service. A payment is made directly to the individual service user who is then free to make their own arrangements to employ personal assistants to meet their needs. Since their introduction, the percentage of people receiving a Direct Payment who are aged 65 and over has increased from 7% in 2001 to approximately 30% in 2005. In the period from 1st April 2004 to 31st March 2005 428 people in this age group received payments. In April 2005 eligibility was extended to older people aged 65 and over assessed as needing care services due to frailty or old age, but this will not be reflected in the present figures (Scottish Executive 2005). Direct Payments have the potential to change the relationship between older people and service providers and create

innovative solutions to older people's care needs but remain relatively new and under-researched.

Finally, there is a need to ensure that communities and community facilities are inclusive with the development of, for example, human scale supermarkets and other community services that are older person friendly and cater for the needs of older people who live alone.

#### **Key points**

- a number of factors emerged which older people, family members and workers associated with quality when supporting older people to eat well. These included: recognising individuality, providing choice, accommodating personal tastes and preferences, appropriate timing of support, addressing cultural issues, supporting people to feel connected to food, allocating adequate time for support, helping people stay in control, providing continuity, co-ordination and good communication, proactive monitoring and reviewing of services and ensuring workers have appropriate knowledge and skills to meet older people's food related needs
- the impact on older people's ability to eat well, and their related physical, psychological and social wellbeing if these quality indicators are not addressed, has not been previously explored
- the consequences of not addressing these aspects of quality could include: older people feeling lack of interest or motivation in relation to food and eating; older people not expressing their food related needs or preferences; food related needs going unmet or poorly met; older people not being aware of their rights and not feeling able to make a complaint; an over-reliance on pre-prepared meals; workers providing support with food outwith their hours and job description; no-one having an overview of the older person's diet and any risk of malnutrition; and the wellbeing of older people being negatively affected
- there is a need to re-examine the aims of food related services and for there to be a shift away from services providing 'food as fuel' to 'food as a route to wellbeing'
- monitoring and review systems which place less emphasis on assessing the time given and tasks undertaken, and instead focus on the outcomes of home care interventions, are also needed
- the recognition of individuality when providing a service should be a key consideration
- Direct Payments have the potential to change the relationship between older people and service providers and create innovative solutions to older people's care needs but remain relatively new and under-researched
- there is a need to ensure that communities and community facilities are inclusive with the development of, for example, human scale supermarkets and other community services that are older person friendly and cater for the needs of older people who live alone

#### **4.7 FUTURE DIRECTIONS**

During interviews, focus groups and workshops, some suggestions were made about how supports and facilities for frail older people could be improved or developed. These are described below.

#### **4.7.1 Improving current services**

Some additions to current services were suggested by participants to improve the ability of older people to eat well. These included a service similar to dial-a-bus, but which offered more support so that people would be enabled to visit a store, choose the food they want and have some social contact.

Suggestions were also made by workers to improve client choice such as expanding the Meals on Wheels service to offer a hot meal in the evening as well as at lunchtime and extending lunch clubs so that they can also provide an afternoon tea or evening meal. It was felt that there would be value in making lunch clubs accessible to frail older people to allow them to benefit from the social aspects of eating. It was also suggested that the dementia club model, where a small group of people go out for lunch in a café or bar with support, should be looked at for other older people.

In order to improve the quality of the meals received by older people, it was suggested that the possibility could be explored of using time more creatively by cooking three meals or so at one time from scratch and freezing them. The potential benefits of developing recipe books or cards with some older people were discussed. The recipe cards could include a photo of what the meal should look like, ingredients, and the method but also things like how long it would keep for in the fridge and other practical tips. A question was raised about whether a community kitchen; a shared facility to be used by older people and workers, could get around some of the problems associated with safety and hygiene.

There was also some interest in undertaking research to find out how those who do not use the service arrange support, in order to learn any new ways they have found to organise this.

#### **4.7.2 Developing knowledge and skills in home care services**

It was suggested that a training needs analysis relating to food, nutrition and cooking skills would be a helpful way forward to start to bridge the gap between the needs of frail older people and the skills of home care workers and managers. As well as identifying the gaps it was felt to be important to pool the collective expertise of home care workers and managers through, for example, developing 'handy hints' cards which could be made available to all workers.

It was felt that the induction process should include information about food and nutrition for frail older people. Mentoring and shadowing were suggested as creative ways of passing on such knowledge and skills. It was thought that this role should not necessarily be limited to those with the most experience or those who have been in the job the longest, but extended to, for example, workers who have come to work from overseas who may have an interesting perspective to share in terms of both culture and food.

There was interest in exploring the potential to advertise for home help/cooks when recruiting staff.

#### **4.7.3 Independent monitoring of service quality**

It was suggested in one area, that in order to get around the difficulty of older people not liking to complain, each older person should get a regular visit (every 2 months or so) from an independent person who is not attached to the service, to ask how things are going and whether there are any problems. It was suggested that it should be the same person who visits

each time to allow the older person to develop a relationship of trust with the visitor. It was hoped that the visit would also help to tackle isolation. It was suggested that the visitor could be a volunteer. It was felt to be important that services listen to the feedback that the visitor collects and act on it. The service may make changes following feedback or may just need to explain something to the older person.

#### **4.7.4 Improving information and communication systems**

A range of suggestions were made about how information and communication systems could be improved. These included:

- Home helps should have a space on their time sheets to write a line or two about the person and how things are going for them so that the office stays in touch.
- Older people should be given a rota or a copy of the office rota so they know who is coming to their home and when there are likely to be changes due to holidays etc.
- The initial visit should incorporate assessment of equipment and facilities as well as likes and dislikes. This information should be readily available to share with everyone involved.
- Care plans should contain more information about food. They could also include recipe cards for favourite meals such as porridge.
- The potential of using photographs to help people to make choices should be explored.

#### **4.7.5 Meeting the needs of those at greatest risk of malnutrition**

It was suggested that an initial assessment is needed which identifies people who need extra support, and assessment tools which are currently available should be researched. A follow up visit to people at risk was also thought to be useful after a meal to explore any difficulties. In order to link better with community dieticians it was suggested that the service could compile a list of questions and arrange with the dietician to come and give advice to staff. It was felt that simple clear information was needed from specialists about optimising nutrition, and dealing with problems such as constipation, through diet.

#### **4.7.6 Accessible communities**

It was felt that planners and designers should create living environments for older people that allow them to feel part of a community. Professionals described built ‘villages’ with terraces of houses or flats with communal cooking and eating areas, a restaurant and a corner shop which can deliver to homes.

It was also suggested that further use could be made of existing community resources in order to meet people’s needs more creatively. It was explained that there are quite a lot of take-aways in each area as well as hotels and clubs that may be willing to meet the needs of older people if approached and asked to do so. In one area, a chip van used to call in a particular neighbourhood and provided small portions for pensioners. It was suggested that hotels and clubs may be willing to do bar lunches which they then deliver to people’s houses. A note of caution was expressed about older people getting food delivered in the evening and having to open the door to the delivery man. It was thought to be important that people were going to a nice place and eating in a different environment and that assumptions about older people “*belonging in church halls*” (Assessor area B) should be challenged. One worker had heard that a nightclub in a local city has diversified by providing a meal and tea dance for older people during the day.

#### **4.7.7 Peer support**

A family member suggested that older people could work together to support each other and maintain their independence. She described a situation in a neighbourhood in which she had previously lived in which four older women who lived in the same block of flats got together and each took it in turns to play hostess for the day. This meant that they cooked an evening meal once in four days and ate in company four days per week. The family member felt that this way of working together had many advantages such as saving on gas and electricity and perhaps trying meals that you would not normally try. She felt that this would be helpful for her mum but was unsure whether such an arrangement could be set up, as she was not in contact with other people in her mother's area who might like to do this.

#### **4.7.8 Conclusions**

A range of creative solutions and ideas were suggested by participants in order to improve the ability of older people to eat well. These included extending existing service to make them more accessible and appropriate for frail older people and making greater use of the potential for community facilities to meet the needs of frail older people, given the right guidance and support. There were very practical suggestions to improve the systems for communication within the service, and between the service and older people and family members. The development of independent monitoring arrangements was also suggested. Better procedures to identify risk and link with specialist services were identified. Finally, co-operative arrangements between older people in a neighbourhood, such as taking turns to cook for each other, were seen to have advantages for older people. These may also require some facilitation or support.

#### **Key points**

- existing service could be extended to make them more accessible and appropriate for frail older people
- community facilities could be better used to meet the needs of frail older people, given the right guidance and support
- systems for communication within the service, and between the service and older people and family members, could be improved
- independent monitoring could be implemented
- better procedures could be implemented to identify risk
- links with specialist services could be improved
- co-operative arrangements between older people in a neighbourhood, such as taking turns to cook for each other, were seen to have advantages for older people

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## 6 APPENDICES

### 6.1 APPENDIX A – MEMBERS OF THE PROJECT STEERING GROUP

|                                      |  |
|--------------------------------------|--|
| <b>Professor Mary Marshall</b>       | Director, Dementia Services Development Centre,<br>University of Stirling  |
| <b>Noni Cobban</b>                   | Consultant, Dementia Services Development Centre,<br>University of Stirling  |
| <b>Andrew Sim</b>                    | Policy Officer, Age Concern Scotland   |
| <b>Jane Boulton</b>                  | Programme Manager, Community Affairs, Zurich<br>Cares Programme, Zurich Financial Services<br>Community Trust                |
| <b>Professor Rosemary Richardson</b> | Department Nutrition & Dietetics, Victoria Infirmary,<br>Glasgow   |
| <b>Helen Biggins</b>                 | Older advisor, Royal Bank of Scotland Centre for the<br>Older Person's Agenda, Queen Margaret University<br>College          |
| <b>Ivy Dell</b>                      | Older advisor, Royal Bank of Scotland Centre for the<br>Older Person's Agenda, Queen Margaret University<br>College          |
| <b>Helen Laughlan</b>                | Older advisor, Royal Bank of Scotland Centre for the<br>Older Person's Agenda, Queen Margaret University<br>College          |
| <b>Linda Garcia</b>                  | Older advisor, Royal Bank of Scotland Centre for the<br>Older Person's Agenda, Queen Margaret University<br>College          |
| <b>Belinda Dewar</b>                 | Senior Research Fellow, Royal Bank of Scotland<br>Centre for the Older Person's Agenda, Queen Margaret<br>University College |
| <b>Chris Jones</b>                   | Research Fellow, Royal Bank of Scotland Centre for<br>the Older Person's Agenda, Queen Margaret University<br>College        |
| <b>Caroline Donaldson</b>            | Research Assistant, Royal Bank of Scotland Centre for<br>the Older Person's Agenda, Queen Margaret University<br>College     |

## **6.2 APPENDIX B - ACCESS PROTOCOL, LETTERS OF INTRODUCTION AND CONSENT FORMS**

### **6.2.1 Access protocol**

The following protocol was used when seeking access to older people and family members.

- QMUC provides site with criteria for inclusion in the study
- Site identifies older people who fit these criteria
- Site and QMUC agree which people should be contacted initially
- Site contacts chosen people and gives information about the study verbally and then in writing in the form of a letter of invitation to take part and an information sheet. Site also seeks permission of the older person to contact family member who is main carer and likely to be the interviewee.
- Site speaks to the family member and gives them a letter of invitation to take part and an information sheet.
- If people agree to take part, QMUC in liaison with site arrange a first contact where researcher meets the person AND the carer together. The person's key worker may also be present at this meeting if the person requests this. QMUC goes through the study information in more detail and the consent forms. If consent is given there and then, QMUC arranges interview times.
- If it is not appropriate for consent to be given at this first meeting, older person and/or family member to get back to site to either agree or decline to participate in the project
- If the older person agrees, consent form is completed and meetings arranged.
- If the person declines, send letter or make phone call saying thank you for meeting and will keep up-to-date re progress.

## 6.2.2 Letter of introduction for older participants

Dear

### **Recipe for Life: Helping Older People who Live Alone to Eat Well**

We are currently working on a project with the Scottish Centre for the Promotion of the Older Person's Agenda at Queen Margaret University College, the Dementia Services Development Centre at University of Stirling and Age Concern Scotland.

We are trying to find better ways to support older people who live alone to eat well. As part of the project, [name] the Project Worker from Queen Margaret University College is hoping to meet some older people who live alone to discuss the issues they have come up against when trying to shop, cook and eat meals.

We are writing to ask you whether you would be willing take part in this project. If you were to take part in the project, this would involve:

- Meeting with [name] for one hour to talk about food and eating, any things you find difficult, supports and services you receive and your local shops.
- Filling in a short diary to record your eating and drinking for three days.
- Meeting with [name] a second time for one hour to talk about the information you have provided through the diary and how services could be improved
- [name] would also like to speak to some people who provide you with support such as a relative or friend and paid workers.

[Name] will be asking some older people if they mind having their weight and height measured. It is perfectly acceptable to take part in all other parts of the study and not have these measurements taken.

If you are willing to help with the project, I will introduce [name] to you and she can give you more information about the project and what it involves. If you decide that you want to take part in the study, you can arrange some dates with [name] when the two of you can meet. You can decide that you do not want to take part in the project after this meeting or at any point during the project.

I will call you next week to discuss this with you further.

Yours

### 6.2.3 Consent form for older participants



## **CONSENT FORM FOR OLDER PARTICIPANTS**

Main contact:

Chris Jones  
Project Development Officer  
Scottish Centre for the Promotion  
of the Older Person's Agenda  
Queen Margaret University College  
Corstorphine Campus  
Edinburgh, EH12 8TS  
0131 317 3771  
email: [cjones@qmuc.ac.uk](mailto:cjones@qmuc.ac.uk)

photo

### **Why is this project needed?**

'Recipe for Life' aims to help older people who live alone to eat well. Many older people do manage to eat well. For others, as we get older, a number of things can lead to us not eating well. In some cases, it may not be easy to get to the shops. In other cases we may have developed an illness or disability which makes it difficult for us to cook or enjoy our food. If we live alone, we may not feel it is worth cooking a meal for one. However, a poor diet can have a major impact on an older person's ability to stay well and in control of their own life.

### **Which organisations are working on this project?**

The Royal Bank of Scotland Centre for the Older Person's Agenda at Queen Margaret University College is working with the Dementia Services Development Centre at University of Stirling and Age Concern Scotland on the project. It is funded by Zurich Financial Services Community Trust under their 'Zurich Cares Older People Programme'.

### **What do we hope to achieve through the project?**

We hope to:

- get a better understanding of the many factors that can lead to an older person who lives alone eating well or not eating well
- get an understanding of the issues facing organisations which provide support to older people with food and eating
- learn about positive policies and good practice ideas that are operating nationally and internationally
- discover some solutions to the problems older people face when trying to eat well.

### **How will we achieve this?**

We will work with three local authorities that want to improve the support they give to older people with food and eating. In Edinburgh we plan to:

- speaking directly to ten older people who live alone
- speak to a family member, friend or neighbour nominated by the older person who provides support
- meet with a group of professionals who are responsible for assessing older people's needs and arranging services.
- meet with a group of Home Care workers and a group of Home Care organisers.
- interview a senior manager in the Social Work Department with responsibility for Home Care services.

### **What do we need from you?**

We are looking for older people who live alone and have difficulty leaving home who are willing to take part in the project. Each older person who participates in the study will be asked to do the following:

- agree to allow the Project Development Officer to read your Personal Plan,
- take part in an initial interview in which the Project Development Officer will ask about your food and eating, any support you get with these and the facilities you have at home and in the neighbourhood to cook and shop,
- fill in a food diary for three days and post it to the Project Development Officer
- take part in a second interview in which the Project Development Officer will ask about the information you have given in the diary and your views about services.

### **What will happen to the information that is collected?**

The information you give will be treated confidentially. It will only be seen by the researchers. It will not be passed onto the Social Work Department or your carer. A report will be prepared at the end of the project which will summarise what we have learned through the project. Your name will not appear in this report and you will not be identifiable. If you raise a concern or a problem in an interview that needs to be addressed, we will let you know where you can get help with this problem. We regret that we cannot give individuals advice about nutrition as part of this study but will let you know if you need to seek further advice from your doctor or community dietician.

### **What difference will the project make?**

We hope that the project will make a positive difference to the support that older people receive to help them eat well. The project report will be made available to older people, carers, social work, health and voluntary organisations. You will also receive a copy. Unfortunately we cannot make any guarantees that the project will have any direct impact on the services that you receive but we feel it is important to try to make improvements in food services for older people generally.

**Please note:** your services will not be affected in any way if you decide not to take part in this project. If you do take part, you are free to withdraw at any time without your services being affected.

## CONSENT FORM

### **I agree to the items below that have been ticked.**

- To take part in an initial interview about food and eating and any support I receive with these.
- To fill in a food diary for three days
- To take part in a second interview about the diary and my views about services
- To allow the Project Development Officer to read my Personal Plan

### **I understand that:**

- I am free to withdraw from the project at any time
- I will not receive personalised nutritional advice but will be advised if I need to see my family doctor or community dietician
- the information I give will be treated confidentially and will only be seen by the researchers from Queen Margaret University College.
- my name will not appear in the final report and all information I give will be made anonymous.
- the information I give will be summarised along with information given by other older people and this summary will appear in a report which will be made available to older people, carers, social work and health staff. I will receive a copy.

**NAME .....** **SIGNED .....**

**If you have any further questions about the study that you cannot raise with Chris Jones, please call Belinda Dewar, the Project Manager on 0131 317 3575.**

#### **6.2.4 Letter of introduction for carer**

Dear ..... ,

##### **Recipe for Life: Helping Older People who Live Alone to Eat Well**

As you know, we are currently working on a project with the Scottish Centre for the Promotion of the Older Person's Agenda at Queen Margaret University College, the Dementia Services Development Centre at University of Stirling and Age Concern Scotland.

We are trying to find better ways to support older people who live alone to eat well. As part of the project, [name] the Project Worker from Queen Margaret University College is hoping to meet some older people who live alone and their family members or carers to discuss the issues older people come up against when trying to shop, cook and eat meals and how these can be overcome.

We are writing to ask you whether you would be willing to take part in this project. This would involve meeting with [name] for one hour to talk about the support that you give to your relative or friend.

If you are willing to help with the project, I will introduce [name] to you and your relative and she can give you more information about the project and what it involves. If you decide that you want to take part in the study, you can arrange some dates with [name] when the two of you can meet. You can decide that you do not want to take part in the project after this meeting or at any point during the project.

I will call you next week to discuss this with you further.

Yours

## 6.2.5 Carer consent form



### **CONSENT FORM FOR CARERS**

Main contact:

Chris Jones  
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## **Why is this project needed?**

'Recipe for Life' aims to help older people who live alone to eat well. As we get older, a number of things can lead to us not eating well. In some cases, it may not be easy to get to the shops. In other cases we may have developed an illness or disability which makes it difficult for us to cook or enjoy our food. If we live alone, we may not feel it is worth cooking a meal for one. However, a poor diet can have a major impact on an older person's ability to stay well and in control of their own life.

## **Which organisations are working on this project?**

The Scottish Centre for the Promotion of the Older Person's Agenda at Queen Margaret University College is working with the Dementia Services Development Centre at University of Stirling and Age Concern Scotland on the project. It is funded by Zurich Financial Services Community Trust under their 'Zurich Cares Older People Programme'.

## **What do we hope to achieve through the project?**

We hope to:

- get a better understanding of the many factors that can lead to an older person who lives alone not eating well
- get an understanding of the issues facing organisations which provide support to older people with food and eating
- learn about positive policies and good practice ideas that are operating nationally and internationally
- discover some solutions to the problems older people face when trying to eat well.

## **How will we achieve this?**

We will work with three local authorities that want to improve the support they give to older people with food and eating. In the Falkirk area we plan to:

- speaking directly to ten older people who live alone
- speak to a family member, friend or neighbour who provides support and is nominated by the older person as an interviewee
- meet with a group of professionals who are responsible for assessing older people's needs and arranging services.
- meet with a group of home care workers and a group of Home Care managers.
- interview a senior manager in the Social Work Department with responsibility for home care services.

### **What do we need from you?**

We are looking for family members, friends or neighbours who provide care or support to an older people with food or eating to take part in the project. You have been nominated by your relative/friend who is also taking part in our project. Each person providing care will be asked to take part in an interview about the support they provide. The interview will last approximately an hour. It can take place in a location and at a time that suits you.

### **What will happen to the information that is collected?**

The information you give will be treated confidentially. It will only be seen by the Project Development Officer and the Project Manager. It will not be passed onto the Social Work Department or the person you support. If you raise a concern or a problem in an interview that needs to be addressed, we will let you know where you can get help with this problem. A report will be prepared at the end of the project which will summarise what we have learned through the project. Your name will not appear in this report and you will not be identifiable.

### **What difference will the project make?**

We hope that the project will make a positive difference to the support that older people receive to eat well. The project report will be made available to older people, carers, social work, health and voluntary organisations. You will also receive a copy. Unfortunately we cannot make any guarantees that the project will have any direct impact on the services that your relative or friend receives but we feel it is important to try to make improvements in food services for older people.

**Please note:** your relative's or friend's services will not be affected in any way if you decide not to take part in this project. If you do take part, you are free to withdraw at any time.

**I agree to the following (please tick):**

To take part in an interview about the support I give to my relative/friend with food and eating

**I understand that (please tick):**

I am free to withdraw from the project at any time

the information I give will be treated confidentially and will only be seen by the researchers from Queen Margaret University College.

my name will not appear in the final report and all information I give will be made anonymous.

the information I give will be summarised along with information given by other carers and this summary will appear in a report which will be made available to older people, carers, social work and health staff. I will receive a copy.

**NAME** .....

**SIGNED** .....

## 6.3 APPENDIX C – DATA COLLECTION TOOLS

### 6.3.1 Interview one with older people

In this interview I would like to ask you about your food and eating and any support that you get with these. We are interested to hear your views about the part that food plays in your life and the services you receive. There are no right or wrong answers to the questions and we don't expect any of the people we interview to have a perfectly healthy diet – who does after all?

#### **A typical day?**

Can you describe a **typical day** and your eating and drinking throughout the day?

(ask about what, where, who with – prompt people to talk about all aspects including menu planning, shopping, storing food, food preparation, cooking, eating and washing up - create a rich picture)

Do you enjoy a **wee tippie/dram**?

Would you say that your eating and drinking habits vary or do you tend to stick to a **routine**?

Do you ever **eat out**?

#### **Appetite**

Would you say you have a **good appetite**?

Has your appetite **changed**?

If so, what changes have you **noticed**?

Do you ever 'take a notion to **/really fancy**' a certain thing or 'take a scunner to **/go off**' something?

Do you have any ideas about what **causes** changes in your appetite?

Are there any ways you've found that help you to **keep up a good appetite**?

#### **Attitude to food - 'eating to live' or 'living to eat' ...**

For some people, food is a very important part of their life and for others it is just something they want to get out of the way as quickly as possible....

**How important is food** and the enjoyment of food in your life?

If it is important, **in what way** is it important?

Do you have a **favourite** food and drink?

**How often** do you get a chance to have your favourite food?

Have you always had the same attitude to food or has it **changed over time**?

If it has changed over time, what do you think has **led to this change**?

#### **Difficulties**

Can you tell me about any **problems** you have with meals and eating.

Are there particular **aspects** of eating and meals that you find difficult?

(prompt people to talk about all aspects including menu planning, shopping, storing food, food preparation, cooking, eating and washing up)

Did **anything specific lead to** these areas becoming difficult for you?

#### **Services received**

Do you get any **help** with these difficulties from health or social services?

What **services** do you get?

*For each service ask:*

**Who** is it that comes to help you?

**How often** do they come to help you and at what point in the day?

**How long** do they stay?

**What** help do they give?

**How long** have you needed help from these services?

How did you come to get this help?

How did they **work out** what you needed?

Did you have a **choice** about any aspects of the service – who does what when?

If not, who made the **decisions** about what you should get?

How do you find the service?

Do you **pay** anything towards the cost of the service?

### **Informal supports**

Do you get any help with these difficulties from friends, family and neighbours?

**Who** helps you?

**How often** do they come to help you and at what point in the day?

**How long** do they stay?

**What** help do they give?

**How long** have you needed this help from friends, family and neighbours?

How did you come to get this help?

Do you **pay** them to help out?

### **Facilities at home**

What facilities do you have at home for preparing, cooking and storing food?

Are there any aspects of your home that make eating and meals difficult for you?

### **Local facilities**

What shops and facilities do you have in your local area to help you with food and meals?

Do you use these shops and facilities?

If so, which ones do you use and how often?

What do you like or find helpful about your local facilities?

What do you not like or find unhelpful about your local facilities?

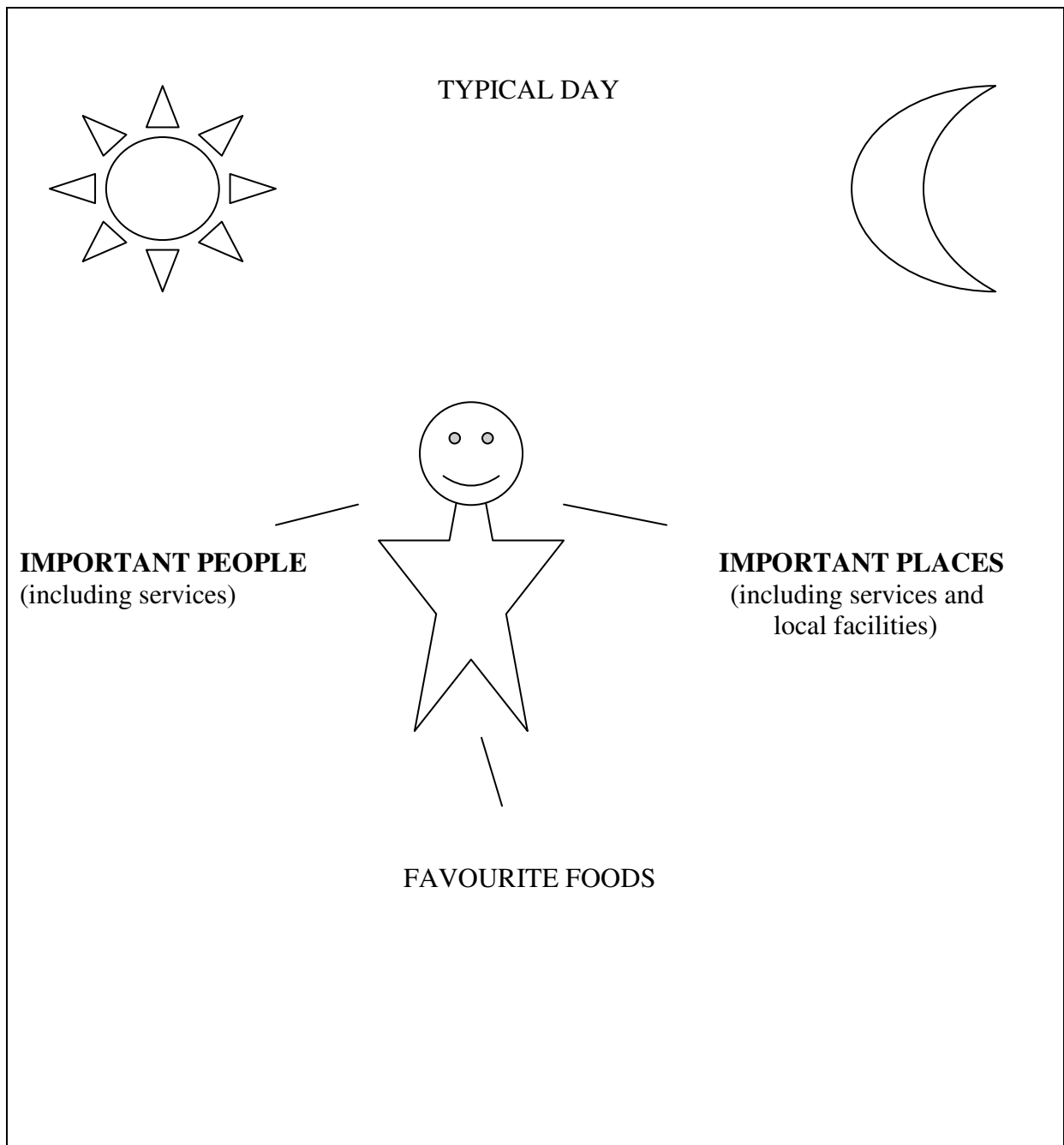
### **Closing**

Is there anything else about your food and eating and drinking that we have not talked about that you would still like to tell me?

### **Diary**

(At the end of the interview the older person will be asked to keep a food diary for three days in the next week and then to post it back to the PDO in a stamped addressed envelope. This information will be discussed in interview two.)

**6.3.2 Rich picture used with interview one**



### 6.3.3 Interview two with older people

In this interview I would like to cover three main areas:

- with your consent, I would like to measure your height and weight and ask about any changes in your weight or appetite.
- I would like to go through your food diary and ask some questions about the information you have given.  
(A nutrition specialist at Queen Margaret University College will look at the information and measurements and we will contact you if there is any concern about your health or nutritional status.)
- I would also like to ask your views about the things that help you to eat well or get in the way of eating well.

What are the biggest problems you face that get in the way of you eating well?  
Do you have any suggestions about how these can be overcome?

Thinking about the help you get from friends, neighbours and family members ...  
What do you appreciate most about the support you get from them with food and eating?  
What would you miss most if they were no longer able to give you support?  
(reassure people that this is hypothetical)  
If you could ask them to do one or two things differently what would you ask them to change about the support they give?

Thinking about the help you get from services ...  
What do you appreciate most about the support you get from services with food and eating?  
What would you miss most if you were no longer able to get these services?  
(reassure people that this is hypothetical)  
Are there any things that you would like to change about the services you get?

Some older people are now using Direct Payments to buy in the care they need and want. They are given the money they need to pay for their support by the social work department. If you had a free hand to buy in the services you need to help with food and eating and had the money to afford these, what sort of service would you want?  
Where would you want to have your meals?  
Who would you like to have meals with?  
What sort of food would you like?  
What sort of help would you want with food and eating?  
When would you want to be given help?  
Who would you want to get help from?

What is the most important thing to you, to help you 'eat well' and stay well?

#### 6.3.4 Examples of vignettes used with older people

|  |  |
|--|--|
| <p>I always enjoyed preparing food. My Home Help knows this and brings the peeler and pot over to my chair so I can sit and prepare some potatoes to have with my lunch.</p>     | <p>I like going to the day centre – at lunch time I eat my meal with some of the others, it's good to have company at meal times</p>   |
| <p>I get into bed and have a wee malt whiskey, and sleep all night!</p>  | <p>I had a serious fall recently; I don't know how it happened only that I felt a wee bit dizzy. I hadn't felt like eating that day.</p>   |
| <p>I have two Home Helps that visit me every day, one to do housework and the other to do my shopping and cooking.</p>   | <p>My home help can only reheat meals with the microwave or cooker. I really miss 'real' home cooked food.</p>   |
| <p>The Home Help who does my shopping regularly picks up the free supermarket leaflets and magazine. This helps to give me ideas for meals so I can vary what I buy and eat.</p> | <p>Recently my Home Help has been provided with a set of recipe cards and what a difference these cards have made to me. It helps me to think of things I would like to eat or sparks ideas for other meals.</p> |

|   |  |
|---|--|
| <p>The Home Help who cooks my food, I never see her wash her hands when she prepares my lunch.</p>  | <p>My Home Help often buys me huge cartons of milk that I can hardly lift let alone use before the date on the label!</p>  |
| <p>I don't enjoy going to the day centre, eating with others. I'm so deaf, I'm embarrassed because I don't hear what people are saying to me, its agony.</p>                      | <p>I used to have a healthy appetite but I now have a stomach disorder which means I can't eat fruit or dairy foods – I always loved a bit of cheese before!</p> |
| <p>Sometimes the meals that I ask my Home Help to cook are new to her. We sit down together and write out the recipe – it's great to have meals cooked just as you like them.</p> | <p>I don't seem to have much of an appetite these days. I end up getting the same old shopping and eating the same old meals. I can't be bothered!</p>           |

### **6.3.5 Family and friends – interview guide**

In this interview I would like to ask you about the following areas:

The support needed by your relative/friend

The support you provide to your relative/friend

Your views about the services received by your relative/friend

Ideas about how food and eating services and supports can be improved.

What aspects of food and eating does your relative/friend have difficulty with?

Can you tell me a little about the type of support you provide to your relative/friend and how often you provide this support.

Does he/she usually eat what you cook for him/her?

Do you share the meal with him/her?

What services does your relative/friend receive?

What are the most positive and helpful aspects of these services?

What aspects of these services are you least satisfied with?

Does your relative/friend usually eat what is provided by the service?

Do you feel that your relative/friend has any needs that are not being adequately met?

Have you been able to raise your concerns with him/her and any of the professionals with whom s/he comes into contact?

If so, what has been the response of your relative/friend and the professionals?

What are the biggest problems your relative/friend faces that get in the way of them eating well?

Do you have any suggestions about how these can be overcome?

What other supports or services do you feel older people need with food and eating?

### **6.3.6 Home care workers - focus group topics**

#### **The service provided**

The aspects of food and eating that Home Care Workers (HCWs) deal with

The most commonly requested meals and most commonly provided meals (traditional foods versus ready meals)

How HCWs get to know the person and their individual needs and preferences

What needs and preferences cannot be met

What happens to this information about unmet need

Bending the rules – when does this happen and how does it make you feel

Lack of time – What impact does this have on HCWs' work and how is this managed?

Who makes decisions about what is done and how?

Role as 'doing for' or 'doing with'

#### **Eating well**

How HCWs define 'eating well' (look for myths)

Is this different for OP as opposed to general population?

The various things they have noticed that help or hinder good nutrition and eating well for older people

Any signs HCWs notice that give clues that an older person may be malnourished or in danger of malnourishment

What HCWs do to encourage people to eat

What suggestions would HCWs make when someone has a poor appetite or is eating the wrong thing or too much?

#### **Co-ordination and monitoring**

Planning and organising a household –is this learned and how?

How do you work together to provide a joined-up service

How HCWs know when things are going well or not so well for OP.

Satisfaction AND outcomes

(e.g. throwing food away, still hungry, leaving food on plate, eating in-between meals, losing weight, putting on weight, feeling unwell, feeling low)

#### **Skills and training**

Aspects of food and eating that HCWs feel most confident about dealing with

Aspects of food and eating that HCWs feel least confident about dealing with

When advice will be given (e.g fruit instead of laxative) and how

Support and training that is available to and needed by HCWs in relation to food and eating/nutrition and more generally?

When would HCWs seek help from another source with someone's food and eating needs or report a concern

The sources of extra help and support that are available locally and how these are accessed

#### **Job Satisfaction**

Parts of HCWs job that they get most satisfaction from

Parts of HCWs job that they feel most frustrated about

How HCWs cope with these frustrations

**Improving the service**

The strengths and weaknesses of the current service offered by Home Care in meeting the food and eating needs of individual older people.

How the service delivered to older people could be improved

Ideas for possible intervention(s) to increase the older person's ability to eat well and stay well.

### **6.3.7 Home care managers - focus group topics**

#### **Services required**

What sorts of problems do older people requiring the service have with food, cooking, eating well?

What help and support does the Home Care/Help Service and the Shopping Service give to older people with food related tasks?

Is the service set up to 'do for' or 'do with' or both?

#### **Eating well**

How would you define 'eating well'?

Do older people have different requirements for eating well than the general population?

Are you ever concerned about older people's ability to eat well?

(Perception of those who are most at risk)

How would these concerns come to your attention?

What would happen when these concerns are raised?

In what circumstances would you refer on to another professional?

#### **Organising the service**

What challenges do you face trying to organise and deliver a good quality service?

How able are you to meet individual needs and preferences (fussiness)

What happens if you cannot meet someone's need or preference?

Is the service 'task focussed' or 'time focussed' or focussed on something else (e.g. outcomes)? (explain)

How do you ensure you provide a joined-up service?

What do you find you spend most of your time doing or dealing with?

#### **Monitoring and review**

What elements of the service do you feel you and your staff are able to do well?

What parts of the service would you and your staff like to do differently or to improve?

How is this dealt with?

Bending rules – how is this looked up by managers?

Do you ever receive complaints? What about?

How do you feel about receiving a complaint?

What arrangements are in place for getting feedback from service users?

#### **Improving the service**

What would an ideal service look like?

Are there any things that get in the way of you making the improvements you want to make or achieving your ideal?

Ideas for possible intervention(s) to increase the older person's ability to eat well and stay well.

### **6.3.8 Social work assessors - focus group topics**

#### **Difficulties faced by older people**

What sorts of problems do older people requiring a service have with food, cooking, eating well?

How would you define 'eating well' in relation to older people?

Are you ever concerned about older people's ability to eat well?

(Perception of those who are most at risk)

#### **Referral and assessment process**

Where do referrals come from?

Can you explain the assessment process when a person is referred for a service? (Single shared assessment?)

Does the assessment process and form used particularly ask about food and eating or is it more general?

What things help or hinder the ability of older people, who live alone and have difficulty leaving their home, to eat well.

#### **Current service provision**

What is the range of services that you can arrange to meet these food related needs?

How do you decide which services to arrange? (e.g. shopping with HH or using shopping service) – and who decides?

Are services set up to 'do for' or 'do with' or both?

When is one or the other appropriate?

To what extent are you able to meet individual requests e.g re timing of service?

When is this not possible?

Are HHs able to provide 'social' support as well as practical help?

What impact if any are local charging policies having on food related services?

#### **Review and monitoring**

How do you know when things are going well or not so well for the older person receiving the service?

What sort of feedback do you expect and get from service providers?

How is unmet need identified and dealt with?

What are your views about the strengths and weaknesses of the services that are available?

What challenges do you face trying to arrange a good quality service?

#### **Role of CCT and others**

What would you do if concerned about an older person's ability to eat well?

What aspects of eating well and advice giving in relation to this would you see as your role?

What aspects would you refer to others?

In what circumstances?

#### **Improving services**

What food related services would you like to see improved?

What would an ideal service look like?

Are there any things that get in the way of you making the improvements you want to make or achieving your ideal?

Ideas for possible intervention(s) to increase the older person's ability to eat well and stay well.

### 6.3.9 Senior manager of home care services – interview guide

Can you tell me which services come under your **responsibility**?

(ask about HCWs, shopping service, MOW, other...)

Do you hold a **budget** for these services?

If not, who holds this and how are decisions made?

Do you have any **contact with clients**?

Which aspects of the services that you provide are you particularly **happy with** and why?

(give examples from participants such as ...the dementia service which gives extra time and different model of lunch club for older people)

Are there any aspects of the services that you provide that you feel could be **improved**?

(give examples from participants such as ... too many HCWs coming into their home)

What **helps and hinders** you in **providing a ‘good quality’ service** to older people who need support with food, meals and nutrition or **making the changes** to poorer aspects of your service?

*Prompt:*

*Local policies (such as the two meal visits per day)*

*Staffing issues (such as recruitment or moving HCWs who are unpopular or problematic)*

*Organisation (such as timing of HCWs delivering the service)*

*Resources*

*User preferences*

When we interviewed people we heard about informal arrangements that are in place between clients and HCWs (e.g. casserole) and how these are considered **‘breaking the rules’**. It must be difficult to manage a situation where someone is ‘breaking the rules’ but it also has positive outcomes for the client. How do you manage that?

A key issue that came out of the pilot related to the **gaps in knowledge** of different staff. E.G. staff had questions about special diets, good diets, length between meals, identifying risk factors etc.

How would staff development needs typically be identified and addressed?

Is the service able to easily find out about best practice? Where from? Could it be made easier?

What opportunities are there for the organisation to get **feedback** about clients, staff and the service?

Are any of the **recent policy or practice initiatives** that have come from the Scottish Executive having an impact on your work?

Prompt - Joint Future, Free Personal Care, Care Standards ....

Are there any **improvements** that you plan to make to home care services to ensure that the food and nutritional needs of older people are better met? Please describe them.

What **barriers** do you face in trying to implement these particular improvements?

## **6.4 APPENDIX D - APPROACH ADOPTED TO COLLECT DATA FROM PEOPLE WITH A COGNITIVE IMPAIRMENT**

### **Recruitment of participants**

Working with a Scottish local authority, persons eligible to participate were identified by Home care service organisers/managers, who also explored with their client whether they would be interested in speaking with a member of the research team about participation.

### **Sample**

Five older people (four females and one male), aged 65 years and older participated in this phase of the study. Four participants had a cognitive impairment (one person with a stroke related impairment, two people with dementia and one person with early signs of dementia). The fifth person had previously suffered a head injury at work, resulting in a speech impairment and tremors.

### **Conveying the project information**

All information regarding the project clearly displayed the project logo, and the researcher wore an identification badge bearing the same logo. Once agreement to participate was given, the researcher wrote the date of the next visit on a card, which also displayed the project logo. Emphasis was placed on this logo as a way of pictorially representing the project, in the hope that this would act as a memory aid for the participant.

### **Context**

All visits were made at a time when the participant would be eating. Context is important memory prompt and the intention was that issues regarding food would be more salient and accessible to the individual at mealtimes.

### **Key Informants**

Where possible, visits were made when a relative/friend or a member of the home care team could be present. Valuable information was gathered from these key informants during the first visit regarding the participant's usual presentation, their behaviours and speech, and how they indicate states of well being and ill being. This information was required and used to ensure the participants well being was maintained during the research process and as an indicator of when consent was given or withdrawn.

### **Visits to participant**

Three visits were made to each participant. The visits were structured as follows:

#### *Initial visit*

An Initial visit was made to give information about the study and to gain consent to return for a further visit, and to begin to explore their experiences, thoughts and feelings regarding food. Information was given in the form of a guided conversation, following the older persons conversation and maintaining a focus on food.

#### *Second Visit*

The aim of the second visit was to conduct participatory observations and guided conversations regarding food. Visiting the participant at times when food and drink are consumed allowed the researcher to make observations of how the older person coped in these situations. More importantly, this gave a context in which to participate and discuss issues of food. During this visit a key informant was also present. The researcher was also

able to observe the interactions between relative/friend or home care worker. Sharing the experience of eating and drinking allowed for observations to be made and information regarding this activity to be gained. This information guided and directed subsequent visits, indicating areas for further exploration.

### *Third visit*

The purpose of the third visit was to further explore food issues, through the use of a guided conversation/unstructured interview technique. Information from the previous visit guided this final interaction, allowing for further exploration of issues raised from previous visits.

### **Method**

In order to gather information from older people with a cognitive impairment, the research team were required to adapt the methodological approach and methods used. This entailed:

- adopting a consent process that enabled the individual the opportunity to choose to agree or decline participation, as opposed to seeking proxy consent from an informal carer/relative.
- adapting the methods employed to collect data. In the main study we had used interview technique alone. We decided to use additional approaches that did not solely rely on the use of the spoken or written word.

Methods used included participatory observations, guided conversations/unstructured interviews, photographs of food and vignettes.

### *Participatory observation*

Participatory observation offers the researcher the opportunity to immerse themselves in the participant's world. As Fielding states '*the participant observer sets out to appreciate the native's point of view*' (Cited in Murphy 1998: p100). By participating in the activities the observer is enabled to '*take the view point of those studied, understanding the situated character of interaction*' (Cited in Murphy 1998: p100)

Participatory observation was an additional tool incorporated specifically for use with this cohort of individuals with a cognitive impairment. This enabled the researcher, through participation in the setting and with the participant, to build a relationship of trust, and to place data collection within the context of the project focus, food. During participatory observations, the researcher would note information regarding the environment, interactions with the older person, theme-specific information (meaning of food, appetite, choice and control, difficulties with food and eating), and researchers thoughts and feelings during the observations.

The researcher made arrangements to visit the individuals at times when they would be eating. For some of the participants this meant data was collected at a day centre as this was where most of their day was spent and gave the opportunity to participate in a lunchtime meal. Engaging in a food activity enabled the guided conversation to take place in a relevant context, the intention being that the participant's experiences, thoughts and feelings regarding the topic of food would be more salient at this time. This also enabled the researcher to use additional prompts, referring back to the aspects of the food activity, for example, '*That was a big plateful*'. The disruption of the researcher participating in this activity was kept to a minimum through gaining their acceptance and participation with the group.

During participatory observations, the researcher took brief notes to be expanded on later or where note taking was not possible, thoughts were recorded as soon as possible after the engagement. Notes were taken regarding the situated context, the activities that were taking place, and the people involved. Information gathered from this method can be pieced together with data gathered from guided conversations/unstructured interviews and information from key informants to give a more holistic view of their personal reality regarding issues of food and eating well or not eating well.

Participatory observation enabled a relationship of trust and acceptance to be built. When visiting at the day Centre, time was spent joining in with the activity that was taking part on my arrival. Participatory observation was conducted, consent for which took the form of asking the participant if they minded if the researcher joined in with their game of dominoes, joined them for lunch, and ate their lunch with the older person.

Our aim in incorporating this method into our approach was to elicit data from 'being' with the person in context. Dewing (2002: p18) states, '*many persons with dementia need environmental cues around them in order to fulfil their capacity for consent*'. So dialogue will usually need to be carried out in the setting that is relevant to the research. For people with a cognitive impairment, context is all-important for conversation. By becoming involved with activities related to food issues enables the person to directly engage with the topic and share their thoughts, feelings and experiences of food and eating.

#### *Guided conversations/unstructured interviews*

Data was gathered using an unstructured interview technique; a guided conversation, By using a guided conversation, the researcher followed the thread of the participant's conversation, but guided the conversation towards the identified themes which were the meaning of food, appetite, choice and control, difficulties with eating and food.

The researcher joined the participant for lunch; the intention was to focus/orientate the individual to the issues of food, which would be discussed once mealtime was over. After lunch the individual participating was asked if they would like to have a 'conversation/chat' with the researcher regarding their experiences of coping at home regarding food in order to find out what life is like for them regarding eating and drinking. Once consent was gained the unstructured interview in the form of a guided conversation was conducted. Participating in, and observing, lunch gave the researcher the opportunity to include this experience into the guided conversation. For example, '*what was your lunch like today, it looked nice?*' The participant responded, '*Eh soup and chicken I think it was I had*'. The researcher furthered the conversation by commenting, '*It was quite a big plateful*'. The participant was still engaged with the previous question, responding, '*Aye, I think it was soup chicken and Angel Delight*.' As the participant did not pick up on the comment regarding the portion size, this indicated that the conversation was cognitively outpacing them, and so the researcher responded with an utterance of agreement, '*Uhuh*' regarding what was eaten. The respondent stayed focused on what was eaten at lunchtime and further commented, '*Oh it's always nice, I always like it*'. This illustrates the importance of monitoring the interaction to avoid compromising the participant's well being. Too many questions, or moving the pace of the conversation along too quickly can confuse and cause distress. Distress was avoided in this instance due to the researcher's awareness of the participant not picking up on the subsequent question. The pace of the conversation was guided by the participant's train of thought, and in this instance the researcher stayed with the focus of what was eaten, following on by

asking if the participant chose to have this for lunch, which the participant was able to respond to.

### *Vignettes*

The vignettes used in this study consisted of short statements related to possible incidents or situations that an older person may experience. The vignettes were devised with older people who were members of the project steering group. The vignettes reflected both examples of good and poor practice. An example of a home help not washing her hands before preparing food was read to a participant. The response to this vignette was, *'Oh well she should tell her'*. The researcher agreed and furthered the discussion with the comment, *'I know, suppose some people don't feel like they can (tell them) if somebody's coming in to make things to eat'*, to which the participant commented, *'well they should know'*. The researcher agreed with the participant which lead the participant to expand the conversation further to discuss working in a kitchen, *'I know that's one thing we had to do, wash our hands and that, even the dishwashers and that too.'*

The vignettes presented a situation to the participant in the third person, which enabled comments to be made about the situation in a way that was removed from the participant.

### *Photographs*

Photographs of food or food contexts, such as the preparation or purchase of food, were used as a prompt. Dewing (2002: p18) makes reference to the usefulness of photographs to promote discussion, *'sometimes photographs of people or objects that may be covered in questions can also promote discussion about what the interview might involve.'* Dewing is referring to using photographs during the consent stage. This study employed photographs during the guided conversation/unstructured interview for the same purpose. This worked well and promoted a lot of valuable discussion. A participant was presented with a photograph of a glass of wine. The researcher asks, *'what about this, a wee glass of wine'*, to which the participant responds, *'Oh well, I'll have one of them!'* The researcher shares with the participant, *'I quite like wine, but I can't drink red as it gives me a headache'*, to which the participant comments, *'Oh I can drink anything'*. The participant went on to share with the researcher that the doctor had recommended that having something to drink before bed would help with sleeping.'

Using the photographs proved very effective in promoting discussion, and for this reason this was the main tool used during this stage of the study. It was important to maintain the focus of the photographs and not switch tools during the guided conversations to avoid confusion.



- Are there any areas of the job description that you feel less confident about?
  
- What would you like to learn during the project?
  
- Are there any specific things you think you need us to help you with in your role as a steering group member?
  
- Are there any project activities other than the steering group that you would like to get involved with (e.g. looking at literature, being a co-interviewer, attending meetings with professionals)

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To be completed following discussion between lay member and Belinda Dewar or Chris Jones.

We agree to do the following:

- 1.
- 2.
- 3.
- 4.