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Food provision for older people receiving home care from the perspectives of home care workers

Abstract

Malnutrition is a significant cause of morbidity and mortality, particularly amongst older people. Attention has focused on the inadequacies of food provision in institutions, yet the majority suffering from malnutrition live in the community. The study aim was to explore barriers and facilitators to food provision for older people receiving home care. It was a qualitative study using semi-structured interviews with nine home care workers in June 2013 employed by agencies in a northern English city. Data was analysed thematically, based on the principals of grounded theory. Findings showed significant time pressures limited home care workers in their ability to socially engage with clients at mealtimes, or provide them with anything other than ready-meals. Enabling choice was considered more important than providing a healthy diet, but choice was limited by food availability and reliance on families for shopping. Home care workers received little nutritional training and were not involved by healthcare professionals in the management of malnutrition. Despite the rhetoric of individual choice and importance of social engagement and nutrition for health and well-being, nutritional care has been significantly compromised by cuts to social care budgets. The potential role for home care workers in promoting good nutrition in older people is undervalued and undermined by lack of recognition, training and time dedicated to food-related care. This has led to a situation whereby good quality food and enjoyable mealtimes are denied to many older people on the basis that they are unaffordable luxuries rather than an integral component of fundamental care.

What is known about this topic:

- There has been a lack of progress in tackling the burden of malnutrition in older people despite a proliferation of guidelines and standards
- Research has focused on food provision in institutional settings, yet the majority of those vulnerable to malnutrition live in the community

What this paper adds:

- Insights into the challenges in providing food to older people from the perspectives of home care workers

- The food and mealtime experience available to older people receiving home care may be compromised by short visit times, restricted access to shopping services and a lack of training

Main article

Background

Malnutrition affects 25% of patients admitted to hospital and costs the NHS £13 billion each year, through increased morbidity, mortality and use of health services (Schenker 2003, Elia & Russel 2009, Brotherton et al. 2010, Russel & Elia 2012). High-profile national campaigns have drawn attention to inadequate food provision and poor nutritional care in hospitals and care homes as significant contributors to the burden of malnutrition (Age Concern 2006, Care Quality Commission [CQC] 2011, Francis 2013), and there has been a proliferation of guidelines and standards on nutrition and meals, most of which are aimed at healthcare professionals in institutions (Caroline Walker Trust 2004, , European Nutrition for Health Alliance 2006, British Dietetic Association [BDA] 2012, National Institute for Health and Care Excellence [NICE] 2012,). However, the continuing lack of progress in improving nutritional care suggests that there remain barriers to implementation (Department of Health [DH] 2009, CQC 2011). Furthermore, the focus on food in hospitals and care homes fails to recognise that approximately 93% of those suffering from malnutrition live in the community (Elia & Russel 2009).

The 440,000 older people receiving home care in England are likely to be particularly vulnerable to malnutrition through a combination of physical and psychosocial risk factors (Payette et al. 1995, Arvanitakis et al. 2008, Health and Social Care Information Centre 2012). Poor health, loneliness and depression have been associated with malnutrition, mediated through a combination of the effects of physical illness, functional limitations and loss of appetite (Schenker 2003, Locher et al. 2005a). Research in hospitals and care homes has found that nutritional care is compromised by low prioritisation of mealtimes, lack of choice of food and inadequate training of staff (Xia & McCutcheon 2006, Centre for Social Care Inspection 2006, Merrell et al. 2012).

However, the challenges to providing good nutritional care to older people receiving care in their own homes are largely unknown. Policies from successive governments have emphasised the importance of enabling individualised care and personal choice in social care (DH 2005, HM Government 2012). However, recent surveys of home care workers suggest that personalised care is compromised by limited time during visits and insufficient continuity of staff (UK Home Care Association [UKHCA] 2012, UNISON 2012). One study in Scotland found a reliance on ready-meals, variable nutritional knowledge and cooking skills amongst home care workers, and poor integration with separately commissioned shopping services (Jones et al. 2005). In order to understand the barriers to implementing guidelines and standards on good nutritional care in the community, the experiences of those providing this care on the frontline need to be explored.

The aim of this study was to explore the barriers and facilitators to food provision for older people receiving care in their own homes from the perspectives of home care workers, including providing and preparing food as well as support with eating.

Methods

This was an exploratory qualitative study based on semi-structured interviews with home care workers. The setting was the local authority of a large post-industrial city in Northern England where home care is contracted out to 13 independent providers. Data collection was carried out in 2013 and the research was approved by a University Ethics Committee, with research governance approval being sought from the relevant Local Authority.

Participants

The managers of all 13 home care agencies were approached and nine agreed to distribute information about the project to their staff. Any care worker employed by one of these agencies and providing home care involving meal provision to older people was considered eligible for the study. Those interested were invited to contact the research team for further information and to arrange an interview either face-to-face or by telephone.

It was predicted that home care workers may be challenging to recruit because they often do not have frequent contact with other staff and are dispersed across wide geographical areas, with crowded and unpredictable schedules (Patmore 2003, UNISON 2012). Due to an initial lack of response, managers were encouraged to discuss the research with staff opportunistically and recruit those who were interested. Snowball sampling was also employed, as this is an effective method of utilising social and professional networks to recruit from hard-to-reach populations (Mason 2002, Bryman 2012). A £10 retail voucher was offered to compensate participants for their time.

Data collection and analysis

An interview guide was produced by the research team, who were researchers interested in the health of older people. Twelve open-ended questions were designed to explore the role of home care workers in the food-related care of older people and to understand the barriers and facilitators to providing meals and support with eating. However, the guide was designed to be flexible as it was important to facilitate spontaneous and unanticipated responses in order to allow new themes to emerge (Legard et al. 2003, Bryman 2012).

Interviews were recorded and transcribed verbatim and the data was analysed using a thematic approach based on the principles of grounded theory, whereby categories and relationships between them emerged from the data and were grouped into overarching themes (Snape & Spencer 2003, Bryman 2012). The themes arising from the initial interviews were used to develop a coding framework, which was agreed by the research team and then systematically applied to the whole of the data to ensure a good fit, with a constant process of adjustment and refinement. The data were then sorted and summarised according to the themes to enable detailed examination and interpretation, with searching for linkages, associations and deviant cases (Ritchie & Lewis 2003, Bryman 2012). The software package NVivo10 was used for transcription, coding and data management (www.qsrinternational.com).

Findings

Nine semi-structured interviews were conducted, 3 by telephone and 6 face-to-face. The characteristics of participants are shown in table 1; five were home care workers and four had roles in management or administration within their agencies, in addition to providing front line care. They were employed by four different home care agencies including regional, national, private and not-for-profit organisations employing 24-59 staff.

All of the participants were responsible for preparing and providing meals for their service users as well as assisting with eating when required. Most also provided a shopping service for one or two of their service users but families were increasingly responsible for purchasing food. Their experiences and views reflected three emerging themes: 'time pressures', 'supply of food' and 'food-related knowledge'.

Time pressures

The greatest challenge to providing food and support with eating was the reduction in time allowed for visits, often only 15-30 minutes. Home care workers felt that mealtimes could be an opportunity to spend time engaging with service users, alleviating the loneliness experienced by many. All of the home care workers interviewed saw the same regular service users and thought it was important to build up a relationship with them. They were therefore frustrated that they did not have time to sit and converse with them while they were eating to mitigate their social isolation. They had observed that lack of company at mealtimes and loneliness could affect service users' willingness to eat and were particularly concerned that they were unable to provide adequate support and encouragement to those suffering from dementia who would often forget to eat:

"I'd like the time to sit down and have...just a five minute, ten minute chat, and then go. But you can't. You've just gotta, do what you've been told and go." (Home care worker (HCW) 1)

"Like one lady...that does not eat...she used to have, an hour...so the carer could stay there, and encourage, to eat...and [the council] just cut it to half an hour and...said, 'Well they can do it in ten minutes; leave her with her food'." (HCW8)

The lack of time during visits had also led to a complete reliance on microwavable ready-meals. Most home care workers assumed that service users were satisfied with these and the few that were not were expected to adjust because there was no real alternative. They thought that the quality of these ready-meals was often determined by each individual's financial circumstances, something out of the control of home care workers and limiting many to meals of they believed to be of poor quality. Whilst home care workers believed that the majority of older people would prefer fresh food cooked from scratch, this was considered an unattainable aspiration:

“Some service users don't mind, the microwave meals...Some don't like them. And, you're limited as to what you can actually provide for them if they won't eat them...I mean they do come round after a bit.” (HCW7)

Five of the home care workers interviewed sometimes stayed longer than the allocated time to prepare a fresh meal or to sit with the service users so that mealtimes were a more social and enjoyable experience. This was particularly the case for those who had worked in care for many years and could remember a time when social engagement and cooking 'proper' meals were considered central components of home care. However, their capacity to do this for most of their service users was limited by crowded rotas and electronic monitoring of visit lengths. Furthermore, it was suggested by two participants that some of the younger staff might not have the necessary cooking skills to prepare quick meals from scratch, although the younger home care workers interviewed did not raise this as a concern. Service users were therefore reliant on the goodwill and personal skills of individual home care workers for anything other than the very basics of food-related care:

“Some people are quite happy just to go in and, put a meal down and rush out and, some people...stay that extra five, ten minutes.” (HCW8)

Supply of food

As shopping services were no longer commissioned by the local authority there was an increasing reliance on families to shop for food and home care workers were concerned that their purchasing

decisions did not reflect the service users' preferences. Families seemed to make assumptions as to what their relatives would like, often without consulting them or appreciating that tastes might change with age. They also tended to buy the same things each week, resulting in a diet with very little variety:

"The family...don't seem to...know them....They'll get things that they don't like..., or they'll get the same things, week in, week out...with no variety." (HCW9)

"You try and sort of, leave...discreet notes like, 'Such and such person wasn't that keen on that, or they had trouble eating it'...Some people's families follow it up, some families just think you're...being awkward and interfering." (HCW8)

Whilst a minority of families could be supportive in providing appropriate meals, the level of involvement of the family and their relationship with the service user were key in determining what food was purchased and when. Some families were very responsive and called in regularly, whilst others tended to do large, infrequent shops, meaning that much of the perishable food went out of date and had to be thrown away:

"You find you'll get a big shop...and within, about three days, it's gone, 'cause half of it's gone off." (HCW8)

Home care workers preferred to have responsibility for shopping, particularly if they could take service users with them because this facilitated choice and provided an opportunity for service users to go out and interact with others. However, this was only available to a minority of individuals, most of whom had to pay for the extra time.

Home care workers felt it was their role to try to provide food that service users asked for, even if their preferred food was not perceived to be healthy. This could create a tension between providing a nutritious diet and enabling choice, particularly as they had found that older people often preferred snacking on sweet foods. There was some concern about the implications of this for diabetics but the majority believed that older people nearing the ends of their lives should be free to eat what they wanted:

"If people want to eat it, who would say no. I mean, at the end of the day they're in their twilight years, so, I'm not gonna say, 'You can't have it, 'cause it's bad for you'." (HCW8)

On the one hand home care workers felt they had little influence over the diets of service users because it was each individual's right to choose what to eat; on the other, their ability to facilitate this choice was compromised by a lack of control over the supply of food.

Food-related knowledge

It was apparent that home care workers lacked knowledge on the nutritional needs of older people. Most could not remember whether they had received any training about nutrition and could not recall the content, although the focus was generally on food hygiene and safety, rather than nutrition. As a result, nutritional knowledge was shaped mainly by personal experiences and health messages aimed at the general population:

“We don't get training in food, no. 'Cause it's just literally, the same [as] what we do...as part of our everyday life...We don't do anything different for the elderly.” (HCW2)

There was a belief that a loss of appetite was an inevitable part of the ageing process and was to be expected in those with chronic illness. This was exacerbated by a lack of involvement of home care workers in the management of malnutrition; most had little or no contact with healthcare professionals, whose role in nutrition was largely perceived as limited to the prescription of oral nutritional supplement drinks. Two participants had encountered dietitians but described their suggestions as unhelpful:

“We leave notes, or ask the family to ask, to leave notes, of what the doctor's said...Because everybody needs to be involved, there's no point in the doctor going or a nurse going and we don't know what they've said.” (HCW8)

“I think [dietitians] are a waste of time...They tend to talk a lot of rubbish...and it all goes over the person's head. And whatever they tell us seems a bit ridiculous, 'cause obviously you're not stupid.” (HCW9)

Some home care workers expressed a desire for more training on the specific dietary needs of older people and the nutritional implications of particular medical conditions. However, others could not foresee any benefit as much of their role, particularly heating up ready-meals, was considered to be common sense.

Discussion

The major barrier to good food and support with eating was a lack of time during visits and the resultant sense of inevitability that service users could only expect ready-meals. To mitigate loneliness and poor appetite, home care workers felt that older people would benefit from social engagement and encouragement at mealtimes but this was currently only possible if home care workers stayed longer than their allocated time. Enabling choice was considered more important than providing healthy food, although this choice was limited by a lack of control over the food available and purchasing of food by families that did not reflect individual preferences. Misconceptions about appropriate nutrition for older people and variation in cooking skills presented additional barriers, reinforced by a belief that providing food was common sense.

This exploratory study provides an important insight into the challenges of food provision in home care. A low response rate limited the number of participants and it was not possible to select a purposive sample because all of those expressing interest were recruited to take part. The inclusion of more senior staff provided a valuable strategic perspective but their views may have differed from frontline care workers, who proved more difficult to recruit. It is possible that managers were more likely to recruit staff considered to be particularly competent or more experienced. However, despite the small sample size, there was diversity in the age and experience of participants, as well as in the characteristics of the agencies. The transferability of these findings to other home care agencies and locations may be limited, due to variation in the commissioning and provision of home care as well as access to shopping services (Patmore 2004, Wilson 2010). However, the findings were very similar to the only other known study investigating the views of home care workers on food provision, despite its contrasting location in Scotland with in-house local authority care providers, rather than independent agencies (Jones et al. 2005).

Several larger studies have raised concerns about the impact of increasingly short visits on standards in home care (Equality and Human Rights Commission 2011, UKHCA 2012, CQC 2013), and this study

demonstrates the specific implications for food and nutrition. There is evidence that loneliness reduces appetite and interest in food and that company at mealtimes has beneficial effects on nutritional intake and overall well-being (Wylie et al. 1999, Callen & Wells 2003, Locher et al. 2005b, Desai et al. 2007, Tomstad et al. 2012). Interventions in care homes and hospitals have demonstrated improvements in energy intake and quality of life after prioritising nutritional care and introducing protected mealtimes or family-style dining environments (Nijs et al. 2006, Dickinson et al. 2008, Ullrich et al. 2011, Barnes et al. 2013, Young et al. 2013). This is in stark contrast to the situation in home care revealed by this study, where encouragement and interaction at mealtimes are apparently considered to be unrealistic and unaffordable aspirations.

Whilst home care workers in this study acknowledged that service users would prefer fresh food, most thought that the majority had got used to receiving only ready-meals. This contrasts with research in a variety of care settings in different countries demonstrating that older people express a preference for traditional, freshly prepared food and dislike or mistrust processed meals (McKie et al. 2000, Sidenvall et al. 2001, Wikby & Fagerskiold 2004, Crogan et al. 2004, Lundkvist et al. 2010, Pajalic et al. 2012). This suggests that service users are 'putting up' with food they do not really want, which could contribute to a lack of appetite and malnutrition in this population (Wikby & Fagerskiold 2004, Crogan et al. 2004, Edfors & Westergren 2012). Older people also value the choice and social interaction associated with going shopping (Sidenvall et al. 2001, Jones et al. 2005, Pajalic et al. 2012, Tomstad et al. 2012), suggesting that decommissioning shopping services is leading to a dissonance between a discourse of person-centred care and cuts to choice-enabling services (Sinclair et al. 2000, Ware et al. 2003, Patmore & McNulty 2005, Wilson 2010).

Home care workers play a central role in providing food and nutritional care to older people receiving care in their own homes, yet this is undermined by a lack of recognition and training, leading to an assumption that providing food is common sense. Similar concerns have been expressed by Cavendish (2013) and Heaven et al. (2013) that the tendency to view fundamental care

as common-sense has led to an under-skilling of the care workforce and a 'de-valuing' of food-related care. However, this study suggests that home care workers could play a valuable role in the management of malnutrition in the community as they often have the best insight into the potential psychosocial factors contributing to poor intake and their knowledge and understanding of service users may in some cases be greater than that of families. Furthermore, externally imposed interventions are unlikely to be implemented by those responsible for providing food if they are unfeasible, inappropriate or if their potential benefit is not understood.

Whilst home care workers would potentially benefit from further training in nutrition for older people, this may simply increase the gulf between what should be provided in theory and what is realistic in practice. It is unlikely to translate into real changes in service delivery without concurrently addressing the more endemic, institutional and resource biases against providing services for social and emotional needs (Ware et al. 2003, Patmore 2004). There needs to be recognition that failure to commission time for home care workers to engage with older people whilst they are eating, or to prepare fresh meals, is likely to be a false economy if the result is poor intake and an increase in malnutrition-related morbidity (Schenker 2003, Alibhai et al. 2005, Arvanitakis et al. 2008).

The views of older people receiving home care on the food available to them and the factors contributing to malnutrition need further exploration and there is an urgent need for evaluations of practical interventions to improve nutritional status in this population. The nutritional implications of a reliance on ready-meals in older people should be explored, building on more general findings that many are not nutritionally balanced, with high levels of salt and saturated fat and a lack of fruit, vegetables and fibre (Celnik et al. 2012, Howard et al. 2012).

Given the central role of home care workers in providing food to older people, it is essential that they are involved in designing and implementing interventions to improve nutrition in this population. However, engaging providers and their staff was challenging in this study, mainly due to

a lack of time and resources. It is also possible that recent media attention on poor standards in social care may have made agencies wary of being approached by external organisations (Buchanan 2013, BBC 2013). It is also possible that a larger incentive may be required to recruit from this low paid population, although this may raise ethical concerns. The shift towards multiple independent providers may therefore have implications for conducting research in health and social care and future researchers will need to dedicate sufficient time for building partnerships with managers in these organisations, who were ultimately essential gatekeepers for accessing frontline staff.

Most importantly, the findings from this study should initiate a wider debate as to whether we as a society are comfortable with the reality that good quality food and an enjoyable mealtime experience are currently denied to many older people on the basis that they are unaffordable luxuries, rather than human rights and an integral component of fundamental care (Oshaug et al. 1994).

Conclusion

This study demonstrates that there are unique challenges to providing adequate and appropriate food as part of home care, in particular the lack of time dedicated to food preparation, social engagement and encouragement at mealtimes. Home care workers are often responsible for all elements of food-related care so it is essential that they receive adequate training but also that they are involved by other professionals in nutritional care. However, without the allocation of extra time it will be difficult for home care workers to address many of the factors contributing to malnutrition, including social isolation, lack of supervision at mealtimes or the purchasing of inappropriate or disliked foods. Despite a rhetoric of individual choice and person-centred care, in reality home care workers are extremely limited in the food and mealtime experience they are able to offer. Perhaps most worryingly, there is a sense of inevitability that within the current financial climate, this is all older people receiving home care can expect.

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