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Received: 10 March 2020 | Revised: 22 July 2020 | Accepted: 23 July 2020

DOI: 10.1111/opn.12343

ORIGINAL ARTICLE

International Journal of Older People Nursing

WILEY

Care home staff's experiences and views of supporting the dietary management and choices of older residents with obesity

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Abstract

Background: Rising numbers of older people with obesity living in care homes is an international phenomenon. Addressing dietary management of residents with obesity is a cause of debate and controversy. On one hand, the 'obesity paradox' suggests obesity protects against morbidity in frail older people. On the other hand, obesity reduces functional status and restricts activity for this group. This paper considers care home staff's experience and views of supporting dietary management and choice for residents with obesity within the context of this controversy.

Design: In this qualitative study, 33 staff from seven care homes in the North East England participated in focus groups, and data were analysed using Braun and Clarkes's (2006) six-phase thematic analysis approach.

Findings: Findings indicate that participants' support of dietary management and choice for residents with obesity may be strongly influenced by the care home environment. Care priorities, dietary management approaches, care home life and family involvement in residents' dietary intake facilitate and encourage weight gain, and as such, pose challenges for staff attempting to support weight management of residents with obesity.

Conclusion: Findings suggest that in the care home setting, nutrition policy, guidelines and service commissioning processes and staff nutrition education should include management of obesity. Furthermore, families should be supported to understand the implications of their own caring behaviours on residents' nutritional status.

KEYWORDS

care homes, nurse, nutrition, obesity, Older people, qualitative, weight management

1 | BACKGROUND

The provision of nutrition support and the management of nutrition are highly relevant to the nursing care of older people. In contemporary society, the increase of obesity has become a major public health priority, and as the population ages, obesity is a significant and increasing phenomena in the older population (Peralta, Ramos, Lipert, Martins, & Marques, 2018). Research focusing on the prevalence of obesity in care homes, primarily USA-based, show prevalence in these care facilities is increasing significantly (Felix, Bradway, Chisholm, Pradhan, & Weech-Maldonado, 2015; Zhang et al., 2019). The prevalence of older residents with obesity in European care homes is difficult to estimate as data are limited, although a study of residents' body mass index (BMI) data in Germany and Austria reported that 16% of residents were obese in those countries (Valentini et al., 2009). In the United Kingdom (UK), the British Association for Parenteral and Enteral Nutrition (BAPEN) have completed nutrition screening surveys in care homes, and the most recent, undertaken in 2011, found 11% of the 522 residents surveyed had a BMI of 30 or greater, compared with 9% of 584 residents in 2008. BMI between 25 and 29 also increased from 25% to 32% in that period (Russell & Elia, 2015).

Addressing the increase in obesity in the care home population is a cause of debate and controversy. A number of studies suggest an 'obesity paradox' occurs in the older care home population in that resident body mass indices (BMI) demonstrating obesity are associated with lower mortality (Grabowski, Campbell, & Ellis, 2005; Kaiser et al., 2010; Lee et al., 2014; Souto Barreto, Cadroy, Kelaiditi, Vellas, & Rolland, 2017). Other studies refute this, proposing multi-morbidity associated with older age, and life style-related conditions prohibit research from making meaningful conclusions about the association between obesity and mortality in this age group (Wei Zanandrea, de Souto Bareto, Cesari, Vellas, & Rolland, 2013; Zhou et al., 2017). Nevertheless, 'obesity paradox' findings have resulted in weight loss interventions in older adults being perceived as controversial, and therefore not generally implemented.

Even if a relationship between obesity and mortality is established, a number of studies have found the negative impact of obesity on residents' health quality of life and health status is a reality. For example, obesity in the care home older population is related to several conditions such as diabetes, hypertension, coronary heart disease and heart failure (Zanandrea et al., 2013), dementia (Atti et al., 2007), skin infections, incontinence and osteoporosis (Folsom et al., 2000; Henderson, Sadlier, & Currie, 2006), falls (Mitchell, Lord, Harvey, & Close, 2015) and depression (Hamer, Batty, & Kivimaki, 2015). Research has also shown a positive relationship between obesity and reduced functional ability in older people, requiring increased support with activities of daily living (Coker & Wolfe, 2017).

The few studies that have explored the care management of residents with obesity (RWO) residing in care homes have revealed a number of care challenges. For example, care home premises are not always adequate to accommodate the care of RWO (Felix, Bradway, Ali, & Li, 2016; Miles et al., 2012). There is a lack of specialist equipment, resources and training to enable staff to provide effective care (Bradway, Miller, Heivly, & Fleshner, 2010; Dimant, 2005; Felix et al., 2016; Marihart, Brunt, & Geraci, 2015). Also, management of RWO requires more intensive assistance with personal care from staff (Harris, Engberg, & Castle, 2018; Kosar, Thomas, Gozalo, & Mor, 2018) and may increase the risk of work-related injury (Bradway, DiResta, Fleshner, & Polomano, 2008). Felix et al. (2016) suggest that these factors are barriers to care home admission for RWO, which result in longer or inappropriate hospital stays. According to studies by Yang and Zhang (2014) and Marihart et al. (2015), financial costs of caring for RWO is significantly higher than for non-obese residents.

Finding a solution that accounts for both the 'obesity paradox', and supporting quality of life and health status for care home RWO is problematic. A number of studies propose that weight management interventions should be considered despite the 'obesity paradox' as they can improve function, cognition and mental health (Chau, Cho, Jani, & St Jeor, 2008; Napoli et al., 2014; Payne et al., 2018). It should be noted that all these authors stress weight management

What does this research add to existing knowledge in gerontology?

- Despite increasing numbers of older people with obesity residing in care homes, nutrition policy, management and education focus only on reducing risk of weight loss and malnutrition.
- In care homes, care priorities, dietary management approaches, care home life and family involvement in residents' dietary intake predispose high-calorie food choices for residents.

What are the implications of this new knowledge for nursing care with older people?

- As environmental and contextual factors in care homes for older people facilitate and encourage weight gain, the risk of obesity increases.
- As nutrition policy, management and education focus on reducing risk of weight loss and malnutrition, this poses a challenge for staff attempting to support weight management of residents with obesity.

How could the findings be used to influence policy or practice or research or education?

- In care homes for older people, nutrition policy, guidelines and service commissioning processes and staff nutrition education should include management of obesity.
- In care homes for older people, both staff and families should be supported to understand the implications of their own caring behaviours on residents' nutritional status.

programmes for older people should be developed by experts in nutrition to maximise safe practice.

Within the context of this controversy, care home staff are attempting to balance the provision of high-quality care for RWO. This involves promoting choice and preferences, supporting maintenance of health and mortality status, managing complex co-morbidities and supporting residents to access social activity and interaction. Given that obesity impacts on all these care activities, it is important to explore how staff support RWO with dietary management and choices. To-date, few studies have considered this area. The aim of this paper was therefore to explore this dilemma.

This paper reports on one aspect of a wider study which aimed to describe the prevalence of obesity in the care home population in North East England; explore care home staff's experiences of caring for RWO, facilitators and barriers to care provision and approaches to weight management; and use insights gained to inform recommendations for the care of older RWO. This article does not represent the study's findings in entirety, but presents one identified theme: supporting the dietary management and choices of older RWO.

2 | METHODOLOGY

This study was undertaken by two academic researchers with expertise in gerontological research, based at a North East England university. As this study aimed to explore care home staff's experiences and views of caring for RWO, a qualitative methodology was adopted within a constructivist paradigm. The research team felt that explorations of shared meanings and understandings within organisational, policy and cultural contexts reflected Crotty's (1998, p.42) view 'that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context'.

COREQ guidelines were used in reporting this study.

Approval to undertake this study was granted by the Faculty of Health and Life Science Ethics Committee, Northumbria University.

2.1 | Sample

For convenience, all care homes offering nursing student placements to the university were invited via email to participate in the study ($n = 78$). The inclusion criterion for care homes was that they provided care for older people. The response rate was low as only seven care homes replied, all seven agreeing to participate. This was considered to reflect judgements that potential participants made about the commitment that focus group participation would require in the context of busy care home environments. Care home managers agreeing to participation were invited to indicate convenient dates/times for focus group interviews. Managers contacted all staff due to be working on those dates/times, providing them with study information sheets and details of how interested parties could contact the research team. The inclusion criterion for staff was that they must have supported residents with dietary management. The aim was to include staff with a variety of roles regarding dietary management in order to capture the views and experiences of staff ordering and preparing food (chefs), supporting residents to eat (health care assistants, registered nurses and students nurses), monitoring nutritional status (registered nurses and student nurses), assessing residents needs prior to admission and providing appropriate facilities and equipment for residents' changing needs (managers and deputy managers). Older person's specialist nurses were included as these staff have particular expertise in the comprehensive assessment and care of older people. Registered mental health nurses were included as in the care home setting, these staff manage the care of older people with mental health conditions and dementia. Recruiting participants with a range of responsibilities and input during the dietary care process maximised discussion about all aspects of dietary care. In total, 33 staff members consented to participate (Table 1). All participants were assigned pseudonyms to preserve their anonymity.

2.2 | Data collection

Data were collected via focus group interviews conducted at each care home. Both researchers were involved in data collection. Focus group size ranged from two to eight participants. In two focus groups, some participants joined after the start of the focus group, or left prior to the end of the focus group. This flexible approach was facilitated to ensure individuals could participate while not detracting from resident care. Focus group interviews lasted no longer than one hour. Focus groups provided an opportunity for participants to give in-depth descriptions of their experiences and views of caring for RWO. In relation to RWO, participants were invited to discuss their experiences and views of caring, challenges and facilitators of managing care, policies and practice guidelines, approaches to care, weight management strategies, access to resources and access to support from external agencies.

2.3 | Data analysis

Audio recordings were made of the interviews. Audio recorded data were transcribed verbatim. Thematic analysis was chosen as it is 'a method for organising, analysing and reporting patterns (themes) within data. It minimally organises and describes data set in (rich) detail' (Braun & Clarke, 2006, p.79). The approach taken was inductive; in other words, the analysis was data-driven, rather than theory-driven. The six-phase guide to conducting thematic analysis, as outlined by Braun and Clarke (2006) was used. During this process, each team member independently coded all transcripts then searched for themes. Outcomes were reviewed and compared by the team in order to validate and define the themes. This allowed elucidation and description of participants'

TABLE 1 Participants' details

Focus group	Participant	Role
1	A1	Manager
	A2	Deputy manager
	A3	Chef
2	B1	Manager
	B2	Registered nurse
	B3	Chef
3	C1	Student nurse
	C2	Registered nurse
4	D1	Manager
	D2	Registered nurse
	D3	Registered mental health nurse
	D4	Chef
	D5	Healthcare assistant
5	E1	Manager
	E2	Registered nurse
	E3	Registered mental health nurse
	E4	Chef
	E5	Health care assistant
	E6	Student nurse
6	F1	Chef
	F2	Manager
	F3	Healthcare assistant
	F4	Healthcare assistant
	F5	Registered nurse
	F6	Registered nurse
7	E1	Manager
	E2	Registered nurse
	E3	Registered nurse
	E4	Registered nurse
	E5	Older person specialist nurse
	E6	Older person specialist nurse
	E7	Healthcare assistant
	E8	Chef

experiences, while creating meaningful themes. A number of themes were identified from the analysis. This paper reports on one of the identified themes: supporting the dietary management and choices of older RWO.

2.4 | Findings

All participants stated that they do care for RWO. Some said that lack of appropriate resources and equipment limited admissions of individuals with obesity to their care homes, but nevertheless, they come to care for RWO because older people who are admitted with low or normal weights risk becoming obese while living in the care home environment:

> G5: We encourage eating because we don't want people to lose weight. As professionals, do we do that. We try and not let them lose weight, so we go too far the other way.

All participants agreed that supporting residents' choice with regard to diet is of paramount importance, regardless whether choices contribute to excessive weight gain:

> E2: It's their choice and if they want to make that choice, then who are we to take it away from them?

The four sub-themes within the theme of supporting the dietary management and choices of older RWO suggested that this support may be strongly influenced by living in the care home environment. These sub-themes were as follows: care priorities; dietary management; care home life and family involvement.

2.5 | Care priorities

Participants suggested that the primary focus of nutrition care in care homes is the minimisation of the risk of weight loss and malnutrition for residents:

> E1: Everything is focused on weight loss and malnutrition and not about weight gain and obesity

All participants recognised that weight loss was a sign of deterioration in residents' health, and some proposed that being overweight afforded residents a level of health protection, in that it constitutes a 'reserve':

> G3: When I think they've got a bit of flesh on them, they're more comfortable…because they've got weight they can lose…so I think the weight's not always bad.

They indicated that this focus is reflected in care homes' nutrition policies, which provide directives about supporting residents to maintain a healthy weight, but omit guidance about management of obesity:

> E5: But, there's no protocol or guidance on what we do with obesity

Participants proposed that negative consequences resulted from nutrition policy that focused almost exclusively on minimising weight loss. For example, some suggested nutrition support for RWO becomes less of a priority than for those at risk of weight loss, because RWO are generally able to eat independently without the need for intervention, so demand less attention than those who are reluctant to eat:

> A1: Residents who are losing a lot of weight we try a lot of encouragement. Whereas, somebody who's obese doesn't

Many participants were concerned that obesity limited residents' quality of life and choices with regard to social interaction and meaningful activity, while requiring more care input because obesity exacerbates risk of chronic co-morbidities:

> D2: People who are obese have a lot of restrictions and they do need more care.

Co-morbidities mentioned by participants included poor skin integrity, reduced mobility, arthritis, increased risk of catheterisation, and breathlessness.

2.6 | Dietary management

Participants suggested that as care home policy and guidelines on nutrition tend to be biased towards weight gain, culinary and dietary management training and practices tend to be oriented towards ensuring residents do not lose weight. Without training and guidance about management of obesity, approaches to this aspect of care are inconsistent. All participants stated that much of the food prepared in care homes is deliberately fortified to ensure residents' intake of calories is at a level where it can protect against weight loss. Some participants proposed that excluding fortified food to account for RWO is problematic, where exclusion represents a deviation from normal nutrition practice:

> C1: In terms of everything being fortified and supplemented they don't get anything separate.

They suggested this is because preparing large numbers of meals several times each day makes it challenging for chefs to adapt the menu for a small number of residents:

> E5: I suppose it would be hard to say, 'we'll try some semi-skimmed there and full fat there.' That would probably be difficult to manage, when you're cooking en masse.

Participants in these care homes said supporting RWO constituted adjusting portion size, or providing limited alternatives such as salads and fruit that residents found unappealing. They suggested these approaches risked residents not feeling full, and supplementing their diets with food they buy personally:

> G1: She [resident] did try to cut down, so we were giving her smaller portions and I think she was getting salads, wasn't she at one point. But she was still just eating all this rubbish out of her fridge.

Other participants indicated that they did adapt food preparation approaches to support residents' individual nutrition needs, while still offering appealing meals. Using their basic knowledge and assumptions about nutrition, they substitute ingredients with lower calorie alternatives without outwardly appearing to deliver meals that are different from everyone else's, for example, substituting cream with semi-skimmed milk:

> F1: It's similar options (on the menu), but it's the method I cook them. I find alternatives to their needs

In some cases, participants said they rely on the internet to provide information regarding how to tailor diets to meet the needs of RWO:

> A1: We've researched on-line to see what we can do to keep these people healthy

Many participants stated that they have access to dietetic services, but said that, unless RWO were diagnosed with diabetes, or malnutrition as a result of acute weight loss, dietitians do not intervene. This is because many Clinical Commissioning Groups (CCG)—organisations that commission and fund services on behalf of the National Health Service (NHS) do not fund dietetic services to support obesity management. Therefore, dietetic services are unable to accept referrals regarding obesity:

> A1: Because we have referred people to the dietitian, but they've said there's nothing they can do about obesity

2.7 | Care home life

Many participants' responses indicated that culture and environment have an impact on residents' dietary habits. They suggested that care home life centres around the cultural traditions familiar to residents—something that both residents and families appreciate. Meals therefore reflect the food and cooking styles of the older generations. Many of these meals include high-calorie ingredients or use fat in the cooking process:

> D1: There's homemade cakes, homemade biscuits, fudge. Traditional meals: It's your shepherd's pie, your mince and dumplings, your corned beef pie

> G8: But everything's got butter on

A number of participants suggested that the day-to-day activities pursued by residents have an influence on their dietary habits. They felt that in cases where residents do not access or engage with meaningful activity, they risk becoming bored which can result in eating out of boredom:

> C1: Sometimes the lack of stimulation and boredom…an example is the guy who had his birthday not long ago and his daughter brought him in a big tray of chocolates and because he had nothing else to do he just sat and ate them all. I think if he'd been given some sort of activity, that wouldn't have happened.

These participants were keen to emphasise that activities must be meaningful to residents; otherwise, engagement is limited. In the following example, participants described attempting to engage RWO in an activity that would both distract them from snacking and provide exercise. They said their attempts are futile unless the activity can be made meaningful, in this case by including children in the activity:

> E1: Doing chair exercises, throwing the ball to one another, that doesn't go down very well in here. We'll get the kids to come and they'll [residents] join in with the kids. But, on their own, it's babyish.

2.8 | Family involvement

Participants proposed that family involvement in residents' diets may predispose residents to consume foods with high sugar content. Some participants suggested that families fear that weight loss signifies deterioration in the health of residents. This fear influences families' attitudes and behaviours regarding residents' dietary intake. A participant reported that in one instance, a family became concerned when a resident with obesity lost weight as a result of a weight loss plan. Although this was perceived to be a positive step by staff, the family was alarmed by the weight loss:

> E5: And that chap we have upstairs, we have the relatives' involvement as well. Even though he's obese, they are worried that he's lost weight.

Other participants indicated that families were not concerned about increasing obesity because they view care home admission as end-of-life care, therefore saw no reason for health promotion or weight loss interventions:

> E1: You go to the family and say this is what her weight gain is. [The family says] 'Well she's old and she's going to die anyway'

According to some participants, families associate changes in residents' weight with quality of care provision: weight gain is synonymous with good care, while weight loss is a sign of neglect:

> G4: To them [family], if they are losing, it is negative care. It means we are not supporting them or caring for them.

Participants suggested such attitudes influence staff's nutrition care behaviours. In order to appease families, staff often acquiesce in nutrition activities that promote further weight gain for RWO, sometimes against their own judgement, or the nutrition care plan.

Participants proposed families also directly influence residents' eating habits by bringing food into care homes as gifts. Even where residents have obesity, food treats such as chocolate and cake are common gifts:

> B1: We can be trying a reducing diet and they can be giving them chocolates every time they come in.

Some participants felt this was a way family members alleviated feelings of guilt for acquiescing in the care home admission, and showing they still care:

> G1: Families fetch them food in, but I think a lot of it is guilt. It comforts them to do that – fetch mam or grandma chocolate.

Other participants suggested families bring in food gifts because they view care homes as an extension of hospitals rather than residents' homes. As bringing food to hospital patients is a cultural norm, this becomes the norm in care homes too:

> B1: It's as if they were in hospital. If they were going to see them in their own home they would probably come in empty-handed.

Most participants agreed that the involvement of families in residents' dietary habits, whether by influencing staff nutrition care activities or by directly bringing in food, is problematic where residents have obesity. Many felt that families should be supported or educated to understand the implications of their actions:

> E5: It would probably benefit having somebody do some education with families.

3 | DISCUSSION

Findings indicate that participants sign up to the ethos of person-centred care and the promotion of choice, in that many were adamant that residents' dietary preferences should be upheld, even if these preferences exacerbate the risk of obesity. Although they acknowledged that obesity can limit other lifestyle choices, for example mobility, social interaction and social activity, interventions to reduce obesity are generally limited, not evidence-based, or focus on reminding residents and their families not to bring in food. Although participants were keen to support dietary management and choice for RWO, in many instances both management approaches and residents' choices are biased. This is because the environment and context in which they live predisposes high-calorie food choices. This is

not a unique challenge, as it is widely recognised that context and environment strongly influence and prejudice lifestyle management and choice (Elliston, Ferguson, Schüz, & Schüz, 2017; Mackenbacj, Lakerveld, & Brug, 2018; Suglia et al., 2016). In this case, findings suggest that dietary management and choices are influenced by a number of factors including the principal focus of nutrition management being reducing risk of malnutrition; cultural and social traditions, and the complexity of families' perception of their role regarding residents' care.

With regard to nutrition management, it is well known that weight loss in frail older people is both a symptom of, and exacerbates, deterioration of health status (Fougère & Morley, 2017; Wirth et al., 2016). The 'obesity paradox' (Souto Barreto et al., 2017) suggests that being overweight reduces mortality risk, a concept that some participants in this study also recognised (overweight residents having something in reserve). These factors influence nutrition management guidelines and practice with regard to the care of older people (National Institute of Health and Care Excellence (NICE), 2012; Public Health England, 2017), and care home residents (NHS Improvement, 2018)—guidelines and practices that focus solely on reducing the risk of weight loss and malnutrition. These, together with high profile reports about older people developing malnutrition while in the care of health and social care services (Russell & Elia, 2015; Age UK, 2013); and close scrutiny by external quality auditors and commissioners (Care Quality Commission, 2012), drive care home operators to focus on preventing weight loss and malnutrition. This may explain participants' proposal that there is a lack of policy and guidelines with regard to managing obesity in care homes. This combined with the prioritising of minimising acute weight loss may contribute to the increasing risk of residents becoming obese while living in care homes and means that obesity issues are at risk of being neglected. Participants did acknowledge chronic co-morbidities, loss of mobility and reduced social interaction and activity increase as a result of obesity, but they were unsure about, or not motivated to address these because they perceived their primary care goal as preventing weight loss.

Prioritising minimisation of weight loss, reinforced by lack of policy and guidelines about obesity management appear to impact on the content of training programmes. Participants proposed that while their nutrition training supports them to reduce the risk of residents' weight loss and malnutrition, it does not prepare them for managing the care of RWO. National training recommendations regarding nutrition training in care homes do not consider obesity, therefore corroborating participants' views and experiences (NICE, 2012; 2018; NHS Improvement, 2018). Lack of training, exacerbated by lack of policy, led to wide variability in food preparation for RWO, as chefs resorted to relying on other factors to guide meal planning, such as self-directed study, and assumptions about what constitutes 'healthy' food. These practices are potentially problematic because they do not necessarily constitute individualised, evidence-based weight management programmes. According Chau et al. (2008) and Payne et al. (2018), weight loss interventions for older people should be individualised and supported by nutrition experts in order to ensure safety and effectiveness. However, expert dietitian input is difficult to access because CCGs do not commission and fund dietetic services to support care home RWO unless they have diabetes or are malnourished due to acute weight loss. Lack of acknowledgement of obesity as a challenge by policy, training programmes and service commissioners may contribute to the 'one fits all' practice followed by some of the care homes in the study of fortifying all meals on the menu. This practice ensures residents at risk of weight loss are nutritionally supported, but does not cater for RWO, as according to participants in this study, the main strategy to address obesity–offering smaller portions to this group of residents, does not work.

Food is not simply a means of gaining nutrition, but a cultural and social activity (Higgs & Thomas, 2016). Findings indicated that in the care home context, food can be used to symbolise homeliness, tradition, and a link to the past, and as such, can be used to support older people and their families to settle into care home life. This may suggest that in the care home context, the food on offer becomes part of attracting and maintaining custom, as it infers the provision of a 'home from home'. Participants also said menus were traditional because focusing on providing food familiar to residents was more likely to tempt their appetite. As many of these traditional dishes are high in calories, they support the primary nutrition care goal of minimising weight loss. For RWO however, choosing alternatives that support weight management can be difficult when they are living in an environment that offers an abundance of tempting high calorie options.

Findings suggest that the perceptions and actions of residents' families concerning nutrition and food significantly influence residents' diets and food consumption. Many participants commented on families' tendency to focus on weight as an indicator of residents' health condition. Families view weight gain positively as an indicator of a good appetite, demonstrating good health. Participants' responses also suggested that families view weight gain as a sign of good quality care all round and become concerned about whether their relative is being adequately cared for by staff, if weight loss occurs. This again motivates staff to focus on weight loss minimisation and pay less attention to the nutritional status of residents who are obese. On the other hand, other participants proposed that family members view care home admittance as a 'waiting room for the old' prior to death and have 'given up' on their older relative's capacity for benefitting from rehabilitation or health promotion. These families perceive food as one of the last remaining pleasures for their older relatives, so facilitate food consumption despite the risk of obesity. This attitude towards older relatives could be construed as a form of 'compassionate ageism', whereby beliefs about characteristics of an age group trigger people's feelings and behaviours towards that group (Finkelstein, King, & Voyles, 2015). According to Finkelstein and colleagues, where perceptions of older people as frail are dominant, feelings of pity result in ageist behaviours.

Participants said that most food brought in by families is by way of a gift, so tends to be 'treat' foods such as chocolate, cake and

biscuits. Some participants said that where a resident has obesity, staff discourage families from bringing in these foodstuffs, but their recommendations often go unheeded. Some felt that families require education to support their understanding of nutrition. Other participants acknowledged that education may not suffice as a means of behaviour change, as families' actions may be driven by emotive reasons rather than lack of understanding about nutrition. These participants said families use food gifts to demonstrate kindness, or to alleviate the guilt they feel that may arise from 'putting their relative in a home'. According to Pearson, Nay, and Taylor (2004) and Wilkes, Jackson, and Vallido (2008) having a relative residing in a care home can result in family members feeling guilt and distress due to perceiving themselves as having failed to take care of their relative, or feeling uncertain about what their role in the caring process is now. In this study, a number of participants also commented on the significance of food as the gift of choice. They proposed that families bring food because this is the traditional gift given to patients in hospital. From the perspective of the participants, families view care homes as facilities for the provision of health care, rather than places of residency or 'home'. If this is the case, this may say something about complexity of perceptions of care homes, as well as gift giving. This would underline Hoof et al.'s (2016) and Rijnaard et al.'s (2016) findings that propose tensions and uncertainty exist regarding residents and families 'feeling at home' within a care facility.

Some participants proposed that some residents' risk of becoming obese is exacerbated by boredom. They suggested that when residents are bored, their days may centre around meals and eating as this constitutes regular stimulating activity. Where families bring in food treats as gifts, eating these might also be a way of alleviating boredom. Care homes do (and are obliged to) provide a range of activities for residents, including physical activities which could contribute to weight management. However, participants indicated that unless activities are meaningful and stimulating to the individual resident, they are unlikely to engage. This is similar to the findings of a number of studies that consider the significance of meaningful activity to older people's quality of life within the care home context (Cooney, 2012; Eyers, Arber, Luff, Young, & Ellmers, 2012). In this study, however, findings suggest that for some residents, lack of access to meaningful activity, including meaningful physical activity, reduces their motivation to exercise and may even contribute to eating to excess.

3.1 | Limitations

This study's findings are based upon the responses of a small number of participants located in one region of England.

Data collection was via focus group interviews. Most focus groups included staff from the management team, which could have inhibited or limited the responses of other staff, particularly when responding to questions about challenges of caring, policies and practice guidelines, and access to resources. It is possible staff felt their answers to these questions were being monitored by management staff, which may have influenced their responses.

Findings account for the views and experiences of care home staff. Further research is required to consider the views and experiences of RWO, their families and external dietetic services.

4 | CONCLUSIONS/RECOMMENDATIONS

Findings suggest that the care management of obesity is not prioritised in care homes for older people. This seems to be because precedence is given to minimising the risk of weight loss and the associated deterioration in health and mortality. Despite the requirement to address weight loss, effective support and management of obesity is required to ensure residents have the opportunities to enjoy their later years unimpeded by the restrictions that having obesity may impose. Of course, residents' choice about their dietary habits should be tantamount, but findings of this study suggest that choices are biased because context and environmental factors make high-calorie foods abundantly available, easily accessible and tempting, while healthier alternatives such as lower calorie foods or activities on offer may be less appealing. To address these challenges, health and social care policy makers, service commissioners and care home operational and clinical managers should consider the following:

4.1 | Policies, guidelines and service commissioning

Policies and guidelines regarding nutrition support for older people should include management of obesity as well as weight loss and malnutrition prevention and treatment. Dietetic services to support obesity management as well as malnutrition prevention should be commissioned and funded to ensure such services are able to provide support that is specific to the needs of individual care homes and individual residents.

4.2 | Staff training/education

Training and education on nutrition should include the management of obesity. Staff need to know how to devise and implement individual nutrition plans that safely support weight management and create meals and snacks that are culturally acceptable and tempting regardless of calorific content, and how to educate and support residents and families with regard to nutrition. Staff training should also highlight links between eating habits and boredom, and the use of meaningful activity, including meaningful physical activity, as an alternative pastime to eating for RWO.

4.3 | Resident and family support

Residents and their families need further support to understand the implications of residency in a care home on the whole family. This might include support to: understand that residents can still benefit

from health promotion despite age and infirmity; to reflect upon families' role in the caring process; negotiate the complexity of their perceptions of care homes ('homes' and/or healthcare provision facilities); and consider alternative gifts to food where the resident has obesity.

Implications for Practice

- In care homes, care priorities, dietary management approaches, care home life and family involvement in residents' dietary intake predispose high-calorie food choices for residents.
- As environmental and contextual factors in care homes for older people facilitate and encourage weight gain, the risk of obesity increases.
- In care homes for older people, nutrition policy, guidelines and service commissioning processes and staff nutrition education should include management of obesity.

CONTRIBUTION

Study design: JT; Data collection: JT and MP; Data analysis: JT, MP and RC; Manuscript drafting: JT; Manuscript reviewing: MP and RC; Study consultation: RC.

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How to cite this article: Thompson J, Parkinson M, Collery R. Care home staff's experiences and views of supporting the dietary management and choices of older residents with obesity. *Int J Older People Nurs*. 2020;00:e12343. https://doi.org/10.1111/opn.12343