A STUDY OF THE NUTRITIONAL EXPERIENCES OF OLDER PEOPLE IN HOSPITAL

By

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Thesis submitted in partial fulfilment of the requirements for the award of

Masters of Science by Research

Awarded by

University of Central Lancashire

September 2003

ABSTRACT

Knowing what it feels like for older patient's eating in hospital is central to nurses giving quality nutritional care. The aim of this study was to gain insight into the phenomena of nutritional care from the patients' perspective, by exploring older people's experiences and feelings in relation to the provision of food in hospital. A descriptive study design was employed to enable patient's own words to offer insight into their experiences. Data were collected from individual interviews with fifteen patients, and analysed according to the principles of phenomenology.

Four key themes emerged from the data: Making choices, anticipation, eating behaviour, and appreciation. The findings are based on informant's descriptions of the specific themes, and their general feeling of each theme being experienced either positively or negatively, and indicate patients' experience of eating was an 'evolving process', termed the 'eating process continuum', that began even before patients received their food. This process was affected by issues such as the variety of foods offered, the content of the meals and the nursing care given at mealtimes. The results of this study will inform nursing practice by describing the participants' experiences from their own viewpoint, and may assist nurses to identify patients at potential risk of nutritional deficiency using the 'eating process continuum' as a framework.

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ACKNOWLEDGEMENTS

I would like to thank the Lord my God for every wonderful thing he has done for me, for placing me where I am today, and guiding me in all walks of my life. I would also like to thank my loving husband Mark Pollitt for all his support. Thank you Ben and Lewis Pollitt for being good boys during the writing of this thesis. Thank you mum and dad for even more prayers and childminding services. Finally, I would like to say a special thank you to Alison Cochrane and Professor Martin Johnson for their invaluable advice, knowledge and support.

PREFACE

Understanding how older patients feel whilst eating on a hospital ward is vital if nurses are to be able to deliver good nutritional care at a time when it is most needed. The long-term consequences of poor nutrition are well documented as muscle atrophy, decreased healing, increased risk of infections, pressure sores and even heart failure (Clay 2000). The significance of good dietary care is an important factor in achieving quality of life (Söderhamn & Söderhamn 2002). However, much of the literature discoursing nutrition and health, over the last 30 years, would suggest dietary care received in hospital is less than adequate often leading to incidences of malnutrition, morbidity and even mortality (Bistrian et al. 1974; Hill et al. 1977; Lennard-Jones 1992; McWhirter & Pennington 1994; Andrews 2000; Söderhamn & Söderhamn 2002). The prevalence of under nutrition in older patients is particularly high within institutional settings, which is of special concern if they are particularly vulnerable (Tierney 1996). Health Advisory Service (HAS) (2000) identified deficiencies in the care of older people, such as non-availability or poor quality of food and drink, and lack of attention or insufficient assistance from the nursing staff with feeding and nutrition. Tierney (1996) believes, that although the issue of under nutrition in older patients has not gone unrecognized in nursing, research on the topic has not been extensive enough. It would certainly seem not only is nutritional care derisory within some healthcare settings, but older people are more likely than anyone to suffer inferior dietary care (Christensson et al. 1999), as will be demonstrated in the subsequent literature. Sidenvall et al. (1996, p.263) believe the development of

malnutrition during admission to hospital is "devastating". It was the above issues that were to prompt the development of the following study described in this thesis.

It was subsequent to completion of my Bachelors degree that I had the fortune of joining a team dedicated to investigating nutritional issues of patients in both the acute phase of their illness and following discharge home. This inspired me to actively begin exploring older patient's experiences of receiving dietary care whilst in hospital. Traditionally approaches to researching the nutritional care of patients have tended to look at nursing interventions, nursing knowledge, screening tools, incidences and causes of malnutrition, and even catering services. For instance, McWhirter & Pennington (1994) notably examined the incidences and recognition of malnutrition in hospitals, Perry (1997) undertook an exploration of the knowledge, attitudes and activities of nurses in relation to nutritional care, more recently Edwards et al. (2000) investigated food service management in hospitals and Ferguson et al. (1999) developed a malnutrition screening tool. Specific resources on the psychology of eating exist, such as Logue (1991) and Mehhrabian (1987). However Elsner (2002) argues no literature exists which examines non-pathological changes in eating behaviour particularly in older people. For instance, Jacobsson et al. (2000) carried out a study into how people with stroke and healthy older people experience the eating process, yet their study was predominantly interested in the practical difficulties of living with dysphagia. In contrast, the study described in this thesis will

examine nutrition from patient's own perspectives with the aim of increasing nurses' insight into individuals' experiences of the eating process as a whole. Different aspects of eating, as described by the participants in this study, will be analyzed and presented. Primarily, the purpose of this study was to describe and analyze the essence of eating on a hospital ward as experienced by older people and described from their own viewpoint.

A phenomenological approach underpinned the project. During the study data were collected from individual interviews with patients and analyzed according to principles of phenomenology. Statements from people with special dietary needs were contrasted with patients taking a 'normal diet'. From this all participants' experiences of eating were conceptualized as 'an evolving process' that began even before patients received their food. Four key themes characterized this process: Making choices, anticipation, eating behaviour, and appreciation. The findings are based on informant's descriptions of the specific themes, and their general feeling of each theme being experienced either positively or negatively.

The thesis will be presented in two sections; **section one** will consider some of the literature relating to nutritional issues and the study itself. In particular, in chapter one I will be introducing the topic of nutrition and discussing the present state of nutritional care in relation to older patients. Then one recent publication, which has impacted on nutritional care in British hospitals, will be critically examined. As with all phenomenological enquiries a literature review was only

performed once the study was completed. However, the results of that literature review are presented early on in this thesis to allow the reader to gain insight into the main issues and problems associated with nutritional care and enable an overview of the topic area. Chapter two will describe the study undertaken, including a rationale for the methodology and process used. In **section two** the findings of the study will be presented, incorporating verbatim quotes and data chunks, alongside syntheses of meaning with reference to other studies and current discourses. Finally there will be a conclusion incorporating a synopsis of the main findings of the study and implications for nursing practice with some recommendations for future nutritional care, followed by discussion of the limitations of this particular study.

SECTION 1

BACKGROUND TO STUDY

An important aspect of any research project is the process used during the study. Therefore, the latter part of this section will discuss in detail the aim of the study, the program of study, the methodology chosen and the participants studied.

Firstly, a small literature review will be undertaken with particular reference to the literature regarding nutrition in hospitals and one prominent publication that has had a noticeable impact within the current debate, that is *'Hungry in hospital'* (Association of Community Health Councils for England & Wales (ACHCEW) 1997). This publication is regularly cited by other authors, such as Cortis (1997), Bond (1997) and Wood (1998), and was instrumental in influencing the staff nurses who helped identified the focus of this current study during the initial pilot study (see chapter 2.1). As such it was felt important to critically appraise the report, and discuss the effects of this publication on the future of nursing practice.

1 NUTRITION IN HOSPITAL

1.1 Introduction

Recent demographic changes have led to a substantial increase in the ageing population, with older adults comprising the fastest growing portion of the world's population (Shaw 2000, Elsner 2002). As a result, older people are more frequently admitted to hospital, and for more prolonged episodes, than other age groups (Department of Health (DoH) 2001a). According to the most recent National Beds Inquiry people over the age of 65 occupy two thirds of hospital beds in the UK (DoH 2001a). Since quality of life is as important to this section of society as to any other, adequate nourishment should be paramount for those caring for older people admitted to hospital, given that good nutrition has a marked effect on health, independence and happiness (Davies 1981). Yet, a recent report by the Association of Community Health Councils for England and Wales revealed how National Health Service (NHS) hospitals were failing to meet the basic nutritional needs of older patients. It claimed people were 'starving' in hospital, and dared to point out how, although aware of this disturbing problem and official guidelines having been put in place, the health care system was not doing enough to address the problem (ACHCEW 1997). As well as highlighting the failure of the NHS to cater to the fundamental need for food, *'Hungry in hospital'* discussed nurses' responsibilities for ensuring patients nutritional status and made important recommendations, such as the DoH clearly defining the role

of healthcare workers at mealtimes and strengthening staff training. In response to the report, a comprehensive resource pack for practioners was developed and distributed throughout the United Kingdom (UK). *'Eating matters'* (Bond 1997) presented strategies aimed at addressing the dietary needs of all patients in health care settings. Its core message was that ward staff, in particular nurses, play a fundamental role in ensuring patients have their nutritional needs identified and met. This notion was reiterated again recently by the Standing Nursing and Midwifery Advisory Committee (SNMAC) (DoH 2001a, p.15) which clearly states, "ensuring each patient has an adequate intake of food and fluid is a nursing responsibility". Yet, for nurses to be able to assist in the maintenance of a good nutritional status they must first have a sound knowledge of what constitutes good nutrition, how it is achieved, and the consequences of not meeting nutritional needs. For this reason the first part of this literature review will explore nutrition in general: what it is, why it is important and how it is managed by older people, followed by nutrition in hospital: how it is provided, by whom and what are the commonly held perceptions about hospital food. Then I will examine what happens when the system fails: how nutritional needs are being met in hospital, malnutrition and the consequences for older patients. Finally, one recent and influential report aimed at highlighting the problem, and the effects that publication had, will be discussed.

1.2 Nutrition

Barker (1991) defines nutrition as the provision of the essential ingredients for cell metabolism of a living organism. In other words, nutrition is what we need to maintain physiological function, tissue growth and repair and is basically essential for human existence. Nutrition is obtained from our diets. In this instance diet means the total solid and liquid intake, with the exception of drugs, for any individual, although Chilman & Thomas (1981) argue the term has been frequently misused to describe a purposeful change in intake that differs from the normal. Intake in which each nutrient is in adequate quantities for the body's needs, with no excesses being either wastefully excreted or stored, is considered a balanced diet. The constituents of a balanced diet are: Proteins, Carbohydrates, Fats, Mineral salts, Vitamins, Roughage and Water. Maintaining a stable body weight is dependant on a balance between energy intake and output. Individual energy requirements are made up of two factors: basal metabolic rate (BMR) and physical activity. The BMR is the amount of energy required by the body to carry out its essential physiological processes. Factors influencing energy requirements are age, sex, size, thyroid function, amount of physical activity and climate, all of which are interdependent variables (Winwood & Smith 1985; Farrell & Nicoteri 2001). When our energy needs are not supplied by the amount of food we eat our energy reserves are broken down to make up for the deficit (Harvey 1993). The continuous breakdown of energy reserves can have a detrimental effect on our health and well-being (see chapter 1.3). Thus,

good nutrition is an important factor in achieving quality of life, and within the area of healthcare nutrition is now recognised as an imperative part of treatment.

According to Farrell & Nicoteri (2001) the latest suggestion for typical energy requirements of an adult man is 2,900 kcal/day and 2,200 kcal/day for women. For the older adult, age ranging between 65 and 84 years, the average daily requirement is 2,300 kcal/day for men and 1,900 kcal/day for women, decreasing to 1,800 kcal/day for both sexes once 85 years and over (Farrell & Nicoteri 2001). In relation to older people Watson (1994) claims, it is generally assumed that their nutritional requirements do not change significantly, or are only slightly reduced, compared with younger sections of the population. In contrast some authors, such as De Castro (1993), argue the energy requirements of older people is reduced as a result of their diminished BMR and decrease in physical activity characterised by the ageing process. Justifiably Noel & Solomons (1992) argue, the nutritional recommendations for older persons are based on untested extrapolations from the requirements of younger adults rather than on the studies of 'healthy' older people themselves. Therefore the uniformly accepted recommendations for adults may be an unreliable indication of older adults actual nutritional need.

The general consensus is that poor nutritional status is not an inevitable consequence of the ageing process. However, as the Committee on Medical Aspects of Food policy (COMA) Report (DoH 1992) points out, less is actually

known about the nutritional needs and status of older people than any other section of society. Many of the studies relating to the nutritional status of older people have demonstrated the tendency for dietary intake to fall during ageing (Stanton & Exton-smith 1970; Elahi et al. 1983; DOH 1992; De Castro 1993). The lower energy intakes consumed by older people may fail to support adequate provision of all the essential nutrients required, resulting in a compromised nutritional status (McCormack 1997). This is confirmed by studies such as McWhirter & Pennington (1994) who reported as many as 40% of patients admitted to hospital in an already undernourished state, and worryingly, 78% of these deteriorated further in nutritional status during their hospital stay.

1.3 Nutrition in hospital

The 2000-based national population projections suggest the number of people over pensionable age is set to increase by as much as 11% from 10.8 million in 2000 to 11.9 million by 2011, and 16 million by 2040 (Shaw 2000). Life expectancy from birth is also expected to increase from 75.5 years for men and 78.9 years for women in 2000 to 80.3 years for men and 83.2 years for women by 2025. In other words, older people will represent nearly 30% of the base population. With the number of older people in Britain rising comes the increased likelihood of this group eventual requiring some form of hospital care. Yet, there is growing evidence that older patients in institutions are at greater risk of nutritional deficiency (Wynn & Wynn 1993; McWhirter & Pennington 1994; Tierney 1996; Arrowsmith 1997; McLaren & Green 1998; Holmes 1998; Kowanko

et al. 2001). Malnutrition occurs when the body has insufficient food to meet its physiological and activity requirement (Copeman 1999). Kowanko et al. (2001) conducted a large-scale study of the nutritional intake of patients in general medical wards in an acute care hospital. Five hundred and eighty five participants' meals were examined over an eight-day period for wastage, of which the average age of participants in the study was 65 years. They found the nutritional intake of many patients was poor, with the predominantly older general medical patient consuming the least adequate diet during their admission to hospital. Kowanko et al. (2001, p.6) claimed, "there is no one single reason for a poor nutritional intake in hospital". However, Holmes (1998) believes contributory factors to under nutrition may be associated with disease, surgery, trauma, infection or treatment related issues. Under nutrition may also develop due to reduced dietary intake, coupled with increased requirements or impaired ability to absorb or metabolize nutrients. Consequently, many factors contribute to under-nutrition and inadequate energy, or food, intake is considered a major factor (Lennard-Jones 1992).

Poor nutritional status has a direct effect on general physical condition, with serious implications for older patients in particular. Patients who are malnourished have a two-fold increase in minor complications, a three-fold increase in major complications and a four-fold increase in mortality (Lennard-Jones 1992). Not only does nutritional status impact on physical health, it also influences psychological and social well-being with depression and apathy

resulting from malnutrition (LeMay 1996). With such serious consequences arising out of inadequate nutrition provision the UK government has put nutrition firmly on its agenda, resulting in the development of reports such as the King's Fund report on hospital nutrition (Lennard-Jones 1992), the COMA Report on *The nutrition of Elderly people* (DoH 1992) and more recently the introduction of the *National Service Frameworks for Older People* (DoH 2001b) and the *Essence of care* document (DoH 2001c). However, debate still exits around who should be responsible for maintaining patients' nutritional status.

Anderson (2000) views nutrition as a fundamental part of nursing care, which is supported by the SNMAC Report's (DoH 2001a, p.15) recent comment "ensuring each patient has an adequate intake of food and fluid is a nursing responsibility". Incredibly, some nurses dispute this claim, and much discourse exists around what those responsibilities are and how able nurses are to carry them out. For instance, Burnham (1996) found just under half the nurses she interviewed did not see patients nutritional care as part of their role. In a previous national survey, Payne-James et al. (1988, p.13) argued many professionals consider managing nutritional care as "competing rather than complementary treatment". Ten years later Holmes (1998) reported the same thing, commenting on how nutritional support was seen by nurses as a supplement to clinical care rather than central to it. Yet how did something Florence Nightingale and Virginia Henderson considered as fundamental become relegated? As Hughes (1999) sees it, somewhere along the line nurses forgot the importance of ensuring those

in their care have enough to eat. Explanations for this abound, one being the expansion or change of nurses' roles, as outlined in the *Making a difference* document (DoH 1999), which resulted in nurses feeling under increased pressure. Thus, responsibility for the provision of food has been consigned to ancillary staff. The assumption being, by freeing qualified nurses from 'non-nursing' duties they can focus on 'higher priority' nursing activities such as drug administration and assisting doctors (Kowanko et al. 1999). As a result, nurses who were originally in a prominent position for monitoring nutritional status are now rendered incapable of carrying out that role effectively.

Lennard-Jones (1992) believes lack of nursing supervision at mealtimes can mean a patient's poor intake goes unnoticed, consequently corrective action is not taken until it's too late. Nevertheless it could be argued, mealtimes provide only one snapshot of patients nutritional status. In fact, qualified nurses could assess and monitor malnutrition whilst administering routine care. However, Hendrickson et al. (1990) analysed how nurses spent their time in acute care hospital settings. Over a seven-day period, researchers observed nurses working different shifts in six major services, that is medicine, surgery, orthopaedics, neurology, obstetrics and gynaecology. They found within a typical 8-hour shift nurses spent 31% of their time, equivalent to two and a half hours, on average with all patients. Time spent with each individual patient was reduced further to as little as 15 minutes per shift on some wards. Hendrickson et al. (1990) believes adequate monitoring of patients' conditions, and early detection of

problems, is not possible in the amount of time nurses allocate to direct patient contact. Only the essential aspects of patient care can be given in that quantity of time. Yet, to date there is no acceptable professional benchmark for the optimal safe amount of time nurses should be spending on direct patient care. With the increases in workload and poor recruitment and retention issues facing the health service in the 21st century, one can only imagine how the findings by Hendrickson et al. (1990) may now be considered a generous view of nurse/patient contact in the ward environment today. As such, nurses may feel powerless to carry out comprehensive care effectively, resulting in the de-prioritising of nutrition.

Although nurses are no longer preparing, serving and, in some cases, feeding patients their food, qualified nurses should still be responsible for nutritional assessments and evaluations (Lennard-Jones 1992; Norton 1996; Arrowsmith 1999). Söderhamn & Söderhamn (2002) believes the assessment of older patients' nutritional status is an essential nursing task and should be integrated as a standard procedure in hospitals to prevent and treat under nutrition. Similarly according to Arrowsmith (1999), nurses already routinely assess patients on admission to hospital and so are in an ideal position to perform routine nutritional screening. Nevertheless, Norton (1996, p.71) argues, "nutritional assessment has been neglected, with neither the medical, nursing or dietetic staff willing to take on this role as routine for all in-patients". In contrast, Perry (1997) found 71% of the nurses she studied felt nutritional assessment was

a nursing responsibility. However, during the study discrepancies were noted between the nurses' statements of activities, and attitudes, and their documentation of assessment activities in the care plan. As a result Perry (1997, p.12) concluded, the study was evidence of the shortfall in nursing knowledge that is "hampering nursing practice".

There remains no consensus amongst healthcare professionals about the efficacy of present nutritional intervention or how efficacy should be achieved and by whom. Garrow (1994, p.934) argues, "the neglect of nutrition in clinical medicine has gone too far", and believes there is a desperate need for a generation of nurses, doctors and managers who understand and care about their patients' nutrition. This position was reaffirmed by the recent ACHCEW (1997) report, but exactly how sincere was this publication in reporting the facts.

1.4 Who's *'Hungry in hospital'*?

'Hungry in hospital' is a health news briefing report, devised by Angeline Burke, for the Association of Community Health Councils for England and Wales in 1997. The aim of the report was to examine why patients were not eating and drinking enough whilst in hospital, and identify who should be responsible for ensuring patients are adequately nourished. The findings of the report was based on information collected from five different Community Health Councils (CHC's) in the United Kingdom, whom where each asked about "their experiences" of patients eating and drinking in hospital (ACHCEW 1997, p.6). Consequently,

each CHC submitted a survey examining catering services, food preparation, food service, feeding and nutrition. It is from these surveys that ACHCEW was to formulate its report and recommendations concerning patients' nutritional status whilst in hospital.

'Hungry in hospital' (ACHCEW 1997, p. 7) claimed "many patients leave hospital in an under nourished state", and indeed research dating as far back as the early 1970's saw pioneers in nutritional research, such as Bistrian et al. (1974) and Hill et al. (1977) demonstrate the high prevalence of malnutrition within hospitalized patients. In particular, Hill et al. (1977) published a report in the Lancet that claimed 50% of the 105 surgical patients they studied in one British hospital were suffering from malnutrition. Previously Bistrian et al. (1974) presented several surveys finding similar results to that of Hill et al. (1977), with as many as 251 patients being examined 50% of which were established as malnourished. Presumably, these studies should have paved the way for improvements in nutritional provision in hospital. However, as late as 1992 Lennard-Jones produced the King's Fund Report '*A positive approach to nutrition as treatment*', which pointed out how 15 years on the problem of malnutrition remains in hospitals. The report alleged nutrition is such a basic need that paradoxically it is sometimes taken for granted by those in healthcare settings. Indeed it was claimed, "Doctors and nurses often fail to recognize under-nourishment" resulting in starvation for some patients (Lennard-Jones 1992, p.1), the blame being attributed to poor training and unsatisfactory arrangements for coping with clinical

malnutrition in the UK. Lennard-Jones argued doctors in medical schools see clinical nutrition as a 'Cinderella' subject, leaving nutritional issues lagging behind other more interesting clinical matters. Thus, it was perhaps of no surprise to read ACHCEW's damming account of nutrition services within the NHS, since all previous reports had produced little or no effect on clinical practice to date. However, *'Hungry in hospital'* was received differently from all previous reports and managed to cause ripples both within the public and clinical domain, and as high up as government office. Initially the report was ignored by the DoH, then it was denied that patients could starve in today's health service and slated as insulting to NHS staff (Bond 1998). However, *'Hungry in hospital'* was successful at creating a debate as well as being instrumental in raising awareness of malnutrition in hospitals again (Bond 1997, Cortis 1997, Monaghan 1998, Andrews 2000). Certainly the media treated the report as scandalous and highly newsworthy (Bond 1998).

Nevertheless, exactly how substantiated were the findings of ACHCEW's report? Arrowsmith (1997) argues *'Hungry in hospital'* was based on anecdotal statements from patients and relatives. For instance, ACHCEW claims one CHC found ordering of food to be carried out by nurses without consulting the patients themselves. Once the meals arrive on the ward the patients then select their meal of choice. This often resulted in the popular choices running out first, leaving many patients without their first choice, and eating food they may not like. ACHCEW's claim went on to be cited by other authors such as Cortis (1997,

p.12). Yet, this claim was made in the Bristol and District Community Health Council (1995) *'survey of preparation and service of food'* report. However, the findings of this report are based on 15 visits, made by 12 different members of the CHC group, to 15 hospital units, where they "talked to staff at all levels and many patients" (Bristol & District CHC 1995, p.2). Within the 12 page report there is no reference to the methodology adhered to during the study, rigor, consistency, qualifications and experience of those carrying out the survey, numbers of staff or patients interviewed, or even measurements and analysis processes. There appeared to be no evidence of a standard, or even non-standard, questionnaire, but instead an abundance of opinions based on the perception of the researchers following ad hoc conversations with subjects. Case in point, "we were concerned to **hear** of patients in acute wards who were unable to feed themselves had their untouched and cold meal being removed without help being offered" and "we **noted** frequent instances of overloading which **seemed** to rob patients of their appetite"; no measurements of food or evidence of reduced appetite presented for either statement (Bristol & District CHC 1995, p.7).

Bristol & District CHC's survey is evidently an example of a weak study, but within ACHCEW's report examples of good studies can be found. For instance, Bassetlaw Community Health Council's survey (1993) entitled *'Patients' views on the food services at Bassetlaw district general hospital'*. This survey had a clearly defined methodology and results section. A pilot survey was initiated before the

main study, which was to shape the final questionnaire design that would be used for all participating subjects. The project drew on the collective skills of catering staff, CHC members as well as a researcher and several members of a well-known academic establishment to help design, trial and amend the questionnaire. Most notably, Bassetlaw CHC acknowledged the limitations of its study such as the poor response rate to the questionnaire, just 48%, and the inconsistency with how the questionnaires were administered and collected.

A further criticism of the report is its pessimistic nature that appeared to demonstrate a predisposed biased view. Wood (1998, p.25) believes the report "painted a sad picture of dependent patients receiving inadequate care because nurses were not involved at mealtimes". Undeniably, nurses received bad press in this report with little, or no, reference to doctors, dieticians, caterers, trust managers (who hold the purse strings) or even the government for its huge contribution to the tribulations facing the health service. ACHCEW demonstrated it firmly believed trained nurses should be responsible for ensuring patients receive adequate nutrition, not volunteers or relatives. This biased representation is clearly exposed by the only statement given by a nurse in the report:

"I confess I have been one of those nurses who have placed food on the patient's bed table, but with every good intention of returning to help. Why did I not return?" (ACHCEW 1997, p.17)

An honest confession! Yet where was the remainder of the statement explaining why she/he did not return and where is ACHCEW's account of why this had

happened? There is no mention of the increase in nurses' workloads stemming from their expanding and changing roles (Murray 2002), neither is there mention of the time constraints on nurses due to the increased rapid throughput of patients aimed at maximizing bed availability (Wood 1998), or the shortfall in nursing numbers due to the increased age of registered nurses resulting in large numbers of retirements (Murray 2002) and the decision made by the government in 1992 to cut training places for student nurses by 28% (DoH 1999).

In its defence the report does acknowledge the shortages of nursing staff facing the NHS, yet it still depicts nurses as playing a lesser role in assisting patients at mealtimes and substituting that role for other more 'glamorous' duties (Bactawar 1999). Yet these assumptions are based on two comments made by relatives, not patients, who had been present during a mealtime, although it remains unclear which particular survey this statement was taken from:

"We were amazed that after each patient was given a meal all staff disappeared and they were left to get on with it. We helped several of the elderly patients that were having difficulties eating"

(ACHCEW 1997, p.19)

1.5 Conclusion

Even when considering its many limitations, *'Hungry in hospital'* was still significant in keeping dietary care high on the nursing agenda (Monaghan 1998). In all fairness, ACHCEW did not claim to be publishing an innovative and astounding empirically researched study. Instead its aims, as stated earlier, were to merely look at "why some patients do not eat and drink enough when they are

in hospital" (ACHCEW 1997, p.1). Misinterpretation, and misquotation, by its readers is possibly an indication of their lack of insight rather a deliberate attempt by ACHCEW to mislead the public for its own ends. Certainly, as a consequence of the report a vital resource pack entitled *'Eating matters'* was developed, which would arguably have as monumental an effect on nutritional care as *'Hungry in hospital'*, and help promote an increase in the number of researched based projects in nutrition including the one to be discussed here. In addition many important messages were conveyed to both healthcare professionals and the public.

2 THE STUDY

2.1 Introduction

This descriptive study forms part of a series of research and development collaborations between the University and local NHS Service providers funded partly through service level agreements and partly from direct University investment. Prior to the main study to be discussed here pilot work was undertaken using an ethnographic action research approach to identify the problem that staff in a Northwest based hospital unit particularly wished to investigate. Participant observation and informal interviews with staff, patients and patients' relatives were undertaken, feeding back the results to ward staff in ward based meetings in order to help set an agenda. The results of the pilot study showed an overwhelming concern with nutritional issues for both staff and patients alike. These results were to direct and provide the groundwork of the current study discussed here. Phenomenology formed the basis of the enquiry for the study. Phenomenology is a qualitative approach to undertaking research and will be discussed in detail in chapter 2, section 3.

2.2 Research Aims

To gain insight into the phenomena of nutritional care from the older patients' perspective, by exploring participants' experiences and feelings in relation to the provision of food in hospital.

2.3 Methodology

"In nursing the primary purpose of both qualitative and quantitative research is the same: to develop nursing knowledge" (Field & Morse 1991, p.1). In particular, nursing research endeavours to improve health, health services and health outcomes (Bowling 2002). A dominant paradigm that has historically influenced research in both health and social sciences is positivism. A central characteristic of positivism is empiricism, which recognizes only what is observable by human senses, using a scientific approach (Polit & Hungler 1991; Parahoo 1997; McEwen & Wills 2002). Notably, positivism often promotes an emphasis on superficial facts with little, or no, understanding of the underlying mechanisms of the phenomena or the meanings given by individuals. In contrast, interpretivist paradigms accept that social worlds are constructed by humans and therefore human behaviour can only be understood when the context in which it takes place and the thinking processes that give rise to it are studied (Parahoo 1997). Yet these processes are not always observable by the human senses, or scientifically measurable. A variety of methods constitute interpretivism one such method being phenomenology, which formed the basis of the enquiry for the present study.

The purpose of phenomenology is to discover the meanings individuals give to their experiences and the nature of those meanings, or as observed by Husserl (1931) it is to recognize the origins of behaviour based in the 'lived experience' and 'life-worlds' of existence. Phenomenologists base their viewpoint on two

assertions, firstly that all experience is a valid and prolific source of knowledge. That is, within phenomenology experience is accepted as it exists in the consciousness of individuals (Husserl 1931; Field & Morse 1991; Koch 1995). Secondly, important insights can be gained into that experience by analyzing an event completely and describing how it occurs in our daily lives (Becker 1992, Field & Morse 1991) in order to discover the essence of phenomena. Judgement regarding the event involves the researcher excluding all preconceived ideas and assumptions about the phenomenon under study, thus allowing the data to speak for itself, or what Husserl (1931) terms as the notion of phenomenological reduction, 'bracketing' or *epoché*. Husserl believed in order to bracket we must suspend all beliefs characteristic of our natural perception of an object or event and go 'back to the things themselves'. Beech (1999, p.36) claims bracketing to be a process by which "the researcher resolves to hold all preconceptions in abeyance in order to reach experiences before they are made sense of". Thus, I began this study by reflecting on personal experiences of eating in hospital, which had been predominantly as a nurse but also as a patient during the birth of my first child. Detailed descriptions were then written of what it had been like, how I had felt and what had happened. The ideas this generated were put to one side and used to control for bias when developing the questionnaires. I also chose to carry out a literature review of the topic area only once all interviews had been completed, therefore prohibiting previous studies influencing the questions and assumptions of the findings during this study. Although, several of the staff interviewed during the pilot study reported reading *'Hungry in hospital'*

and *'Eating matters'* which may have been, in part, responsible for raising their concerns with nutritional care on the ward, I myself did not read the documents until the study had been completed. In addition I maintained a reflective journal in which I logged my experiences and progress throughout the research process in order to identify and correct my unsolicited influences on the data collection and analysis.

Notably, many authors question the ability to bracket personal experiences and preconceptions. Benner (1994) argues when interpreting data researchers cannot avoid their own experiences and social backgrounds influencing their judgment, and Mitchell (1993) believes there is no understanding without the pre-understanding that comes from our own experiences. Consequently Heidegger (1962), a former student of Husserl's, sought to develop a phenomenology that embraced researchers' preconceptions, using them to gain understanding into how people experience phenomena differently. Heideggerian hermeneutics, as it came to be known, focuses on the experience of understanding as opposed to Husserl's focus on the experience itself (Koch 1995). Central to this approach is its interest in how personal history, past events, education and even social class influence phenomena. In other words, existential phenomenology reveals the inter-relatedness of socially constructed worlds with our being (Jones 2001). For this particular study how each individual experienced nutritional care in hospital, as viewed subjectively, was considered essential to informing the general findings, rather than why these patients were having this experience, based on

past life events. Therefore, Husserlian phenomenology was the method of choice, since according to Jones (2001 p.74) "by endorsing the inter-subjective nature of human experience, phenomenology grants nurses a means by which to appreciate the totality of human experience".

2.4 The program

Prior to commencing the study formal ethical approval was sought and gained from the Local Research Ethics Committee (appendix 1 and 2). That is, a research proposal, sample consent form and patient information sheet were submitted to the Preston, Chorley and South Ribble Local Research Ethics Committee. The ethical approval gained from this research proposal was to support both the pilot project and the main study. The latter aimed to examine the needs of older people in and out of hospital from a nutritional aspect. The research proposal referred to: the researchers who would carry out the project; how the project would be done; the methodology to be used and when the project would be started and completed. Once ethical approval had been gained and the pilot study completed I was employed as a research fellow to undertake the fieldwork and in-depth analysis of the main study results. The terms of this employment were that aspects of the main study would be used to form the main impetus for an MSc, which was required to be undertaken within this role. At the time, the MSc portion was not seen as a separate project, but instead as a different aspect of the same project, therefore further ethical approval was not sought. In particular, the focus of the project remained the same, the subjects

taking part; the aims and the environment in which the project took place also remained unchanged. However, during the course of the MSc, the methodological approached was changed from that of action research to phenomenology. The rationale for this change was that phenomenology aims to answer experiential questions and therefore fitted the title and aims of the study more appropriately than action research. The information gained from utilising a phenomenological approach could not only generate new knowledge but would be useful in knowing how to implement change. It was envisaged that this study would inform practice. As this was a change in approach, further ethical approval was sought and a research proposal was submitted highlighting the new change (See appendix 2). This research proposal was submitted to the Faculty of Health Ethics Committee, which was being newly formed at this time, and not the Preston, Chorley and South Ribble Local Research Ethics Committee. Reasons for this were that the changes were seen to be at a purely academic level rather than at a practical level as there would be no changes apparent to the patients themselves. That is, the way the data was to be analysed was changed but not the way that subjects were recruited; the ward base was chosen; the topic areas were to be discussed or the method of interviewing. Thus, none of the changes were felt to have any practical, and consequently detrimental, effects on the respondents. The Faculty of Health Ethics Committee granted approval for these changes.

A convenience sample of fifteen study participants were chosen from one ward base, for which the inclusion criterion was that informants be aged 60 years and over, an in-patient on the unit and with no cognitive impairment as determined by the ward manager. In other words, a deliberate and non-random method of sampling was used as described by Bowling (2002), to ensure shared characteristics of older age and experiences of hospital based nutrition. Consequently, eight men and seven women, with ages ranging from 60 to 91 years old, the mean age being 74, were individually interviewed in-depth. Seven of the patients ate a 'normal' diet during their admission to hospital, normal pertaining to requiring no special dietary needs. Five of those interviewed required a diabetic diet; two patients required a reducing diet, one patient a puréed diet and one patient a soft diet, although a second patient had required a soft diet from the beginning of her admission but at the time of interview she was consuming a normal diet. Of the fifteen patients interviewed only one female patient required a combination of a diabetic and reducing diet during her admission. The dietary profiles of participants (see Figure 1, 2 & 3) are based on the total number of meal options consumed during respondents entire admission on this ward until, and including, the date of the interview.

Facilitating older patients to make an informed choice regarding taking part in the study was an important aspect of the process. According to Johnson (1992, p.218) "Patients ought to be able to decide whether to participate, based on reasonable information as to risks, potential benefits and discomforts or

inconveniences". As such an information sheet was given to each patient selected to participate in the study several days prior to the interviews taking place (see Appendix 3). Thus, enabling subjects to discuss issues concerning them about the project with their relatives, staff on the ward and the lead researcher. All interviews were prior arranged at each patient's convenience, the initial interviews taking place in the clinical environment. Most were held in one of the wards day rooms where it was felt there would be privacy and minimal disturbance in a comfortable and semi-familiar setting. This particular dayroom was seldom used, since most patients preferred to congregate in the second day room close to the nurses' office. However, three interviews were held in the day hospital garden room, where some of the more agile patients spent their afternoons. Using an unstructured interview method, that is topic based interviews led primarily by the informant, patients were asked to describe their experiences of eating on the ward in-relation to their dietary habits, appetite, likes and dislikes (see Appendix 4). This method of obtaining data allows complex issues to be explored in more depth, with respondents telling their own story in their own way (Bowling 2002). Loffland & Loffland (1995) describe this approach as a guided conversation; hence I was able to encourage participants to express their experiences, feelings and attitudes concerning the phenomena freely. All interviews were audio taped, with the verbal permission of the respondents, to allow accurate recording of the information.

Dietary Type of Participants

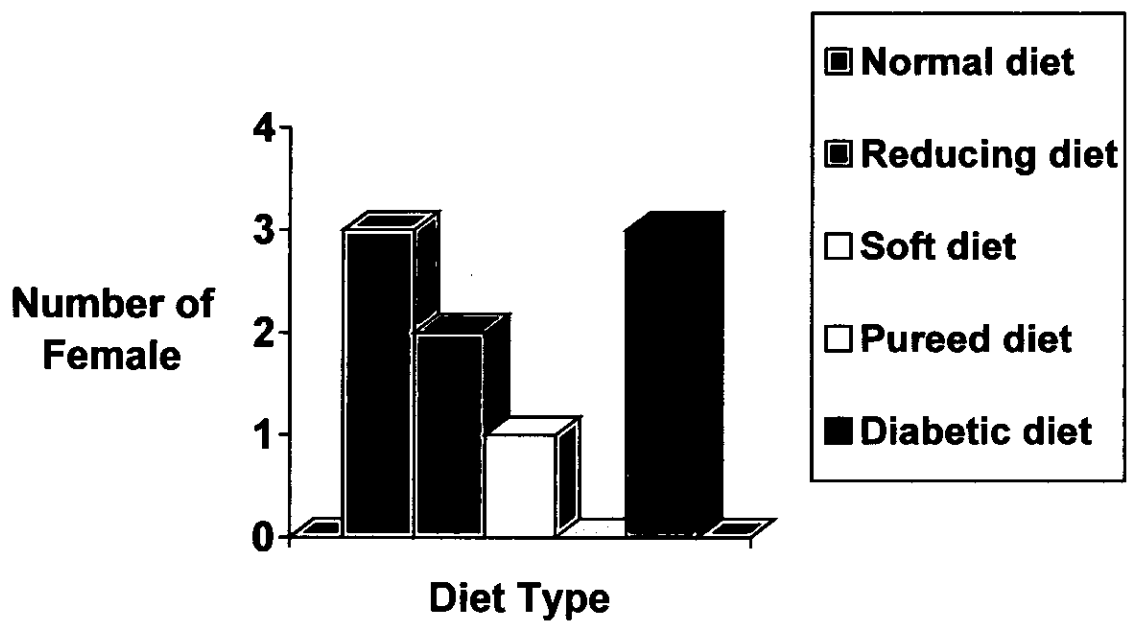

Figure 1

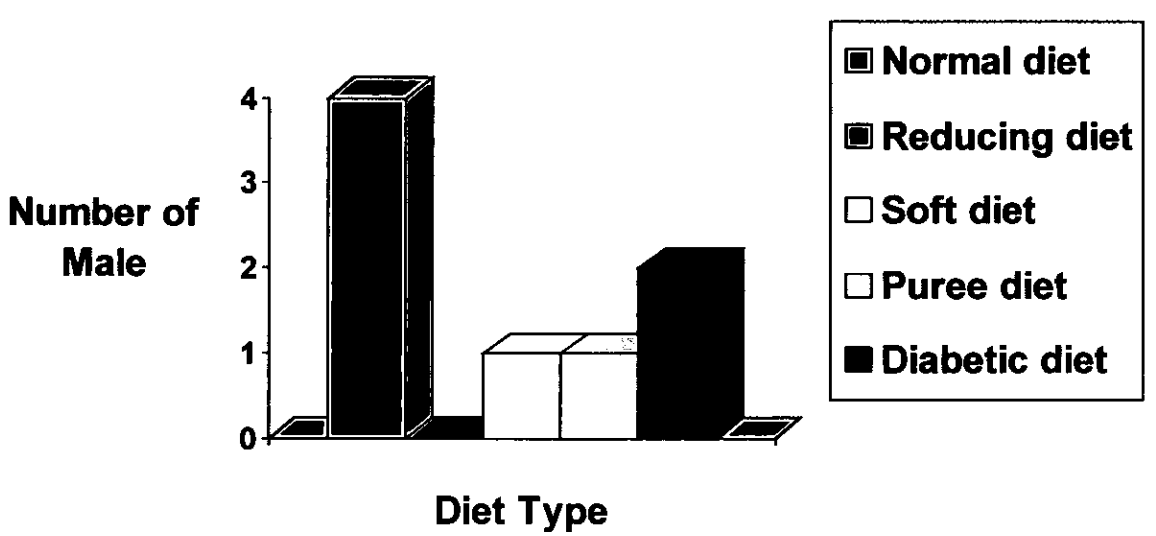

Figure 2

Dietary Type of All Participants

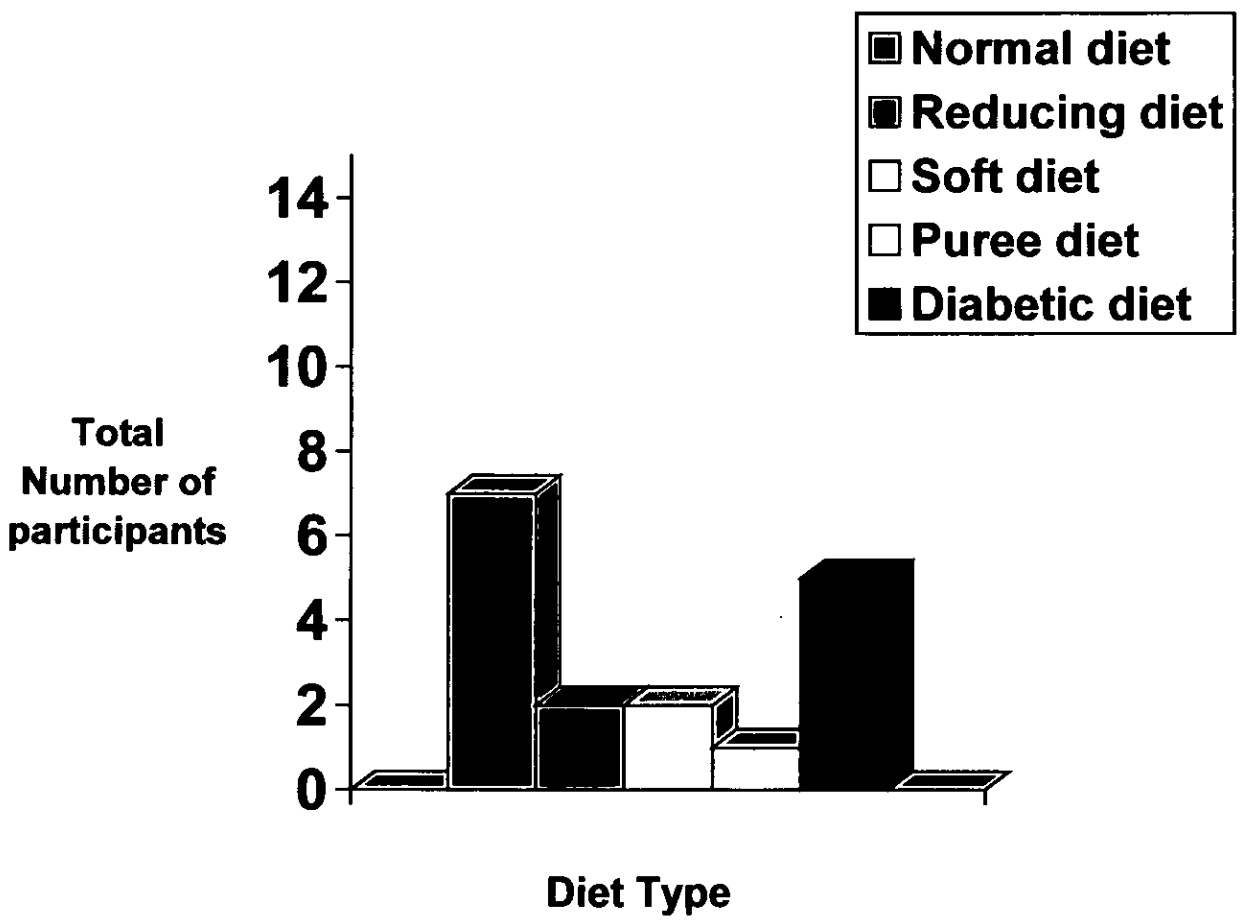

Figure 3

2.5 Data analysis

Data was analyzed by applying Colaizzi's (1978) seven-step reductive framework (Cited in Hallett 1995), which is underpinned by Husserl's phenomenology;

1. Acquisition of a sense of meaning through listening to and transcribing the taped interviews
2. Extraction of significant statements
3. Formulation of significant statements into a more general restatement
4. Formulation of a statement of meaning and validation of that meaning by a recognized subject expert
5. Organization of formulated meaning into themes, theme clusters and theme categories
6. Integration of themes into an exhaustive description of phenomena of interest
7. Formulation of the statement of the essential structure by study participants

Hence, following each interview I transcribed and analyzed the descriptions by reading through the entire interview to form a general picture, then extracting the thematic statements that were essential to describing the phenomenon, examining, then clarifying the units of meaning for each statement. For Colaizzi

this validation of the data occurred through returning to each participant for confirmation of the meanings explicated (Beck 1994). Thus, a further stage of the process involved those same patients having a second interview in their own homes following discharge; to both clarify the meanings of the themes generated and to add depth to the study by generating more discussion around the themes. Within this study the participants themselves became the recognized experts in step four of the process, as it was felt the meaning-giving individual was in a greater position to validate the essence of the phenomena. Again, prior consent was sought and each interview was arranged initially by phone and then in writing at the participants' own convenience. Further issues concerning reliability and validity of the findings will be discussed in chapter eight.

2.6 The schedule

Following the initial pilot study, during which time the research proposal had been written, submitted and ethically approved, I spent two months familiarising myself with the ward staff, patients and research equipment to be used. To achieve this I worked as a member of the nursing staff for the two months, carrying out health care assistant tasks. A further one month was spent in an observer role taking field notes, writing memos and designing the interview questionnaire based on topics for discussion. Fifteen interviews were then conducted during the next nine months; this time also incorporated transcription and analyses of the data. A further two months was spent disseminating the initial results at international conferences and local universities in the form of verbal and poster presentations,

as well as writing for publication. The final six months involved re-interviewing many of the participants in their own home, then again transcribing, analysing and assimilating the results for completed verbal and written presentation, as well as for this completed thesis (See Appendix 5).

2.7 Equipment & Facilities used

Fieldwork and interviews were carried out on a mixed sexed ward specialising in the care of older people and stroke rehabilitation. Approval had also been given for some interviews to be carried out in respondent's homes once discharged from the ward. However, this was only carried out with suitable candidates when the full consent had been given by the respondent following detailed discussion about the work being done. Much of the data analyses and written reports were carried out on the university campus where there was full access to a private office, computer and transcribing machine, as well as on-site supervision and guidance when necessary. A small Sony Walkman was used for recording the interviews, since this was considered less obtrusive and distracting for patients than the usual large, cumbersome recorders with microphones. This promoted the creation of a relaxed, conversational style of interview. The data were then transcribed using a transcribing machine, which was time saving and made re-listening to the interviews simpler. Finally the data were transferred on to computer floppy discs and securely stored under lock and key to retain confidentiality.

SECTION 2

FINDINGS

PATIENTS' EXPERIENCES

Patients' experience of eating in hospital was not merely a matter of consumption, but was a complex evolving process that began even before the food was placed in front of the patient. Four major themes characterized this process: (1) Making choices; (2) Anticipation; (3) Eating behaviour; and (4) Appreciation. All themes were influenced by many variables, each one capable of affecting how the patient experienced the four core elements of what I have termed the 'eating process continuum' (see Figure 4). The themes followed in succession, as described above, and all four elements have an individual influence on how the entire 'eating process continuum' is experienced.

The findings presented in the following four chapters are based on informant's descriptions of the specific themes and variables, their general feeling of each theme being experienced either positively or negatively, and the implications of that experience on their nutritional care in hospital. The final chapters will discuss the main findings in relation to the research aim and the broader literature, followed by concluding remarks.

Eating Process Continuum

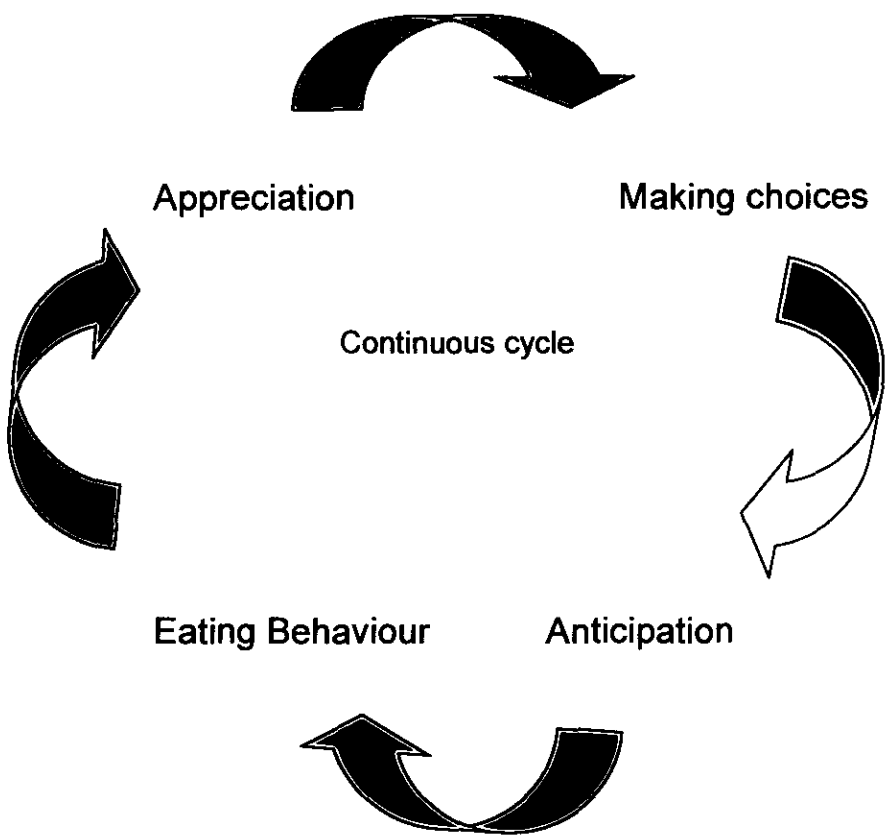

Figure 4

3 MAKING CHOICES

3.1 Introduction

For all patients making choices about the meals they would eat was the beginning of the 'eating process continuum'. In a similar way to how all individuals make their choices a fundamental aspect of the process was the pre-selection of the food each patient would like at each mealtime. This pre-selection was affected by many different variables; the variety of choice available, usual eating habits and routine of an individual, health status, dietary requirements, even gender, age and cultural background influenced the kind of choices some participants made in relation to food, as will be demonstrated in more detail during the following chapter. The names cited in the following chapters are pseudonyms used in order to maintain confidentiality.

3.2 Pre-selection

The ward operated a 24-hour pre-selection system; therefore patients would order their meal the day before they would be eating it. Most patients were able to complete the menus for themselves, two required assistance from nurses with the selection, and only one had a set menu i.e. puréed diet. In several instances the patients interviewed claimed pre-selection of the meals added to the enjoyment of eating since it tended to increase the appetite of those looking forward to their chosen meal, as described by John a 79 year old man admitted

following a stroke and Joseph a 91 year old admitted with frequent falls, who when asked how they felt about filling in the menus the day before replied:

John...It's no problem; I look forward to it (my meals), today especially its Lamb's livers.

Joseph...I've got use to it easy enough. I look forward to me meals from about half-past eleven onwards; in fact it'll not be long now (looking at his watch).

All respondents verbalised understanding of 24-hour meal pre-selection systems in hospital. Some even justified the system with explanations such as poor staffing levels, lack of time and the shear volume of patients being catered for, as illustrated by Kathryn and Edna below. Some patients in particular maintained acceptance of the system as unavoidable rather than understandable:

Kathryn...Choosing the previous day helps, yes it's a good thing. When your cooking for so many they've got to know the day before how many dinners they're looking at, at that particular time.

Edna...I just think they're short of staff.

Charles...I accept these things as inevitable and do what you can! Make it easier for the staff.

Bill...well I don't see as there's anything you can do really. I mean to say, the amount of people you're dealing with and the amount of people that go to deal with the patients.

Susan...they've got to be a system that suits everybody haven't they, and it's very difficult.

Not all patients found this a satisfactory approach to ordering their meals, as Jean an 81 year old lady with diabetes explains when asked how she felt filling in the menus the day before the selected meals arrive:

Jean... It's all right if they take any notice. You ask for one thing and you get summate else. Yea, I've asked for orange juice I got grapefruit juice. I asked for fruit and custard and I got a pudding, ye see it varies. I asked for fresh fruit – I put banana down - I get a flaming apple and it's that hard, you can't even cut it never mind chew it! It'd been in the fridge that long - frozen solid. What I order I fancy but when you get summate different and that, then that's a different thing altogether.

Bond (1997) agrees, ordering off the menus using a 24-hour pre-selection system raises many issues, in particular, the obvious difficulty of trying to predict what individuals will want to eat well in advance of them actually eating it. Patients often lack enthusiasm about eating pre-ordered meals they no longer 'fancy', but same day ordering systems may encourage older people to eat more (Bond 1997; ACHCEW 1997). Same day ordering systems would be in keeping with the Patient's Charter (DoH 1995), which stipulates patients should not have to order more than two meals in advance. Bond (1997) cites a project by East Yorkshire Hospitals, which aimed to introduce offer a same day ordering system on all their wards, with patients being able to choose the food they want as it is being served. Their evaluation of the system after 6 months in use was that there were significant cost benefits to catering management since there was evidently

less food wastage, and much greater satisfaction with the food service amongst the patients.

3.3 Variety

The variety of foodstuffs available on the menus provoked different responses from the patients interviewed, many were both pleased and surprised at the variety of choice available and seized the opportunity to try foods new to them. John the gentleman who claimed to look forward to his meals describes his experiences with the food options very positively. Although admitted following a stroke he did not have swallowing difficulties and ate a normal diet during his admission:

John...I can't make a grumble at anything. I've been delighted at the freedom of choice that comes up on the menu. There's a good choice, I don't get the same choice at home put it that way.

Alison a 68 year old admitted following a stroke admits:

I'm eating things that I've always pulled my nose up at before, like sauces, I never try them at home. Fish with parsley sauce and things like that, or even fish with lemon on, I'm eating them here just to try them. Because I would annoy my husband at home you see, he'd say "I've made such and such a thing" and I say "oh I don't want that". Well you see here there's no one to complain to, so I eat it and enjoy it.

This may suggest during their admission to hospital patients are in an ideal position to be re-educated regarding eating habits, and be given the opportunity to sample healthier eating options they may never otherwise experience. On the other hand, patients may feel obliged or even coerced into eating foods they would not normal consume. However, that did not appear to be the case with the respondents interviewed in this study. Some patients did encountered problems selecting something they actually wanted to eat, reasons for this included meals being unfamiliar to the patient; 'foreign foods', difficult to eat; crusty pies, apples, and inappropriate such as sandwiches and salad as the only teatime choice in winter. Some patients expressed serious concern about the amount of 'foreign food' offered on the menus. Their interpretation of 'foreign food' ranged from simple pizza, or pasta with cheese, to the more exotic Chinese or Indian meals:

Martin...Well they've a lot of foreign foods on the menu, which I don't like. The wife doesn't like foreign foods. We always buy British you know and have it that way. See – if we have rice we have it in a pudding you see and they have it in meals and that, you know, and we don't like it that way.

Alison...Well, the lasagne and all them sort, I've never been brought up to eat them you see. It's all plain Lancashire food you know. Lasagne and that 'golden stuff', its Bolognese...well I don't like them, no.

Basil...I don't eat fancy stuff either, fancy cakes or anything like that. I do eat cake, but err, generally what my wife makes you know. Well her food is very plain, I suppose I'm used to plain!

Although one patient did admit to trying the foreign alternative once, a second, Charles the oldest respondent claimed to enjoy the different foods:

Susan...well I like salad with no spice, just ordinary common and garden food. No spice because I've been brought up like that. Although, I had a lasagna the other day and I quite enjoyed that but it was too much so I ate half of it and that was sufficient.

Charles...they seem to be a bit different, but I've enjoyed it apart from the pizza being a bit on the cold side.

The format of a standard structured menu, as recommended by the nutritional guidelines on menu planning (South East Thames Regional Health Authority (SETRHA) 1993), is similar throughout most UK hospitals. However, according to an analysis of catering options within NHS acute hospitals by Hwang et al. (1999), the most number of main course choices is three, one less than the suggested standard menu and although traditional English foodstuffs such as potatoes and roast beef dominate the menus, other less familiar cuisine such as pizza, pasta and rice, form the remaining options. The implications of this is that many older people, may not be familiar with, or enjoy, some foods such as pasta or curry that are now common to younger adults (Bond 1997). Hence, main course choices can be reduced even further, to as little as one or two, since consumption and acceptability of foreign foods are low in older patients with many reluctant to ask about unfamiliar foods listed on hospital menus (Herne 1995). Furthermore, a study based on a food choice questionnaire, by Steptoe, et al. (1985), showed familiarity to be one of the nine most important factors

underlying food choices. This verifies the studies findings that lack of choice on hospital menus is reduced further for older patients who demonstrate a preference for traditional familiar foodstuff.

3.4 Special dietary needs

Within this study patients with special dietary needs experienced the worst food choices overall. This included Frank, a 73 year old gentleman, admitted to the ward following a stroke that left him with a left sided weakness and dysphagia. In particular Frank had reduced tone in the pharynx, which had led to pooling and residue of food that he had begun to aspirate into his lungs. Frank's cough reflex, which is usually triggered when food or fluid enters the larynx, was also poor following his stroke and he had been silently aspirating for some time culminating in him developing aspiration pneumonia. Frank was also suffering with oral thrush, which made eating and drinking difficult and painful. As a result Frank was placed on a puréed diet to prevent further aspiration. Consequently, he describes experiencing each stage of the 'eating process continuum' differently to other patients interviewed due to his special dietary requirements. His experience is worsened by his lack of true understanding about his condition, as he demonstrates here:

Frank...It (the food) has a tendency to go down my lungs. They gave me a chest X-ray but they won't tell me what they've found! I've never had trouble like this before. I said to them give me a decent meal and I'll have a do at it. Well they said, "*you'd start coughing*", well I haven't had a cough.

Below, he describes what it felt like for him making his food choices:

Frank... It's the food it's not been available, I'm not a fussy kind of fellow! Well they tell you what's on then I order it, I've ordered it off the card but what's come, I can't explain it... I never expected to be served that kind of food.

Edith, a 75 year old lady with diabetes of several years, was also admitted following a stroke. Although Edith said overall she had enjoyed all her hospital meals, at the same time she claimed to have lost her appetite and some weight since admission. In relation to the diabetic menu options Edith states:

Edith...Well I'm diabetic so I have to be careful with my diet see, and the doctor said I've to have brown bread, so I have brown bread, but these last few mornings they haven't had any. There's no variety at all if your diabetic...you can't have meat pie, you can't have sausage rolls, you can't have anything with cream on, so what can you do!

Later in the same interview when Edith is asked if she thinks the hospital caters well enough for diabetics she replies about the puddings:

Edith...Well they have cream crackers -- I usually get 2 of them, and 2 for my supper at night before I go sleep to break it up – that's the pudding. The pink blancmange I can have them. But you see the blancmanges they're pink every night, well you get sick of them you know what I mean. It's like having bread and butter every night you'd get fed up wouldn't you. At home I'd make myself a trifle with unsweetened jelly, a can of non-sweetened fruit and no cream on top. Well really they could make a big non-sweetened fruit trifle couldn't they? And just give a spoonful

to anybody. I think so anyway. They haven't got nothing for diabetics. They've got them with cream on for ordinary people and they've got cakes and meat pie and god knows what – they've nothing for us. I think for diabetics it's very poor, there's no variety at all. I'm sick of seeing those pink blancmanges, I really am.

Mary, a 64 year old lady interviewed for the study, made a similar point about the special diet options as Edith and Frank based on her observations of mealtimes on the ward:

Mary...I think maybe there could be a bit more choice for people on soft diets, the older people. The lady in the next bed to me, she's old, not quite a lot older than me, and she's been on a soft diet and sometimes there aren't enough things for them to choose. Like yesterday it was vegetable pie, um, she ended up having to have lasagne, and she's not, what I mean is a lot of old people don't care very much for spicy foods do they? To find her a nice meal it was difficult you know, I thought it was a shame sometimes.

In several instances this distinct lack of variety led to a monotonous and potentially unhealthy, or inadequate, diet being consumed during their admission. This was particularly the case for individuals with special dietary needs who at times chose not to eat at all rather than have the item they were required to eat:

Frank...I was looking forward to it and they gave me that, so I binned it. I tried to stick a fork in it but I couldn't, I had to get a spoon in the end to put it in my mouth and chew it. I give it up as a bad job, had to spit it out. That was it!

Susan, a 79 year old lady who arrived on the ward following a second stroke, had initially been commenced on a soft diet when first admitted to the ward. However, at the time of interview Susan no longer required a soft diet but instead ate a normal diet. Here she recalls her thoughts about the soft diet:

Susan...Well I was on, err, soft diet and I didn't like that. I found that difficult until I got used to them. What I didn't like about the soft diet was that you got the same old thing like pie and potatoes and meat and potato pie, with just the one item I could have I found I was eating meat and potato pie all the time. Now I'm having proper food, as I call it, they cut it up for me into small pieces as much as I like.

From this study it appeared having choice taken away immediately started to decrease some of the pleasure of eating for patients with special dietary requirements. Bond (1997) and ACHCEW (1997) both agree that although there have been many improvements in hospital catering, poor or unavailable options result in some patients eating very little or not eating at all. Other studies have shown that changes in the variety of foods offered at a meal can increase energy intake and simultaneous increases in the variety of foods offered also elevates intake (Bellisle & Le Magnen 1981; Rolls et al. 1981a,b; Rolls 1985). Those same patients who experienced the greatest choice reduction described being the most dissatisfied with eating in hospital (see Figure 5). For instance Alison, a 68 year old lady admitted with a stroke and myocardial infarction, had recently been diagnosed with diabetes she also had high cholesterol and had a

body mass index >26. As a result she was placed on both a diabetic and reducing diet:

The chef wouldn't let me have even one chip with my tea, well I couldn't understand this so I asked and I could have chips with the diabetic diet but I couldn't have chips because they were too fattening. Now there's a thing about egg in sausage meat put in the hole kind of thing (scotch egg), he won't let me have that and I can't understand that. I didn't think that would be fattening or dietary (non-diabetic). I think he delights in saying no to me, 'No you can't!'

Normal diet	-	most satisfied
Diabetic diet	-	fairly satisfied
Reduced diet	-	dissatisfied
Soft diet	-	most dissatisfied

Figure 5

3.5 Conclusion

In conclusion, it is apparent variety is as important an aspect of our diets as nutritional content, for both psychological and physiological reasons. Evidently, without variety we may become apathetic with our meals. That is, eating the same thing daily for long periods of time could result in mealtimes becoming monotonous, dull, uninteresting and even tedious. The frequency of which certain meals are served is also detrimental to its acceptability. One study suggested

dishes served most frequently in a hospital setting had as much as an 83% decline in acceptability following a high initial score (Herne 1995). Frequently served food has a fatiguing effect on acceptability (Zellmar 1970), particularly for patients on long stay wards where the menu turnover cycle may seem shorter. ACHCEW (1997, p.11) argue, "being presented with the same old meals can put people off their food", and suggest sufficient variety of food would allow menus to cover 14-day periods without undue repetition. A consequence of this repetition and lack of variety is not enjoying our food. Since eating is a fundamental and frequent ritual of daily life it is paramount we as health professionals aim to incorporate a level of enjoyment into those meals for our patients, which as we will discover in the following chapters, may facilitate an increased appetite and consumption levels.

4 ANTICIPATION

4.1 Introduction

The anticipation element of the 'eating process continuum' follows on from the patient's making choices about the meals they will eat. The length of the anticipation phase will depend upon the context in which the 'eating process continuum' is being experienced. In this study that period was as much as 24-hours due to the menu ordering system employed on the ward as discussed earlier. It is during this phase patients will formulate judgements about the meals they have ordered even before it has arrived on the wards. Factors shaping their opinion can stem from previous experiences of the food they have ordered. For instance, if the meal was something they had enjoyed eating prior to their hospitalisation period that experience tended to favourably influence the anticipation period in a positive way. Additionally, the way in which the patients interviewed made their choices had a powerful affect on their experience. Therefore, those who experienced a good range of choices often described looking forward to their meals, and using this time as psychological preparation, or getting ready, for eating. For instance Edna a 75 year old lady admitted following a second stroke claims:

I'm always ready for my tea, always yea. I look forward to them. My favourite is hotpot, err, well its like potato pie really, it has some sort of crust on, and liver!

4.2 Appetite

Several respondents indicated how reflecting on and looking forward to their chosen meals had inadvertently increased their appetites or even enjoyment of the hospital meals. As Susan the patient who had difficulty getting used to a soft diet, but was now able to consume a normal diet explains:

I look forward to teatime mostly, when I can have a sandwich. That I enjoy. I've never had a big appetite just little and often, that's my motto, I don't like being over-faced, so I just take my time and enjoy mealtimes. I don't see the point in rushing it cos I'm not going anywhere, am I?

When patients' choices were reduced, or unfamiliar, it had the opposite affect. Consequently, patients with limited food choices, predominantly those on 'special diets', expressed a more negative anticipation experience. For instance, on this particular ward a puréed meal was simply labelled 'purée' on the menu, with no indication of what the meal may be or consist of. Patients requiring a puréed diet would not know what they would be eating until it was presented to them. Thus, Frank with his limited choice of puréed diet described a negative anticipation experience, not only was his appetite not increased during this period, but he actually experienced a loss of appetite. When asked how his appetite had been since his admission to hospital he replied:

Shocking, seriously! (Frank motions as if pushing food away), it worries me that I weren't eating the food that I should have been.

Edith, the lady with diabetes described earlier, also recalls a decreasing appetite influenced by her anticipation of the meals. Although this mainly appeared to be the teatime meals, during which only limited cold options of sandwiches, salad and soup were available due to a lack of evening catering services in this particular trust:

Well me eating was all right only for them sandwiches, everybody was fed up with them, they were really boring. After I'd been in a good bit me appetite was very poor. Although I'm not a big eater anyway, it was just them sandwiches - oh I dreaded nighttime coming, when it was teatime - I really did! I had no appetite at all when I came here, to eat. I just didn't want nothing, everything was off – you know – I didn't want it.

Not only was appetite not increased during this phase, but also many actually experienced a loss of appetite. Knowing that your next meal is something on the whole you do not like, and would not have chosen had there been other options, would reduce a healthy appetite in most of us, but for those with special dietary needs this is a particularly unpleasant situation. Those having special diets reported worrying more about their meals since they had to be careful of what they ate. This was especially true of those with diabetes such as Charles a 91 year old gentleman who had been diagnosed with Non insulin dependent diabetes mellitus (NIDDM) 9 months prior to this recent hospital admission. During that time he claims to have lost a large amount of weight:

I always thought I had a good appetite; consequently I had to restrict it through diabetes.

I think I'm probably a bit frightened of it, you know. In so far as if I do the wrong thing I'd be putting myself in a bit of a dilemma about complications.

It is well documented how psychological factors may have a direct affect on appetite, for instance Herne (1995) in her review of food choice in elderly people lists: depression, locus of control, expectations, attitudes towards eating, priorities, self-esteem and even food meanings as influential on food selection and consumption. Oliver & Wardle (1999) went further suggesting anxiety and stress might inhibit appetite. In a community based study they claimed some adults reported under eating when feeling stressed. Ottlley (2000) in her discussion of the links between food and mood argues the impact of individuals' thoughts and expectations in relation to food cannot be underestimated. Furthermore our thoughts towards food may have the ability to override any positive physiological effects on appetite, but equally they might also enhance them.

4.3 Anxiety

Anxiety about diet and nutrition featured prominently in four of the five interviews with patients with diabetes.

Edith...Well I'm diabetic so I have to be careful with my diet so see. If you're diabetic, you can't have meat pie and you can't have sausage rolls, you can't have anything with cream on, so what can you do? I never eat nothing I shouldn't.

Alison...I can't have sugary things because I've got diabetes, and the queer part is my brother has suddenly gone diabetic, and my eldest son. Well its in families, that's why my eldest sons got it, so I'm watching my youngest son now. Before I used to have fruit in syrup and things like that, well of course I can't have that now, and you get stumped for what to have. It's hard to plan things to eat, err, like in bread – too much bread can higher your blood sugar and I didn't know that.

Charles...Well I think I was a bit too stringent with myself as regards what I was eating – you know – I was trying to be too careful, afraid that if I didn't I might develop complications and happen result in limb amputation, heart disease and things of that sort. So maybe I've been too scrupulous about it and consequently I've suffered.

Jean...I have to plan ahead all the time. Make sure I've got stuff in like if my (blood) sugar goes too low. In here they give you biscuits to eat at night so that's OK, but sometimes I worry about getting my meals on time, before I start to feel funny or something.

Thus, for individuals who have to consider meal timings carefully, as well as the type of food they can eat without endangering their health, meals and eating appear to play a larger role in their daily lives than for the others interviewed. A new environment, such as admission to hospital, where they must rely on others for their diet can increase this anxiety. For most newly diagnosed stroke patients admission to hospital is a time when their energy and thoughts should be focussed on rehabilitation, exercising and getting well, rather than worrying about their next meal. For Jack, a 60 year old stroke victim, renal failure resulted in him requiring his fluids to be restricted to 150mls (1 cup full) daily. This restriction had led to him having difficulty eating most foods, unless they were moist, and feeling

thirsty all the time. As a result Jack was placed on a soft diet. For him, anxiety about his nutrition was all consuming:

It's this fluid job, well I can't eat and I can't drink, I can't swallow anything. If I had summate here to eat now and I had a glass of water I can more or less moisten it and it helps it go down like. I'm only 10 stone now, I used to be 13. I worry about trying to get it back on an all, what can I eat to get it back on?

I could eat T-bone steaks and all sorts (before recent admission) – I've no appetite for them now. I suppose the fluid is a lot to do with it (restricted fluids), they're struggling to give me something with a bit of moisture in it you see, Steak! Couldn't eat steak now, I could nearly throw up thinking about it.

Evidence supports these findings and proposes, individuals feeling anxious or stressed are more vulnerable to patterns of unhealthy eating (Oliver et al. 2000, Mac Evilly & Kelly 2001). Two suggested mechanisms for stress induced changes in appetite and consumption are physiological: that is reduced appetite resulting from the processes associated with stress, and circumstantial: practical changes in food availability, meal preparation and eating opportunities, all of which may be applied to Jack's situation (Oliver et al. 2000).

4.4 Health status

Being particularly unwell can affect appetite during the anticipation phase; the following patients discuss their appetite changes following admission to hospital and the consequences of that. Basil was a 77 year old gentleman admitted

following a stroke. Although this had not affected his ability to swallow and he was able to consume a normal diet, since his admission Basil had suffered with bouts of headache and sickness, which is not uncommon following a stroke, resulting in him losing his appetite as he describes below.

One day I had a very bad headache, and lets be fair, I don't care what you put in front of anybody, if their heads aching they'll not eat will they? Because you feel, not only headachy, but you feel sickly too. Two or three times I've felt like that and there's still a bit now and again.

At this point Basil was asked what he had been eating whilst in hospital and during the times he felt particularly unwell? To which he replied:

Nothing, nothing to drink either, my mouth looked like a ploughed field, in the end they washed my mouth round here and in me mouth with orange. See I had to lay on me back, I was sick all the time, almost perpetually being sick. So that was the position, I was sick so consequently when you're sick you don't want to eat anything do you?

Mary, the 64 year old lady discussed earlier as being on a diabetic and reducing diet admits to usually having a very good appetite and claims prior to her admission:

Oh I always have a good appetite, I always have. Even if I was worried about something I'd eat more, I never went off me food.

Thus, even when facing dilemmas or worries in other areas of her life she has never lost her appetite, but would often eat more during times of distress.

However, during her interview she mentions experiencing a loss of appetite during the early stages of her admission, when asked why she thought this had happened she replied:

Well half of the thing is I couldn't eat; I couldn't move this side (points to her left arm). It was things like that really. I couldn't swallow properly either, I mean its better now, its just now and again if I eat something dry like crumbs it starts me coughing, cough, cough, cough, I nearly choke sometimes! But mostly I'm all right. It was like that at the beginning, but I wasn't bad enough to need the blended stuff and I didn't keep food in my mouth. I just had to chew slowly because it does make me cough. And it's frightening, even now that cough, cough, cough and you can't get your breath you know.

Jacobsson et al. (2000) study examining the eating experiences of older people with strokes, revealed similar findings. Of the 45 participants they studied, most of whom had suffered a stroke, expressed feelings of fear and uncertainty in relation to eating, in particular they spoke about being afraid of choking whilst eating. Understanding of patients' fear of eating could have significant implications for nursing practice, with nurses playing an increasingly important role in training patients with eating difficulties to counteract their fear (Jacobsson et al. 2000).

4.5 Change in routine

An overriding theme of almost all the interviews were the routines associated with mealtimes at home and how that had changed since coming into hospital.

Patients described establishing longstanding routines, which ranged from rigid and regular dietary schedules:

Kathryn...we eat meat twice, maybe three, times a week. Vegetables we lean very strongly on and wherever possible we go for organic. We just sort of have a lite breakfast, we have a salad sandwich at lunchtime with our cooked meal at night, and that's our dietary program. That's what we do every day.

Others merely allowed their appetites and circumstances to dictate the schedule:

Mary...At home I tend to be a bit, um, eat when I'm hungry you know. I sort of have my cereal at lunchtime. At home I never have a breakfast, I really sort of have two meals a day, cereal at lunchtime and an evening meal really so. I got a bit haphazard at home but I think they're more even in here.

John...Me and the wife we only eat when we were hungry. We might have five or six meals a day you see – we only eat when we are hungry.

Bill...Dietary habits? Well you couldn't really call it a diet; it's just what I fancy really. I never bothered. I'd go two or three days and not even bother. I did once suspect I'd got anorexia because I've lost a lot of weight. I can't be bothered making ought you know, well basically I'm not hungry.

Their environment, culture and even their working lives had often helped shape these routines and continued to be of influence late in their lives:

Kathryn...As I say, it's taking a little while to get use to this, I mean all the sandwiches at teatime. I sometimes have soup if there's soup but it comes so early see, I'm not use to eating at five o'clock. See when I was working I was not getting home till about half past six you see, and even when we were at home five o'clock is the time when I'm thinking about what we will have for our evening meal. I'm not sitting down at five o'clock eating, and I find that's what I getting use to now. I lived overseas for many years where of course you didn't eat until night time you know, and you didn't just have a very little something.

However, when patients have been admitted into the hospital environment the first thing they begin to encounter are the many different hospital routines. There are routines based around most activities in hospital, from complex admissions and discharge procedures, treatment regimes and nursing workloads, to less complex domestic tasks. There are almost countless new and unfamiliar routines that each patient will face; mealtimes are just another one of those routines that every patient will experience in one form or another. The mealtime routine may appear complex to those unfamiliar with it and even daunting for those experiencing it for the first time. Field notes taken from the ward being studied revealed the daily routine to consist of set meal and snack times throughout the day (see Figure 6). For most of the patients interviewed here the new routines encountered in hospital had led to some level of change in behaviour, from small and incremental, to some large and quite radical, changes.

Breakfast	-	07.30
Tea / coffee	-	10.30
Lunch	-	12.00
Tea / coffee	-	14.30
Dinner	-	17.15
Supper	-	20.00

Figure 6

When asked how she thought her dietary habits had changed Kathryn replies:

It's a whole way of changing my eating habits. I'm changing a lifetime's eating habits. They (dietary habits) have changed quite considerably since I came in here in as much perhaps because of the timings of the food. I understand being in a regime like this everybody has to have their lunch or main meal of the day at that time, but that is totally foreign to me. I'm battling a little bit to come terms with the way the meals are staggered and what they are. I've always had my main meal late at night, well half past six, seven o'clock see, and that's our one main meal a day the one that we had between about half past six to seven, mainly for Ted and I. If we had people round than we would invariably eat at eight because we sat round the table till midnight chatting and you know all the rest of it.

She continues:

See when I was working I was not getting home till about half past six you see, and even when we were at home, five o'clock is the time when I'm thinking about what we will have for are evening meal. I'm not sitting down at five o'clock eating and I find that's what's so difficult, I am getting use to the idea now.

Alison also experienced a change in routine from her norm but in contradiction to Kathryn's thoughts, Alison believed the timings of the meals to be too late:

The meals come a bit later than what thy do at home. I have tea at 5.25pm in here, well 5pm to half past is very late for me. I would normally have it at 4pm to half past, and I mean you're absolutely starving by the time the teas come in here, which isn't good when you're a diabetic.

But a change in behaviour is not always just the result of enforced hospital routines. Sometimes that change can occur out of medical necessity or as a result of certain treatments, again Kathryn demonstrates this:

Because I have a catheter I tend by in large to stick to water, cranberry and juice. I really have been an enormous tea drinker, I mean I would drink about eight mugs of tea before I ever left the house in the morning, but I don't have tea here because of the catheter and to keep every thing nice, light and clear. At one time I was on a fluid intake, they liked you to drink a lot, I just drink water because I'm here. At home I would probably revert back to tea. I know the rules; I'm in hospital so you get on with whatever's there. It's keeping me alive; it's keeping me well, why must I grumble? It will just be different when I get back into my own kitchen.

Again, these findings are of no great surprise, since busy hospitals can be formidable places, with unfamiliar surroundings and routines causing

psychological distress for many patients, alongside the existing stress of an illness (Bond 1997). This stress, as already discussed in previous sections, can be a precursor to loss of appetite and any subsequent consequences.

4.6 Conclusion

In conclusion, what takes place leading up to and during the anticipation phase of the 'eating process continuum' can facilitate either a good or a poor appetite, which in turn will go on to influence the remaining two stages of the process. Influencing factors include; how the making choices phase was experienced, health status, anxiety levels and any changes to normal routine. No apparent studies have directly examined the link between enforced variations in routine and nutritional status. However, it is clear in relation to the above that nurses can have a positive influence on these factors, ultimately facilitating a stable or increased appetite, as will be discussed in more detail during the implications for nursing practice section in chapter seven.

5 EATING BEHAVIOUR

5.1 Introduction

The meals arriving on the ward instigated a whole catalogue of different actions all themed 'eating behaviours'. Once more, many different factors influenced each individual's response to this phase, such as their appetite leading up to the meal, the smells, presentation and taste of the food when it arrived, the social context of the meal and even nursing staffs' behaviour at mealtimes as will be discussed in the following pages.

5.2 The Food

Throughout the study a number of patients commented on the texture and appearance of the food, suggesting presentation of meals is an important factor in 'eating behaviour'. A number of patients commented on the texture and appearance of the food. With descriptions ranging from unappealing to hard to eat:

Susan...I get what I ordered and because there wasn't much, only spicy stuff and it's all mixed up, I ordered the meat and potato pie. I don't like jumbled up food so I made it presentable myself. I shall eat half of it, or three quarters of it, a good portion of it and leave the rest.

Frank...I reckon as soon as I saw them, blob, blob, blob (patient demonstrates pushing food away). I can't explain it. You'd give it to a child of three to play with looking at it, a blob of this and a blob of that...

Edna...I can't cut the meat and Yorkshire pudding; I could have pitched it through the window. I couldn't get in it with the knife, and I could have upped the Yorkshire pudding and threw it, but I didn't. I waited; well I got someone to cut it up for me.

Further properties of food include taste and smell. Various descriptions included meals being delicious and excellent to bland and unpalatable, as Martin a 75 year old gentleman admitted with a fractured neck of femur describes:

Martin...Well, the food is it's not up to scratch. There's too much waste see. I've seen it here with other patients and that, they've had one mouthful - don't like it. See there's no seasoning in - the salt and pepper and that so it tastes bland to me – you see and mm I don't like it like that. I'd sooner have a bit of seasoning in so you can enjoy it yes, but same as potatoes - there's no salt in them. Mashed potatoes there's no salt or pepper in them, it's just mashed up. I don't know, we always have butter in it and salt and pepper and that, and mashed up proper.

Later in the same interview:

Martin...Well, its time they started putting seasoning in! There wouldn't be as much waste that's what I think. Of course, even the bloke next door to me in there - he got salt and pepper what had been brought from home so they're his own you see. It proves one thing you see, that they don't like the food without any seasoning. You can only ask the people what brings the meals "have you any salt or pepper on?" Very few times they have it on. The little packets you see and very few times they have it on.

John...The only problem I have, well not a problem, the only thing against it is there's no seasoning on. Well I can't taste it, never have. That's the only fault I have with them like.

Even the temperature of meals had an influence on how much participants enjoyed them. The preference was for hot meals' to be hot and cold meals cold, but neither too hot or too cold:

Basil...They're lovely and hot when you get them. I don't like having cold meals. But they're nice and hot when you get them, and they are very good at serving you. They are all very good.

Charles...as I say the only thing I dislike is when the meals are cold like they have been in the evenings (only sandwich and salad options), and I suppose nobody likes cold meals!

The size or portion of food served to the patients was indicated as an important factor in relation to the meals' presentation. The menus patients select from, during the making choices phase, included a section that enables all patients to specify the size of the meal they want to be served. For Edith and Basil this system worked well:

Edith...I'm not a very big eater so I usually write small portion (on the menu) which I get so I'm alright.

Basil...For one thing, I've had a small portion every time, what's the point in having it if you can't eat it, so I had a small portion every time. Portioning is a good idea, so people can eat it. I don't like being over faced. To some people the meals are not enough, but to me they're quite sufficient. On the menu where you can tick for a small, medium or large portion I think I put a small one, or a medium, I put small as a rule.

However, some respondents described often feeling 'over faced' by the meals, even though they may have selected a small portion only, for one patient being 'over faced' put her off her food which may have resulted in her eating a smaller amount than she would perhaps normally eat:

Jean...Well if you put small down you get near enough large (voice raised). Say - you put small - they say small, medium and large. I always put a small but when I get it, it looks like it's a large one because it's piled up you see. It's like they want to get rid of the food. You see it puts you off does too much.

Bill...The meals I have here – there's usually too much for me, but I have a dabble at what's there. Sometimes I'll finish it. Your meals in general (in hospital) are OK and there's always plenty for me, too much. I mean to say 15 – 20 years ago I'd have probably scoffed the lot in one go, but now there's ample for me as it is.

Feelings of being 'over faced' may have been exacerbated by the pre-plated system of meals service in use on this particular ward. In other words, pre-plated meals are served on trays with all three courses of the meal being presented to the patient in one go, as opposed to the bulk meal delivery service where meals are delivered to the wards in a large hot trolley and individually plated and served by the staff on the ward. Evans (1997) argues bulk meal delivery ensures food is hotter, more appetising and allows better control of individual portion sizes compared with pre-plated systems. During her second interview, following her discharge home, Edith recalled her experiences of eating in hospital and expressed concerns about all the above issues:

My eating was all right until I went in hospital and had to have those sandwiches. Everybody was fed up with them. They were really boring. Although I didn't want a big meal because I don't eat that much anyway, but them sandwiches were tasteless, and I think they put a little too much inside them. You know they were thick and it puts you off when they're thick like that because you can't handle them. I always cut mine in half, but they were really boring. In actual fact its just come to me, they made those sandwiches during the day and put them in the fridge, well when we got them at night (5.30pm - dinnertime) I had ice on mine, so I couldn't eat it! Many a time I' would eat only a quarter of a slice for my tea because you can't eat them with ice on like that, can you?

Strategies used to deal with these problems included asking the nurses for help with the meals, avoiding food that had previously caused problems or not eating at all, as was the case with this patient:

Jean...The Brussels sprouts - I tried to stick a fork in it and I couldn't. I had to get a spoon in the end to put it in my mouth...and chew it! I gave it up as a bad job, had to spit it out, that was that.

In essence, John who previously described looking forward to Lamb's liver, may have facilitated a good appetite by thinking about and looking forward to the meal. If once his meal arrives, it looks and smells as he expected and more importantly tastes as good as he had hoped for, his enjoyment of that meal may encourage him to consume a significant amount. Hence pleasure appears to play a role in determining food choice, since people tend to consume foods they enjoy eating and, as revealed by Frank's statement, avoid those they don't (Ottley

2000). This also demonstrates a strong link between palatability of food and its affect on appetite. From this it is clear at least three features contributed to John's 'eating behaviour'; he received what he was expecting, its presentation and its taste. On the other hand Frank, who had experienced a decreased appetite, described experiencing eating 'unpalatable' meals, due to his expectations and its presentation:

Frank...you haven't seen what they're offering me. I can't explain it.

You'd give it a 3 year old to play with looking at it. A blob of this, a blob of that

I never expected to be served that kind of food, I wouldn't give it to a grown up, I'd play with it that's about all. A blob of potatoes, chew, chew, chew, I can't describe it any other way.

This is in keeping with Yeoman's (1998) study, which demonstrated a strong link between palatability of food and its affect on appetite. Similarly, Edwards, Edwards & Salmon (2000) claimed patients, from their study of food service in hospitals, commented on the bland texture and colour of the meals, which did nothing to enhance appetite. ACHCEW (1997) assert the appearance of meals takes on a greater significance for people who are particularly unwell and have experienced appetite loss. Arguably, this principle should extend to all areas caring for older patients where the appearance of meals is significant whether particularly unwell with a poor appetite, or well with a good appetite. The significance of meal palatability is reiterated further by Kissileff & Guss (2001) who interestingly claim, all studies on human food intake are based predominantly on Davis & Levine's (1977) model, the chief assumption of which

is that how much of a meal is going to be consumed is anticipated from the outset based on the palatability of the meal. Hence the effects of palatability of food must not be underestimated. Sawaya et al. (2001) in their investigation into the effects of food palatability, feeding and substrate oxidation and blood glucose in men, offer a physiological explanation for the process. They suggest, multiple digestion-related processes that prepare the body to absorb nutrients are activated during the cephalic phase of post-prandial metabolism, which is initiated by olfactory, gustatory and cognitive stimulation. This in turn enables digestive enzymes to initiate the breakdown and absorption of carbohydrates. Depleted carbohydrate stores are one of the primary signals for hunger (Flatt 1988), hence initiating an increase in feelings of hunger and subsequent consumption levels. In other words, the more palatable the meal looks, smells and tastes, the more salvia is produced. Increased salvia production accelerates the amount of starch digested and in turn reduces feelings of fullness and facilitates increased feelings of hunger, culminating in individuals eating more.

5.3 Environment

The environment in which people are expected to eat had a less significant influence than first anticipated. Although most patients referred to eating either in or by their beds at some stage during their admission, non verbalised finding this difficult or unpleasant:

John...I only have my breakfast in bed the rest I have in the chair, it doesn't bother me, not what so ever. As long as I can eat I don't care where I sit.

What was more significant was the social aspect of the eating environment. Almost all respondents indicated how important it was for them to be in company when they where eating, but not just anyone's company but of friends acquired during their stay in hospital:

Kathryn...I think having a meal with company around a table brings an air of normality to it and just at that moment you could be – well you are – with friends. You can sometimes forget because you know everybody's the same.

John...I was at the chiropodist and it was a bit late in the morning so they said stay down here and have your dinner, but I didn't like it. Well I was amongst strangers and nobody spoke or anything like so I said "Oh get me back to the ward, let's have a look at me friends", kind of thing.

Edna...Well I'd rather have my meals in the garden room (day hospital), there's more people and we're talking about what we're having, and there's always a conversation while your having your meal. I like it down there. I don't like weekends because I have my meals in my room alone. I don't like that.

Basil...You can have natter with them can't you, well I prefer to be gregarious than on my own.

Mealtimes become a social event that offers an escape from the monotony of the ward routine, as well as a 'counselling' opportunity where mutual advice, support and sharing take place. For the patients in this study social interaction at mealtimes added to the enjoyment of eating, even increasing the amount consumed during a meal:

Edith...Well, they just told me I had to eat a lot, or else I wouldn't get home, then I got friendly with people so I ate a bit more – you know.

It can be seen from these results emphasis on the social context of eating was a strong theme throughout this study, with a clear relationship being demonstrated between eating in company and increased appetite. This is similar to the findings of Bell & Meiselman (1995) who also showed the importance of social factors in determining both the foods chosen and the quantity of food eaten. This would suggest all patients should be given the choice of eating in pleasant, communal areas, where social interaction is encouraged. This is in contrast to eating in isolation either by or in their beds, which may adversely affect appetite, and eating. Wykes (1997) went further and suggested, from their literature review of the benefits of social mealtimes, that the presence of nursing staff throughout mealtimes also benefited patient nutrition. Patel & Schlundt (2001) in their investigation into the relationship of moods and social context on eating behaviour concluded, meals eaten with other people increased significantly the amount consumed compared to meals eaten alone.

5.4 Eating difficulties

Eating difficulties are defined by Westergren et al. (2001, p.2) as "difficulties that alone, or in combination, negatively interfere with the preparation and intake of food and/or beverages", and it is in accordance with this definition that five of the patients interviewed revealed having some eating or swallowing difficulties on, or

since, their admission to hospital; although only three of these patients had required a soft or puréed diet whilst in hospital. Reasons for the eating difficulties were many and varied, ranging from dysphagia to problems with their dentures. The affect this had on eating behaviour also varied for each individual with some learning to adapt to their difficulties, others seeking treatment or help and still others avoiding eating foods that caused them difficulty altogether. For instance, although admitted following a stroke Mary was not diagnosed with dysphagia, was not on a soft or puréed diet, and during her initial interview claimed not to have any problems swallowing her food. However, it was during her second interview that Mary identified having problems swallowing very dry food, which would cause her to cough uncontrollably and even nearly choke on some occasions, and at one point Mary does claim to have had problems swallowing some fluids and explains how she managed this difficulty:

Mary...I did have trouble drinking milky drinks when I first came in. I just seemed to have a job to swallow it, but I've no problems at all now, its gone. I just drank water in between and missed out on the tea and coffee. I just sort of drank water for a long time, then I just added the odd cup of tea till it sort of got easier and a bit easier, until it was fine.

Jean also described experiencing some eating difficulty on occasion, for which she had not been diagnosed of, or treated for. Her reaction to the problem was to avoid some foods altogether:

Well, I don't know why it is but sometimes I just can't seem to take it, the food like. It just seems to get stuck round about here (patient points to gullet area), especially if I'm eating fast, so I just try to take it slow. But some of the food I eat here makes it worse, like them sandwiches. I just can't seem to digest them well. I've started ordering just the soup at night instead, 'cause I can't manage them sandwiches no more.

Susan had required a soft diet when she was admitted following a stroke, however she attributes her eating difficulties to a different problem and once this problem was solved she managed to maintain a normal diet:

Of course I had trouble with my teeth, I had a relining. I found that difficult until I got used to them. You see they were slipping and I was going to get them relined a couple of weeks before hand, but they did them for me in here and they're grand (Lancashire term for good) now.

On the other hand, Kathryn describes having difficulty eating due to the timings of the meals themselves, as identified in chapter four:

I find it difficult sometimes getting the food down, and I do find sometimes I'm eating it because I know I have to, because of the times.

Some of the above issues have been recognised as having a detrimental affect on eating behaviour, for instance Finestone et al. (1995) and Jacobsson et al. (1997). Other studies such as Westergren et al. (2001) have attempted to address some of these issues by examining the types and extent of eating difficulties experienced by patients with strokes and the need for assistance with

eating. Although this study was useful in adding to current knowledge and understanding of the problems faced by patients with eating difficulties, its recommendations were similar to many other studies on this topic, that is registered nurses must systematically assess patients' eating ability, without suggesting how this could be achieved.

5.5 Nursing care

Nurses responsibilities in relation to nutritional care have been fervently debated in the literature, as demonstrated in the literature review chapter one of this thesis (Lennard-Jones 1992, Norton 1996 and Arrowsmith 1999). Although no clear consensus exists as to what those responsibilities are, all of the relevant literature does agree that nurses play an important role in nutritional care. In some way the findings in this present study may corroborate this belief since all respondents interviewed talked about nursing care during mealtimes at some level, however few were clear about how that care was delivered. For instance all respondents commented on the practice of giving the meals out and most of the data references to nurses appeared to be in factual or physical terms, that is describing what nurses do:

Mary...Well they come in with the meal at night, or breakfast, they ask you what you want which is fine and you get exactly what you want, and they serve it to you, absolutely fine no problems. I've just no grumbles at all here, I think probably because they're made for you, and they come round and they are nice (the nurses). You get plenty to eat, because you can always ask for more at mealtimes, and they will give you more if you

want any more. So you've no need to go hungry at all. They'll give you more if you want more, just ask. It's your own fault if you're hungry.

Notably none of those questioned distinguished any difference between qualified and unqualified nurses roles at mealtimes, and all but one respondent referred to the nurses as simply 'they'. This may suggest staff in general as opposed to specific nurses, such as healthcare assistants, deliver most of the nutritional care. The person serving meals and giving nutritional care may vary daily, or even with each meal. Yet there was no indication from this study that this form of dis-continuity posed a problem. Instead nurses were described as either helping or not helping the patient:

Susan... Now I'm having proper food, as I call it, they cut it up for me into small pieces as much as I like. There's nothing too much trouble for them.

John...one of the nurses will cut my meat up or something like that, otherwise I manage quite well.

Jean...the vegetables are not soft in here, they're hard. You get a knife and try to cut one, well you can't. One nurse was stood there the other day, she said "are you having trouble love?", and then she took the meat off my plate and cut it up for me.

Edna...they feed them here, yes, they don't just leave you there with a plate.

Edith...they are very good at serving you, they are all very good.

Joseph...here its very homely and the staff help you all they can. Yes they're very helpful and the food, well there's no limit to it, if you want more or that kind of thing.

Although one patient seemed to find it difficult seeking help form the nurses, as Edna, who was previously described as having problems cutting meat and feeling like she wanted to pitch it through a window, explains:

Well I don't ask. I got told off by the ward sister the other today, she said I should ask, that's what they're there for. No but I just think they're short of staff.

However, It did appear that nursing care, in particularly nurses' activities in relation to food service at mealtimes, could have some affect on patients eating behaviour, either by facilitating or impeding eating. For example, Mary who previously claimed she had no problems with nurses helping her and serving her food did express a different experience when she was first admitted to hospital, although it was initially on a different and more acute ward. The care given by the nurses was to affect her eating behaviour in a negative way with Mary attributing her initial loss of appetite directly to the nutritional care given:

Interviewer...how is your appetite?

Mary...well I usually have a good appetite, but err at first I did lose it.

Interviewer...why do you think that is?

Mary...well half the thing is I couldn't eat. I know one day at the hospital they brought me dinner and it was a chicken leg and I thought well - there were nobody to help -they were so busy, you

know nobody could help you and I just thought well! – and I've false teeth at the front so I couldn't bite it and I certainly couldn't cut it with one hand, So I just didn't eat it. You know, and it was things like that that really. I know they're so busy and short staffed. But if there were more nurses to help maybe they could have cut it up for me and I would have perhaps enjoyed it. But I found that happened a lot. They haven't time to see if you'd eaten your lunch you know and just left it there and took it away. It's not their fault. They're just short staffed and that. So they used to put it on end of the bed on your tray, and if they hadn't pushed it up well you'd no chance. You couldn't move! I went down there for two weeks and then I went to this ward and it was different altogether. You know, oh they were brilliant.

Hospital meals are often referred to as food service within the literature, of which nurses form part of that service (Bond 1997). Similarly, respondents in this study also appeared to see good nutritional care as some kind of a service, a good service being one which is reliable, good, easy, and speedy and where they receive what they expect to receive. For instance, Mary describes finding meal service easier in hospital than at home:

I got a bit haphazard at home but I think they're more even in here (the meal time routines). Its easier here than at home really because your meals are regular and you can sort of pace your self really which is good. Yes, you just ask for what you want and you get what you want.

Bill...What I enjoyed most about the meals in hospital is I don't have to get up and make it.

Notably, several patients identified the attitudes and approaches of those serving the food as important characteristics of good nutritional care:

Edna...I can't find fault with them (the nurses) whatsoever, the foods served up with a smile and they look after them what can't eat.

Mary...they're pleasant, they're polite; they give you what you want.

Edith...they're very good at serving you.

5.6 Conclusion

In conclusion, it has been demonstrated that there are many influential features of the eating behaviour phase within the continuum. The contents of the meal, respondents ability to eat, and the nursing care given at the time of the meal all played an significant role in facilitating consumption of that meal. Palatability of the meal was also shown to be an imperative factor, which was in keeping with much of the literature on eating behaviour and food consumption. Therefore, it would appear vital for meal service providers, alongside nursing and medical staff, to acknowledge these key issues and ensure this is reflected within all future provision of meal. In particular from the interviews conducted with these respondents it emerged eating behaviour would have an effect on the final stage of the 'eating process continuum', as will be demonstrated in the following chapter.

6 APPRECIATION

6.1 Introduction

The final stage of the eating process is the appreciation of the meal. During this stage individuals will make judgements, assumptions and decisions, based on their feelings, attitudes towards and experience of the event as a whole. The levels of enjoyment, approval or disapproval, as well as the circumstances leading up to, and during, the making choices, anticipation and eating behaviour phases determine those judgements.

6.2 Reflective stage

Initially respondents reflected on the individual stages of the 'eating process continuum', identifying either good or bad practice, often giving a rationale for why those experiences were either positive or negative ones, and in some instances providing justification for that experience. There was some evidence of respondents reflecting on either their own personal experience or even other patients' experience of the 'eating process continuum'. In the following example Mary demonstrates reflecting on a fellow patients experience of the making choices phase. Mary recognizes the lady in the next bed was having a poor experience of the making choices phase, she then describes what had happened with the lasagne, gives the rationale of older people generally not liking spicy foods and identifies the real cause of the problem being the lack of choice on the menu:

Mary...I think maybe there could be a bit more choice for people on soft diets, the older people. The lady in the next bed to me, she's old, not quite a lot older than me, and she's been on a soft diet and sometimes there aren't enough things for them to choose. Like yesterday it was vegetable pie, um, she ended up having to have lasagne, and she's not, what I mean is a lot of old people don't care very much for spicy foods do they? To find her a nice meal it was difficult you know, I thought it was a shame sometimes. She really has a job, cause I help her mark her menu you see, and we really had difficulty at first. Now she's gone back on ordinary food, but to find her a nice meal it was difficult you know, because, it was funny they said have hot pot, well the hot pot had big lumps of chewy meat which really isn't right is it for soft diets, but sometimes that was the only choice she had you know, the rest was sort of like spicy or chicken what have you, and she couldn't chew that. But I think perhaps they could do with a little more, you know , for people on soft diet. Not for me because I've not been on a soft diet!

Next we observe Jean the 81 year old lady with diabetes reflecting on her experience of her eating behaviour in hospital. Again she is aware of having problems swallowing some of the food she is presented with. The rationale she gives is that she may be eating too fast and so tries to slow down. However later in the same interview she identifies the consistency of the food in hospital as being too hard, including the sandwiches, meat and vegetables. As a result she has now resolved to eat only soup for her evening meal rather than a more balanced diet of soup, sandwiches and vegetables:

Jean... Well, I don't know why it is but sometimes I just can't seem to take it, the food like. It just seems to get stuck round about here (patient points to gullet area), especially if I'm eating fast, so I just try to take it slow. But some of the food I eat here makes it worse, like them sandwiches. I

just can't seem to digest them well. I've started ordering just the soup at night instead, 'cause I can't manage them sandwiches no more. The vegetables are not soft in here, they're hard. You get a knife and try to cut one, well you can't. One nurse was stood there the other day, she said "are you having trouble love?" and then she took the meat off my plate and cut it up for me. Even the Brussels sprouts - I tried to stick a fork in it and I couldn't. I had to get a spoon in the end to put it in my mouth...and chew it! I gave it up as a bad job, had to spit it out, that was that.

Kathryn also reflected on how her eating behaviour had changed since her admission into hospital:

Here I'm not eating nearly the amount of vegetables that I eat when I'm at home, but that's not because the variety isn't here, it's just not cooked the way I would cook it and that's what I find you know, a little bit foreign. I like steamed veggies at home or I boil them in very little water and they come out just sort of a tad crunchy. But, you can't do that when you're cooking on mass, as you are for a hospital. By in large I think the food is good. I've got no moans, I've never gone hungry, but I do know that where the vegetables are concerned they're not done in the way that I personally cook my own in my own kitchen. My eating habits in a sense have changed but, I'm not saying that they have changed for the worse it's just the timing and their content, or perhaps the way that they're prepared. But that isn't leveled as a criticism; I understand why these meals have to be the way they are and how you have to be regimented when you're dealing with so many numbers. But I do prefer my own cooking as indeed I think any body does.

Although Kathryn had some negative experiences of the meals in hospital, for instance the timings and content, overall she judged her experience as a positive one, unlike the previous two respondents who appeared to judge the experiences they described as negative ones.

6.3 Negative experiences

Sadly, informants who judged the experience as a negative one often went on to assume their next 'eating process cycle' would also be negative, rather than believing this had been a one-off bad experience. Those who had this belief verbalised a loss of appetite since admission, and were the ones who went on to lose weight. This suggests significant links between positive eating experiences and appetite maintenance, alongside negative eating experiences and reduced appetite leading to weight loss. For instance, Frank who previously expressed experiencing a poor variety of choice from the puréed diet, a negative anticipation stage, and even a distressing eating behaviour phase which had led to him refusing to eat and losing 2 stones in weight during his admission to hospital, had this to say:

There is no food 'ere as I can say "oh I really enjoyed that". They just don't give me an appetite – do you know what I mean. There was nothing wrong with me appetite (prior to hospital admission).

All patients who reported negative eating experiences demonstrated making conscious decisions about that experience which would determine future behaviour. For instance, some chose to avoid either the food or the situation that had caused dissatisfaction as their coping strategy:

Edna...My favourites liver, but I'm not ordering it tomorrow because the liver seems to be too hard to cut and chew. No, so I'm not having it tomorrow, I'm having haddock instead.

Worryingly, others choose to avoid the whole eating process altogether, leaving the food ordering to the nurses, then not eating the meals ordered when they arrive. These two respondents required special diets, both had experienced reduced appetite and weight loss at the time of the study, both had refused to eat many of their meals during their admission:

Jack...I'm not eating like I used to, I can't, simple as that.

Frank...You haven't seen what they're offering me, simple. It worries me that I weren't eating the food I should have been eating...they think I've thrown the towel in and I haven't! No it's just the food it's not been available.

One patient, Martin who had no special dietary requirements but previously described feeling his food choice in hospital was limited due to the large amount of foreign food options on the menu, indicates being made to feel almost like a second class citizen or at least a low priority, when it comes to meal service in hospital:

Martin...I don't know (sounding cross), they (caterers) made some cakes and they burnt them. The nurses wouldn't eat them, the doctors wouldn't eat them so they passed it onto the patients. Well we couldn't eat them because they were burnt. They were solid. They all went in bin. You see, now what the doctors and nurses wouldn't eat they tried to palm onto the patients, they wouldn't know any better you see. But the cakes were burned to a cinder really, you couldn't eat them. Same as the custard now, it's that sweet I can't stomach it. The food has gone down the drain here.

Of the respondents reporting negative eating experiences here, all had experienced some appetite loss and both Jack and Frank had lost weight, suggesting that the negative eating cycles had continued at least until the time of each interview:

Jack... I'm only 10 stone now, I used to be 13. I worry about trying to get it back on an all, what can I eat to get it back on?

6.4 Positive experiences

Encouragingly, many respondents in this study did describe having positive eating experiences at all levels of the 'eating process continuum', which was to have a favourable influence on their decisions regarding eating in hospital in the future, although most had no special dietary requirements one, Mary, was on a reducing diet:

Mary...I always leave a clean plate; it doesn't affect my appetite or anything. There's a good choice, it's beautiful food here. I'm quite satisfied with it all, doesn't mean to say everybody is like, but I know I am.

Edna...One day this week I really enjoyed the food and I see some of these people around me, they really enjoy it.

Joseph...as for the food, anybody as a grumble well they must be short of something to grumble about. I'm quite satisfied (with the meals) I can't fault them, it's ate as soon as they come.

Of the three respondents reported here all had managed to maintain a healthy appetite and, other than Mary who was attempting to loose weight, non reported any weight loss since their admission.

6.5 Conclusion

In conclusion, it has been shown how respondents' individual experiences of each stage of the 'eating process continuum' can shape their understanding of, feelings towards and even evaluation of eating in hospital. This in turn will direct any future decision they will make about their consumption of the meals during the remainder of their hospital stay. Ottley (2000) reiterates these findings suggesting that other than hunger previous exposure to certain foods, taste and pleasure will affect a person's food choices. Sadly, of those respondents who had a negative experience of nutrition in hospital, at least two, that is 15% of those interviewed, appeared to make decisions about their eating which could be detrimental to their health status.

7 CONCLUSION

7.1 Summary of findings

In summary, this study sought to explore older people's experiences and feelings in relation to the provision of food in hospital. Following interviews with fifteen respondents the data were transcribed and analysed according to the principles of Husserlian phenomenology. On listening to the respondents' narratives it has emerged that eating in hospital is characterised by four main stages that formulate the 'eating process continuum'. It has been shown how each stage is influenced by many different variables and interacts with each other in important ways, facilitating the experience as a whole to be a pleasant or even unpleasant one. The first stage of the process is making choices which can be perceived as a physical act but which also incorporates psychological aspects. Therefore, this stage was shown to be affected by the variety of choice and the availability of food. In addition, this phase was influenced by individual food preferences and past experiences. The age of the respondent may appear to have been an influential factor, with a majority describing a preference for plain Lancashire food. However, it could be argued this preference was based on individual experiences rather than age since some of the lower to mid-range older respondents complained about too much foreign foods on the menu, and yet it was one of the oldest respondents who admitted to enjoying the different foods. It was documented how patients with special dietary needs experienced the worst

food choices overall, and how a lack of variety could go on to influence the following three stages of the 'eating process continuum' for the worse.

Stage two of the process was revealed to be the anticipation phase. The key psychological aspects of this phase involved respondents either looking forward to or dreading the coming meal. The psychological response to this phase at times manifested in physical ways. For instance, patients who suffered from heightened anxiety levels during this phase often described an eventual loss of appetite leading to some weight loss. The presenting health status of the respondent, and even the level of changes in individuals' usual routines, had an affect on their experience of the anticipation phase. With those suffering the most anxiety, and the most radical changes, experiencing the worst anticipation phase overall. The link between a negative anticipation phase and the eating behaviour stage was underlined. Hence respondents who had not looked forward to their meals, but instead had become anxious about mealtimes described consuming the lowest amount of those interviewed. Of course other variables that came into play during this stage may have counteracted the negative experiences of the previous two stages. For instance, high palatability foods may have increased the appetite of those initially anxious about the food. However, this did not appear to be the case for those respondents in this study. Within the eating behaviour stage the ability to eat, nursing care given and the environmental and social context of each meal were equally important features. All had the ability to influence the amount of the meal consumed by the respondent. Those with some level of swallowing difficulty described consuming less than they felt they should

have been. Those who required help with their meals, for example with cutting up their food, but did not receive that help from the nurses also expressed consuming less, yet those who ate socially with other patients described consuming more.

The appreciation stage was the final phase of the 'eating process continuum'. During this stage respondents reflected on the present cycle as a whole. Their experience of that cycle would facilitate a decision making process to take place. What is clear from this study is that choices regarding eating in hospital as a whole would be made and would remain largely unchanged. Therefore, if a respondent had a positive or good experience, they appeared to assume further experiences of eating in hospital would also be as good. Similarly, respondents who had a negative experience of the 'eating process continuum' appeared to presume all further experiences of eating in hospital would be negative ones. In response to these assumptions individuals appeared to subconsciously make decisions regarding their nutritional intake for the remainder of their admission to hospital. What is less clear from the study is how many cycles of the 'eating process continuum' it would take for respondents to formulate their judgements and make their decisions regarding consumption of the meals. For some respondents, such as Susan the lady initially placed on a soft diet when admitted to the ward, the decision to eat very little appeared to have taken place early on in her admission. For example, Susan claims she will always only eat half or three quarters of most meals and leave the rest even though at the time of

interview she was consuming a normal diet. Yet others identified trying to resolve the situation before formulating their judgements and making decisions. For instance, both Frank and Jack attempted to convince the ward staff to allow them to eat 'proper' or normal food as apposed to the puréed and soft diet. When their requests where refused both chose not to eat at all for the remainder of their admission. Sadly Jack passed away before he could be discharged, it was unclear whether this was a result of the anorexia that he was suffering from by the time of his death. It was identified Frank also went on to lose a significant amount of weight.

For a normal cycle to proceed, each phase of the continuum must be experienced. Thus, if any part of the cycle is disrupted or does not occur the process is incomplete. For instance, an individual may choose and anticipate a meal but if they are called away at the precise time the meal arrives they may not go on to experience the eating behaviour phase of that meal and therefore can not experience the appreciation stage of the meal.

7.2 Recommendations

I believe the patients' experiences reported in this thesis and the themes generated have significant implications for present nursing practice.

- From this study it emerged that having choice taken away decreased some of the pleasure of eating, particularly for those patients with special

dietary requirements. Therefore, it is recommended all ward areas implement a more substantial menu for those patients requiring a puréed diet. This menu should include a wide choice of meals, similar to those on a standard menu. This would enable a patient to choose what they would prefer to eat and have this puréed, rather than ticking a puréed box with no indication of what that meal might be.

- One of the issues highlighted by this study was the change in the meal routine from their home routines. On the unit where this study was carried out the routine was for cooked meals to be served at lunchtime and cold options at dinner, around 5pm. However, several respondents had commented on how difficult they had found it to get used to the limited cold options of sandwiches or salad available to them for their evening meal. Therefore, it is recommended that all ward areas provide a hot meal option in the evenings, rather than just a cold sandwich or salad. This would enable patients to maintain a similar routine in hospital to their routine at home. As indicated in the study many people have their main hot meals in the evening due to work commitments, and this routine appeared to continue even into retirement.

- This study showed that four main stages make up the eating process and each stage influences and are influenced by many other factors. Yet it is felt this study reveals only the tip of the iceberg in relation to the process

of eating. Therefore, further development of the themes is recommended for which this study could form a baseline. A thorough understanding of the phenomenon of eating in hospital would result in increased knowledge, empathy, caring and the application of valuable intervention strategies. As a result both patient care and nursing education could benefit.

- It is recommended that a nutritional assessment tool be devised, or existing assessment documents be revised, incorporating elements of the 'eating process continuum'. This would provide a useful tool since both in primary and secondary care, nurses ought to be in a position to locate where along the 'eating process continuum' deficits of care exist. This would enable them to implement appropriate intervention strategies, such as providing an increased choice of favourite foods for patients deemed at risk of nutritional deficit, thus maximising positive experiences for older people in hospital.

7.3 Concluding comments

In conclusion, this enquiry has revealed how meeting the nutritional need of older patients is far more complex than was first anticipated. Nurses play a central role in promoting adequate nutrition, but that role has tended to focus on the provision of diet, identifying nutritional problems and educating patients as regards healthy eating. Although all these issues are incredibly important, few studies have

demonstrated the importance of understanding how patients feel about their diet and eating in hospital. This knowledge could only improve nursing care since it would allow nurses to recognize which part of the eating process individuals are having difficulty with and introduce strategies to manage those problems. In this way the nursing profession has much to learn from listening to the voices of older people if they are to give quality care. From a patients' perspective the phenomenon of eating in hospital is a multifaceted process, and for too long this process has been ignored. Incalculable resources have been spent on improving catering facilities, updating nutritional guidelines, expanding nurses' nutritional education and in the advancement of assessment tools. Yet, with all these things we cannot make patients eat who do not want to, only awareness of why they choose not to eat can help us to help them.

8 LIMITATIONS OF THE STUDY

Although this project has achieved what it set out to achieve, that is expressing the needs and feelings about nutritional care for older people in their own words, a study like this clearly has some limitations. One limitation is that the study was confined to a single hospital base and a specific age group. In addition, although the patients who contributed to this project were rich in experience, generating a wealth of data, this study may have benefited from a wider cultural mix. This is particularly the case since the Northwest of England where the study was based has a large multi-ethnic population, although the exclusion of participants from different ethnic backgrounds was wholly circumstantial. Whilst these issues may restrict transferability of the findings, the themes generated in this study are still relevant to all healthcare professionals and exploration of the themes is to be encouraged in a wider range of clinical settings.

A further limitation of the study may have been in the methodological approach chosen to underpin the project. Certainly phenomenology presents a perspective which may illuminate and clarify some of the most fundamental and important issues within nursing (Hallett 1995), embracing a holistic approach (Polit & Hungler 1991; Van der Zalm & Bergum 2000) and giving a voice to human experience (Jardine 1990). However, once I had identified phenomenology as the investigative strategy which aligned most with my volition to seek an understanding of older patients' nutritional experiences, like others before me, such as Koch (1995) and Paley (1997), I discovered inconsistencies in its

philosophical underpinnings and application. Similarly, Crotty (1996) believes there to be a lack of relationship between the philosophical traditions of pure phenomenology as championed by Husserl, and the 'new phenomenology' espoused by nursing researchers such as Giorgi (1985). This is reaffirmed by Van Manen (2001) who believes qualitative researchers now utilize approaches and methods that have moved far beyond traditional methods and methodologies, which can be seen when comparing the works of traditional phenomenological philosophy with the work of phenomenological research in the multi-disciplinary field. For instance, the structure added to the interpretation of phenomenology by social scientists, such as Colaizzi (1978), is disparate from the origins of Husserl's 'science of essences' aimed at revealing true essence by peeling back the phenomenon and facilitating the reader to attempt an understanding of the individuals' lived experience for themselves (Corben 1999). This lack of relationship became increasingly evident as I studied the expansive literature concerning phenomenology. In addition there appeared to be no clear defining consensus of phenomenology, which made it increasingly difficult to adopt as a specific approach. Wimpenny & Gass (2000) argue this lack of congruence equates to lack of rigor and lower acceptability to the research community. It was precisely these arguments which may have led me to compromise my personal position. In other words, I had initially been determined to use Husserl's pure approach to phenomenology which, in relation to bracketing, would have required me to empty my mind of all data relating to a phenomena's context and situation (Hallett 1995), which is in contrast to the

principle of intentionally bringing these elements into view and using them to control for bias in a study as I did. In addition, Paley (1997) argues true Husserlian phenomenology is based on intuition and description, not induction nor deduction. Furthermore he suggests pure phenomenology is not an empirical procedure but an imaginative one found in the researcher's own conscious once eidetic reduction is achieved. This is reiterated by Corben (1999) who also suggests Husserl viewed phenomenology as essentially a descriptive process with conclusions being presented as raw data, giving no reference to analyses beyond bracketing. Controversially, Paley (1997, p.192) claims owing to their misinterpretations of Husserlian phenomenology "nurses are not entitled to make use of Husserl's terminology, and should abandon their attempts to ground phenomenological research". As Hallett (1995) observes, it is precisely these issues and judgments that cause many nurse researchers to feel under pressure to conform to a more 'scientific' form of phenomenology, such as Colaizzi's, which offers a criteria of rigor, objectivity, and validity as I ultimately did. Essentially, this allowed the reader to map my decision making processes throughout the study, whilst I systematically attempted to justify those decisions in order to ensure the study is acceptable to the research community. In retrospect this trepidation may have stifled the creative and naturalistic style which arguable should be fundamental to a phenomenological approach. However, ultimately I feel I was able to successfully utilize many positive aspects of valuable philosophy to enlighten my understanding of the nutritional experiences of older patients in hospital.

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APPENDIX 1

UNIVERSITY
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Department of Acute &
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Preston PR1 2HE
Tel 01772 893602
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Martin Johnson
Head of Department

February 15, 2000

Mary Sykes
Administrator
Preston, Chorley & South Ribble LREC
Lancs Centre for Medical Studies
Royal Preston Hospital
Sharoe Green Lane North
Preston PR2 9HT

Dear Mary,

RESEARCH PROPOSAL

I am pleased to enclose copies of our research proposal for the consideration of either the Chair or the full committee as thought fit. Given that the study is a small qualitative one for which we already have the approval of all the relevant nursing staff and the Nurse Exec, the former may be quite enough, but we are happy to seek your advice on this.

This is my first approach to your particular committee so please forgive any variation in your style or the way we have met your requitrements. I look forward to your reply.

Sincerely,

Martin Johnson
Professor of Nursing
University of Central Lancashire

Professor Martin Johnson,
Head of Department of Acute & Critical Care Nursing,
University of Central Lancashire

ASL/ASL 03/39

12 March 2000

Dear Prof Johnson,

A study of the needs of older people in and out of hospital: nutritional aspects.

Your protocol was considered at the LREC meeting of 6 March 2000.

It was suggested that the word "well" in the Patient Information Sheet be changed to "able", so as to remove any confusion with illness. There were one or two other minor errors, such as a surplus "at" in the Why Have I Been Chosen paragraph. It would also be worth printing on either Hospital or University headed paper.

The study was approved.

To comply with National guidelines, all Ethics Committees need to compile an annual report of research activity within their District. We would like to hear from, you 12 months from now as to the progress of your study and in particular if the study is terminated prematurely or suspended for any reason. Ethical approval lasts for 3 years after which it should be reviewed if the study is not completed. We would also be most grateful if you could let us know if any publication results from your study.

Yours sincerely,

AS Laurence, MA, MBBChir, FRCA, MD,
Chairman, Preston, Chorley and South Ribble LREC.

Copy to: Sister Anita Tunstall, Ward A1 Sharoe Green Hospital,
Helen Camm Senior Lecturer, University of Central Lancashire,
Alison Cochrane Senior Lecturer in Nursing, University of Central Lancashire

A study of the needs of older people in and out of hospital: nutritional aspects

Research Proposal submitted for Consideration by the Preston, Chorley and South Ribble Local Research Ethics Committee

By

Professor Martin Johnson, Head of Department of Acute and Critical Care Nursing, University of Central Lancashire, Greenbank, Preston, PR1 2HE
Email m.johnson2@uclan.ac.uk

Sister Anita Tunstall (and colleagues)
Ward A1, Sharoe Green Hospital, Watling Street Road, Preston, Lancs.

Helen Camm, Senior Lecturer in Nursing, University of Central Lancashire

Alison Cochrane, Senior Lecturer in Nursing, University of Central Lancashire

***Correspondence to Martin Johnson please**

Title

A study of the needs of older people in and out of hospital: nutritional aspects

Lead Applicant

Martin Johnson, RN, MSc, PhD (Manch) is Professor and Head of a Department of Nursing at the University of Central Lancashire. His recent work includes *Nursing Power and Social Judgement, Ashgate, Aldershot* which is a qualitative study how patients come to be seen as 'popular' or 'unpopular' patients, developing the work of Stockwell and others. He has wide experience of the conduct and supervision of qualitative research having supervised three PhD students to completion of their studies and has published widely in this field, particularly on ethical and methodological concerns (c.v. attached)

Location of the study

The study is a collaboration between the staff of the Sharoe Green Hospital and the University of Central Lancashire.

Preliminary work

Following discussions with Dame Pauline Fielding and as part of a commitment to relate as much as possible to local NHS service providers, staff from the Department of Acute and Critical Care Nursing at the University of Central Lancashire last year undertook a period of orientation to clinical settings at the Sharoe Green Hospital.

Following consultation with staff of all grades, it was agreed that preliminary work would be undertaken to develop and action research study of an issue of concern to the ward and its staff. This work included participation in clinical activity and informal collection of ideas for a joint action research study. It was felt in meetings with the ward team that a useful focus for a study of patients' experiences of care would be that of nutrition. This arose partly out of the publication of 'Hungry in hospital' (Burke 1997) and 'Eating matters' (Bond 1997), and the interest that several clinical staff had in the area of patients' eating and nutrition.

The ward in question (A1) has particular reason to be concerned to provide sound nutrition since many of the patients have suffered 'stroke' or other debilitating illness which might reasonably compromise their normal pattern of eating and drinking.

Introduction and literature

The care of older people has never been more worthy of study, as this group of people form ever greater part of an ageing society. Whilst multi-disciplinary and nursing research has a long history in the area previously known as 'Geriatrics', there remain many areas for substantial exploration and improvement (Nolan 1994).

Older people are often seen as a drain upon resources, of low priority for critical interventions and out of place in today's youth-oriented society (McCormack 1997). An area of particular concern in the care of older people has been highlighted as their nutrition. Wide ranging concern has been expressed that older people admitted to hospital may already be suffering from poor nutrition (Edwards 1997). Furthermore, during their stay their illness or disability, hospital routines or cultural factors may limit satisfactory intake of food. It has been argued that to some extent this is compounded by a general reduction in responsibility for the selection, presentation and monitoring of food intake by nursing staff (Edwards 1998).

As a result of this interest, more specific attention is now given to the assessment and monitoring of nutritional state of patients in, for example, Sharoe Green Hospital. Some authors have, however, claimed that the reliability and validity of such measures warrants further evaluation as aids to the clinical assessment of nutritional status (McClaren and Green 1998).

Various measures of nutritional status are available. Anthropometric techniques (body measurement) have value in the healthy, but among the elderly, frail or disabled they may be difficult to use reliably and without discomfort to the patient. Accurate measurement of height and weight can present problems with these groups (Chu 1998). Patient history and physical examination has a strong part to play in the assessment of risk in the nutritionally compromised, but scoring systems are as yet insufficiently predictive (Edwards 1998). Biochemical tests of, for example, serum albumin, correlate well with malnutrition and other indices, and are commonly routinely undertaken in hospital patients but not those in the community.

Whilst a good deal of the attention paid to the rehabilitation of patients with stroke and other chronic disabling conditions, little resource has been devoted to the assessment of their continued ability to provide adequate nutrition after discharge. Whilst some attention has been devoted to the investigation of the effectiveness of discharge procedures and after-care, little work has examined the ability of those discharged to the community to maintain adequate nutrition, particularly in the context of an acquired disability such as a stroke.

Research Aims

The proposed study has the following aims:

1. To provide a focus for collaboration between the Trust and the University.
2. To examine the needs and experiences of patients in relation to the provision of food and drink in hospital.
3. To examine the needs and experiences of patients in relation to food and drink after their discharge into the community.

Methods

The study will take the form of 'action research'. By this we mean that all steps in the process will be collaborative, drawing on the skills of both University and Hospital staff. Outcomes of the project will be fed back to and 'owned' by members of the ward team and lecturers jointly. In particular, ward staff will be assisted by experienced researchers in collecting and interpreting data. Researchers will be supported and assisted in relating appropriately to patients.

Specific strategies for data collection and analysis will include:

Phase 1
- Preliminary orientation to the setting. Lecturers participate in the clinical setting at agreed times.
- Informal interviews with consenting in-patients identified by staff as suitable.

Phase 2
- Semi-structured tape recorded interviews with consenting discharged patients undertaken by ward staff supported by lecturers.
- Consensus meetings with ward staff to discuss outcomes of interviews and compare with wider evidence base.
- Development and use of appropriate non-invasive measures of nutritional status.
- Development of practice guidelines if appropriate.

Phase 3
- Report to the Preston, Chorley and south Ribble Local Research Ethics Committee
- Written report to Executive Nurse
- Dissemination of outcomes as Trust-wide or University seminar or study day
- Joint presentation at appropriate conferences e.g. British Society of Gerontology, Rcn Research Society Conference

- Development of research proposal(s) for in-depth nutritional assessment study, perhaps of the very ill, to include biochemical indicators if appropriate. This work will involve collaboration with Professor Peter Aggett and colleagues in the Lancashire Postgraduate Centre for Medicine and Health. Further ethical approval would be sought for such a study.

Rationale

Though far from new, action research is gaining acceptance in health care as an appropriate strategy for combining local practice development with the principles of sound investigation (Hart and Bond, 1995). Although unable to meet the 'scientific' canons of some forms of experimental research, through detailed study of relevant literature, rigorous collection and interpretation of data and good collaboration with local staff, highly relevant and worthwhile outcomes can be achieved.

Although some descriptive data will be quantitative, the majority of the data relating to patient experiences will be qualitative. Interviews will be transcribed and analysed into categories of significant meaning for patients. Whilst our mind is quite open to the sorts of experiences patients will relate at this stage of the study, we will be focussing on their food and drink preferences, their supply mechanisms, who prepares their food, similarities and differences with 'hospital' foods and routines, and wider coping behaviours on discharge.

Sampling

The patient sample will be drawn from patients currently or recently in-patients of ward A1 at Sharoe Green Hospital. Whist strict randomisation will confer no statistical benefits in a study of this type, every effort will be made to gain a sample in which age, gender, ethnic origin, broad diagnostic category and social class are fairly represented.
Very ill persons (in the opinion of the Ward manager) will be excluded from the study at this stage. This may seem paradoxical, since the very ill are the most nutritionally vulnerable, but the study team would prefer to examine issues for this group in a future study when objective indicators of nutritional status will be able to be used.

Ethical Issues

The team are aware of potential ethical issues and have strategies for their resolution. Patients will be interviewed only with their formal consent. In the case of patients interviewed at home, a researcher/lecturer will be accompanied by a member of the ward team

to facilitate continuity for the patient. Interviews will be conducted by appointment only, with a letter of confirmation going to potential respondents. Respondents at home will be asked to give written consent after a full briefing and information leaflet.

The conduct of research in health care settings and in people's homes requires strict adherence to principles of anonymity and confidentiality. Normally researchers will undertake not to intervene in the daily lives of respondents except to discharge a duty of care under the UKCC Code of Conduct. Action research fortunately provides a framework within which genuinely helpful behaviours are not excluded from the researcher's activities, such as, for example, giving nutritional advice.

Data analysis

Data will be rendered anonymous as soon as possible and analysed according to the principles of 'grounded theory' (Strauss and Corbin 1990) in which the researchers have experience.

Using this approach allows ideas and experiences of relevance to respondents to emerge as important rather than simply the expectations of the researchers.

Project management

The project is jointly owned by the Preston and Chorley Acute Hospitals NHS Trust and the University of Central Lancashire. It is being performed within a service level agreement between these two parties. Academic Leadership if the project will be by Professor Johnson.

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Strauss AL and Corbin J (1990) *Basics of qualitative research: grounded theory procedures and techniques,* Newbury Park, Sage
Wood S (1998) Full service: putting nutrition back into nursing, *Nursing Times, 94, 32, 24-26*

CV of Professor Martin Johnson

Current Post
Head of Department of Acute and Critical Care Nursing
University of Central Lancashire, Preston PR1 2HE

Qualifications

1974	RGN, Manchester Royal Infirmary
1983	MSc in Nursing, University of Manchester
1993	PhD, University of Manchester

Experience

1974-79	Staff Nurse/Charge Nurse, Varied Roles Manchester Royal Infirmary
1982-85	Nurse Tutor, Stockport Health Authority
1985-89	Senior Tutor, Education and Research, Trafford Health Authority
1989-90	Senior Lecturer in Nursing, Sheffield Polytechnic
1990-95	Principal Lecturer in Nursing, University of Huddersfield
1995-97	Senior Lecturer in Nursing, later Associate Dean, University of Manchester

Selected Recent Professional Activities

1996	Consultant to West Midlands Regional Nursing Executive, Postgraduate Programmes for Advanced Nursing Practice Tendering Process
1996	Consultant to Nazarene College of Nursing, Manzini, Swaziland, Southern Africa
1996	Consultant to and Member, Comite Technico, Organizacion Colegial de Enfermeria en Aragon, Spain
1996-	Assessor for the Scottish Higher Education Funding Council Teaching Quality Assessment Programme
1997-	Subject Reviewer in Nursing, Quality Assurance Agency for Higher Education
1998/9	Consultant in quality assessment to Sheffield and Leeds Metropolitan Universities

External Examinerships

1989-91	External Examiner, University of Liverpool BSc/RGN course
1993-6	Chief External Examiner, Leeds Metropolitan University BSc (Hons) Nursing
1994-8	External Examiner, University of Wolverhampton MA Health Studies
1995- 9	External Examiner, University of Sheffield MA in Education for Health and Social Care
1999-	External Examiner, University of Glasgow Degree of MNurs.
1999-	External Examiner, Edge Hill College, BPhil Degree, (University of Lancaster)

Research Degree Examinations

1996 Internal Examiner MPhil University of Manchester, JP Fell
1996 Internal Examiner, PhD University of Manchester, J Merrell
1997 Internal Examiner, PhD University of Manchester, S Buller PhD
1997 Internal Examiner, PhD University of Manchester, K Wilson
1997 External Examiner, PhD, University of Glasgow, M Gray
1998 Internal Examiner, PhD, University of Central Lancashire, A Alty
1999 External Examiner, PhD, Cranfield University, L Bellman

Research Degree Supervision

PhD University of Manchester: AJ Long, Experiences of Families Caring for Infants Who Cry Persistently (Awarded)
MPhil University of Manchester: S Worth, Clients Experiences of Participation in Their Care (Awarded)
PhD University of Huddersfield: A Topping, Experiences of Women with Breast Cancer
PhD University of Manchester: J Alasad, Phenomenology of Intensive Care Nursing (Completed)
PhD University of Manchester A White, Men's experiences of coronary care nursing (Completed)
MPhil University of Manchester B Pateman, Men's experiences of urological nursing (Awarded)

Selected Recent Conference Presentations (*refereed)

1996 The Wildebeest perspective: ethics of intervention in health research, *University of Central Lancashire Consensus in Bioethics Conference*
1996 Ethics of intervention in qualitative research, *3rd International Qualitative Health Research Conference, University of Bournemouth*
1999 Symposium: Critical Perspectives on Nursing Knowledge, *Rcn Research Society Conference, Keele University* (with Professor Keith Cash)

Selected Recent Publications (*refereed academic)

1996 Student nurses: novices or practitioners of brilliant care? *Nursing Times,* June 26th, 92, 24, 34-37
1997* Observations of the neglected concept of intervention in nursing research, *Journal of Advanced Nursing, 25, 1,* 23-39
1997* *Nursing power and social judgement*, Avebury, Aldershot
1997* Nurses, clients and power, In, Birchenall, P and Birchenall, M (Eds) *Sociology and social policy in nursing,* London, Baillière Tindall
1998* The complexities of nursing research with men, *International Journal of Nursing Studies, 35, 41-48* (with Alan White)
1999* Observations on positivism and pseudoscience in qualitative nursing research, *Journal of Advanced Nursing,* 30, 1, 67-73.
1999 Invited Editorial: Scholarship, namedropping and the 'five-minute test', Nurse Education Today, 19, 599-600
2000* Commentary on Clifford's International politics and nursing education: power and control, *Nurse Education Today, 20, (forthcoming)*

APPENDIX 2

Memo

UNIVERSITY
OF CENTRAL
LANCASHIRE

18th December 2001

Re: Samantha Pollitt

Subject: Postgraduate research degree

Dear Ian,

I am pleased to inform you that I have submitted copies of my research proposal for consideration by the Faculty of Health Ethics Committee. I shall be happy to notify you of their reply in due course.

Sincerely

S Pollitt

Sam Pollitt
Lecturer
Dept of Nursing
University of Central Lancashire

December 18, 2001

Matti Hayry
Health Center for Professional Ethics
Vernon Building
University of Central Lancashire
Preston

Dear Matti,

I am a postgraduate student in the Department of Nursing, currently in the process of registering for MSc (by Research). The study I am proposing has already been submitted and passed by Preston, Chorley & South Ribble LREC in Feb 2000, see enclosed letters. However, my rapporteurs, Ian Levitt and Carol Miles, feel my proposal must also be submitted to the newly formed faculty ethics committee. The problem is I am expected to submit my completed work shortly and hoped you could review my propsal prior to the committee sitting on the 22nd Jan 2002.

Please find my research propsal enclosed.

Yours Sincerely

Sam Pollitt
Lecture
Department of Nursing
University of Central Lancashire
Ext: 3624

A study of the nutritional needs of older people

Research proposal submitted for consideration by Dame Pauline Fielding and Professor Martin Johnson, towards the award of Masters of Science by Research

By

Samantha Pollitt, RGN, BA (Hons),

Research Fellow, Department of Acute and Critical Care Nursing,

University of Central Lancashire, Greenbank Building, Preston, PR1 2HE

Email s.j.pollitt@uclan.ac.uk

I find this research proposal ethically acceptable.

17/01/02 Preston

Malli Hayry

Malli Häyry, Chair, Faculty of Health Ethics Committee

In conjunction with

A study of the needs of older people in and out of hospital: nutritional aspects

By

Professor Martin Johnson, Anita Tunstall, Helen Camm and Alison Cochrane.

Introduction

Recent demographic changes have led to a substantial increase in the ageing population. Quality of life is as important to this section of society as to any other. Thus, since good nutrition has a marked effect on health, independence and happiness (Davies 1981), adequate nourishment should therefore be paramount for those caring for older people admitted to hospital. However, the publication of *'Hungry in hospital'* (ACHCEW 1997) revealed how NHS hospitals were failing to meet the basic nutritional needs of older patients. It claimed people were 'starving' in hospital, and dared to point out how, although aware of this disturbing problem and official guidelines having been put in place, the health care system was not doing enough (ACHEW 1997).

In response to this, a comprehensive resource pack for practioners was developed and distributed throughout the UK. *'Eating matters'* (Bond 1997) presented strategies aimed at addressing the dietary needs of all patients in health care settings. Yet, regardless of the increased awareness amongst health care professionals, malnutrition is still on the increase in hospitals (McLaren 1998, Holmes 1999, Edwards 1998, Palmer 1998).

This implies patients' rights to adequate food and drink are being ignored by the NHS, at the same time patients are being exposed to conditions detrimental to their health and recovery, since malnourishment impedes wound healing, impairs the immune system and increases morbidity (Reilly 1988, Watson 1994). Although many localised projects have attempted to deal with the problems, such as improving hospital-catering facilities, few have considered the needs of older patients from their own perspectives.

This suggests the need for a project, such as this, that examines closely those needs as identified by the subjects themselves during the study.

Research aims

- To examine the needs and experiences of patients in relation to the provision of food and drink in hospital.
- To examine the needs and experiences of patients in relation to food and drink following their discharge into the community.

Objectives

- To review and summarise current literature on the nutrition of older people and malnutrition in hospital.
- To work alongside the staff and the patients in the clinical setting assigned for the study.
- To commence informal interviews with consenting in-patients identified by the staff on the ward as suitable candidates for the study.
- To commence semi-structured tape recorded interviews with consenting discharged patients in the community.
- To hold consensus meetings with ward staff to discuss outcomes of interviews and compare with wider evidence base.
- To complete written report of findings
- To present findings in both written and verbal form to all parties necessary.

The study design

The study is designed to discover the nutritional needs of older people through use of a qualitative methodology, in the form of action research. This strategy was chosen for its ability to foster, and enable, collaboration between ward staff and researchers.

Sampling

The subject sample will be drawn from in-patients selected by ward staff as suitable for the study. Every effort will be made to gain a representative sample, across age, gender etc.

Ethical issues

Strategies have been developed to resolve potential ethical issues. For example, patients will only be interviewed with their written formal consent and confidentiality will be maintained throughout the project.

Data analysis

The data will be analysed according to the principles of 'grounded theory' (Strauss & Corbin 1990), since this method allows the respondents experiences and ideas to emerge as important as opposed to the researcher's conceptions concerning a phenomenon. Some quantitative data may be analysed using the NUD*IST data management package.

References

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APPENDIX 3

A study of the needs of older people in and out of hospital: nutritional aspects

Patient Information Sheet

We would be pleased if you would consider being involved in a research study. Before you take part you will want to know why the research is being done and what it will involve. Please read the following carefully and discuss it with friends, relatives, your nurse or doctor if you wish.

Ask us if anything is not clear or you would like more information. Taking part is entirely voluntary.

Why is it being done?
The study is being done to find out how well people are able to eat and drink in hospital and then when they get home afterwards.

Why have I been chosen?
You are a patient at Sharoe Green Hospital and we want to see how you manage at to eat and drink in the hospital and then when you get home.

Do I have to take part?
It is up to you to decide. You may decide not to take part or you may withdraw at any time without giving a reason. This will not affect the care you receive.

What do I have to do?
If you do decide to take part a researcher, who will probably be a nurse, will come to talk to you in hospital and then again once you have gone home. They will ask questions about eating and drinking. The researchers will not visit without an appointment which they will make by writing to you or telephoning.

Will I have any extra tests or treatments?
No. The research is just to find out your opinions. The researchers (who will be qualified health personnel) will, however, be able to answer and questions you may have, or will refer you to the right person if you have any difficulties.

What are the risks of taking part?
No drug or treatment is being tested so there are no risks in that respect. You will be giving up an hour or so of your time.

What may be the benefits of taking part?
If you have any specific problems that you want help with we will do our best to refer you to whoever can help.
We hope eventually to improve the help that we provide to older people at home.

Will I be identified?
Any report the researchers write will not identify anyone by name.

Who is organising the research?
The University of Central Lancashire and the Sharoe Green Hospital. The project leader is Professor Martin Johnson. He is working with Sister Tunstall of Ward A1 whose names and addresses are below:

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Martin Johnson
PhD MSc RNT RGN DipN
RMN DANS RCNT

Title of Project:
A Study of the Needs of Older People in and out of hospital: nutritional aspects

Name of Researcher:

_____

CONSENT FORM

Please initial box

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that sections of any of my medical notes may be looked at by responsible individuals from the University or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐

4. I agree to take part in the above study. ☐

_____	_____	_____
Name of Patient	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

APPENDIX 4

Nutritional study Areas for discussion

In hospital

1) Dietary habits before admission
2) Dietary habits since admission
3) Appetite
4) Ability to eat
5) Special needs
6) Food preferences
7) Likes
8) Dislikes
9) Describe a typical mealtime on the ward
10) Describe the context of mealtimes for you on the ward

    (Surroundings, environment, smell, noise etc)

11) Suggested changes

APPENDIX 5

The Schedule

• Pilot study	• 12 months
• Participant observer	• 2 months
• Observer	• 1 month
• Subject recruitment	• 12 months
• Interviews	• 15 months
• Re-interviews	• 6 months
• Data analyses	• 22 months
• Reporting findings	• Ongoing