**Title**: Developing Practice through Action Learning to Improve the Nutritional Status of Elderly Care Home Residents at Horton Cross Nursing Home, Ilminster, Somerset

**Keywords**: Nutrition, nursing home, action learning, action research

**Duration of Project**: 12 Months

**Project Team**:
Glynnis Walsh, Sister, Horton Cross Nursing Home
Jackie Gingell, Matron, Horton Cross Nursing Home
Alison Overd, Care Assistant, Horton Cross Nursing Home
James Boyland, Care Assistant, Horton Cross Nursing Home
Louise Webber, Cook, Horton Cross Nursing Home
Julia Clarke, external facilitator, RGN, BSc (Hons)
Liz Walsh, academic supervision, RGN, BSc (Hons), MSc, PhD

**Location of Project**: Horton Cross Nursing Home, Ilminster, Somerset

**Contact Details**:
Mrs Glynnis Walsh, Sister,
Horton Cross Nursing Home, Horton Cross, Ilminster, Somerset, TA19 9PT
Tel: 01460 52144

**Acknowledgments**
We are grateful to the Foundation of Nursing Studies for funding and supporting the project team to undertake this work; to the residents, staff and managers at Horton Cross Nursing Home, for their involvement, support and encouragement.
Contents

1. Background .................................................................................................. 4

2. Methodology .................................................................................................. 5
   2.1. Action Research .................................................................................... 6
   2.2. Action Learning ..................................................................................... 7

3. Aims and Objectives .................................................................................... 7

4. The Action Learning Group .......................................................................... 7

5. The Process ................................................................................................... 8
   5.1. Meeting 1, June 2006 (facilitated) ......................................................... 9
   5.2. Meeting 2, July 2006 (not facilitated) .................................................... 10
   5.3. Meeting 3, October 2006 (facilitated) ................................................... 10
   5.4. Meeting 4, December 2006 (facilitated) ................................................ 11
   5.5. Interim meeting with funder December 2006 ....................................... 11
   5.6. Meeting 5 & 6, February 2007 & May 2007 (not facilitated) ............... 11
   5.7. Meeting 7, June 2007 (Facilitated) ...................................................... 12

6. Findings and Evaluation ............................................................................. 12
   6.1. Practice Developments ........................................................................... 13
      6.1.1. Screening and assessment to identify patients nutritional needs .... 14
      6.1.2. Planning, implementation, and evaluation of care for those patients
             who require a nutritional assessment .................................................... 14
      6.1.3. A conducive environment (acceptable sights, smells and sounds).... 15
      6.1.4. Assistance to eat and drink .............................................................. 16
      6.1.5. Obtaining food (includes having sufficient information) ............... 17
      6.1.6. Food provided ................................................................................ 17
      6.1.7. Food availability ............................................................................ 18
      6.1.8. Food presentation ........................................................................... 19
      6.1.9. Monitoring ..................................................................................... 19
      6.1.10. Eating to promote health ................................................................. 19
6.2. Supporting Development through Action Learning ........................................ 20
   6.2.1 The Issue Tree & Implementation Matrix .............................................. 20
   6.2.2. Action Learning ................................................................................ 21
       Group Composition .................................................................................... 21
       A Safe Environment ................................................................................... 22
       Sharing Problems & Raising Awareness .................................................... 22
       Learning ..................................................................................................... 23
6.3. Barriers to Action Learning ...................................................................... 24
       Organisational & Personal Commitment .................................................... 24
       Dwelling on Non-Achievements ................................................................ 24

7. Implications for Practice ............................................................................. 25

8. Conclusions ............................................................................................... 28

9. References .................................................................................................. 30
   Appendix 1: Issue Tree .................................................................................. 34
   Appendix 2: Implementation Matrix .............................................................. 35
   Appendix 3: Action Plan ............................................................................... 36
   Appendix 4: Questionnaire .......................................................................... 37
   Appendix 5: Updated Implementation Matrix ............................................... 45
   Appendix 6: Diabetic Fruit Cake .................................................................... 46
1. Background

The importance of appropriate nutrition for the older person is well documented in both the health literature see Ghalili & Amella (2005); Coull (2003); Chen et al (2001); Ennis et al (2001) and at a strategic level by the Department of Health, see The National Service Framework for Older People, (Department Of Health, 2001) and The Essence of Care, (NHS Modernisation Agency, 2001). In a recent initiative, the Royal College of Nursing is also supporting the improvement of nutrition and hydration for patients, see [www.rcn.org.uk/nutritionnow](http://www.rcn.org.uk/nutritionnow).

The provision of adequate nutrition for the elderly is important for a variety of reasons such as disease prevention, promotion of wound healing, general health promotion and psychological well being; see Sandars (2001), Smith (2001), Kelly (2001), and Clay (2001). According to Berkley & Prentice (1999: 455) ‘Many residents in nursing homes are likely to be very frail, suffer from multiple disabilities and have increased nutritional needs’. Indeed, Copeman (2005:277) states that ‘malnutrition and dehydration are serious and common problems among older people in nursing and residential care homes’.

Food and nutrition have been reported as having a low status in the residential and hospital settings possibly because ‘food and its nutritional value are not always at the forefront of health professionals’ education’, Kelly (2001:112). The education of healthcare workers and the development of their practice to support and sustain improvement in nutrition for service users is the cornerstone of supporting and sustaining improvements in practice and ultimately, patient care.

According to Garbett and McCormack (2002:88), ‘Practice development is a continuous process of improvement towards increased effectiveness in patient-centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflects the perspectives of service-users’. Practice development in this respect therefore,
not only aims to develop practice through direct intervention, but also aims to influence and support practitioners to transform the context and culture of care. In this context, action learning was deemed the most appropriate mechanism to support practice development. According to McGill & Brockbank (2004:11) action learning is ‘…a continuous process of learning and reflection that happens with the support of a group or ‘set’ of colleagues, working on real issues, with the intention of getting things done’. They continue that ‘the voluntary participants in the group or ‘set’ learn with and from each other and take forward an important issue with the support of the other members of the set’.

An inspection of Horton Cross Nursing Home by the Commission for Social Care in August 2005, identified issues concerning nutrition that needed to be addressed. These included improved monitoring of fluid intake, availability of food between 5pm and 9am, and the monitoring of food and fluid intake, especially for those deemed at high risk of malnutrition. In March 2006, further issues pertaining to nutrition were highlighted e.g. lack of menu display, the need for more adequate documentation and the need to more closely address the service users’ preferences; see www.csci.org.uk for details of both reports.

In order to help address these issues, whilst simultaneously providing an opportunity for the development of staff through action learning, funding was granted from the Foundation of Nursing Studies for a small project to be undertaken.

2. Methodology
The principles of action research, i.e. cycles of planning, action and evaluation, were adopted as an overarching framework to guide project progress, with action learning identified as the most appropriate mechanism for achieving this. It is also worth noting here that given the ‘real life context’ within which this project was undertaken, the ideas concerning flexibility and flexible designs as proposed by Robson (2002) in respect of ‘real world’ research also informed the approach to this work.


**2.1. Action Research**

According to Williamson & Prosser (2002:587) ‘action research as a tradition has developed since the 1940’s as a tool for producing change in organisations with workers’ involvement’. The potential to produce change with the involvement of the workforce provided the impetus for us to utilise action research for this project. Sandars & Waterman (2005:295) suggest that ‘Action research is characterised by a process in which there is an initial analysis including critical reflection, fact finding and conceptualisation about the problem. This is followed by planning and delivery of an intervention, which in turn, is followed by more fact finding or evaluation. The whole cycle of activities is repeated so that there is both improved action and greater understanding of the problem’. In addition to solving complex problems, action research also has an element of educational activity associated with it, Corbett et al (2007).

The following diagram illustrates the stages of the action research cycle
2.2. Action Learning

As been previously mentioned, action learning is ‘...a continuous process of learning and reflection that happens with the support of a group or 'set' of colleagues, working on real issues, with the intention of getting things done’, McGill & Brockbank (2004:11). In addition, we suggest that action learning is an approach to practice development where the method itself makes a difference to practice, and is transformatory for those involved. Action learning and action research are inextricably linked in terms of the reflection on complex problems and experiential learning through cycles of action. There are two types of action learning, facilitated and self-facilitated both of which can be initiated by the organisation and indeed, be initiated independently.

Examples of action learning used in supporting workplace learning and nursing practice can be found in Bourner & Frost (1996); Graham (1995) Heidari & Galvin (2003); and Jones et al (2005);

3. Aims and Objectives

The aim of this project was to improve the nutritional status of residents at Horton Cross Nursing Home. It was proposed that this could be achieved through action learning to initiate and sustain developments and changes in practice.

4. The Action Learning Group

Given the size of this nursing home, one action learning group was deemed to be adequate. Initially, it was proposed that there would be membership of two registered nurses (one of which is the home manager), two service users, two health care assistants, and the home’s cook. However, following further consideration and advice from the funders of the project, it was decided that because the focus of the action learning group would be on discussing professional issues and challenging practice, the inclusion of service users would not be appropriate. Instead, the project team committed to identifying
other ways in which meaningful involvement of service users could be achieved.

The importance of good facilitation is noted in the literature, see Haddock (1997); Zuber-Skerritt (2002). This group was facilitated by an external facilitator with both experience in facilitating organisational change and nursing experience. In this context, the primary role of the facilitator was as an ‘enabler’. Harvey et al (2002:581) consider an enabling role as ‘more likely to be developmental in nature, seeking to explore and release the inherent potential of individuals’.

In order to assemble the action learning group, individual staff were approached by the project lead and invited to join. These staff were advised of the purpose of the action learning group and the proposed project plan. In selecting staff to invite, the project lead considered both the operational role and level of professional development attained. Given that action learning has both change and development as its focus, some staff we invited in order to compliment their current professional studies. In addition, it was deemed to be important to have representation from across the multidisciplinary team hence a range of staff were included. Staff who expressed interest in becoming members of the group were assured that they would be provided with the time to attend meetings.

Initially, meetings were planned for every two months over a period of 12 months, with some additional meetings convened as deemed necessary. However, given the real world nature of the project and understanding of the constraints often affecting a rigid meeting schedule, some meetings were cancelled and re-scheduled whilst others were held without an external facilitator. All meetings were held in a day room at the home.

5. The Process
We have chosen to report this project by detailing the process of the action learning group meetings separately to the changes in practice which occurred as a result of these meetings. This is to enable the reader to appreciate the
processes involved in action learning group meetings in addition to learning of the outcomes of the project. Therefore, the process of the action learning group meetings is detailed below.

**5.1. Meeting 1, June 2006 (facilitated)**

This project commenced with the first action learning group meeting held at Horton Cross Nursing Home in June 2006. At this meeting, the aims and objectives of the project and proposed methodology were discussed, with members being given time to contribute their thoughts and ideas for future work. Implicit in this meeting was the need to agree ground rules for the group. The main agreements made concerned the need for a non-judgmental approach in discussion and when challenging ideas, agreement regarding confidentiality, the need for commitment to attending and contributing to the group and finally the recognition of the equal status of each member. It was felt that this was important given the composition of the group e.g. home manager and health care assistant involvement.

At this first meeting, the external facilitator introduced a systematic approach to considering the priorities of the group in developing and changing practice. An ‘Issue Tree’ was devised (see appendix 1) through whole group involvement. The benefits of this approach are discussed in section 6.2.

Following the compilation of the issue tree, members were asked to consider solutions and actions which could be implemented in order to address the issues arising from their issue tree. They were asked to write their ideas on post-it notes which they proceeded to place on a large matrix with two axis, one labelled ‘Impact’ the other labelled ‘Ease of Implementation’. See appendix 2 for completed matrix. Members were asked to place their solution/idea in the matrix depending on how easy they thought it would be to implement their idea whilst being cognisant of the impact it would have in practice.
Following the identification, group members discussed each idea/solution in turn and each agreed to take forward the associated actions. An example of the action plan devised can be seen in appendix 3.

Given the amount of potential actions generated from this activity, it was decided that there were some issues which required further discussion and consideration. These issues pertained to patient assessment and diabetic service users needs.

One of the actions agreed at meeting one was to devise a survey to ascertain the preferences of the residents, given that much of the discussion held at the meeting was based on the anticipation of resident preferences. It was concluded that with support, a questionnaire would be devised and piloted with a couple of residents in the first instance, to then be rolled out across the home. It was decided that the health care assistants in the group would be best placed to support the administration the questionnaire given their more frequent interaction with residents. Literature provided by the project’s academic supervisor informed the questionnaire design and administration; see Fehily et al (2004) & Drennan (2003). A copy of the questionnaire and a summary of the results can be found in appendix 4.

5.2. Meeting 2, July 2006 (not facilitated)

At this meeting, action learning group members met without the external facilitator in order to reflect on the actions being undertaken and, in essence, to ensure that momentum was maintained, given the success of meeting one. At this meeting, the questionnaire was agreed by members and general updating of changes/developments in practice and reflection on learning was undertaken.

5.3. Meeting 3, October 2006 (facilitated)

At this meeting, the facilitator returned to the ease of impact matrix devised at meeting one, to reflect and reconsider actions and outcomes from earlier work. Following discussion and reflection, the matrix was amended; see appendix 5, and group members discussed the next steps. Part of the
discussion at this meeting concerned the commitment and motivation of the group in terms of agreeing continued support from home management and further discussion and potential resolution of barriers to change which were becoming apparent in the wider home.

5.4. Meeting 4, December 2006 (facilitated)

At this meeting, concern was expressed about member and organisational commitment to the project. Barriers to the project were discussed and solutions to overcome problems were debated. At this meeting, the service user survey results were reported. Some of the findings from this survey prompted members to reconsider their own perspectives on what they felt service users wanted as there was some dissonance between the expected and the actual.

Following this meeting, an interim evaluation was undertaken in the form of individual interviews with the project's academic supervisor. These interviews were based on a semi structured interview format in which discussion was centred around the members’ experience of the action learning group process, their feelings about the external facilitator and a reflection on the learning which they felt they had undertaken as a result of their involvement in the project.

5.5. Interim meeting with funder December 2006

Although this meeting was an update meeting with the funders of the project, it was still viewed as a learning opportunity for all members of the project team who attended and, in keeping with the underpinning action research philosophy of the project, issues discussed fed into the action research cycle

5.6. Meeting 5 & 6, February 2007 & May 2007 (not facilitated)

These two meetings took place as a result of cancelled facilitated meetings, which were cancelled due to operational and logistical difficulties. At both these meetings, work in progress and planned actions were discussed and reported.
5.7. Meeting 7, June 2007 (Facilitated)

At this meeting, the difficulties encountered by the group in terms of attendance due to organisational issues, and barriers to change from the wider home were discussed. It was felt that although one more meeting was planned, the motivation and commitment of some members and indeed, the wider staff was lacking and not conducive to further work. This will be discussed later in this report.

6. Findings and Evaluation

It was proposed that the overall evaluation of this project would be undertaken through audit and survey of service users. However, following further consideration and development of the project, the action research nature of the work began to lend itself to ongoing evaluation which is, of course, part of the action research cycle. This on-going evaluation was complimented with interim stage individual interviews with action learning group members in order to ascertain both evaluation of changes in practice and their experiences of action learning. Included in this interim evaluation was the external facilitator who provided a written reflection of the work from her perspective. To add to the ongoing evaluation, members were initially asked to complete a written evaluation at the end of each meeting, in confidence for the project supervisor. However, this proved ineffective due to poor response rates and in keeping with the flexible ‘Real World’ approach to the work, a more informal approach was adopted.

In addition to eliciting the views of the residents and action learning group members, it was felt that staff views could be examined in terms of any improvements they had seen in practice. A short questionnaire was attached to staff payslips at the midway point of the project with a letter updating staff on the project and indeed, asking for any suggestions they felt may improve practice at the home with regard to nutrition and hydration. Disappointingly, there were no appropriate responses to either the questionnaire or the request for ideas.
Other materials utilised in this evaluation include documentary evidence gathered from official inspection reports published by the Commission for Social Care Inspection, and examples of adapted and developed policy and practice documents e.g. menu forms and meal planning policy.

The final evaluation work undertaken at the end of this project was completed in the form of a focus group, conducted at the end of the last action learning group meeting. Members were asked to reflect on their experience of action learning in this project, but also to consider what they felt were the successes of the work, and indeed, what the limitations were. Discussion was also directed to consider what the members would do differently next time and indeed, what they would like to continue to do.

The findings from this project are therefore two fold. They detail not only changes in practice but also the efficacy of action learning as an approach to supporting and implementing sustainable change. Given the nature of the funding body for this work, it is felt to be important that not only changes in practice are noted, but also that the way in which the project was conducted, in order to generate ideas for practice development in arenas other than nursing homes is highlighted.

6.1. Practice Developments
In order to capture the extent of the changes which occurred at the home both directly and indirectly as a result of this project, we have chosen to report these developments using the framework provided by Essence of Care, as it ‘provides a tool to help practitioners take a patient-focused and structured approach to sharing and comparing practice’, NHS Modernisation Agency (2001:1).

In the Essence of Care document, there are ten factors which it is suggested are areas in which practice can be examined. In this report, each ‘factor’ serves as a subheading through which changes and developments in practice which occurred as a result of the project work undertaken by action learning group members are detailed.
6.1.1. Screening and assessment to identify patients nutritional needs

At Horton Cross, all residents are screened and assessed to ensure that their nutrition needs are identified. Therefore, it was decided to try and improve the standard of assessment and screening at Horton Cross. During action learning group meetings, the need for provision of training sessions for staff in assessment and screening was highlighted and some discussion centred on the use of current documentation. The need for closer links with other members of the multi disciplinary team was also noted as important in improving screening and assessment. In enhancing assessment and screening, the key issues were felt to centre on raising staff awareness and improving multidisciplinary working. As a consequence of these considerations, links with a local speech and language therapist for the assessment of residents requiring a liquid diet were strengthened, and training needs discussed. One major result from the improved assessment and raised staff awareness enabled some residents, previously on a pureed diet, to move to a soft diet. More awareness raising about assessment and screening through teaching, regular checking of documentation and the use of new equipment has improved the situation at this home.

6.1.2. Planning, implementation, and evaluation of care for those patients who require a nutritional assessment

In this section, we have identified developments and changes to practice which have improved the care for all residents at the home, given that they all require a nutritional assessment. The group noted that in addition to better assessment and screening for nutrition, better evaluation of on-going care would be vital to improving the nutritional status of residents. Therefore, more staff training was proposed with all group members planning to raise the awareness of other staff through general daily interaction.

One issue of concern for some group members was the oral health of residents. Given the obvious links with adequate oral health and the desire/ability to eat and drink, (see Touger-Decker, 2005) it was deemed an essential issue to address. Holmes (2006) notes the importance of dental
assessment and oral hygiene in enhancing the food intake of older people with chewing difficulties in particular although it was felt in this project that all residents would benefit from assessment. As a consequence of action learning group activity, more support was provided for health care assistants in communicating the oral states of residents to registered nurses, and more training was provided for staff to refresh their oral assessment and mouth care skills.

Overall, the training and development needs of both health care assistants and registered nurses have been identified and further self directed learning workbooks in addition to more teaching sessions are planned.

6.1.3. A conducive environment (acceptable sights, smells and sounds)

This was an area where it was felt a great deal could be achieved by the group in addressing what appeared to be 'small' issues but which would prove to be major factors in improving the nutrition at the home.

The group felt that not enough residents ate out of their rooms, or indeed got out of bed to eat their meals. It was felt that by providing a more conducive environment to eating, more residents might be motivated to eat in the dining room. It was suggested that residents chose not to eat in the dining room for a number of reasons including an inability to actually get there without help, the temperature of the room (the dining room has a glass conservatory which gets very warm), the décor, the table arrangements and seating arrangements. In order to address some of these issues, a number of items were purchased to enhance the environment e.g. new serving dishes and tray cloths, changes made to the seating arrangements and changes made to staff routines to enable more ‘protected time’ for meals.

Staffs were encouraged to support and motivate residents to eat their meals either out of bed but in their room, or in the dining room with other residents. Continued encouragement was supported at each mealtime by the manager in charge. Fans were arranged for the dining room to manage the temperature
and a member of staff detailed to check the dining room prior to meal times. At the time of writing, a marked increase has been noted in the numbers of residents taking their meals in the dining room. In addition to improving their nutrition, it has had a noticeable effect on the mental well-being of residents as they socialise more frequently with one another during meal times. Indeed, friendships have developed. The importance of the social aspects associated with food are noted by Manthorpe & Watson (2003) in their paper concerning dementia and eating. They note that ‘studies centre on the problems of providing food instead of the experience of those receiving food’, (Manthorpe & Watson, 2003:162)

Staff routines were adapted in order to manage a protected time for meals where in particular, no drug rounds were interrupting meals. This has proved to be difficult, given the way in which staff are often resistant to change. However, perseverance and reminders to staff are on-going. The importance of a protect meal time policy which places food first is discussed in Murray (2006) through consideration of improving nutrition for older people in the hospital setting and notes the importance of nursing staff making mealtimes a priority.

6.1.4. Assistance to eat and drink

One of the issues identified at the first action learning group meeting related to the way in which hot drinks were often too hot for residents to drink straight away and as such, some carers would add more cold milk in order to cool the drink. Group members felt that encouraging carers to change their practice and perhaps pour the drink earlier than they would normally, and allow it to cool naturally rather than adding milk, and returning to assist with drinking, would result in a more acceptable drink for the resident. This would also provide a space for the carer to work with the resident more closely, thus building a more therapeutic relationship. This required a change in routine which was encouraged and supported by management. In addition to assisting residents to eat and drink, group members discussed the benefits of assessing need and purchasing specialist cutlery, cups and plate guards, to
enable residents to feed themselves more easily, thus empowering them to make their own choices about eating their meals, more readily.

The appointment of an Activities Co-ordinator during the life of the action learning group provided discussion as to the importance of their involvement at mealtimes. Therefore, this member of staff was soon involved in meal times to assist and support residents.

6.1.5. Obtaining food (includes having sufficient information)

When considering how the residents obtain their food, the action learning group members examined the choices given to the resident in determining their meals. This consideration was two fold. There was an operational issue concerning the process involved in eliciting resident meal preference whilst considering how the resident would make their choices. In terms of making the choice, it was clear that the residents would need to continue to choose from a menu, but that the menu needed to be redesigned to ensure better understanding and to provide a more reasonable choice. Menu forms were redesigned and piloted. Following feedback from both staff and residents, they were further developed and are now in daily use. In terms of the process, the system was examined and changed. Resident menu choices are now made one day in advance, with kitchen staff assisting residents in the morning, and health care assistants in the afternoon. This is deemed to be more acceptable in terms of the amount of information managed by residents, and also fosters better relationships with kitchen assistants, health care assistants and residents.

6.1.6. Food provided

During the initial action learning group meeting, it was decided that more variety of food and drink, examination of the soft diet option and the temperature of the liquidised food were issues of concern. Over the life of the group, work was undertaken to consider a wider variety of food and drink whilst being mindful of the particular needs of the service users. The options for a soft diet were considered as was the way in which liquidised food was served. As a consequence, over time, a number of key changes were made.
According to Gosney (2003) there is often significant wastage of nutritional supplements due to intolerance of them by older patients often due to flavour, temperature and consistency. At Horton Cross Nursing Home, prior to this project, the nutritional supplements provided for residents who needed them were purchased in sweet flavours. In order to provide more choice for residents, they were purchased in savoury flavours, which interestingly, were not as popular as had been anticipated. However, by introducing savoury flavours for a short time raised awareness amongst staff that alternative flavours are available, thus enabling resident choice. In improving choice, alcoholic drinks which previously were already available but rarely offered, are now more frequently offered to residents; fruit smoothies are now available, and orange juice, which was previously available at breakfast, is now promoted. Cooks are beginning to add more salt to meals to enhance flavour, adding cream and butter to mashed potatoes to raise calorific content, offering more choice of toppings for toast, providing more salad options, supplying a two course tea at 530pm instead of sandwiches and offering a choice of three vegetables at lunch time. In addressing the issues with liquidised food, communication between health care assistants and kitchen staff is better and liquidised meals are being provided at a lower temperature than before. In addition, the home has purchased some liquidised food moulds in order to improve the presentation of food.

In addition to these obvious changes, the cooks have devised new menus, based on a 4 week cycle and in keeping with the preferences of the residents. Prior to this work, a four week menu cycle was in operation, however, due to the raised awareness of nutrition and hydration through this work, these menus were reviewed.

6.1.7. Food availability

The residents at Horton Cross nursing home have traditionally had their meals at set times. Although in many cases this pattern is often to ensure the smooth running of a daily regime, action learning group members discussed the need for residents to be given flexibility around mealtimes. One of the
outcomes from this project concerns the way in which changes have been made to make food available to residents at times when it suits them. Breakfast has been made more flexible but lunch and tea have remained as before. However, in order to address the evening hunger of those residents who eat tea early and stay awake late, sandwiches, crisps, cakes and cheese and biscuits are more readily available during the evening and night.

6.1.8. Food presentation

The importance of presentation cannot be overestimated. At the home, afternoon tea has been changed to improve presentation. The cake, which used to be a ‘slab’ of cake, is now a choice of individual cake, presented on a cake stand. Morning coffee and biscuits is now served with the biscuits on a side plate, rather than balanced on the saucer. What appear on the surface to be small changes in practice have been well received by residents.

Food presentation has also been addressed in terms of providing residents with the option of using a china cup rather than a beaker; using nicer day to day china for plated meals, and the use of serving dishes for vegetables enabling residents to have control over their portion size and choice of vegetable.

6.1.9. Monitoring

It is clear that monitoring of food and fluid intake is important in the holistic care of the service user. The action learning group highlighted documentation as an important issue in monitoring and assessing nutrition and as such, the raised levels of awareness has ensured that appropriate monitoring continues.

6.1.10. Eating to promote health

In addressing the impact of nutrition on the health of residents, it has been demonstrated that it is not just physical health that improves as a result of better nutrition. At Horton Cross, the social element to sharing meals has had a marked impact on the lives of some of the residents. Where once some residents would have eaten in bed, in their room, or alone, now many eat in
the dining room with fellow residents. This social aspect to mealtimes has resulted in some residents becoming friends.

There have been other developments at the home with regard to promoting health through nutrition. Recipes which incorporate more fibre, such as fruit cake with figs, is helping to reduce constipation, and kitchen staff have purchased new cookery books to help them with creating new dishes in order to promote variety. In addition, a fruit cake has been developed specifically to cater for the diabetic residents. The recipe can be found in appendix 6.

6.2. Supporting Development through Action Learning

In reflecting on the work done by this action learning group, it can be seen that there have been many changes to practice and indeed, to the way in which the multidisciplinary team at the home work together. Although these positive changes are important to recognise it is also important to note the impact that action learning has had on both the staff engaged directly and other staff in the home. Therefore, this section addresses the way in which action learning impacted on the group members and also reports on the use of the Issue Tree/Implementation Matrix in supporting action learning.

6.2.1 The Issue Tree & Implementation Matrix

The Issue Tree and Implementation Matrix (see Appendices 1 & 2) were used in the first meeting of the action learning group in order to provide some structure to further work and to assist in crystallizing the thinking of members, many of whom were new to action learning.

The interim report from the facilitator reflects the four main benefits to creating an issue tree within a novice action learning group.
The act of creating and working with the issue tree and implementation matrix was very positively evaluated by group members following the initial meeting and indeed, has been cited as one of the major learning experiences of this project and an approach likely to be used in future development work at the home. This method of critically examining the issues surrounding nutrition appeared to provide members with a safe space in which to clarify their thinking and provide motivation in order for ‘action’ to be important to them.

6.2.2. Action Learning

Engagement with action learning not only enables practice to be developed, but also provides a forum in which members can reflect on their practice and challenge that of their peers. In this group, the current practices and routines of the home were discussed and challenged whilst members began to consider their own input into the care of residents.

Group Composition

One of the major issues to emerge from the evaluation action learning as a way of developing practice was the way in which members felt that being part of a multidisciplinary group enabled a better understanding of one another’s roles and responsibilities leading to a greater appreciation of the factors which

---

**Figure 1. Creating an Issue Tree: Benefits**

Enables the group to:
- Work together on an equal footing breaking down any professional boundaries
- Recognise the extent of their own personal knowledge of the subject and see the value of their contribution
- Recognise the limitations of their own knowledge and see the value of others contributions
- Fully appreciate the scope and complexity of the issues around nutrition for their patient group
constrain the development of practice in different positions. The benefit of action learning to encourage a better understanding and knowledge of colleagues is well documented in the literature; see Bourner & Frost (1996). This was evident in discussion with home management who acknowledged the value of including different grades of staff within the action learning group. Some members expressed regret that there was no opportunity for more staff from varying grades to join the group as it was felt that having more varied opinions would be useful. Of note is the recognition through action learning that communication and closer working between health care assistants and kitchen staff would support many of the proposed developments. The acknowledgment that the opinions of all grades of staff are equally important resonated clearly with all of the group members.

**A Safe Environment**

The need to have the appropriate environment for action learning group meetings was noted as important in providing a safe space for members to state their ideas and challenges others. One member noted how they felt that the informality of the action learning group supported them in feeling confident to input into the discussions. Another identified the way in which there was no hierarchical structure as making them feel comfortable in airing their opinions. The importance of feeling safe in action learning is noted in the literature; see Bourner & Frost (1996) and Heidari & Galvin (2003). It is also suggested that the supportive, safe environment of the action learning group not only encouraged full participation but also enabled a sense of ownership in terms of developments and changes in practice.

**Sharing Problems & Raising Awareness**

The action learning group provided a forum in which members could share their problems both in terms of actual implementation of ‘action’ and in terms of perceived barriers to implementation. In sharing problems concerning both attempted action and possible barriers to action, members began to develop more confidence in testing out ideas both verbally and in practice. The ability to share problems somehow encouraged members to manage them with confidence. In addition to feeling more able to share problems amongst the
action learning group members, it is suggested that involvement in action learning also provided confidence for some members to spend time raising awareness of both the project and importance of nutrition with their peer groups. In examining the actual changes in practice as a result of this project, many of them can be seen to be attributed to a better awareness of nutrition, rather than actual direct physical intervention.

**Learning**

The action learning group experience was reported to be useful for all members, both in terms of developing practice in the home, but also for members’ own learning. Practical learning such as how to develop and pilot a questionnaire, how to plan changes and the impact of other professional perspectives on care were highlighted by members as key learning outcomes from involvement in the group. However, personal learning was also a key outcome from this project. One member reported that they had not realized they made so many assumptions about what residents would prefer in terms of meals, mealtimes, crockery etc. Feedback from the survey undertaken and ongoing feedback from members served to reinforce some incorrect assumptions made about resident preferences.

Members learning occurred on a variety of levels. Experiential learning took place as reflection was entered into at each meeting regarding the agreed ‘actions’ that had/had not taken place for each member since the last meeting. In addition, theoretical learning took place as theoretical perspectives emerged for example in designing questionnaires and managing resistance to change. This input often came from the facilitator and project’s academic supervisor.

Another area of learning noted by some of the action learning group members centered on the concept of nutrition and what it actually meant in practice. Some members reported their improved knowledge and understanding of nutrition, the implications of poor nutrition and the impact of linked issues e.g. appropriate oral care, well fitting dentures etc. One member remarked ‘now I know it’s not just about food’.
6.3. Barriers to Action Learning
The use of action learning as a method of supporting developments and changes in practice is not without its limitations. There are many reasons why action learning can fail to support practice development and in this project, many barriers to action learning were faced frequently.

Organisational & Personal Commitment
The initial motivation of group members was high. Following the first meeting, many actions were agreed and members were enthusiastic to proceed. However, some subsequent meetings were cancelled and rescheduled due to unavoidable operational constraints at the home. Despite assurances that members would be able to attend meetings when on duty, there were issues with provision of cover and issues with communication which led to poor and sometime non-attendance. These issues were initially addressed informally, with the majority of members noting commitment, however, organisational support for them to meet their commitment appeared to be lacking. Lack of organisational commitment as a barrier to action learning is well documented; see Bourner & Frost (1996).

Lack of commitment was examined through discussion and evaluation with the project supervisor. Further assurance was then sought from the Director of the home that staff would be supported to attend meetings and the importance of attendance reiterated to all members. In addition, new pathways of communication were realised in terms of future times and dates of meetings. Whereas the date and time for the subsequent meeting was agreed by members at the previous meeting, reminders were sent out to all staff via the matron and meetings were noted on the staff off-duty.

Dwelling on Non-Achievements
Another barrier to action learning appeared to be centred on the concentration of what had not been achieved rather than what had been achieved. As has been demonstrated, a great deal of development and change has been achieved at this nursing home in terms of nutrition; however, action learning
group members had a tendency to not recognise the full extent of their influence on practice. During periods where meetings had been cancelled and rescheduled, thus leaving longer than appropriate gaps, the morale of the group dipped, thus leading to a decrease in enthusiasm, possibly due to the lack of time spent developing further action and reporting successes. The change in the group following a facilitated action learning group meeting was markedly upbeat.

7. Implications for Practice
Although this report is centred on a small development project undertaken in a nursing home, it is felt that the learning gained from this work, can be translated into any clinical setting. The use of an action learning group approach to developing practice is in itself worthy of discussion, and the experiences of improving nutrition through a variety of methods at the home, are also transferable in to any setting where nutrition is, or should be, a priority in providing holistic care to any service user.

The barriers to effective action learning in this project have been identified previously as being related to commitment and dwelling on non-achievements. At this point, consideration needs to be given to the possible underlying reasons for these issues.

The need for both organisational and personal commitment to action learning is recognised as a pre-requisite for successful action learning. However, the reasons for what is viewed as a lack of commitment are varied, and it is these reasons which need to be considered in any plan for resolution. The possible reasons in this project are suggested to centre on: decreased motivation (for various reasons), peer pressure, resistance to change, disempowerment, and a poor grasp of action learning. In addressing these issues, there are short term interventions which could be considered such as re-iteration of the principles of action learning to the group and open discussion of reasons for poor attendance and renewed commitment. Issues of disempowerment and resistance to change/peer pressure, require a more long term approach and could utilise the action learning group in order to consider them in more detail.
and discuss possible strategies for resolution. These issues would also be well placed for discussion within a clinical supervision forum as they could well be related to and have an impact on, the individual practice in general, not just on an approach to action learning.

In dealing with a perceived lack of organisational commitment in the early stages of this project, a meeting was sought between the project lead and the Director of the home in order to re-iterate the purpose of the project, the benefits of the project to both resident care and to the reputation of the nursing home. In addressing this issue from a position which would be appreciated by a non health care professional, support was offered freely.

Dwelling on non-achievements rather than on successes was seen to be a natural state for this action learning group prior to intervention by the facilitator. Dwelling on the non achievements serves only to decrease motivation and lowers morale, thus making it difficult to recover any momentum for change. In managing this approach to reflecting on the action learning group activity, each meeting began with an overview of what had happened at the last meeting, whilst reinforcing the distance the group had travelled. Affirmation from an external facilitator frequently reassured the group that they had undertaken a great deal of work in improving the nutrition at the home. It is this external affirmation which in some way appeared to give the group permission to congratulate themselves. Through supervision, this natural retreat into consideration of ‘failure’ rather than focus on success was discussed with some members and again, appears to be linked to the issue of disempowerment. However, once this was highlighted, and indeed, reinforced on several occasions, there was improvement.

In improving the nutrition of the residents of this nursing home, a great deal of work was undertaken which, when considered in a more theoretical context, appears to be concentrated mostly on raising awareness amongst colleagues and managing resistance to change. The action learning group approach has proved useful in providing a safe space for members to both identify potential areas for change and devise a plan for change. However, it has also
encouraged the discussion and development of strategies to combat resistance by identifying possible resistors prior to implementation. This appears to have supported sustainable change.

In making changes to practice in terms of nutrition at the home, three major issues which may be of note to other practitioners embarking on developing practice include: an underestimation of the complexity of nutrition, recognition that small changes can make a big difference, and the importance of not making assumptions about resident preferences.
8. Conclusions

In developing the nutrition at the nursing home, this project has met its initial intention. However, there are other issues that have been highlighted as a result of this project. Through the action learning and action research approach, it has become clear that training and education of staff in nutrition and hydration is necessary for standards to be maintained and developed further. It is documented in the literature that nurses working in nursing homes often have issues in accessing both funding and opportunities for education and professional development, Nazarko (2007). What is important to remember is that professional development and education does not need to be expensive and can be supported through robust systems of clinical supervision and reflective practice.

One of the key barriers to action learning in this project concerned the way in which the group often relapsed into focussing on the perceived ‘failures’ rather than rejoicing in their achievements. It is suggested that supporting any development work with an underpinning philosophy and methodology of Appreciative Inquiry. According to Johnson & Leavitt (2001:129), Appreciative Inquiry is ‘an organizational transformational tool that focuses on learning from success. Instead of focusing on deficits and problems, the Appreciative Inquiry focuses on discovering what works well, why it works well and how success can be extended throughout the organization’. It is suggested that Appreciative Inquiry could provide an ideal approach to developing practice, especially in contexts where staff feel disempowered. It is an approach that has been used in both clinical and academic settings, see Meyer et al (2006) and Moody et al (2007) for more information.

The definition of practice development proposed by Garbett & McCormack (2002) and mentioned earlier in this paper, notes that practice development is an activity which changes practice, develops knowledge and skills and transforms the context and culture of care. In this project it is felt that the members of the action learning group certainly developed their knowledge and skills with regards to both nutrition and developing practice, with one notable learning experience being the use of the issue tree in determining
It is also clear that members experienced periods of self discovery and transformation in action learning group meetings. However, communication of this transformatory experience and the knowledge and skills gained in both nutrition and practice development to the wider professional groups within the home was limited. It is suggested that this is for a variety of reasons, including feeling disempowered and focussing on perceived ‘failures’. It is suggested that changing and developing the culture of care in the home with a view to sharing experience and learning, could be effected by ensuring that action learning group meetings have a specific focus on disseminating good practice and communicating developments to colleagues.
9. References

Berkley A & Prentice S (1999) Combating malnutrition in nursing and residential homes, Nursing and Residential Care, 1(8), 455-460


Copeman J (2005) Promoting nutrition in older people in nursing and residential homes, British Journal of Community Nursing, 5(6), 277-284


Coull Y (2003) The importance of nutritional screening in care homes, Nursing and Residential Care, 5(11), 521-524


Kelly C (2001) Aspects of nutrition for older people in institutional care, *Nursing and Residential Care*, 3(3), 112-113


Sandars J (2001) Problems of undernutrition in nursing and residential care, Nursing and Residential Care, 3(3), 109-111


www.csci.org.uk [last accessed 09/08/07]

www.rcn.org.uk/nutritionnow [last accessed 09/08/07]


Appendix 1: Issue Tree

How can we improve our nutritional Standards?

Not able to eat

Can't chew
- Dentures absent
- Dentures ill fitting
- Teeth / mouth sore

Can't swallow
- Consistency – need soft diet
- Decreased muscle tone
- Anxiety

Food not available
- Kitchen “closed”
- Limited dexterity - can’t cut the food or lift food into mouth

Can’t feed self
- Poor sitting position
- Dementia / confusion - forget to eat
- Decreased conscious level

Illness
- Room temperature
- Company at the table
- Feeling unwell
- Depression

Loss of appetite
- Dementia / confusion - forget to eat
- Decreased conscious level
- Feeling unwell

Embarrassed
- Don’t like the equipment
- Make a mess
- Being fed by nurses

Don’t want to eat
- Don't like the food
- Taste
- Presentation

Would like more choice
- Culture / religion / personal diet choice eg vegetarian
- Bored by same thing
- Would like to eat at a different time

Dentures absent
- Dentures ill fitting
- Teeth / mouth sore

Can’t feed self
- Food not available
- Can’t swallow
- Illness

Illness
- Room temperature
- Company at the table
- Feeling unwell
- Depression

Loss of appetite
- Dementia / confusion - forget to eat
- Decreased conscious level
- Feeling unwell

Embarrassed
- Don’t like the equipment
- Make a mess
- Being fed by nurses

Don’t want to eat
- Don’t like the food
- Taste
- Presentation

Would like more choice
- Culture / religion / personal diet choice eg vegetarian
- Bored by same thing
- Would like to eat at a different time
Appendix 2: Implementation Matrix, devised at meeting 1, June 2006

- **1.** Give hot drinks early & go back to help (not put more milk in)
- **2.** Non-slip mats
- **3.** Lighter cups
- **4.** Nice china
- **5.** Training for kitchen staff
- **6.** Create a positive environment
- **7.** Improve standard of patient assessment
- **8.** Extra staff to help
- **9.** All eat in the dining room
- **10.** Training re: diabetic diet
- **11.** Extra help for patients
- **12.** Improve communication
- **13.** Mouth care
- **14.** Monitor quality of food
- **15.** Redesign charts
- **16.** Adjust room temp
- **17.** Consistency of food appropriate
- **18.** Ensure choice of vegetables
- **19.** See dentist if necessary
- **20.** Survey patient wants
- **21.** Liquidised food out of trolley earlier
- **22.** Feed patients discreetly
- **23.** Patient assessment carried out
- **24.** Plate guards
- **25.** Sit out of bed
- **26.** Tactfully rearrange seating
- **27.** More specialist cutlery
- **28.** Patients help themselves to portions
- **29.** Assess need for equipment
- **30.** Nicer alternative to feeder cups, bibs etc
- **31.** More choice of mealtime
- **32.** Increase variety
- **33.** Get good position
- **34.** Stagger mealtimes

In progress: $\Box$
Completed: $\Box$

EASE OF IMPLEMENTATION

- **Hard**
- **Easy**

IMPACT

- **High**
- **Low**
## Appendix 3: Action Plan
devised at meeting 1: June 2006

### Actions before next meeting (9th September 2006 – 18.30hrs)

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Rounds” at mealtimes to check all patients sitting out of bed / positioned appropriately and getting help they need</td>
<td>Jackie</td>
</tr>
<tr>
<td>Devise questionnaire re: patient satisfaction, what they would like in terms of food variety, meal times, feeding equipment.</td>
<td>Glynnis</td>
</tr>
<tr>
<td>Pilot questionnaire then distribute to all patients</td>
<td>Alison, James</td>
</tr>
<tr>
<td>Investigate “nicer” alternatives to feeder cups, bibs etc (also in survey)</td>
<td>Glynnis</td>
</tr>
<tr>
<td>Assess demand and order additional equipment eg non-slip mats, plate guards, cutlery</td>
<td>Jackie</td>
</tr>
<tr>
<td>Encourage involvement from other care staff</td>
<td>Alison</td>
</tr>
<tr>
<td>Encourage involvement of kitchen staff</td>
<td>Jackie</td>
</tr>
</tbody>
</table>
Appendix 4: Questionnaire. Administered summer/autumn 2006

Dear Resident

We are anxious to improve service and provision of food/drink at Horton Cross and would value your input by completion of this questionnaire.

Please be assured that your replies will remain anonymous and questionnaires will be destroyed once we have completed our project.

Are you male or female?

Given the choice, would you prefer to eat in your room or in the dining room?

What do you dislike about eating in the dining room?

What do you dislike about eating in your room?

Would you like a set place in the dining room?

If you use a bib at mealtimes, would you rather use a large napkin?

What time of day would you like to eat your:

BREAKFAST:

LUNCH:

TEA:

Do you get offered enough to drink?

Would you like more frequent access to hot drinks?

Would you like more frequent access to cold drinks?

Do you find the cups easy to use?
Do you get enough to eat?

Are you ever hungry?

Would you like snacks in between your meals?

What are your 3 favourite meals?

What are your 3 favourite puddings?

Would you like your meal ready plated, or would you prefer to help yourself?

What do you dislike most about the food provided at the moment?

What do you like most about the food provided at the moment?
Results of Questionnaires Completed Summer/Autumn 2006
40 Questionnaires delivered
25 Questionnaires completed and returned
62.5% response rate

Non-responders: did not want to participate; were confused and had no next of kin to assist them or were too unwell to contribute.

Contents
Section One: Dining Location
Section Two: Aids to Eating & Drinking
Section Three: Timing & Frequency of Meals/Snacks
Section Four: Drinks
Section Five: Food: Quantity & Presentation
Section Six: Resident ‘Likes’ & ‘Dislikes’
Section One: Dining Location

Q. Given the choice, would you prefer to eat in the dining room or in your own room?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t mind</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Dining Room</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Own Room</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Depends on Mood</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Q. What do you dislike about the dining room?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Too hot/noisy</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Glum faces/depressing</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Messy eaters</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Seeing people being fed</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Q. What do you dislike about eating in your room?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Room not designed for eating</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Lack of assistance when needed</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Confined to room after meal</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Q. Would you like a set place in the dining room?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Don’t mind</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>N/A (eat in room)</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
Section Two: Aids To Eating & Drinking

Q. If you use a bib, would you rather use a napkin?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Napkin</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Bib</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Neither</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Q. Do you find the cups easy to use?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Section 3: Timing and Frequency of Meals/Snacks

Q. What time would you like to eat breakfast?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 0800</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>0800-0830</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>After 0830</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Don’t mind</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Q. What time would you like to eat Lunch?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200-1230</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>1230-1300</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>1300-1330</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Don’t mind</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Q. What time would you like to eat Tea?
<table>
<thead>
<tr>
<th>Time Period</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlier than 1700</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1700-1730</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>1730-1830</td>
<td>7</td>
<td>8 (mostly 6pm)</td>
</tr>
<tr>
<td>Later than 1830</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Don't mind</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Q. Would you like snacks between meals?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1 (bananas)</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>12</td>
</tr>
</tbody>
</table>

**Section Four: Drinks**

Q. Are you offered enough to drink?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Q. Would you like more frequent access to hot drinks?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

Q. Would you like more frequent access to cold drinks?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>
Section Five: Food – Quantity & Presentation

Q. Do you get enough to eat?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>1 (not at breakfast)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 (not at night)</td>
</tr>
</tbody>
</table>

Q. Are you ever hungry?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Q. Would you like your meals ready plated?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Don't know</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Resident Likes and Dislikes

Favourite Meals
Male: Roast dinners, fish & chips, steak & kidney pie
Female: Roast dinners, fish & chips, spaghetti bolognese, lasagne

Favourite Puddings
Male: Jam roll, rice pudding, apple tart
Female: Ice cream, rice pudding, trifle

General 'Dislikes'
Male: foreign food, blackcurrant squash, carrots undercooked, everything!, food is sometimes cold, liquidised food
Female: White thin sliced bread, soggy uninteresting breakfasts, food could be hotter

General 'Likes'
Male: English food
Female: Good cooking/presentation, I enjoy it, things with tomatoes (resident likes pasta dishes), cheese on toast
Appendix 5: Updated Implementation Matrix, October 2006

<table>
<thead>
<tr>
<th>EASE OF IMPLEMENTATION</th>
<th>IMPACT</th>
<th>In progress</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Give hot drinks early & go back to help (not put more milk in)
2. Non-slip mats
3. Lighter cups
4. Nice china
5. Training for kitchen staff
6. Create a positive environment
7. Improve standard of patient assessment
8. Extra staff to help
9. All eat in the dining room
10. Training re: diabetic diet
11. Extra help for patients
12. Improve communication
13. Mouth care
14. Monitor quality of food
15. Redesign charts
16. Adjust room temp
17. Consistency of food appropriate
18. Ensure choice of vegetables
19. See dentist if necessary
20. Survey patient wants
21. Liquidised food out of trolley earlier
22. Feed patients discretely
23. Patient assessment carried out
24. Plate guards
25. Sit out of bed
26. Tactfully rearrange seating
27. More specialist cutlery
28. Patients help themselves to portions
29. Assess need for equipment
30. Nicer alternative to feeder cups, bibs etc
31. More choice of mealtime
32. Increase variety
33. Get good position
34. Stagger mealtimes
Appendix 6: Diabetic Fruit Cake

1lb Currants
10oz sultanas
5oz grated carrot
4oz dried apricots (chopped)
14 fl oz unsweetened apple juice
4 fl oz whisky
13oz wholemeal flour
2 teaspoons baking powder
1 – 1.5 teaspoons cinnamon
2 teaspoons bicarbonate of soda
2 eggs
4 oz butter

Method:
Put fruit and veg in a bowl with the whisky.
Heat the apple juice, apricots and butter until the butter melts.
Dissolve bicarb into the hot mixture
Pour over the fruit and veg
Add dry ingredients, eggs and mix well

Bake in a 9” square cake tin for about 55 minutes at 160 degrees.