



Improving the Health of Older People: Implementing Patient-Focused Mealtime Practice

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Summary of project

This project has promoted healthy ageing by improving the experience of mealtimes in a discharge unit for older people. Mealtime care was explored from the perspective of patients and staff using focus groups, interviews and observation of care. Action learning, educational sessions and role modelling in practice have been used to support and enable the development of staff. As a result, all the staff have been actively involved in identifying problems, developing action plans and evaluating the impact of change. Many improvements in care have been identified. The eating environment and presentation of food has improved. Patients are getting more choice about what they eat and where they eat it. All of the ward staff are actively involved in mealtime work, this means help is available to patients who need it and consequently they are eating more. This is having a positive impact on their recovery and rehabilitation, not only because they are better nourished but also because staff and patients are working together so that the older people can exercise choice in other aspects of their care.

Background

Poor nutrition and increased risk of malnutrition for patients have been recognised as a problem in the hospital setting for decades (McWhirter and Pennington, 1994). Older people are particularly vulnerable (Tierney, 1996) and poor nutrition increases both length of stay and chance of readmission (Department of Health, 2001). However, despite knowledge of the prevalence of undernutrition in institutional settings being widely acknowledged, the problem remains.

Reasons proposed for the incidence and prevalence of undernutrition include the argument that nurses have become less actively involved with mealtimes in recent years. Others argue that poor hospital food, inflexible catering (Association of Community Health Councils, 1997) and inadequate education of both nursing and medical staff contribute (Palmer, 1998; Royal College of

Physicians, 2002). Responsibilities around food, mealtimes and nutrition are complex and ill defined (Manthorp and Watson, 2003) and may fall between professional disciplines and departments (Leat, 1998). Helping patients with eating is frequently delegated to less qualified staff further reinforcing the idea that mealtime care is unskilled and unimportant. Historical origins of older people's care may continue to impact on current practice, with the needs of older people taking second place to organisational needs (McCormack, 2004). There have been calls for work to explore and understand the importance of place of eating to the experience of older people (Wiles, 2005).

Research has largely concentrated on biomedical perspectives of nutrition, failing to acknowledge eating as a complex activity with social, psychological and biological perspectives. Any attempt to improve the health of older people through better nutritional care therefore needs to take a wider focus in order to address this complexity.

Aims and objectives of the project

The project aimed to implement patient-focused mealtimes for older people within a hospital unit:

- To promote healthy ageing through improving mealtime care, by working towards the achievement of a patient-centred and enabling culture.
- To contribute to the professional development of both individual staff and teams through establishing a supportive, learning culture, through action learning, the development of 'facilitators of learning' and 'critical companionship'.
- To assess the usefulness of a model to support the implementation of sustainable change in the real world of practice.

Though this study focused on nutritional care, we anticipated that the project, through addressing the unit culture, would have an impact on other aspects of care and thus other dimensions of older people's health.

The specific objectives of the project were:

- To work with staff to help them to describe and explore the current mealtime environment on the unit.
- To explore with staff, ways of focusing mealtimes towards the needs of patients.
- To help staff to make changes to the mealtime environment and their practice.

Methods

Action research

The overarching approach used for this project was action research. Action research aims to generate knowledge about social systems as well as attempting change (Hart and Bond, 1995). Considering the long history describing and measuring the nutritional problems associated with hospitalisation, an action research project which aimed to address the issues within the real world of practice seemed timely. Action research

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operationalises a cyclical process of 'look, think and act' (Koch and Kralik, 2001) in order to effect change. Four main features are central to an action research approach:

- collaboration between researcher and practitioner
- solution of practical problems
- change in practice
- development of theory

(Holter and Schwartz-Barcott, 1993).

Kemmis and McTaggart (1988) additionally identified the importance of understanding the context within which practice is located.

Ethics approval for the project was granted by the Local Research Ethics Committee.

Changing practice

Changing practice is a complex process that has been found to be difficult to achieve (Kitson et al., 1998) and any approach used to develop practice has to account for this. This project used a framework developed by McCormack et al. (1999) to inform the process. This framework proposes that the implementation of a change in practice is most likely to be successful when there is good evidence to support change, the context is receptive to the planned change and there are facilitators to enable the change.

In this project, two of the nurses on the ward acted as internal facilitators whilst an academic link person acted as an external facilitator. The approaches that they used to support and enable change are outlined below.

Action learning

Action learning has been defined as: '...a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done.' (McGill and Beatty, 2001). Action learning sets were established and continued throughout the project. There were two different groups running, each of which had a different focus. One focused on exploring nursing practice and the other on the mealtime environment.

Action learning sets frequently operate as 'closed' groups with the same membership over time. In a ward setting this may prove difficult to achieve, therefore the decision was made that these groups would be made open to whichever staff were working on the day that they had been organised. Ground rules were established at the first set meeting but revisited at the beginning of each session.

Facilitation of learning

Towards the beginning of the project, the internal facilitators worked alongside members of their teams in order to facilitate clinical learning (Binnie and Titchen, 1999) by:

- Role modelling in practice.
- Encouraging reflection in practice both by self and within the team.
- Giving feedback to team members on their personal development and helping them to recognise their specific learning needs.

Critical companionship

Titchen (2001) has proposed a framework of critical companionship as a method of facilitating learning from practice through critical reflection and the interaction between practitioner and facilitator. This process enables the development of both the practitioner and the social systems by facilitating learning, understanding change and enabling transformation of practice. In this project the external facilitator acted as a critical companion to the internal facilitators and particularly drew upon the

relationship, rationality-intuitive and facilitation domains of the critical companionship framework.

Education

Formal education sessions relating to nutrition were implemented and continued throughout the project.

The project was divided into three phases which will be outlined below.

Phase 1

In this phase, an exploration of the current mealtime care and environment was undertaken in order to describe and explore factors contributing to patients' experience of mealtimes and their care. This included:

- Observations of six mealtimes by two members of the project team using an observational schedule designed to include the location of eating, involvement and activity of nursing staff and timing and duration of events.
- Three focus groups involving 19 staff (health care assistants, nutrition assistants, qualified nursing staff, occupational therapists and physiotherapists) were held to explore staff views about the mealtime experience. The focus groups were tape-recorded and transcribed verbatim.
- Six patients were interviewed by members of the project team and encouraged to describe their own experiences of mealtimes. The interviews were tape-recorded and transcribed verbatim.
- Benchmarking using Essence of Care (Department of Health, 2003).

The data collected during this phase were analysed using interpretive, inductive approaches. This involved listening to the audiotapes and examining the observation schedules in order to gain a general sense of the data. Themes and categories were then identified. Analysis was undertaken and agreed by all of the project team.

Three main themes relating to factors that impacted on patients' experience of mealtimes and their care were identified. These were:

- institutional and organisational constraints
- nursing care at mealtimes
- the eating environment

Overall, it was concluded that mealtime care operated in a routinised and ritualistic way with little thought about the appropriateness of this style of practice. Nurses were mainly unaware of their role and responsibilities for the nutritional care of the patients, and patients were passive recipients of care.

These findings were presented to staff in a number of ways, including verbal and written presentations of the data. This prompted many discussions among the staff teams and resulted in an eagerness to try and do something about the situation.

Phase 2

In collaboration with the staff, the data from Phase 1 and evidence from academic literature was used to inform the development of action plans towards achieving a patient-centred approach to mealtimes. It was agreed at this stage that the focus of the work would be on nursing practice at mealtimes and the mealtime environment. The changes were planned utilising a series of smaller change cycles within these major themes in order to make them achievable and thus sustain motivation and a sense of achievement. Action learning, facilitation of learning and educational sessions were used to enable the changes in practice.

Phase 3

This phase involved evaluation of the project by repeating the baseline data collection and comparing any differences. This included:

- Three focus groups involving fifteen staff..
- Four patients were interviewed.
- Benchmarking using Essence of Care (Department of Health, 2003)

Interviews and focus groups were tape recorded and transcribed verbatim.

The process of change was also documented by the project team through recording field notes and reflective diaries.

Changes to practice

A number of changes have been made to both nursing practice and the mealtime environment which are having a positive impact on both patient and staff experiences of mealtimes (see Box 1).

Box 1. Examples of changes introduced

Nursing care

- Drug round no longer takes place at the same time as meals
- All nurses involved in mealtimes
- Care plans observed to be more patient-centred
- Handovers observed to be more patient-centred than task-centred
- Language used by nurses in handover noted to be less 'labelling'
- Meal presentation given higher priority
- One person serving meals rather than everyone crowding around trolley in disorganised chaos
- Introduction of MUST nutritional assessment tool
- Plate guards no longer necessary as deep dishes used
- Greater understanding of nursing roles and personalities within the team, enabling improved teamwork
- Nurses searching from evidence using the computer

Environment

- Introduction of new crockery, trays and napkins
- Use of over bed trays so patients have their meal in front of them
- Staff bring equipment they feel will be useful for mealtime use e.g. light mugs with bigger handles, tablecloths, unbreakable plates etc.
- Outside eating area improved with planting
- Inside eating area improved with tablecloths, lighting, pictures and clutter clearance

At the start of the project, mealtime care was provided mainly by health care assistants while qualified nurses focused on tasks such as administering drugs and paperwork. During the project, qualified nurses changed the time that they gave out medications, in order to be available to assist at mealtimes. Recognition of the importance of nutritional assessment and monitoring of nutritional intake is evident. The importance of 'knowing the patient' is a new aspect to the assessment and monitoring practice of nurses on the ward. Staff now work closely with the patients, taking time to find out what they would like to eat and discussing their care with family and friends (particularly when patients have cognitive impairment) and reflecting on practice with colleagues.

Recognising and using their skills, staff have a new appreciation of the importance of spending time with the patient and patience to help individual people to eat. Staff agree that the major change for them is the prioritisation of nutritional care and being actively involved in mealtimes. They are now in a position to observe and monitor what patients are eating and be aware of difficulties they are experiencing.

Nutritional assessment is now a continuous process based on observation and knowing the patient. Person-centred strategies for addressing poor nutrition are enabled through improved communication throughout the nursing teams.

Mealtimes are no longer perceived to be a chore, avoided if at all possible, and to be done as quickly as possible. An environment is now created in which patients can enjoy their food. Choices are given, both in the food they eat and where patients eat it and people are available to help when they need assistance. Food is carefully presented in an appetising way in order to maximise enjoyment.

The project journey

The project journey was not entirely smooth. People can be resistant to change, perceiving it as a threat. However, this project has demonstrated that fear of change can be overcome and that the ward culture can be changed to one where change is embraced.

A reflective approach to change has been important to staff on the unit and it has enabled the project team to recognise, value and build on the diverse skills and knowledge which individual team members bring. Reflections on the project journey have highlighted several issues:

- Patient care can easily become routinised, with an assumption that previous choices are fixed and unchanging. If left unchallenged, such approaches to care can remove choice for patients which may leave them feeling disempowered, unhappy and malnourished.
- The data collected in phase one enabled the project team to gain knowledge that was specific to the ward culture at the time. This provided an opportunity to challenge assumptions about existing ways of working in order that they could help staff to develop an understanding of what needed to be changed and explore how this could be achieved.
- Binnie and Titchen (1999) agree that novices taking on a new role may feel under confident because new roles created in response to change can be confusing and initially lead to role ambiguity. Working in a different way can shake the foundations of traditional modes of practice which can be unsettling for some and means that they require particularly sensitive support. The external facilitator acting as a critical companion to the internal facilitators provided vital support. This support was found to be particularly significant at difficult points in the project, but was also important when breakthroughs were made in order to encourage further progress and to reflect on what had contributed to the progress.
- In order to progress towards person-centred care, it was accepted that the first step was to recognise and value the contributions of all of the staff and acknowledge them as individuals. No one approach was found to be effective to engage all staff, therefore it was important not to give up and to continue to try and find something that would be of interest to different staff, thus building on individual strengths. This may

include supporting staff to find evidence on the internet to solve a clinical issue, or giving them the responsibility for choosing new equipment.

- In a system as fluid as the health service, contextual changes over time are inevitable. This project faced two major events, a ward move which resulted in some staff leaving and the long-term compassionate leave of the ward manager. Whilst it is acknowledged that both events had a significant impact on staff morale, it is believed that the activities engaged in during the project, particularly the action learning sets helped to maintain the cohesiveness of the unit. This may give an early indication as to the sustainability of the practice changes.

Framework for implementing change

One of the aims of the project was to reflect on the usefulness of the McCormack et al (1999) framework as a model to support the successful implementation of change. Overall, the team did not find the model particularly user friendly as it was difficult to understand and apply. If models are to be useful in day-to-day practice, some simplification and real practice examples are required. The team would also suggest that the usefulness of any model may depend on the personal characteristics of facilitators of learning and individual role interpretation.

The team found that the action learning sets were a particularly powerful method of facilitating change in practice. Staff reflected that this may have been because of the involvement of everyone in identification of the issues, planning solutions and evaluating changes in practice.

Conclusion

This project has resulted in a number of very positive changes which appear to have had a beneficial effect on the mealtime experiences of patients and subsequently, their nutritional status.

The project has had a positive impact on the health and well-being of patients. This has been achieved by attempting to work in an empowering way with patients and each other, increasing the control and choice available to patients and working to preserve and where possible, improve the health status of older people. By intentionally focusing on activities around mealtimes with a broad interpretation of 'meatime care', there have been shifts in the way other elements of care are undertaken.

Much of the project focuses on the development and empowerment of staff. This was achieved by first exploring the context of the care to raise awareness. Change was then achieved by enabling staff to enhance their understanding through reflection on practice and to increase their educational knowledge and skills. This has increased staff confidence in their skills and abilities and they are proud of and value their achievements. There is an eagerness among staff to continue to develop and change practice.

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Further Reading

A copy of the full project report can be downloaded from the FoNS website: www.fons.org/healthy_ageing/projects/meal.asp

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