



THE 2006 HEALTHY AGEING CONFERENCE

NUTRITION AND OLDER PEOPLE IN RESIDENTIAL AND COMMUNITY CARE SETTINGS

Conference Proceedings



National Council on Ageing and Older People

2006 Healthy Ageing Conference

Nutrition and Older People in Residential and Community Care Settings

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Yvonne McGivern (Editor)



National Council on Ageing and Older People
An Chomhairle Náisiúnta um Aosú agus Daoine Aosta

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Contents

Foreword	6
Introduction	8
Opening Address	9

Opening Session: Nutrition in Later Life

Chair: *Cllr Éibhlin Byrne*

Nutrition, Malnutrition and Older People: An Overview	<i>Dr Clare Corish</i>	12
Food in Later Life: Findings From an EU Study	<i>Dr Margaret Lumbers</i>	21
Community Meals Provision in the North West of Ireland: Perspectives on Service Provision and Use	<i>Michelle Share</i>	37
Questions Following Opening Session		43

Parallel Sessions: Good Practice in Promoting Nutritional Standards for Older People

Workshop One: Nutritional Standards for Older People at Home

Chair: *Margaret Feeney* 47

Older People and the Financial Cost of Healthy Eating in Ireland	<i>Denise McCarthy</i>	48
Supporting Carers in Improving the Nutrition of Their Clients	<i>Niamh O'Keeffe</i>	53
Discussion: Good Practice and Barriers to Good Practice		55

Workshop Two: Promoting Nutritional Standards for Older People, in Day Care and Meals-On-Wheels

Chair: *Mary Flanagan* 58

The Resource Pack	<i>Mary McKeon</i>	59
Realising the Nutritional Potential of Meals-On-Wheels		

	<i>Sinead Quill and Olga McDaid</i>	60
Discussion: Good Practice and Barriers to Good Practice		65
Workshop Three: Promoting Nutritional Standards for Older People in Long-Stay Care		
	Chair: <i>Julie Ling</i>	69
Nutritional Status of Older People in Long-Stay Care		
	<i>Lisa Corbett</i>	70
Adaptation and Use of the Malnutrition Universal Screening Tool (MUST) in St Mary's Hospital, Dublin		
	<i>Mary Stafford</i>	74
Discussion: Good Practice and Barriers to Good Practice		78
Workshop Four: Nutritional Training and Multi-Disciplinary Actions in Long-Stay Care		
	Chair: <i>Caroline Connelly</i>	82
Undernutrition in Residential Care: Multi-Disciplinary Nutrition Teams in a Residential Care Setting		
	<i>Pauline Dunne</i>	83
Essence of Care: Food and Nutrition Benchmark		
	<i>Anne Jones and Mary Barron</i>	87
Discussion: Good Practice and Barriers to Good Practice		90
<i>Final Session: Overcoming the Barriers – Policy and Practice Priorities for the Future</i>		
	Chair: <i>Ursula O'Dwyer</i>	
Panel Discussion: Moving Forward		
	<i>Sheena Rafferty, Dr Margaret Lumbers, Dr Dermot Power, Geraldine Hanna</i>	94
Closing Address		
	<i>Bob Carroll</i>	107
Contributors		109
Terms of Reference		110

Foreword

The conference attracted over 230 delegates from the statutory, voluntary and private sectors, and provided the opportunity for delegates to focus on issues facing particular vulnerable groups of older people.

I would like to express my appreciation to Mr Bob Carroll for his opening and closing addresses to the conference. I would also like to thank Dr Clare Corish, Dublin Institute of Technology (DIT), who presented an overview of nutrition, malnutrition and older people. I would like to thank Dr Margaret Lumbers of the University of Surrey who presented an overview of the findings of the EU Food in Later Life Project. I would like to thank Michelle Share of the Health Promotion Department of Health Service Executive (HSE) West who presented the findings of a study on the provision and use of community meals in the North West of Ireland.

The four parallel workshop sessions that took place were very informative and of great interest to the delegates. I would like to extend my gratitude to the speakers in these workshops for presenting such excellent papers.

I would like to thank those who chaired each of the plenary sessions (Bob Carroll and Ursula O'Dwyer) and those who chaired the workshop sessions and reported the key points arising from the sessions (Margaret Feeney, Mary Flanagan, Julie Ling – who stood in for Dr Dermot Power – and Caroline Connelly). I would also like to thank the rapporteurs for collating the information from the sessions and the conference participants for their valuable contributions to the workshop discussions.

The Council would like to thank its Director, Bob Carroll, and Olga McDaid, its Healthy Ageing Programme Coordinator. A special thanks is due to the Council's administrative staff for their invaluable assistance in organising the

conference. Finally, thanks to Yvonne McGivern who prepared the proceedings for publication.

Dr Ciarán Donegan

Chairperson

Introduction

The format of these proceedings follows the structure of the conference.

Opening Session: Nutrition in Later Life

This session included presentations on:

- nutrition, malnutrition and older people
- findings of the EU Food in Later Life Project
- findings of a study on the provision and use of community meals in the North West of Ireland.

Second Session: Good Practice and Barriers to Good Practice in Promoting Nutritional Standards for Older People in Different Settings

This session comprised a series of parallel workshops focusing on identifying good practice and barriers to good practice in four areas:

- promoting nutritional standards for older people at home
- promoting nutritional standards for older people in day care and meals-on-wheels
- promoting nutritional standards for older people in long-stay care
- nutritional training and multidisciplinary actions in long-stay care.

Final Session

This session included feedback from the parallel workshops and a panel discussion focusing on moving forward. The aim of these workshops was to identify and discuss the challenges faced by these vulnerable older people and to suggest strategies for addressing the challenges.

The Closing Address was given by Bob Carroll of the NCAOP. Sean Power TD, Minister of State at the Department of Health and Children (DoHC) was unable to attend.

Opening Address

Bob Carroll, Director, NCAOP

I would like to welcome you all to the 2006 NCAOP Healthy Ageing Conference. Thank you very much for taking time out to be here.

As you may know, we are an advisory body to the Minister for Health and Children on all aspects of ageing and the welfare of older people. We are also required to promote the health and autonomy of older people.

In 1998 the Council published a health promotion strategy for older people with the DoHC. The promotion of health in old age is very important in Ireland – we are in bottom position in the EU life expectancy tables at age 65. Maximising the health and autonomy of older people already affected by illness or impairment is particularly important, given the potentially great quality of life returns this brings for such older people, who tend particularly to value what health and independence they retain.

In this context, while much of our attention today will be on nutrition and the nutritional status of older people, we must not forget the importance of the enjoyment of food and its quality and presentation to the quality of life and well-being of older people, especially those whose enjoyment in other life pleasures may be restricted.

Whilst we have experts and colleagues who will provide the stimulus for our discussions, essentially the day is about exchange. We hope that all of you will have a chance to contribute if you wish to do so, particularly during the parallel sessions and the end of session discussion.

We start with the issue of nutrition in later life, then we move to good practice in different settings and we look at the barriers to good practice, and finally we try to move forward identifying the priorities for the future.

Last year the focus of our healthy ageing conference was social inclusion for older people at the local level; the year before it was safety and older people. While it is taking time, I am pleased to say that significant progress is being made in these areas and particularly with regard to developing a national strategy for the

prevention, treatment and management of falls and fractures amongst older people. We hope that we will be able to publish this strategy early in 2007 in conjunction with the HSE and the DoHC.

Opening Session

Nutrition in Later Life

Chair: Cllr Éibhlin Byrne, Chairperson, NCAOP

Nutrition, Malnutrition and Older People: An Overview

Dr Clare Corish, Lecturer in Human Nutrition and Dietetics, DIT, Kevin St., Dublin

Introduction

The aim of this paper is to give an overview of the nutritional status of older people. It covers five main aspects:

- the current nutritional status of older people in Ireland
- factors which increase the risk of malnutrition in older people
- consequences of malnutrition in the older person
- identification and assessment of older people at risk of malnutrition
- providing nutrition support for older people.

The current nutritional status of older Irish people

Body mass index (BMI) provides a measure of relative body weight for height. It is calculated as weight in kilograms divided by the square of the height in metres (kg/m^2). It gives a general indication of whether body weight falls within a healthy range. In a cross-sectional study (Corish and Kennedy, 2003), to determine the current nutritional status of healthy older Irish people (a sample of 874 people recruited through interest groups for the active retired), we found that, in keeping with the high prevalence of overweight and obesity in the adult Irish population, 69 per cent of older men and 61 per cent of older women were either overweight or obese. Seventeen per cent of the men and twenty per cent of the women were obese, that is, they had a BMI of greater than or equal to 30kg/m^2 , a similar proportion to that reported in the Irish adult population where overall eighteen per cent are obese (twenty per cent of men and sixteen per cent of women).

We found that the average or mean BMI was 26.8 kg/m^2 for men and 26.7 kg/m^2 for women, that is, in the overweight range (25 to 29.9 kg/m^2). Only 3 per cent of the sample had a BMI of less than 20kg/m^2 , indicative of possible poor protein-energy status. The average BMI was significantly greater in the lower compared to the higher socioeconomic groups (27.1 kg/m^2 versus 26.2 kg/m^2) and greater BMI was associated with lower physical activity and fewer occasions of active leisure. Fat

mass decreased significantly with increasing age only in women, while height, weight, BMI, mid-upper arm circumference and calf circumference all declined with age in healthy older people of both genders.

Physical activity and active leisure

In terms of physical activity and active leisure, 88 per cent of our sample reported that they engaged in a moderate to high level of activity. On further questioning, however, only 73 per cent of older men and 54 per cent of older women spent at least twenty minutes four or more times a week engaged in active leisure or domestic activities. Among those aged over 75 years, 47 per cent said that they take part in regular activity but 17 per cent reported never doing so.

Dietary intakes

Data from previous studies conducted among Irish people including the 1990 Irish National Nutrition Survey and the 1998 Survey of Lifestyle, Attitudes and Nutrition (SLÁN) tell us some interesting things about the food intake of older people.

The 1990 survey found that older people's intake of vitamin D and folate (a B complex vitamin also known as folic acid) are below the optimum level. Vitamin D helps the body absorb calcium. Few foods contain large amounts of vitamin D. Oily fish, liver, and egg yolk contain natural vitamin D. Some foods are fortified with vitamin D including some milks, soy drinks, spreads and margarines. Folate is needed for the production of red blood cells.

The 1998 SLÁN survey reported that 56 per cent of older people took fewer than six servings of cereals, breads and potatoes daily; 42 per cent ate fewer than four portions of fruit and vegetables; 63 per cent ate three or fewer servings of dairy products; and 73 per cent ate two or fewer servings of meat, poultry and fish. Butter and margarine consumption was greater in the over 65 age group compared with the adult population.

The 1998 SLÁN survey also showed that the contribution of fat and protein to total energy is greater in lower socioeconomic groups and that the contribution of carbohydrate to energy is greater in higher socioeconomic groups.

SLÁN 1998 also observed that average calcium intakes among men aged over 65 years were borderline in relation to recommended intakes and that average iron intakes among older women were below the intakes recommended. It also reported that the diets of older Irish people were lacking in vitamin D. Other studies show that up to 55 per cent of community-based women aged 51 to 75 years have low vitamin D status (less than 50nmol/L¹) during late wintertime; that 56 per cent of the older population in Belfast attending hospital with fragility fractures (vertebral or multiple) had low vitamin D status; and 88 per cent of older people in Belfast with a hip fracture had low vitamin D status.

Another study (Collins *et al.*, 2006) found that intake of vitamin K1 (phylloquinone), a vitamin needed for blood coagulation and bone health, was low in post-menopausal women aged 50 to 75 years (20 per cent below UK recommendations and 34 per cent below US recommendations).

The 1998 UK National Diet and Nutrition Survey conducted among people aged 65 years and over found that older people were generally well nourished although they had suboptimal intakes of vitamin D, potassium and magnesium.

According to the Recommended Dietary Allowances for Ireland (1999), there is 'no evidence that nutrient requirements (as distinct from energy requirements) of the elderly differ from those of adults except for vitamin D'.

Undernutrition in older Irish people

Using a BMI of less than 20kg/m² to define undernutrition, we found that 16 per cent of all older people (in a sample of 235) compared to 14 per cent overall (a sample of 569) fell into this group on admission to hospital. Among a very small sample of people (26) attending a Medicine for the Elderly department in a Dublin teaching hospital, 21 per cent fell into this undernourished group, as did 15 per cent of a small sample (48) attending their GP (Corish *et al.*, 2000). In the small sample GP study, we found that undernutrition was more likely to be associated with poor appetite, eating alone and long-term illness; and that being overweight was more likely to be associated with old age, smoking and also with long-term illness. The 1998 UK National Diet and Nutrition Survey found that a similar proportion of those living in

¹ A measure of concentration – nano moles per litre.

institutions (15 per cent of men and 16 per cent of women) were undernourished as we had observed on admission to hospital.

Nutrition risk on admission to hospital

Using a 'nutrition risk' score developed by Reilly *et al.* (1995) that assesses the risk of nutritional deterioration during the course of a hospital stay, 22 per cent of all patients are at high risk and 16 per cent are at moderate risk of deteriorating nutritionally when admitted to hospital. Among older people, 23 per cent are at high risk and 25 per cent are at moderate risk on admission to hospital.

Using a different measure, the Nutrition Risk Index (NRI)² (Veterans Affairs, 1991), 5 per cent of all patients are at high risk and 39 per cent are at moderate risk. Of older people, 8 per cent are at high risk and 48 per cent are at moderate risk.

Although the two scores categorise patients differently, both agree that almost half of all older people admitted to hospital are at risk of a deterioration in their nutritional status.

Nutritional status of healthy and hospitalised older people

A BMI of less than 18.5kg/m² indicates poor protein-energy status is probable. A significantly greater proportion of hospitalised older people (6 per cent of a sample of 218) compared to healthy older people (0.6 per cent of a sample of 874) have a BMI of less than 18.5kg/m². A significantly greater proportion of hospitalised older people (48 per cent of a sample of 218) compared to healthy older people (36 per cent of a sample of 874) have a BMI of 18.5 to 24.9kg/m². The pattern is different for those with higher BMI scores – a significantly greater proportion of healthy older people compared to hospitalised older people have BMI scores in the overweight (25.0 to 29.9kg/m²) and obese groups (30kg/m² and above).

Factors which increase the risk of malnutrition in older people

Malnutrition, according to the UK Malnutrition Advisory Group (2000), is defined as:

² NRI calculated as 1.1519 albumin (grams per litre) + 0.417 per cent of usual body weight.

A state of nutrition in which a deficiency or excess (or imbalance) of energy, protein, and other nutrients causes measurable adverse effects on tissue/body form and function, and clinical outcome.

Factors which increase the risk of malnutrition in older people include the following medical and social conditions or factors:

- acute illness/disease related
- anorexia/reduced appetite
- dementia
- depression
- drug treatment
- decreased mobility, inability to go out shopping
- social isolation, bereavement, loss of spouse
- economic hardship
- alcohol consumption and smoking
- institutionalisation.

Physiological factors also play a role. These include:

- changes in taste and smell
- reduced gastrointestinal function
- decreased visual acuity
- joint problems and hand tremors
- hearing problems.

These factors may make it more difficult to prepare and eat food and to digest and absorb nutrients.

The 1998 UK National Diet and Nutrition Survey, which collected data from people aged 65 years and over, found that the better your oral health, the better your diet and nutritional status. Around one in seven people (13 per cent) said that their oral status adversely affected their daily living. Fruit and vegetable intake in particular was linked to the number of teeth a person had – twenty teeth or fewer seems to be the cut-off for poor nutrition. The survey found that older people without teeth were more likely to be housebound, to have restricted mobility and to have a lower BMI.

The study also found that older people in residential care have the worst teeth, the worst dietary intakes (except for calcium and carbohydrate), the worst nutritional status and that they consumed more sugar and more sugary foods.

The US National Health and Nutrition Examination Survey (NHANES III), with a sample of 5,958 people over fifty years of age, reported associations between dental health and lower dietary intakes of vitamin A, β -carotene, vitamin C, folate and dietary fibre; and between dental health and lower blood levels of vitamin C, folate and β -carotene. These associations were independent of age, gender, ethnicity, education, poverty and smoking status.

Consequences of malnutrition in the older person

Malnutrition adversely affects well-being and quality of life; it is related to increased apathy and depression, weakness and fatigue, and impaired thermoregulation.

Consequences also include the following:

- higher mortality
- longer hospital stay
- increased need for nursing home care following hospital discharge
- reduced likelihood of discharge from nursing home
- increased risk of institutionalisation
- increased need for non-elective hospital readmission
- pressure ulcers
- greater use of medications
- lower activities of daily living
- increased falls
- greater dependence on mobility aids
- greater dependence on home help services
- increased risk of sepsis
- lower total lymphocyte count
- increased complications.

Identification and assessment of patients at risk of malnutrition

The aims of identification and assessment, according to the European Society for Parenteral and Enteral Nutrition, are as follows:

- improvement or at least prevention of deterioration in mental and physical function
- reduced number and severity of complications of disease and its treatment
- accelerated recovery from disease and shortened convalescence
- reduced consumption of resources.

Every older person on admission to care, and at regular intervals during their care, should be given a nutritional assessment. This should include consideration of the following:

- medical and medication history
- social history and current level of support
- weight loss/changes
- current dietary intake
- chewing or swallowing difficulties
- ability to feed oneself
- oral health
- cultural, religious or special dietary needs
- food likes/dislikes
- skin condition.

Where appropriate, advice and support should be sought from a dietitian.

Providing nutrition support for older people

The benefits of nutrition support for older people include the following:

- lower mortality
- improved functional status
- increased activity and activities of daily living
- reduced number of falls
- improved immunological benefits
- incidence of pressure sores decreased
- shorter hospital stays.

Studies show that nutritional intervention has positive outcomes. However, there seems to be a high percentage of older people, particularly those already malnourished, who will not benefit from support. It, therefore, is important that people are prevented from deteriorating nutritionally.

There are several ways in which we can improve the nutritional status of older people. These include the following:

- food fortification
- nutritional snacks
- nutritional supplements
- flexible portion sizes
- food presentation
- flexible timing of meals and snacks.

Other aspects of care that can help include the following:

- paying attention, observing
- offering encouragement and support
- putting the person in a suitable sitting position and adjusting posture
- giving sensitive help at mealtimes
- providing suitable cutlery and eating utensils
- ensuring the mealtime environment is appropriate
- paying attention to mouth care.

Summary

We know that many older people are likely to be nutritionally at risk. Malnutrition in the older person can be prevented and treated. The multi-disciplinary team involved in patient care, including (but not restricted to) nurses and carers, is in an ideal position to recognise and tackle malnutrition. It is vital that attention is paid to the nutritional adequacy of the diet and the needs of individual older people.

Recommendations for the future

We would recommend that a set of nationally agreed standards and practice guidelines be put in place with adequate management policies that are suitably resourced.

In addition, we recommend the following:

- improved provision of food in institutions
- adequate training for medical and nursing staff

- adequate recording of nutritional status in medical and nursing notes
- adequate and appropriate referral for nutrition and dietetic intervention.

Food in Later Life: Findings from an EU Study

Dr Margaret Lumbers, Food in Later Life Project Coordinator, University of Surrey

Introduction

The aim of this paper is to give you an overview of the EU-funded project, Food in Later Life, and to highlight some of its key findings to date.

The objectives of the project are to understand the barriers and constraints to food procurement and preparation. In particular, the aim was to examine differences between men and women; between individuals living alone and those living with others; between two age groups, those aged 65 to 74 years and those aged 75 and over; and between the eight countries involved – Denmark, Germany, Italy, Poland, Portugal, Spain, Sweden and the UK.

Project design

The project is divided into eight different work packages (WP). WP1 is the overall project management package and WP8 is concerned with dissemination and exploitation of the project's results. Each of the other six work packages included a qualitative research component (in-depth, semi-structured or open interviews) and a quantitative component. All participants completed a background questionnaire that covered the following:

- where the sample participants shop
- where they eat out
- reason for choosing foods
- transport available
- health (including SF-36³)
- physical activity
- nutritional screening
- social characteristics.

³ The SF-36 is a short form measure of generic health status in the general population.

Several other methods of data collection were included across the work packages:

- in WP2, repertory grid method
- in WP3, observational techniques
- in WP4, critical incident techniques
- in WP5, food and shopping diaries.

In the rest of the paper we set out the specific objectives of work packages two to seven and present the main findings from each of them.

WP2: Food selection in later life

The two objectives of WP2 were:

- to investigate beliefs and perceptions of functional and convenience foods
- to compare perceptions of functional and convenience foods across cultures, age groups and living circumstances.

In terms of perceptions of convenience foods, we found that products of higher levels of convenience were perceived in similar way across countries, though lack of familiarity with these products may have influenced elicitation. Foods perceived to be tasty were not associated with the attribute 'easy/quick to prepare', confirming the hypothesis that the more an individual can enjoy taste, the more inclined this person would be to invest time and energy in activities that provide this sensation.

Participants from the southern countries associated the attribute 'I like taste' more frequently with decreasing levels of convenience of the product.

In terms of understanding and perceptions of functional foods, those in the southern countries related more to the attribute 'familiar with product'. In particular the brand was meaningfully important among consumers in Spain and Portugal. The functional yoghurts (e.g., probiotic yoghurts and vitamin enriched yoghurts) were perceived in a vague and uncertain manner. The probiotic yoghurts and the cholesterol lowering yoghurt were significantly associated with the attribute 'it contains additives' by German seniors. Similarly, Spain perceived these yoghurts as a 'new product (artificial)'.

WP3: Shopping for food and preparing meals

The objectives of WP3 were as follows:

- to examine strategies used to overcome problems in shopping, meal planning and preparation
- to compare food procurement and meal preparation plans across cultures, age groups and living circumstances.

To examine the issues of procuring foods and preparing meals, we used a 'Prior to shopping questionnaire', which participants completed up to three weeks prior to an 'accompanied shopping' trip. At the point of purchase during this accompanied shop, the researcher asked the participant several questions including how they got to the shop, the type of shop used, reasons for selection of a product and whether purchases were planned or impulse. An in-home interview was carried out between four and seven days after the shopping trip. This was a semi-structured, face-to-face interview, recorded by the interviewer.

We found that procuring food and preparing meals is influenced by a number of factors at the level of the individual and at the level of the environment.

At the level of the individual these factors are as follows:

- age
- gender
- living circumstances (living alone, caring for others, kind and location of housing)
- health status, attitudes, preferences
- economic situation.

At the level of the environment these factors are as follows:

- the kind of shop
- the shop fixtures
- the kind of food available
- support systems
- the staff
- lighting
- public/local transport.

Changes – shopping

In terms of shopping, what we found was that if there are no changes – as long as older people are in a good health status and as long as there are no big changes in their living circumstances – then there are no problems.

When we looked at first changes due to living circumstances (among couples), we found that men start shopping after their retirement, their wives' illness or wives' death.

Access to shops

We found that, in all countries, decreasing health status causes problems and has great influence on shopping. In three countries (the UK, Germany and Portugal) access to shops has changed. In terms of transport, we found that the use of the car is of primary importance in the UK, Germany and Denmark; the bicycle is important in Germany and Sweden; public transport is important in the UK, Germany and Spain; and to go by foot is important in all countries.

Problems in shops

Participants reported several structural issues with shops including problems with doors (particularly in the Poland sample); and problems with stairs (in Denmark, Portugal, Poland and Spain). The findings from all countries showed that people had problems with shopping trolleys. Orientation was also a common problem across all countries with mention of changes in product locations, store layout changes or rearranged shelves and assortment changes. Support by staff was an issue.

Choice of foods

In the UK and Germany we found that if the person experiences no changes, then traditions are retained. Among the total sample there was a perception of development and increasing availability of all kinds of foods and in the UK, Sweden, Germany and Spain there was mention that food was of a better quality today.

Those in Germany, Poland and Spain commented on the change in the amounts of products they need. Those in the UK, Germany, Sweden and Denmark reported

increasing use of convenience products for dishes that they used to make themselves.

Problems associated with choice of food

The problems identified with choosing food were related to increasing health concerns and/or problems that lead to a different choice of products than before; for example less meat, less fat, less salt and soft products.

Problems with choice were also related to the cost of products. In Portugal, Poland and Spain in particular, respondents said that products were too expensive and that there were economic constraints on what they could buy. In the UK, Italy and Germany the price:performance ratio was a factor. In Italy, Portugal, Poland and Spain there was distrust of some products, with no confidence in some of them. Those in the UK, Germany, Denmark, Poland and Spain said that product size and the multiportion nature of some products meant that they were too big and/or too heavy. Packaging was an influence on those in the UK, Germany, Portugal and Spain.

Preparation and cooking methods

Again, in particular in the UK, Germany and Portugal, people reported that if they experience no changes in health or living circumstances, then there were no problems with preparation and cooking.

For those in UK, Germany and Poland, cooking in general has become easier over the life course. Across all countries people said that they had simplified their food preparation and cooking or had reduced them, and that they now used different cooking methods. Those in the UK reported preparing and cooking new cuisines.

WP3 conclusions

Health status, living circumstances, gender and cooking abilities, attitudes, preferences, economic situation and support systems have more influence on shopping and meal preparation than age itself. Health status has a substantial influence on independent food shopping; if the person finds that food shopping is no longer possible, an independent meal supply can only be maintained by use of formal and informal networks.

WP4: Food-related service satisfaction

The objectives of this work package were as follows:

- to identify the role that user satisfaction plays in service delivery and policy formation (e.g. day centres and meals-on-wheels)
- to compare user satisfaction with food-related services across cultures, age groups and living circumstances.

In reviewing food-related services, the quality of the food or meal and the choice and variety available appear to be the most important. When the food was good quality, people commented on its freshness, portion size, presentation and how well things are cooked, as these comments show:

Yes, and fresh vegetables, ... and not just the tinned or frozen packets.

Woman, age 66

Yes, adequate and if you need a smaller meal you can have a smaller meal.

Woman, age 83

Well, the chef does them very well, he's got imagination really ... it's usually beautifully laid out, and I just enjoy salads.

Woman, age 82

I like a good old meat pie. Well, the pastry for one thing. The meat is well cooked and the pastry is also well cooked.

Man, age 72

When the quality of the food was bad, comments included those on taste and presentation. For example:

[The] ... baked potato skin was always hard. ... I don't know if it's the way they cooked them.

Woman, age 77

And its not really presented right you know, they do mashed potatoes on some meals and it's just flopped off the spoon, like there's no presentation.

Man, age 69

They [sausages] had no flavour, they didn't look right somehow, they weren't what I call brown and sizzling brown, they looked anaemic and they didn't taste right, so I said, right, no more sausages.

Woman, age 89

I do find the vegetables get overcooked and they're generally frozen and they seem to just go mushy.

Woman, age 65

However, provision of meals, as we found out, '... is [about] more than just the food', as these comments show:

People who come here for line dancing ... and that, don't tend to eat here. ... I don't know why, there must be a reason, maybe if we put some more adventurous menus on maybe they would. I'm not saying that would happen but I think there is a possibility.

Manager of a day care centre for people aged 60 to 80

They come in because they get a meal, if they didn't get a meal they probably wouldn't use the day centre ... but it's so nice they can have all these different things.

Manager of a day care centre for people aged 75 to 95

The importance of evaluation of service and products was noted by service providers, as was the need to focus the marketing of services and products:

We make great assumptions that it is working very well, we are very busy, so we can't ask for customer feedback and really take that on board.

Local authority key informant

Customer satisfaction surveys are fairly new to us in this service and we are having to re-look at them because they are really of no value until they are honest with us and it is very difficult getting it across to this client group that

actually we would prefer them to be honest rather than say everything is fine because we can't respond to their needs.

Operations manager

We have got to get focused on what we are promoting and where, we've got to look at the competition, got to look at buyer behaviour, ... why are we really providing this service because it is not cost-effective but it is meeting a demonstrated need and it is meeting a perceived need.

Local authority key informant

WP5: Seven-day food diaries

In WP5 we collected data in seven-day food diaries. For the first day the interviewer recorded the data in the diary; for the other six days the participant filled in the diary themselves and returned it by post. In the diary, the participant recorded all food (and drink) events each day including the following:

- time of 'meal event'
- name of 'meal event'
- what was eaten and/or drunk (list of content)
- degree of ease of preparation
- who prepared the meal
- where eaten
- who ate meal with.

In analysing the diary data we used a degree of elaboration of meal events. Building up a picture from details recorded in the diary, we categorised meal events in the following way:

- drink only
- snack
- light meal – cold light (small) meal, hot light (small) meal
- main meal – cold main meal, hot main meal, elaborate main meal.

From the data we were able to group people into four categories, depending on their circumstances, as Table 1 below shows. We examined eating habits among each of these four groups. We look at some of the findings below.

Table 1

	Living with another	Living alone
Continuity of living circumstances	Always together	Always alone
Discontinuity of living circumstances	Newly together	Newly alone

Always together

We found that sharing food and meals is important to people, as these quotations show:

We always eat together and I do think you should: sit together, keep each other company.

Anneka, always together, woman, 65-74 years group, Sweden

My wife always waits for me. We eat together.

Artur, always together, man, 75 years and over group, Poland

Well, I often eat lunch on my own, because he is out for the whole day. Sometimes I don't bother, I will just have an apple or a banana or something It is not very interesting sitting on your own eating a sandwich.

Martha, always together, woman, 75 years and over group, UK

We found that among the 'always together' group there were, in Northern Europe, men cooking for leisure:

Well what I enjoy about cooking is it gives you a sense of creating something. It is a bit like an artist. You have got your paints and your palette and your canvas and you make something out of it. ... It is just a sense of having accomplished something.

Tom, always together, man, 65-74 years group, UK

I have a husband who loves to cook ... he has always had the interest ... he makes specialities of all sorts and kinds.

Frida, always together, woman, 65-74 years group, Sweden

Among those 'newly alone' we saw evidence of disrupted routine:

I suffer from depression because loneliness is very sad ... sometimes I do not even eat, because I do not want to do anything at all.

Claudia, newly alone, woman, 75 years and over group, Spain

When I eat on my own, it is so sad.

Gabriella, newly alone, woman, 65-74 years group, Italy

She [wife] used to make these big paellas in a great big pan and also as I said the omelettes. ... I miss the things she cooked.

David, newly alone, man, 65-74 years group, UK

For some 'newly alone' women the focus goes; for others there is a freedom:

Honestly, I cannot be bothered to cook ... because I am alone.

Eva, newly alone, woman, 65-74 years group, Denmark

Now you can have the same kind of food for two days When you see something in the shop that looks nice – I can buy it. I do not have to think about that I have to buy it for another five people.

Astrid, newly alone, woman, 65-74 years group, Sweden

Some of the 'newly alone' men are what we called 'reluctants':

I never cooked ... and I don't know how to do it.

Jesuino, newly alone, man, 75 years and over group, Portugal

I have never cooked in the past, and now being alone I have to cook, so I only do it strictly when necessary.

Elmo, newly alone, man, 65-74 years group, Italy

It's just a matter of getting nourishment to the body. Nothing else.

Eugen, newly alone, man, 75 years and over group, Sweden

I can eat anything okay, but as long as I am eating something then I am not starving, that is my theory. ... Half the battle, I think, is to get a meal someone else has cooked. It is put in front of you. It is taken away and they do the washing up. I have had a meal.

Bernie, newly alone, man, 75 years and over group, UK

Some 'newly alone' men we classed as 'competents':

I'm able to do everything ... I can even bake a cake, no problem.

Dorek, newly alone, man, 75 years and over group, Poland

I learned it step by step and it built up and wasn't really so difficult. I was happy that I could do all that. I wasn't even able to make a single sauce, even though it's so easy to make and I thought that I couldn't do it, but it's really easy.

Friedrich, newly alone, man, 75 years and over group, Germany

Food as support

We found evidence of food as support, as these quotations show:

Today I bought some meat, and also, to give my son something – this one who has lost his job and lives on his own – I went to get him some squid, some sole, ham and fruit to take with him. ... Before I did not used to make him food packets but now, as he only gets unemployment benefit and he has to pay the mortgage, when he comes once a week, he takes this bag with him.

Corazon, always together, woman, 65-74 years group, Spain

We visit our daughter ... but to tell the truth, it's us who prepares most of the food.

Holleb, always together, man, 65-74 years group, Poland

My son comes for lunch because his wife finishes work late and he finishes at 13:00 hours. ... I do not mind because he keeps us company, and we talk and that.

Luisa, always together, woman, 75 years and over group, Italy

There was evidence of gender differences in Southern Europe in the view of food as support:

He looks after me a lot but I also look after him [son] ... the cooking – I do it myself ... I make him lunch and we eat together.

Eldora, always together, woman, 75 years and over group, Spain

It is always me doing the cooking for everybody [adult child's family].

Donna, always together, woman, 65-74 years group, Italy

P: Alone at home? I am never alone. Because I brought my son and daughter-in-law to my home when my wife was already sick ...

I: I understand. But tell me Mr António, who cooks at your place now? Is it always your daughter-in-law?

P: Yes, always. Usually I don't cook.

António, always together, man, 75 years and over group, Portugal

There was evidence, too, that reciprocity changes:

[My daughter] I cannot invite her to what I cook.

Hermann, newly alone, man, 75 years and over group, Germany

I visit them [family] more often now, because preparing all those dishes ... it's so troublesome for me.

Oles, newly alone, man, 65-74 years group, Poland

[My wife] she was busy and arranged all the time to have everybody round ... but I don't want to keep offering and try too much to get the children home to the old man.

Fisk, newly alone, man, 65-74 years group, Sweden

I never eat at my children's. I have enough trouble dragging them up here for my birthday once a year ... my daughter has her own shop and my son-in-law runs his own shop, too, so it can be difficult for them to take the time.

Klaus, newly alone, man, 65-74 years group, Denmark

There is also evidence of support for 'newly alone' men from their children:

I have a daughter who visits sometimes ... she usually has food with her, prepared dishes for two or three days.

Thor, newly alone, man, 75 years and over group, Denmark

Sometimes I phone my daughter and she gives me cooking tips.

Rafal, newly alone, man, 75 years and over group, Poland

I eat everyday at my son's house, since my wife died ... on Sunday I go eat at my daughter's place.

Alexandre, newly alone, man, 75 years and over, Portugal

She said to me: 'Grandpa ... I don't see you a lot. ... So you are going to eat at my place every Thursday'.

Matteo, newly alone, man, 75 years and over group, Italy

For 'newly alone' women, it appears that support is delivered through networks of widows:

I have a lady friend and on Sundays we cook for each other ... we have done this for three years now.

Ulrika, newly alone, woman, 75 years and over group, Sweden

We haven't got a man to get back for or anything like that, you know, or children, so we can please ourselves ... we have got a girls' club virtually, or ladies who lunch.

Polly, newly alone, woman, 65-74 years group, UK

This friend of mine, she comes almost every evening ... share a cup of tea and some sweets. And a glass of wine.

Tesia, newly alone, woman, 65-74 years group, Poland

WP5 conclusions

Continuity in living circumstances affords a continuity of established food roles and these are reflected in sustained domestic food activities. Discontinuity in living

circumstances, on the other hand, means a disruption of established roles and relations, demanding re-evaluation. Life stage is crucial to the meaning and understanding attached to food and its relationship with social roles and relationships. Older men and women tend to regard food preparation within a framework of traditional gender roles. Traditions of differential family roles in the north and south of Europe are evident in the data.

WP6: Meals in later life

Diet, eating and household work – a life course perspective

During the life course the meaning of food shifts. In childhood and youth the role was to be food receiver. At marrying, young women had to learn to take the responsibility for healthy eating in their family. In older age the female role of being food giver continued but a traumatic shift occurred if the receiver died. This entailed a loss of meaning of eating, implying risk for food insecurity. Disability could also force a wife to give up cooking and her spouse to become food giver.

Food preparing was done in advance among women working outside their home and heated up at lunch the following day. Local availability and economic status directed the type of food consumed. Sunday meals were most important, giving both the best of food and meal sharing.

The representation of being old and ill

Getting a diagnosed disease was a strong reason for changing food habits (e.g. diabetes, hyper blood cholesterol, stomach problems or heartburn and diseases treated with surgery). Changes in smell and taste, medication and teeth problems affected food habits like loss of appetite.

Physical weakness could imply changed cooking methods. Weight was also important for health and illness. Being too heavy was not good for the heart or for the joints. Participants from Poland and Portugal declared the importance of following the doctor's diet advice while persons from Germany and Sweden had a more pragmatic view. Following advice too strictly created dissatisfaction with food. Taste was the most important factor for food choice.

Perceptions and beliefs of healthy eating in old age

Older Europeans are aware of the idea healthy eating – to implement this in daily life people simplify and categorise food into healthy and unhealthy foods. Eating healthy food is considered to prevent and control diseases and weight and is thereby a way to maintain independence.

The strategies to reach healthy eating vary. For example, people can exchange foods and compensate for unhealthy eating. They believe that regularity, variation, balance and moderation are ways to reach the goal. The strategies chosen are influenced by social relations and situations, as well as by the situation of the individual older person.

The meaning of the meal

The meaning of the meal is closely linked to the social aspects – the concept of commensality, which means sharing food, thoughts and table. Both women and men appreciate being together at table. For women, the goal of cooking is entertaining family members, and also friends, with tasty food at a beautifully laid table.

WP5/6: Consuming alcohol

In some countries, it is unusual to talk about ‘alcohol’ when referring to wine or beer. Those who drank tended to name the beverage, e.g. beer, wine, liqueur or schnapps, whereas abstainers used the generic term ‘alcohol’ or ‘alcoholic drink’.

In societies with an ambivalent, morally charged relationship with alcohol (e.g. the UK), ‘celebration’ is used as an excuse for drinking; whereas in societies in which alcohol is a morally neutral element of life (e.g. Mediterranean countries), alcohol is strongly associated with celebration but this is not used as a justification for drinking every occasion. For most participants alcohol provided the ‘social glue’ of an ideal or proper meal, which was one shared with family and friends, whether a special occasion or routinely.

There were substantial gender differences in narratives of alcohol, but these were less marked than the differences between the countries. Women tended to drink less than men and in later life tended to have reduced their consumption more significantly than men. Both men and women were likely to reduce drastically, or

cease drinking alcohol, in the presence of very poor health, but women would give up sooner.

WP7: Satisfaction with food-related life

We aimed to obtain a score for each participant on a measure called 'satisfaction with food-related life' (SWFL). The original scale containing the following items:

- food and meals are positive elements in my life
- when I think of my next meal, I only see problems, obstacles and disappointments
- I'm generally pleased with my food
- food and meals give me satisfaction in daily life
- food is not as enjoyable a part of my life as it could be
- my life in relation to food and meals is close to my ideal
- I wish my meals were a much more pleasant part of my life
- with regard to food, the conditions of my life are excellent.

WP7 conclusions

The SWFL scale was shown to be valid and reliable. Respondents were in general quite satisfied with their food-related lives according to this measure.

We found that the resource with the highest impact on older people's satisfaction with their food-related lives was 'a good appetite'. 'Sharing meals with others', the social aspect of eating, and 'good health' were also resources with a high impact. No single resource is all-important for older people to be satisfied with their food life. We found that the SWFL score is related to both nutritional adequacy, as measured by a dietary variety score, and physical and mental health. This underlines the significance of SWFL as a monitoring tool.

Acknowledgement

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Community Meals Provision in the North West of Ireland: Perspectives on Service Provision and Use

***Michelle Share, Senior Research Officer, Health Promotion Department,
HSE West***

Introduction

The aim of this short paper is to present an overview of the findings from a research study on community meals provision in the North West of Ireland. Key issues from the research are framed using the principles of equity and fairness, derived from the National Health Strategy. It is envisaged that the recommendations from the research be used to inform policy and practices in meal provision for older people and other vulnerable groups.

Community meals

Community meals include meals provided to non-residents of day centres, health centres and day hospitals, to people living in community homes and to people living in their own homes ('meals-on-wheels').

For the most part people who receive community meals are likely to be:

- living alone with physical/mental learning disability
- living in group homes
- in convalescence
- living with inadequate cooking facilities
- older people.

In addition, children and adolescents in care and adults with special needs receive community meals.

Research

A research study was undertaken in 2004 in the HSE North Western Area to understand how community meals services operated and the views of service users.

Primary research was needed for two main reasons. Firstly, there was no documented, local evidence available on the extent and provision of community meals. Despite the large body of research on the benefits of good nutrition throughout the life course and the particular nutrition issues for vulnerable groups, (for example widowed, those living in long-term care, housebound older people and people with dementia) there is little attention paid to service aspects of food and nutrition and the social context of eating. Secondly, the research was intended to inform national and regional policy for community meals and evidence was needed with which to do this (for example in the UK there are the Caroline Walker Trust Guidelines for the provision of community meals and for meal provision for 'looked after' children).

The overall aim of the study was to describe the extent and type of community meal provision in the North West area with specific research objectives to:

- conduct a survey of service providers to examine a range of service issues including service type, client base, training, food safety practices, nutritional assessment, costs and meal choice
- conduct a service users' survey to examine level of satisfaction with services, how services are used, food and nutrition issues.

Data were collected from two groups of people: service providers and service users. All fieldwork was carried out between July and December 2004.

Service providers' survey

The survey of service providers set out to examine the following issues:

- service type
- training
- food safety
- nutritional assessment
- costs
- meal choice.

The Environmental Health Services (EHS) database was used to develop a sample frame of community meal service providers. Organisations in the following sectors that are outside the remit of EHS were also sampled. These included children's residential homes and group homes. The sample included a variety of service

sectors: mental health services, children's services, community services and the grant-aided voluntary sector.

A questionnaire was posted to 93 service providers in total, all in the North West HSE area.

Service users' survey

The survey of service users set out to examine the following:

- level of satisfaction with the community meals service
- how the service is used
- food and nutrition issues.

The service users sample was a convenience sample of 87 people who were in attendance at community meal centres at six day hospitals and two health centres in counties Sligo, Donegal, Leitrim and West Cavan.

An interviewer provided participants with verbal and written information about the purpose of the study and the format of the questions, and participants were asked to give their consent before being interviewed. Interviewers administered the questionnaire in person in the day hospitals and health centres.

Findings: service providers' survey

There was a very high response rate from service providers. Eighty eight questionnaires were returned out of a total of ninety three distributed. Eleven questionnaires were deemed ineligible for inclusion. This provided a final response rate therefore of 82 per cent. The sample included health service sectors and the grant-aided community sector in Donegal, Sligo, Leitrim and West Cavan: 55 per cent were from providers in Donegal; 36 per cent were from providers in Sligo; 8 per cent from Leitrim; and 1 per cent from West Cavan.

Just under half the sample provided on-site meals to non-residents only (42 per cent), 26 per cent to community residences only and 4 per cent provided meals-on-wheels only. Twelve centres (16 per cent) provided on-site meals services and meals-on-wheels; 8 per cent provided on-site meals services to day clients and to

community residences whilst three centres (4 per cent) provided all three types of service.

In terms of eligibility, most providers reported that there were no eligibility criteria to use the community meals service. In terms of funding and charges, service providers described a range of ways in which meals are funded, including central health service funding; central funding and charge to clients; and direct charge to clients only. This results in a variety of charging arrangements and charges to clients. The average (modal) charge was €2.00 to €2.50.

Two thirds of the service provider sample offered therapeutic meals such as coeliac, diabetic or low fat. The majority of providers consult service users about preferences. There were differences across the sample in terms of whether or not service users received a choice of main course. The majority of meals-on-wheels service providers do not provide a choice of main course and do not consult service users about preferences.

Some service providers show different interpretations of menu cycle and the extent of menu rotation is unclear. Whilst some centres reported fortnightly or three-weekly menu cycles, others reported daily or weekly rotation suggesting perhaps some confusion about this terminology. Most reported using the Hazard Analysis and Critical Control Point (HACCP) system, a food safety management system. There were differences across the sample in terms of the level of formal training on nutrition and food safety. More than half the sample of service providers (58 per cent) reported that they trained staff. Of these, 15 per cent reported on training that was not food-related. Most providers reported that they do not have access to nutritional assessment of meals.

Findings: client survey

The average age of respondents to the client survey was 78 years. Most respondents were women; half were widowed; and one third received a meal two days a week. For most, the community meal makes up half of their daily food consumption.

The majority of survey respondents said they were satisfied with the meal service. Most were satisfied all of the time with the key aspects such as friendliness and

respectfulness of staff (95 per cent), and the time of the meal service (95 per cent). Most were also satisfied all of the time with the temperature at which the food is served (90 per cent), its smell (90 per cent) and taste (87 per cent). For those who did pay for a meal, two thirds were satisfied with the cost. In response to the question, 'What is the best thing about coming to the centre?', 80 per cent emphasised the social aspect, saying things like:

Meeting people – keeping in touch.

Friendship – the friends you make. I was decaying away at home.

Meet people, make friends, chat and news.

Most (74 per cent) said they had no suggestions for improvements. Those that did said they would like more space and/or that they would like the centre to open more often. In terms of the food, they said that they would like a change of main course more often.

Recommendations

This study makes several recommendations based on evidence from the research literature on food, nutrition and vulnerable groups and from the surveys of service providers and service users. Firstly, in terms of service provision, it is recommended that charges, choices, eligibility, food safety and training be made more equitable across service providers. Also, it is recommended that a regional policy be developed and a set of guidelines drawn up for the provision of community meals. Service providers should have access to nutritional assessment of meals – provision needs to be made for this.

In terms of social issues, it is recommended that structured, health promoting activities be provided in meal centres such as physical activity programmes, cooking, gardening, music therapy and nutrition education. It is also recommended that there be continued consultation with service users about their preferences.

Summary and conclusions

Existing research evidence on nutrition and vulnerable groups, and previous policy recommendations on community meals support the findings from the present study:

there should be equity and fairness in all aspects of community meal provision. Nutritional standards and assessment of nutritional needs are important and necessary, especially for vulnerable groups of people. The social importance of food and eating should not be underestimated – food is more than just nutrition and community meal centres contribute much to social networks and social capital. Meal centres have the potential to build on the existing social networks and provide other opportunities for health-promoting activities.

Questions Following Opening Session

Questions for Dr Clare Corish

Q. Why have we no studies from residential settings on nutritional status of patients?

Clare Corish: It is difficult to say exactly why this is so. I understand that academics at University College Cork (UCC) are doing some work in this area. It may be to do with the availability of funding for the research as well as the level of interest that researchers and academics have in the topic. Many dietary surveys have been conducted among the total adult population and among young children. I understand that Prof. Michael Gibney's team at University College Dublin (UCD) is conducting a survey among adolescents. I am also aware that there is a plan to carry out a dietary survey on community-dwelling older people, although as I understand it, this is dependent upon receipt of funding.

Q. Could you say something about how representative of the general community-dwelling population your study is? I understand from your presentation that you were drawing on people from active retirement associations, people who presumably were in fairly good health and active. Maybe the estimated result for the general population of older people would be that there would be more concerns about the nutritional status.

Clare Corish: The study aimed to look at healthy people. The results were similar to those found in the UK for free-living individuals (the average BMI was exactly the same). We drew on the sample of healthy older people so that we would be able to compare that group with those in hospital or residential care. Our sample did not include people who do not attend activities for older people so it is likely that in that group there is a greater proportion who would be vulnerable. (No work has been done on this in Ireland.)

Questions for Dr Margaret Lumbers

Q. Did you find any evidence that the reluctance of older people to complain was linked to the voluntary nature of the service provision?

Margaret Lumbers: We found in all countries that there was what we call social desirability. It was not associated particularly with the fact that the service provision was voluntary because we looked at a range of providers (commercial, non-commercial and charities) across all countries. One of the things that people did comment on was the cost and that for that amount of money what more can you expect. I think it is also about what older people have lived through – the war, food rationing and, in other countries, periods of extreme hunger. As a result there is a sense of gratitude and release from having to find food for themselves.

Q. I work in a hospital where we cater one hundred meals-on-wheels a day. We offer a choice of meal. Over the years we have seen the number of volunteers who collect the meals-on-wheels decline. Is there any incentive for older people to do this sort of work – how could we attract more people to this voluntary work?

Margaret Lumbers: We found in our sample and certainly in the UK sample it became increasingly difficult to employ or to use the voluntary sector meals-on-wheels services because of the need to have certain food hygiene certificates and legislation which caused it to be problematic for some of the volunteer organisations to do that training. I am not saying that couldn't be overcome, but that was certainly something that was cited by our respondents.

Question for Michelle Share

Q. In my experience people who are institutionalised do not tend to be interested in anything other than very plain food, whereas those in living in the community are interested in a range of different foods. Could you comment on that?

Michelle Share: We asked service users what their favourite meal was and I was surprised that most said very plain food. Favourite meals were chicken, bacon and cabbage, and fish. So it can be hard to change menus and to introduce new things. At present providing culturally or religiously appropriate meals is not an issue in Ireland but it may be in the future.

Parallel Sessions

Good Practice in Promoting Nutritional Standards for Older People

Workshop One: Nutritional Standards for Older People at Home

***Chair: Margaret Feeney, Director of Services for Older People, HSE
Dublin Mid-Leinster***

Older People and the Financial Cost of Healthy Eating in Ireland

***Speaker: Denise McCarthy, Researcher for Mental Health, HSE Dublin
Mid-Leinster***

Introduction

Research shows that some older people are at risk of food poverty. Food poverty is defined as a lack of, or insufficient availability and intake of, food and nutrients, taking into consideration affordability and access. Both the Cardiovascular Strategy and the Government's Health Promotion Strategy 2000-2005 recognise that adverse dietary habits impact on general health and well-being. The DoHC's 1995 Food and Nutrition Policy emphasises the importance of a healthy diet for disease prevention. However, the current dietary recommendations (Food Safety Authority of Ireland [FSAI], 1999) have not been assessed thoroughly in terms of how achievable they are based at the level of the individual in terms of household capacity.

So in 2004 we undertook research to find out more about the financial cost of healthy eating for older Irish people living alone. The overall aim of the research was to determine the direct cost of purchasing a healthy diet among older people living alone. More specifically, the research objectives were as follows:

- to identify the pattern of household food purchasing among older people
- to develop a range of healthy food baskets based on purchasing patterns and the food pyramid
- to identify how much it currently costs to eat healthily, as recommended by the food pyramid, and to determine whether this cost varies by type of retail outlet
- to identify the financial resources available to older people living alone.

The research process was made up of four main stages:

- determination of food purchasing patterns
- food basket development
- pricing of food baskets
- assessment of the financial capacity of single older people.

Every four years the Central Statistics Office (CSO) conducts the Household Budget Survey (HBS). The main purpose of the HBS is to determine the pattern of household expenditure across a representative sample of private households in the state. At the time of our research, the most up-to-date HBS data was that collected between June 1999 and July 2000. It covered a total of 7,644 households. From this sample of all households we chose a sub-sample of single person households aged 65 years and over. In particular, we wanted to look at those households with a low income. We took the HBS income variable and split it into five groups (quintiles). Based on recommendations from the Combat Poverty Agency, a cut-off value of the bottom 20th percentile of the income distribution in the HBS data was adopted to represent low income.

Having isolated our sample of low income single person households, we examined the data from it to work out food purchasing patterns. We also compared food purchasing patterns between each of the five income groups. We worked out the financial resources available to each group.

The HBS data contained information on 146 different food items purchased for home consumption. The average amount spent on each individual foodstuff was identified and added together to determine overall food expenditure. Table 2 below shows the average weekly income of the groups within our sample and their corresponding average weekly spend on food.

Table 2: Income and food expenditure

Income category (percentiles)	Sample size	Average weekly income (€)	Average weekly food expenditure (€)
20th (Low income group)	230	109.18	39.61
40th and 60th	282	139.65	38.59
80th	181	195.01	40.93
100th	134	375.53	53.29
Total sample	(827)		

Food purchasing patterns of single older people

White bread, potatoes and breakfast cereals were common purchases across all of the income groups. The amount spent on brown bread was low. Spend on fruit and vegetables was similar across all groups. The most common buys were fruit juices, tomatoes, carrots, cabbage, onions, tinned peas, parsnips, bananas, eating apples and oranges. In terms of dairy products, we found that spend decreases with increasing income. The largest proportion of total food expenditure in the dairy category in all income groups was on fresh milk. The greatest proportion of income was spent on meat, fish and alternatives. A small proportion of the sample, across all income groups, bought fresh fish. Sausages and bacon were common purchases in the lower income groups. Chicken, cooked ham and pork were common in all groups. A high proportion of spend in all groups went on sweets, soft drinks, biscuits, cakes and buns.

We also found that more or less the same food was purchased each week. Generally, it was not in compliance with dietary recommendations and it reflects the difficulty in accessing and availing of healthy options. There was a predominance of refined, cheap filler foods lacking in fibre and B-vitamins.

Menus and food basket

Based on the purchasing patterns we saw in the data and on healthy eating guidelines, we put together a seven-day food menu and from that decided what should be in the healthy eating food baskets. We felt that it was important not to develop baskets that were unrepresentative of what we had seen in the survey data, nor to develop baskets that were unacceptable to older people. Therefore foods such as sausages and biscuits, which the HBS analysis shows are regularly purchased by older people, were included. (It is important to note, however, that we did not test the acceptability of the seven-day menus on the population concerned.) The items in the baskets were in what we called 'purchasable' quantities, for example one litre of milk, one block of cheese.

Once we had decided on the basket contents, we identified the price of the products by sampling prices in a cross-section of shop types in Galway city (including multiple retailers Dunnes and Tesco; symbol group retailers Centra and SuperValu; 'foreign' shops, Aldi and Lidl; and independents or corner shops). We checked these prices at national level using the Tesco online database.

Cost of food basket

We found that the cost of the foodstuffs varied depending on the type of shop and the brand of product bought (either the market brand or the retailer's own brand). Availability also varied by shop type and not all outlets stocked own brand items (in particular, the independently owned shops and the symbol group shops). Where this was found to be the case the market brand equivalent was used. (Also, we found that own brand products tend to come in larger pack sizes.)

Based on national pricing, the total basket cost for the market brand was €74.65; and the total basket cost for supermarket own brand products was €65.83. The average cost across all retail outlets was €63.99 for market brands and €62.65 for own brands. The least expensive outlet was an Aldi or Lidl type outlet at €50.75 and the most expensive was an independently owned shop at €70.42.

The cheaper shops – multiples and the Aldi/Lidl outlets – tend to be located on the outskirts of towns, to which there is often no public transport, thus making it difficult for older people to shop there. Often the only options are the more expensive but local independent shops.

Financial resources available

In working out the financial resources available to people, we used disposable income data adjusted to income levels at June 2003. For this low income group at that time the average disposable income was €131 and the old age contributory pension for a single older person was €165, according to the Department of Social and Family Affairs (DoSFA).

On average, the cost of the food basket using the own brand foods would take up half of this average disposable income. An older person living alone needs to spend 38 per cent of his or her social welfare entitlement to eat healthily.

Our findings from the analysis of the HBS data show that single older people are not spending the amount of money on food that would be needed to buy the healthy basket of food – on average, the healthy basket cost €62.65; our data show that the average actual food spend is €45.36.

Conclusions

It is clear that there is inadequate availability of low cost healthy options, whereas unhealthy options are readily available. To afford the healthy options basket it is clear that there needs to be an increase in the level of social welfare benefits. The food budget is a flexible priority for low income households – healthy food baskets are unlikely to be bought unless financial provision is made. This suggests that there is a need to set a minimum income standard to correspond with adequate standards of living.

Furthermore, older people may find it difficult to get to those shops that provide quality, affordable items. Solutions should include adequate transport and/or free home delivery. Own brand products appear to represent better value for money but are often available only in larger pack sizes that make them unsuitable for an older person living alone. This is something that could be addressed by suppliers and retailers.

Supporting Carers in Improving the Nutrition of Their Clients

***Speaker: Niamh O’Keeffe, Acting Senior Community Dietitian, HSE
Dublin Mid-Leinster***

Introduction

As a result of the 2001 National Health Strategy, a partnership was set up between the former Midland Health Board’s Services for Carers and the Carers’ Association. The aim of the partnership was to improve the nutritional status of clients living in their own homes by supporting their care givers in the provision of nutritionally adequate meals.

We set ourselves three main goals:

- to plan, develop and deliver a nutrition education session
- to evaluate these sessions using questionnaires
- to incorporate education on nutrition into ongoing training for carers.

Action taken

So, how did we do this? A ten-week course was set up to include a series of two-hour weekly modules. The modules were delivered by various therapists including a speech and language therapist and occupational therapist, as well as nursing staff, manual handling officers and the community dietitian.

The nutrition training, delivered by a community dietitian, included the role of nutrition in achieving good health, the nutritional needs of different population groups, diet therapy and hydration. Active participation in these sessions was encouraged. Following completion of each session, participants were invited to complete an evaluation questionnaire.

We received very positive feedback from participants. We found from analysing the qualitative data provided by them on the questionnaire that many were interested in further training on specific areas and in relation to specific groups of people. As a result, we are developing training in caring for persons with dementia and caring for persons with a disability.

Conclusion

The National Policy for Older Persons (2000) advocates maintaining individuals in the home. To do this we need to provide carers with the necessary information and skills to help them improve the quality of their service. We have found that there is a continuous demand for training programmes, which in itself shows that there is a need to develop this area further.

We found that training such as that outlined here enhances the caregiving role. It helps to instil in carers the confidence and competence to provide adequate nutrition.

Discussion: Good Practice and Barriers to Good Practice

Rapporteur: Liza Costello

The following emerged in discussion following the presentations:

The importance of food

It was noted that, according to Maslow's Hierarchy of Need, food is a basic requirement. If a nutritious and balanced diet is not accessible to older people, this can be considered to be a form of elder abuse.

Prevention of undernutrition

It was agreed that prevention of undernutrition is vital. It was agreed that it is important to promote a life-course approach to healthy eating and nutrition and to make it clear that healthy eating is for everyone, not just older people. It was agreed that this should be an important part of government policy.

It was agreed that a national information campaign should ensure widespread dissemination of information on healthy eating for older people. It was recommended that food suppliers consult with older people or their advocates and carers to ensure that information on food products is user-friendly and accessible: for example, that print size on food labels is large enough; that recommended amounts are expressed in user-friendly terms such as a teaspoon or a half teaspoon.

It was noted that older people often experience digestion problems, which can lead to a preference for plain food. It was also noted that some older people have a preference for traditional foods. It was agreed that these preferences should inform and guide the recommended food in the healthy eating food basket. It was agreed that the underlying aim of any nutrition initiative for older people should focus on the benefit it has for them.

Access to healthy food

The cost of healthy eating was identified as a particular barrier for older people. It was noted from the work done on the cost of the food basket and the financial resources available to older people that older people living in poverty cannot benefit from a healthy diet. It was agreed that tackling poverty among older people thereby ensuring that they have sufficient income to allow them to eat well is an important strand of government policy.

It was also mentioned that older people's ability to shop for healthy food was threatened by the closure of local shops in recent years and the increase in the number of 'out of town' supermarkets.

The value of a meals-on-wheels service

The benefit of a meals-on-wheels service was acknowledged.

The difficulty in attracting volunteers to work in the service was noted. It was suggested that the service be developed so that it provides social support as well as meals to older people.

It was suggested that meal preparation should be under the remit of the HSE and that the catering be contracted out by tender to accredited catering bodies. It was suggested that this would allow volunteers to spend more time building social relationships with service users.

It was suggested that transition year students are a potential untapped source of volunteers. Their involvement could be a model for intergenerational work and could also raise awareness of older people among the younger population.

Nutritional training programmes

It was acknowledged that there is a need to support carers to improve the nutrition of their clients and a need to train carers in the skills they need to provide adequate nutrition and to improve quality of service. It was recommended that the HSE take a national standardised, structured approach to the support and training of carers.

It was acknowledged that all training programmes should be evidence-based and should promote best practice.

Model for developing policy

It was suggested that the 1986 World Health Organisation (WHO) Ottawa Charter for Health Promotion be used as a framework for building public policy and creating the supporting environments, developing the skills, activating community action and reorientating services that are needed to address the issue of healthy eating and nutrition for older people.

Workshop Two: Promoting Nutritional Standards for Older People, in Day Care and Meal-On-Wheels

Chair: Mary Flanagan, Director of Nursing, HSE Northern Area

The Resource Pack

Speaker: Mary McKeon, Community Dietitian, HSE Mid-Leinster

One of the areas of our work as community dietitians is to address the nutritional needs of older persons. We do, however, work under time constraints and to make our use of time more efficient, we developed what we call the resource pack. The pack was pilot tested at ward level. It contains relevant resource material for the dietitian, including food diaries, diet therapies and information on nutritional sip feeds and enteral feeds as well as important addresses. We audited the use of the pack and the results were positive.

We developed another, separate resource pack for the catering department. It is now available on all wards and in all kitchenettes. It is used as part of the induction process with new staff members. We also use it to provide the older person's family members and/or carers with information.

The information in all the packs is updated on an ongoing basis.

Our next step was to develop a resource pack for use in day care. We found, however, that this required more input. Some of the issues that arose in developing the day care resource pack were due to the varied group of clients/patients that used the day care meals service, their need for privacy, and the need to produce a greater amount of practical information. To address these issues we developed a four-part training module that covered, for example, the food pyramid, fibre and fluid, diet therapies and so on.

Our plans for the future development of the packs include developing packs for specified groups of older people; including more practical information on shopping, preparing meals for one person and so on.

Realising the Nutritional Potential of Meals-On-Wheels

Speakers: Olga McDaid and Sinead Quill, NCAOP

... in recognition of the importance of meals-on-wheels in the range of services which help to support older people to continue living in their own homes.

Minister for Health and Children, Mary Harney TD, 2005

Introduction

The meals-on-wheels service is an important part of the continuum of community care services. It should be made available to older people on the basis of need. Research shows that it promotes the nutritional well-being of older people and that it may enhance social interaction and prevent social isolation. In other words, it enables older people to remain in their own homes for as long as possible.

The importance of good nutrition for older people

A good diet in later years has several positive effects. It reduces the risk of disease, it allows you to manage the signs and symptoms of disease, it contributes to quality of life and it enables older people to maintain independence.

Poor nutrition in later years, on the other hand, can cause illnesses; can prolong recovery from illness; puts the older person at increased risk of being institutionalised, with the associated costs which that entails; and can lead to poorer quality of life.

Evidence of poor nutrition among older Irish people

According to a report by the FSAI published in 2000, *Recommendations for a National Food and Nutrition Policy for Older People*, the key determinants of poor nutrient intake among older people are as follows:

- low income
- low level of educational attainment
- inadequate housing

- inadequate cooking facilities
- inability or a lack of motivation to shop
- inability or a lack of motivation to prepare food
- difficulty digesting certain foods
- lack of education about nutrition
- social isolation or loneliness.

The FSAI report defined community meals for older people as those provided by the meals-on-wheels service and in luncheon clubs, community centres and day centres. They noted that some services provide a frozen meal delivery to the home of the person.

The meals-on-wheels service is provided to more vulnerable older people. Its main aim is to offer a nourishing meal to persons who are unable to cook for themselves, either temporarily or in the long-term, in their own home. A secondary aim is the provision of a home visit and social contact to socially isolated older people.

Anecdotal evidence suggests that the main barriers facing the meals-on-wheels service are funding, transport, staffing, adequate premises, insurance and lack of nutritional standards for meals being provided.

The meals provided by the service must be of a sufficient standard to contribute to the recipient's health and well-being. The FSAI provides the following information and guidance:

Those providing community meals, for example, day care centre workers and those preparing meals-on-wheels, should be aware of the specific needs and preferences of the older person. Practical easy-to-follow food based dietary guidelines should be developed and made available to those caring and providing meals for older people.

Barriers to achieving this include lack of standards and lack of regular review of meals and the meals service. Possible solutions include the development of a template or framework for standards and the use of incentives to service providers.

Resourcing

Resourcing is a major issue. A plan or strategy must be drawn up for the provision of an adequate community meals service and it needs to be adequately resourced if it is to respond to the identified needs. At present, as a service that promotes ageing in place, it suffers from severe resource constraints, which impede its strategic development. It should be an organic service responding to local need. As such, it has enormous value.

Sustainable, adequate and flexible funding is needed to protect the current service and to allow service expansion on the basis of assessed need.

Funding should cover costs relating to the following:

- the provision of nutritious meals
- employment of core staff to prepare and deliver the meals, as required
- the provision of a clean, safe and modern food preparation environment
- cooking and heating requirements
- delivery requirements
- communications and technological requirements.

Education and training

Education and training of those involved in the service is needed. Many effective services may still require specific information relating to nutritional requirements. There is much to be learned from evidence-based materials that merge international experience and local experience.

Barriers to effective education and training at present include the absence of suitable materials and the lack of opportunities for training of volunteers.

Supporting specific dietary requirements

There is a need for the service to support specific dietary requirements. As Clare Corish noted in her paper, around 16 per cent of older people fall below the BMI of 20kg/m² used to define undernutrition and 14 per cent of the overall population are undernourished on admission to hospital.

There is a need to acknowledge the diversity of the older population and thus to acknowledge the specific dietary requirements of that diverse population. This may include the following:

- a low-fat, low-cholesterol diet for heart disease
- a low-sodium diet for high blood pressure
- a low-calorie diet for weight reduction
- a diabetic diet
- a gluten-free diet
- a lactose-free diet.

Best practice suggests that the meals-on-wheels service should be in a position to tailor provision to these specific requirements. The main barrier here is the identification of the client's specific nutritional needs and requirements.

Food safety issues

Nutritious meals can be compromised by poor food safety and hygiene control on the part of the meal providers and the meal recipients. Education and guidance are needed.

At present, however, there is a lack of availability of educational materials and a lack of training on food safety and hygiene issues. We need to ensure that providers and operatives are adequately trained in the nutrition requirements of older people and in safe food handling.

Identification of 'at risk' older people

There is a need to develop a mechanism or tool with which to identify 'at risk' older people and others at risk of undernutrition in the community and attract them to the service. This identification tool should address the factors that contribute to poor nutrition in older people. The availability and use of screening tools are critical if we are to maximise the benefits of the service. We are not aware of whether such a tool exists for use in an Irish context. If such a tool is to be used, it will be important to make the eligibility criteria for the service more consistent and transparent.

Consumer consumption and satisfaction

There is still a stigma associated with using a community meals service. According to data collected for the *HeSSOP I* study, 29 per cent of older people said that they would find using the service either 'very embarrassing and would be unacceptable' or 'fairly embarrassing but would be acceptable with difficulty'. Using a community meals service was associated with living in a rural location and having a lower income. It was seen as symbolising a loss of independence and presented a challenge to the identity of some older people.

There is clearly a need for the service to be 'normalised' and tailored in such a way that there is increased acceptability of it among potential service users, as the authors of *HeSSOP I* noted. We need further research to help work out how this can be achieved.

There is a need to consult existing and potential service users in planning and in evaluating services. As service recipients, they are best placed to report their reservations, needs and recommendations for the enhancement and development of a person-centered service. Consultation, however, is time-consuming and in some cases unrealistic for an already overstretched service. A solution may be to set up an independent system to assess user satisfaction and to perform a needs assessment with service recipients on a regular basis, to ensure that the service is most appropriate and to assess patterns of food wastage to determine popular or less popular choices. It may be useful to set up user groups to reflect on the service and to feed back suggestions and complaints.

Discussion: Good Practice and Barriers to Good Practice

Rapporteur: John Heuston

During the discussion that followed the presentations the following points were made:

Developing the meals-on-wheels service

The value of meals-on-wheels in supporting older people in their own homes – that it is, in fact, part of the continuum of care – was acknowledged. It was agreed, however, that there are many ways in which the service could be developed for the better.

It was noted that at present it is not a standardised service; there is a lack of information on where it is available and what sort of service is available, and there is huge variation in how it is staffed and run. It was noted that in some places volunteers prepare the meals while in others the staff of funded organisations including community hospitals prepare them.

It was acknowledged that this raises issues in relation to training, food hygiene standards and insurance, among others. It was noted, for example, that some volunteers, particularly older women, can find it difficult to accept the need for training in how to cook when they have given their time and effort to the service.

There was some concern about the impact of lack of training, in particular in relation to food hygiene issues. This was also linked, it was noted, to the issue of insurance cover and the danger of producing 'one wrong meal' and the implications of that for the service.

There was also a concern about whether volunteers have the skills to cater to clients' specific dietary needs. There was also a concern about the ability of service providers to prepare a range of meals that met special dietary needs (e.g., coeliacs) within their limited budgets. It was noted that there is a need to investigate service providers' views of what constitutes high quality meals. It was also noted that people are now much more aware of potential problems with food and may refuse to eat certain foods.

The issue of personal insurance for volunteers, in particular volunteer drivers, was also noted. It was agreed that there is a need to clarify what cover is available for volunteers who use their cars for delivering meals. An example was given of an 84-year-old volunteer who had an accident while delivering meals; her insurance company covered her but not her car, which had to be replaced.

The shortage of volunteers was noted, as was the fact that it is now 'the old who are providing meals for the old'. There was a fear that there would be an even greater shortage of volunteers in the future.

Identifying potential 'customers'

In addition to the variations in how the service is staffed and run, it was noted that there is also variation in terms of who makes the decision about who receives the service. There is the related issue of funding – funding the service as well as funding for those who are eligible to avail of the service.

It was recommended that a multi-agency approach was needed in order to standardise the service and develop it further. The need for a coordinated approach to improve the quality of the service was highlighted by several comments suggesting that a major issue at present in getting the service to the people who need it is a lack of communication between the HSE, staff on the ground (including the social worker, the GP and the Public Health Nurse) and the meals-on-wheels providers. It was noted, for example, that on a day-to-day basis providers do not always know how many people require a meal, and numbers can increase at short notice, leading to pressures on those preparing the food.

It was pointed out that it can be difficult for those in sheltered housing to avail of the service. It was noted that the NCAOP is currently conducting research into meals-on-wheels in collaboration with the Social Policy and Ageing Research Centre at Trinity College Dublin (TCD) as well as research on sheltered housing. The NCAOP is also involved in the HSE programmes Advancing the National Agenda.

Image and stigma

It was mentioned that some people, particularly older women, are reluctant to use the meals-on-wheels service because of the loss of independence that its use implies. The wider issue of the stigma around using meals-on-wheels was considered an important one to address. One participant said that in 2005 retirement groups in Galway city were consulted about this. The consultation revealed that the name 'meals-on-wheels' was where the stigma lay for many people. As a result of this finding, a decision was taken to change the name from 'meals-on-wheels' to 'community catering'. It was hoped that this would give the service a more positive image.

Gathering feedback

The importance of gathering information on the performance of the service was noted. This information could be used to develop the service further, it was suggested. It was acknowledged that older people rarely complain, mostly because they are grateful for what they get and fear that there may be negative repercussions. It was acknowledged that this should be taken into account in evaluating the service. One participant noted from experience that a residents' committee offered a safe environment in which to discuss preferences. Another noted that through observation at meal times it was possible to gather large amounts of useful information. For example, it was found through observation that round tables enabled greater interaction amongst the diners, that some older people were worried about etiquette at the table, that the atmosphere in a large hall could be improved by screening off sections of it, that noise (including the noise from radios) could be too loud, that often meals were rushed and that the smell of the cooking could be off-putting for some.

Government involvement

In terms of government involvement in the meals-on-wheels service, a participant commented on experiences of providers elsewhere in the EU. These providers had wanted government resources but found that receiving them led to an increase in bureaucracy – with the result that they now wanted government involvement to be kept to a minimum.

Conclusion

It was agreed that the workshop and discussion was very useful indeed. In particular, it served to highlight the diversity of users of the meals-on-wheels service, the different types of providers of the service, and the major barriers to be overcome in developing the service.

Workshop Three: Promoting Nutritional Standards for Older People in Long-Stay Care

Chair: Julie Ling, DoHC

Nutritional Status of Older People in Long-Stay Care

Speaker: Lisa Corbett, Community Nutritionist, HSE West

Introduction

In Ireland there is a growing population of older people. With an unbalanced diet, life expectancy decreases and morbidity (the incidence of illness or disease) increases. Between 80 to 100 per cent of patients in hospitals and institutions depend solely on the food provided to them for their nutritional support. The aim of our research study was to gather data on the nutritional status of older people in long-stay care to help develop a community nutrition and dietetic service for older people.

We took a sample of 12 per cent of the total population of residents from the six Western Health Board (as it was then) community nursing units (CNUs). This gave us a total of 51 older people (22 of them were men and 29 were women; the average age was 79 years). We also interviewed the matron and the head chef from each of the six sites.

We designed separate questionnaires for each of the sample groups: one for the residents' sample, one for the matrons' sample and one for the chefs' sample. These were based on the Davies and Holdsworth (1979) A-Z of assessing nutritional 'at risk' factors in residential homes for older people. We also designed a Davies and Holdsworth questionnaire to collect and record general observations.

In addition, we used the Mini Nutritional Assessment (MNA) tool to assess the nutritional status of the sample of residents. It includes 'screening' questions, for example: 'Has food intake declined over the last three months due to loss of appetite, digestive problems, chewing or swallowing difficulties?' It also includes 'assessment' questions, for example: 'How many full meals does the patient eat daily?' Each answer is assigned a score and the assessment and screening scores are added together to give a total assessment score (a maximum total score is thirty points). This total assessment score is interpreted according to a malnutrition indicator score, where less than 17 points indicates that the person is malnourished and 17 to 23.5 indicates that the person is at risk of malnutrition.

Findings

According to the MNA scale, we found that around half the sample of 51 residents were well nourished and around twenty of them (about 40 per cent) were at risk of malnourishment. Around five of them (around 10 per cent) were malnourished according to the MNA scale; however, 18 out of 51 viewed themselves as malnourished.

We found that 28 out of 51 had a BMI of more than 25 while four out of the 51 had a BMI of less than 19.

In terms of food consumption, 42 out of the 51 residents ate three full meals a day, 47 of the 51 consumed at least one serving of dairy products a day, 32 out of 51 consumed at least two servings of fruit and vegetables a day and 20 out of 51 drank less than five cups of fluid a day.

Most residents (31 out of 51) said that the portions of food they received were 'just the right amount'. Five residents said that there was sometimes not enough to eat and one resident said that there was often not enough to eat. At the other end of the scale, one resident said that often there was too much to eat; and 13 said that sometimes there was too much to eat.

Residents offered suggestions for what they would like to eat. These included the following:

- home-made bread
- cheese
- fresh fruit
- yoghurts
- boiled eggs
- beans
- chips, jacket potatoes
- a greater variety of vegetables
- a greater variety of fish
- meat: ribs, sausages, rashers, mincemeat, chops, roast mutton, roast pork
- desserts: apple tart, ice cream, jelly, tapioca, rice pudding
- sweets, cakes, buns.

In terms of availability of snacks, two units said they did not provide them, two said they provided them if the residents asked and two said they left snacks out for residents to choose.

We found that half the matrons and most of the chefs did not have access to the services of a dietitian. Only one of the units used the recommended three-weekly menu cycle. All units used nutritional supplementary drinks but only one administered these on a prescribed basis. In two of the six units we found that the residents were never weighed.

Conclusions

The research shows that there is a demand for a dietetic service for older people, and an unmet need that must be addressed in this region. Assessing the nutritional status of older people is essential. The views of both staff and residents need to be considered if we are to develop an appropriate nutrition and dietetic service. Nutrition should be considered in the holistic health-promoting environment of every long-stay institution.

There is a need to train staff in long-stay care homes and an overwhelming need for the nutrition and dietetic service to advise and assist with menu planning, appropriate prescribing of nutritional supplements and weight management of residents (since the research was conducted, all CNUs have received chair scales).

Going forward

A Food and Nutrition Policy pilot project has begun in a CNU in Roscommon that has around 150 residents. The aim is to develop a system to provide nutritionally balanced food for older people. It is the responsibility of all staff to provide the appropriate food for each patient. For example, staff involved should include the director of nursing, the clinical nurse manager, staff nurses, chefs and cooks, care assistants and, if available, speech and language therapists and occupational therapists.

The education sessions run as part of the pilot will include the following:

- menu planning

- therapeutic and modified consistency diets
- developing a food and nutrition policy
- minimum standards for improving the nutritional status of older people that address the following: unhurried meal times, three meals – at least one hot meal, meals at intervals of not more than five hours, the interval between evening snack and breakfast not more than 12 hours, snacks available at all times and offered regularly, modified diets to be attractive and appealing, staff ready to offer assistance with eating where necessary
- nutrition awareness days for staff on cholesterol, blood pressure, BMI, waist circumference and healthy eating advice.

As the comedienne Lucille Ball once said, 'The secret of staying young is to live honestly, eat slowly and lie about your age'.

Adaptation and Use of the Malnutrition Universal Screening Tool (MUST) in St Mary's Hospital, Dublin

Mary Stafford, Dietitian Manager, St Mary's Hospital, Dublin

Introduction

Malnutrition is underrecognised and undertreated. Nutritional intervention is proven to improve outcomes. Any healthcare worker can use the Malnutrition Universal Screening Tool (MUST). It enables appropriate early intervention and continued monitoring and can be used in all adult care settings.

As Florence Nightingale said in 1859, 'It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort.'

A recent report by the Royal College of Physicians (2002) highlighted the need for nutritional screening and care as a regular and integral part of clinical practice. My aim in this short paper is to show you how these requirements can be met by using MUST.

The benefits of MUST

MUST helps the user to identify adults who are undernourished and those who are obese. It allows comparable nutritional screening across different healthcare settings and by different healthcare workers. In others words, it is a valid, reliable and practical method of nutritional screening. This is important especially when patients move in and out of hospital or from speciality to speciality: use of MUST ensures consistency of approach and thus can be used to support the care plans set up for each individual.

It is an extension and adaptation of the Malnutrition Advisory Group (MAG) community screening tool which has been in use since 2000. It was developed, validated and tested by a multidisciplinary team across care settings and within the wider community. So we know that it is user-friendly and suits the needs of a diverse range of healthcare professionals.

Using MUST

It is not a complex tool to use. It consists of five simple steps: in steps one to three, the user takes three measurements – BMI, weight loss and acute disease effect – and scores them against the scale provided. In step four the scores are added together to identify the overall risk of malnutrition. In step five an appropriate care plan is formed in line with local policy.

MUST and BMI

BMI is a measure that not only establishes current weight status but is also a key indicator of protein-energy status. It can be a simple, objective and reproducible measurement that uses height and weight. Height and weight, however, can be difficult to measure in the older person. For example, an older person's weight measurement can be inaccurate due to constipation, cardiac oedema or renal failure; height can be difficult to measure if the person has osteoporosis. In the event that BMI is unavailable, alternative measurements can be taken. These include ulna length, demi span, knee height and mid-upper arm circumference (MUAC). The MUAC has proved reliable in the older female population. A MUAC of 23.5cms is equivalent to a BMI of 20kg/m². I turned this into an equation for dietitians to work with:

$$\frac{20 \times \text{MUAC in cms}}{23.5} = \text{BMI}$$

23.5

To measure the MUAC, the subject's left arm should be bent to a 90° angle with the upper arm held parallel to the body. Measure the distance between the bony protrusion on the shoulder and the point of the elbow. Mark the midpoint. Ask the subject to let the arm hang loose and measure around the upper arm at the midpoint. Make sure the tape is snug but not tight.

Step one: BMI measurement and scoring

If MUAC is 23.5cm, BMI is likely to be 20kg/m ²	Score 0
If MUAC is 20 to 23cm, BMI is likely to be 18.5 to 20kg/m ²	Score 1
If MUAC is less than 19.5cm, BMI is likely to be less than 18kg/m ²	Score 2
If MUAC is 30cm or more, BMI is likely to be greater than 25kg/m ²	Score 2

Step two: weight loss score

Unintentional weight loss:

The resident has no history of weight loss Score 0

The resident has known weight loss:

Women – 2kg (4½lbs) per month Score 1

Men – 3kg (6½lbs) per month

Women more than 3kg (6½lbs) per month Score 2

Men more than 4kgs (9lbs) per month

Or

If the resident appears to have lost weight:

Clothes and/or jewellery have become loose Score 1

Clothes and/or jewellery have become very loose Score 2

Step three (a): acute disease effect score

If the resident is acutely ill and/or has eaten less than 25 per cent of the food presented for more than five days Score 2

This score applies only to those residents who have had or are likely to have no nutritional intake for more than five days. If this is the case, give them a score of 2. They will automatically be at high risk, regardless of BMI or weight loss.

Step three (b)

If the patient's medical condition results in:

- malabsorption (e.g. coeliac condition, Crohn's disease, diarrhoea and so on)
- raised energy needs (wounds, dementia and so on)
- modified-texture diets, enteral feeding
- newly diagnosed diabetic.

Step four

Add the scores from steps one, two and three

Step five

Score 0 No risk

Score 1-3 Medium risk

Action → Initiate eating and drinking care plan

Score 4 or more High risk

Action → Refer to a dietitian

All high-risk residents must be referred to the dietitian who will treat him/her until they have returned to medium risk.

Conclusion

Malnutrition has a major impact on the person and on the healthcare system yet it is underrecognised and undertreated. Nutritional screening recommendations are integral to many of the UK NHS policies and guidelines. Evidence supports nutritional intervention for functional improvements, clinical and financial benefits. MUST is a validated screening tool that is simple and easy to use. It should help us achieve our main aim, which is to identify those at risk and take the appropriate action.

Discussion: Good Practice and Barriers to Good Practice

Rapporteur: Kate O'Connor

The discussion that followed the presentations covered the following points:

Approaches

It was agreed that approaches to nutrition in residential care should take a person-centered approach.

It was agreed that nutritional interventions should be multi-disciplinary.

It was agreed that practical difficulties with nutritional screening must be overcome. To this end, it was suggested that one screening tool^{4,5} be chosen and standardised for national use. This would have many benefits, including increasing the sustainability of nutritional screening. It was suggested that each person be screened on admission to a residential unit and at regular intervals throughout their stay.

It was noted that the Essence of Care (EoC) benchmark on nutrition was found to be effective.

Training

It was agreed that training is essential if best practice is to be achieved. Training should be provided to all staff (regardless of grade) involved in the care of older people. It was suggested that training should cover the importance of nutrition, the effects of a varied diet, preparation of nutritionally suitable meals, the social aspects of food, and so on. It was suggested that training and education resources be developed in order to bring about greater understanding of the issues.

⁴ The MUST tool, described in the workshop presentation, is a modified version of the validated MAG BAPEN MUST tool which is used in the UK.

⁵ BMI measurement was queried during the workshop. Standard guidelines for using BMI are available from the WHO.

It was suggested that the word 'feeding' be replaced with the term 'assisting people to eat'. It was noted that helping people to eat is a skill and should be acknowledged as such.

Resources

Lack of resources was identified as a major barrier to bringing about change.

Resources were defined and discussed in a variety of ways including:

- money – one participant said that in a residential care unit in which she had worked there was a budget of 80 cent per resident per day for all foods, snacks and beverages
- time – time for staff to help residents to eat, time to train and be trained and time to conduct nutritional screening
- access to services – lack of adequate access to the services of a dietitian, a dentist (oral hygiene and mouth care are significant factors in the nutrition of older people) and a geriatrician.

Quality and choice

It was suggested that the food served to residents should be of a standard acceptable to the manager and staff of the facility.

It was suggested that menus should be changed on a three-week rotation basis.

Non-local food production is seen as a barrier to effective delivery of nutritious meals. When contracts are awarded to food suppliers through central administration it establishes complicated lines of communication and thus makes it more difficult to change menus or respond effectively to residents' needs. It was also noted that producing food on site can be a more homely and a more nutritionally sound way of doing things.

It was agreed that even small changes to the eating environment can have a significant effect on a person's ability to eat. It was agreed that it is important to pay attention to when, where and how residents eat. Consultation with people about their preferences is important, as is being able to offer choice. The importance of presentation should be recognised – for example, cook/chill meals, which many

residential units use, can appear 'institutional-looking'; liquidised food, which some residents need, can appear off-putting.

Timing of meals is important. It was noted that residents in some care settings are served their last meal of the day at five or six o'clock and may not receive anything else until breakfast at seven the next morning (which is outside the 12-hour maximum recommended). Drinks and snacks should be available to residents at a time of their choosing, just as they would be at home. These drinks and snacks should be healthy drinks and snacks, thus making the healthy choice the easier choice (smoothies were suggested as a good option).

Those residents who have 'high alert' nutrition needs should be identified to staff. This might be done, for example, by using coloured trays or napkins.

Feedback and input

Mechanisms need to be set up so that older people's views and opinions can be heard and their choices addressed. This was noted to be of particular importance to residents who cannot speak for themselves, for example those suffering from dementia or dysphasias. It was agreed that there is a need for patient advocacy groups in this regard. Another approach suggested was to observe each new resident's eating habits for three days to find out what their likes and dislikes are.

Medication

It was suggested that the effect of medication on eating and nutrition needs to be examined further. It was noted that some medications, for example, have an anorexic effect, reducing the user's appetite. While they may be necessary for managing a person's condition, it was suggested that their use should be considered in the context of the person's overall quality of life. It was agreed that medication (and its effects) needs to be reviewed on a regular basis.

Conclusion

It was agreed that small changes – in what food is served, how it is served, when it is served and so on – can make a big difference. It was agreed a national, standardised approach to nutrition and nutritional screening should be developed and

implemented in residential care units. It was agreed that to do this – and to implement all of the suggestions and recommendations noted above – would require increased resources.

Workshop Four: Nutritional Training and Multi-Disciplinary Actions in Long-Stay Care

***Chair: Caroline Connelly, Practice Development Facilitator, Irish Nursing
Homes Organisation***

Undernutrition in Residential Care: Multi-Disciplinary Nutrition Teams in a Residential Care Setting

Speaker: Pauline Dunne, Community Dietitian, HSE Dublin Mid-Leinster

Introduction

The National Diet and Nutrition Survey carried out in the UK on the over-65 age group found that one in six residents of residential homes were malnourished (16 per cent of men and 15 per cent of women). This compared with 3 per cent of men and 6 per cent of women of similar age living at home in the community.

The Council of Europe 2002 document, *Nutrition in Institutional Care*, identifies five common barriers in Europe:

- lack of clearly defined responsibilities in planning and managing nutritional care
- lack of sufficient education (nutrition) for all staff groups
- lack of influence and knowledge of the patients/residents
- lack of cooperation between different staff groups
- lack of involvement from management.

It recommended that an organisational framework for food and nutrition in hospitals be developed along the following lines:

- to establish food and nutrition as a management issue
- to conduct nutrition screening and assessment
- to provide nutritional support
- to set up nutrition teams
- to provide education and training
- to develop and implement policies and standards of care.

Our project

We have established nutrition teams in nine long-stay residential care sites for older people in four counties of the HSE Dublin Mid-Leinster area (Longford, Westmeath, Laois, Offaly). We started in 2001 and phased this roll-out over a three-year period.

Team members include the following:

- chairperson: community dietitian
- director of nursing
- nursing staff
- catering staff
- catering project manager
- care assistants/attendants
- speech and language therapy
- occupational therapy
- day care staff.

We aim to do the following:

- to increase awareness and understanding of the role of nutrition for the older person
- to focus on food
- to improve and standardise nutrition and feeding practices for the older person
- to develop and implement nutrition policies for care of the older person.

Our roll-out plan was made of five steps. In step one we collected baseline data and set aims and objectives for each site. At step two we set up screening and assessment and examined menus including modified-texture foods, snacks and suppers. At step three we looked at meal ordering systems, meal times and feeding practice. At step four we set up training programmes and began the policy development process. At step five we conducted evaluations and an audit.

In step one at the ward level we conducted satisfaction surveys among staff and residents. We looked at laxative use and recorded a baseline figure of total orders over a six-month period. We did the same for oral nutritional supplement use. We examined organisation at mealtimes including 'hands on' assistance, staff allocation and staff breaks. In terms of 'feeding' practice, we looked at the use of appropriate utensils, eating positions and time allocation. We recorded the times at which main meals, snacks, suppers and drink rounds were served.

At the catering level, we conducted a menu analysis including nutritional content, available choice, therapeutic diets and modified-texture diets. We also looked at the presentation of meals, including modified-texture meals, and we looked at portion

sizes. In terms of meal ordering systems, we looked at the structure of communication between wards and catering.

Findings

Our first impressions from this data gathering were that nutrition was low on the agenda. We found that staff had a poor attitude to nutrition, summed up by the statement, 'It's not my job'. There appeared to be a lack of structure and no system.

We found that barriers to good nutrition included the following:

- poor awareness and understanding amongst staff
- failure to identify residents at risk of malnutrition
- inadequate menus
- poor provision for modified-texture diets
- poor communication structures
- poor standard of feeding practices
- little attention to dining environment and presentation of meals.

In steps two to five of our process at ward level we looked at on-site training/education for the following topics:

- dysphasia, malnutrition, screening and assessment, therapeutic diets
- nutrition for dementia programme
- management of percutaneous endoscopic gastrostomy patients.

We introduced a nutrition screening and assessment tool, the MNA. We devised a structured system of referring residents to the community dietitian. We set up improved communication structures including a meal ordering sheet and a process of continuous feedback between catering and the ward. We set up regular monitoring of food intake with the use of food diaries and documentation in care plans. We encouraged a 'little and often' approach with in-between meal snacks and supper menus. We created nutrition resource packs.

At the catering level we provided training for cooks including training on nutritionally adequate recipes, food fortification techniques and standardised therapeutic diets and modified-texture diets. We introduced standardised menus using the three-week menu cycle and incorporating modified-textured diets. We provided appropriate snacks and evening supper. We introduced the nutrition resource pack.

Outcomes

In terms of outcomes, we now have standardised practice with the development of regional policies. We have improved nutrition awareness amongst staff. We are able to identify early on residents at risk of malnutrition. We have improved nutrient intake (by an average of 881 kilocalories a day). We have shifted our focus to food. We have set out and defined staff roles and responsibilities.

Further developments

At the local level there are several projects being developed by staff including a fluids awareness programme and a fibre project.

We have developed regional policies including those on nutritional screening and assessment, the use of oral nutritional supplements, meal provision for the older person, management of constipation and management of enteral tube feeding.

Our next steps will be to evaluate the baseline data and write up the findings for the period 2005 to 2006. We also plan to do annual audits of policies. We plan to run the EoC nutrition benchmarking at a pilot site. We are setting up person-centred care projects at two pilot sites.

Conclusion

We have found that nutrition teams are an effective forum for highlighting nutrition-related issues. We have managed to raise the profile of nutrition and staff are now empowered to make appropriate decisions on residents' nutritional status. We have improved the communication links between ward staff and catering, and between management and staff.

Essence of Care: Food and Nutrition Benchmark

Speakers: Mary Barron and Anne Jones, RGNs, New Houghton Hospital, Wexford

The health system must become more person-centred with the interests of the public, patients and clients being given greater prominence and influence in decision making at all levels.

Quality and Fairness – A Health System for You, DoHC, 2001

Introduction

EoC is a set of patient-focused benchmarks for clinical governance. It lists ten areas under the nutrition benchmark:

- screening and assessment to identify patients'/clients' nutritional needs
- planning, implementation and evaluation of care for those patients who required a nutritional assessment
- a conducive environment (acceptable sights, smells and sounds)
- assistance to eat and drink
- obtaining food
- food provided
- food availability
- food presentation
- monitoring
- eating to promote health.

To work towards this EoC benchmark for nutrition involves five stages:

- stage one: agree best practice
- stage two: assess clinical area against best practice
- stage three: produce and implement plan to achieve best practice
- stage four: review achievement towards best practice
- stage five: disseminate improvements or review action plans.

We look at how we approached each of these in more detail below.

Stage one: agree best practice

To agree best practice we needed to understand patients' values and preferences and understand the views of staff. To gather the data needed we conducted a series of initial patient interviews, recording likes and dislikes and reviewing the menu. We found, for example, that patients wanted less fish, more bacon and cabbage, new meals such as beef stew, and savoury 'soft' diets for tea. In gathering staff views we met the dietitian, catering staff and all relevant health care personnel.

Stage two: assess clinical area against best practice

To do this we used the staff and patient satisfaction surveys and the EoC audit tool, which helps identify where current practice lies on the continuum between poor and best practice. We recorded these baseline audit scores in April 2005.

These gave us an indication of the level of quality of service. On none of the ten benchmark measures did we record 100 per cent scores. On three measures – screening, care planning and promoting healthy eating – the scores were zero.

Stage three: produce and implement plan to achieve best practice

We set out to improve communication and planning. We set up charts in the wards for those requiring supplementary diet and drinks and for those needing special diets. We conducted nutritional assessments on all current in-patients using MUST. Those whom we found to be at low risk we assigned to routine care with repeat screening every two months; those at medium risk we supervised and encouraged at mealtimes; those at high risk we referred to a dietitian (unless this would be detrimental or if there was no benefit to be had from nutrition intervention, for example, the imminent death of the patient).

Other developments at this stage included in-service education for all staff; the provision of drinks tray in day rooms; the use of supplementary drinks rounds; the provision of fresh fruit; the use of diet charts in the kitchen; and the use of special diets manuals in the wards and in the kitchen.

Stage four: review achievement towards best practice

At this stage (April 2006) we conducted an interim audit. We found that patient satisfaction was widespread – all 15 of those surveyed said they were satisfied with the friendliness of staff, the wholesomeness of food, the taste of the food and the overall variety of it. In terms of the variety of snacks and the times of meals and snacks, we found that there was room for improvement.

We found that staff satisfaction among the 13 people surveyed was reasonable but not as widespread as that of the patients.

A comparison of the baseline audit scores and the review audit scores shows that improvements have been made, particularly in relation to screening, care planning, conducive environment, obtaining food and promoting healthy eating.

Stage five: disseminate improvements or review action plans

To achieve this we are providing ongoing training for staff. We have set a list of target factors to be addressed. These are as follows:

- bowel health
- swallowing assessments
- variety of puréed meals
- repeat menu analysis
- repeat satisfaction surveys (early 2007)
- review timing of meals.

We are currently sharing the EoC nutrition benchmark and the indicators of best practice with regional sister hospitals.

Discussion: Good Practice and Barriers to Good Practice

Rapporteur: Lean O'Flaherty

The following points were raised during the discussion:

Guidelines and policies

It was noted that while nutritional assessment is extremely important there is no national policy nor are there national guidelines for nutrition standards for long-stay care settings in Ireland. A set of national minimum standards have been produced in the UK. It was suggested that these be used as a resource.

It was agreed that it is important to use a nutritional screening tool that has been validated and that is appropriate to the person and the setting.

Nutrition teams

It was reported that setting up a nutrition team in advance of embarking on the nutrition part of EoC benchmarking process was very useful. It was recommended that the team include staff from all disciplines (including those who deliver the food and those who serve it, as well as nurses, therapists and other medical staff) as well as residents and their relatives, carers and/or other representatives. It was noted that input from patient action groups and from catering staff is vital. It was noted that sharing the results of the nutritional screening with relatives can be useful, especially when explaining why, for example, certain supplements were given.

It was noted that in rolling out the use of nutrition teams and the EoC benchmark, there were many challenges including:

- the need to train all staff involved with helping residents eat
- the need to make all staff aware of the relevant guidelines and policies and how these came about
- the need to raise awareness among staff about nutritional issues
- the need to allow staff to air their concerns and to address these concerns
- the timing of meals
- the need to change staff work schedules and routines to suit new mealtimes

- the need to ensure that there is 'protected time' to enable staff to carry out their food-related duties
- the need to ensure that there are enough staff on duty to help clients at mealtimes
- the need to encourage family members to visit and to help out at mealtimes.

Many of these issues, it was noted, were related to the culture of the institution and the attitudes of the staff. It was agreed that there was a need to change both behaviour (including custom and practice routines) and attitudes if nutrition issues were to be addressed effectively.

Meeting clients' needs

It was acknowledged that the times of meals in a hospital or other residential setting are for the most part different from what people are used to in their own homes. This can be problematic for newly admitted clients, especially when they do not have access to snacks and drinks when they would like them, and when there is a long gap between the serving of the last meal of the day and the first meal of the following day (supper is not always provided.)

There were some suggestions for addressing this:

- change meal times
- provide drinks trays and fruit in day rooms throughout the day
- provide an evening supper.

It was noted that there is often a lack of communication between those working in catering units and those working on the ward. This inevitably leads to a failure to pass on/take action in relation to patients' likes and dislikes.

The challenge of promoting client independence in relation to food was raised. In response to this, it was noted that clients could be helped to enjoy food more through simple measures, including improving the taste, smell and appearance of the food and by changing the crockery on which it is served.

It was noted that the ability to provide a suitable meal for a patient on a modified diet is an issue. It was reported that what tends to happen is that the patient gets the same meal twice a day and/or the same pudding every day, or a pudding in place of

an evening meal. In other words, the ability to offer variety is a problem, and there appears to be difficulty in preparing and/or sourcing puréed meals.

It was acknowledged that lack of access to dietetic services is a problem, for all types of settings but in particular for private nursing homes. It was acknowledged that this lack of access should not prevent private nursing homes setting up nutritional teams of their own in order to address the issues. It was noted that there are some dietitians working in private practice; they can be reached through the Irish Nutrition and Dietetic Institute.

Medication

The timing of medication rounds in relation to mealtimes was raised. It was clear that different practices are in place throughout the country and that there is no clear policy or set of guidelines in relation to this.

It was pointed out that a drawback of the EoC nutrition model is that it does not specifically cover issues such as the effect of medication on nutrition, or the effect of a disease or condition such as diabetes. It was suggested that these sorts of issues are priorities for different units within a hospital or residential care setting and that the EoC benchmarks are best used as an overall framework to be built on.

Final Session

Overcoming the Barriers – Policy and Practice Priorities for the Future

Chair: Ursula O'Dwyer, National Nutrition Policy Advisor, DoHC

Panel Discussion: Moving Forward

Speaker: Sheena Rafferty, Dietitian Manager, HSE Dublin North East

I would like to give you some background to my experience and to talk briefly about how the issue of nutrition and older people has moved on over the years.

When I took my job as nutrition advisor for older people in St Mary's Hospital, Dublin, in 1995 I was covering the whole of the Eastern Health Board region as it was then with 11 residential units and 2,000 beds and ten community care areas. We have come a long way since then. We have more staff but the task is just as daunting. For example, I was dismayed to find that older people were not to be included in the sample for a national nutrition survey. We heard from Dr Clare Corish that this work is only being done now. So I suggested to the FSAI that it was important that we develop a policy for older people and nutrition. They commissioned me to develop the policy, which was published in report form in 2000. The report presents an overview with recommendations for a food and nutrition policy for older people.

In developing the policy we encountered a lot of the same barriers that have been noted in the workshop discussions. There was a lack of scientific information on what community-dwelling older people were eating and what older people in residential settings were eating. We now have some information on that but there is still a need for more scientific evidence.

So what is happening now? It is important to acknowledge that nutrition in older people is a complex topic. Older people are a diverse group with different sets of nutritional needs. This means that there can be different barriers to be overcome in providing for the needs of older people from different backgrounds, living in different settings with different health status.

Providing effective nutrition can be challenging. There are so many people involved in the process that it can fall down at any point. To effect a change – to improve the nutrition quality of a meal, for example – although it is a relatively small thing, can involve many people.

From a residential care point of view, I think it is a good idea to get to know your purchasing officer and your catering officer. They are two key people who can help you effect change.

Following the publication of the FSAI report in 2000, the DoHC in 2005 published healthy catering guidelines for staff and visitors in health care facilities. Guidelines on preventing undernutrition in acute hospitals are due to be published soon. We are hoping that guidelines for food and nutrition in long-stay care facilities will follow; a set of national standards would be very useful in effecting change at a local level.

It is important to bear in mind that, as Dr Margaret Lumbers noted in her paper, there is no single thing that makes older people satisfied with their 'food life'; rather it is lots of little things. It is these little things that we need to change and that we can change: the crockery, the way the food is presented, the dining room and so on. It is these things that can make a huge difference. We have the scientific evidence to say that if you improve nutritional intake in older people it will improve clinical outcome. So there can be no argument that it is worth doing something about.

Dr Dermot Power, Consultant Geriatrician, Mater Misericordiae and St Mary's Hospitals, Dublin

I work in the Mater Hospital where I am on the general rota and at St Mary's where I work in residential and sub-acute medicine; it gives me an interesting perspective on things.

A bugbear of mine is the issue of medications and the fact that they are often not reviewed. There is a frightening statistic: among those aged 75 and over, 5 to 25 per cent of all admissions to general hospitals are either caused by or the admission is facilitated by the medications that the person is on. These are not medication errors – the person had been given these medications for the right reasons but they are probably not being monitored correctly or they are not being reviewed adequately. Drugs can affect weight and nutrition in many ways; they can diminish the amount of food you take in because they switch off your appetite (for example, antidepressants, particularly the SSRI family of drugs which includes Prozac and Cypramil); they might diminish or cause malabsorption of certain foods (for example the proton pump

and medication for excess acid) or they can increase your energy expenditure (for example Eltroxin, the SSRI antidepressants).

I am not advocating that we stop giving drugs to older people – I do think that there needs to be a general review undertaken on a regular basis, however. In particular, we should review the medications of those in residential settings.

With medications it is important to remember that what is right for you today may not be right for you next year – your priorities may have changed. It may be that you are not trying to prevent the next stroke but you may be trying to ensure that your last couple of months of life are an enjoyable couple of months.

In St Mary's we looked at a couple of aspects of nutritional status in our older patients. We did an assessment of a group of patients at admission and at three months into their stay. We found that quite a number were malnourished or underweight on admission; three months later things had improved – from half of them being malnourished to only a third of them being malnourished. We congratulated ourselves but when we looked at their level of function we had disabled them by putting on weight. What we had essentially done was made them fat and less able to get up and walk around. We need to look in a multi-disciplinary way at what we are doing with nutrition in older people – we should not just focus on getting their weight right; simple targets like that are often inappropriate and may actually be detrimental to the patient. The second thing that was illustrated was that there needs to be a scientific approach because an awful lot of what we are doing is anecdotal.

It has been clear from today that there are what you could call islands of expertise all around the country and they are dispersed nationally and often don't talk to each other apart from at a forum like this. I think there is a need to join up. I heard about coloured tray systems being used in some places to signal that a patient has certain needs; we use a little tag at the top of the bed to tell if a patient needs assistance with eating because we have a lot of agency nursing staff who don't know the patients and so a little green tag means they need assistance eating.

Dr Margaret Lumbers, Food in Later Life Project Coordinator

It is interesting that from a marketing point of view older people represent the only market segment that is growing; they also have the highest disposable income. For manufacturers, retailers and service providers they are potential new customers whose needs are likely to be quite different from our current cohort of older people.

In many western countries our retired people do not see themselves as old: chronological age is not very useful in many respects – we tend to think of ourselves as being at least ten years younger than we actually are. It is also interesting to note that mobility and disability have been compressed into quite a short period, which is preceded in retirement by quite a long and active period of life. When we were trying to recruit participants for our study we found it quite hard to find slots available in their busy social diaries. So younger older people and some older older people are doing lots in life and have much to offer to the volunteer sector and as mentors.

Another point to note is that older people's psychological status can sometimes be judged on their physical appearance. Often when older people experience disability and decline in a social context they experience the loss of social status. I talked about some of this in relation to meals; women, during their married life, for example, have often been giving meals as a gift almost and that to lose that represents quite a loss to them. So there may be opportunities within the care sector for enabling them to be more empowered, to continue those roles rather than to become dependent.

Also, when someone gets a diagnosis of illness such as diabetes or high blood cholesterol, we found in our study that it led people to prefacing every discussion they had with 'I can't eat ...'. That can be difficult because it means that they have to drop familiar routines of eating and sometimes finding new food is not that easy.

I think that successful ageing is a cultural norm that includes healthy and active life in a consumer culture and becoming old and becoming ill do not belong in this context. Older people pay greater attention to staying healthy and independent. Our study helps to draw attention to the fact that there are barriers to food procurement and preparation which can be removed. What we have found should be of use to food service providers, food manufacturers and retailers. Dependence does mean a loss of full membership of society. Being advised to change long-term eating habits can

cause problems, mainly because finding new foods is not easy if your appetite is poor and that can lead to people becoming more vulnerable in terms of their eating situations and leads to undernutrition. We have to be careful about how we give advice. We have to think about it in the context of the person's eating habits, their social life and their living circumstance.

We know the importance of maintaining lean body tissue yet we found that many of our study participants got into the car to go to the supermarket, which means that there is a reduction in walking to local shops. The loss of local shops is an issue in the UK – there are no longer many specialist local shops compared to, for example, the number in Germany where many older people cycle to the local shops and markets.

In terms of food services, it is hard for older people to find out what can be provided if they have recently been discharged from hospital. We should make it easier for them to find out what is available, for example by displaying information in everyday settings such as the Post Office or GP surgery, pharmacy, health centre and local authority office; we should set up benchmarking against other community food provisions and we should look at the competition – the pubs and cafés and restaurants.

I think that it is important that we apply national guidelines and codes of practice. We found in our study that these were not being implemented. At the same time, however, we have to think about taste of food and enjoyment of food. I think the other thing we need to do is to be proactive and set up reflective user groups that can feed back suggestions and complaints about meals and even instigate competitions among users for best suggestions. I think we should look at the feasibility of day centres, for example, offering take-home meals and snacks on a routine basis and meals-on-wheels being an all-day approach rather than just a lunch or one meal.

Geraldine Hanna, Assistant Health Promotion Officer, Health Promotion Centre, HSE West

I think it is important from a health promotion perspective that we keep people at the centre of what we are doing. Very often the barriers that we need to overcome are the ones that we put up for ourselves.

It struck me that we talk about older people at home and we talk about older people in long-term care but for those older people long-term care is their home. If in our own homes we choose what we like to eat, we choose when we want to eat or we are consulted about it then we need to think about things in the same way for older people in long-term care.

The 1986 WHO Ottawa Charter was suggested as a stepping stone for developing policy. Over the years I have worked in various places to develop policies – in schools, in residential places for older people, in workplaces – and developing a policy is often a challenge. Implementing the policy is an even bigger challenge. It requires joined up thinking, joined up actions and it involves change. We have to be prepared to do all of that if we are going to overcome the barriers.

Creating supportive environments is important. I was delighted to hear that the social aspect of nutrition was acknowledged. I grew up in an environment where we sat together over food, we socialised around food, we comforted each other with food. We use food as a tool for so many issues in society. It was suggested in one of the workshops that drinks and snacks should be available on demand to those living in a residential care setting. Several years ago I worked with a boarding school principal on a healthy eating policy for the school. One of the things that he said to me was, 'Young people graze, that is how they eat. I want the policy to say that they can graze.' I thought, this is wonderful. It is difficult to provide food 24 hours a day – we have tidy systems that do not like to be flexible. It is a challenge: we need to think about whether we can be more responsive. There may still be limits – there are practical and other issues to face.

Strengthening community action is important. I work on part of a programme for revitalising areas of disadvantage. In the early days of the programme communities

were asked to identify what they would like to do in relation to different population groups. One of the things they decided that they wanted to do in the area in which I was working was to increase the meals-on-wheels service for older people within the community. The next questions were: what will we need and how do we do it? Somebody wondered whether anyone had asked the meals-on-wheels volunteers what would happen if we extended the service: if we extend it, will that increase the volunteers' workload? Can we get more volunteers? Have we got the facilities for those volunteers to work in?

So we need to plan ahead and think about what is involved and what resources are needed. We also need to think about the people involved. We need to develop personal skills; we need to provide people with information in a way that is appropriate and in a way that is useful for them.

Another issue that we need to address is preparing people for discharge from hospital. In a care setting, people get their medication handed to them. On discharge home they are asked to self-medicate. That can be a challenge. They need to have information, and in some cases they need to have the skills. We need to provide training and development at the different points of access.

It is important that we reorientate the health services. At present all of us within the HSE are experiencing change and reorientation is part of that change. It is complex and difficult. We need advocacy. We need to mobilise communities and groups so that they influence us to provide a service that is appropriate to their needs. We need to consult them and we need to listen. We need to listen and ask the questions and we need to listen to and hear the answers. We listen with our eyes as well as our ears and we need to do that in order to reorientate the health service.

Questions and Comments From the Floor

Q. I work in the private nursing home sector. I think it is important that we don't accept the fact that everybody working in the health service is the best person for the job. We need to create a culture in which staff members can tell us if things are not right. We then need to deal with it directly.

Q. I am a dietitian in Care for the Older Person. I am based in an acute hospital and I also go out to the district and community hospitals in our area. The main learning point for me is the importance of the need to bring in basic standards. MAG in the UK brought in very basic standards several years ago and we are maybe ten years behind trying to reach those. For example, simple things like weighing patients – we did an audit in our hospital and found that only 10 per cent of patients on admission were weighed. There are other things, such as people being asked on admission what are their likes and dislikes, that are very, very important for someone being admitted to residential care. Often when a person is admitted they might be able to tell you, 'I like bacon and cabbage. I dislike fish'. Six months later they might not be able to tell you that information.

Sheena Rafferty: It is very important that we have national standards. We hope that the DoHC will be developing them soon. In relation to meals-on-wheels, the issue of setting eligibility criteria was mentioned in one of the workshops. I would like to raise a word of caution on this. The meals-on-wheels service is a very valuable one within the community. It is important that Public Health Nurses, GPs, carers and relatives have access to some form of meals-on-wheels or day care for older people. Perhaps in drawing up eligibility criteria we might bear that in mind that there needs to be some flexibility – it would be better if someone who isn't strictly eligible nevertheless does get meals-on-wheels before they begin to slip into malnutrition.

Q. I was wondering if Geraldine could answer this: are you looking at developing standards of care for community care centres and residential homes? Is that going to be the role of the expert advisory group for older people or is there any sort of advisory capacity or policies of recommendations that that group is going to create?

Geraldine Hanna: First of all, can I just say that the expert advisory group has not yet had its first meeting so I can't answer that question. I think that there is

overwhelming agreement that we must have standards and we have to develop those standards. I think that will happen. It is important that all the stakeholders provide input into those standards so that when we reach the implementation stage we are not working backwards.

Sheena Rafferty: Could I check, Ursula, that guidelines for long-term residential care settings will be developed by the Department?

Ursula O'Dwyer: Yes. I work mainly with the Health Promotion Unit, which is now called the Health Promotion Policy Unit. Since I am the only dietitian within the Department I also work on other areas. When hospital food came up as an issue to be tackled I said that I did not think that is a health promotion issue, but actually it has been very good and very challenging. It has taken a long time, particularly to get out the latest guidelines which have been ready now for almost a year. These were the guidelines for preventing undernutrition in acute hospitals. We wanted to make sure that all the stakeholders were happy with what was put in it. It is a very detailed document and will address standards that can be used as a baseline for long-stay hospitals. That was to be the next stage so I think that will happen.

The catering guidelines for staff and visitors have been published. In order to motivate people and to encourage all health care facilities to put these into practice there is an award scheme. The criteria for that award scheme have been drawn up and were published in June 2006. The health promoting hospitals are rolling it out at present. We are hoping to publish the guidelines in relation to undernutrition in acute hospitals by the end of 2006. They have been modelled on a Council of Europe initiative. The document, which will be sixty or seventy pages long, will contain information on standards and on screening tools as well as information on some of the issues that have been raised here. In putting together the document we asked the Irish Nutrition and Dietetic Institute for their help and we involved catering managers as other key stakeholders.

I would like to point out that it is an opportune time to lobby government about these issues for two reasons: the Act is being reviewed and we are nearing a general election.

Q. I want to ask Dr Power how many consultant geriatricians are there in the country? We have a hospital of 170 beds in our community residential unit and we

have 15 hours a week medical input. I agree that medication review is so important. So I would just like to know how many of your colleagues are around.

Dr Dermot Power: There are about fifty geriatricians nationally now. What I have suggested in a communication to the HSE and DoHC is that they consider appointing community geriatricians whose principal focus is on older people in community settings rather than in a hospital setting. I think you still need some sessions within the acute hospital to facilitate admission and investigation where you discover a significant pathology. We have seen nothing in terms of appointments as yet but I am hopeful that we will see something.

Q. I would like to respond to Dr Margaret Lumbers on behalf of dietitians working in care of the older person and some of the people whom you may have met who are on restrictive diets. Our philosophy is that we try to provide the best quality of life and we will only restrict wherever necessary. Our emphasis would be on enjoyment of food and remembering to eat and, as you say, to try to facilitate shopping, preparation and cooking.

Dr Margaret Lumbers: I agree entirely. I think that some of our respondents didn't always get access to a dietitian so I think they were self-imposing their own health beliefs and imposing dietary restrictions which weren't necessarily reflective of dietetic input.

Q. Much has been said about meals-on-wheels but there are many parts of the country that do not have access to meals-on-wheels. We should mention the role of Home Helps and the restrictive budget that we have for Home Helps. For most of the patients that we discharge it would be very difficult to get a Home Help for even an hour a day for five days a week. It is very hard to cook and provide proper nutrition for any older person in one hour, never mind having to do housework or other tasks. I think that it is an area that needs to be looked into as well.

Geraldine Hanna: I would like to endorse that. I think that is really important. There is evidence to show that carers themselves are an ageing population. It is important that we look after the carer. I think it is really important in relation to nutrition that we give people the information so that they can make the best possible use of their position to enhance nutrition for older people. Time, money, resources and people

are factors. There are many determinants of health and access to good nutrition is one of them.

Q. Do you have any older people on any of your consultative committees and if not, why not?

Geraldine Hanna: From a health promotion point of view we include all stakeholders in the planning and development of anything we do. I think it has to be more than tokenism. I work from a community development approach. I have found that time is the biggest issue. Things take time and sometimes the deadlines and the goals that we work to are not always in harmony with the reality of where people are living and working.

Q. Most of us have time to give but we are not asked to.

Q. This is a question for Dr Power. I am a clinical nurse specialist in health and well-being in a residential nursing unit. We have done a lot of work in relation to medication. One of the nursing staff asked me to ask about supplementary folic acid – vitamin E. When I was training twenty years ago in St James's Hospital everybody in the elderly care units were automatically put on these. Now we review our medications regularly – every other week. What are your thoughts on that?

Dermot Power: I may be corrected by some of the dietitians but I will tell you my thoughts. I think in terms of the evidence base, calcium and vitamin D for all institutionalised older women is proven. It reduces falls and reduces fracture risk. For institutionalised older men it doesn't seem to be quite proven but I think where I work we supplement everybody with calcium and vitamin D. In terms of the other vitamin supplements, we tend to use Kiddy Pharmaton. It is reminiscent of an old-fashioned tonic. It is mainly a B vitamin supplement with vitamin D. There is no iron in it. We find that it is a good appetite stimulant and generally a good multivitamin. There have been trials of multivitamins – they don't have a negative impact but their work hasn't been proven. Someone mentioned aspirin. It is not a nutritional supplement but if you have good blood pressure control aspirin is a good worthwhile addition to anybody's prescription.

Female Speaker: On vitamin supplementation, the National Institute for Clinical Excellence (NICE) in the UK has recently published guidelines on ordinary nutrition.

It recommends that anyone whose diet is likely to be deficient or not complete should take a multivitamin that includes all the minerals and vitamins. Other examples that we would use would be Centrum 50+ and Sanatogen Gold. Anyone with a well-balanced diet should be fine without a general multivitamin.

Q. Would the panel or anyone who is dealing with dietetics and nutrition have any comment to make on the fact that there has been a depletion in the nutritive value of food in the last thirty to forty years?

Sheena Rafferty: I think that shows that some of the issues for older people are the same as the issues for the general population. There has been a change in food production, manufacturing and delivery over the last thirty to forty years. Change can come about through people lobbying at every level to question why we can't have our food produced in a different way. Consumers tend to vote with their feet. There has been an increase in marketing of foods with fewer additives. Once people buy them and the food companies see that, they will produce more of them. The big thing is to make sure that we have a choice.

Ursula O'Dwyer: There does have to be a balance somewhere between foods that are convenient and foods that are healthy. I think that is where we are probably losing some ground.

Dr Margaret Lumbers: The issue about having local supplies is becoming an important one. In Surrey, for example, we have a local food group where we try to bring together people with an interest in food across all sorts of agencies including consumer groups and trading standards. Sourcing food locally for schools and other public sector institutions may have some benefit.

Female Speaker: We recently set up a food partnership to enable people to have local access to food and to address food poverty. One of the things we have done is to set up a food bank in Dublin and one in the Mid-West to give access to food for those who are experiencing health inequalities. With the local food cooperative we want to encourage people to grow their own food.

Female Speaker: There is a very interesting initiative that has just recently come underway called Healthy Food for All. It is spearheaded by Combat Poverty Agency, St Vincent de Paul and Cross Care. They want to ensure that healthy food choices

are affordable, accessible and available to everybody in the community but particularly to those in areas of social need. In their budget submission they are looking for €10,000,000 next year to move forward on this issue around food for school meals and food right across the board for all age groups. I think that the whole area of food poverty is an area people are at the moment ready and willing to work on.

Olga McDaid: To pick up on Dr Power's point about sharing local information and knowledge, the NCAOP has a healthy ageing database and we would appreciate it if people could populate that database by adding to it their own locally based projects, including those presented at the conference. This should mean that the information can be shared and knowledge transferred more easily.

Ursula O'Dwyer: I would like to thank you all for your contributions and I would like to congratulate the NCAOP on what has been a very useful and very interesting conference. Unfortunately, Minister Sean Power, who was to close the conference, is unable to attend so I would like to invite Bob Carroll, director of the NCAOP, to draw proceedings to a close.

Closing Address

Bob Carroll, Director, NCAOP

I just want to say a few final words. The first is to assure you that the NCAOP does not see this conference as an end in itself. I think that is very important to say. It brings you together and helps in terms of the sharing and exchange of information and ideas in good practice with other motivated people. I think that that is very important.

We are working with the HSE and the Department and hope to commission a study on meals-on-wheels; we are supporting a study on oral health of older people which we hope will inform a strategy in that particular area, again very important to healthy ageing. I did note Dr Dermot Power's suggestion that the Council would continue to facilitate the exchange of good practice and we will closely reflect on today's deliberations to identify new priorities for this type of exchange. We have agreed today that doing a lot of little things can make a big difference. I have noted a number of big issues too which require attention; issues relating to resources, standards and training (on quality of care but also quality of life issues).

What we have been talking about today is very important to the quality of life of older people, no matter what settings they find themselves in.

Purchasing seems to be a major issue which we should be aware of – behind the scenes there are people who have this important role, important to the eventual nutrition and enjoyment of food for older people in care settings and in particular residential.

So I would like to thank everybody most sincerely for coming here today and for all your contributions. I would like to thank the contributors who prepared papers, we appreciate the work that went into these and recognise that we are the beneficiaries of that.

Thanks to the staff of the Tullamore Court Hotel for an excellent venue. Finally, thanks to the Council staff and particularly to Michelle, Samantha and Joanne for

organising the conference so expertly and also to Olga McDaid, our Healthy Ageing Programme Coordinator, the brains behind this particular conference.

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Terms of Reference

The NCAOP was established on 19 March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:
 - (a) measures to promote the health of older people
 - (b) measures to promote the social inclusion of older people
 - (c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health
 - (d) methods of ensuring coordination between public bodies at national and local level in the planning and provision of services for older people
 - (e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people
 - (f) meeting the needs of the most vulnerable older people;
 - (g) means of encouraging positive attitudes to life after 65 years and the
 - (h) means of encouraging greater participation by older people
 - (i) whatever action, based on research, is required to plan and develop services for older people.
2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:
 - (a) undertaking research on the lifestyle and the needs of older people in Ireland
 - (b) identifying and promoting models of good practice in the care of older people and service delivery to them
 - (c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people
 - (d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3. To promote the health, welfare and autonomy of older people.
4. To promote a better understanding of ageing and older people in Ireland.
5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

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