Collegian (2014) 21, 171—177

Available online at www.sciencedirect.com

SciVerse ScienceDirect

journal homepage: www.elsevier.com/locate/coll

'*Two dead frankfurts and a blob of sauce*': The serendipity of receiving nutrition and hydration in Australian residential aged care

Maree Anne Bernoth, PhD, MEd(AdultEd&Training)(HonsClass1), RN*, Elaine Dietsch, PhD, RN, RM, Carmel Davies, RN, RM, BA, MTH

Charles Sturt University, School of Nursing, Midwifery and Indigenous Health, Locked Bag 588, Wagga Wagga, NSW 2678, Australia

Received 17 April 2012; received in revised form 1 February 2013; accepted 11 February 2013

KEYWORDS
Nutrition;
Hydration;
Frail aged;
Elderly care;
Residential aged care

Summary
Background: This paper explores the serendipity of residents accessing adequate food and fluids in aged care facilities. It draws on the findings of two discrete but interrelated research projects conducted in 2009 and 2011 relating to the experience of living in, or having a friend or family member living in, residential aged care.
Methods: Participants were recruited through media outlets. Indepth interviews with participants were audiotaped, transcribed verbatim and thematically analysed.
Findings: This paper discusses a theme that was iterated by participants in both projects that is, the difficulty residents in aged care facilities experienced in receiving adequate and acceptable food and fluids. Unacceptable dining room experiences, poor quality food and excessive food hygiene regulations contributed to iatrogenic malnutrition and dehydration. Implications for staffing, clinical supervision, education of carers and the impact of negative attitudes to older people are discussed.
Conclusion: The inability of dependent residents in aged care facilities to receive adequate nourishment and hydration impacts on their health and their rights as a resident, and is an ongoing issue in Australian residential aged care.

Introduction

A theme related to nutrition and accessing adequate food and fluids emerged from the thematic data analyses of two research projects (Bernoth, 2009; Bernoth, Dietsch, & Davies, 2012) which explored access issues in relation to aged care services. In response to this finding, a literature search was conducted using EBSCOhost (Health) and CINAHL databases with the keywords aged care, nutrition, mealtimes, malnutrition, dehydration and starvation. Items published in the preceding decade were accessed.

Background literature revealed that the companionship of meal sharing enhances the nutritional status of older

* Corresponding author. Tel.: +61 269332492; fax: +61 269332866.
E-mail address: mabernoth@csu.edu.au (M.A. Bernoth).

1322-7696/$ — see front matter © 2013 Australian College of Nursing Ltd. Published by Elsevier Ltd.
http://dx.doi.org/10.1016/j.colegn.2013.02.001

people (Vesnaver & Keller, 2011). Furthermore, at a time when our current older Australian-born population was young, their diet was based on bread, dripping (fat left in a cooking utensil from frying meat), lamb and tea, with porridge for breakfast with the oats soaked overnight. Any frying was done with dripping from the dripping tin (adding exponentially to the fat consumed); there were slabs of bread and treacle or bread and dripping. The Sunday lunch was generally roast lamb followed by cold leftovers for most of the week. When visitors arrived it was scones with cream and homemade jam (Symons, 2007). During World War II, to reduce the impact of rationing, food was often grown in the backyard, eggs gathered from the fowl-yard and any excess was shared with neighbours, according to the *Australian Women's Weekly* of the time (8 April, 1944 as cited in Symons, 2007). Meals were prepared by women who stayed at home. The kitchen was the focal point of activity and the smell of food being prepared and cooked pervaded the home, stimulating appetites. Meals were eaten together, at a set time, around the table (Symons, 2007).

The outbreak of war in 1939 found Australia's food industry 'woefully unprepared' (Farrer, 2001, p. 246) with the outcome being that, during and for some time after the war, Australians experienced food rationing. They tolerated food restrictions to contribute to the war effort. However, the end of World War II brought with it new food experiences and diversity in the people populating Australia. This meant diversity in the type of food eaten and the means by which it was prepared (Symons, 2007). Increasing affluence and cultural diversity allowed Australians to be more adventurous and they took advantage of the new restaurants, broadening their culinary experiences. It was possible to eat away from the home in affordable restaurants. Coffee and wine consumption increased, oil replaced dripping, garlic and herbs and spices came into common use and terms like stir-fry and pasta became familiar. New migrant cuisines produced exciting dishes (Dyson, 2002). Those who lived this history are now in their seventies, eighties and nineties with some requiring residential aged care (RAC) (Australian Institute of Health and Welfare, 2007).

Food has meaning, memories and traditions and these become more significant to those in residential aged care. Mealtimes are one aspect of the day that residents should be able to anticipate. Chisholm, Jensen, and Field (2011) discuss the link between a pleasant milieu and optimal nutrition. It is important that residents, including those from culturally and linguistically diverse backgrounds, find comfort and familiarity in their traditional food culture (Miller, 2009). The question needs to be asked: to what extent are we respecting food preferences when older Australians enter residential aged care? Food preferences are significant (Miller, 2009) but enabling residents to access adequate nutrition and hydration to avoid malnutrition is of even greater significance.

The impact of malnutrition on the older person can have multiple consequences. Age related changes to muscle mass, mobility and circulation render the older person vulnerable to increased morbidity and mortality when they are malnourished (Koch, Hunter, & Nair, 2009). Malnutrition is a risk factor for pressure ulcers and associated pain (Dawson, Nelan, Pace, & Barone, 2012). Banks, Bauer, Graves, and Ash (2010) state that pressure ulcers in 33% of patients in acute hospitals in Queensland are caused by malnutrition, costing the health system more than $12 million dollars per annum. Inadequate nutrition results in prolonged healing and recovery times from acute illness and longer hospital stays (Koch et al., 2009) which then have a declining, spiral effect on functional capacity and quality of life.

The World Health Organization (1999) and the Australian government (National Centre for Classification in Health, 2008) utilise definitions of malnutrition focused on body mass index, unintentional loss of weight, subcutaneous fat and moderate muscle wasting. While there is no universally accepted definition of malnutrition, Elia (2000) argues that: '... [it is] a state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), function or clinical outcome'. This definition has been amended by a number of government instrumentalities (National Institute for Health & Clinical Excellence, 2006, p. 20; NSW Health, 2011, p. 2) and is particularly useful in the context of RAC services.

Gaskill et al. (2008) found that almost half (49.5%) of the residents in their study of south east Queensland RAC facilities were malnourished. Malnutrition screening tools, which can quickly identify the risk of malnutrition have been developed for residents in Australian aged care settings (Isenring, Bauer, Banks, & Gaskill, 2009). Even though policies and nutritional guidelines are written regarding nutrition, the implementation of these is problematic for many reasons including the skill mix of staff, time constraints and inadequate staffing (Merrell, Philpin, Warring, Hobby, & Gregory, 2012).

Methods

Research design and ethics approval

The purpose of the first research project informing this paper was to explore the perspectives of family and friends who have someone they love in residential aged care (Bernoth, 2009). The second project investigated the impact on family, friends and communities when the older person had to leave rural and remote communities to access aged care services (Bernoth et al., 2012). In both projects, the participants spoke of difficulties their loved ones experienced in accessing adequate food and fluids; receiving nourishment and hydration became a matter of chance rather than a basic human right. The accidental nature of receiving adequate food and fluids in residential aged care was perceived as serendipitous. The word serendipity has connotations of luck, chance and accidental discovery (Hannan, 2006) and best describes in this context access to acceptable and adequate nourishment and hydration in aged care facilities. This was the implicit theme revealed in the two research projects informing this paper (Bernoth, 2009; Bernoth et al., 2012).

Both projects were phenomenological in nature and were approved by the Charles Sturt University (CSU) Institutional Ethics Committee (2010/011 and 2010/034 respectively). Legal and ethical principles related to research with vulnerable populations were adhered to at all times, including referral of participants to statutory authorities such as the Complaints Investigation Scheme, when appropriate.