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ORIGINAL ARTICLE

Can trained volunteers make a difference at mealtimes for older people in hospital? A qualitative study of the views and experience of nurses, patients, relatives and volunteers in the Southampton Mealtime Assistance Study

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Background. Malnutrition is common amongst hospitalised older patients and associated with increased morbidity and mortality. Poor dietary intake results from factors including acute illness and cognitive impairment but additionally patients may have difficulty managing at mealtimes. Use of volunteers to help at mealtimes is rarely evaluated.

Objectives. To obtain multiple perspectives on nutritional care of older inpatients, acceptability of trained volunteers and identify important elements of their assistance.

Design. A qualitative study 1 year before and after introduction of volunteer mealtime assistants on one ward and parallel comparison with a control ward in a Medicine for Older People department at a UK university hospital.

Participants and methods. Semi-structured interviews and focus groups, in baseline and intervention years, with purposively sampled nursing staff at different levels of seniority; patients or close relatives; and volunteers.

Results. At baseline staff felt under pressure with insufficient people assisting at mealtimes. Introducing trained volunteers was perceived by staff and patients to improve quality of mealtime care by preparing patients for mealtimes, assisting patients who needed help, and releasing nursing time to assist dysphagic or drowsy patients. There was synergy with other initiatives, notably protected mealtimes. Interviews highlighted the perceived contribution of chronic poor appetite and changes in eating patterns to risk of malnutrition.

Conclusions. Improved quality of mealtime care attributed to volunteers' input has potential to enhance staff morale and patients'/relatives' confidence. A volunteer mealtime assistance scheme may work best when introduced in context of other changes reflecting commitment to improving nutrition.

Implications for practice. (i) A mealtime assistance scheme should incorporate training, supervision and support for volunteers; (ii) Good relationships and a sense of teamwork can develop between wards staff and volunteers; (iii) Impact may be maximised in the context of 'protected mealtimes'.

Key words: acute care system, nutrition, older people nursing, qualitative methods, voluntary sector

Background

Malnutrition is a common problem amongst older in-patients with an estimated prevalence of 39% in a pooled analysis of data from 12 developed countries (Kaiser *et al.*, 2010). Poor nutrition has important consequences, being associated with worse outcomes of hospital care including higher mortality (Stratton & Elia, 2006), longer length of stay (Kerr *et al.*, 2006) and increased personal and economic costs (Elia, 2009).

Malnutrition often predates admission, but older patients' nutritional status frequently continues to deteriorate in hospital (Stratton *et al.*, 2003). Reasons for poor dietary intake include the effects of acute illness; symptoms that make eating uncomfortable; fatigue; early satiety; low mood and cognitive impairment (Chen *et al.*, 2001; Daniels, 2003; Mudge *et al.*, 2011). The hospital environment may also contribute with mealtime interruptions for clinical care (Hickson *et al.*, 2011), unpleasant eating environments (Naithani *et al.*, 2009) and physical barriers to accessing food (Naithani *et al.*, 2010). Additionally Age UK (2010) highlighted a lack of assistance given to older people at mealtimes as an important cause for concern, including food trays left out of reach and little encouragement or help with eating. This has been attributed to nurses not having time to ensure that all patients in their care eat properly, a problem also identified in Australia (Xia & McCutcheon, 2006) and the USA (Robinson *et al.*, 2002). Adequate staffing is part of a complex mix of organisational and clinical factors which impact on quality of care, including nutrition, in acute settings (Bridges, 2012; Maben *et al.*, 2012). The UK College of Nursing reported that older peoples' wards in the UK have low staffing levels and a more dilute skill mix than other types of ward (Hayes & Ball, 2012). A study that examined processes affecting nutrient/food intake in hospital patients highlighted, moreover, the problem of establishing the status of feeding assistance as a skilful activity worthy of investment and support (Heaven *et al.*, 2012).

A range of initiatives have been implemented to improve older patients' nutrition. These include use of 'red trays' to serve patients at risk of poor nutrition, reminding food service staff not to remove the tray without checking with a member of the nursing staff (Age Concern, 2006) and 'protected mealtimes', when clinical care stops so that staff can serve food and assist patients without interruptions (Hospital Caterers Association, 2004). A study of the introduction of protected mealtimes at two UK hospitals (Hickson *et al.*, 2011) found that more patients had the opportunity to wash their hands, were served at uncluttered tables and monitored using food/fluid charts, although there was no difference in the number experiencing mealtime interruptions, and no increase in energy or protein intake. This study did not seek the perspectives of patients, relatives or staff on these changes.

The use of volunteers to assist older patients at mealtimes has been poorly evaluated. A systematic review of the use of volunteers to provide mealtime assistance to adult patients or care home residents identified 10 articles published between 1990 and 2009, including four studies conducted in acute hospitals (Green *et al.*, 2011). The authors noted that whilst reporting some benefits these studies were limited by design factors, and evidence of effect remains limited.

The Southampton Mealtime Assistance Study aimed to evaluate the impact on dietary intake of introducing trained volunteer mealtime assistants to help patients on one acute medical ward for older people, with a parallel comparison with patients on an adjoining ward; the study design has been described elsewhere (Roberts *et al.*, 2013). Here, we describe one component of the evaluation of this intervention – the qualitative exploration of the experience and views of nursing staff, patients, relatives and volunteers in hospital in the year before and after the introduction of trained volunteers.

Methods

Setting

The study was conducted on two acute wards in the Medicine for Older People Department at a UK university hospital. Both wards had similar medical and nursing care and case mix, admitting unselected female patients aged 70 and over from the Acute Medical Unit and Emergency Department. There was 'usual' nutritional care on both wards during the baseline year; in the intervention year, trained volunteers helped patients on the intervention ward during weekday lunchtimes whilst the control ward continued with 'usual' care.

Sampling, recruitment and data collection

Interviews and focus groups with participants were conducted by one experienced qualitative researcher [JR] and digitally recorded with participants' permission. Table 1 indicates the topics covered.

Staff

Small group and individual semi-structured interviews were held separately with senior and junior nurses, in broadly equal numbers from each ward, during the second half of each year of the study: (Table 2). This approach encouraged

Table 1 Topics covered in interviews and focus groups

Nursing staff – baseline year
Perspectives on what constitutes good nutritional care of older in-patients
Challenges and difficulties associated with providing that care
Nursing staff – intervention year
Impact of changes in the delivery of nutritional care on both wards, for patients and staff
Patients and relatives – baseline and intervention year
Appetite
Choosing what to eat
Managing at mealtimes [*with prompts to explore the experience, if any, of the mealtime assistants on the intervention ward in year 2*]
Food/fluid intake during hospital stay
Volunteers – all groups during intervention year
The experience of providing mealtime assistance
The challenges they faced
Perceptions of the difference their involvement made

junior nurses to talk freely without senior staff present. Seventeen individuals participated, three of whom were interviewed in both years [20 responses altogether]. Matrons and ward sisters were all invited to participate. Junior staff participants comprised a convenience sample based on availability to be released from clinical duties.

Patients and relatives

Patients were selected purposively from each ward to reflect a mix of age; body mass index (BMI) to indicate nutritional status; and home situation (Table 3). In the intervention year, more were sampled from the intervention ward to maximise opportunities to explore experience of the mealtime assistants' activity. All patients interviewed [10 in baseline year, 15 in intervention year] confirmed consent prior to interview at their bedside. Interviews lasted between 11 and 48 minutes.

Additionally, in both years, we interviewed five relatives who were regular visitors of patients from both wards who were too confused to consent and speak for themselves. All relatives recruited were daughters, although we had not intended to restrict the relationship *a priori*. They responded to questions on the basis of familiarity with their mothers and observations of how they were managing at mealtimes in hospital. Interviews lasted between 20 and 43 minutes.

Table 2 Staff interviewed in each year of the study

	HCA	Staff nurse	Ward sister	Matron	Housekeeper	Total
Baseline year	2	2	3	2	0	9
Intervention year	5	0	4	1	1	11

Table 3 Selection characteristics of patients for interview in each year of the study

	Year 1 *n* (%)	Year 2 *n* (%)
Age (years)		
Under 80	0 (0)	1 (5)
80–84	2 (13)	9 (45)
85–89	8 (54)	6 (30)
90 and over	5 (33)	4 (20)
Total	15 (100)	20 (100)
Preadmission home situation		
Lives alone – no help with meals	4 (27)	12 (60)
Lives alone – has help with meals	4 (27)	1 (5)
Lives with spouse, family or friends	3 (19)	5 (25)
Lives in residential care	4 (27)	2 (10)
Total	15 (100)	20 (100)
Nutrition status		
BMI <18.5, *At risk*	3 (20)	5 (25)
BMI 18.5–24.9, *Normal*	7 (47)	9 (45)
BMI 25–29.9, *Overweight*	3 (20)	4 (20)
BMI 30+, *Obese*	2 (13)	2 (10)
	15 (100)	20 (100)

Volunteers

Information about the qualitative study was handed to the volunteers by research nurses. Six attended a focus group in month 2 [intervention year], of whom five took part in a second group in month 7 and 4 came to a third group in month 11. A further six volunteers who joined the project later participated in a focus group in month 9.

The study received ethical approval from the local research ethics committee and was registered with ClinicalTrials.gov (NCT01647204).

Analysis

Digital recordings were fully transcribed. Facilitated by QSR International's NVivo 9.2 software (http://www.qsrinternational.com/about-qsr.aspx), data were managed and analysed thematically using Framework (Ritchie & Lewis, 2003). The researcher (JR) and principal investigator (HR) worked separately and together to agree topics for an initial analytic framework, based on *a priori* understanding of the issues and emergent concepts arising from reading the transcripts. Participants' accounts were summarised into charts and the data worked through in detail to draw out the range of experience and views, identifying commonalities and differences within and between participants. The analysis aimed to develop themes or categories of experience that captured the full range of perspectives. The researcher was satisfied that the interviews reached a point where little new information was emerging.

Results

Baseline year

Elements of good nutritional care identified by staff were the following: assessment and monitoring; provision of a choice of appropriate food, acceptable to patients; and provision of assistance and encouragement at mealtimes where needed. Here, we report the views and experience of staff, patients and relatives relating to these elements and highlight challenges faced and identified by nurses at different levels of seniority.

Assessment and monitoring

Staff noted that on admission to the ward patients should be weighed and malnutrition risk assessed *via* the Malnutrition Universal Screening Tool [MUST], as the basis for a care plan, which might include repeated weighing, referral to dietician and monitoring food charts together with informal monitoring and consulting relatives. In the baseline year, patients interviewed displayed little sense that nurses were routinely monitoring how much they ate; relatives' accounts suggest they were not generally kept informed by nursing staff and typically were unsure how much patients were eating. Some assumed monitoring was taking place, others tried to gauge food intake by visiting around mealtimes or looking at food charts.

Providing a choice of food acceptable and appropriate to patients

In principle, meal options were conveyed to patients via printed menus but nurses reported that in practice, due to lack of menus or patients' difficulty reading them, the options were given via the food service staff (host/ess), employed by the catering contractor. In the baseline year, few patients interviewed [4/10] had seen the printed menu. They reported host/esses typically employing a sequence of broad questions [*Hot meal or cold? Beef, chicken or pork?*] to steer choice and narrow options, rather than expecting patients to have seen and chosen from the menu. Nurses commented that host/esses lacked time and/or training and communication skills, and often did not offer patients the full range of meal choices.

Patients had mixed views. Some found it difficult to choose without having a menu to refer to:

> Lovely girls, no menus. Usually she'll say: Well what would you like for lunch? And then: Chicken, beef, lamb? But you don't know how. It could be fried, it could be anything... so it is difficult to choose [ID03 ward 1]

In contrast, patients who were visually impaired or struggled to read the menu liked having options given to them and valued continuity and support with making choices:

> I've had lamb, beef, chicken and fish since I've been here, so yesterday I said: What can I have for a change? She said: Would you like some pasta? and I said: Oh yes I love that, She's very good, the same lady I've seen all the time...She more or less knows what I like. [ID04 ward 2]

Relatives typically recognised that, owing to dementia or frailty, their mothers would rarely or never be capable of making choices for themselves. Few were aware how choices were being made for them and it was unusual for relatives to have been invited to indicate patients' likes and dislikes. They described feeling concerned that their mothers had been given food they disliked and sceptical when nurses reported them enjoying items that they never ate at home.

Patients who were able to decide for themselves determined their meal choices by the following: ideas of what is nourishing; restrictions such as diabetes and swallowing problems; established likes and dislikes; previous experience of hospital foods; the opportunity to have foods they would not get at home; and ideas about how much would sustain them until the next meal or they could manage given current appetite.

For patients who indicated that their appetite was *normally good,* factors depressing appetite included acute illness, pain; reduced activity levels; anxiety at being in hospital; variable mood and limited availability of preferred foods. Loss of appetite was typically rationalised as understandable and likely to be temporary. Additional factors identified by relatives as associated with patients' *chronically poor* appetite and intake were swallowing difficulties, digestion problems and dementia with unpredictable variation from 1 day, or mealtime, to the next.

Portion size was a recurring theme with patients, who wanted flexibility to ask for a small portion or forgo components of a meal, and daughters who thought patients should be coaxed with small helpings. They reported bringing high-calorie treats or drinks to tempt appetite and appreciated staff who took initiative to provide patients with food they would enjoy:

> The other evening I said is there an alternative?...She came back with a bowl of hot custard, and mum loved it. [NOKID29 ward 2]

Providing assistance at mealtimes

From the nursing perspective, this encompassed feeding people who could not feed themselves; offering encouragement to those who lacked motivation to eat; and supervising the confused.

In the baseline year, many patient interviewees had been managing independently at mealtimes, often relying on carefully thought out strategies:

I try and order something I can eat with a spoon and a fork. I can't cut it, because I have had cellulitis. [ID03 ward 1]

Their observations of staff feeding those who needed help revealed understanding of the challenges and limitations of what could be achieved:

Nurses help them with it, sometimes, but it depends how many are on...They could do with more nurses to help... They do their best...but some patients just won't eat any more. [ID12 ward 1]

Relatives described their mothers as largely dependent on help or supervision. They were typically unsure but inclined to trust that staff assisted them whilst recognising the limits on staff time:

They're very busy these nurses, and while they're trying to feed a patient, somebody else wants to go to the toilet or another nurse says: I need two people to move somebody... They just haven't got enough staff. [NOK ID28, ward 2]

Concerns were expressed that patients who were difficult to rouse were allowed to sleep through mealtimes and miss meals. Relatives wished more help was available:

I think there is room for a carer type person to help the nurses.... [NOK ID30, ward 2]

Challenges for nursing staff

Nurses at all levels highlighted the time required to help frail or confused patients; the difficulty of coaxing those who choose not to eat; and the coincidence of mealtimes with other nursing priorities. Health Care Assistants [HCAs] and staff nurses described feeling powerless to respond adequately at mealtimes, unsure how to prioritise when many patients needed help:

It's really hard to weigh up who needs to be done first, because they all need to be done at the same time really.... [IDSB3, HCA]

The responsibility of delivering against competing priorities was also felt by senior staff:

There are so many pulls and demands on your time. You know it's important that everybody gets fed but you also know it's important they get their observations done, that they're turned, that their dressings are done, that their relatives are spoken to.... They're all important, but they're not as important as someone who suddenly becomes acutely unwell, because you can't feed a dead patient. [IDSB6 Sister]

It was acknowledged that the consequence of having insufficient staff available to help whilst meals were given out and remained hot was that, even where staff 'multitasked', feeding one patient whilst verbally encouraging others, patients sometimes went without food:

It's not difficult to monitor people for their intake. It's not difficult to weigh everybody once a week. It's not difficult to tell the dietician who's losing weight, but it's difficult to try and feed everybody three meals a day, when there's not enough people to help' [IDSB4 Staff nurse]

Ward sisters identified the difficulty of dovetailing meal service by the host/ess and nursing assistance with feeding; wanted guaranteed times for meal service and expressed frustration about lack of continuity of ward host/esses. Matrons aspired to improve the training and communication skills of host/esses; develop the ward housekeeper role to coordinate the meal service with staff availability to help; and trial the red tray system. They emphasised the importance of empowering ward leaders to ensure a 'standardised consistent approach'; proposed changing times of nurses' meal breaks to maximise staff present at mealtimes and recognised the potential contribution of volunteers.

Intervention year – changes in organisation of nutritional care

On the intervention ward, 29 trained volunteers assisted at lunchtime on weekdays (2–4 volunteers/day), supported by a researcher who identified patients needing assistance, allocated volunteers to each bay and was available to answer queries. Typically, one volunteer assisted in each six-bedded bay preparing tables, cleaning hands and assisting with opening packaging for any patients who welcomed that assistance and feeding patients as required. Volunteers did not assist patients with swallowing difficulties, who were helped by nursing staff (Roberts *et al.*, 2014). Coincidentally, other initiatives were implemented across both wards during the intervention year: times of nurses' meal breaks were changed; the new mealtime coordinator role was put into operation; the red tray system was implemented and there was more rigorous enforcement of 'protected mealtimes'. On the control ward, sisters devised and introduced a food preferences chart.

Interviews in the intervention year

Providing choice of food acceptable and appropriate to patients

In the intervention year, a greater proportion [9/15] of patients across both wards had seen a menu, and menus were perceived to be more widely available than previously to inform patients' meal choices. However, many [12/20 including those represented by relatives] described or were

perceived to have a chronically poor appetite, usually associated with dietary intake regarded as inadequate, and this had a bearing on patients' experience of making food choices. Over time, it seems that patients adapted to chronically poor appetite by identifying and choosing the kinds and quantities of food they could manage:

I haven't eaten a lot for a long time, but I'm eating even less now. I only have snacks at home and I don't cook any meal. I used to have a good appetite, but that's gone. I don't know what's causing it... I suppose it is just old age ... I don't seem to be able to overcome it. [ID43 ward 1 -intervention]

A contrasting approach was making an effort to eat, despite difficulties:

I'm not eating much at all. I try to eat something because I think otherwise you get in a bit of a state but never finish a whole meal [ID40 ward 1 -intervention].

Providing assistance at mealtimes – a focus on the introduction of volunteers

As in the baseline year, some patients were keen to manage without help. Others had difficulties including seeing what they were eating, reaching food if it was not placed suitably, opening packaging, lifting and pouring from the water jug and managing cutlery. Staff on the intervention ward described positive aspects of having trained volunteers who provided extra pairs of hands to support patients needing more straightforward help, enabling nurses to feed patients with swallowing difficulties and be available for other care:

I think it just runs more smoothly. Because we've got support from the mealtime assistants we can do so much more. The patients are a lot happier because they are being fed. [IDSB16 HCA]

Volunteers saw that that the 'time' they offered made a difference to both patients and nurses:

I've spent three quarters of an hour trying to persuade someone to eat half a meal. [Volunteer ID04, FG1]

That's what we're there for isn't it, to take the pressure off the nurses. [Volunteer ID06, FG1]

Staff and patients appreciated that volunteers prepared *all* patients for mealtimes:

There are some volunteers who come round and actually sit and spoon feed people who need it. But one lady in particular she comes around to make sure you've got cloths to wipe your hands with and your table napkins and so on. I was very impressed with that. [ID 47]

Volunteers had no doubts that this was worthwhile:

That's why I think the patients like it. If they're asleep you wake them up, they can clean their hands, you can wipe those tables... You might not be feeding that person, but their trolley is in the right place, ready for them so when the meal comes, it's not out of reach. [Volunteer ID01 FG1]

By cutting up meat or removing packaging, volunteers enabled those who might otherwise struggle to manage for themselves:

Instead of wasting their energy on struggling with a lid and trying to get the cutlery out of the plastic thingy their energy can go on actually eating. [Volunteer ID02, FG2]

Nurses observed that volunteers could encourage and motivate patients who seemed to have lost interest in food and provide social interaction thereby gleaning valuable information about a patient's mood which could be shared with staff. Patients perceived the volunteers as a fresh face on the ward but also a regular presence with potential to build relationships. Volunteers thought that patients respected them for helping without being paid and might 'make an effort' to eat in return. They recognised, however, that refusing food may signify a deteriorating condition and that some patients will not eat despite encouragement.

Nurses welcomed volunteers' careful attention to completing food charts; an indication that both recognised the benefit of having accurate information about patients' dietary intakes to pass on to relatives and inform decisions about care. Relatives interviewed were uncertain if their mother had been helped by a volunteer but welcomed the possibility, emphasising the benefits of encouragement and social interaction identified by staff:

I know that people in hospital generally don't get much help but I feel that elderly people could do with the encouragement. That thing about volunteers going in and being able to spend the time and encourage, that would be beneficial certainly. [NOK ID75]

Nurses reported feeling concerned initially that the ward would seem overcrowded with volunteers in bays, yet good relationships and a sense of teamwork developed:

I think they needed to find their feet and staff needed to know what was expected of the volunteers... You get to know their names and faces, and they are like members of the team. [IDSB14 Sister]

They respected the volunteers' good attitude combining confidence, willingness to ask for help without being demanding, commitment and reliability.

Nurses appreciated that the volunteers had been well trained and supported by the research team and they had not been asked to take on this responsibility themselves:

I've seen they're not just left to their own devices. People spend time showing them what they have to do. They're not just chucked in at the deep-end and it isn't left to us. It's not an extra role for us to have to show them around the ward. [IDSB14 Sister]

Not surprisingly, staff were hopeful that the volunteers would continue:

I think it will be a massive blow if we don't keep it going, because you get into that routine where you're used to having them. … It's just so much easier. When it comes to weekends you think, oh it's the weekend, they're not coming [IDSB16 HCA]

Providing assistance at mealtimes – broader changes in delivery of nutritional care

Staff accounts indicate that the impact of department-wide developments in nutritional care was felt on both wards. They described increased awareness of the importance of nutrition and mealtime care, reflected in the mealtime coordinator role and greater stability and regularity in meal service timings. Reorganising staff meal breaks to maximise personnel on the ward at mealtimes was seen as worthwhile, whilst 'protected mealtimes' was seen as work in progress to secure full cooperation of all health care professionals.

The *particular* synergy between other initiatives and the introduction of the volunteers on the intervention ward was highlighted:

The way it's come in, it's worked. Because you've had the mealtime assistants come in, then they've introduced the red trays, more than what they did, and now we have a mealtime coordinator, which is normally our housekeeper for breakfast and lunch, and then one of us for supper. And it means we go around making sure everyone gets the right meal, a drink, and is sat upright It's just all fitted and works really well now. When they brought in the protected mealtime as well that made everyone's lives even easier, because it meant that the mealtime assistants can get on and do their feeds. [IDSB16 HCA]

Staff on the control ward indicated that they knew little about the volunteer scheme on the intervention ward. They seemed concerned to give a good account of how they delivered mealtime care without the benefit of volunteers yet this appeared to be at the expense of nurses' well-being.

To be honest I don't know much about how it works, I'm just aware that they have the service and a bit jealous that we don't. But I'd like to think that with or without them, the patients on our ward get the same amount of food. I just think probably the nurses eat and drink less. [IDSB6 Sister]

Discussion

During the baseline year, nursing staff on both wards identified challenges related to delivering good nutritional care. Staff at all levels, patients and relatives recognised that staff were struggling with competing pressures and insufficient staff to assist everyone needing help during the short period of time food is available and hot. This was seen to be to the detriment of patients' welfare with consequences for staff morale.

Introducing trained volunteers addressed the shortage of helpers and proved popular with staff who identified a range of benefits for patients with different levels of needs, and respected the volunteers' competence, commitment and caring attitude. Patients who observed or experienced support from volunteers spoke highly of them, and relatives recognised the potential benefits of the initiative. The volunteers were perceived to increase the quality of mealtime care by creating a clean ordered bedside environment for patients, enabling those who were able to feed themselves and feeding those who needed assistance. They also provided social interaction and encouragement and contributed to formal and informal monitoring processes by completing charts and passing on concerns about patients.

These findings are in line with the few previously published studies, which report perceived benefits of the use of volunteers to assist with mealtime care in different settings, albeit on the basis of 'informal feedback' from stakeholders or 'anecdotal evidence'. In the UK, Sneddon and Best (2011) found the introduction of trained volunteers on a hospital's acute wards was generally perceived positively by patients and staff. Nurses reported that patients received their meals and assistance to eat sooner, and those needing encouragement rather than physical help to eat were judged to have benefited most because volunteers helped to make mealtimes a more sociable event. Similarly, Brown and Jones' (2009) pilot study of volunteers assisting frail older hospital inpatients found that reluctant eaters appeared to benefit from extra time and attention and nurses felt more supported in mealtime care.

A finding of this study was that a range of initiatives, coincidentally implemented by the hospital to prioritise mealtimes, operated synergistically with the introduction of volunteers. A climate was created in which staff were receptive to volunteers who became valued team members and symbols of a concerted effort to address shortcomings in mealtime care. There were indications that patients' and carers' experience in the intervention year reflected the totality of these changes: for example, more patients had seen menus. The volunteer mealtime assistance project was,

however, the only *additional* resource and staff valued this highly as it relieved pressure and stress for them as well as being of benefit to patients. The training, supervision and support provided by the research team, which is described in more detail elsewhere (Roberts *et al*., 2014), was important, and nursing staff were initially unsure how they would manage this if the scheme was rolled out. Despite these misgivings, the scheme has been embedded in clinical practice since the research study ended in 2012 with ward staff successfully supervising and supporting volunteers on a day-to-day basis. The continuation of the scheme had the encouragement of the hospital Board of Directors and the Director of Nursing and ongoing support of the manager of the established hospital voluntary services team.

Hickson *et al*. (2004) reporting on a UK trial of additional HCA support with feeding, noted the importance of suppressed appetite in the development of malnutrition. Our study has demonstrated that chronic poor appetite may be a long-term change to which patients have adapted. This was highlighted in patient interviews during the intervention year. Whilst patients had a similar range of BMI in both years of the study, more of those in the intervention year lived alone without mealtime help [Table 3], a factor which may facilitate altered eating patterns in response to poor appetite. Thus there is a need for a broad strategy to address underlying poor appetite, both temporary and chronic, taking account of strategies patients have adopted. It is important to facilitate choice of food appropriate to health needs and personal taste by allowing patients adequate time to choose from the menu and finding ways to accommodate food preferences; and to offer and provide appropriate levels of encouragement and practical help at mealtimes, recognising that patients want to retain independence and this must not be undermined. The findings of this study suggest that volunteers can be a valuable component of such a strategy.

Limitations and strengths

This was a single centre study in one country, albeit facing similar issues to those reported in the literature from other hospitals in UK, USA and Australia. In the context of single sex wards, the study findings give the perspective of women patients only but we note that women make up 75% of hospital inpatients in this age group. However, this study had many strengths. A robust qualitative method was used to explore the experience and views of four groups of stakeholders interactively and face to face, and to develop 'rounded understandings' based on interpretation of their perspectives (Ritchie & Lewis, 2003). Interviews were conducted by a single experienced researcher and there was purposeful sampling to seek the perspectives of a diverse group of staff and patients, including the physically and cognitively frail, as well as volunteers. The use of a control ward enabled us to capture department-wide changes in the delivery of nutritional care and gauge the impact of these changes both with and without the volunteer mealtime assistants. The pragmatic selection of volunteers for the role of mealtime assistants via the Hospital volunteer service mirrored that which would apply in routine 'real life' practice.

Conclusions

The introduction of volunteers was perceived to improve the quality of mealtime care for patients. The sense that no effort has been spared to improve patients' mealtime care and dietary intake has the potential to impact on the confidence of patients' and relatives and the morale of staff as well as on patients' well-being. This study has highlighted the contribution of chronic poor appetite to the risk of malnutrition amongst older people, suggesting that a strategy to increase dietary intake should take account of changed eating patterns linked to poor appetite as well as ensuring availability of assistance and encouragement to eat. A hospital scheme to involve well-trained and supported volunteers at mealtimes can be a valuable component of such a strategy but may work best when introduced in the context of other changes in delivery of care reflecting a broad commitment to improving nutrition.

Implications for practice

- A hospital volunteer mealtime assistance scheme should incorporate training, supervision and support for volunteers.
- Good relationships and a sense of teamwork can develop between wards staff and volunteers.
- The impact of volunteers may be maximised in the context of 'protected mealtimes'.

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Contributions

Study design: JR, ME, AJ, CC, AAS, SR, HR; data collection and analysis: JR, HR and manuscript preparation: JR, GR, ND, AP, ME, AJ, CC, AAS, SR, HR.

Conflict of interest

None.

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