

Memories, identity and homeliness: the social construction of mealtimes in residential care homes in South Wales

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ABSTRACT

Mealtimes in residential care homes are fundamentally social occasions, providing temporal structure to the day and opportunities for conversation and companionship. Food and drink are imbued with social meanings and used to express and create relationships between people. There is a dearth of research exploring care home residents' mealtime experiences in the United Kingdom. This paper reports on particular findings from a qualitative study which investigated factors influencing nutritional care provided to residents in two different types of residential care settings in South Wales, UK. Data were generated through focus group interviews with relevant staff members (N = 15), individual interviews with managers (N = 4) and residents (N = 16) of the care homes and their informal carers (N = 10), observation of food preparation and mealtimes throughout the day, and analysis of appropriate documents. Data were analysed using thematic analysis. This paper's focus is on the ways in which care home residents' experiences and understandings of mealtimes were influenced by various environmental factors, such as the home's geographical location, physical lay-out and ambience. Moreover, the shared meaning of mealtimes for residents, informal carers and staff was constructed from each group's socio-cultural background, family experiences and memories, and was integral to residents' sense of normality, community and identity.

KEY WORDS – residential care homes, older people, nutrition, social construction, qualitative.

Introduction

In this paper particular findings from a qualitative study which investigated the factors influencing the nutritional care provided to residents in two different types of care homes providing personal care, namely those

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providing communal living and unit-based or group living accommodation, are reported. Following Savage and Scott, the term 'nutritional care' refers to 'a patient-centred, co-ordinated, multi-disciplinary approach to meeting individual needs for food and fluids' (2005: i). Specifically, we sought to gain an understanding of the ways in which the contextual factors in two different environments impede or facilitate the nutritional care provided to residents. Additionally, the perspectives and experiences of residents and their informal carers of eating in different care environments were investigated. The study was conducted between April 2009 and March 2010 in South Wales.

The literature indicates the complexity of issues surrounding mealtimes for older people in care homes and identifies a dearth of research of residents' mealtime experiences and provision of nutritional care. Food and drink are imbued with social meanings and are used to express and create relationships between people (Douglas 1975; Helman 2000; Murcott 1982; Savishinsky 2003). Additionally, mealtimes and the sharing of food are integral to kinship and friendship networks (Lupton 1996), which are important aspects of quality of life. Within the care home literature, whilst research into the quality of life and quality of care of older people in care homes has been central (*e.g.* Commission for Social Care Inspection (CSCI) 2008; National Care Homes Research and Development Forum (NCHR&DF) 2007; Smith *et al.* 2009; Townsend 1962; Willcocks, Peace and Kellaher 1987) and mealtimes and the food environment have been commented upon in terms of the physical and social environment, there has been no detailed investigation conducted to date.

In 2010 in the United Kingdom (UK), approximately 419,000 older people lived in care homes managed by statutory local authorities, private and voluntary agencies (GHK Consulting Ltd 2011; Office of Fair Trading 2005). Two types of care homes are provided in the UK; those providing personal care such as assistance with personal hygiene, dressing, and eating and drinking (formerly termed residential care homes), and those which in addition to personal care provide nursing care (formerly termed nursing homes). In England it is estimated that two-thirds of people living in care homes have some form of dementia and that 28 per cent of care homes places are registered to provide specialist dementia care (CSCI 2008). In December 2011 there were 698 care homes providing 23,191 places for older people in Wales (Care and Social Services Inspectorate Wales 2012). As people are living longer, often with complex conditions such as dementia and chronic conditions, the number of older people living in care homes is predicted to increase (CSCI 2008).

For older people in care homes, mealtimes have been described as the highlight of the day (CSCI 2006), providing structure to the day

(Savishinsky 2003) and affording opportunities for conversation and companionship (Caroline Walker Trust 2004). The importance of sociability and companionship at mealtimes is frequently noted (Wright, Hickson and Frost 2006; Wikby and Fagerskiold 2004), although there is a dearth of literature focusing specifically on residents' mealtime experiences in British care homes. The links between meeting older people's nutritional needs and their cultural and social needs in care homes also appears to be a neglected area.

Drawing on a key theme of our original study findings (Merrell *et al.* 2010) regarding the social context and meanings, we explore the ways in which care home residents' experiences and understandings of mealtimes were constructed through their particular social and spatial environment and also by their culturally specific personal memories, identities and histories. Individuals' nutritional state or physical health and wellbeing are not reported. Our findings highlight the myriad influences on residents' eating experiences in care homes.

Literature review

A literature review of research articles identified through searching CINAHL, ASSIA and PUBMED databases from 1999 to 2009 and through citations from published articles was conducted. Additionally, two seminal works relating to care homes which pre-dated 1999 were utilised, namely *The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales* by Townsend (1962) and *Private Lives in Public Places* by Willcocks, Peace and Kellaher (1987). Search terms included: residential facilities, care home, nursing home, nutrition, food, diet, meals, older people, elderly and geriatric. UK Government and Welsh Assembly Government (WAG) reports and policy documents were also reviewed.

Mealtimes and the opportunities afforded for companionship and social engagement are fundamental to the quality of life of older people in care homes which is central to policies, guidance and standards for care homes, as evidenced in reports such as *Creating a Home from Home – A Guide to Standards* (Residential Forum 1996), *Home Life: A Code of Practice for Residential Care* (Centre for Policy on Ageing (CPA) 1985), *My Home Life* (NCHR&DF 2007) and *Putting People First* (Department of Health 2007). These policies and guidance emphasise the need for person-centred care, shared decision making, maintaining privacy and dignity, and the importance of maintaining and developing links and relationships (NCHR&DF 2007; Residential Forum 1996). The challenges of meeting individual resident's needs in the context of different types of residential care homes has been recognised for

some time, particularly from research conducted in the 1980s when the majority of care homes were provided by statutory local authorities (Willcocks, Peace and Kellaher 1987). They sought to identify factors of the residential care process which influenced elderly residents' satisfaction, particularly focusing on exploring the effects of the physical environment and organisational structure in their study of 100 public-sector residential care homes. Different types of care homes were compared: those which had a traditional design encompassing communal living, large dining rooms and lounges but often had 40 or fewer residents, with those which were unit-based and involved group living with six to eight residents per unit with small dining areas within the units, but accommodated 50 or more residents. Whilst group living yielded benefits for residents including more control over their environment, being more engaged in everyday activities and more likely to interact with other residents, residents' reported greater dissatisfaction with their relationships with staff and had higher than average levels of worry. Similarly, care home staff also had higher than average worry scores and reported low job satisfaction in group-living homes (Willcocks, Peace and Kellaher 1987: 127). The design of unit-based group living with access to kitchens and single bedrooms meant that residents were not always in view within an environment which posed potential risks, which heightened staff's anxiety. Other problems encountered were interpersonal relations between residents involving arguments and personality clashes, and some residents rarely interacted with others outside their group resulting in group isolation (Willcocks, Peace and Kellaher 1987: 131). Group living was also perceived as being more demanding on staff-resident relations as it involved providing more flexibility over routines and daily practices, which staff unprepared for this more complex role found challenging. Similarly, some residents preferred the security of the more structured and routinised practices in the more traditional care home and the relative anonymity of being in a large group. With this notable exception, residents' experiences of mealtimes in different types of British care homes remains under-explored. The importance of nutrition and the consequences of malnutrition for older people's health and wellbeing are now considered.

Malnutrition in older people

Malnutrition, defined as 'a state of nutrition in which a deficiency, excess or imbalance of energy, protein or other nutrients, including minerals and vitamins, causes measurable adverse effects on a person's body function and clinical outcome' (Royal College of Physicians (RCP) 2002) remains a source of concern for older people in the UK and other parts of the world (Beck and Ovesen 2002; Margetts *et al.* 2003). Older people living in care

homes are deemed to be particularly vulnerable (British Association of Enteral and Parenteral Nutrition (BAPEN) 2007; Cowan *et al.* 2004; Malnutrition Advisory Group 2000). Although malnutrition is not an inevitable consequence of ageing, the physiological changes that occur in older adults increases the risk (Hickson 2006). Malnutrition may lead to physical weakness and poor health (BAPEN 2003), and is related to increased mortality and morbidity rates (Lehmann 1991); moreover older people are less likely to recover from malnutrition (European Nutrition for Health Alliance 2006).

Wales and UK policy context

Older people are recognised as a priority group in the nutritional strategy for Wales (Welsh Assembly Government (WAG) and Food Standards Agency Wales 2003) and deemed vulnerable to malnutrition. Malnutrition affects over 10 per cent of the UK population aged over 65 and throughout the UK costs the National Health Service more than £7 billion a year (BAPEN 2005). The *Strategy for Older People in Wales* (WAG 2008) recommended further action to address malnutrition in community settings, including care homes. The document *Fundamentals of Care* (WAG 2003) recommends that people who are unable to feed themselves adequately are quickly identified and that assistance is provided. The delivery of improved nutrition and food security for users and their carers is part of the government's ten-year social services strategy *Fulfilled Lives, Supportive Communities* (WAG 2007). The Welsh Consumer Council (2008) also recommends that ensuring people are well nourished should be a key element of the 'Dignity in Care' agenda for Wales. In the UK the need to detect, prevent and treat malnutrition in older people has been recognised (BAPEN 2007; Department of Health 2000, 2001; WAG 2003, 2006) and incorporated into national guidelines, for example, the National Institute for Health and Clinical Excellence (2006) guidelines for nutritional support in adults. However, there is little research into the impact of these guidelines on residents' experiences.

In the UK a number of ongoing studies to improve nutrition for older people in hospitals and other care settings are being conducted as part of the 'New Dynamics of Ageing' programme (www.newdynamics.group.shef.ac.uk). This eight-year programme is a multidisciplinary research initiative aimed at improving the quality of life of older people and completes in 2013. Studies include: the 'Multidisciplinary approaches to develop prototype for the prevention of malnutrition in older people' (MAPPMAL) project, which explores production and delivery of food to older people and the 'Novel assessment of nutrition and ageing' (NANA) project to help identify older people at risk of under-nourishment and improve targeting of interventions.

Whilst these studies will hopefully yield insightful data with regard to identifying and addressing malnutrition in hospital and community settings, they do not address the issue of the provision of nutritional care and the mealtime experiences of older people living in care homes. Yet food and drink provide more than nutrition and hydration and the social context of nutrition in care homes is now explored.

The social context of nutrition in care homes

Sources from sociological and anthropological disciplines illustrate that ‘food is a cultural affair ... a product and reflection of the norms and values of the society in question’ (Murcott 1982: 678), and that the sharing of meals constructs and communicates relationships between people (Crogan *et al.* 2004; Douglas 1975; Evans, Crogan and Schultz 2005; Helman 2000; Lupton 1996; Murcott 1982). Mealtimes provide temporal structure to the day for people in residential care homes (Gubrium 1997; Nijss *et al.* 2006; Savishinsky 2003) and are important ‘indicators of time, place, social interaction and “normality”’ (Pearson, Fitzgerald and Nay 2003). Mealtimes and coffee breaks bring people together in care homes (Savishinsky 2003) and are fundamentally social occasions, providing opportunities for conversation and companionship (Caroline Walker Trust 2004; CSCI 2006; Wikby and Fagerskiold 2004; Wright, Hickson and Frost 2006). In Gubrium’s (1997) ethnographic study of a North American care home, he noted the centrality of mealtimes to residents’ daily lives and that preparing themselves for and talking about mealtimes were major ways in which residents passed their time. Similarly, mealtimes have been described as the ‘highlight of the day’ for people in care homes (CSCI 2006).

The physical environment of a care home is particularly important to all aspects of residents’ experiences, including their mealtime experiences (Department of Health 2003; Johnson, Rolph and Smith 2010; Parker *et al.* 2004; Townsend 1962; Willcocks, Peace and Kellaher 1987). The maintenance of homeliness in the care home environment has informed the rhetoric of care policy for some time (CPA 1996; Department of Health 2003; WAG 2004) and much of the literature. There is a potentially fruitful body of literature from the sub-discipline of environmental gerontology, which explores the ways in which spatial settings hold meaning and shape relations between older people (Wiles 2005). Additionally, Willcocks, Peace and Kellaher (1987) highlight the importance and meaning of ‘place’ in older people’s lives, whilst also noting that the physical environment is just part of the larger whole of a person’s experience in a care home. Spatial arrangements in dining areas and the organisation of meal delivery have also been shown to be influential, although there is a dearth of UK research

in this area. A North American study by Remsburg *et al.* (2001) reported 'buffet-style' dining, where food was served on a steam table allowing residents to choose from a selection of foods and choose second helpings of favourite foods, was effective in increasing sociability and enjoyment. In a Dutch study Nijs *et al.* (2006) found that 'family-style' mealtimes, which included table dressing and seating organisation, were effective in maintaining quality of life, physical performance and body weight. However, Kofod and Birkemose's (2004) small qualitative study conducted in Denmark of the influence of 'stay-and-living' environments, where residents eat in small groups, indicates the complex nature of residents' perceptions of mealtimes. In this study of 19 nursing home residents, although half of the group reported positive reactions, the other half found this environment embarrassing or difficult. Similarly, Sidenvall, Fjellstrom and Ek's (1994) qualitative study of 18 patients in a Swedish nursing home indicated that patients with eating difficulties found it a strain to share tables to eat with other people and would have preferred to eat alone. Moreover, people without eating difficulties were sometimes disgusted by 'inappropriate behaviour' from other patients. Whilst these studies are useful there may be issues of transferability from the Nordic, Dutch and North American context to the UK situation and all were conducted in *nursing* homes.

Methodology and methods

The aim was to investigate factors influencing the nutritional care provided to residents in two different types of residential care settings. By nutritional care, we refer to the ways in which individuals' needs for food and fluids are met. As previously stated, we sought to gain an understanding of the ways in which the contextual factors in two different environments impede or facilitate the nutritional care provided to residents. Additionally, we sought to explore the perspectives and experiences of residents and their informal carers of eating in different care environments. Residents and informal carers were included in the steering group to ensure their perspectives informed the study. The steering group included a dietician, two academics with expertise in the care of older people, the research team, two care home managers and two residents and informal carers. The steering group met regularly throughout the timeframe of the study and informed the study design, for example, advising on the interview schedules, the timing of mealtimes to inform the periods of observation, and local nutritional guidelines and policies. For presentational purposes we refer to residents' relatives as 'informal carers', although acknowledging this was not their role following their relative's admission.

A qualitative methodology informed by ethnography (Hammersley and Atkinson 1995) was deemed appropriate to address the research aim and objectives. Ethnography is based on observational work in a particular setting (Silverman 2005) and seeks to explore and understand how the behaviour of individuals is influenced by the culture in which they live, in this instance, within the care home setting. As is typical with ethnography in addition to observation, multiple data collection methods were used (Bryman 2001) including interviews, focus groups and documentary review, to gather a comprehensive picture of the nutritional care provided to residents. The philosophical underpinnings were 'interpretivist' inasmuch as our concern was on the ways in which the people in our study interpreted, experienced and produced their social world.

A situated study – location and access

Ethical approval was gained from the University Ethics Committee and approval and permissions were gained from appropriate gatekeepers within the Social Services Department in the study area to conduct the study.

The care homes were owned and managed by the same local authority and registered to provide personal care only. Both care homes also had 'day centres' attached, which provided services for older people who need support but are able to continue living at home. In the local authority under study, there were seven care homes for older people requiring personal care, each with between 24 and 48 beds, of which five were based on communal living and two were unit-based, that is the homes comprised six separate eight-bedded units. We purposively selected one home of each type.

Home One (H1) was a communal living care home and had 29 single rooms spread over two floors with communal bathrooms, toilets and lounge facilities. There were communal dining rooms on each floor, with residents usually using the dining room on the same floor as their bedrooms. Meals were provided to each communal dining room from a large central kitchen.

Home Two (H2) was a unit-based care home and had 48 single rooms which were divided into six separate units spread over two floors. Each unit had eight single bedrooms, a lounge and dining area, a kitchenette with cooking facilities, communal bathroom and toilets. A large central kitchen provided all of the units with main meals. There were also communal lounge facilities and other areas for shared use on both floors, including an internet room.

In terms of geography, both homes were similarly situated in traditional working-class urban areas on the outskirts of the same city. Both areas had developed in the mid to late 19th century to accommodate local workers, mainly skilled and semi-skilled manual workers in the coal mining and steel

industries, and much of the terraced housing remains. However, H1's location is described by the local authority as a 'suburb', two miles from the city centre, whereas H2's situation is described as a 'village', five miles from the city centre. According to local authority data, the population of people aged 65 and over living in the localities in which the homes are situated was lower than that for Wales (15.7% for H1, 17.7% for H2 compared with 18.4 and 16.4% for Wales and the UK, respectively) (Office for National Statistics 2012). The proportion of people aged 75 and over in the local population surrounding H1 was higher (8.3% compared with 7.1% for H2 and 7.9% for Wales, respectively). The homes also differed in terms of where their residents came from inasmuch as H1 tended to admit people from further afield, whereas many (although not all) H2's residents' original homes were quite close and part of the community where the home was situated. Consequently, many H2 residents maintained links with people and places (such as the chapel and the public house) in the surrounding locality; they were also more likely to know people who came into the attached day centre. Hence, the community inside H2 residential home appeared to be more anchored into the surrounding community than that of H1.

There were also important differences between the two homes in terms of access to their attached day centres. H1's access was through a separate outside entrance; there was also a walkway from the home to the day centre but visitors from outside the home would use the separate entrance. However, access to H2's day centre was through a secure door from the central foyer of the home, drawing outside visitors first into the main body of the home. Thus H2 had less of a structural boundary between itself and the outside world.

Sampling of participants

Participants were recruited following a presentation given by two of the researchers at each home and information letters to residents, staff and informal carers. Individuals were invited to indicate through a reply slip if they wished to participate. A total of 15 catering (including cooks and kitchen assistants) and care home staff from both care homes (eight from one and seven from the other) were purposively selected (according to criteria set out below) from the reply slips. The two care home managers and two assistant managers (with responsibility for managing catering services) from each care home were also invited and agreed to be interviewed. The criteria for selection of staff (both managers and care home staff) were that they were willing to take part in the study, had worked in the care home for at least six months and were involved with meeting the nutritional needs of residents as part of their role. All the staff who met these criteria participated.

Eight residents from each care home (28.5% from H1 and 16.6% from H2) who had spent at least one month in the care home were purposively selected from the reply slips, giving a sample size of 16 residents. The inclusion criteria for residents were that they were over 65 years of age, taking food orally, had the ability to communicate and able to give consent. Those unable to give consent included residents with moderate to severe cognitive impairment. The residents' sample comprised three men and 13 women (ratio of men to women in H1 was 8:29 and in H2 was 3:48) and their time in the home ranged from 12 months to seven years. The average age of the residents' sample was 80 years in H1 and 93 years in H2 (average age in H1 was 84 years and H2 was 87 years, respectively). A quarter of the residents interviewed had special diets, mainly diabetic diets (27.5% in H1 and 10% in H2 had special diets, mainly diabetic and low-fat diets). The functional ability of residents interviewed ranged from those who were mainly self-caring to those who used wheelchairs or walking aids and had chronic medical conditions including diabetes, arthritis and a neurological disorder and who were dependent for their care needs. All were mentally capable of decision making. The functional ability of residents in the homes varied as H2 had two units which were specifically for residents with moderate to severe dementia and these units were excluded from the study.

The functional ability of residents is presented in [Table 1](#), which indicates that over half of the residents in H1 were physically and mentally active and mainly self-caring compared with 11% in H2. Another important difference was that in H2, 32% of residents used a wheelchair and had no capacity to support themselves and had increasing dementia, whilst a further 8% were totally dependent for their care needs and were in the later stages of dementia. Most but not all of these residents resided in the two units which were excluded from the study.

Five informal carers of residents from each care home were purposively selected, giving a sample of ten informal carers. The inclusion criteria for informal carers were that they were willing to take part in the study, had a relative who had spent at least one month in the care home and were able to give consent. The informal carers' sample comprised two men and eight women; eight daughters, one son and one husband. No participants who wished to participate were excluded in that all those that responded met the above criteria.

Methods of data generation

Data were generated through a range of methods, which included focus groups with care home and catering staff and individual semi-structured interviews with managers, residents and informal carers. Additionally,

TABLE 1. *Functional ability of residents in Home One (H1) and Home Two (H2)*

	Functional ability	Percentage of residents	
		H1	H2
A	Ambulatory, but uses a cane for support Independent, can clean and dress self Physically and mentally active	5 ²	11
B	Uses a walker Can support self to some degree Has a combination of medical conditions Incontinence problems are beginning Stiff and painful joints due to rheumatism	3 ⁰	3 ⁸
C	Sits in wheelchair Left side hemiplegic Some capacity to support self Can stand for short periods Mentally capable of decision making Urine incontinent Dependent on care	18	11
D	Sits in wheelchair No capacity to support self Cannot stand unsupported Increasing dementia Double incontinence	0	3 ²
E	Passive resident Almost completely bedridden In later stage of dementia Decreasing in weight Double incontinent Totally dependent	0	8

observation of food preparation and mealtimes throughout the day and analysis of appropriate documents such as assessment tools and residents’ case notes were conducted. The issues explored through these methods were informed by reference to the National Minimum Standards for Care Homes for Older People (Department of Health 2003; WAG 2004) and nutritional guidelines and recommendations for care homes (e.g. BAPEN 2007; National Institute for Health and Clinical Excellence 2006).

Focus groups

A focus group, using a topic guide, was conducted with a sample of catering and care home staff (seven in H1 and eight in H2) in each home by two of the researchers. In total two focus groups (N=15) were conducted. The focus groups were useful in uncovering shared views and understandings of

particular issues within the groups of staff. The topic guide derived from the literature on nutritional guidelines and standards for care homes (BAPEN 2007; National Institute for Health and Clinical Excellence 2006; WAG 2004) included issues such as the use of nutritional assessment tools, assistance provided with eating and drinking, and their knowledge regarding older people's nutritional needs.

Interviews

Semi-structured interviews, using an interview schedule, were conducted with managers in a private area in each care home. Such interviews allowed flexibility in the way questions were asked; whilst the use of an interview schedule ensured the research questions would be addressed (Green and Thorogood 2009). The interview schedule was also derived from the literature and explored issues such as procurement of food and ensuring food quality, staff education on nutrition, and use of nutritional screening and assessment tools to identify residents at nutritional risk.

Additionally, semi-structured interviews, using an interview schedule, were conducted with residents (N=16) and residents' informal carers (N=10) in residents' own rooms or in a private area in the care homes; this helped to ensure anonymity and the familiar surroundings facilitated rapport between the interviewer and participants. Issues explored with both residents and informal carers included choice, quality and quantity of food, and in addition informal carers were asked whether or not they supplemented their relatives' meals. With participants' permission the focus groups and all interviews were audio-taped.

Observation

All observation of food preparation and mealtimes throughout the day was undertaken by two of the five members of the research team; this included informal conversations with staff. This involved observation of food preparation in the kitchens and observation of all mealtimes during the week (breakfast, lunch and dinner, mid-morning and mid-afternoon refreshments) in each care home; where it was possible and appropriate researchers would sit down and share residents' meals with them. Observation was conducted only during weekdays and the researchers adopted the role of 'observer as participant' (Gold 1958), interacting with the residents and staff but not adopting any specific role or being involved in any specific tasks. One researcher observed food preparation in the kitchens of each home from 8.45 am to 12.00 noon (6.5 hours of observation in total). During this time period, observations included food delivery, storage and preparation. Observation of mealtimes was organised so that one researcher observed

the serving of breakfasts in both homes (three hours of observation in total), one researcher observed the serving of lunches in both homes (three hours in total) and these same researchers observed the serving of an evening meal in each home (two hours in total). Observations also included mid-morning and mid-afternoon refreshments and attending residents' meetings in the care home, such as menu-planning meetings (1.5 hours in total). Sixteen hours of observation was conducted in total and recorded as field notes. Finally, a purposive sample of documents pertaining to nutrition in both care homes, such as policies, residents' care plans, assessment forms and menus, were reviewed and analysed with permission from residents where appropriate. These documents were considered in terms of their substantive content and also their context, that is the ways in which they were produced and how much attention was paid to them by those who used them.

The total sample size was 45 participants, which included 19 care home staff including managers, 16 residents and 10 informal carers; this sample size was considered adequate and appropriate to address the research aim and objectives (Sandelowski 1995).

Ethical considerations

The researchers provided a presentation about the study's purpose to all care home staff (catering, managers and care staff) and residents in each home. A written information sheet was provided to all those who attended the presentations and information packs were left with the managers to distribute to care home staff who were unable to attend the presentation and to informal carers when they visited their relatives. A poster about the study was also displayed prominently in each care home. All participants were given a written information sheet and the opportunity to ask questions about the study prior to giving written consent. Written permission to conduct observation of food preparation and mealtimes was obtained from the care home managers. All data presented have been anonymised.

Data handling and analysis

Data from the focus groups and individual interviews were transcribed verbatim by those who had conducted the interviews in order to ensure accuracy. Observation of food preparation and mealtimes were recorded in the form of field notes. The data generated were read by four members of the research team and analysed using thematic analysis. The aim of the thematic analysis was to identify key patterns and themes in the data using a process of coding, developing categories from clusters of coded data and then generating themes from these categories (Bowling 2002).

On a practical level, the initial coding was done using a highlighter pen accompanied by notes in the margins as the data transcriptions were read and re-read. Initial codes were grouped into categories and finally into themes; then the data were returned to in order to check that all the initial codes were encompassed into these themes. Analytical rigour was strengthened through the use of an iterative process, involving all four researchers moving between the data and the agreed coding framework (Barbour 2008).

Similarly, documents were analysed thematically in terms of their content and the context of their production (Prior 2003). Through making explicit the details and rationale of our key decisions throughout the study, we have provided an 'audit trail' (Guba and Lincoln 1989) which may be followed by readers and enhances the rigour of the study.

In discussing findings, excerpts use the abbreviations 'I' for interviewer, 'P' for participants (care home staff), 'M' for care home managers, 'R' for residents and 'C' for informal carers. Notes taken during the periods of observation are reported as field notes.

Findings and discussion

From analysing and synthesising all the data, four key themes emerged which were:

- sufficiency and quality;
- choice;
- assessment and responsiveness to needs;
- the social context and environment.

This paper reports findings from the last theme, the social context and environment which encompassed two main categories namely the physical or spatial environment and the socio-cultural aspects of food and mealtimes, particularly regarding shared meanings and memories of food. We discuss the ways in which care home residents' experiences and understandings of mealtimes were shaped by the inter-linked physical and socio-cultural environment of their lives. The physical elements of the environment include the homes' geographical locations and their physical layouts, both of which underpinned residents' experiences and their sense of community and identity. Thus, these physical features link to socio-cultural elements of the environment, which are complex and include people's socio-cultural backgrounds, their family experiences and memories, and their sense of community and identity; all of which inform their understanding of mealtimes. The findings were derived from the analysis and synthesis of the data generated by the multiple methods of data collection.

The physical environment

Mealtimes provided in care homes are organised according to a routine which has been viewed as structuring the day for residents (Nijs *et al.* 2006) and provide important opportunities for social interaction and companionship (Wright, Hickson and Frost 2006). In line with government policy, both homes provided a menu on a four-week rotation, offering a choice of meals, which was available for residents to read or have read to them prior to the meal to allow them to make a choice. Each home provided a summer and a winter menu, and residents were included in menu design and could raise any concerns about the menu at the monthly residents' meeting. Whilst both homes sought to provide personalised care and offered choice in respect of food options, where meals were consumed and to some extent when, especially with respect to breakfast, mealtimes were usually dictated by the home's routine. Mealtimes in each home were served around set times which took into account staff break times. Lunch was served between 12.45 and 1.00 pm and the evening meal between 5 and 5.30 pm in each home. In H1 breakfast included a cooked breakfast and was served from 9 am, whilst in H2 the timing of breakfast was more flexible and some residents were able to serve themselves breakfast of, for example, cereals. Whilst residents in H2 could have a cooked breakfast, cooking of hot food was rarely undertaken on the units due to health and safety concerns, so this was cooked in the main kitchen and brought up separately, so few residents opted for this choice. The last hot drink of the day with a snack, if requested, was served at 8 pm in each home. Snacks were available at any time, if requested by the residents, and fresh fruit was always readily available in both homes.

Regarding the spatial environment for mealtimes, residents in both homes took their meals in the dining rooms where the seating arrangements were broadly similar, as can be seen from the floor plans (Figures 1–3).

The dining rooms in both locations represented a significant community meeting point for residents, some of whom may not have seen much of each other during the rest of the day. Residents who used wheelchairs were sometimes brought to the dining room first but sometimes arrived in their own time; there were no strict rules about it. They also stopped to socialise on their way to (and through) the dining room.

In both homes the positioning of chairs and tables was described by staff as 'family style' inasmuch as residents ate at small, four-seater, circular dining tables, pleasantly laid with linen cloths and napkins, pretty china and flowers. However, as can be seen from Figures 2 and 3, H1 had two larger communal dining areas with three tables upstairs and six downstairs; whereas as Figure 1 indicates, H2, was organised into six separate eight-bedded units, each with

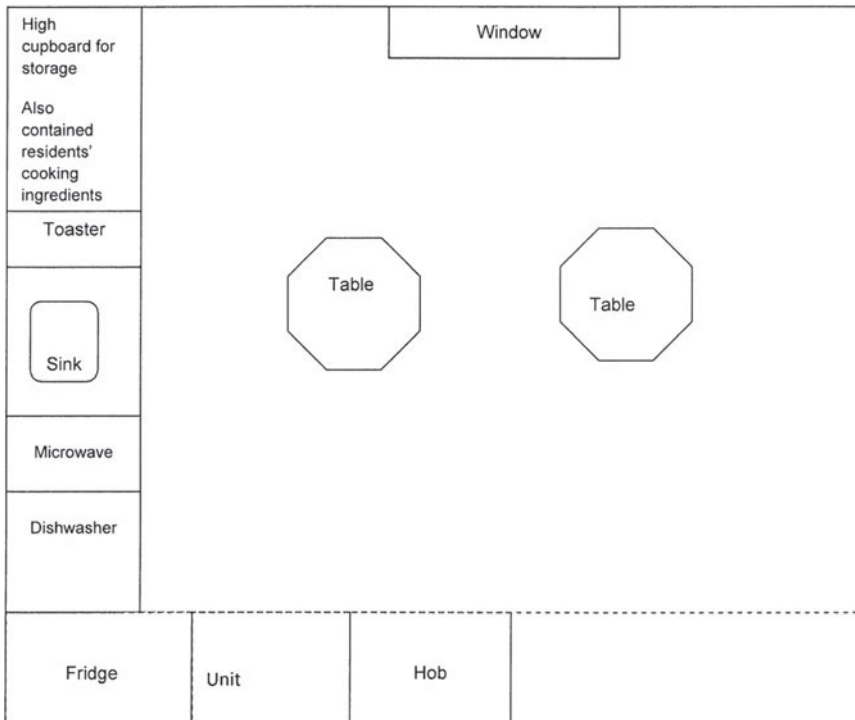


Figure 1. Dining area, Home Two.

its own smaller dining area containing just two tables, which undoubtedly enhanced the ‘homeliness’ of its dining areas. In addition, as can be seen from Figure 1, H2’s small kitchenettes adjacent to each dining area, with cupboards, a refrigerator, a sink, a toaster, microwave, dishwasher and a small hob, engendered the sense of a ‘normal’ kitchen-dining room. H1 had a similar set-up in its upstairs dining room, although there was no hob or sink; the downstairs dining room though was much larger, in more of a ‘canteen style’, and did not need a kitchenette as the main kitchen led off this room. The main kitchens in both homes housed large stoves, refrigerators, dishwashers and storage cupboards. In H2, whilst there was no large communal dining area, when whole home events were organised, for example at Christmas, these were held either in the attached day centre or in the large foyer area on the ground floor.

The spatial arrangements also contributed to important differences in the manner in which food was served to residents in both homes. In H1’s upstairs dining room, due to its distance from the main kitchen, food was served from a hot trolley into tureens from which residents served themselves at the

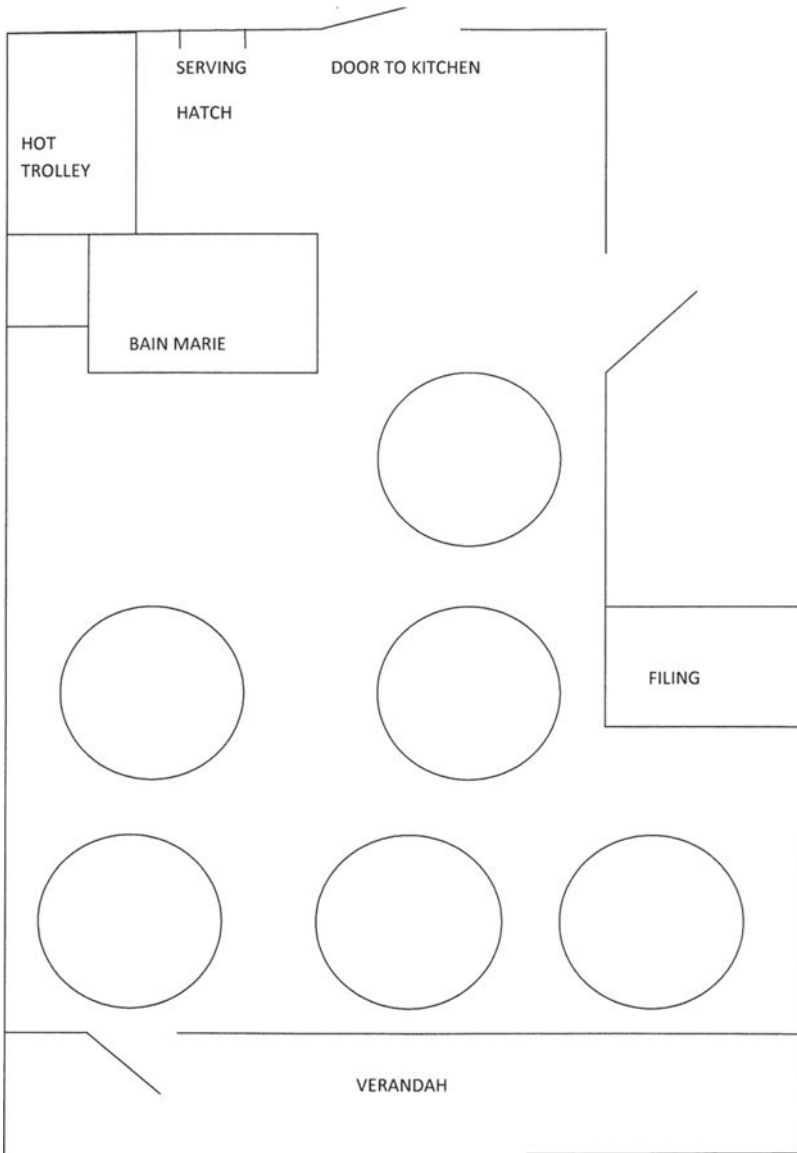


Figure 2. Downstairs dining room, Home One.

table; whereas in the downstairs dining room, which was adjacent to the main kitchen, food was plated up by staff directly from the hot counter. Residents were served their meals by the staff and did not collect their meals directly from the hot counter as per restaurant-style dining, to avoid any potential



Figure 3. Upstairs lounge/dining room, Home One.

safety risk. In H2, where the small unit-based dining rooms were some distance from the kitchen, staff plated up the meals from the hot trolley. Whilst staff did check with residents regarding their food choices, as staff were familiar with residents' food preferences, developed through their long-standing relationships with residents, there was a tendency to make assumptions about what residents liked and disliked. The implications of this

in terms of paternalism or beneficence are explored in the section below titled 'Food Choices and Identity' and is discussed further elsewhere (Merrell *et al.* 2012). With respect to portion sizes, portions were observed to be generous and there was always sufficient food. Indeed as one of the residents commented:

Oh yes! Enough for me. Dishes of vegetables on the table, yes. A lot gets wasted. Oh (whistles). My mother wouldn't have had it. She wouldn't waste a crust of bread. (R8, H1)

Having the downstairs dining room in H1 adjacent to the main kitchen meant that residents in this dining room were in close proximity to the smells of cooking; this was generally perceived as a good thing, adding to sensuous anticipation, stimulating the appetite and providing links to earlier memories. Whereas the other dining areas were quite distanced from the cooking areas and their sensory stimuli, which according to the code of good practice for residential and nursing care homes, can be viewed by some as a deprivation (CPA 1996).

There are different ideas as to what constitutes homeliness and concepts of community, as suggested by the following comment from a staff member in H1 who argued that the larger dining setting created a greater sense of community in that it provided opportunities to mix with a broader range of residents:

This is the old-fashioned way. I think it's better. In units you get six people who don't mix with anyone else. Here everyone has to see other people at mealtime. (Field notes, H1)

This view supports the findings by Willcocks, Peace and Kellaher (1987: 131) who report that unit or group living can be socially isolating. A further socially constraining factor inherent in the homeliness of the smaller units was that their size also led to congestion, especially if each table had a number of wheelchairs in position. This discouraged other people, such as friends and relatives or staff, from joining them for meals. Sharing meals with friends and relatives is one of the ways in which they may be encouraged to take part in the daily life of the care home (Brown Wilson, Davies and Nolan 2009; CPA 1996), enhancing its sense of community. This rarely happened in either of the care homes apart from special occasions, when relatives could share the buffet, which would be served in a larger communal area.

Choice of seating and social relationships

Residents would almost invariably sit in the same chair and hence with same people for each meal and in most cases had done this for many years.

However, the ‘choice’ was constrained by which seats were available upon their admission to the care home. Sitting in the same seat was encouraged by the staff and appeared to be conducive to conversation, support and companionship which others have reported (Pearson, Fitzgerald and Nay 2003; Sidenvall, Fjellstrom and Ek 1994), as exemplified in this interview excerpt with a resident:

I: And do you always sit in the same place?

P: Same place yes, same chair.

I: So you’ve got to know the other ladies quite well now have you?

P: Ooh *yes, yes* . . . Well the lady who sits by me, she’s been here for years. They’re all very helpful to me. I’ve got no faults at all here.

I: Are people friendly?

P: Oh yeah . . . very friendly.

I: So are you able to have a chat with people at mealtimes?

P: Oh yes, we talk a lot.

I: So you don’t get lonely?

P: Oh no. We sit by the table often after having food you know and have a chat you know. (R6, H2)

There were apparent social protocols and conventions for residents to negotiate in terms of joining dining tables where there were spaces; the following excerpt from a female resident suggests a certain amount of choice for both the would be joiner and the incumbent. The reference to the need to create a ‘family’ is also significant and will be returned to later:

I: And you always sit in the same place?

P: Oh yeah, yeah.

I: So how many other people are on your table?

P: Three and they’re all men – (laughs)

I: Is it a nice chance to have a chat?

P: Oh yes there’s X, Y and Z.

I: And they all talk?

P: Oh yeah, yeah.

I: So you enjoy having a social occasion as well [as your meal]?

P: Oh yes. I come on there and X wanted to come on there and he said ‘Can I join you?’ and I said ‘yeah come on we’re all one big happy family’. Well we are. You’ve got to be at our age isn’t it? (R3, H1)

Our observations also indicated a sense of sociability, companionship and community:

Around the room residents are sitting at tables of around four people and many are discussing the next day’s menu choices with each other. The residents are helping each other to make choices for the next day. There’s a sense of camaraderie – they sit

on the same table for each meal and so know each other quite well. (Field notes, lunchtime, H1)

However, sociability and companionship are greatly influenced by the nature of one's companions (Sidenvall, Fjellstrom and Ek 1994) and not all residents perceived their mealtimes as conversational opportunities. Some reported very limited conversation on their table as their dining companions were very quiet, hard of hearing or simply had nothing to talk about, as exemplified by these residents in H2:

We're very quiet up there all of us ... (laughs) because we're hard of hearing. (R8, H2)

There's not much talking because we're old people and the others have got nothing to talk about because they don't go out. (R2, H2)

The desultory nature of conversation between residents, chiefly revolving around their food and the weather, was also apparent in some of our observations in both homes; however, mealtimes were still essentially 'social' occasions and residents made efforts to ensure that those with impaired hearing were included in the conversations. There was evidence of reciprocity and mutual support in the social relationships between residents as they helped each other by passing condiments, pouring drinks for each other and ensuring that everyone had what they needed; thus encouraging a sense of belonging (Godfrey, Townsend and Denby 2004).

The following excerpt with a resident suggests that sitting on the same table with the same people every day may not necessarily be conducive to meaningful conversation or sociability:

I: Where do you sit?

P: On the same table each time.

I: How many people are on your table?

P: Three and with myself four.

I: Do you know them very well?

P: Yes through here yes but ... people are not very talkative.

I: Do you wish they were?

P: Yes ... I get very, very lonely and very depressed.

I: Oh dear. Why do you think people are not very talkative?

P: Well it's because of their age ... and ... their illnesses they're going ...

I: When you go to the dining room do people say hello?

P: They say good morning and that's about all.

I: Is that just on your table or are they all like that?

P: No, one table they're very talkative, but the table I'm on is very, very quiet.

I: Would you like to be on the more talkative table?

P: No not really, I just accept it as it is. (R1, H1)

Environmental influences on mealtimes were not entirely structured by the spatial confines of the dining rooms as residents could choose to eat alone in their rooms if they wished. This sometimes happened if residents were unwell or particularly tired, but was not viewed as desirable in the long term by residents, their family or staff. It was apparent that sociability and companionship were viewed as being very important. Some residents evidently thought that it was ‘easier’ for the staff if they went to the dining room, as indicated in this account from one of the oldest female residents; this excerpt also illustrates reciprocity between residents and staff and the ways in which mealtimes also provided mutual support:

I: When you have your mealtimes – do you go to the dining room?

P: Most times. It’s very rare I ask ‘em if I can stay here . . . if I don’t feel like rushing . . . I don’t want to rush sometimes . . . I have my cup of tea in here. It’s very rare I stay here for dinner . . . I make an effort because it’s easier for the girls. X [one of the other residents] is like a mother to us . . . Oh she’s wonderful. I’m older than her but she advises us if we want advice. She tells us to eat this or to eat that and we respect her. (R7, H2)

A staff member in H2 explained that sometimes residents did prefer to eat alone, suggesting possible reasons for this, which echoes the findings from Sidenvall, Fjellstrom and Ek’s (1994) study:

. . . [she] comments that it may not only be an issue of familiarity, but also discomfort at eating with people they don’t know, especially if they are self-conscious about eating difficulties. (Field notes, H2)

Drawing on the data primarily from the interviews with residents and their informal carers, some residents ate their meals outside the care homes, which is now considered.

Eating and socialising in other environments

Residents were able to move from their dining rooms entirely and take meals in the attached day centre, providing opportunities to meet people (some of whom they knew prior to their admission) from outside their home and to maintain links with the outside community. The design and layout of H2 with its easy access to the day centre directly from the care home facilitated the promotion of links with the outside community which were impeded by the design of H1, which despite having a walkway to the day centre, staff and visitors used the separate entrance. As neither day centre had separate cooking facilities the meals were cooked in the main kitchens of the care homes and transferred to the day centres in hot trolleys. Whilst residents from both homes rarely consumed main meals in the day centre, principally because the day centres were full to capacity, residents from H2, but not

from H1, would attend the day centre prior to or after lunch for morning coffee or afternoon tea and cake. This was especially the case for residents who were staying in the home for respite care and for those who were more independent, although H2 care home staff would accompany residents to the day centre on request. The design and physical environment of the homes, as evident from the floor plans (*see* Figures 1–3), impacted on the way in which food was served and the choices residents had with respect to where and with whom they ate their meals. Our findings reinforce those of Willcocks, Peace and Kellaher (1987: 115) that there is a reciprocal relationship between institutional design and institutional organisation. Moreover, some of the residents from H2 moved even further afield and took meals and refreshments with friends and family outside the care home and some residents attended various clubs outside the home where meals and wider social interaction were provided; some residents from this home also went shopping for food outside the home. The ability to take part in these outside activities depended on residents being physically able and also having family and friends outside the home, which indicates the heterogeneity of the residents and hence of their experiences. Residents in H2 were more likely to have resided within the community in which the home was located which engendered shared identities, whereas the residents in H1 came from a wider and more dispersed geographical area. The geographical location of the home also impacted on the ability to sustain relationships and integrate with the local community so that the community inside H2 appeared to be more ‘of’ the local community as opposed to that of H1 which was primarily just located ‘in’ the community. The lack of organic links and community integration of residential homes has been highlighted as an issue for some time (Willcocks, Peace and Kellaher 1987: 2).

The concept of community encapsulates ideas of both locality and social relationships and is notoriously difficult to define; although contested and value-laden, the term is generally viewed positively (Titmuss 1968; Williams 1984). A key element of community relates to shared identity which, C. A. Davies argues, it ‘both promotes and depends on; this aspect of community is constructed around cultural symbols and is closely tied to people’s identities and sense of belonging’ (2003: 3). Shared identities for H2 residents was enhanced by the fact that in many cases they knew each other from their previous lives, in some case going back to school days, and there were siblings and spouses in this home. Many of the staff in both homes were also recruited locally. In relation to care homes, S. Davies (2003) argues that both the residents and staff benefit from a sense of community due to its potential to enrich residents’ relationships and quality of life and to improve staff morale and job satisfaction.

This section has indicated that various aspects of the care homes' physical environments influenced residents' sense of sociability and community and hence their dining experiences. The difference in location and spatial arrangements between the two care homes has also been shown to influence social interactions and mealtime experiences. However, it is also clear that the physical environment is intrinsically bound up with socio-cultural elements; it is to these that we now turn.

Socio-cultural aspects – shared meanings and memories of food

People's understanding of food and its meanings is grounded in their socio-cultural background and we identified a web of shared meanings and memories of food amongst residents, informal carers and staff. It was noticeable that traditional food was viewed positively by all groups, for example, one of the cooks described himself as an 'old-fashioned cook – tripe and onions, faggots – that's me' (Field notes, H1). All the women residents and one of the men looked back warmly on their own cooking experiences prior to admission, recalling tastes and smells and preparing meals for their families. There were mouth-watering descriptions of cooking traditional Welsh food, joyfully recounted, rekindling memories of their earlier selves and confirming cultural identity as exemplified below:

I: Before you came in here did you used to do a lot of cooking?

P: Well yes, I used to. Lived with my mother didn't I (laughs). So I did what she said . . . and the family, the boys, liked their food, always have.

I: What kind of things did you cook for them?

P: Well dinner . . . cook a dinner and soups they used to like – home-made soups. Laver bread we used to like – oh yes. . . . laver bread oh yes we used to love laver bread.

I: How did you cook it?

P: Well you fry it in the frying pan . . . lovely. (R6, H2)

Many residents described their enjoyment of making a 'cooked dinner'; indeed residents, staff and informal carers all held in high regard and had a particular understanding of, what constituted a cooked dinner, often described as a 'proper meal'. A cooked dinner comprised roast meat, accompanied by potatoes and other vegetables and gravy (although pies could also be substituted for the roast meat) and was served in the middle of the day. The cooked dinner was seen as the *appropriate* meal for residents and was referred to approvingly by residents, informal carers and staff alike. For example, an informal carer referred to the lunchtime meal as a 'proper lunch . . . a cooked dinner and there's a pudding' (C4, H1).

Staff saw it as important to encourage residents to eat a ‘*nice hot, cooked dinner*’. In the unusual case of one resident who was unable to eat the proper dinner, the staff liquidised it:

So we blend her food most of the time so she has a hot dinner and gets the protein from the meat. (Focus group, H1)

The importance of the ‘cooked dinner’ in this area resonates with Murcott’s (1982) study of women in South Wales who regarded the cooked dinner, which in their case consisted of meat, potatoes, at least one other vegetable and, importantly gravy as the ‘“proper meal” par excellence’ (Murcott 1982: 677). Murcott refers to the ‘major symbolic significance’ of the cooked dinner and also notes that the women in her study had no concerns for their families’ health ‘as long as they were getting their dinners’ (1982: 678). It appears that this time-honoured meal provides significant links for residents, staff and informal carers to their collective memories of family mealtimes, reinforcing their own cultural identity; moreover, the traditional foods and customs are important in maintaining social cohesion (Evans, Crogan and Schultz 2005).

This connection by the women in Murcott’s study of the cooked dinner with the maintenance of health suggests the social construction of ideas as to what constitutes a healthy diet. Contradictions between the pleasures of taste and what is perceived as healthy shaped residents’ eating experiences. Savishinsky (2003) notes that eating may be one of the few sensory experiences left to many people and the tastiness of food and the memories it evoked was frequently mentioned by residents. This contradiction is illustrated in the following resident’s account in relation to chips:

P: [The chips] ... which are not tasty again. Everybody says that. Well the majority of them – the people that I’ve spoken to – they say there’s no taste with the chips at all. What it is I think they cook them in oil ... I think, I don’t know ...

I: And what did you cook yours in?

P: Well you know if I cooked bacon and I’d put the fat from the bacon with the chips then it was nice and tasty.

I: Oh my – very nice (both laugh). (R1, H1)

The staff had particular understandings, shaped by their socio-cultural backgrounds and political rhetoric, of what constituted a healthy diet, the cooked dinner was frequently referred to, as were fresh meat and vegetables; staff and informal carers used the word ‘fresh’ as a positive indicator of nutritional goodness (Lupton 1996):

We do have quite a lot of cooked dinners and we do cook a lot of fresh vegetables and things like that here. (M1, H1)

Moreover, the (UK) health promotion mantra of five portions of fruit and/or vegetables a day was frequently referred to, as was the avoidance of salt:

We look to try and give them the five vegetables a day and all this you know, health options and . . . They're pretty lucky, they have fresh meat every day, they have plenty of vegetables, five a day. Salt is not added in cooking, it's put on the tables for them to help themselves. We can't take the choice away from them, but then again we don't encourage it. (M2, H1)

The staff's perceptions of the meaning of healthy food were not gleaned from formal training although they had completed mandatory health and safety courses, which were concerned with food hygiene, storage, cleanliness and cooking temperatures for meat. Health and safety policies were strictly adhered to. There was also an expectation that adults would know about food and nutrition from their own personal repertory of skills:

Um, they attend, well, basic food hygiene, obviously they're all parents, mothers, grandparents, so they all prepare food, they're always talking about different recipes, comparing recipes. They understand the importance of presentation. (M2, H1)

People's own experience, the media and 'common sense' were frequently referred to as sources of knowledge about food. Despite this assumption that staff would know what constituted a healthy diet through common sense, instinct or general knowledge, there was generally a lack of awareness of current nutritional advice and recommendations for older people, and evidence of confusion in relation to saturated fats as exemplified in the following comments from staff:

. . .she [staff member] highlights the use of whole milk and tells me that it's important that older people have whole milk to ensure that they get enough calcium. (Field notes, H2)

. . .but then you can't give them *too* much bread because that's not good for you because we have the proper salted butter. We have got Flora as well obviously for . . . we have got one lady who we have to monitor her weight, obviously we've got others who need certain things for cholesterol and what have you. But more often than not on toast they would have butter. (M4, H1)

Although there were undoubted gaps in the staff's knowledge of nutrition, which could be rectified with appropriate education, our study highlights the ambiguities inherent in providing nourishment, in the full sense of the word, to older people. Arguably, if food provides pleasure, comfort and links with cultural roots which symbolise identity for residents, it could, in one sense be considered to be 'healthy' (*cf.* Evans, Crogan and Schultz 2005).

The symbolic meanings inherent in taking food and drink together are brought to the fore in their use to celebrate or commemorate significant

events; in both homes residents would come together into a large communal area (not their usual dining rooms) to mark these occasions. Buffet meals were also provided for residents and relatives in communal areas to mark the occasion of a resident's funeral. The customary Christmas fare would be served over the Christmas period and traditional Welsh dishes such as 'cawl' (a stew/broth of lamb and vegetables) and Welsh cakes would be served to celebrate St David's (the Welsh Patron Saint) Day. These celebrations were enjoyed by residents, staff and informal carers; the latter group commented on how nice the food was on these occasions. Residents were also taken out for celebratory meals at Christmas time and their birthdays were celebrated with specially made cakes and sometimes glasses of wine.

In addition to marking traditional ceremonies by eating foods, residents were encouraged to get involved in their preparation, again as a communal activity. For example, at Christmas residents were encouraged to participate in the preparation of mince pies:

And of course we were putting sherry in with the mince pie mix and some of the residents were having a sherry. Things were lovely. We had Christmas carols on at the time we were doing it, and obviously the Christmas decorations. And it was a lovely, lovely atmosphere, you know. (M3, H2)

These familiar rituals are symbolic of community, links to earlier memories and important in maintaining people's *identity*, which it is fruitful to explore further.

Families, food and identity

Lupton (1996) notes the ways in which the social dimensions of eating and those of emotion are linked through the context of the family. For most of the residents, admission to the care homes entailed separation from their families, although there were instances of spouses and siblings living in the same homes and sharing the same dining tables. Despite this separation, the influence of families permeated residents' and staff's perceptions of food and mealtimes in various ways.

First, the use of 'family-style' dining with small tables as described above was viewed very positively by the staff in that it was perceived as engendering a more homely atmosphere, which was regarded as beneficial to residents' dining experiences (*cf.* Crogan *et al.* 2004; Evans, Crogan and Schultz 2005; Nijs *et al.* 2006). Providing homeliness has been part of the rhetoric of care policy in Wales and the UK for some time (CPA 1996; WAG 2004), and it was also valued by residents and informal carers in both homes. Dining was embedded in familiar home and family rituals, such as coming to the small tables, helping each other with drinks and

condiments, recapitulating their personal memories of home and family, and reconnecting residents with their identities as individuals (Evans, Crogan and Schultz 2005)

Second, for residents and staff, the meaning of food and mealtimes was grounded in their own family experiences. The residents' accounts of their enjoyment of cooking and sharing meals with their families prior to admission indicate its importance to their sense of identity and continuity; whilst care staff, who tended to come from a similar socio-cultural background as the residents, also drew on their own family experiences for their understanding of cooking:

Most women working here are mothers – they've brought up children, they might have looked after their own parents. Umm, so I think you're probably relying on, you know your own instinct really and what's a good diet. (M3, H2)

Family and homeliness are also linked to ideas of normality and again staff set great store by achieving a semblance of normality for residents. The social interactions surrounding food and mealtimes were also demonstrative of 'normal' behaviour and residents took pleasure in sitting together for meals. Similarly, their reminiscences of earlier cooking for their families were also accounts of ordinary, everyday activities, connecting people back to their normal lives and selves. The staff in H2 recognised cooking as a normal activity which residents would have done in their own homes and, when possible encouraged this activity, which was also facilitated by the spatial arrangements – the unit-based kitchens – in this home. It was evident that the provision of the kitchenettes within the units and group living encouraged residents to participate more in mealtimes, enabled the storage of residents' own ingredients and provided opportunities to participate in cooking. Maintaining residents' involvement in food preparation is also recommended by the National Minimum Standards for Care Homes (Department of Health 2003). Experiences of normality, reciprocity and pleasure bound up with cooking are evident in the following quotation:

I think residents like cooking ... we had a lady ... she quite often went to cook something different. Whether it would be a curry, or something like that. And she'd have it on her unit then, for tea. Maybe with some of the other residents who would like that, you know. I just think it's a nice activity to do. It's something normal that people are used to doing. (M3, H2)

Sometimes staff members in H2 encouraged residents to join them in cooking, usually cakes, which would then be shared at tea-time. Our observations captured happy scenes of busy, chattering people, doing what was very familiar and normal to them, with tempting smells, evoking family memories and links to earlier roles, emanating from the ovens.

Although staff sometimes cooked with residents in H2, they did not take their own meal breaks with residents in either home, which arguably would enhance 'normal' social interactions between staff and residents, creating feelings of reciprocity and community (Davies 2001). Sharing of meals with residents appears to raise a number of contradictory issues; the key prohibiting factor raised by the staff was that sharing mealtimes would entail staff losing their entitled break (from their work) and they would consequently need additional time off as well as their mealtime. Clearly, despite the rhetoric about mealtimes being framed into categories of 'homeliness, normality and family', they are categorised by the staff as 'work'. Separation of residents and staff at mealtimes is a way of demarcating residents from staff and reinforcing status differentials, as Peace and Holland (2001) identified in their study of UK residential care homes registered to accommodate four or fewer residents. They found that even within these small care homes which were mainly adapted large domestic houses, activities and the division of domestic labour resembled that of a larger institutionalised residential care home setting rather than that of a 'normal' domestic home.

Informal carers also did not share residents' meals, which contradicts the above rhetoric; although they were often offered tea or coffee when afternoon snacks were being brought around for residents and were able to share in this refreshment activity. The importance of encouraging residents to invite guests in for either a meal or for just tea/coffee and biscuits to maintain relationships is highlighted by the Caroline Walker Trust (2004). Some informal carers commented that they felt it was inappropriate for them to 'intrude' on communal mealtimes, which suggests a different understanding again of the meaning of mealtimes. Informal carers' discomfort in sharing communal meals with their relatives may stem from the fact that this was not the norm in these homes, perhaps if this practice was established, informal carers would have less qualms about it. Best practice as evidenced by a review of international research evidence (NCHR&DF 2007) emphasises the need to promote a relationship-centred approach to creating community and developing a positive culture in care homes. Maintaining residents' identity through adopting a person-centred approach is encompassed within the eight best practice themes of the My Home Life programme developed by the UK Charity Help the Aged for improving the quality of care for all people (residents, relatives and staff) in care homes in the UK (www.myhomelifemovement.org). Opportunities for enhancing the involvement of residents' family and friends in the care home, through actively encouraging the sharing of meals, promotes a sense of community and contributes towards personalising residents' lives.

Food choices and identity

The ability to make choices relates to both psychological and physical wellbeing; the greater the perceived level of control, the less vulnerable the person feels (Crogan *et al.* 2004; Reker 1997; Westerhof *et al.* 2010), and is central to individual identity (Caplan 1997; Department of Health 2003; WAG 2004). As previously stated, both homes offered a choice of meals and a menu was available for residents to read or have read to them prior to the meal to allow them to make a choice. The following excerpt indicates flexibility and understanding in the event of memory problems:

Memory can be a problem as a number of residents forget what they ordered or forget what food they like. The cooks always prepare a few extra meals in anticipation of this but are also aware of many of the residents' preferences and are sometimes able to intervene. (Field notes, H1)

However, the notion of choice is nuanced through various elements of institutional care. First, the very nature of communal living necessarily restricts choice for the individual, as exemplified by staff in the following excerpt:

I: How is the menu designed?

P: Well, we have meetings we do, and we get residents' suggestions for what they would like to eat. And then we try to build a menu together with the residents and the officer in charge.

I: Are there any difficulties with that?

P: You always get one that's not happy don't you?

P: You can't please everyone can you? (Focus group, H2)

Resident choice was further complicated by staff's understandings of what was appropriate for them and 'knowing what they liked'; understandings that were grounded in their own socio-cultural background, as illustrated in the following excerpt concerning menu-planning, which significantly does not include residents:

...it's a combination ... the team, X and the kitchen staff. 'Cos we know what they like. If they like curry we'll put it on. But not many of them like curry so it's an option. We know what they like you see. (Focus group, H1)

Such paternalism indicates restricted choice for residents and suggests an imbalance of power (Phillips 2007). However, some residents expressed pleasure and approval that the staff knew them and their likes and dislikes; it represented 'knowing' them as people and enhanced their sense of belonging. As one resident commented:

The girls know what I want and they don't bring me things I don't like. (R7, H2)

Residents' choice is also linked to the previously discussed tension between what staff saw as their responsibility for providing what they understood as 'healthy' food and attempts to ensure resident autonomy and choice:

And you're looking in a, you know, healthy content. So you're not really having greasy chips and a greasy fry up. So you're looking at nutritional content. That way you're actually serving you know, obviously, fresh fruit and orange juice, things like that. Umm, for the clients, it's alright you know. Obviously we're a residential home and clients are able to say ... It could be the healthiest menu you could have but they could still refuse it. (M₃, H₂)

For the staff, the complexity of providing a healthy yet pleasurable diet for the residents in their care appears to be summed up in the following excerpt:

'They like the same things as us – the bad things. But if they're not going to eat anything healthy it's better for them to have a bit of something.' (Field notes, staff member, H₂)

This indicates the staff's identification with the residents' position but also a pragmatic approach to issues of health and choice.

Conclusion

This exploration of the factors influencing the nutritional care provided to residents in two different types of residential care settings and residents' experiences of mealtimes indicates the ways in which this experience was mediated through physical and socio-cultural environmental factors. The geographic and spatial context of the care homes was shown to be influential in shaping residents' mealtime experiences, especially in relation to their opportunities for conversation and companionship. In this study, we have highlighted that both types of environment, unit-based and communal, appeared to offer different opportunities and challenges for residents' socialisation. The unit-based accommodation did provide additional opportunities for residents to exercise more choice, for example, in terms of the timing of breakfast and in maintaining or developing their cooking skills, although the latter was dependent on staff resources. Residents themselves were far from an homogeneous group and their eating experiences to some extent were shaped by their physical bodies in terms of their communication abilities, their mobility and also by their links with the outside world.

Shared understandings of mealtimes from residents, their informal carers and care home staff all contributed to the construction of the meaning of food in the care homes. A key and novel finding relates to the complexity of the social construction of what constitutes 'goodness' in a meal. This

construction was informed by health policy rhetoric, but interpreted through the lens of their shared socio-cultural background. This interpretation incorporated some understanding of official views of a 'healthy' diet, but also included other important aspects of food, such as pleasure (especially in terms of 'tastiness') and links to home and family. These shared understandings, drawn from histories and memories, of the meanings attached to food and mealtimes were also important signifiers of community and homeliness in the care homes, adding to residents' sense of identity and self. These shared understandings sometimes posed dilemmas for staff in seeking to provide a healthy diet, whilst also being responsive to individual needs and resident choice and autonomy.

The findings indicate the importance of facilitation of social interaction at mealtimes through providing opportunities and seating arrangements which enable staff, residents and their families to eat together. We have also identified a need for appropriate training for care home staff on nutrition, including special dietary needs, to ensure that good nutritional care is provided. Since completing the study, catering and care staff within all the care homes in the local authority have been provided with relevant training on the nutritional needs of older people.

This qualitative study is limited in terms of its size and participants. Two residential care homes located in the same local authority were studied and additional research involving a larger number of homes over a wider area, including the independent sector, is needed. Moreover, residents with moderate to severe cognitive impairment were excluded and it is recognised that further research is necessary to capture the perspectives and needs of this vulnerable group. Lastly, due to the geographic locality of the study, there were no residents, informal carers or staff from minority ethnic groups which, given our concern with cultural influences on understanding of mealtimes, is an important, though unavoidable, omission. Further research in an area with a more diverse population would also be beneficial.

To conclude, this study has contributed knowledge to the paucity of research which has focused specifically on residents' mealtime experiences in care homes. We trust that we have provided sufficient information about the context of the study to enable readers to judge the transferability of the findings. Our findings have demonstrated how the physical and spatial environment is an important factor in influencing the organisation and delivery of meals, which in turn influences opportunities for social interaction and residents' mealtime experiences, which supports findings from research mainly conducted in nursing homes (Nijs *et al.* 2006; Remsburg *et al.* 2001), as there is a dearth of contemporary UK literature on this issue. However, in addition, this study has highlighted the complexity and myriad influences on residents' eating experiences in care homes,

of which the physical and spatial environment is one important factor, and clearly demonstrated the importance of the links between meeting older people's nutritional needs and their social and cultural needs, which to date has been a neglected area.

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