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The Role and Future Development of the Meals-on-Wheels Service for Older People in Ireland

Report No. XX

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National Council on Ageing and Older People

An Chomhairle Náisiúnta um Aosú agus Daoine Aosta

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Foreword

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Glossary of Terms

AUD	Australian dollars
BMI	Body Mass Index
CE	Community Employment Scheme
CSO	Central Statistics Office
DNA	Deoxyribonucleic acid
EBT	Electronic Benefits Transfer
ENP	Elderly Nutrition Program (USA)
ERHA	Eastern Regional Health Authority
EU-SILC	The EU Survey on Income and Living Conditions
FAS	Ireland's National Training and Employment Authority
FETAC	Further Education and Training Awards Council
FSAI	Food Safety Authority of Ireland
HACC	Home and Community Care Program (Australia)
HACCP	Hazard Analysis and Critical Control Point
HSE	Health Service Executive
LHO	Local Health Office
MNA	Mini Nutritional Assessment
NCAOP	The National Council on Ageing and Older People
NSP	Non-starch polysaccharide
NSW	New South Wales (Australia)
PHN	Public Health Nurse
RDA	Recommended dietary allowance
RNA	Ribonucleic acid
SPSS	Statistical Package for the Social Sciences
WHB	Western Health Board
WISP	Weighted Intake Software Package

Council Comments and Recommendations

Council Comments and Recommendations

1. Introduction

A satisfactory nutritional status is of paramount importance in establishing a good quality of life, particularly for older people... while poor nutritional status can precipitate the development of both chronic and acute conditions which naturally can increase morbidity and mortality as well as prolonging length of hospital stay.
(Food Safety Authority of Ireland, 2000)

In recent years, the National Council on Ageing and Older People (NCAOP) has noted the increased recognition of the importance of the meals-on-wheels services in improving older people's nutritional status, health and quality of life. In addition, there has been an increased awareness of the service as a vital source of social contact and connectivity for many older people who are vulnerable to social exclusion and social isolation:

The meals-on-wheels service provides regular meals and essential social contact for many older people. In this way the service will contribute to older people remaining at home and in better health.

Though the meals-on-wheels service has been in existence for some decades, the Council noted a dearth of information relating to it. **As a result, the NCAOP commissioned this study in order to provide a comprehensive picture of the service. The Council now recommends that its findings be used by all stakeholders to inform future service developments.**

Organisational Diversity

The most striking research finding relates to the wide organisational diversity found among meals-on-wheels services in terms of:

- number of clients
- number of days of operation
- management structure
- status (charitable organisation, voluntary, HSE)
- location
- cooking arrangements
- numbers and type of staff (paid/voluntary)
- sources of funding
- eligibility criteria
- training provided to staff
- perceptions of the quality of the service provided
- nutritional awareness among service providers.

Previous Council research has also found this diversity to be a characteristic of other community-based services for older people, such as day services and supportive housing. This diversity has arisen as a result of the key role played by voluntary providers in the organic development and delivery of services, in response to specific local needs, and often in the absence of more formally provided services, support structures and policies. Indeed, this research found that 80 per cent of meals-on-wheels services were either registered charities or did not have any formal status. 89 per cent of all meals-on-wheels staff are volunteers. However, though the meals-on-wheels service is characterised by diversity, the research has highlighted a number of factors common to most organisations, which challenge effective, efficient and high quality service provision.

Responsibility for the Support and Development of Meals-on-Wheels Services

Currently there is no legal entitlement to receive or obligation on the State to provide meals-on-wheels to older people. As a result, there is no clear direction as to who should be responsible for the support and development of the sector. Though the service is primarily a voluntary one, the Health Service Executive (HSE) supports the sector through the provision of Section 39 grants, in acknowledgement that the services provided are 'ancillary or similar' to those provided by the HSE. In its recent national service plans, the HSE has stated that it *provides* some services, including meals-on-wheels, *in partnership* with a range of statutory, non-statutory and community groups.

However, the research found that meals-on-wheels service providers consistently referred to the limited assistance and support provided by the HSE in the setting up, management and running of the services. **Given the increased recognition of meals-on-wheels services as part of the homecare services continuum and the acknowledgement by the HSE that it provides meals-on-wheels in partnership with other groups, the Council recommends that the HSE be responsible for the overall support and development of the sector.**

The Council notes the practical assistance provided by HSE Community Support Workers to meals-on-wheels providers in the HSE South region as an example of innovative practice in support of the service and the Council recommends that consideration should be given to the establishment of Community Support Workers nationally.

Operational Standardisation of Meals-on-Wheels Services

The meals-on-wheels service caters for the nutritional requirements of older people who may be considered as the most vulnerable of the community-dwelling population. It is critical, therefore, that the service provided is of the highest quality. **The Council notes the recent HSE review and professionalisation of the home help service and recommends that a similar exercise be conducted for meals-on-wheels services for older people in ireland.**

The Council is concerned that the role of volunteers in the provision of meals-on-wheels should not be jeopardised in any initiative to quality-proof the service. However, it supports recent statements in Towards 2016 (Government of Ireland, 2006) in relation to the regulation of voluntary provision of health and social care services:

While the Government should not seek to control and be involved in every aspect of voluntary activity, it does have a responsibility to provide an enabling framework to help the sector. While this involves direct supports, a delicate balance must be struck between having a relatively light regulation and maintaining proper accountability. (Government of Ireland, 2006)

Given the organic and resulting diversity of the sector, the Council recommends the development of national guidelines for the operation and management of meals-on-wheels services by the HSE in conjunction with voluntary stakeholders.

Clarification of Roles and Responsibilities: the Statutory/Voluntary Interface

Shaping a Healthier Future (DOHC, 1994) proposed that a specific statutory framework would be created between statutory health authorities and voluntary health organisations, which would recognise the roles and responsibilities of each sector. **Such a framework has yet to be developed and, in its absence, the Council recommends that service level agreements be developed between meals-on-wheels providers and the HSE as a prerequisite for the allocation of Section 39 grants. These agreements should be used as a mechanism for clarifying roles and responsibilities in the delivery of services.** Service level agreements should also, at a minimum, cover the following:

- stated service objectives
- evidence of needs assessment having been carried out
- number and type of staff to be employed
- quantum and type of services to be offered
- breakdown of costs
- number of clients to receive the service
- amount of funding to be allocated with funding dates/intervals specified.

The Council also proposes that the merits of using such agreements as a form of quality control should also be investigated. The Council welcomes that the HSE is in the process of finalising a national service level agreement that will be applicable to all services that it subsidises.

Funding

The service providers who took part in the study reported that fragmented, limited or sometimes inadequate funding threatened the sustainability of their operations. Furthermore, lack of information on funding sources and lack of access to certain funding schemes also affect services. While it was acknowledged that the HSE provided the largest financial subsidy to providers, it was considered insufficient to meet costs associated with service provision, such as:

- rent
- food produce/ingredients
- containers
- wages
- ESB
- gas
- insurance
- petrol
- alarm
- sundry expenses
- training
- telephone

Towards 2016 states that 'the Government is committed to appropriately resourcing the (Community and Voluntary) sector into the future as part of the agreement' and that 'the Government remains committed to reviewing the funding mechanisms for the Community and Voluntary sector, to identify areas of overlap and gaps' (Government of Ireland, 2006). Furthermore, the Government has committed to the provision of funding to cover core costs including staff, administration and on-going running costs for up to three years on a contract basis, subject to an agreed work plan and periodic review.

The Council welcomes this commitment and, in the first instance, recommends that the HSE increases the value of the subsidy that it allocates to meals-on-wheels services. In order to provide a robust rationale for increased revenue

funding, the Council recommends that the cost of providing a meal within a variety of organisational structures be quantified in order to inform the HSE of the adequacy or otherwise of its meals-on-wheels subsidies. The Council would be pleased to offer its assistance in this regard as appropriate.

The Council further recommends that standardised grant application procedures for voluntary organisations wishing to set up meals-on-wheels services should be established with clearly defined criteria for grant eligibility.

Assessment of Need

When asked about future concerns in relation to the provision of their service, meals-on-wheels service providers referred to difficulties in relation to estimating and meeting demand for their services. Currently, older people often receive health and social services, including meals-on-wheels, on the basis of where they live rather than on the basis of need.

The Council has made numerous recommendations in the past in relation to the need for a standardised and holistic needs assessment tool to measure the level and type of impairment or need among community-dwelling older people. A standardised needs assessment tool would enable better planning at a national level and would lead to a more equitable spread of service provision on the basis of need. The Council reiterates the need for such an assessment tool as a necessary first step in ensuring that older people can be directed to the services most appropriate to their needs and preferences. The Council understands that the HSE is currently engaged in the development of such a tool and would welcome the opportunity to assist in its programme of work in this regard.

Referral, Eligibility and Discharge Criteria

In addition to a standardised needs assessment tool, there is the need to develop standardised referral, eligibility and discharge criteria for all health and social care services, including meals-on-wheels services provided to older people in the community. These are critical to ensure that the right care is provided in the right place at the right time and necessary for the promotion of an efficient and equitable allocation of scarce resources.

Therefore, the Council recommends that the HSE lead the development of national referral, eligibility and discharge criteria for the meals-on-wheels service in liaison with relevant stakeholders. These criteria will become

increasingly important given prospective changes in client's demand for the service, reflecting higher dependency levels arising from the Government's commitment to maintain all, but the most dependent, in the community (DOHC, 2006).

3. Consultation with Meals-on-Wheels Clients

Service-Related Stigma

One of the aims of the research was to investigate the perceived stigma attached to the meals-on-wheels service that was reported in the *HeSSOP I* report (Garavan *et al.*, 2001). In this report, significant minorities of a representative sample of older people reported that they would feel embarrassed or somewhat embarrassed at using the service, even if they felt that they needed it. It is interesting to note that the meals-on-wheels clients who took part in this research did not refer to any feelings of stigma in availing of the service. Any misgivings that they had about using the service were more related to a reluctance to admit loss of autonomy rather than to embarrassment at using the service.

Sometimes services are offered in a manner that reinforces the notion that older people can no longer manage their own lives. It is critical, therefore, that the meals-on-wheels service is 'marketed' in such a manner that doesn't impinge on older people's sense of autonomy and encourages them to avail of it when needed. **Therefore, the Council recommends that current and potential clients be involved in developing services that are both acceptable to them and appropriate to their needs.**

Encouraging Feedback from Clients

Quality and Fairness: A Health System for You, (DOHC, 2001) proposed that monitoring and evaluation must become intrinsic to the approach taken at all levels of the health service and that there is a need for a more focused and in-depth assessment of the quality, equity and person-centredness of services. The Council notes that a number of participatory service evaluation initiatives have recently been implemented by the HSE and recommends that it should further encourage service providers to evaluate their meals-on-wheels services. A crucial component of any evaluation should be consultation with clients.

Though many of the older people who took part in the research were very complimentary about the meals received, opinions varied in relation to quality, variety, lack of choice, portion size and the temperature of the meals when they were delivered. Furthermore, the service providers who took part in the research reported limited complaints mechanisms and opportunities for the meal clients to provide feedback in relation to the service. **The Council recommends the development of clearly signposted complaints mechanisms within meals-on-wheels services and that, at a minimum, older people are encouraged to provide feedback periodically on the meals that they receive.**

4. The Social Role of Meals-on-Wheels

The maintenance of social links has a positive influence on older people's mental and physical health. Meals-on-wheels services play a vital role in providing social contact to clients, and this supports people to feel a connection to their communities and to remain living independently at home.

Most of the older people who took part in the research referred to the critical importance of the social contact that the service provides. However, only some of the service providers agreed that the delivery of the meal was only one part of the service. **The National Development Plan (Government of Ireland, 2006) has recognised the dual functionality of the service and the Council recommends that the service be resourced sufficiently to ensure that parity of esteem is extended to both aspects of service delivery.**

A critical factor militating against drivers having sufficent time to engage with clients was the need to keep the meals at an appropriate and safe temperature for other clients. Long journeys in rural areas and traffic congestion in urban areas further limits the time drivers can spend with clients. The Council considers that a possible solution in this regard may be an increased use of the cook-chill method of food preparation by meals-on-wheels service providers.

Fostering Volunteerism

The service providers who took part in the research outlined a number of difficulties in relation to sourcing volunteers to assist in delivering the service. This was considered as a significant threat to the future sustainability of services, given the reliance on volunteers (89 per cent of all staff are volunteers). *The White Paper on Supporting Voluntary Activity* (Government of Ireland, 2000) identified that 'there is a need to promote the active involvement of people in Community and Voluntary groups as an essential component of democratic society' and proposed that 'measures that encourage active participation in the community will be promoted'. *Quality and Fairness: A Health System for You* (DOHC, 2001) further promised that measures would be introduced to 'foster volunteerism' in the community, particularly with regard to providing services for older people.

Though many of the recommendations have yet to be been implemented, the Council notes the renewed focus on enhancing civic participation arsing from the Report of the Taskforce on Active Citizenship and hopes that explicit measures will be developed and funded to attract the wider public to volunteering generally and, specifically, to voluntary services for older people.

The Council notes the increasing role that Volunteer Centres are taking as brokers between individuals who want to undertake voluntary activity and organisations that seek to involve volunteers. The Council welcomes recommendations made recently in the report *Volunteers and Volunteering in Ireland* (Joint Committee on the Arts, Sports, Tourism, Community, Rural and Gaeltacht Affairs, 2005) that the existing volunteering infrastructure be developed through volunteer centres and Volunteer Centres Ireland (VCI) and that this recommendation has been matched by funding to employ dedicated development officers. **Given that the Council has made numerous recommendations in the past in relation to the establishment of volunteer bureaux, it recommends that the VCI be supported to encourage the development of volunteer centres nationally and funded appropriately.**

The Council also recommends that meals-on-wheels organisations engage in measures themselves to promote volunteering and to attract volunteers to their services, such as:

- effective communication about what volunteering is
- effective communication about the rewards of volunteering

- recruitment drives through second- and third-level institutions
- recruitment drives through existing volunteers.

Managing Volunteers

If the contribution of volunteers is to be truly acknowledged, investment will be needed to recruit, train and support them. However, even with the growing recognition of the value of volunteering in society, volunteers are frequently (and often inadvertently) not fully supported by the organisations they are involved with. The Citizen's Information Board (CIB) publication, *Managing Volunteers: A Good Practice Guide* (CIB, 2008) provides practical advice in relation to:

- managing volunteers
- the volunteer policy
- recruitment
- training
- support
- expenses for volunteers
- insurance for volunteers
- legal structures
- management committees
- resource agencies/funding agencies.

Furthermore, Volunteering Ireland, the national volunteer development agency offers a volunteer management training programme and provides a number of fact-sheets and leaflets in relation to managing volunteers.

The Council recommends that consideration should be given to using these resources as a basis for a training programme to assist meals-on-wheels organisations in supporting their volunteers. However, while the Council acknowledges the importance and potential of the social economy in providing community-based services for older people, it again recommends that the primary responsibility for supporting the development of services remains with the HSE.

Statutory Support

Towards 2016 (Government of Ireland, 2006) states that the Government remains committed to the principles underpinning the relationship between the State and the voluntary sector as set out in the *White Paper on Supporting Voluntary Activity* (Government of Ireland, 2000). The White Paper stated that 'statutory support will be available to the sector for mutually agreed programmes of activities and where these programmes are consistent with national policies and objectives, or where other public interest criteria apply'. Meals-on-wheels services enable more people to remain in their own homes and reduce instances of expensive and inappropriate institutionalisation, which is consistent with Government policy objectives for older people. **The Council, therefore, recommends enhanced statutory support for staffing should be available to the meals-on-wheels service.**

It is likely that such support will be critical to service development in the future given difficulties in attracting volunteers and the increasing need to pay some staff, particularly drivers, for their services. Furthermore, concern was expressed by some of meals-on-wheels service providers that funding provided through the FAS and CE Schemes for staff was constantly under threat of being terminated. **The Council recommends that the appropriateness of such a mechanism for the long-term funding of meals-on-wheels staff be addressed in order to ensure appropriate service development.**

6. Nutrition and Meals-on-Wheels Services

Policies and Guidelines

In recent years, the Council has become increasingly concerned to promote the importance of good nutrition among older people in all care settings[1]. In 1998, it launched its Healthy Ageing Programme and, with the Health Promotion Unit of the DoHC, jointly published a Health Promotion Strategy for Older People, *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998). Nutrition is one of the priority area addressed in the strategy and the overall goal in this regard is:

To ensure that older people have an affordable diet, which provides adequate nutrition and which optimises their health status.

1 The Council's 2006 annual Healthy Ageing conference, *Nutrition and Older People in Residential and Community Care Settings* (McGivern, 2007) focused on the importance of nutrition in later life, identified good practice and barriers to good practice in different settings, and identified priorities for the future, among them being the meals-on-wheels service.

In addition, the nutritional assessments of the sample of older people who took part in the research, though not representative of older people in general, corroborate the findings of research conducted by Corish and Kennedy (2003) and point to a high incidences of obesity and malnourishment (or a risk of malnourishment) among community-dwelling older people. The Council is extremely concerned at these findings, given the significant health risks associated with both, which include:

- higher mortality
- longer hospital stay
- increased need for nursing home care following discharge
- reduced likelihood of discharge from nursing home
- increased need for non-elective hospital readmission
- pressure ulcers
- cancer
- cardiovascular disease
- diabetes
- greater use of medications
- lower activities of daily living
- increased incidence of falls
- greater dependence on mobility aids.

Though the nutritional assessments of the sample of meals provided by the services that took part in the research indicated that they provided adequately for the energy requirements of clients (both male and female), levels of vitamin C, vitamin D, folate and calcium were found to be inadequate. The meals were also considered as being over-reliant on meat and provided limited fresh vegetables, fruit and dairy produce.

These nutritional deficits are worrying given that the research also found that the clients were very reliant on the nutrition from the meals provided to them for their overall daily nourishment. Though the Food Safety Authority of Ireland (FSAI) has developed nutritional guidelines specifically for older people (1999), currently, there is no legislation requiring those providing food services for older people to meet minimum nutritional requirements. Therefore, the Council agrees with

the FSAI that there is a need for a National Food and Nutrition Policy for Older People (FSAI, 2000).

Given the importance of nutrition to older people's health and quality of life and the reliance of many clients on the meals that they receive from meals-on-wheels, the Council recommends that, at a minimum, all services be required to avail of input and guidance from a dietician in the development of menus. This is a critical requirement given that the research demonstrated that currently only one in four services has benefited from input in this regard.

Training

Training of staff at all levels is critical to ensuring that a quality service is delivered. While the research highlighted that levels of health and safety training for staff in the preparation of food was high, it was reported that only one in four organisations had staff that attended training on the nutritional requirements of older people. **Therefore, the Council recommends additional training for meals-on-wheels providers in relation to the nutritional requirements of older people.** The FSAI has also recommended that:

Those preparing meals-on-wheels should be aware of the specific needs and preferences of the older person. Practical easy-to-follow food based on dietary guidelines should be developed and made available to those caring and providing meals for older people
(FSAI, 2000).

The Council concurs with this recommendation and would be pleased to assist in the development of such materials in consultation with relevant stakeholders. The Council notes that community dieticians in HSE Mid-Leinster have developed resource packs for hospitals and day care centres. These could also be used as models on which to develop resource packs and training for meals-on-wheels providers.

Nutritional Support for Older People

The Council notes, with alarm, the general eating patterns of some of the older people who took part in the research. Several clients spoke of how they 'stretched' the meals that they received over a number of days. In addition, many stated that they did not cook a proper meal on the days that the meals were delivered. **It is clear, therefore, that some older people require the service on a seven day per week basis and the Council recommends that services be extended to accommodate increased**

need as appropriate. The Council acknowledges the resource implications, in terms of funding and staffing, that an extension of the service would require. However, it also highlights that the gains in providing nutritious meals on a continuous basis and keeping older people healthier and in their own homes for longer, in many instances, outweigh these short- to medium-term increased financial outlays.

While it is recommended that meals-on-wheels services be provided on a seven days per week basis, there may be other (relatively inexpensive) measures that could assist older people in the acquisition of an appropriate level of daily nutrition. The research found that, among other things, the need for meals-on-wheels was related to an inability to shop and to cook meals. **In the first instance, the Council recommends that innovative measures be piloted to assist older people with their shopping.** For example, many local councils in the UK have introduced a weekly shopping service as part of their Support at Home Service, whereby a Home Support Worker collects shopping orders and delivers groceries to older people on a set day of the week.

Furthermore, where mobility is impaired, the Council recommends the development of a voluntary service, allied to the meals-on-wheels service, to assist with home cooking. Finally, for those who do no know how to cook (particularly recently bereaved men), the role of day services in providing cookery classes could also be investigated.

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Executive Summary

Executive Summary

Chapter One

Chapter One

Introduction

1.1 Background

Meals-on-wheels services have been operating in Ireland for many years, with some services dating back to the 1950s. It is one of the first services offered to older people as they become more dependent, but are still capable of continuing to live in their own home. As such, meals-on-wheels services are of first order importance in making initial contact with vulnerable older people and monitoring their care needs over time. Meals-on-wheels are also vital for some (younger) people with disabilities, who are able to live independently because of the support the service provides.

Meals-on-wheels can be of invaluable help not only to those experiencing difficulties with grocery shopping or operating cookers or microwaves, but also those who have come out of hospital or whose physical well-being has deteriorated for a variety of reasons. The benefits of meals-on-wheels can also stretch beyond the impact on meals clients themselves, as they can provide relief to informal carers and help to foster a sense of community within local areas. Meals-on-wheels services are often a local response to local needs and offer those living in the community an opportunity to provide support to their neighbours in need of extra assistance. In many cases, meals-on-wheels provide an opportunity for locally-based health services and the local community to work in partnership, and thus ensure that the needs of older people are catered for in a holistic way.

The aim of meals-on-wheels in Ireland is twofold: firstly, to improve the diet and nutritional status of meal clients; and secondly to increase the level of social contact afforded to clients, which also enables the early detection of need for other care services (McGivern, 2006). In many countries, where services have been systematically evaluated and where minimum standards for their operation have been defined by law, meals-on-wheels have been shown to be successful in achieving the two central aims of meals-on-wheels services i.e. improving the nutritional status of clients, including those at-risk of malnutrition (Keller, 2006; Millen *et al.*, 2002), and reducing levels of loneliness (Grant and Jewell, 2004).

However, there is currently little information available on the operation of meals-on-wheels services in Ireland. In addition, neither legislation regarding the nutritional value of the meals, nor national eligibility criteria for meals-on-wheels services in Ireland, currently exist.

As such, while the benefits of meals-on-wheels may appear self-evident, it is still important to ensure that the service is operating in an efficient and effective manner, is meeting the needs of clients and is operating to the highest standards.

This study presents the results of the first comprehensive overview of meals-on-wheels services in Ireland, highlighting the benefits and shortcomings of the service and outlining options for their future development. As the population of those aged 65 and over living alone is expected to double by 2021 (Connell and Pringle, 2005), it is important to ensure that the meals-on-wheels service is a high-quality, client-focused service and is in a position to meet the expected future growth in demand.

1.2 Rationale for the Study

The rationale for this study emerged out of concerns of the National Council on Ageing and Older People (NCAOP) in relation to the knowledge deficit regarding meals-on-wheels services for older people in Ireland. Prior to the study, very little was known about the availability, characteristics, impact, quality and future viability of meals-on-wheels services as they currently operate in this country. There was a dearth of data on even the basic characteristics of the meals-on-wheels service in Ireland. It was unclear whether services met demand, and anecdotal evidence suggested that the level of usage underestimated the true need for the service.

1.3 About the Study

The research was tasked with:

a) obtaining a general picture of all meals-on-wheels services in Ireland

b) conducting detailed case studies with six organisations and a selection of key staff members and volunteers from these organisations

c) carrying out nutritional assessments and semi-structured interviews with a sample of older people in receipt of meals-on-wheels services.

These three tasks were carried out by conducting a survey of all meals-on-wheels services in Ireland, collecting data on funding and meals provision from the Health Service Executive's (HSE) thirty-two Local Health Offices (LHOs), and undertaking interviews with staff from organisations from various locations around the country. In addition, in-depth interviews and nutritional assessments were carried out with over 60 meals-on-wheels clients in order to identify clients' levels of satisfaction with the service, as well as to assess whether meals-on-wheels plays a role in meeting their nutritional needs. The main components of the interview related to the pathway to becoming a meals-on-wheels client, experiences of the service, food shopping, eating habits, and possible changes in circumstances that may have affected eating habits and food intake (e.g. bereavement or illness). The Mini Nutritional Assessment (MNA) and a 24-hour dietary recall, administered by qualified dietitians, were used to establish each client's nutritional status. This combination of social and nutritional data makes the study unique and of relevance for policy-makers, service planners and other front-line staff; all of whom share a concern with improving the well-being of the older population of Ireland.

1.4 Structure of the Report

The next chapters of this report consist of an overview of relevant literature, an outline of the process involved in conducting the study and a detailed discussion of the findings. Chapter Two and Three review the international and national literature on meals-on-wheels and other relevant issues, such as alternatives to meals-on-wheels and the statutory support available to meals-on-wheels services in Ireland. Chapter Four offers an overview of nutrition and older people, the interface between food and socialisation, and older people and food poverty. Chapter Five outlines the methods used for the study, while Chapter Six presents the results of the survey of meals-on-wheels organisations and Chapter Seven outlines the findings from the interviews with coordinators, volunteers and main referral sources of selected services. Chapter Eight presents the findings of the social interviews with clients of meals-on-wheels while Chapter Nine outlines the results of the nutritional assessments carried out with the same group and the assessment of a sample of meals obtained from meals-on-wheels services. Finally, Chapter Ten presents the conclusions and recommendations for the future development of meals-on-wheels services in Ireland.

Chapter Two

Meals-on-Wheels: The International Context

Chapter Two

Meals-on-Wheels: The International Context

2.1 Introduction

Meal provision services can play an important role in improving the quality of life of older people who have difficulties shopping or preparing meals. They can also be a crucial component of community care policies that seek to maintain older persons in their own homes. This chapter examines the international contexts for meals-on-wheels and other community meals services.

2.2 Overview

Meals-on-wheels services are used in several countries to provide meals to older people and people with disabilities, and are usually one of a range of services designed primarily to support older people to continue living in their own homes. Meals-on-wheels services are not the only meals services for community-dwelling older people. Community meals services can be classified into two categories, meals-on-wheels and meals served in a congregate setting (centre-based meals). Meals-on-wheels and centre-based meals reach approximately 7 per cent of the older population in the United States (Millen *et al.*, 2002), while approximately 2 per cent of British people aged 65 and over, 2.6 per cent of older Australians, and 3.7 per cent of older Swedes receive meals-on-wheels (Statistics UK, Australian Meals-on-wheels Association, 2006; Australian Bureau of Statistics, 2007, Swedish Association of Local Authorities and Regions, 2006). This compares with approximately 2.4 per cent of older people in Ireland using meals-on-wheels services.[2]

2 Based on figures from O'Hanlon *et al.*, 2005. Data on the number of older people using centre-based meals services in Ireland is not available.

2.3 Profile of Meals-on-Wheels Clients

It has been suggested that a number of factors increase the risk of older people becoming under- or malnourished. Such factors, discussed in greater detail in Section 2.3, include social isolation, widowhood, dental problems, poor mobility, low socio-economic status, feelings of depression, illness or a medical condition, medication which impacts on the absorption of nutrients and living in care institutions (Forster and Gariballa, 2005; Sharkey, 2002). Additional research has shown that age, gender, low levels of physical activity, living arrangements and social isolation all influence the nutritional status of older people (Corish, 2006). In addition, poor oral health, polypharmacy, depression, illness and cognitive decline have a negative impact on the nutritional status of older people (Morley, 1997). The close link between the social and nutritional aspects of people's lives is highlighted in a study by Davis *et al.* (1990) that established a link between living alone, decreased psychological well-being and inadequate dietary intake.

Indeed, meals-on-wheels services tend to target the most vulnerable of all older people. Many studies report that meals-on-wheels clients are more likely to be aged 75 or older, female, living alone, widowed, less mobile, more socially isolated and to have lower incomes than the general (older) population (de Graaf *et al.*, 1990; Lee and Frongillo, 2001; Office of the Public Advocate, 2002; HDG Consulting Group, 2004). Other studies have shown that applicants for meals-on-wheels services are likely to be at higher risk for poor nutritional status (Coulston *et al.*,1996; Salmon and Gooden-Bridges, 2005).

2.4 Benefits of Meals-on-Wheels Services

2.4.1 Improving the Nutritional Status of Older People

Where targeted appropriately, meals-on-wheels services can prevent or remedy a deterioration in the nutritional status of individuals belonging to at-risk groups. Keller (2006) observed that clients of formal support (meals-on-wheels and other meal programmes with a social component) in Ontario, Canada, were less likely to be at high nutritional risk when followed up 18 months after the original screening process. Millen *et al.* (2002) showed that the nutritional status of those availing of the Elderly Nutrition Program (ENP) in the United States of America (USA) was significantly higher than that of non-participants. As can be seen in Appendix I, the ENP has consistently achieved positive results since its inception in 1983.

2.4.2 Maintaining Older People in Their Own Homes

While the primary benefit of meals-on-wheels programmes is the nutritional value they provide, many studies outline other advantages, such as their role in supporting individuals to remain living in their own homes for as long as possible. According to a survey of meals-on-wheels service clients carried out in the USA in 2004, home-delivered meals clients exhibited much greater levels of frailty or impairment than the general population aged 60 years and over, suggesting that these services contribute to maintaining individuals in their homes (Administration on Aging, 2004b).

Many older people use meals-on-wheels on a temporary basis, such as after coming out of hospital. In such cases, the service can enable the individual to regain full independence. In addition, many meals-on-wheels clients also use other types of meals services, such as centre-based meals (Bartholow *et al.*, 2003; HDG Consulting, 2004). Garavan *et al.* (2001) reported the following comment by a meals-on-wheels client in Ireland indicating how meals-on-wheels is an important element of the continuum of services that maintain older people in their own homes:

> *But now, I'm going down to the day centre Monday, Wednesday, Friday, I have meals-on-wheels Tuesday, Thursday. I've only weekends to think of … it was a lot off my daughters' [minds], that they were not worrying about me getting my food, because I always love my food.*

2.4.3 Building Social Capital

Many older people living alone lack social interaction opportunities as the social networks[3] available to them in the past have deteriorated; friends have passed away and reduced mobility and a reduction in income can close off other socialisation opportunities.

Grant and Jewell's study (2004) found a relatively low level of loneliness among clients using meals-on-wheels services, while Millen *et al.* (2002) reported that clients achieved higher levels of socialisation, when compared with non-participants, perhaps suggesting that meals-on-wheels services may play a role in alleviating loneliness, although it should be noted that neither study identified a definitive causal link between meals-on-wheels and levels of socialisation. However, meals-on-wheels staff

3 Social networks refer to the ties between individuals or groups and constitute one aspect of a concept known as 'social capital'. Social capital refers to the number of social networks or social supports available to an individual and how these networks can help one another. Citizenship, civic engagement and community networks are other elements of the social capital model. According to Pinquart and Sörensen (2001), the level of social capital is influenced by the quality of the social contacts of an individual, their socio economic status and the degree of involvement in social networks.

or volunteers are an important point of contact with meals clients and, if adequately trained, can play an important role in identifying changes in the client's health status.

The principal points of referral for older people to meals-on-wheels services in Ireland are Public Health Nurses (PHNS) and family members. However, access to and the decision to avail of meals-on-wheels may be seen in some cases as a function of the older person's embeddedness in their local community (Cartwright and Bartlett, 2004). In other words, access to and the decision to avail of the service may also be related to awareness of other people using the service, contact with health and social care professionals, knowledge of the organisers of the service and the level of trust they have in the service.

Grant and Jewell (2004) revealed in their study that two out of every three clients valued the personal contact with the volunteers providing the service as highly as the meal itself. Seventy-four per cent were happy with the amount of contact they had with the person who delivered their meal (although data on the time spent by volunteers with meal clients were not provided). Eighty-four per cent of clients reported that it was not necessarily important that the same person deliver their meal each week.

Meals-on-wheels can increase social capital and reduce social exclusion for older people by linking people with their communities and linking local areas into a social network of awareness. This can help an older person who is housebound to feel less socially isolated while also acting as an important contact point for emergency situations.

Meals-on-wheels can also reflect and enhance the social capital of the people who are involved in the preparation and delivery of meals. Cox (1997) has argued that volunteering is an important component of social capital at community level, which is significant as meals-on-wheels services are primarily operated by volunteers. Meals-on-wheels services can therefore be seen to create a social network and a network of trust, thus increasing a community's and society's social capital.

2.5 Shortcomings of Meals-on-Wheels Services

While the benefits of meals-on-wheels are evident, many services experience difficulties. These problems and challenges can be analysed from the perspectives of both the client and the provider. The clients may not derive the full potential benefit from the service for a number of reasons, including a lack of support for providers by the State and poor operating practices, e.g. a lack of knowledge and information

about the nutritional and social needs and preferences of actual and potential clients. Hutchin (2006) identified the lack of governmental support as one of the principal reasons why meals-on-wheels organisations in North Dublin experienced difficulties. Many of the meals-on-wheels organisations in the area were displaying signs of resistance to change with regard to managerial practices, compliance with health and safety legislation, and new approaches to meeting the growing demand for the service within their catchment area. According to Hutchin, this was as a result of the inadequate level of government funding, along with a lack of training for staff or volunteers in complying with new health and safety regulations, as well as direct pressure from HSE staff to increase service provision.

Many of the organisational and operational challenges that meals-on-wheels services face have been resolved in other countries through the establishment of a national meals-on-wheels association. For example, the Australian Meals-on-Wheels Association has a mandate to support meals-on-wheels services through the provision of training and information. The Association also aims to raise the profile of meals-on-wheels services and help with the recruitment of volunteers. Given the size of Australia, much of the support work is carried out regionally. The aims, objectives and services of one such regional association are outlined in Appendix I.

Another important factor for service provision is the lack of emphasis placed on meal utilisation by service providers. 'Meal utilisation' is a term used to denote the proportion of the meal actually consumed. The assumption that all of the meal is actually consumed leads to an overly positive picture of the nutritional value of meals and the effectiveness of the service. In reality, many clients throw out or share all or part of a meal, or keep it for later use without using appropriate storage which can lead to consumption of unsafe food (Henry, 2006; Fey-Yensan *et al.*, 2001). A study by Fogler-Levitt *et al.* (1995) observed that, on average, just 81 per cent of the energy content of meals was, in fact, consumed. The best utilised components were soup and desserts, indicating that these could be utilised as vehicles for incorporating additional nutrients to meals. Many reasons have been put forward for the practice of full or partial meal storage, including the provision of unappetising meals or food with unsuitable textures or consistencies, as well as food poverty, meaning clients cannot afford to buy meals on the days they don't receive meals-on-wheels (Henry, 2006; Gollub *et al.*, 2004).

It is also possible that some meals-on-wheels services do not provide meals with adequate nutritional value in the first instance. A study by Pargeter *et al.* (1986) of 124 meals-on-wheels clients using 24-hour dietary recall and 3-day dietary records found that some 55 per cent of study participants had sub-dietary requirement intakes

of protein and calcium. In a study by Stevens *et al.* (1992), 70 per cent of meals-on-wheels clients had intakes below 66 per cent of the dietary requirement for three or more nutrients. This figure of 66 per cent was thought to be significant as less than 70 per cent of the recommended dietary allowance is the threshold for nutritional risk. Asp and Darling's study (1988) of 27 meals-on-wheels clients found calcium, B vitamins and energy intakes of less than 67 per cent of dietary requirements. They also reported that foods eaten by meals-on-wheels clients in addition to the delivered meals provided low levels of these nutrients, indicating that nutrition education is essential for improving the overall dietary intakes of clients. Owen (1994) established that mean nutrient intakes of 44 female meals-on-wheels clients were inadequate in calcium and energy.

Among the reasons for sub-optimal meal utilisation are: an inability to eat certain foods; chewing difficulties; lack of appetite; inappropriate delivery time; dislike of the type of food provided;, disagreeable texture; and unfamiliarity of the food (Fogler-Levitt *et al.*, 1995). Fey-Yensan *et al.* (2001) noted that the risks associated with delayed consumption of home-delivered meals could be avoided through the provision, by community dietitians, of home-based food safety education for homebound older people, their families and caregivers.

Share (2005) reported in her analysis of service providers in the north-west of Ireland that considerable variation exists in food safety practices and food-related training of staff, while Hutchin (2006) noted that one volunteer to whom she spoke expressed a high level of hostility in relation to food safety standards, proclaiming 'I've never poisoned anyone yet'. However, as the typical client of a meals-on-wheels service is frailer, more likely to be malnourished or undernourished and to have reduced immune system response (Fey-Yensan *et al.*, 2001), special care should be taken to promote the health and safety of this vulnerable group.

Share (2005) also reported that nine out of every ten providers operating in the north-west of Ireland do not have the nutritional content of meals assessed by a dietitian. In addition, when asked about whether they use a menu cycle or menu rotation (i.e. a regularly changing menu to ensure that clients are given a well-balanced diet), many did not understand either term, perhaps suggesting that few have formally incorporated this practice into their service. Such practices are fairly standard in the USA, as a result of the stipulation that meals served under the ENP must provide at least one third of the recommended daily intake established by the Food and Nutrition Board of the National Academy of Sciences National Research Council (Administration on Aging, 2004a), with results of a recent national survey indicating that dietary intake is as good as or better than the dietary intake for the general population aged 60

years and over (Administration on Aging, 2004b). In addition, regular evaluation and analysis of services means that the Administration on Aging helps to ensure that each organisation is providing clients with nutritious and well-balanced meals. In Australia, the recommended nutritional value of meals is defined in the Commonwealth Department of Health Nutrition Guidelines.[4]

In the United States, Asp and Darling (1988) carried out an evaluation over a six-year period of the nutrient content of home-delivered meals and compared these with federal guidelines for meal pattern and serving size. They found extensive variation in serving sizes and failure on the part of some organisations to deliver some components of the meals. The study recommended increasing the serving sizes for meat, fruit, vegetables and desserts, greater variety in fruit and vegetables, the inclusion of high-calcium foods and the delivery of milk with the meals. In Australia, the Northern Sydney Area Health Service study (1992), found that meal sizes differed considerably between services, and appeared to be governed by the size of the foil trays used and subjective judgments of catering staff. Baghurst (1989) recommended improving meals by adding skimmed milk to sauces and casseroles, including more fresh fruit instead of fruit juice and using leaner meat. Olin *et al.* (1996) recommended that meal providers increase the nutrient density of meals in order to bring about adequate energy intakes. Stevens *et al.* (1992) also suggested that nutrient intakes could be improved by providing more individualised meals, i.e. accommodating both needs and preferences within the nutritional requirements of the clients.

Several studies (Lipschitz, 1991; Herndon 1995; Coulston *et al.* 1996) recommended the use of nutritional screening protocols to assess the nutritional status of existing and potential meals-on-wheels clients. While highly sophisticated nutritional assessment tools exist, they are often not practicable in community settings where a wide range of professionals, most of whom are not trained dietitians, are involved in screening. In many countries, 'quick and easy' but also reliable nutritional screening protocols have been adopted for use by non-nutritionists who can, where appropriate, refer individuals of concern to a dietitian for a more detailed assessment. For instance, the Northern Sydney Area Health Service developed a nutrition assessment guide for use by workers with no previous nutritional assessment experience. Figure 2.1 below outlines the ten questions contained in the Nutrition Risk and Monitoring Tool that was developed by dietitians in the State of Victoria in Australia and that is now used by a wide range of community care professionals (Vos, 2007).

4 MOW should aim to provide two-thirds of RDI for vitamin C, half of the RDA for vitamin A, thiamine, riboflavin, niacin, protein and minerals and one third or more of the RDA for energy.

Figure 2.1: Nutrition risk and monitoring tool

Check for:

- Obvious underweight or frailty
- Unintended weight loss
- Reduced appetite, reduced food or fluid intake
- Mouth, teeth or swallowing problems
- Follows a special diet
- Unable to shop for food
- Unable to prepare food
- Unable to feed self
- Obvious overweight affecting life quality
- Unintentional weight gain

Refer person to dietitian if answer to one or more questions is YES as the person may be at risk of malnutrition.

Demographic and social change in several countries, such as the USA, Australia, Canada and the UK have also led to difficulties in providing an optimal service. A growing older population coupled with a decline in the number of people willing to volunteer due to busier lifestyles means that many meals-on-wheels services are struggling to meet demand as a result of difficulties in sourcing enough volunteers to deliver the meals (City of Edinburgh Council, 1999; HDG Consulting, 2004; Owen, 2006). It is likely that such problems are being experienced by service providers in Ireland as the population of those aged 65 and over is growing, and longer commuting and working times have led to a decline in volunteerism (National Committee on Volunteering, 2002; Connell and Pringle, 2005). However, little research has been carried out on this issue in Ireland. Furthermore, the increase in the older population born outside Ireland will also create a new challenge for service providers, who will need to offer more diverse and culturally appropriate meals. Countries that have a longer history of ethnic diversity and immigration have already begun to respond to this challenge: in Australia, for instance, some meals services provide meals for the Aboriginal and Chinese communities. Indeed, meals-on-wheels services in Victoria, Australia, have managed to overcome many of the challenges faced by meals providers (Appendix I).

2.6 Barriers to Using a Meals-on-Wheels Service

It has been suggested that stigma acts as a powerful barrier to the take-up of meals-on-wheels. A review of meals-on-wheels services in Edinburgh carried out in the late 1990s reported evidence that some people who qualified to use the service did not take it up due to the stigma attached to the service (City of Edinburgh Council, 1999).

Stigma has also been reported to be a significant barrier in Ireland. Ten per cent of older people interviewed in 2004 in two of Ireland's four former health board areas (the Eastern Regional Health Authority and the Western Health Board) viewed the prospect of using meals-on-wheels as fairly or very embarrassing, while a further 20 per cent found the prospect somewhat embarrassing (O'Hanlon *et al.*, 2005).

It is possible that the stigma associated with receiving meals-on-wheels arises to a large extent from the means-tested nature of the service that to older people in some countries in particular is reminiscent of 'poor relief' and similar charitable 'handouts' (Costigan *et al.*, 1999). A number of organisations in the UK and USA have stopped using eligibility criteria or have started imposing a small charge for the meals in an attempt to minimise any perception of stigma. Such practices serve to remove the purely charitable character of the service that can deter take-up of the service by older people or people with disabilities who do not perceive themselves as being in need of free services. However, it is important to set the charge at a level that does not have the unintended consequence of deterring the poorest from using the service. In Ireland, over half of all those aged 65 and over have incomes below the relative weekly income poverty threshold of €252 (CSO, 2006).

A growing body of literature indicates that there is a low take-up of health and social services by older people for a variety of reasons. Individuals who refuse help are likely to include those who are availing of an alternative source of care; those whose knowledge of a programme or service is limited; those who may feel that the service does not meet their needs; those who fear direct or indirect financial costs; those with a lower level of self-esteem; and those with psychopathological issues (e.g. individuals who feel that they are not entitled to services as a result of a mental health problem) (Oliver and Mossialos, 2004; Howse *et al.,* 2005). Howse *et al.* suggest that service providers can encourage a higher level of take-up by involving older people in service planning and some organisations emphasise the health benefits of meals-on-wheels to encourage reluctant individuals to avail of the service.

Collecting feedback about meals-on-wheels services with a view to understanding the strengths and weaknesses of the service from the point of view of clients can also be very challenging. De Graaf *et al.* (1990) state that it is difficult to assess opinions about delivered meals due to clients' fears of losing the service as a result of criticism. Furthermore, as was pointed out above, meals-on-wheels can be seen as charity by many people who therefore have low expectations regarding the service and do not feel that it should be subject to criticism.

2.7 Targeting the Right Users

One of the difficulties experienced by many meals-on-wheels organisations is ensuring that the service is being used by those who need it the most. This is often done by using eligibility criteria or referral systems, usually focused on income level, health status or age. While using eligibility criteria has some disadvantages, they can be useful for prioritising those most in need of the service. However, in order for such a system to be effective, the method used to select new clients must be transparent and consistently applied.

A study recently carried out in the UK indicated that eligibility criteria used for referral systems are not consistent throughout the country and are rarely reviewed to ensure that they are fully transparent (Lumbers and Hunter, 2005).

In the USA, Sun Lee *et al.* (2005) reveal that over 60 per cent of food-insecure older people had not received services from the Elderly Nutrition Programme due to inefficient referral or targeting methods, such as a failure to administer a standard eligibility test to the target group[5]. They concluded that it is thus possible that a large proportion of eligible individuals are not receiving, or perhaps not even aware of, the service.

Where limited resources exist, methods of targeting those most in need are often necessary and need to ensure that all those in need of the service can access or apply for the service easily. It is also important that the social benefits of the service be recognised by service providers and referral sources.

5 Food insecurity refers to lack of access to sufficient food to meet basic needs fully at all times due to lack of financial resources (US Department of Agriculture, 2006).

2.8 Alternatives to Meals-on-Wheels

Meals-on-wheels are not the only source of nutritious meals for older people. Many community and voluntary organisations, as well as the State, also run other services with a view to ensuring that older people remain well-nourished.

2.8.1 Centre-Based Meals Services

Centre-based services are provided in sites, such as day centres for older people in many countries, usually by community and voluntary organisations. A lunch or main meal is provided along with other activities such as a form of physical activity. The clients of community meals services share many of the characteristics of meals-on-wheels clients. Clients of the ENP's congregate meals service tend to be from lower socioeconomic groups, aged 75 and over, and have a higher than average nutritional risk (Administration on Aging, 2004b). The social function of community meals programmes is a central component of the service. A number of studies have shown that socialising is one of the principal reasons people attend lunch clubs or congregate meals (Dichiera *et al.*, 2002; Share, 2005; Lumbers and Hunter, 2005). Centre-based meals services often provide other activities along with the meals, such as physical activity, cooking programmes and health education classes. In the UK, programmes for meals to be provided in a pub rather than in a community centre have been initiated to try to minimise the stigma attached to receiving a meal subsidised or paid for by the State, as well as to give socially isolated older people the opportunity to socialise in a more relaxed environment. For older men, in particular, such arrangements in the 'normal' setting of a café, pub or restaurant used by all age groups may be a more approachable and acceptable alternative than a day centre or similar setting that can be perceived of as a 'women's club' (Davidson *et al.*, 2007).

2.8.2 Shopping Assistance

One of the factors that leads to a high nutritional risk among older people is poor mobility (Corish, 2006). Therefore, a number of programmes now provide transportation to shopping centres or deliver uncooked food to older people so that they can prepare their own meals. Some services also offer a shopping companion to those unable to manoeuvre around the shop by themselves (Spark and Frongillo, 2004). A study recently carried out in the UK indicated that supermarkets can be difficult for many older people to move around. Many barriers, such as poor lighting, narrow aisles and unreachable shelves act as a disincentive for older people to go shopping, thus creating a dependency which could otherwise be easily avoided (Arber and Hunter, 2005).

2.8.3 Provision of Uncooked Food

Another State-funded programme currently operating in California, called the Brown Bag Program, provides surplus unmarketable edible fruit, vegetables and other unsold food products to people aged 60 and over on low incomes. The food is not intended to meet all of the nutritional needs of older people, but to supplement their diets (Bartholow *et al.*, 2003).

2.8.4 Assistance for Purchasing Food

The Food Stamp Programme in the USA operates in a similar way to the Brown Bag Program. Operated by the Food and Nutrition Service, it enables low-income families to buy nutritious food with Electronic Benefits Transfer (EBT) cards in authorised food stores.

2.8.5 Frozen and Cook-Chilled Meals

Several meals-on-wheels organisations have started to offer cook-chilled or frozen meals as well as or instead of hot meals. Cook-chill meals are meals that are cooked and at the same time pasteurised, immediately chilled to minimise nutrient loss and stored at safe temperatures (0-3oC). Cook-chill meals are regarded by many as hygienically safer and more nutritious than meals that are delivered hot. Cook-chill or frozen meals give individuals a choice of when to eat their meal, relieve the pressure on drivers to deliver meals while they are still hot and enable individuals to buy or receive more than one meal at a time, which is useful when the local meals-on-wheels service does not deliver every day. However, concerns have been raised about whether it is beneficial to serve frozen or cook-chill meals rather than fresh food, given that some meal clients have difficulties in reheating meals (Owen, 2006). As such, many services carry out assessments to ensure that clients can safely reheat the meals. Cook-chill foods have also been criticised for the rigidity of the portion sizes, a loss of flavour and difficulties in supplying meals of a modified consistency. In addition, it is important to distinguish between frozen meals prepared by meals-on-wheels services, as opposed to those offered by supermarkets; the nutritional content of which has been questioned by dietitians, due to their high levels of salt, saturated fat and sugar (Farm 1997; Brinck, 2000; Arvén, 2003).

2.9 Summary

Meals-on-wheels have many benefits. They can help to ensure that the nutritional requirements of older people are met and thus can contribute overall health, well-being and quality of life. They provide clients with a measure of social contact and a 'check-in' on the days the meals are provided and thus can both decrease feelings of loneliness and enable early detection of problems that require further interventions.

However, the service has some shortcomings. There is no guarantee that a client will eat the whole meal straight away or at all, thus reducing the nutritional benefit of the meal. Also, meals-on-wheels services are often provided by voluntary organisations that may suffer from a lack of funding and governmental support. This can result in services facing financial pressures and resource problems, which can affect the quality of the service. The lack of standards for the provision of services can create a situation where the availability and quality of the service varies greatly.

Those in need of meals-on-wheels services may not always be able to access them. In many countries, meals-on-wheels are provided to those deemed most in need, as a result of inadequate resources; those who are borderline may be refused the service. This is compounded by the fact that eligibility criteria are rarely strictly adhered to; service providers can use their own discretion as to who can receive meals-on-wheels. It is possible that many of those in need may not be able to access the service as a result.

Several countries currently face further difficulties in providing the service. The increase in the population of older, vulnerable people, coupled with a reduction in the number of people available to volunteer, has led to difficulties delivering meals to those in need. The needs of older people are also becoming more diverse, both in terms of ethnicity and tastes. With similar trends developing in Ireland, the need to plan future service provision is paramount.

Chapter Three

Meals-on-Wheels: The National Context

Chapter Three

Meals-on-Wheels: The National Context

3.1 Overview

Very little research has been carried out on meals-on-wheels or community meals provision in Ireland. Availability of meals-on-wheels increased in the 1960s, with the introduction of Social Service Councils throughout the country, on foot of recommendations in *The Care of the Aged Report* (Report of an Inter-Departmental Committee, 1968). However, meals-on-wheels services, along with other home care services for older people, were not set up in a structured or planned manner. This means that services are more widely available in some parts of the country than in others (Garavan *et al.*, 2001).

Currently there are only approximate estimates of the scale and level of provision of meals-on-wheels services and virtually no information on the characteristics of service providers. A number of surveys that have not focused on meals-on-wheels exclusively have nonetheless included estimates of levels of service utilisation in Ireland (see Section 3.2).

A small number of studies focusing specifically on meals provision for older people in local areas have been carried out in recent years. Share's (2005) analysis of community meals (i.e. centre-based meals and meals-on-wheels) provision in the north-west of Ireland indicated that services were reaching the most vulnerable in the area and that clients reported a high level of satisfaction overall. However, some potentially serious problems were also brought to light, namely the low level of input from dietitians in devising menus and a high degree of variation in food safety practices among service providers. Hutchin (2006) revealed that voluntary organisations perceived a low level of support from the State in running their organisations. Furthermore, she argued that many community-run organisations were finding it increasingly difficult to meet increased demand for the service, due to the need to comply with strict food safety and hygiene regulations, coupled with a decline in volunteerism.

3.2 Current Level of Service Utilisation in Ireland

An examination of health and social services for older people, conducted in 2000, and repeated in 2004, indicated that 4 per cent of people in the urban ERHA area and 1 per cent in the WHB area were using meals-on-wheels service (Garavan *et al.*, 2001; O'Hanlon *et al.*, 2005). While the sample used for the study was not necessarily representative of the older population, it is reasonably safe to estimate that the percentage of older people in receipt of meals-on-wheels in Ireland in 2004 was approximately 2.3 per cent. Those in higher socioeconomic groups were more likely to be using the service, as were females, those aged 80 and over, those living alone and those with lower levels of mobility (O'Hanlon *et al.*, 2005). These characteristics are similar to the characteristics of meals-on-wheels clients identified in studies conducted in other countries. Meals-on-wheels were used on average three times per week with 91 per cent of users indicating that they were satisfied with the service (Garavan *et al.*, 2001).

3.3 Forecasting Future Demand

While the proportion of older people in Ireland currently availing of meals-on-wheels services is low in comparison with other European countries, this is expected to change, with Ireland 'catching up' with some European countries over the next two to three decades (Connell and Pringle, 2005). Projections of population ageing in Ireland carried out by Connell and Pringle indicate that the percentage of males aged 65 and over in the general male population will increase from 9.7 per cent in 2002 to between 13.9 per cent and 14.1 per cent in 2021, while the percentage of females aged 65 and over in the general female population is expected to increase from 12.5 per cent in 2002 to between 15.8 per cent and 16.4 per cent in 2021. Connell and Pringle also forecast a doubling of the number of older people living alone.

As growth will be most rapid in the oldest age groups, the 'oldest old' will make up a higher proportion of all older people in Ireland. While the proportion of the older population in need of health and social care may in fact decline due to improvements in health, the absolute number of individuals in the 'oldest old' age group, where care needs most frequently arise, is set to increase significantly. This demographic change, in combination with social and economic changes such as higher levels of female labour market participation, is likely to lead to an increase in the demand for services to support older people, including meals-on-wheels. If the 2.3 per cent of the older population estimated to be in receipt of meals-on-wheels (Garavan *et al.*,

2001) is translated into absolute numbers, the total number of clients in 2002 was approximately 10,000 (based on Census figures for 2002). If a similar percentage of older people were to receive meals-on-wheels in 2021, this number will rise to approximately 16,000, on the basis of Connell and Pringle's estimates. When the increase in the number of people living alone and the increase in the population aged 75 years and over are taken into account, it is possible that the number of older people requiring meals-on-wheels services in 2021 may have doubled to approximately 20,000 people. However, it should also be considered that the needs of the generation that is due to retire in the next 10 to 15 years may differ from current users of services for older people, as has happened in Victoria, Australia. Indeed, given that they are generally healthier and better educated than the current generation of meals-on-wheels clients, the future users of meals-on-wheels may be more aware of the choices available to them, such as ordering groceries over the Internet or ordering cooked meals over the phone from restaurants. More in-depth analysis of the likely future demand for meals-on-wheels thus needs to be carried out in order to ensure services can meet diversifying needs.

3.4 Health and Social Care Services for Older People in Ireland

The provision of meals-on-wheels and community meals for older people takes place within the context of National policy on care for older people. As such, it is useful to outline some of the relevant policies affecting service provision at present and likely to affect it in the event of future changes to the services provided.

At the heart of national policy is the goal of maintaining older people at home at an optimum level of health and independence. This policy was first put forward in *Care of the Aged: Report of an Inter-Departmental Committee* (1968), established to examine and report on the general problem of the care of older people and has remained a central tenet of policy on older people (Working Party on Services for the Elderly, 1988; Department of Health, 1994). The Irish State has encouraged both families and the community and voluntary sector to play an active role in the care of older people. One of the reasons for this policy is the perceived need to control public expenditure in the area of long-term care, and the belief that maximising the involvement of families and voluntary sector organisations helps to achieve this and other (non-financial) aims such as solidarity towards older family and community members (Inter-Departmental Committee, 1968).

Many policy analysts believe that this over-reliance on voluntary organisations has had a negative effect on service development for older people. Ruddle *et al.* (1997) pointed to significant gaps in the care options for older people, while Convery (2001) noted the gross underdevelopment of formal community services for older people living at home. In recent years, public funding of community care has greatly increased, giving rise to a complex mix of public, private and non-profit providers active in the area of services for older people (Timonen *et al.*, 2006).

Timonen *et al.*, (2006) highlight some of the shortcomings of the current system of domiciliary care in Ireland, particularly the lack of clarity and consistency regarding entitlements and the respective responsibilities of the State and individuals, the uneven distribution of services throughout the country and the lack of coordination between services. The profile of meals services has similarities with the wider Irish domiciliary care services sector, especially with regard to the complex purchaser-provider model and mix of providers where public, private and non-profit sector organisations all derive their funding to varying extents from the State. It is therefore important to understand that, as with homecare services, meals-on-wheels services form part of a system that has developed in an organic manner over many years and, as such, may not be organised as efficiently or effectively as those that have been developed with a greater degree of control and coordination over a long period of time.

3.5 Funding for Meals-on-Wheels Services

While meals-on-wheels is not a state-run service, it is subsidised by the HSE. In December 2005, the Minister for Health and Children announced the details of funding for a range of services for older people. Among the initiatives announced, additional funding was promised for organisations providing meals-on-wheels services to older people. This included an additional allowance of €2.5 million for 2006, bringing the total spend for that year to €12.5 million, and a further increase of €2.5 million for 2007, bringing the total spend to €15 million.

In preparation for the research study, an analysis of the funding available to organisations providing meals-on-wheels was carried out in order to ascertain how this additional funding was allocated, and also to give an overview of the level of funding available to meals-on-wheels services in general. All LHOs were asked to provide details of the funding supplied to services operating within their area. Each was asked to give a breakdown of the total funding given to each organisation operating within their area between 2003 and 2006 and the subsidy provided per meal for each year. A total of fourteen offices (43 per cent) provided the information requested.

Table 3.1 shows the average subsidy per meal and per organisation provided between 2003 and 2006. The average subsidy per meal rose from €1.27 in 2003 to €1.47 in 2006. Taking inflation into account, this represented an average increase of 7.8 per cent.[6] In 2006, organisations received a subsidy of between €1.27 and €2 per meal from the HSE, depending on the area in which they operated. The amount allocated per meal changed little between 2005 and 2006. In just one HSE area, the amount per meal had risen from €1.33 to €1.40.

The subsidy given to each organisation on an annual basis varies according to the number of meals provided, from between €1,500 to €200,000 in 2006. However, looking at the average subsidy received by each organisation over the last number of years, it is likely that a significant amount of funding would have to be sourced from elsewhere to ensure a service can operate smoothly, meet health and safety requirements, and provide all of the nutritional requirements of clients.

Table 3.1: Average subsidy per meal and per organisation provided by the HSE to meals-on-wheels services, 2003-2006

	2003	2004	2005	2006
Average subsidy per meal	€1.27	€1.27	€1.33	€1.47
Average subsidy per organisation	€13,561	€12,512	€15,155	€16,937

Meals-on-wheels services in Ireland allow a multiplier effect that enables a greater level of service provision than would be possible with the subsidy alone, through direct payment from clients and from other funding streams. However, an exploration of additional funding sources available to voluntary organisations in Ireland indicated that the terms of reference would not ordinarily allow meals-on-wheels services to apply for funding. Funding streams that would appear to include support for meals-on-wheels services within the stipulations of the grant include:

- HSE Lottery Grants (statutory)
- Dormant Accounts (statutory)
- Dublin Bus Community Support Programme (statutory)
- Church of Ireland Priorities Fund (non-statutory)
- Community Foundation Small Grants Scheme (non-statutory)
- St Stephen's Green Trust Foundation (General Grants Scheme) (non-statutory)
- Katharine Howard Foundation General Grants (non-statutory).

6 Based on annual inflation rates (www.cso.ie)

However, it is important to note that many grants would be more likely to cover 'once-off' special initiatives, rather than providing revenue funding for the core activities of the organisation.

3.6 Health and Safety Requirements and Meals-on-Wheels Services

Following the introduction of the Food Safety Authority of Ireland Act, 1998, all meals-on-wheels service providers are obliged to adhere to the Hazard Analysis and Critical Control Point (HACCP) principles. HACCP is based around seven established principles, as outlined in Appendix 2. HACCP is a tool that uses a systematic approach to identifying and controlling hazards, whether microbiological, chemical or physical, that could pose a threat to the production of safe food. In simple terms, HACCP involves identifying what could go wrong in a food system and planning how to prevent crises.

The HSE employs Environmental Health Officers (EHOs) to implement national and EU laws on food safety and hygiene. In certain cases, they also provide services for the local authorities. Among their responsibilities in the food safety area are:

- food control including maintaining a register of food premises, inspecting all premises where food is manufactured or sold and investigating complaints about unfit food
- enforcing the smoking laws in public places
- enforcing the rules on sale and storage of poisons.

EHOs also play an important role in educating service providers on food safety standards. As such, they provide courses on food safety and also support to organisations providing meals to older people.

For meals-on-wheels services, the use of HACCP regulations means that meals are prepared safely and with a view to preventing the occurrence of food poisoning, particularly important for vulnerable older people with poor nutritional status who are susceptible to food poisoning as a result of weakened immune systems.

3.7 Summary

The statutory support received by meals-on-wheels organisations in Ireland is varied and in many ways fails to take into account the fact that non-statutory services are implementing national policy in the area of care of older people. While there is support to ensure that basic health and safety requirements are met, each organisation must develop its own policies and practices to ensure that their meals provide their clients with the general and specific nutrients they require. Given that much of the information on the nutritional requirements of older people is not widely known, it is possible that organisations providing meals-on-wheels may be lacking in support to provide their clients with adequate nutritional sustenance. Furthermore, given that the amount of funding varies from area to area, many organisations may not have adequate resources to take the general, let alone specific, nutritional requirements of their clients into consideration. This is likely to be particularly true of smaller organisations, when the principle of economies of scale is taken into account (organisations producing more meals per day are likely to incur lower costs per meal than those producing fewer meals). The effect of the varied support will be discussed in greater detail later in this report.

Chapter Four

Nutrition, Food and Older People

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Nutrition, Food and Older People

4.1 Introduction

There is an important link between the nutritional status and the health status of a population (Food Safety Authority of Ireland, 2000). Nutrition is one of the main modifiable risk factors in the prevention of (chronic) diseases in the population (Government of Victoria, 2004). As the population of Ireland ages, there is an increasing need to ensure that older people have access to nutritious meals in order to improve health and maintain quality of life. Such improvements have the potential to delay the onset of illnesses and disabilities, as well as entry into long-term care, and therefore may result in lower aggregate costs to individuals and the State.

4.2 Dietary Patterns of Older People in Ireland

The benefits of a balanced diet in terms of reducing the risk of poor physical and mental health for all age groups are well-known. Many studies have shown that older people are generally healthy and well-nourished (Finch *et al.*, 1998; Manton and Gu, 2001). However, a recent Irish study revealed some worrying trends in the food consumption of people aged 55 years and over including an increase in the number of those eating more than the recommended amounts of foods that are high in saturated fat (e.g. crisps, biscuits, cakes and chocolate) – a probable contributor to the increase in the number of overweight and obese older adults in recent years (Shiely and Kelleher, 2002). In addition, there remains a small but significant proportion of older people in Ireland who are underweight. The same study revealed that one in twenty older people are underweight, with the proportion of people who were underweight increasing with age (Shiely and Kelleher, 2002). Outside these extremes of over and underweight, it is also evident that consumption of nutritious food is a highly important component of health and quality of life for all older adults. While malnutrition typically occurs in underweight individuals, it can also occur in normal or overweight individuals whose food intake does not provided them with the appropriate level of nutrients.

A cross-sectional study of healthy older adults living at home showed that 69 per cent of older men and 61 per cent of older women were overweight or obese (Corish and Kennedy, 2003). Only 3 per cent were found to be underweight (i.e. had a body mass index (BMI) ≤ 20kg/m²). Fat mass was shown to increase in ageing women while height, weight and BMI, as well as mid-arm upper circumference and calf circumference (both used as a standard measure of muscle mass and thereby physical activity decreased with increasing age in both genders (Corish and Kennedy, 2003). Such loss of muscle mass and increase in fat mass may be contributed to by low physical activity levels, which were also recorded. This trend is consistent with findings from studies carried out elsewhere which indicate that a decrease in total energy expenditure is the primary cause of obesity in older people (Villareal *et al.*, 2005). This also results in a decrease in basal metabolic rate (Elia *et al.*, 2000).

The 1990 Irish National Nutrition Survey reported that dietary intakes of folate and vitamin D among the older population were lower than recommended levels. Low vitamin D status is attributable to a number of factors including low intake of foods with high levels of vitamin D (e.g. dairy products, fortified spreads and margarines, oily fish and eggs), limited exposure to sunlight and the reduced capacity of the skin to synthesise the vitamin (Jacques *et al.*, 1997). Shiely and Kelleher (2004) reported that 56 per cent of older people eat less than the recommended six servings of bread, cereals and potatoes per day, 42 per cent ate less than four fruit and vegetable servings per day, 63 per cent ate less than three servings of dairy products per day and 73 per cent ate two or fewer servings of meat or fish per day. The study also showed older people had a lower vitamin D status than recommended. Butter and margarine consumption, however, was greater than recommended. While these studies show that many older Irish people eat a balanced diet, there are significant numbers who do not.

Community-dwelling older people in the UK have a similar nutritional status to their Irish counterparts; while the majority are well-nourished, many have lower than recommended levels of vitamin D, potassium and magnesium (Fiske, 1999). The 1998 UK National Diet and Nutrition Survey also found that people with better oral health had a better nutritional status and, in particular, ate more fruit and vegetables, most likely due to their increased ability to chew a wider variety of foods than those with fewer teeth (Finch *et al.*, 1998). Finch *et al.* also reported older people without teeth were also more likely to be housebound, with restricted mobility and a decreased BMI.

4.3 Malnutrition and Older People

4.3.1 Defining Malnutrition

There is no universally accepted definition of malnutrition (Stratton *et al.*, 2004). The definition generally accepted in the UK and Ireland is 'a state of nutrition in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), body function and clinical outcome' (Stratton *et al.*, 2003). In the developed world, over-nutrition has become a problem as a result of populations eating excess amounts of macronutrients, while protein-energy undernutrition is a problem for a small minority (Corish and Kennedy, 2003; Finch *et al.*, 1998). Even individuals with diets that provide adequate or more than adequate energy may be consuming foods that are a poor source of one or more vital micronutrients.

4.3.2 Prevalence of Malnutrition

Evidence suggests that older people residing in long-stay care are at greater risk of undernutrition than older people living in their own homes (Finch *et al.*, 1998), with prevalence data of approximately 37 per cent versus 1 per cent respectively in the USA (Guigoz *et al.*, 2002). However, there is no single identifier or gold standard to predict when malnutrition will occur. While community-dwelling older people are shown to have a better nutritional status than those living in long-stay care (Finch *et al.*, 1998), they are still at an increased risk of malnutrition due to a variety of factors, the incidence of which tends to increase with age. These factors include:

- social isolation/loneliness
- widowhood
- reduction in income
- inadequate facilities to prepare food
- reduced mobility
- being housebound or inability to go food shopping
- poor dentition
- physiological ageing e.g. reduced gut motility, reduced taste acuity and olfactory dysfunction

- polypharmacy (reduced absorption and metabolism of nutrients as a result of medication)
- loss of appetite
- depression and apathy
- dementia/forgetfulness
- chronic ill-health
- cognitive impairment
- low socioeconomic status. (Corish, 2006)

Approximately 10 per cent of people aged 65 years and over in the UK have been found to be malnourished (Elia *et al.,* 2005).

4.3.3 Consequences of Malnutrition

The consequences of malnutrition can be profound. Malnutrition leads to an increase in morbidity and mortality. Undernutrition leads to problems associated with inadequate intake, such as lowered immunity (Potter *et al.*, 1995; Incalzi *et al.*, 1996), increased risk of pressure ulcers (Pinchofsky-Devin and Kaminski, 1986), constipation (Kassianos, 1993) and decreased lean body mass including that of the heart and lungs (Young, 1992). These changes may lead to a state of fatigue resulting in an overall deterioration in quality of life and an increased need for help from others (Wissing and Unosson, 1999).

Some studies have also linked malnutrition to diseases including cancer, dementia and macular degeneration (Department of Health and Social Security, 1998; Rosenburg and Miller, 1992; Sneddon *et al.*, 1994). Deficiencies in certain micronutrients will also lead directly to disease. Inadequate intakes of calcium and vitamin D may contribute to osteoporosis and low intakes of iron can result in anaemia.

Being overweight and obesity are associated with the 'younger old' (FSAI, 2000). One large study that carried out anthropometric measurements on older people has shown that the majority of older community-dwelling Irish people (61 per cent of females and 68.5 per cent of males) are overweight or obese (Corish and Kennedy, 2003). A high BMI negatively influences cardiovascular health as it increases blood pressure, blood cholesterol, triglyceride levels and the likelihood of developing Type II diabetes (Eckel and Krauss, 1998). Cardiovascular disease is one of the most common causes of death in those aged over 65 in Ireland.

4.4 Nutritional Requirements for Older People

4.4.1 Overall Food Requirements

Older people in Ireland are advised to follow the food pyramid as a guide to optimising their nutritional status (see Figure 4.1). Using the food pyramid as a guide to intake ensures adequate intakes of all nutrients to optimise health and nutritional status. In some circumstances, supplementation of certain micro- or macronutrients is also recommended. However, this should only happen under the supervision of a health professional (FSAI, 2000).

Figure 4.1: The food pyramid

Source: DOHC, 2005

At present there is no legislation requiring those providing meals services for older people in Ireland to meet minimum nutritional requirements However dietary guidelines for older people have been prepared by the FSAI (FSAI, 2002) as shown in Table 4.1.

Table 4.1: Dietary guidelines for older people

- A wide variety of foods, including those with high nutrient density should be eaten regularly.
- Energy intake should be balanced with physical activity.
- Starchy foods should be eaten throughout the day. For people with an acute and/or chronic illness with a limited appetite, intake of starchy foods should be modified to suit their individual needs. Excessive consumption of sugar dense foods should be avoided.
- For those who are healthy, four or more portions of fruit and vegetables should be eaten daily. People with an acute and/or chronic illness should modify their fruit and vegetable intake to suit their individual needs.
- An adequate intake of high fibre foods and fluid should be maintained.
- Meat, poultry and fish should be eaten regularly. Dairy foods such as milk, yogurt and cheese should be eaten daily. For those with an acute and/or chronic illness, an increased intake of dairy foods may be recommended. Fortified milk should be consumed by all older people unless otherwise recommended.
- For those who are healthy, a moderate fat intake, with a mixture of fats should be included in the diet. For those who have an acute and/or chronic illness, fat intake should be modified to suit their individual needs.
- At least eight cups/glasses of fluid should be drunk each day.
- Enriched foods, fortified foods and dietary supplements should be used where specifically indicated for an individual but a nutritional is required prior to such food modification. The use of dietary supplements should be reviewed regularly.
- Alcohol should be consumed in moderation.

Source: FSAI, 2002

4.4.2 Specific Nutritional Requirements

Although the overall nutritional requirements of older persons remain similar to those of younger people, special consideration must be given to a number of nutrients. Calcium and vitamin D are vital nutrients in the maintenance of skeletal health. Peak bone mass is achieved at approximately 25 to 30 years of age after which net demineralisation of bone begins (Heaney *et al.*, 2001). Demineralisation of the skeleton is inevitable but the rate at which it occurs can be slowed by both dietary and non-dietary factors. Dietary factors include achieving the recommended dietary allowance (RDA) of calcium and vitamin D. The RDA for calcium is 800mg/day (FSAI, 1999). To ensure that this is achieved three portions of dairy foods should be consumed daily. The RDA for vitamin D is 10µg/day (FSAI, 1999). This can be achieved by the inclusion of vitamin D-enriched spreads and oily fish in the diet and it is also important to ensure sufficient exposure to sunlight. Non-dietary factors that can enhance skeletal health include smoking cessation and weight-bearing exercise (Atkinson and Ward, 2001).

Iron intakes are generally adequate in the older population (FSAI, 2000). However, older people have a higher prevalence of iron deficiency than their younger counterparts because of the incidence of disorders that interfere with iron absorption, such as gastrointestinal losses (Webb and Copemann, 1996). Therefore it is important to maintain a good dietary intake of iron. The RDA for iron in older people is 9mg/day for females and 10mg/day for males (FSAI, 1999). Dietary sources of iron include red meat, offal, fortified breakfast cereals and green leafy vegetables.

Folate deficiency is also common in the older population (Lowik, 1990; Joosten *et al.*, 1999). Reasons for this include overcooking, cooking in large volumes of water and lengthy storage of folate-rich foods, all of which reduce the folate content of the food (Dept. of Health and Social Security, 1992). Non-dietary factors, such as polypharmacy, alcoholism and chronic medical conditions, can all contribute to folate deficiency (Russell and Suter, 1993). The RDA for folate is 300µg/day (FSAI, 1999). Green leafy vegetables and fortified foods, such as milk and breakfast cereals, are rich sources of folate.

Vitamin B12 serum levels have been shown to decline with age (Joosten *et al.*, 1993). Gastric atrophy, mal-absorption and other gut pathologies can lead to vitamin B12 deficiency (Seddon, 1994), which in turn can cause megaloblastic anaemia and neural degeneration. It is important that older people consume the RDA of 1.4ug/day (FSAI, 1999) by eating adequate quantities of red meat, offal, eggs and dairy produce. Dietary fibre is also a particularly important nutrient for older people as it helps to prevent constipation. An adequate intake of fruits, vegetables, wholemeal bread and wholegrain breakfast cereal increases the dietary fibre content of the diet.

Fluid intake is important for older people as they may have an impaired sense of thirst, higher perspirational losses due to thinner skin and reduced kidney function which leads to higher urinary losses (Thomas and Bishop, 2007). Poor fluid intake causes dehydration, constipation and confusion, so it is vital that older people achieve the recommended fluid intake of 6-8 cups/day (Thomas and Bishop, 2007). Water, milk, tea and juices are all suitable fluids provided the older person does not have difficulties eating certain foods or with feeding in general.

4.5 Food, Socialisation and Older People

> *'Food is never 'just food' and its significance can never be purely nutritional… It is intimately bound up with social relations, including those of power, of inclusion and exclusion as well as with cultural ideas about classification, the human body and the meaning of health.'*
> (Caplan, 1997)

The benefits of eating balanced meals extend beyond the physiological well-being of an individual, especially where such meals have a social dimension. Meal times provide a context in which families and communities socialise, celebrate and even conduct business together. In fact, it has been argued that food and mealtimes can been used as a mirror for analysing how a society functions (Fernandez-Arnesto, 2002). Food can also act as a powerful marker of social exclusion. For instance, the diets of socially excluded and deprived populations can be very unhealthy and omit certain food types that are expensive or difficult to obtain in 'food deserts', such as housing estates with a poor provision of grocery shops.

As we age, physical changes can play an enormous part in our attitude towards food and eating. As described in Section 4.3.2, older people can be at greater nutritional risk as a result of physical changes, such as an impaired sense of taste, poor dentition and decreased mobility.

However, psychosocial changes can also affect older people's attitudes towards food, as well as their shopping and eating patterns. The meaning of eating and mealtimes changes throughout the lifecourse; while children are usually the ones to receive food, by adulthood, they have grown into the role of provider (Lumbers, 2006). In older age, one's relationship with food can change as a result of changes in personal circumstances, such as widowhood. Loneliness, loss of status following retirement from paid work and bereavement may lead to depression, a loss of interest in food and a disruption in the patterns of food procurement and consumption (Lilley, 1996).

For instance, an older woman who is used to shopping and cooking for two and sharing the meal with her partner may find the change in this routine following the spouse's death extremely distressing, with a resulting loss of appetite and possible reduced food and nutrient intake.

Davidson *et al.*, (2007) examined the role of food in later life, and how mealtimes can often reflect significant life changes, such as retirement or widowhood. The study indicated that men and women often react differently to such changes. The authors identified five different relationship status groups. These included older people who had been married or had cohabited for many years, those who had always lived alone, those who were newly alone (e.g. recently divorced or widowed), those who were in a new partnership and living together, and those who were in a relationship but living apart. Differences emerged between the various groups. Davidson *et al.* argue that, 'eating together is pivotal within daily routine for … older men and women [who have always been living together]'; for never-married older people food tends to be 'functional'; and for the 'newly alone' the disruption in the food routine 'was often a distressing change that highlighted the loss of social relationships and the commensality experienced with a long-term table companion' (Davidson *et al.*, 2007). Furthermore, those who were in lifelong partnerships often employed a traditional gendered division of labour throughout the marriage, with men taking on some domestic duties and women assuming the management role. After retirement of one or both of the partners, such roles were likely to remain unchanged. For such couples, eating together was fundamental to the daily routine. When other demands meant that a couple could not eat together, the meaning and content of the meal altered:

> *Sometimes I don't bother, I will just have an apple or a banana or something … It is not very interesting sitting on your own eating a sandwich.*
> (Davidson *et al.*, 2007)

Mealtimes often served as a painful reminder of a change in living circumstances for many of those who had recently been widowed or separated, manifested in a disrupted food routine and the loss of a long-term table companion (Davidson *et al.*, 2007), with many displaying a reluctance to continue to put effort into food preparation. However, within each group, there were notable differences. Many newly retired men living with their wives or partners described a new involvement in cooking, while some of the 'newly alone' group also became enthusiastic about cooking, taking advantage of the flexibility around mealtimes, as well as the opportunity to cook food their partner would not have enjoyed.

Shahar *et al.*, (2001) discussed how the newly widowed may be at nutritional risk in two ways. One is the practical aspect of losing a partner in the task of food provision. The other is the profound grief reaction and its impact on self-care, self-feeding and appetite. The authors assessed the effect of recent widowhood on weight, dietary intake and habits involving 58 recently widowed older people and 58 older people who were still married. The results showed that weight loss and the prevalence of weight loss were significantly higher among widowed participants, who tended to eat more meals alone and a higher proportion of ready-made meals, as well as fewer snacks and homemade meals. With the cessation of a long relationship came loneliness and a lack of interest in activities surrounding eating, such as cooking and grocery shopping. This resulted in a diminished appetite and a lack of enjoyment of the meals themselves. Similarly, research conducted by Locher *et al.*, (2004), revealed that older persons who are married are less likely to skip meals and are better able to afford them. The authors found that older men who are not married, particularly those who are widowed, are vulnerable to experiencing poor nutritional health because they have not been socialised to be feeders and often do not know how to shop or cook for themselves.

Sidenvall *et al.*, (2000) argued that older women who cook for others can perceive this activity as preparing a gift, a long process that involves deciding what food to serve, sourcing fresh ingredients, presenting the food and enjoying the 'gift' together. They advocated that the meaning of cooking was lost among those who no longer had anyone to cook for and indicated that such women were at risk for poor nutritional intake. These findings relating to female food consumption patterns are of particular relevance for the future planning of services in this area as meals-on-wheels clients are predominantly female (largely due to the fact that they are in the clear majority among those who reach very old age and live alone). However, as highlighted above, men's preferences for food and the location of consuming food can be very different from those of women, and must also be taken into account in service planning.

4.6 Older People and Food Poverty

Low income in retirement has a considerable impact on the nutritional status of older people. Those of lower socioeconomic status may not be able to afford to purchase food, in particular, food that is of high nutritional value. Furthermore, those who are housebound can face the double burden of not only paying for their food but paying for someone to deliver their food (Locher *et al.*, 2004).

Older adults in Irish society are at a greater risk of being at risk of poverty than the population as a whole. In 2005, over half of all people aged 65 years and over had incomes close to the poverty threshold and just over 20 per cent were at risk of poverty (i.e. had an income of less than 60 per cent of the national median income) (CSO, 2006).

According to an analysis of the European Union's Survey on Income and Living Conditions (EU-SILC) 2004 data conducted by Fahey *et al.*, (2007), the number of older people living at risk of poverty is about one and a half times the rate for the total population and the working age population. Older people are also over-represented in the last quintile of the income distribution. Only 17 per cent of the working age population as opposed to 29 per cent of those aged 65 years or over are in the lowest fifth of the income distribution, whereas the top fifth hosts 24 per cent of the working population and only 7 per cent of those aged 65 years and over. In other words, a high proportion of those aged 65 years and over are among those with the lowest incomes in Ireland.

One of the consequences of income poverty is the increased risk of food poverty (Friel and Conlon, 2004). Food poverty is defined as a lack of, or insufficient availability and intake of, food and nutrients, taking into consideration affordability and access (McCarthy, 2007). Expenditure on food constitutes a high proportion of the disposable income of most older people in Ireland. An older person living alone, surviving solely on social welfare payments needs to spend 38 per cent of their income to eat healthily (Friel *et al.*, 2004). However, many of those living at risk of poverty spend less than 20 per cent of their total income (including social welfare payments and other sources of income) on food (Friel *et al.*, 2004). In monetary terms, the amount spent on food is small. As a result, older people on low incomes are less likely to eat a well-balanced diet, the consequences of which have been outlined earlier.

However, food poverty does not only affect an individual's health status. The link between income poverty and food poverty is perpetual; just as income poverty inhibits the activities of individuals, food poverty can affect social behaviour and can contribute to social exclusion (Friel and Conlon, 2004). Meals-on-wheels can help to break this cycle through the provision of affordable meals to those most at risk of food poverty. The added benefits of social contact and subsequent contribution to social capital and social networks of the individual can help to break the cycle of poverty, when at risk factors are identified and appropriate services are provided.

4.7 Summary

Malnutrition adversely affects the health of older people contributing to fatigue, apathy, weakness, illness and decreases quality of life. Nutrition is one of the main modifiable factors in the prevention of (chronic) diseases. Thus, all efforts should be made to ensure the adequate nutritional status of older people in an effort to maintain their overall health. If targeted and used appropriately, meals-on-wheels can help to prevent malnutrition among older people with poor nutritional status in Ireland or those who are at risk of deteriorating nutritionally.

Chapter Five

Methodology

Chapter Five

Methodology

5.1 Introduction

This study is the first comprehensive analysis of meals-on-wheels services in Ireland. It set out to collect baseline data on the current operation of meals-on-wheels services in order to generate recommendations for the future role and development of meals-on-wheels. It also aimed to analyse meals-on-wheels services from both supply and demand perspectives, taking into account a number of considerations in the examination of both aspects.

5.1.1 Supply Side Considerations

On the supply side, the study sought:

- to establish the level of meals-on-wheels service provision for older people living in the community
- to establish the demographic profile of the users of the service in order to enable a more effective targeting of potential users who may benefit from the service
- to ascertain the views of service providers and others e.g. PHNs in relation to the current strengths and weaknesses of the services
- to ascertain service providers' perceptions of current and future opportunities and threats to meals-on-wheels service development
- to investigate service providers' awareness of the nutritional requirements of older people
- to review the nutritional content of the meals provided
- to investigate barriers to the provision of meals with a high nutritional value
- To investigate the capacity of the meals-on-wheels service to tailor provision according to specific needs.

5.1.2 Demand Side Considerations

On the demand side, the study aimed:

- to investigate service-related stigma in order to provide guidance on how the service could be delivered in such a way as to achieve maximum take-up by those who need it.

5.2 Overview of Approach Taken

At the outset, it was intended that the research would be conducted in three discrete but overlapping phases, using quantitative and qualitative techniques (Figure 5.1). This mixed methods approach was intended to ensure that both the overall picture with regard to service provision and the 'picture on the ground' were captured. The project team consisted of both social and health science researchers to reflect the dual purpose of the meals-on-wheels service, i.e. its nutritional and social aspects.

5.3 Survey of Meals-on-Wheels Services

5.3.1 Mapping the Services

As the first step in the process of characterising meals-on-wheels services for older people in Ireland, a comprehensive survey of meals-on-wheels organisations operating throughout the country was carried out, using a postal questionnaire.

5.3.2 Mapping of Services

Prior to this study, no comprehensive and up-to-date list of meals-on-wheels services operating in Ireland existed. The first task in this regard was to develop a list of service providers operating within the country. A decision was made to collate details of day services providing meals to older people and not just meals-on-wheels services, because many provide both.

The managers of the HSE's 32 Local Health Offices (LHOs) were contacted and asked for details of meals providers operating within their areas. A total of 31 responded to this request. The Internet, the Golden Pages and annual reports of other sources of funding, such as the Department of Community, Rural and Gaeltacht Affairs and the National Lottery, were also used to supplement the search, as the HSE does not fund all meals services for older people, and also to verify that each list was up to date. A list of 510 organisations was compiled.

5.3.3 Questionnaire Development

A questionnaire was designed and pre-tested with five meals-on-wheels coordinators based in the Dublin area. Following minor adjustments, the questionnaire was sent out to all identified service providers in order to obtain baseline data on service provision in Ireland (Appendix Three).[7]

The topics addressed in the questionnaire included:

- full and up to date contact details for organisation
- organisational information (staffing, legal status, funding)
- main referral sources
- eligibility criteria
- current number of clients and number of clients on a waiting list
- profile of clients (age group, gender, living alone)
- number of days per week the service operates
- amount each client is charged per meal
- level of input into the service from clients
- information on meal provision (nutritional content, health and safety, special dietary requirements)
- aims and objectives of service
- challenges to the future development of the organisation.

An open-ended question inviting any further commentary was included at the end of the questionnaire.

Postal questionnaires were sent out to 510 organisations in the listing in January 2007, of which 405 constituted a valid sample. As can be seen from Table 5.1 below, a response rate of 42 per cent was obtained after the first wave, with a final response rate of 69 per cent following a reminder letter sent out in February 2007 and follow-up phone call. The final response rate compares very favourably with postal surveys in general as well as with other postal surveys of services for older people in Ireland.[8]

7 Please note that permission from authors and the NCAOP is required for using the survey instrument in other studies.

8 For example, Murphy *et al.*'s (2006) study of nursing homes obtained an overall response of 62% of all long-stay care settings in Ireland, while a survey of organisations providing nutrition services to older people in Massachusetts obtained a response rate of 61% (South Shore Community Action Council, 2005).

Table 5.1: Survey response rate

	Wave 1	Final Response Rate
	N	N
Returned completed questionnaires		
Organisations providing meals-on-wheels	125	206
Organisations providing centre-based meals only	48	74
Total	**173**	**280**
Excluded questionnaires		
No longer in operation	6	7
Not applicable	81	89
Insufficient address	8	9
Total excluded questionnaires	**95**	**105**
Non response	242	125
Response rate	**42%**	**69%**

5.3.4 Data Analysis

All of the data from the questionnaires was entered into SPSS (Statistical Package for the Social Sciences) Version 14 and preliminary checks were made to ensure all data had been entered correctly. Any outliers or unusual responses were removed from the analysis.

The answers to the question on funding presented some difficulties during the coding and preliminary data analysis stages; in some cases, the responses given did not equate with figures given elsewhere in the questionnaire. For example, a number of organisations did not include revenue from the contribution of meals clients in their total funding for 2006, although earlier in the questionnaire they had indicated that at least a proportion of their clients paid a contribution towards each meal. Given the importance of funding information, it was felt that the question should not be excluded from the analysis. Instead, data relating to funding from organisations where a discrepancy could be identified was not included in the analysis. A degree of caution is therefore advised in the interpretation of data relating to funding (Section 6.3.10).

The purpose of the survey of meals-on-wheels services was to provide an overview of the organisation of such services in Ireland. Therefore, the analysis of the survey data concentrated mainly on descriptive statistics. However, some inferential

statistical tests were used, including correlations to establish whether a significant relationship existed between the level of funding received by each organisation and the number of paid staff employed, and the proportion of staff that had completed food hygiene training. An independent samples t-test was used to examine whether a significant difference could be established between the total funding received by each organisation and whether or not the organisation had liability insurance.

5.4 Interviews with Service Providers

5.4.1 Introduction

The planned third phase of the project was to consist of a series of case studies with six organisations providing meals-on-wheels services. The aim of these case studies was to validate the information from the questionnaires as well as to examine the operation of meals-on-wheels organisations in more detail, with a view to developing greater insight into the challenges facing such organisations and to identify the changes that could be made to enable the organisations to deliver their service more effectively. This process, known as triangulation (where more than one method or source is used to validate the research findings), is commonly used within the social sciences, and is particularly useful in researching previously under-researched areas, where it is not possible to consolidate the findings by comparing them with prior studies.

It is important that the difficulties encountered in sourcing case study sites be documented.

Originally six organisations were invited to act as case study sites selected on the basis of their size, location, legal status and whether or not they had a day centre.

5.4.2 Access Negotiation

Three organisations refused to take part due to time and resource limitations or because they felt they needed to protect their clients, in spite of assurances from the researchers that the best interests of clients would be taken into account and confidentiality ensured at all times.

As a result of the difficulties encountered in sourcing suitable case study sites, a decision was made to replace the case study aspect of the fieldwork with interviews with 30 coordinators, staff and volunteers from thirteen organisations, as well as principal referral sources e.g. PHNs, in order to identify common themes related

to the service and to contextualise the findings from the survey. Indeed, the large number of organisations accessed via the interviews helps to better illustrate the diversity among providers of meals-on-wheels.

5.4.3 Interview Guide Development

Semi-structured interview guides were drawn up for each respondent group (Appendix Four). The interview schedule for coordinators and managers of services aimed to explore the benefits and challenges involved in running a meals-on-wheels service, including the establishment and development of the service; seek information on the referral system and eligibility criteria used, including estimates of unmet need within the community; examine demographic information on the meals clients; find out the client's opinion of the level of satisfaction of clients with the service; and seek information on staffing, meal preparation and delivery, funding, challenges with regard to complying with health and safety legislation, and challenges for the future.

Interviews with paid staff or volunteers aimed to look at their pathway to the service, their views of the service and their experiences of working with the service.

5.4.4 Process

Face-to-face interviews were carried out with fifteen coordinators or managers, six paid staff and nine volunteers from a total of thirteen services. All interviews took place between April and May 2007. In six organisations, interviews with the coordinators, paid staff and volunteers took place in the central kitchen or day centre. All six were industrial-style kitchens funded by the HSE or Dublin City Council. In two cases, the meals were supplied by a local hotel or supermarket and consequently the interviews were carried out in the coordinator and volunteers' own homes. The interviews lasted between 25 and 90 minutes. Almost all of the 15 coordinators or managers interviewed were female and ranged in age from mid forties to early seventies. All six of the paid staff were female. However, the majority of the volunteers interviewed (n=7) were male and all volunteers were over 60 years of age.

5.4.5 Data Analysis of Interviews

All of the interviews with meals-on-wheels managers/coordinators, staff, volunteers and main referral sources were audio-recorded and transcribed. Permission for this was granted by all respondents. Data analysis was carried out using a thematic analytical approach (Aronson, 1994). Common themes were selected from each of the interviews, followed by a process whereby related patterns were catalogued into sub-themes. The sub-themes were then analysed easy to explore the over-arching

story, or pattern, emerging from the data. This approach was considered most appropriate, as it allowed the findings emerging from the qualitative interviews to contextualise the survey data. All of the interview transcripts were analysed in Nvivo (Version 7).

5.5 Interviews and Nutritional Assessments with Meals Clients

5.5.1 Introduction

The third component of the research methodology comprised of a series of interviews and nutritional assessments carried out with a sample of meals-on-wheels clients.[9] It was considered important that meals-on-wheels clients should be given the opportunity to identify aspects of the service that they felt could be improved, and thus play an important role in the research. A total of 66 interviews were carried out with a sample of meals-on-wheels clients sourced from 16 meals-on-wheels services based in Leinster, Munster and Connacht.

Almost all (n=63) were carried out in conjunction with the nutritional assessment in each person's own home. Three individuals were reluctant to have researchers visit their homes and so interviews were conducted over the phone. Each interviewer was carried out by one of two trained social researchers during May and June 2007.

5.5.2 Interview Guide

The interview guide (Appendix Four) aimed to explore each individual's pathway to the service; their overall views on the service; their opinion on the importance of the social aspect of meals-on-wheels; their use of other services; eating habits (including whether they ate alone or with others, possible changes in food-related behaviour as a result of major life changes); and the role played by food in their life over time.

9 Originally it was intended to carry out these assessments and interviews with older people who were about to start receiving meals-on-wheels, and to follow up with these respondents after a period of 6 months in receipt of meals-on-wheels. The purpose of this was to assess the impact of meals-on-wheels on both the nutritional status and eating habits of the clients. However, upon embarking on this stage of data-gathering, the unfeasibility of such a complex design quickly became apparent due to the difficulties associated with gaining access to a sufficient number of new entrants to the service within a geographical area that researchers would have had reasonable access to. Facilitating the original design would also have required the cooperation of a large number of organisations over time (in the capacity of alerting researchers to new entrants) which, for reasons outlined in Section 5.5.4 would not have been possible in the absence of additional support to the organisations in meeting this task.

5.5.3 Nutritional Assessment

A nutritional assessment was carried out on each study participant in receipt of meals-on-wheels in order to establish their nutritional status and examine the contribution of meals-on-wheels to their overall dietary intake. The assessments were carried out using a nutritional assessment screening tool (the Mini Nutritional Assessment) and a 24-hour dietary recall, all carried out by qualified dieticians.

5.5.3.1 The Mini Nutritional Assessment

The Mini Nutritional Assessment (MNA) is an assessment tool that can be used to identify people aged 65 years and over at risk of malnutrition. It was designed for use by various health professionals, including nurses, doctors and dietitians. The tool has two components: screening and assessment. A score of 11 or less on the screen indicates a problem and the need to complete the assessment portion. The assessment score is then added to the screening score; if the total score on both parts falls within the range of 17-23.5, there is a risk of malnutrition, while a score of <17 indicates existing malnutrition (Amella, 2007). The MNA assess four areas of health to provide a holistic picture of an individual's nutritional status – anthropometric measurements, dietary pattern, global health and the individual's subjective assessment of their own health status. The MNA has been validated in many settings including hospitals and nursing homes, with ambulatory care patients and with those living in the community. It was developed to be user-friendly, quick and non-invasive (Amella, 2007).

The MNA requires clients to recall various aspects of their health and diet, including whether they have lost weight in the previous three months, the number of portions of fruit and vegetables they eat, and the number of cups of fluid they drink each day. The subjective nature of this component of the assessment means that difficulties can arise if clients have memory loss problems or attempt to give the 'right' answer, resulting in a response bias. For example, an individual may state that they consume five portions of fruit and vegetables a day, as they may be aware that this is the amount recommended, even if they do not actually consume this amount.

In order to overcome these challenges, the assessments were completed by trained dietitians with experience in carrying out these assessments. In cases where doubts were raised as to the validity of the answers, all relevant data for the individual was removed from the analysis.

5.5.3.2 24-hour Dietary Recalls

In order to validate the results of the MNA and gauge a typical day's intake, 24-hour dietary recalls were also undertaken and compared to the RDA for the Irish population (FSAI, 1999). The 24-hour dietary recall is a tool used by dietitians and health professionals to obtain information on food and fluid intake for the previous 24 hours. It is assumed that the intake described is a typical day's intake. It is easy to administer and is not dependent on the literacy of the client (Edens and Lohse Knous, 1999).

The 24-hour dietary recall allows information to be collected on the number of meals eaten per day as well as, the type and quantity of foods consumed. It also enabled researchers to identify the contribution of meals-on-wheels to the total dietary intake of each individual. The method has been validated as a useful dietary record tool in many studies.

As such, it is clear that the use of the 24-hour dietary recall is prone to errors. If a client has a poor memory they may not be able to recall what foods they ate in the previous 24 hours. Therefore it was necessary for the interviewer to ask probing questions about timing of meals and snacks eaten etc. In addition a Food Atlas was used to estimate portion sizes consumed by recipients (Nelson, Atkinson and Meyer, 2002). The Atlas consists of colour photographs of seventy-eight foods commonly consumed by British adults. Each food has a series of eight photographs showing a range of portion sizes from very small to very large. Clients were asked to select the portion size that best reflected the amount they usually consumed. Studies have shown that the use of food atlases can significantly help to improve the accuracy of portion sizes consumed (Nelson, Atkinson and Darbyshire, 1996; Foster *et al.*, 2005).

While other more reliable methods exist for measuring overall food intake, such as a three-day dietary record, these could not be used for this study, given the time and resource limitations, particularly as they are not without their own limitations. Therefore, in order to minimise error, the 24-hour dietary recalls were carried out by trained dietitians, with experience in carrying out probing questions, reassuring clients and using props to 'jog' the memory of clients. As with the results of the MNAs, any data collected that was considered unreliable were discarded.

5.5.4 Recruitment Process

It was initially envisaged that meals-on-wheels clients could be selected for interview from the case study sites, with local PHN's acting as a further group of gate-keepers to help with the recruitment of additional clients or former clients, in order to ensure that a sufficient number of individuals would take part to allow for meaningful analysis

of the data. However, the recruitment of suitable clients through meals-on-wheels services proved to be problematic. In addition, some clients indicated that they were reluctant to take part in the study for fear of negative repercussions, particularly if they gave negative feedback to the researchers on the service.

In order to recruit a sufficient number of clients, 40 meals-on-wheels services were approached. Contact was made over the telephone and permission was sought to post out information sheets, which coordinators or drivers could then distribute to clients. These information sheets gave clients information on the study and a phone number that they could ring if they wished to participate. Approximately 1,200 information sheets were posted out for coordinators to distribute to their clients. Approximately six of the services were visited by a member of the research team in order to give more information to the coordinator on the study. Notices were also put in parish newsletters and announcements were made at weekly Masses to raise awareness of the study and increase interest among potential respondents. Clients from a total of sixteen organisations were recruited as a result of these activities. Other potential gate-keepers, such as home help organisations, active retirement groups and day centres, were also approached and informed of the study.

While it was originally planned to interview a sample of individuals who had either 'refused' or no longer availed of meals-on-wheels, as a result of the nurses' work-to-rule, only three individuals who no longer availed of meals-on-wheels were interviewed, giving an insight into the reasons why individuals might turn down or 'drop out' of meals-on-wheels services.

5.5.5 Sample Characteristics

A total of 66 interviews and assessments were carried out with meals-on-wheels clients (including former users of the service). The average age of the sample was 78.5 years. Five respondents were younger than 65 years of age, illustrating that meals-on-wheels can support younger people with disabilities to remain independent. The oldest respondent was aged 93 years. The majority of respondents (n=54: 81 per cent) lived alone. These characteristics are broadly consistent with the characteristics of meals clients estimated by the coordinators of meals-on-wheels services (see Chapter Seven). Of the three interviews with former users of the service, all were with females and all three were based in the greater Dublin area. It was felt that saturation point was reached with the interviewers, as no new themes emerged during the last interview.

5.5.6 Data Analysis

5.5.6.1 Interviews

The interviews with meals clients were audio recorded and transcribed. Data was analysed using Nvivo and using the same analytical design as that used for the interviews carried out with service providers and referral sources described earlier.

The interviews with clients were voice-recorded and transcribed. Data was analysed using Nvivo, using the same analytical design as that used for the interviews carried out with service providers described in Chapter Seven. As with the interviews with service providers, the interviews with meals-on-wheels recipients were analysed using Aronson's (1994) thematic analysis approach. Common themes were selected from each of the interviews, with related themes then coded into sub-themes. The interviews were then explored to identify related themes, such as the experience of receiving meals-on-wheels, the role played by meals-on-wheels in each individual's life, a person's enjoyment of meals-on-wheels and the role played by food in their life over time.

5.5.6.2 Nutritional Data

The results of the nutritional assessments were analysed using the software packages WISP (Weighted Intake Software Package), Tinuviel Software, Warrrington, UK, and SPSS. The results of the 24-hour dietary recall were also analysed using WISP. WISP has been utilised in many studies to collect and analyse dietary information, including the North-South Food Consumption Survey (IUNA, 2001) and the more recent Irish Children's Dietary Survey (IUNA, 2005). The WISP programme was also used to analyse food intake records and food frequency questionnaires, and to analyse the sample meals obtained from service providers (see Section 5.7).

Findings from the MNA were analysed using SPSS and principal findings from the WISP analysis, including each individual's calcium and protein intake, were included in the analysis. Given the small sample size, inferential statistical tests were not included in the analysis. Instead, descriptive statistics were used to identify the proportion of the sample that was under-nourished; to analyse the overall dietary patterns of meals-on-wheels clients; and to explore the extent to which meals-on-wheels contributed to the nutritional status of each individual.

5.6 Assessment of Selected Meals

An analysis of a sample of meals (five PHNs) was also carried out in order to examine the nutritional value of meals-on-wheels against RDAs (.ie. the amount of energy and nutrients required to met the nutritional needs of healthy persons, taking age and gender into account). A number of sample meals were collected from meals-on-wheels organisations throughout the country. In each instance, data was collected from the cook and included information on menu planning, menu rotation, portion sizes, cooking methods, storing methods, and packaging and delivery.

The assessment of the sample meals was also carried out using the WISP programme. The contribution of meals-on-wheels to the overall nutrient intake was assessed by comparing the nutrient intakes of the sample of clients of meals-on-wheels services with the RDAs available through WISP in order to ascertain whether the meals made up one third of the RDA for important nutrients.

5.7 Interviews with Referral Sources

Interviews with referral sources for meals-on-wheels services were also carried out in order to examine the methods used to prioritise those most in need of the service and to assess whether those in need were likely to be aware of the service. The opinion of the service and any recommendations referral sources may have for the future were also sought.

While it was originally hoped to interview twelve referral sources, including both PHNs and General Practitioners (GPs), no nurse was willing to speak to a member of the research team during the period of the nurses' work-to-rule, which occurred during the data collection phase of this study. While more than ten GPs were contacted and invited to participate in the research, all refused. After the nurses' work-to-rule was discontinued, five were interviewed. The analysis of these interviews aimed to examine the relationship between PHNs and meals-on-wheels services, to examine the role of the former in referring clients to the service, and in certain cases, to explore their role in defining and policing eligibility criteria for the service.

5.8 Ethical Approval

As the literature on meals-on-wheels clients indicated that many may be frail, vulnerable and lacking in social support, a number of precautions were taken to ensure that the well-being of meals clients participating in the study was not in any way compromised and that informed consent was obtained. Coordinators of centres were asked for their assistance in determining suitable interview candidates and were asked to distribute information leaflets only to clients they felt were capable of taking part in the study. Consent was obtained in four stages:

1. meals clients were given details of the study through the meals-on-wheels service or via an information sheet

2. while setting up the interview, the researcher spoke to each respondent over the phone and outlined verbally the topics that would be covered during the interview. The details of the nutritional assessment process were also outlined. It was stressed that participation in the study was voluntary. Each interviewee was asked to confirm that they would still like to participate after this information was conveyed to them

3. immediately prior to each interview, respondents were given a consent form, in which they were informed that their participation was voluntary, that the information they gave was confidential, that they did not have to answer any question with which they were not comfortable and that they could end the interview at any time. The aims of the study were outlined

4. during the course of the interview, the interviewers looked out for signs of fatigue and discomfort, and used their own discretion to end interviews early or to avoid topics that may have distressed the interviewee.

In a total of eight cases, researchers were not satisfied that potential respondents had given their informed consent to take part in the study and were thus excluded from participating.

While research has shown that participation in research may have benefits for study participants, including intellectual stimulation, self-awareness and empowerment (Chouliara *et al.*, 2004) and that older people often have a genuine interest in taking part in research (Williams, 1993), every effort was made to ensure that taking part in the interview and assessment was a positive experience for every respondent. As such, care was taken to ensure that the interview:

- was carried out at a time and location that suited each participant
- that a rapport was built up between the research participant and researcher, and an atmosphere created in which each participant felt comfortable and did not feel obliged to discuss any matters that they did not feel comfortable with
- that each person was aware that there were no right or wrong answers and that the interview could be stopped at any time
- that each person was aware of the importance of their contribution.

In addition, a €10 shopping voucher was given to each meals-on-wheels participant as a gesture of thanks for taking part.

Ethical approval for the study was obtained from the Ethics Board of the School of Social Work and Social Policy in Trinity College Dublin (TCD) as it was judged that adequate measures were in place to assure that participants would not suffer any negative consequences as a result of their participation.

5.9 Limitations of the Study

All research has its limitations and this project was no exception. This report has already alluded to a number of difficulties which arose during the fieldwork carried out for this study, resulting in a number of limitations that should be borne in mind when interpreting the results.

Firstly, as no full list of all the meals-on-wheels services and organisations providing centre-based meals exists, it is unclear whether the sampling frame for the survey of services was complete, even if the figures derived are validated to some extent by previous research carried out by Garavan *et al.* (2001).

It is also important to note that a significant proportion of the fieldwork for the study was carried out during the nurses' work-to-rule, which took place from 2 April 2007 to 24 May 2007,[10] which made it impossible to use them as gate-keepers for the recruitment of meals-on-wheels clients. It had been intended that a number of people who had been offered but had turned down meals-on-wheels service could be sourced through the PHNs. As a result of the work-to-rule, this sub-group was omitted from the study, meaning that it was not possible to explore the various

10 The fieldwork for the study took place between April and June 2007.

reasons why individuals turn down meals-on-wheels fully (although some insight into these reasons was gained from other interviews).

Due to the nurses' work-to-rule, coordinators of meals-on-wheels services acted as the main gate-keepers, asking their own clients to participate in the study. Given the relatively small sample size typical of qualitative studies and the possible bias in the sample resulting from gate-keeper selection (i.e. time and resource limitations of meals-on-wheels organisations, their protectiveness of their clients' privacy and a possible fear of repercussions following negative feedback from some clients), it is possible that the sample of meals-on-wheels clients interviewed for the study is not fully representative of those who receive meals-on-wheels in Ireland. While these limitations are typical of qualitative studies and do not render the findings invalid, it is important that they be taken into account for any reading of the results.

Chapter Six

A Profile of Meals-on-Wheels Services in Ireland: Survey Results

Chapter Six

A Profile of Meals-on-Wheels Services in Ireland: Survey Results

6.1 Introduction

This chapter presents the findings of the survey of meals-on-wheels services in Ireland. The findings from the survey are based on the analysis of 280 questionnaires returned following a postal survey of all meals-on-wheels and community meals services in Ireland.

The chapter begins with an overview of the organisational details of meals-on-wheels services, including a breakdown of their legal status, geographical coverage, staffing arrangements and training provision, as well as their overall aims and objectives and average length of time in operation. This is followed by an overview of the operational aspects of the services, including details on the referral system and eligibility criteria, numbers of meals provided per week, profile of meals-on-wheels clients, details on the meals provided and a description of the main sources of funding. The chapter ends with an overview of the concerns of meals-on-wheels services for the future.

6.2 Organisational Details

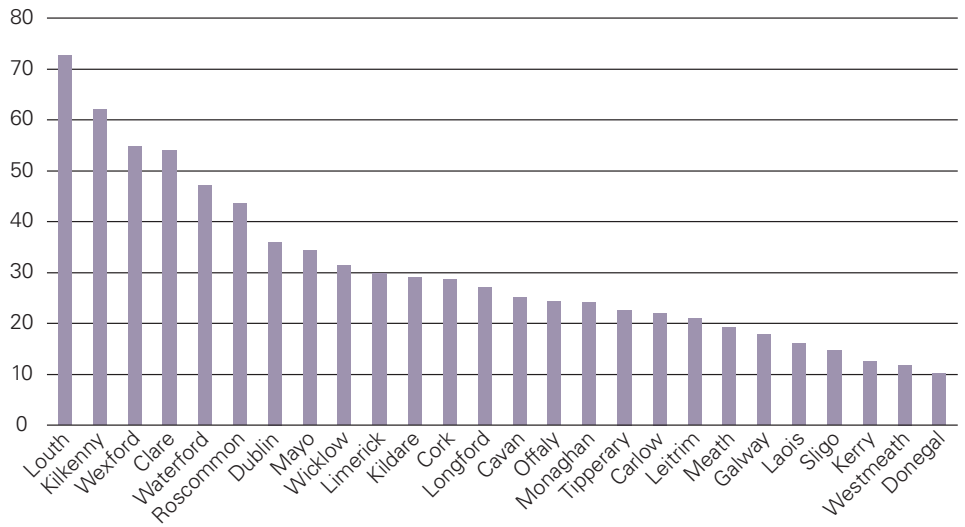
It was reported that meals services (both centre-based and meals-on-wheels) have been operating on average for twenty-five years, i.e. in most cases since the early 1980s. However, more than one tenth were established in the 1950s or 1960s (n=29; 12 per cent), while a similar proportion (n=26; 9 per cent) have been in operation since 2000. Almost three out of every five organisations surveyed (n=156; 58 per cent) were registered charities. Of these, a quarter had also registered as a company or operated as part of the HSE (Table 6.1). A large proportion, 18 per cent, had no formal status, operating solely as a group of volunteers.

Table 6.1: Legal status of organisation

	N	Percentage
Registered charity	116	43.4%
HSE	42	15.7%
Limited company	19	7.1%
No formal status	48	18.0%
Charity and limited company	30	11.2%
HSE and charity	10	3.8%
HSE and limited company	2	0.8%
Total	**267**	**100.0%**

Services are abundant in many counties and scarce in others, relative to the total population of older people living in the county (i.e. those aged 65 and over). Based on the average number of clients served by each organisation (41), it can be seen that one place exists for every ten people in Donegal, but for every 72 people in Louth (Figure 6.1). It is possible that the relative scarcity or abundance of meals-on-wheels services is partly as a result of the size of the county and the degree of population dispersal within it; large but sparsely populated countries would obviously need a large number of services to be able to reach their clients conveniently. However, a large number of other factors are also likely to contribute to these disparities.

Figure 6.1: Average number of people aged 65 years and over per meals place per county



Almost half of all organisations (48 per cent) only service those living in the parish or surrounding area, highlighting the fact that meals-on-wheels services are largely a local response to local needs. One hundred and thirty-one organisations (47 per cent) serve a slightly larger area, such as their village, town and surrounding area. In less than 5 per cent of cases, organisations serve a significant proportion of their county. This is usually in counties with a small number of meals-on-wheels services, including Clare, Kilkenny, Louth and Roscommon, and may indicate that meals-on-wheels providers operating within these counties have developed the capacity to cover a wide geographical remit. However, it is also possible that services currently in operation are not in a position to cater for potential clients living in remote areas.

6.3 Operational Aspects

6.3.1 Aims and Objectives

All organisations were asked to outline the broad aims and objectives of their service in an open-ended question. This was used as a crude indicator to ascertain the extent to which organisations had engaged in strategic planning exercises, and also to identify whether organisations viewed the social aspect of their service as an important aspect of the service, relative to the nutritional function. More than one in four organisations (n=52; 26 per cent) did not respond to the question. Of those that responded, only a small proportion (26 organisations; 17 per cent) saw the organisation as having a dual-mandate, namely the provision of a meal and some social contact (Table 6.2). The majority (59 per cent) believed that the main objective of the organisation was to provide a meal for those unable to provide for themselves. While many of these may have recognised the value of the social contact of the service, it is significant that this was not formally recognised within the aims and objectives of the organisation. A small number of organisations (11 per cent) saw meals-on-wheels as one of a number of services available to older people or people with disabilities in their local area, while only 8 per cent of organisations recognised the value of meals-on-wheels in implementing national policy, i.e., supporting older people to remain in their own homes for as long as possible.

Table 6.2: Aims and objectives of meals-on-wheels service providers

	N	Percentage
Provide a meal for those unable to cook for themselves	89	59.4%
Provide a meal and social contact	26	17.3%
Caring for older people or people with disabilities	17	11.3%
Enable people to remain living in their own homes for as long as possible	12	8.0%
Combat social isolation by visiting older people	3	2.0%
Develop the organisation into the future	3	2.0%
Total	150	100.0%

Note: Respondents were not given response options for this question. Response items extrapolated from responses given by respondents.

6.3.2 Referral Sources

Among organisations providing meals-on-wheels, PHNs were the most commonly used referral source (68 per cent) (Table 6.3). Hospital social workers also played an important role in referring people to meals-on-wheels services, such as when individuals are discharged from hospitals. Just over one in ten people in all cases were referred to the service through their GP. Family members and individuals themselves played an important secondary role in engaging the service. In certain areas, parish priests or other services, such as St Vincent de Paul, can refer individuals to the meals-on-wheels service. PHNs were also the most common referral source for day centres (53 per cent), while family members, friends and neighbours also play a role in referring individuals to day centres (20 per cent).

Table 6.3: Main referral sources used by meals-on-wheels services

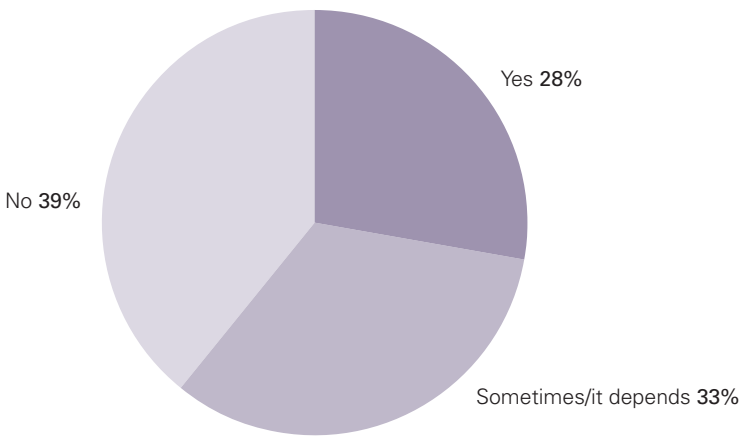
	Most common referral source (N=203)	Second most common referral source (N=180)	Third most common referral source (N=148)
PHN	68.5%	17.2%	10.1%
Family/friends/ neighbours	15.8%	32.8%	34.5%
GP	7.8%	11.7%	12.2%
Self-referral	3.9%	8.9%	25.7%
Social worker	2.0%	28.3%	16.2%
Other	2.0%	1.1%	1.3%
Total	100%	100%	100%

6.3.3 Use of Eligibility Criteria

As meals-on-wheels services are provided by a large number of organisations, the majority of whom operate on a voluntary basis, no system exists whereby organisations are obliged to ensure individuals must meet certain criteria before they can avail of the service. As can be seen in Figure 6.2 below, less than one in three organisations used strict criteria to allow people to start using the service. Eligibility criteria tended to be based on need, as perceived by referral sources, rather than income. Two in every five organisations that used a referral system, either formal or informal, indicated that individuals needed to be above a certain age, have a disability or be living alone. Just 5 per cent of organisations indicated that an individual's income was taken into account when they were assessed for the service.

From the survey data, it appeared that an individual's ability to avail of meals-on-wheels services was in many cases based on subjective criteria. Only 32 organisations (13 per cent) had people on a waiting list for the service, suggesting that, where an individual asks for or is recommended to use the service, they are rarely refused. In organisations where waiting lists were in use, the wait was two months on average. A higher proportion of day centres (17 per cent) had a waiting list, perhaps highlighting the greater flexibility of meals-on-wheels services to take on new clients. Eligibility criteria for day centres were similar to those used by meals-on-wheels services, namely age, disability and whether or not an individual is living alone. However, some day centres also indicated that they take the needs of all service users into account. For example, a small number (n=4; 11 per cent) indicated that they did not accept people with dementia.

Figure 6.2: Use of eligibility criteria by meals-on-wheels services (n=203)



The lack of established eligibility criteria also creates difficulties for some meals-on-wheels services. For example, one coordinator commented:

> *There seems to be no set criteria for referring clients. Often those referred are able-bodied and are basically availing of a 'cheap meal'. There is also no cut-off point when a client returns to full health, which does frequently occur. We have clients who are receiving meals for years and are perfectly mobile.*
> (Coordinator large, urban meals-on-wheels service)

6.3.4 Days of Operation

Meals-on-wheels organisations varied in terms of their number of days of operation with only 52 (20.6 per cent) operating on a Saturday and 20 (10 per cent) organisations operating on a Sunday. Just 26 per cent operated or made alternative arrangements to accommodate clients on bank holidays. The majority of organisations (82 per cent) sated that they operated between two and five days a week, with just fourteen (7 per cent) operating either six or seven days a week respectively (Table 6.4). A significant proportion of organisations, almost one in five, operated either one or two days a week. The issue of how service users cope on the days meals are not delivered will be discussed in greater detail in Chapter Eight.

Table 6.4: Number of days of operation per week

No. of days	N	Percentage
1	8	4.0%
2	31	15.4%
3	58	28.7%
4	18	8.9%
5	59	29.2%
6	14	6.9%
7	14	6.9%
Total	202	100%

The majority of organisations (n=183, 89 per cent) provided clients with a midday meal a day, with a small proportion (n=18; 9 per cent) providing a main meal in the evening instead. Just six organisations (3 per cent) provided breakfast, of which three provided breakfast only and three provided both breakfast and lunch. Five organisations (3 per cent) provided a light tea to clients, of which four also provided a main meal. A small number of organisations (n=10; 5 per cent) indicated that they provided clients with

snacks along with their meal. However, it is unclear whether some organisations regarded soup or desserts, provided as part of the meal, as a snack.

6.3.5 Number of Clients

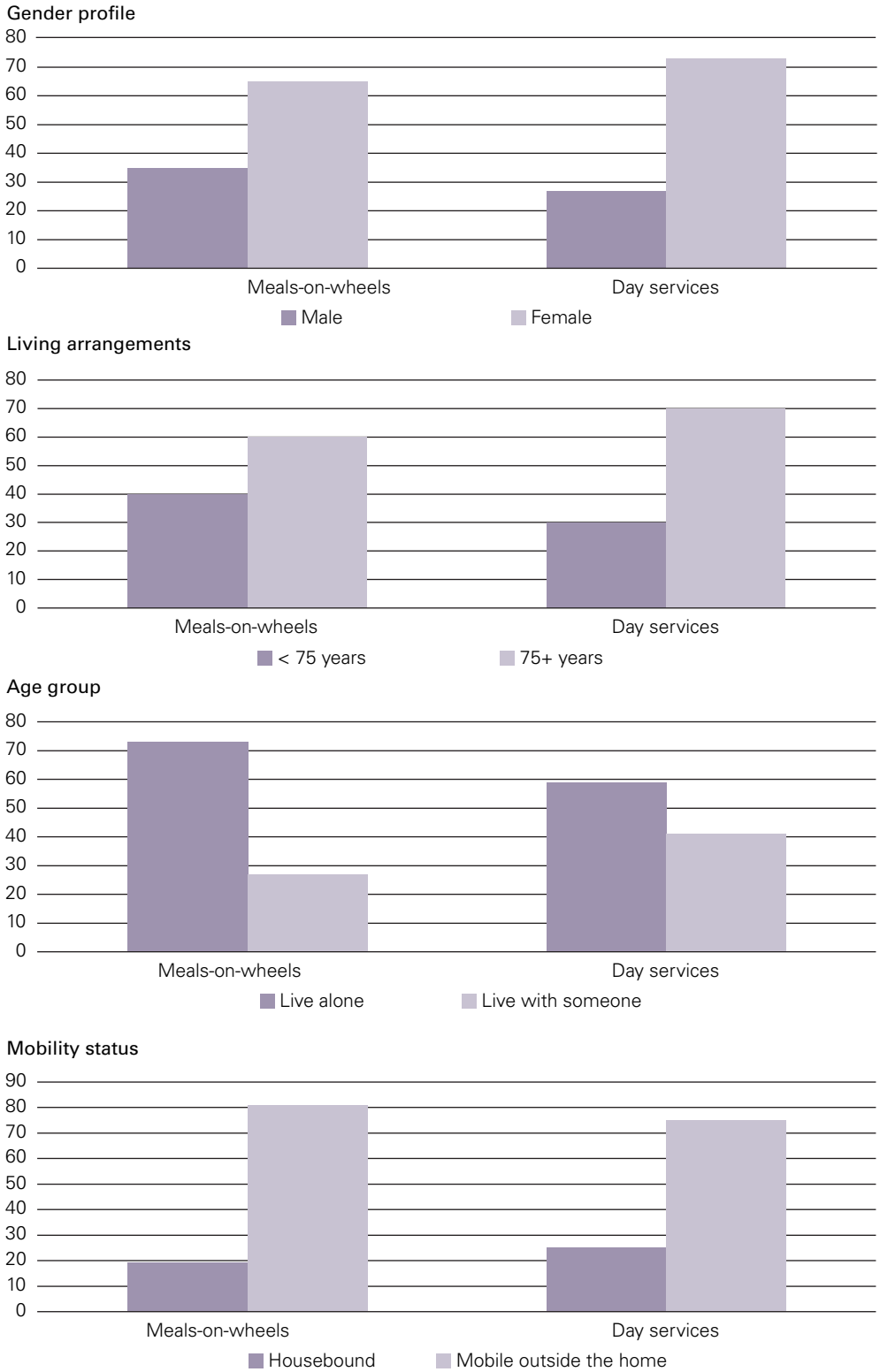
Based on the estimated total number of meals-on-wheels services operating in Ireland at present (305) and using an average of 41 clients for each service from which survey data were obtained, it can be estimated that between 10,000 and12,000 individuals are in receipt of meals-on-wheels in Ireland. This overall figure is similar to that extrapolated from the findings of Garavan *et al.* (2001). The average number of clients per meals-on-wheels service was 41, although there was a large variation in the number of clients per service (SD = 35). Fifteen per cent of services had less than ten clients, while 4 per cent of services had over 100. Interestingly, day centres had a higher average number of clients, again with large variation between services (n=52; SD = 45.2). This may indicate that meals-on-wheels is seen by many services as an 'add-on' to the day centre, i.e. a meal can be dropped into an individual's home without too much additional difficulty. However, this is clearly not the case for all services; for example, 11 meals-on-wheels services catered for over 250 individuals.

6.3.6 Profile of Clients

As can be seen from Figure 6.3, there were some differences in the demographic profile of meals-on-wheels and day centres. A slightly higher proportion of meals-on-wheels clients than day centre clients were male (35 per cent and 27 per cent on average, respectively). While the proportion of those living alone made up the majority of clients in both services, the difference was more pronounced for meals-on-wheels clients.

Two in five meals-on-wheels clients were under 75 years of age, highlighting the fact that meals-on-wheels acts as a valuable resource for people of all ages unable to cook for themselves. In addition, coordinators estimated that one in four meals-on-wheels clients (26 per cent) were housebound or had limited mobility outside the home. Many day centre services either did not provide or provided limited transport (41 per cent and 14 per cent respectively),

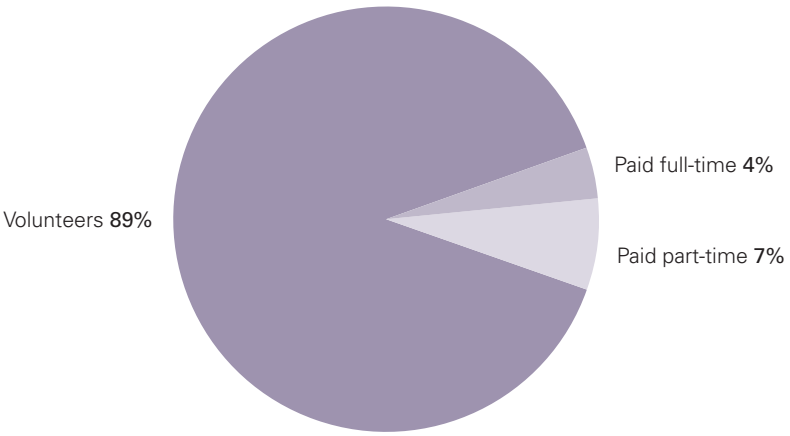
Figure 6.3: Demographic profile of meals-on-wheels and day centre clients (n=280)



6.3.7 Staffing Arrangements

Just under one third (29 per cent) of meals-on-wheels services did not have any paid employees. While just 4 per cent of staff in meals-on-wheels organisations were paid full-time staff and 7 per cent were paid part-time staff, almost nine in every ten workers (89 per cent) in meals-on-wheels services were volunteers (Figure 6.4). However, almost half of all meals-on-wheels organisations (46 per cent) employed full-time staff; of these, 58 per cent employed one or two full-time staff. A higher proportion of meals-on-wheels services (49 per cent) employed part-time staff. Again, a high proportion of organisations employed between one and two people on a part-time basis (57 per cent). This perhaps negates the commonly held view that meals-on-wheels is a voluntary service. There was no significant correlation between the number of paid full-time staff in each organisation and the total funding received (r=.197, n=77, p=.087), indicating that organisations that employed paid staff were not necessarily more affluent than those that relied on volunteers and part-time paid staff.

Figure 6.4: Breakdown of staffing arrangements for meals-on-wheels services (n=209)



Many coordinators stressed the difficulties they faced in recruiting and retaining volunteers. These difficulties were placing an enormous pressure on organisations' capacity to deliver meals, highlighting the potential problems that may arise in the future, should demand for the service rise or difficulties in recruiting volunteers continue:

> *Most of my drivers are in their 70s or soon to be. As there are no young volunteers coming along … I can see that within 5 years our service will collapse. I would deeply regret this, as over the years, we have built up relationships with each other and more importantly, with our clients, who in many cases treat us as family.*
> (Coordinator, large, urban meals-on-wheels service)

6.3.8 Choice of Meals and Client Input

Three in every five organisations (61 per cent) provided just one standard meal with no choice for clients (Table 6.5). Regular client input into meals-on-wheels menus was also quite low with only 77 (38 per cent) organisations reporting that this was standard practice. A higher proportion of day centres (34 per cent) indicated that they provided a choice of meals to their clients every day.

Table 6.5: Percentage of organisations providing a choice of meals

	N	Percentage
Yes	25	13.1%
Sometimes/it depends	49	25.7%
No	117	61.3%
Total	**191**	**100.0%**

Sixty-eight per cent of organisations (n=125) indicated that they catered for special dietary requirements, such as low-sodium, gluten-free, and low fat meals with 61 (32 per cent) organisations unable to meet such requirements.

A high proportion of organisations (n=139; 74 per cent) indicated that a system to take feedback or complaints from clients existed. While organisations were not asked to provide details of the system in place, findings from the case studies indicated that wide discrepancies can exist between a service provider's view of the meals and that of their clients. This shall be discussed in further detail in the next chapter.

6.3.9 Adherence to Hygiene Regulations and Nutritional Guidelines

A high proportion of organisations (68 per cent) had sent at least one staff member on a food safety training course. This high figure can be explained by support from the HSE's EHOs in the provision of training. Indeed, analysis revealed a significant positive correlation between the total funding of a meals-on-wheels service and the proportion of staff that had completed food hygiene training ($r=.317$, $n=79$, $p=.004$), indicating that organisations with more funding were more likely to provide food hygiene training to their staff.

Just 25 per cent of meals-on-wheels organisations had at least one staff member who had completed a training course on the nutritional requirements of older people. In addition, only 48 (26 per cent) organisations had received input into the menu from a dietitian. A menu rotation/menu cycle system was in use in 134 (71 per cent)

organisations. However, 55 per cent of these rotated their menu on a weekly basis, thus limiting the variety of the meals provided to clients.

Just five organisations (3 per cent) provided cook-chill or frozen meals, with 97 per cent (n=194) providing hot meals. Of these, just five (3 per cent) provided some clients with cold meals for the next day. While the questionnaire did not and could not identify poor practices in adhering to hygiene legislation, it appeared from some of the results that some organisations provided clients with two meals, one intended for consumption the next day.

6.3.10 Funding and Client Charges

More than 90 per cent of organisations charged their clients for the meals, although only half (n=94; 51.4 per cent) of organisations charged all of their clients (Table 6.6). Clients paid an average of €2.96 per meal, although the charge varied from €0.67 to €6.50. A similar proportion of organisations charged clients for day centre services (n=60; 92 per cent).

Table 6.6: Breakdown of meals-on-wheels services by percentage of clients charged for meals

Percentage of clients	N	Percentage
1-24%	8	4.4%
25-49%	9	4.9%
50-74%	17	9.3%
75-99%	55	30.1%
100%	94	51.4%
Total	**183**	**100%**

On average, organisations received a total of €35,201 per annum, between subventions from the HSE and other public bodies, fundraising, charges received from clients and other sources. Including capital funding received on a once-off basis from the HSE, meals-on-wheels services received an average of €6.33 per meal. The funding received from the HSE per annum worked out at an average of €2.94 per meal (including once-off capital funding). There appeared to be large differences in the total funding received by meals-on-wheels services from the HSE, with some receiving up to €8 or €9 per meal (including capital funding), while others received no funding. Once capital funding was excluded from the analysis (where possible), the average amount per meal provided by the HSE was €1.28, slightly lower than the

average of €1.47 extrapolated from the data supplied by the HSE's LHOs (Chapter Three). Total funding received per meal was €6.30, with one or two organisations indicating that they received funding of up to €18 per meal. Funding received through the HSE and charges/contributions were the largest source of funding received by meals-on-wheels services. On average, meals-on-wheels services received €2,946 from fundraising (e.g. through church gate collections or sales of work). An analysis of the data indicates that there is a strong positive correlation between the number of meals provided by each organisation per week and the total funding received (r= .604, n=91, p=.001]. The principle of economies of scale would suggest that larger organisations thus have a greater opportunity to invest money in other areas, such as staff training, rather than in meeting overheads.

Overall, however, difficulties in sourcing funding were a major source of concern for many coordinators; this has negative impacts for clients of the service as well as staff:

> *I would like the Government to finance us. We have just installed a new kitchen (forced to or else closure) at great expense, most of it fundraised. I don't think we get any recognition from any Government body, but the people of (local area) have always given of their time and money, so thanks to them we can keep going.* (Coordinator, large, rural meals-on-wheels service)

6.4 Future Concerns

Organisations were asked to indicate the three biggest challenges they were likely to experience. There was a high degree of consensus among organisations about the difficulties they were likely to emerge in the future: recruiting volunteers (48 per cent) and securing funding (23 per cent) were reported to be the greatest challenges facing organisations (48 per cent and 23 per cent respectively) (Table 6.7).

Table 6.7: Greatest challenges facing meals services (n=280)

	Greatest challenge	Second greatest challenge	Third greatest challenge
Recruiting new volunteers	48.0%	10.2%	9.4%
Securing funding	23.0%	23.0%	16.0%
Meeting increased demand	10.3%	22.6%	20.4%
Recruiting new (paid) staff	8.7%	12.4%	9.4%
Meeting health & safety regs.	5.2%	18.6%	23.2%
Sourcing insurance coverage	1.6%	5.3%	5.0%
Premises	1.2%	0.0%	0.0%
Paying for insurance coverage	0.0%	6.2%	14.9%
Transport	0.0%	0.4%	0.0%

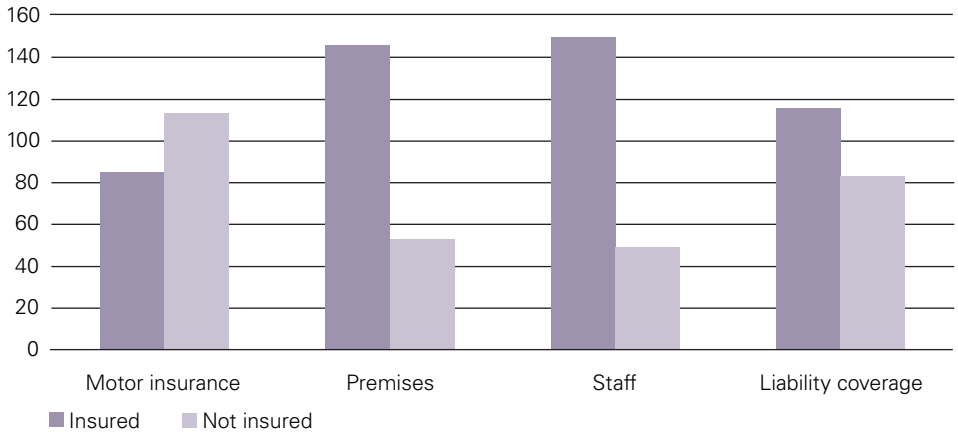
Several organisations highlighted the difficulties they already experience, due to limited funding and difficulties sourcing volunteers:

> *We fear meals-on-wheels is in a state of crisis. There is great difficulty in getting funding. There is great difficulty in recruiting new volunteers. Meals are not monitored for their nutritional value, appropriateness or presentation and there are no guidelines governing meals-on-wheels e.g. ensuring meals are kept hot.*
> (Coordinator, large, rural meals-on-wheels service)

> *Difficulty in securing suitable drivers and the age profile of those volunteering were of serious concern. We also were concerned about transporting meals, perhaps on hot summer days in the boot of a car. The question of whether clients ate the meal on the day or kept it in unsuitable temperatures for another day was also an issue. The advent of strict HACCP regulations regarding food temperatures arose. So consequently we discontinued meals-on-wheels. There is no service in this area now.*
> (Ex-coordinator, small, rural, discontinued meals-on-wheels service)

While the challenges facing organisations will be discussed in greater detail in the following chapters, it is worth noting that a significant proportion of organisations were not fully insured to cover emergencies. In particular, 41 per cent of organisations (n=83) did not have any liability coverage (or were not aware that they had coverage) (see Figure 6.5). There was no significant difference between organisations with and without liability insurance in terms of the total funding of the organisation ($t(87)=.682$, $p=.497$), perhaps indicating that finance may not have been the main reason for such a low uptake of coverage.

Figure 6.5: Insurance coverage taken out by meals-on-wheels services



6.5 Summary

Chapter Five presented the findings from the first survey of meals-on-wheels providers in Ireland. The survey indicates that organisations currently provide meals 4.4 times a week on average, serving 10,000 – 12,000 people in total. The majority of organisations are charities or voluntary-based. The results showed a great deal of variation in the level of service provision throughout the country, with some counties, such as Donegal and Westmeath, having a high number of services per head of population and others having a low number, including Kilkenny and Louth. Only a small proportion of service providers saw the organisation has having a dual mandate, namely, the provision of a meal and some social contact to those in need. The majority saw their main objective as providing meals to those unable to provide for themselves.

Public Health Nurses were the main referral sources of meals clients, while Social Workers and family and friends also played a role in referring individuals to the service. Few organisations used strict eligibility criteria, and indeed, the absence of a waiting list for the majority of services indicated that services made every effort to accommodate new clients, though some co-ordinators remarked on the difficulties they faced in extending their client list. The majority of organisations operated between two and five days a week. Less than seven per cent operated on Saturdays or on Sundays.

Organisations relied heavily on volunteers to operate. Almost nine out of those working for meals-on-wheels services were volunteers. Just less than one-third of organisations had no paid staff. Only 4% of all staff were paid full-time staff members. Indeed, among the biggest challenges facing organisations in the future were the recruitment of volunteers and sourcing funding.

Few organisations provided clients with a choice of meals on the days they delivered. Just a small proportion offered clients chilled meals, which offer greater flexibility in terms of the time they can be eaten and the type of food that can be provided. The majority provided hot meals, and the survey results indicated that a large proportion of organisations had at least one staff member who had completed a food safety course. The majority of organisations charge clients for meals. Organisations received €6.30 for each meal, on average, from a variety of sources, including client contributions, the HSE and fundraising. Of this amount, an average of €1.28 was provided by the HSE.

The next chapter presents the findings from the interviews with a sample of staff of meals-on-wheels services.

Chapter Seven

Profile of Meals-on-Wheels Services in Ireland: The Interviews with Service Providers and Referral Sources

Chapter Seven

Profile of Meals-on-Wheels Services in Ireland: The Interviews with Service Providers and Referral Sources

7.1 Introduction

This chapter is based on the findings from interviews carried out with thirty coordinators, drivers and cooks from thirteen meals-on-wheels services throughout the country, as well as interviews with five PHNs, who play a role in referring individuals to meals-on-wheels services. These interviews were carried out in order to validate the findings from the survey of meals-on-wheels services presented in Chapter Six and provide more in-depth information about the topics reported in that chapter, including the benefits and challenges involved in running a meals-on-wheels service, namely the establishment and development of the service; information on the referral system and eligibility criteria used; demographic information on the meals clients; information on staffing levels; meal preparation and delivery; funding; challenges with regard to compliance with health and safety legislation; and challenges for the future. Innovative practice identified during the course of the fieldwork is highlighted throughout the chapter.[11]

7.2 Management Structures

The management structures of the thirteen organisations from which interviewees were drawn varied: widely: five were part of a larger organisation, such as a Social Services Committee, a locally-based charity or the HSE, while eight were run as independent organisations. Seven had either a board of management or committee to provide support and advice, and make decisions on the strategic management of

11 Innovative practices highlighted throughout the chapter are attributable largely to three organisations. In order to protect the anonymity of these organisations, details that may reveal the identity of the organisation are kept to a minimum.

the service, while six organisations relied solely upon the coordinator to manage the finances, operate the service and plan for the future. This variety in management structures appears to be related to the evolution of meals-on-wheels services around the country, with local groups identifying and working to meet a need among older people and people with disabilities in the community.

Innovative Practice: Management Structures

One large meals-on-wheels service in an urban area is part of a larger organisation providing a variety of services for older people in the local area. It is given funding and support its parent body, which allows it to meet the needs of its service users. The organisation has a board of management that deals with all aspects of the organisation and ensures that meals-on-wheels is fully integrated with other aspects of the service. Given the size of the organisation, strategic planning is vital and the likely future demand for the service has already been estimated, along with plans on how any additional demand can be met.

The expertise of the individuals on the board of management is used effectively in the management and operation of the meals-on-wheels service. In addition, the presence of the parent body has allowed the meals-on-wheels service to become more client-centred, as funding from other activities can be channelled into the service without it incurring large debts. As such, the meals-on-wheels service operates seven days a week and has a formal feedback system to ensure that clients' needs are met.

Given the importance of the organisation for older people in the local area, positive working relations have been developed with PHNs in the area. This presents an opportunity for those who are in need meals-on-wheels but cannot afford to pay the charge to be further subsidised by the HSE in the area.

7.3 External Support

The support available to the coordinators from outside the organisation was varied. Some had the support of their parent organisation, such as the branch of the charity operating in their local area, however this support was often limited. In some areas, local HSE staff had provided assistance in setting up the service, or advised the coordinators on the day-to-day running and funding of the organisation. Two coordinators noted that community workers in the HSE southern region play a role in supporting meals-on-wheels services. However such posts do not exist in all regions

and several coordinators indicated that they received little practical input from the HSE. One coordinator received some support from attending meetings and training sessions provided by a community worker in the local partnership company, however few coordinators had meaningful contact with other meals-on-wheels services.

Coordinators who received some form of external support appeared to have benefited from this; displaying a better understanding of the funding streams available, or appearing less pressured in terms of the day-to-day running of the service. Coordinators were aware of the need for, or the benefits of, advice and assistance from various sources. The following comment from one coordinator highlighted the lack of support available to meals-on-wheels organisations:

> *I was afraid I was going to miss out on something you know that's why I followed it (the research project) up really.*
> (Coordinator, small urban meals-on-wheels and day centre)

The PHNs interviewed for the study did not consider that they had a role to play in supporting meals-on-wheels services. Indeed, three of the nurses indicated that it was the meals-on-wheels service that provided them with much-needed support. Most felt that they had a good working relationship with their local service, and praised both the quality of the meals and the role played by the service in maintaining older people in their own homes. One PHN remarked that 'the meals really are of excellent quality … all it takes is one phone call and I can get someone added to their list', while another noted that 'it is a valuable service – they have someone calling everyday'.

7.4 Staffing and Training

Maintaining an adequate supply of staff was one of the biggest challenges faced by all of the organisations. Eleven of the thirteen organisations employed at least some staff, principally trained cooks to prepare the meals, although seven also employed drivers to deliver the meals. Many organisations either out-sourced cooking or employed staff on the FÁS Community Employment (CE) Scheme. In addition, nine of the coordinators were in full-time paid positions, with funding coming from a variety of sources, including the HSE, local charities and other sources. Many indicated that, without the CE Scheme, the service would have to shut down.[12] It has been suggested that the CE Scheme may not be in operation for much longer, which was a major concern of many coordinators:

12 The FÁS CE Scheme is an initiative that aims to facilitate the re-entry of the long-term unemployed into the workforce and provides those who take up the Scheme with targeted training courses.

… there is no problem there. We don't need people for the kitchen at the moment. As long as we have the CE Scheme here. If that scheme was withdrawn, I don't think we would be continuing. I don't think we could …
(Coordinator, small urban meals-on-wheels service)

Sourcing volunteers appeared to have been one of the biggest problems faced by coordinators interviewed. Many of the coordinators remarked that the age profile of volunteers had changed over the years; several noted that as many women are now in paid employment, many volunteers are often retired men or women willing to give up a few hours a week to support their local community. Indeed, the recruitment of volunteers was problematic for many coordinators, perhaps resulting in a lack of safety precautions in some cases:

I: How do you go about trying to get voluntary drivers?

R: Oh my goodness, I'd be involved in the church now and I'd be putting things in the newsletter up there, and I'm on another committee and I'm touting for drivers everywhere. Everybody I know I'm asking 'have you any time? What do you work at?' Even at bus stops and all I do be asking people!
(Coordinator, large urban meals-on-wheels service)

The interviews with volunteers indicated that they contributed their time for a variety of reasons:

When I retired I found that I was home … and I got to the stage where I said to the wife one day, 'I'm going to go down to the Social Services and see if they want me for anything or other'. It's a case of giving something back rather than what you've got. Do you understand me?
(Male voluntary driver, urban meals-on-wheels service)

About six years ago, they were looking for volunteers … They hadn't got many so she asked me would I do a day or two … so I volunteered for one day a week at the time and it's like all these volunteers, you don't want to be committed to something for a full week … I'd much rather be out playing golf!
(Male voluntary driver, urban meals-on-wheels service)

However, all of the voluntary drivers stressed how much they enjoyed volunteering for the service. They felt that they were giving something back to the community and providing an important service to those who may otherwise have difficulties.

Many spoke of the relationships they had built up with the clients:

I: So in your opinion how much of a difference does that bit of interaction make to each person that you call to?

R: Well some people, all of them, they're so delighted. They'd make you feel you're doing marvellous work. My last person I might talk to for a while and then I might change my little route and not have the same person last you know. I've kind of got to know them because I do the same route anyway you know. I went to visit one of the ladies in the nursing home because she had given me a present, a Christmas present …
(Female voluntary driver, rural meals-on-wheels service)

It appeared that some volunteers personally recruited a replacement driver so as not to create problems for the organisation:

I: Why did you decide to start volunteering in this organisation?

R: An old local man who drove for the organisation talked me into doing it, he wanted to give up doing it but he wouldn't give up until he got someone else.
(Male voluntary driver, urban meals-on-wheels service)

Some of the PHNs also identified the shortage of volunteers as one of the central problems faced by meals-on-wheels services. One nurse spoke of the difficulties faced by clients of her local service who, on occasion, did not receive their meal when voluntary drivers who had to cancel their shift could not be replaced. She suggested 'even one paid driver would be a help'.

Four organisations had both paid and unpaid drivers, of which the coordinators of two indicated that tension had arisen between the drivers as a result. In one organisation, the coordinator stated that the paid driver was 'just in it for the money' and had to be carefully managed in order not to upset the other drivers:

R: That's the [paid] driver […] now. He's being paid by the health board … He's getting paid to deliver meals everyday when he might only have to deliver them one day a week. Now in the summer I'll have him everyday because I'll be short drivers everyday.

I: Could you not put him down to drive everyday?

R: Ah but I'll lose my voluntary drivers then.
(Coordinator, large rural meals-on-wheels service)

The second organisation that reported similar problems also suggests that paid drivers may not have the same altruistic motives as volunteers:

> *I've noticed in the last few months a lot of tension between the drivers. Two drivers have had a go at each other … and this is not acceptable. So, I met them individually and in groups and I've now extracted from them what I needed … what I was observing which was bullying going on. Like the quiet person was being pushed around to all the long routes and the hard routes.*
> (Coordinator, large rural meals-on-wheels and day centre)

Despite this, some of the coordinators indicated that they considered paid drivers preferable to voluntary drivers in many instances. While the majority of coordinators recognised the advantages of working with voluntary drivers, some felt that voluntary drivers worked better if they were only 'burdened' with one or two hours a month, as over-reliance on them was unfair and led to resentment of the service. While the question of providing training for drivers was raised, few coordinators felt that drivers would be willing to give up more of their free time to do so.

None of the coordinators sought Garda clearance for their voluntary drivers, with some indicating that the amount of time taken to obtain such clearance may deter individuals from volunteering. Many of the drivers appeared unaware of what procedures they should follow if a client did not answer the door. None had received training in either customer care skills or manual handling, nor had any received information on the organisation's procedures should a client fail to answer the door.

I: OK, has it ever happened – if people don't answer the door?

R: Oh yes, it has yes.

I: And do you have any system in place – what do you do or ...

R: They would probably go next door and see if there was anybody there. They will come back [here]… they may go back again. I know somebody that has called three times.
(Coordinator, small, urban meals-on-wheels service)

The procedure followed by drivers in one organisation was to phone back to the centre if an individual did not answer the door. The centre would then either instruct the driver to try calling again after an interval or else contact the individual or a family member. If it was felt that something may have happened, appropriate actions would be taken, such as calling the emergency services or requesting family members to check up on the client. One organisation had developed a set of guidelines for drivers of the service.

Innovative Practice: Guidelines for Delivery Staff

The following guidelines were developed by one meals-on-wheels service for delivery staff.

- Be of a pleasant and friendly disposition.
- Personal hygiene and tidiness is essential.
- Do not rush in and out of the house of the client.
- If there is a possibility that you may be late delivering a meal, please inform the client.
- Take the time to talk to clients for a short period.
- Take note of client's overall disposition: cleanliness; tidiness; speech. Should you notice any changes or anything unusual, please report to main office.
- Listen, take note of and report any complaints with regard to meals. Complaints will then be investigated internally and will be reported to the HSE if necessary.
- Do not discuss your personal problems with clients; they may have their own to contend with.
- Do not bully, harass or raise your voice in argument with any client.
- Observe confidentiality guidelines at all times.

7.5 Role of the Coordinator

The interviews with various staff members revealed the importance of the coordinator. It appeared that the skills base and attitude of the coordinator tended to determine how effectively the organisation was run and also the attitudes of other staff towards the service

The backgrounds of the fifteen meals-on-wheels coordinators interviewed were varied. Five had a background in community development, nursing or business development. Three were living locally and had established a local service after seeing a need for meals-on-wheels in the area. All of the remaining seven had been asked to replace a previous coordinator. Of these, two had previously been working as cooks in the service.

The responsibilities of meals-on-wheels coordinators varied from one organisation to another and included: liaising with clients, PHNs and social workers; recruiting volunteers; organising the delivery of meals on a day-to-day basis; buying or supervising the purchasing of food; ensuring health and safety legislation was adhered to; reporting to the board of management; organising training for cooks; and managing the financial accounts. Some coordinators also had other responsibilities, such as organising and supervising day services, while others were carrying out their duties on a voluntary basis.

The majority of coordinators enjoyed their role, reporting that they found it rewarding and stimulating. However, a small number, particularly the voluntary coordinators, reported a degree of 'fatigue' and indicated that they would be willing to hand over to a suitable individual who would be willing to take on the role, if such a person could be found:

> *That era seems to be … passed where people work for nothing. And the amount of work … is … well it's very onerous as well and I think that day has gone … I was saying to a friend that I met at the church, when we sort of fall out, I can't see anybody falling in.*
> (Assistant coordinator, small, urban meals-on-wheels service)

The skills and knowledge of the coordinator played an important role in the level of effective functioning of the organisation, including: the amount of time each gave to the service; their style of management; and their knowledge of the needs of older people, funding streams and organisation of services for older people both locally and nationally. While some coordinators had a good deal of experience of running large organisations and had knowledge and understanding of care for older people and funding streams, others did not. It is possible that such knowledge, or the lack thereof, had an impact on the operation of the meals-on-wheels service:

> *Well we've learned from others as well, do you know what I mean we've learned and we're 20 years at it. So, we've had to learn the system and learn from others and they've learned from us and it's not us that have the monopoly of knowledge or experience.*
> (Coordinator, large, urban meals-on-wheels service)

Innovative Practice: Sourcing Funding

The training and foresight of one coordinator has enabled a small organisation, originally established to provide a befriending service and day centre for older people in the local area, to grow into a larger organisation that now provides a wide range of activities and services to a larger number of clients in a wider radius including bowling, monthly socials, counselling, art, bingo, drama, community visits, chiropody and reflexology.

The coordinator, with a background in community development, has undertaken a number of training courses in applying for funding grants, in order to learn the process of submitting funding applications. The coordinator also found such training courses to be a useful source of information on the various funding streams available for community and voluntary groups.

The complicated funding applications submitted have had some unexpected positive outcomes for the organisation. For example, many funding applications require the submission of detailed strategic and operational plans, which compelled the coordinator to develop strategic planning mechanisms. Strategic and operational planning is now an integral part of the role of the coordinator and has helped the organisation to develop a better, more client-focused service.

7.6 Referral System and Eligibility Criteria

As mentioned in Chapter Six, PHNs are among those most likely to play a role in referring people to the service, together with GPs, family members and social workers, referring at least some clients to 95 per cent of meals-on-wheels services. In eleven of the thirteen organisations, there was no formal referral system in place. Only two coordinators indicated that all referral sources must come through a formal channel, such as the PHN. Individuals could refer themselves to any of the other eleven services; family members, a healthcare professional or social worker could also do it on their behalf.

None of the PHNs interviewed used standard eligibility criteria for referring people to the service, relying instead on personal judgement. It must be remembered, however, that this is not necessarily representative of the practice used by all PHNs. By and large, they were guided by the maxim that anyone who is unable to provide for themselves, because of an inability to shop or cook, could avail of the service. Those

who live alone, have been recently bereaved or have alcohol abuse problems were also reported by the PHNs as indicators of a need for the service. However, one PHN admitted that income would 'come into it a bit' when referring an individual to the service; if they are well-off and could afford to go to a hotel for their meals, she may not refer them.

Coordinators themselves occasionally refused those in need, principally due to resource limitations, although some coordinators made remarks that suggested that they may refuse individuals that they feel do not need the service:

I: And you … you take whoever you feel that needs it?

R: Well, if they were young you wouldn't but if there was somebody sick in the house or if they are elderly or on their own or … any of them that we have are … well I shouldn't say deserving but like, they deserve the meals-on-wheels service, to save them cooking you know.
(Coordinator, small rural meals-on-wheels service)

And then you have people across the road and they'll see such-and-such getting it, and then 'well, I'm 80 I should be getting it as well' and they're ringing up just because they're 80. They're out and about and they're going around to day care centres … and this other woman rang up and we were absolutely flummoxed at the way she done it. She went to her doctor's surgery and she got our number there and decided to ring up for herself … She rang up and she said, 'well I'm 80 and I should be having it' and I said, 'we can't bring it' … She said, 'I have a home help coming, she could go down and collect it for me.' The woman is out and about, she's over in [names centre], all around the place and all, and just because she was 80 she felt it was her divine right to get in.
(Coordinator, large urban meals-on-wheels service)

7.7 Estimated Unmet Demand

Few of those interviewed could estimate the extent of unmet demand in their areas, although some coordinators felt that most of those in need of the service were aware of or were already availing of it. Coordinators were asked whether they advertised the service to ensure that those who may want to avail of it were aware of it, but many seemed reluctant to do so, perhaps due to concern that it might significantly increase demand for the service, with which they might be unable to cope.

Two PHNs who reported high levels of unmet need in their areas were working in areas that were not directly supplied by meals-on-wheels services. One PHN was helping to develop a client base for a service in the process of being established, while another noted that some of the district she served fell between the areas covered by two local services. She indicated that both services could be inflexible and neither would 'go even one street out of their jurisdiction to take on any of my clients'. It is unclear who had been responsible for drawing up the 'jurisdictions', based on parish boundaries, and why these could not be breached, although some coordinators indicated that they had to put limits on the service they provided out of concern that the workload would expand significantly. Both PHNs were forced to make alternative arrangements for clients they felt needed extra nutritional support. One recommended that individuals buy frozen ready-made meals, while another tried to persuade a local meals-on-wheels service to take on her most needy clients; one of whom she considered to be under-nourished from a diet of frozen meals bought in the local supermarket.

Several reasons were put forward regarding why individuals might decline meals-on-wheels services. One PHN noted that 'no-one really refuses it', although she stated that 'gentle persuasion was sometimes needed to encourage individuals to take up the service.

Feelings of stigma about using a charity were identified by several coordinators, drivers and PHNs as a possible reason for refusing the meals:

I: Do you ever get anyone who has been offered to come in here or used the meals or whatever and who said no?

R: Yes. [laughs]

I: And how often would that happen?

R: Quite a bit.

I: Does it?

R: Because there's just a stigma.

I: OK …

R: People, you know, 'Oh well I'm not coming to that place, it's an institution or something'.
(Coordinator, small urban meals-on-wheels and day centre)

One of the PHNs interviewed noted that she no longer had time to automatically visit all those in her catchment area who had turned 65 to inform them of the services that were available to them, thus limiting her ability to identify and prevent problems before they arose. It also limited her knowledge of the clientbase. None of the PHNs interviewed was able to estimate the level of unmet demand for the service in their catchment area.

7.8 Operational Aspects

7.8.1 Service Model

The service models used by the organisations from which interviewees were selected varied considerably and appeared to be based on both the resources available and the time each coordinator had available to commit to the organisation. One small, rural service paid a local supermarket to cook all of the meals, which were then collected and delivered by volunteers. Another organisation used a similar model, paying a local hotel to provide the meals. The other eleven services had their own kitchens and had either full- or part-time paid staff to cook the meals, some of whom were subsidised by the CE Scheme or the HSE. Five of the services also operated day centres, with some clients eating their meals on-site. The number of days per week each service provided meals also varied, from two to seven.

7.8.2 Health and Safety

All of the services were regularly inspected by EHOs from the HSE to ensure that they met minimum health and safety requirements. A number of coordinators spoke about occasions when shortcomings in meeting these requirements had been identified:

I: *And how do you find the regulations? Have they changed a lot over time?*

R: *I think they are good. Except that your man wagged his finger at me and told me he would hold me legally responsible if anybody gets ill. I have it in writing. We are on slightly better terms now. … But if you have happen to have the cooked meat in the raw meat section, black mark against you. Well you get a letter. And that is the … yes the last inspection we had … what was wrong? I think it was something to do with the meat. It was in the wrong place. One of the girls was taking chicken out and she had just actually left it down on the counter to bring it on to the other counter. That's the story anyway. But he happened to walk in. [But…] as far as we know, nobody ever got sick from what was done here. As far as we know.*
(Coordinator, small urban meals-on-wheels service)

However, others felt that adhering to health and safety regulations was vital, given the vulnerable clientbase of the service:

R: *What you need is somebody trained in that area … see they do the basics and that's good and that's what keeps us on the ball and that should be … that's the way it is and we have a good rapport between each other. Our own environmental officer … our own food officer that we pay every month, she comes in and she would inspect all the food. … We have to have … there's no excuse. That's the law. We have to have the highest of standards in cleanliness, hygiene, food, regulations. It has to be done and if you know…we welcome the environmental officer in.*

I: *And why does it have to be so high?*

R: *Because the people deserve it. The first thing is that a lot of the old people that we serve meals to are ill so their immune system is lower, so therefore they're prone to food poisoning if the food isn't right. So, that's one of the main reasons. Two they are entitled to it.*
(Coordinator, large rural meals-on-wheels and day centre)

In addition, none of the organisations carried out tests on the meals once they had left the kitchen to ensure that they were of the right temperature.

7.8.3 Nutritional Aspects

As reported in Chapter Six, a quarter of all service providers indicated that they had received input from a dietitian. Three of the services from which the interviewees were drawn had input from a dietitian in devising the menus, while another indicated that this had been prioritised in the action plan for the following year. Among those with no input from a dietician, coordinators and cooks felt that the meals were nutritious and enjoyed by clients:

I: *And have you ever had any advice from a dietitian or anything?*

R: *Look darling, we are cooking and cooking for more years than I care to remember!*

I: *Fair enough, OK.*

R: *I don't have the certificate to prove it but I feel I have a reasonably competency …*
(Coordinator, small urban meals-on-wheels service)

In other organisations, staff reported recognising the need to listen to clients and ensure they were happy with the meals:

I: And why did you stop doing the mince?

R: They just didn't like, they weren't mad about mince you know, so I said just said look there's no point doing it … The way I look at it is that, they're paying for their dinner, so they should be getting something that they eat, do you know what I mean, not something that they don't like.
(Cook, large, urban meals-on-wheels and day centre)

The cost of providing the service was reported as one of the principal challenges to improving the service provided:

I would reckon now that if you include everything; the transport, the food itself, the cooking, the heating, the lighting, petrol, use of car, staff, volunteers for all their time in. At least I would reckon at least €12. Between €12 and €15.
(Coordinator, large, urban meals-on-wheels and day centre)

Innovative Practice: Meeting Food Safety Standards

Adhering to health and safety regulations in the provision of meals for older people or people with disabilities, who are vulnerable and may be at an increased risk of infection due to reduced immunity, is one of the main challenges faced by all meals-on-wheels services. While regular inspections and a certain level of support from EHOs has ensured that standards are generally high, two organisations have gone further than meeting minimum standards and have gone to great lengths to ensure that their clients receive the highest quality service.

One organisation has recruited a consultant food hygiene officer to inspect the premises on a regular basis, provide training to staff, and ensure that the organisation receives up-to-date information on best practices and technology that could help to improve standards for staff and clients. While this has been an additional cost to the organisation, staff feel that it has proven to be an effective way of raising standards and has given them greater reassurance with regard to the needs of clients. The organisation continues to provide hot meals, and is currently examining methods of ensuring that the quality of the meals is not affected once they have left the premises.

Another organisation that had renovated its kitchen felt that one way of ensuring high standards of food hygiene would be to consult with the HSE's EHO regarding the plans for the new kitchen, prior to any work being carried out. This resulted in opting for a low ceiling that proved easier to wash down each day, and facilities to allow meat and other foods to be stored and prepared separately. In addition, the layout of the kitchen means that no one enters the kitchen unless they have a reason to do so; this elimination of 'through traffic' has made a considerable difference in reducing the risk of food contamination.

7.8.4 Delivery Time and Cooking Methods

The time at which meals were typically delivered to clients varied from 11.30 a.m. to 2.00 p.m. As a result, a period of two to three hours could pass between the cooking and delivery of meals. The impact of this on clients is discussed further in the next chapter. However, it is important to note that several coordinators expressed frustration with the inadequacy of the containers used to deliver the meals. Containers funded by the HSE were thought to be inadequate to keep the meals warm.

However, few coordinators looked at alternative cooking times (or alternative cooking methods such as cook-chill meals) as a viable alternative. In many instances, meals were cooked and delivered early to accommodate staff and volunteers. One coordinator commented on the frustration of the paid kitchen staff about a new driver who spent time chatting to clients, resulting in the kitchen staff staying late on the days she delivered the meals:

> *We have a new driver and I believe she is lovely. I haven't met her … she is just retired I think – and she loves this but – the girls were waiting for ages for her to come back. [laughs] The girls finish at half one …*
> (Coordinator, small urban meals-on-wheels service)

7.8.5 Feedback Mechanisms

Just one of the services had a feedback system in place, in the form of a questionnaire, while the rest used more informal methods, e.g. clients either remarked on their level of satisfaction to drivers or phoned the coordinator directly. All of the coordinators reported that most of the feedback they received was positive:

I: *I was just wondering about the clients. Do they have any way of feeding their views back on what they think to you or to the other staff?*

R: *Oh, well yesterday … I was delivering meals yesterday and one lady came out to me and she said, 'Am I getting a special delivery today' and I said 'yes, just because you're special' and she said, 'You know what I tell everybody about your meals. They are absolutely beautiful, I keep telling them all that live around here like me that they should be getting their meals off you.' And I said 'Thanks very much.' 'But they are lovely' she said. Which is lovely.*
(Coordinator, small urban meals-on-wheels and day centre)

Reactions to any negative feedback varied. Some staff stated that they welcomed positive and negative feedback, and were prepared to make the necessary changes to ensure that clients were provided with a satisfactory service, while others saw those

who complained as 'problematic' and as such, were unwilling to examine whether such complaints may have been accurate:

> *I think there's one small problem there, that the food is not hot enough … em … fairly hot right, fairly hot, satisfactory, cool. So we'll have to look at that you see, warm … now we've improved since that, we've improved our containers.*
> (Coordinator, large rural meals-on-wheels and day centre, looking through the results of questionnaires sent out to all clients every quarter)

> *Now I have to say we went to another woman and she's a moaner. She is a moaner … 'I don't want this' and 'I don't want that' and 'Oh, I didn't want that big dinner'. She didn't want that big dinner. [laughs] … Like nothing ever pleased her. [One driver] hated serving her. He hated it. He'd say, 'don't send me over to her' because she always had something to say. So they are difficult, there is some difficult ones but the ones who are nice 100 per cent really and they make up for the bad ones.*
> (Coordinator, small urban meals-on-wheels and day centre)

Where meals-on-wheels services were operated from a day centre, the opportunities for those receiving meals-on-wheels tended to be limited. In some day centres, feedback mechanisms had been established, although the way they operated may have prevented meals-on-wheels clients from contributing to the consultation process. One coordinator highlighted how the formal feedback system available for clients of the service could not be used by meals-on-wheels clients. In addition, the appropriateness of the system for the needs of service users was not considered:

I: *So, do you have any kind of complaints or feedback system or anything for people as your guides?*

R: *We have actually. There was a box up on top there with complaints. I don't think anyone ever put anything it in but we would regularly sit down with them and they would be … they'd be vocal enough in telling us if there was any problem.*
(Coordinator, small rural meals-on-wheels and day centre)

Innovative Practice: Client Input into the Service

One meals-on-wheels service has done a great deal of work in ensuring that the service operates using a client-centred approach. The service has developed its own user-friendly website to give information to anyone who may be interested in using the service, has printed leaflets with information on how to avail of the service and has changed its name in order to encourage take-up by those who may not wish to avail of a meals-on-wheels service.

The organisation has developed a formal feedback system to ensure that clients have an input into the service, in the form of anonymous postal questionnaires. In order to demonstrate the benefits of highlighting the shortcomings of the service, changes are made to the service on the basis of suggestions from clients whenever possible. In addition, both the coordinator and drivers encourage informal feedback from clients.

While the service is not in a position to provide clients with a choice of meals each day for financial reasons, the menu is regularly rotated to ensure that clients get a good variety of meals. In addition, special dietary requirements and individual likes and dislikes are taken into account.

7.9 Future Concerns

Coordinators were asked to outline any concerns they had regarding the future of their service. None of the organisations had formally evaluated their service, perhaps due to time and resource constraints, althought it appears that some organisations did not see the need:

I: You have never kind of done any evaluation or review of the service here, no?

R: In what way?

I: Well, kind of … I don't know – in any formal way looked at – the service and kind of how good it is or how it could be improved or anything like that?

R: Well, if anybody had any energy left over, you know. No, I just feel the fact that the service is there at all is – you know, marvellous …
(Coordinator, small urban meals-on-wheels service)

Chapter Six revealed that few organisations had liability insurance or knew whether they were covered by an insurance scheme. The interviews suggested that this may be due to the prohibitive cost or lack of awareness, rather than a lack of availability[13]:

I: Would you have kind of insurance coverage, for the centre or for the driver or anything?

R: I wouldn't … to be honest you are raising things I hadn't ... you know, we don't have it for the driver. I presume that she has it for herself.
(Coordinator, small urban meals-on-wheels and day centre)

Just one coordinator appeared to have strategically planned for the future, with thought given to methods of recruiting staff, sourcing funding, analysing the future demand for the service and how to improve the service in the future. Indeed, several of the coordinators interviewed were pessimistic about the future of their organisation and indicated that it would not be able to continue in its current form in the medium-to-long term, given funding levels, difficulties sourcing voluntary drivers, increasingly stringent regulations and, in some cases, difficulties in sourcing a new volunteer coordinator. When asked what they thought would be the best option for the organisation in the future, many felt that it would inevitably be taken over by the HSE:

> *I think the only way meals-on-wheels will work in another couple of years when all of these voluntary people are gone because you can see you're not going to get younger, I think myself the only way to work it is if the health board takes over the meals-on-wheels themselves.*
> (Coordinator, large rural meals-on-wheels service)

The problems associated with the extra costs of funding drivers' salaries, if voluntary drivers could not be sourced, was also remarked upon by several coordinators, while one coordinator also remarked on her own uncertain job status:

I: So what'll happen then if, God forbid, something happens to the driver? The main driver, what'll you do?

R: We'll have to go to someone else pleading will they do an extra day or whatever … it gets bad now from now till the end of the summer because they're all going on holidays.

I: Do you think the HSE might eventually be prepared to pay somebody to do it?

13 For example, the Citizens Information Board has an insurance scheme for voluntary social service organisations, operated through Allianz Corporate Ireland (www.citizensinformationboard.ie).

R: *I don't know, we've been asking for years … or for us even to be under a proper umbrella so that we could be health board officials, you know that kind of way? We're kind of out in the middle of the ocean …*
(Coordinator, large urban meals-on-wheels and day centre)

Just one coordinator made reference to the future role and development of meals-on-wheels on a national basis:

> *First of all the whole thing of community care and looking after, and working with, for and by older people is on a legislative basis. … The whole community care basis should be put in legislation like child protection, like the disability law, the disability legislation. […] It's in their strategies, it's not in legislation … But they've got to bring it in … they've no alternative.*
> (Coordinator, large rural meals-on-wheels and day centre)

Such findings are similar to those from the survey of service providers, in which the recruitment of new volunteers, securing funding and meeting increased demand for the service were reported as the three biggest challenges organisations were likely to face in the future.

Innovative Practice: Strategic and Action Planning

Two of the organisations had recently developed strategic plans in order to clarify the objectives and future development of the organisations. Both organisations had included mission, vision and values statements, a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis and had set targets for the development of the organisation/service. In order to ensure that the plans were workable, consideration was given in both cases to the likely future demand for the service, the costs involved, funding and fundraising, as well as staff and volunteer management. Both plans also included how the implementation of the plans would be monitored and evaluated.

One organisation had worked with an external consultant who provided advice on the opportunities and threats facing the organisation and how such threats could be avoided or overcome. The development of the strategic plan helped both organisations to reflect on the aims and objectives of the organisation, which allowed them to recognise the many benefits of meals-on-wheels services, apart from the nutritional element. Strategies for considering the options for delivery of meals were also considered, in light of the increased difficulties in recruiting staff. Public perception of the organisation and how it was marketed were also considered, as it was felt that this would help with the recruitment of both new service-users and volunteers.

7.10 Summary

Based on the interview findings, this chapter has highlighted the positive work carried out by meals-on-wheels services throughout Ireland and the efforts made to ensure those in need of the service are looked after, in spite of limited funding, resources and staff.

Among the thirteen organisations from which interviewees were recruited, both the management structures and service model used were varied. The results showed that co-ordinators were adept at adapting the standard model to suit local needs and resources. In general, there was good adherence to health and safety regulations, with several co-ordinators indicating that it was vital to adhere to the highest standards in order to provide clients with the best service possible. Just three of the thirteen organisations had received input into the menu from a dietitian, and those who had not received such input felt that they provided clients with adequately nutritious meals. Delivery times varied widely and in several organisations, the time at which meals were prepared and delivered was lengthy.

The level of external practical support available to service-providers varied and depended on the area in which the organisation was bases. Due to their heavy workload, Public Health Nurses interviewed indicated that they were not in a position to provide additional support to meals-on-wheels services, though all felt that they had a good working relationship with their local service. None of the organisations had set eligibility criteria and co-ordinators interviewed stated that they made every effort to accommodate those in need of the service, even where resources were limited. However, in certain cases, co-ordinators had discretion to refuse individuals and remarks made by one co-ordinator suggested that she may refuse individuals if she did not feel they needed or deserved the meals.

Staffing levels and the recruitment of volunteers was one of the biggest difficulties faced by service providers, and was one of their greatest concerns for the future. Due to the difficulties in recruiting volunteers, some services had taken on paid staff. Co-ordinators differed in their views on whether paid or unpaid drivers were preferable. None of the co-ordinators looked for Garda clearance for drivers, as the process was too lengthy, and it was felt that this may have deterred individuals from giving up their time to deliver the meals. The findings from the interviews indicated that the abilities, skills and experience of the co-ordinator tended to be reflected in the operation of the service. Those who were highly skilled or had relevant experience tended to operate services that were more client-centred, had fewer financial worries and made efforts to plan strategically for the future. The views of clients of the service are presented in the next chapter.

Chapter Eight

Profile of Meals-on-Wheels Services in Ireland: Interviews with Clients

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Profile of Meals-on-Wheels Services in Ireland: Interviews with Clients

8.1 Introduction

As international best practice suggests that meals-on-wheels should be a client-centred service, it was considered important that clients of the service be consulted about its role and future development.

This chapter presents the findings of interviews carried out with a total of 66 older people for the purpose of identifying the role played by meals-on-wheels in their daily lives, including their pathway to the service and their opinion of the service, as well as related issues, such as their shopping patterns, relationship with food, and use of other health and social services. The majority of the interviewees were in receipt of meals-on-wheels at the time of the interview, although a minority no longer used the service, the reasons for which are outlined below.

8.2 Pathway to Service

Interviewees availed of meals-on-wheels for a wide variety of reasons. The majority had just come out of hospital and it had been suggested to them that they should avail of the service, either in the short-term or for the foreseeable future. A quarter were not able to cook their own meals due to a deterioration in their health. A small number, almost all male, stated that they availed of meals-on-wheels as they had never learned to cook and had either been bereaved or the health of their spouse had deteriorated. A significant proportion indicated that they were in receipt of meals-on-wheels as it was available in their area and the service had been offered to them. Many recognised that meals-on-wheels was perhaps a more preferable alternative than the other options available to them:

This year I was in hospital in January and they wanted me to go to a nursing home, which I didn't like, I didn't want. I said I'll get meals-on-wheels instead. So I did.
(Female meals-on-wheels client, aged 83)

However, for many interviewees, it was their inability to shop that created difficulties and resulted in the need for meals-on-wheels:

I: So do you do your own food shopping?

R: I do light shopping. My neighbours are kind but you can't ask them to do everything. So, that is why I took meals-on-wheels because I knew I wouldn't be able to do heavy shopping.
(Female meals-on-wheels client, aged 88)

A small number of couples (n=4) were interviewed, and in all cases, the deterioration of the wife's health had resulted in meals-on-wheels being delivered to both husband and wife, as all four men admitted that they could cook very little, although they could still shop and carry out other everyday activities. This perhaps highlights the need for referral sources to take the overall picture of the potential client into account; providing meals to one spouse may have little impact if it is not also provided to their partner or spouse. On the other hand, it is essential to ensure that clients are in need of the service. On the other hand, it is paramount to ensure that clients are actually in need of the service. The following quote is from a meals client:

It seems to me whoever is running the local institutions must have got word I had retired. And this was a new estate and they were visiting all the people that had moved in … I am not from here. You know what I mean, I am from (names town). And I think that was more or less called welcoming you to the estate and then because you are retired the nurse calls. Nurse calls about once a year. Yes she is in a clinic down the street and she tells you if you want anything call to see her. I never bothered her because I am not too unhealthy as you can see like. For my age! Just the meals came …
(Male meals-on-wheels client, aged 69)

However, it appeared that all other respondents were in need of the service, as they were unable either to shop or cook for themselves.

As was noted previously, where referral systems and eligibility criteria are used, they were rarely reviewed. Approximately one fifth of the interviewees had either been involved in cooking or delivering meals in the past, or knew someone who was currently involved and indicated that this had helped them to avail of the service. The

lack of a formal referral process in sourcing eligible clients for, and referring them to, meals-on-wheels may have implications for both users and non-users of the service:

> *It's funny when the woman in charge … oh she was insisting that everything would be alright because my wife put in her stint doing it …*
> (Male meals-on-wheels client, aged 69, referring to his wife's previous involvement with meals-on-wheels service)

While many of the coordinators believed that one of the reasons people may not want to avail of meals-on-wheels services was the stigma attached to the service, few interviewees indicated that they had reservations about availing of a 'charity'. Rather, misgivings experienced by clients appeared to have resulted from their own personal struggle to retain their independence. Indeed, many indicated that they had been grateful and relieved when offered the service, as having cooked meals delivered was convenient and saved a lot of trouble. Any reservations clients had had initially, disappeared once they came to accept their growing dependence and once they realised that the service would save them a good deal of trouble in preparing meals:

I: So how did you feel about getting the meals-on-wheels then?

R: Well, I wasn't madly enthusiastic but we had to face the fact that we had no choice.

I: Ok, and how do you feel about it now?

R: Oh I think it's great. See I can't do anything, I'm in a wheelchair and all the table tops are all up high and anyway my OT won't allow me to do anything or cook or anything so it's not a possibility for me.
(Female meals-on-wheels client, aged 72)

Therefore, it is possible that it is a difficulty in accepting the ageing process or a growing level of dependence that may be responsible for individuals being reluctant to take up the service (see Section 8.6).

8.3 Opinions of Meals-on-Wheels Services

The majority of those interviewed had a great deal of praise for meals-on-wheels services, although the majority felt that the service had some shortcomings. Of those who liked the service, most felt that the convenience of having meals delivered and the fact that someone was calling to the door were the principal benefits of the service:

I: *And what, what kind of pushed you to that decision or what was behind that?*

R: *Well, to save me cooking.*

I: *So you're happy with the quality of the meals overall?*

R: *Oh absolutely. The service is impeccable … And, of course, you get a visit, you know.*
(Male meals-on-wheels client, aged 79)

However, opinions tended to vary widely on the quality of the food and depend on, among other factors, the organisation from which meals were supplied. Where a client of an organisation felt that the quality of the food was good, with a good deal of variety, adequate portion sizes and temperature, and friendly staff, others from the same service were likely to have a similar opinion. The converse was true in the case of other services: clients complained of a lack of variety and quality in the food provided and the inconsistency in delivery times, limiting their ability to leave the house:

Quite often I'll throw it out, one particular thing, a ham thing, I throw it out the minute I see it.
(Female meals-on-wheels client, aged 83)

They're alright. They've no variety about them …
(Female meals-on-wheels client, aged 81)

I: *So you get the meals-on-wheels two days a week. If it was on offer five days a week would you take it the other days*

R: *No, it'd be too monotonous.*

I: *Too monotonous, and what's monotonous about it?*

R: *Well you know every Tuesday that you're going to get chicken and every Thursday you're going to get brown meat. It would be lovely if they could have a rota and change.*
(Female meals-on-wheels client, aged 86)

Well the meals were coming between 12.00 p.m. and 12.30 p.m. kind of, but as you know … the traffic is such that they just can't get here. It's long after 1.00 p.m. now when they come, you know. It would be now 1.25 p.m. sometimes and you'd be wondering what on earth is keeping them.
(Female meals-on-wheels client, aged 85)

In addition, satisfaction with the quality of the meals was affected by other factors, most notably, the length of time that had elapsed from the time the meals were cooked to

when they were delivered. Interviewees who were at the beginning of the 'run' tended to report higher levels of satisfaction with the meal, while those towards the end of the 'run' tended to have a lower opinion, which may indicate the difficulties faced by organisations in maintaining food at an adequate temperature while en route to clients:

> *It's really hot and the woman said, 'you'd nearly want to put on gloves, it's so hot'. We must be first on the list because where it's prepared, its only down in (names place) there which is only about, its not even a mile away.*
> (Male meals-on-wheels client, aged 87)

> *The cook arrives at 7.30 a.m. to prepare the meals for about 70 people, that's the average. The meals are delivered about 11.30 a.m. or soon after. Now that's four hours to get the meals ready … This has consequences with regard to taste as we eat it cool. This suits the cook if she leaves at about 11.00 a.m., she will be ready for a similar job elsewhere. The drivers will be early home also [but] the clients suffer as a consequence.*
> (Female meals-on-wheels client, aged 93)

A former meals-on-wheels client explained why she had used the service for a limited time, before giving it up:

R: I disliked every part of it, there was nothing I liked about it, not a thing. They were not very cold, but lukewarm, you know, they just weren't nice. And it was tasteless too.

I: And the fact that, you know, somebody was delivering it to your door from maybe a charity, would that have bothered you at all?

R: No, no, no, no, no it wasn't that. It was just that I couldn't eat it.
(Female former meals-on-wheels client, aged 83)

One client remarked that she had only accepted the meal because she felt she had no other choice after she became ill. However, her return to health had prompted her to reassess the options available to her:

I: And are you happy with the meals that you get now from them?

R: Now that's a question, I was very happy for a long, long time, I suppose when I really couldn't do anything I was very happy with them. And then I started, I mean I'd go maybe three days a week, maybe I dropped it here and there. As you improve yourself and feel you can do things, you're not satisfied with something you would have accepted before, you know.
(Female meals-on-wheels client, aged 85,)

Many clients recognised that meals-on-wheels services catered for a variety of individual tastes and needs, and it would be impossible to please everybody all the time. However, it is important to recognise that services in other countries have overcome this by offering clients a choice of meals each day, giving them a greater level of autonomy over the service. Chapter Seven reported that most coordinators and cooks believed that the majority of their clients were happy with the service. One of the reasons for the discrepancy between coordinators' and clients' perspectives appears to be the reluctance of clients to raise their concerns with coordinators:

> *But you know I suppose … I haven't said this to the women that deliver because they're only delivering you know. And I wouldn't like to complain you know because they're very good to bring a dinner you know. But actually I would prefer if the meat was minced you know because you'd be able to eat it. It's not that there's anything wrong with the meat. And now yesterday there was two big slices of lovely roast beef. But after you heat it up like it's a bit drier you know what I mean and now I couldn't eat that you know. I couldn't chew it with the teeth. And it was a shame like really to have to throw it out.*
> (Female meals-on-wheels client, aged 82)

Reasons for the reluctance of the majority of clients to complain were unclear, although several stated that they were afraid to complain for fear they would be looked upon unfavourably by those who delivered the meals:

> *I've never complained to meals-on-wheels about that anyway. Maybe it's the fear that they might snap it off.*
> (Male meals-on-wheels client, aged 69)

In addition, many clients felt that it would not be appropriate to complain, given that they were in receipt of a voluntary service for which they paid very little, in which individuals were giving up their time, free of charge, to deliver the meals:

> *Well they are only €1.50, you know, you can't grumble at that price … No, I'm not really [happy], but what do you expect when you're only paying €1.50? And they're voluntary workers. And I mean I think they're great.*
> (Female meals-on-wheels client, aged 75)

In general, those who were paying more than average for their meal were more likely to be satisfied with the service, while several stated that they would be willing to pay more to receive a better service:

I think, I personally would feel better if I was able to put another few quid extra in now and then, that if there was something that I could say, 'well, I have enjoyed that.'
(Female meals-on-wheels client, aged 87)

Clients of organisations that charged higher prices and had formal feedback structures in place were more likely to complain, although the general views of the service tended to be more positive for these organisations:

It was excellent, and the cooking and the presentation. I think it's marvellous. I filled in a questionnaire now not long ago and I put excellent for everything on it.
(Male meals-on-wheels client, aged 87)

8.4 Social Role of Meals-on-Wheels Services

Almost all of the meals clients interviewed stated that the social role played by meals-on-wheels services was as important or more important than the nutritional aspect of the service. A number of clients detailed the relationships they had developed with those delivering the meals:

Well, it is nice to see someone coming in, you know what I mean, because like with me in an office for so many years and meeting so many people everyday, it could be very lonely and it's a great idea to have somebody coming in and having a bit of a chat you know for a few minutes … and you get to know the person and they get to know you and you can ask about different things. It is very important, I think. It's very important to have callers coming to you when you are retired you know.
(Female meals-on-wheels client, aged 79)

However, such individuals tended to be in the minority; on the whole, volunteers tended to stay less than twenty seconds with each client:

I go to the door, I take it in and I say, 'thanks very much' and that's it.
(Female meals-on-wheels client, aged 83)

The length of time the driver spent with a client did not appear to represent a significant problem to interviewees, perhaps as all understood the need for drivers to complete their 'run' while all of the meals were hot; the fact that someone was calling was a comfort and presented an opportunity to have a regular visit:

I just go to the door when they call, say hello and give them €2 if I have it and that's it. I enjoy it now, it's very nice, they're good … they're nice people that come with it. They don't just leave it on the door or anything, they make sure I'm here.
(Male meals-on-wheels client, aged 70)

However, some clients felt under pressure to be ready for the driver:

Very often on Friday there's a young chap. Well I suppose he's in his twenties. He's very brisk and business-like and … he's all business. And I like to be sure for him because he fits it in maybe between his studies or his employment or something and … I have the door nearly open and I have a tray. And he does be delighted with me, I never delay him.
(Male meals-on-wheels client, aged 87)

While the element of security provided by meals-on-wheels was not discussed directly in many interviews, it still appears to be an important element of the service, as demonstrated by the account of one interviewee of being found after a fall by Transition Year pupils who were helping the meals-on-wheels driver:

Two little girls came with my dinner and the driver was out in the car and they were looking at me. But, I couldn't get up and I was sitting there at that door. All the doors were open, the television was on, the lights were on since the night before, and I needn't tell you they got frightened. … I told them, I said 'Don't be frightened. I'm alright.' I said, 'only I can't get up. Tell the man in the car.' So they went out, they ran down to see him. And the man came up. I never saw him before and he was gone like a shot. I said, 'I'm ok only I can't get up.' I must of know that I was in my own home but I was frightened. I couldn't see the furniture. So, then I was trying to get up on it and I was worn out and I think I kind of laid down during the night and but if that had a happened me out there [in the kitchen] I mean I would have banged my head off the concrete … and do you know...
(Female meals-on-wheels client, aged 86)

The lady reported that the driver responded promptly, contacting both the GP and Gardaí, who arrived quickly and tended to her.

While using post-primary school pupils to deliver meals has benefits in terms of intergenerational solidarity, the above quote brings into question the appropriateness of using those without the competence necessary to deliver meals.

8.5 General Eating Patterns of Clients

Almost all of those interviewed live alone and eat almost all of their meals by themselves. Given that the meals tend to arrive between 11.30 a.m. and 2 p.m., few clients eat their meal as soon as it arrives, although many eat it later on that day. Very few explicitly stated that meal times are occasions to be enjoyed; rather, many see eating as a functional activity:

> *I eat to live, I don't live to eat.*
> (Female meals-on-wheels client, aged 86)

In general, women tended to be more selective about the food they ate, with men more likely to eat whatever they were given. It appeared that women invested more of themselves in meal times, and missed having companions to eat with, using television or the radio as a substitute:

> *I usually have my breakfast in the kitchen and I have my lunch in the kitchen and then I bring my tea in here …. watch the telly, whatever programme … just put it on a tray and that is a cold tea.*
> (Female meals-on-wheels client, aged 88)

> *This table for breakfast and lunch, and then I go into the back room for my tea because the sun comes in there.*
> (Female meals-on-wheels client, aged 89)

However, some continued to make the effort to make meal times special.

I: *And would you cook yourself a dinner everyday apart from the days you're getting the meals-on-wheels?*

R: *Oh yes. And I'd also sit down at the table and the table is laid properly as well. Not leaning against the kitchen sink! (Laughs) You can get into an awful habit! When I finish breakfast here I always set the table for my lunch right away so that when you come in, you know you're out in the garden or something and you haven't got to do that, to get it ready.*
(Female meals-on-wheels client, aged 89)

Many of those interviewed (both male and female), made a distinction between meals eaten alone and those eaten in company:

R: *And you'd have a whole different meal you know, a whole different meal when you're with your own family, something like you might have cooked yourself. You know you'd have soup and you'd have … I mean last Sunday when I was out I was saying 'God the size of the dinner plate I've got I don't know what I'll do with half of this.' But I managed to eat it all at the same time. [laughs]*

I: *That's good. So you mean like by a different meal that it's a nicer meal when you're … ?*

R: *Well not really but you get more of it you know. It's different, it's just different when it's family cooked and everything you know.*
(Female meals-on-wheels client, aged 85)

Many respondents recalled how their attitude to food and meal times had changed over the years, either as a result of the loss of a dining companion, or decreased mobility and inability to cook:

R: *I used to love cooking but I hate it now, because getting a meal, preparing it, cooking it, sitting down, eating it on your own and washing up, it's no fun.*

I: *When did that kind of change for you?*

R: *When all of the family left, my husband died and that was it. Well I wasn't here when it all, I'm here ten years.*
(Female meals-on-wheels client, aged 86)

Some individuals indicated that they saw meals-on-wheels as reinforcing their growing dependence on others. It appeared that their lack of interest in food arose as a result of the lack of choices now available to them with regard to mealtimes and the quality of the food they ate. It appeared that several clients 'stretched' the meal, by retaining half for another meal later in the day or the next day. Many of those who received soup or a dessert with their meal kept it for consumption as part of another meal. However, many clients did not cook a main meal on the days that meals-on-wheels were not delivered, preferring instead to keep some of the meals-on-wheels meal for the following day:

I: *And would you eat the meal when it's delivered or would you keep it 'til the evening?*

R: *I mostly wait till the evening but I eat some of the stuff at lunchtime, a few mouthfuls.*
(Female meals-on-wheels client, aged 83)

It appeared that others did not eat a main meal at all on the days they did not receive meals-on-wheels, rather simply making do with food they could consume easily. Some simply did not eat at all. Few respondents were prepared to admit this openly, perhaps suggesting that they were unwilling to express the difficulties they faced in sourcing and preparing food:

R: I had the meals-on-wheels at about 12.30 p.m. and then I had nothing until I think 9.00 p.m. last night.

I: Right. And do you remember what that was?

R: Oh yes. I, I was after buying a packet of Boasters down in Dunnes. The biscuits. You know. And that's what I had.

I: Alright. So how many biscuits did you have?

R: I, I finished the packet… It was enough. I, I felt happy with them.

I: And how many cups of tea would you have every day?

R: Oh I might go through sixteen, eighteen.
(Male meals-on-wheels client, aged 73)

But I don't make a salad … to be perfectly honest with you, I mean, I might, I wouldn't eat possibly all the meal that you get at dinner time … And I keep half that for the … you know… Maybe, depending on what's, like what size it is too you know…Yeah and then the other half in the evening? Yes.
(Male meals-on-wheels client, aged 77)

Others consumed less than the standard three meals per day:

I: So how many full meals would you have in the day then?

R: Well, we'd have the breakfast, we'd have the dinner [from meals-on-wheels] and we'd have a cup of tea at night, two full meals.
(Male meals-on-wheels client, aged 82)

It also appears that food poverty may be a factor for some of those who had a poor diet, although respondents were not asked about their income levels. The reluctance to spend a high proportion of their income on food may have encouraged some interviewees to keep some of the meal they received from the meals-on-wheels service:

I: And what do you think of food in general, do you think it's expensive?

R: Oh, it's a shocking price! (Laughs) But then, I'm careful in what I buy, I mean I won't buy things that are a ridiculous price.

I: *What would be a ridiculous price?*

R: *Fresh vegetables are ridiculous. Cabbages are 30c or 40c a head, that's ridiculous.* (Female meals-on-wheels client, aged 89)

I: *Okay. And do you find, all the shopping and that, do you find it expensive?*

R: *Ah no. No. No. No.*

I: *Okay*

R: *I don't. No. I get sure bread and tea and sugar and milk, you know.*

I: *And if you had a bit more money would you buy other bits?*

R: *Oh I would if I had but I don't have it*
(Female meals-on-wheels client, aged 64)

8.6 Meals-on-Wheels Clients and Issues of Dependence

Many of the interviewees appeared to have shifted from an initial reluctance to avail of the service, to a gradual acceptance of their need for it. As mentioned previously, those who were reluctant to avail of meals-on-wheels felt that using the service meant that they were relinquishing their independence. Many appeared to have struggled, or continued to struggle with increased dependence; overcoming or living with illness; and the requirement to rely on others to carry out everyday activities. The struggle to retain independence can often bring problems that could be avoided by using the services that are available:

R: *When I started I joined for the seven days, just until I'd see how I'd get on with them … Monday was a bank holiday and they don't deliver on Monday, so, I said maybe this was a good week now to [reduce], so I said I think I'll ring up and say I'm going to take a week off and see what I can do myself. So, now we're at Friday and I have to do something for myself again. [laughs]*

I: *Okay. And so what have you been doing for yourself the whole week?*

R: *What have I been doing now? First of all with the meals … With the meal I got last Friday I got a lot of meat, I got two lovely slices. So, I immediately took out one and said that would be for Sunday's dinner now, or it would do on Saturday. And on Sunday I got invited out, which happens a lot. So, that was for my Monday dinner, so that was Monday then. Actually what I did, I didn't go out now*

and buy anything, no I didn't buy anything. There's a butcher down there but I mightn't get as far as him. I know that yesterday I had a rasher and I had plenty of roast potatoes – I mean frozen potatoes that I could roast. So, I always had potatoes and veg, meat was the one thing I mightn't have had. Yes I had a rasher yesterday. Gosh it's amazing I can't remember what I did the rest of the week.
(Female meals-on-wheels client, aged 85)

For some, meals-on-wheels enabled them to retain their independence, particularly among those who had reached a personal acceptance of their declining mobility and increased dependence over time.

I felt a bit funny. I felt, 'oh, I'm old'. This is me, I got old. My age never struck me because I was working but when you suddenly have to do all those things … But, however, I'm very happy … It was so easy, before I left the hospital, they arranged it … Means that I don't have to be getting a meal ready.
(Female meals-on-wheels client, aged 79)

For others, meals-on-wheels became associated with a restricted lifestyle, limiting their autonomy and even their eating patterns. This can be linked in many ways to the limited choice of meals, lack of variety and the varying times of delivery:

I frequently ask myself will I cancel the whole thing or will I not. Because, you do have to be here from 11 o'clock on, really for it … to answer the door when they are coming. It means you have to stay in, it's only three days a week I have to stay in, there's no point staying in Friday or Monday.
(Female meals-on-wheels client, aged 83)

They're varied enough but they're the old style. Well that's what we would have been used to alright but never anything new at all … But then whether these poor frail old people (laughs) want something different or not I don't know. The way … [they think] the people that they're delivering to are the old-fashioned people and they probably want what their mothers supplied years ago and they're not up to pasta and Chinese and any of these things.
(Male meals-on-wheels client, aged 87)

However, as indicated in Chapter Seven, it appears that coordinators may not be aware of the difficulties that clients can experience when beginning to avail of the service. Indeed, just one of the services had made efforts to support new clients to overcome any difficulties they might experience as they grew accustomed to the service.

8.7 Meals-on-Wheels in the Continuum of Health and Social Care Services

While the primary role of meals-on-wheels services is not to maintain the health of their clients, it could be argued that, as a strong pillar of the community and voluntary sector, they have an obligation to ensure the general well-being of their clients. The following interview extracts highlights the need for greater support for older people and people with disabilities, through the co-operation and collaboration of relevant services:

I: Do you, do you get cold in here during the winter as well?

R: Oh it's a very cold house in the winter. I had no heater there for a whole month of the winter.

I: Why is that?

R: Because I rung them a hundred times and they rung them. They never come out. The yoke used to drop down there and I wasn't able to fix it . …

I was broken in here a couple of times there not so long ago, in March. And all the money was in it. They took it and that's all and I told them, and I showed them the door and the guards never come out. They didn't do anything for me.

I: And what about the personal alarm, have you one of them?

R: Can't have one. I haven't a phone. When they're putting in the phone they want €240 for the phone. They're after plaguing me with letters, with solicitor's letters. I got the other day a solicitor's letter. She gave me three days to pay it and then she wants to take me to. [So I said] 'Ah you can take it out'.
(Female meals-on-wheels client, aged 65)

Most of those interviewed had family or formal supports available to provide them with support where necessary. Over half received home help and some interviewees mentioned having a cleaner or a care assistant. As such, for the majority of respondents, meals-on-wheels supplemented the care they received, and played an important role in providing respite for carers and enabled home helps to undertake other tasks. However, a number of clients felt that they were forced to rely too heavily on family members, as their needs were not being met through the care available to them. One individual expressed her frustration at having no choice but to rely on her family for support:

Because, while my daughters don't … one lives in [a nearby village], [another] lives in another [village], the other one lives in [a third village]. You'd be amazed how difficult it is to get in sometimes, when you have your own home to look after and a husband and maybe a child or something, you know, and having to look after mum. I don't know really … I have seven kids … One of them lives in [village], she has a family of her own and a husband down there. They would come … the kids are grown up now but … there again, when the kids are grown up the mothers and the fathers don't be that well and her husband had a very big operation some years ago and he had to retire. He was only 48 and he had to retire, so she's enough of her own problems, you know? But she would come visiting me and I would go visiting her but I would never want her to be having to come … The family will always kind of organise each other, that somebody is there to take mother around if she needs it. But [I feel] I have to get back to normality …
(Female meals-on-wheels client, aged 87)

The same woman believed that she had a right to the statutory services available to her:

I mean, somebody said to me, 'I wouldn't accept it' and I said, 'no, I bloody well do accept it,' … First of all my sons and daughters know that the rest of them are paying tax and I'd like to think that when they get to my age, if they do, that they will have the same comfort that I have.

Perhaps more worrying is the situation for those who have no family to rely on. Almost half of those interviewed had no immediate family involved in their care. In many cases, the limited support such individuals received from home helps, carers, neighbours and friends was inadequate, with many struggling to cope with various aspects of everyday life. For these individuals, meals-on-wheels alone were not sufficient to maintain their health and well-being. For example, many individuals use the limited home help hours available to them to have their shopping done, limiting the time that could be devoted to cleaning and other household tasks. One respondent explained how she could only use one hand, and could neither cook nor feed herself. She relied on her home help to feed her the meals-on-wheels every day. However, evening meals were more of a struggle:

I: And what do you do for the other meals during the day? Are you able to get it yourself?

R: I get pizzas. And things that aren't as messy.

I: Do you think that your nutritional status is good or do you think that you have problems nutritionally?

R: I'm too fat and I think it's probably the pizzas and that that I'm getting.
(Female meals-on-wheels client, aged 55)

Similarly, another woman with no family support and limited income described her daily food intake:

> *I'll have four slices of bread. And then at night then, about 7.00 p.m. I have the same. That's all the meals, bar rice or something. … Sometimes I get rice here for my dinner. But usually I don't get. That's all I eat.*
> (Female meals-on-wheels client, aged 64)

Respondents who ate some of their meals in a day centre indicated that being able to use the two services together was beneficial, as it meant in certain cases that they had more company, flexibility, variety in their meals and main meals on more days of the week:

I: Would you have a lot of contact with other people?

R: No. I don't really. Just the people here. I go to the day centre. Come over every day because otherwise I would be sitting around in my dressing gown. I wouldn't get dressed or washed. So I come over here and it gets me out, you know. It gets me going.
(Female meals-on-wheels client, aged 70)

Few of the respondents indicated that they lived close to, or were aware of, a nearby day centre. Many thought that it was a service they might use, if it was close by, although there was reluctance on the part of some to avail of the service, which appeared to be related to the personal preferences of individuals:

R: And I mean that centre down at the (location) is great. Now she [interviewee's wife] gets a lovely meal there. They play bingo and have chats and that like you know. Ah they've won awards ….

I: And you wouldn't go yourself?

R Ah well, you know it's all women. Sure I'd be maybe raped. [laughs] Ah sure there'd be about thirty odd forty women down there. No men.
(Male meals-on-wheels client, aged 87, referring to the centre his wife attends)

I: And do you ever go down to the centre yourself?

R: I used to go down to the centre but what I found about the centre was eh, they used to talk about one another. … What I found was the food was very good there … but for example if you went to [sit] at a table, someone would shout, 'that's my place.
(Female meals-on-wheels client, aged 78)

If meals-on-wheels services are to act as a support to enable older people to remain living in their own homes for as long as possible, there is a need to ensure that they are provided as one of a range of services that together meet the needs of community dwelling older people. This means that appropriate services must be available, affordable and accessible to all those in need.

8.8 Summary

Meals-on-wheels clients took up the service for a variety of reasons. The majority started on the service after returning home from hospital or after deterioration in their general health. However, a small number of men had never learned to cook and so started receiving meals-on-wheels following the death of their wife. It appeared that stigma did not appear to have been a factor in deciding whether or not to avail of the service. Rather, difficulties in accepting that they were becoming more dependent and in need of support were among the main reservations of those initially reluctant to start on meals-on-wheels. However, it must be noted that the views of those who had been offered and who had turned down meals-on-wheels were not included in the study.

Opinions of the service were mixed. The convenience and the social aspect of the service, including the element of security, were among the positive aspects mentioned by those interviewed. However, several had misgivings about the quality of the food, identifying the temperature of the food, the lack of choice and the taste as among the main shortcomings. However, many were afraid to voice their complaints.

The general eating patterns of respondents varied significantly. It was clear that meals-on-wheels encouraged some people to eat, though others indicated that they regularly threw out or saved some of their meal for later or the next day. Some also stated that they did not cook a main meal on the days that they did not receive a main meal. The results highlighted the lack of collaboration between meals-on-wheels and other services, with a small number of respondents living in poor conditions with little support.

Chapter Nine

Nutritional Value of Meals-on-Wheels

Chapter Nine

Nutritional Value of Meals-on-Wheels

9.1 Introduction

If the potential of meals-on-wheels service to support older people to remain in their own homes and in good health is to be maximised, the meals provided by the service must provide clients with at least one-third of the RDA for energy (FSAI, 1999). Unlike many other countries, the nutritional content of meals-on-wheels in Ireland is not monitored and providers are not obliged to serve well-balanced meals. This chapter presents the findings of the analysis of a sample of meals provided by meals-on-wheels services as well as the nutritional assessments carried out with meals clients. This information was collected in order to analyse the nutritional content of meals-on-wheels and to assess their contribution to the nutritional intake of clients. Data on the typical daily food intake and the overall nutritional status of meals-on-wheels clients is also presented.

9.2 Nutritional Value of Meals-on-Wheels Sample Meals

Menus and a sample of the meals of eight meals-on-wheels services throughout Ireland were analysed in order to assess their nutritional value against Irish RDAs (i.e. the energy and nutrients required to meet the nutritional needs of practically all healthy persons, taking into account their age and gender), as well as to explore the variety of meals provided to clients. It is important to note that the small sample size means that the results are not necessarily representative of all meals-on-wheels services and are described here to illustrate the factors that need to be considered by meals-on-wheels services when planning menus.

Recommendations for a national food and nutrition policy for older people, which make reference to meals-on-wheels, are available in Ireland (FSAI, 2000). However, due to the lack of regulations governing the nutritional value of meals-on-wheels in Ireland, neither nutritional guidelines nor recommended recipes are available to support meals-on-wheels services. To a certain extent, this is reflected in the nutritional content of the meals analysed for this study. Just four of the eight

organisations had a set menu, one of which appeared to rotate ten meals on a continual basis, perhaps explaining the number of comments made by meals clients regarding the lack of variety in the meals. A number of services provided a two or three course meal each day while others provided just one course. Of the meals observed, many had substantial portions of meat and potatoes, while vegetables, fruit and dairy portions were small or absent. The portion sizes and diversity of meals provided varied widely between organisations; in some organisations, the same vegetables were provided every day while others provided a wide variety of vegetables. Three out of the eight organisations regularly offered clients a choice of meals every day. Three organisations were not in a position to cater for the special dietary requirements of clients, though seven of the eight catered for individual preferences. Staff in seven of the eight organisations had completed HACCP training, while the co-ordinator of the eighth confirmed that staff in the local hospital (from where meals were collected) had also completed relevant training courses. Three of the eight organisations had had input into their menu planning from a dietitian.

Table 9.2 displays the average nutrient content of the meals. As can be seen, the energy (kcalorie) content of the average meal was 719 kcalories which contributes 35 to 40 per cent of the recommended dietary allowance (RDA) for males aged 65 years and over, and 42 to 45 per cent of the RDA for females aged 65 years and over, significantly in excess of the 33 per cent required in the USA. The RDA for protein for a male aged 65-74 years weighing 71kg (50th percentile for age) is 53.25g/day. Therefore, the average meal provided 67.5 per cent of the RDA. The RDA for a female aged 64-75 years weighing 63kg is 47.25g/day. Therefore, the average meal provided females with 76.1 per cent of the RDA for protein and just over one third (33.7%) of the RDA for iron for both men and women. The RDA for vitamin B12 was surpassed with the average meal containing 1.5 g. However, the average meal contributed 25 per cent or less of the RDA for vitamin C, vitamin D, folate and calcium, suggesting a need for more calcium-rich foods, as well as fruit and vegetables.

Table 9.2: Average nutrient content of meals-on-wheels meals

Nutrient	Average nutrient content	Recommended Dietary Allowance (RDA)*	Percentage of RDA Met by Meals
Protein (g) Males: Females:	35.95	0.75g/kg body weight/day	N/A 67.5% 76.1%
CHO (g)	63.4	No quantitative guidelines for carbohydrate intake in Ireland	N/A
Fat (g)	37.5	No quantitative guidelines for fat intake in Ireland	N/A
Energy (kcalories) Males: Females:	719	 1793-2032 1601-1721	35.4%-40.1 41.8%-44.9
Iron (mg) Males: Females:	3.2	9-10 10 9	33.7% 26.9% 35.1%
Calcium (mg)	167.2	800	20.9%
Vitamin D (µg)	1.16	10	11.6%
Vitamin B12 (µg)	1.5	1.4	107.1%
Folate (µg)	74.3	300	24.8%
Vitamin C (mg)	21.2	60	25.3%

*RDAs taken from FSAI, 2000.

While these results are not representative of all meals-on-wheels services, it is possible that other meals-on-wheels organisations also provide their clients with meals that do not meet the RDAs for various nutrients, given that only a quarter of all organisations surveyed had received input into the menu from a dietician and over 60 per cent of all services either do not rotate their menu or rotate it on a weekly basis only.

9.3 Nutritional Impact of Meals-on-Wheels on Clients

The nutritional content of the meals provided by meals-on-wheels service (based on the analysis of the 24-hour dietary recall carried out with meals clients) was analysed in order to assess the contribution of meals-on-wheels to the dietary intake of each individual, and thus assess the extent to which individuals are dependent on the meal as a source of nutrition.

On average, the delivered meal provided 32.6 per cent of clients' RDA for energy, similar to the 33 per cent required in the USA. However, it is possible that some respondents depend significantly on the meals provided for their RDA for energy; 5 clients (10 per cent) consumed more than 50 per cent of the RDA for energy by the meal provided. Perhaps more worryingly, twenty-seven respondents (52 per cent) consumed less than 33 per cent of their RDA from the meal suggesting that the average meal was deficient in this regard (see Table 9.3).

The delivered meals provided 42 per cent of the client's average actual daily energy intake (i.e. the total number of kcalories actually consumed that day). The significant difference between the required and actual intake suggests that many clients are relying too heavily on meals-on-wheels, and other meals eaten during the day do not provide them with sufficient energy to ensure that they consume their RDA; this may be due to difficulties shopping or a lack of interest in food. Forty-one clients (79 per cent) received more than one third of their daily energy intake from the meal supplied by meals-on-wheels services and 13 clients (25 per cent) received more than 50 per cent of their daily energy intake in one meal (again suggesting an over-reliance on meals-on-wheels meals). Eleven clients (21 per cent) received less than one third of their daily energy intake from their meals, suggesting that other meals eaten during the day contained high levels of energy-providing nutrients, resulting in them surpassing their daily energy requirement.

Table 9.3: Contribution of meals-on-wheels to daily energy requirements and actual energy intake of clients

Energy	Requirements		Actual Intake	
Percentage	N	Percentage	N	Percentage
1-32%	27	51.9%	11	21.2%
33-65%	25	48.1%	37	71.2%
66-100%	0	0.0%	4	7.6%
Total	52	100.0%	52	100.0%

On average, the delivered meal provided almost one third of the RDA for protein (33 per cent). Only 8 per cent of clients consumed less than one third of the RDA from the meal, suggesting that, in general, meals delivered by meals-on-wheels services provided clients with the RDA for protein. More than two thirds (67 per cent) consumed over 50 per cent of the RDA for protein from the meal and a total of nine respondents (17 per cent) consumed more than 100 per cent of their protein requirements from the meal (Table 9.4). It is likely that this was due to large meat portions. An over-reliance on protein can lead to difficulties, including dehydration and

ketosis, while consequent smaller vegetable portions may lead to respondents eating less than the required daily intake of various micro-nutrients, suggesting that standard menus should be in place for the meals-on-wheels service.

The delivered meal provided 52 per cent of the client's average actual daily protein intake (i.e. the total amount of protein consumed), which suggests that clients may be relying too heavily on meals-on-wheels to meet their protein requirements, with some depending solely on meals-on-wheels to provide them with their daily protein requirements. Just four clients (7.7 per cent) consumed less than one third of the RDA for protein from the meal, while 25 clients (48.1 per cent) consumed between 33 per cent and 65 per cent of their daily requirement in one meal. Nine respondents (17.3 per cent) consumed more that their daily requirement in one meal, suggesting that protein portions provided by meals-on-wheels were too large.

Table 9.4: Contribution of meals-on-wheels to daily protein requirements and actual intake of clients

Protein	Requirements		Actual Intake	
Percentage	N	Percentage	N	Percentage
1-32%	4	7.7%	5	9.6%
33-65%	25	48.1%	35	67.3%
66-100%	14	26.9%	12	23.1%
>100%	9	17.3%	0	0.0%
Total	52	100.0%	52	100.0%

9.4 Typical Daily Food Intake of Meals Clients

Twenty-four hour dietary recalls were obtained from each participant in order to gauge their typical daily food intake. Most 24-hour recalls included the delivered meal from the previous day, although some clients did not eat the meal or did not receive a meal on the day in question.

9.4.1 Protein

Protein is necessary for growth and repair of body tissues. It is found in many foods, including meat, poultry, fish, dairy products, eggs and pulse vegetables. The RDA for those aged 65 and over is 0.75g/kg body weight. As the range of weights in the sample was wide, a wide range of protein requirements was also observed (33.8g-82.8g/day).

The average daily protein intake reported by respondents was 122 per cent of the RDA, similar to that reported in the literature, with older people living at home appearing to consume sufficient levels of protein (Department of Health and Social Security, 1992; Department of Health and Children, 1998). However, 23 respondents (37 per cent) did not consume the RDA for protein.

9.4.2 Energy

Energy is necessary to maintain bodily functions and fuel physical activity. When energy intake exceeds energy output in adults, obesity may develop. Conversely, when energy output exceeds energy intake, weight loss and sarcopenia (the degenerative loss of skeletal muscle mass and strength) may occur. Maintaining energy balance is therefore important to optimise nutritional and thus health status. Energy requirements depend on a person's gender, age, weight, physical activity level and (if applicable) health status.

The average energy intake for respondents was 73.7 per cent of the RDA (ranging from just 12 per cent to 133 per cent). Eleven respondents (21.2 per cent) consumed less than one third of the RDA from delivered meals and may be at risk of unintentional weight loss and eventual sarcopenia.

9.4.3 Vitamin D

Vitamin D is a fat-soluble vitamin, which is necessary is to maintain normal serum calcium and phosphate levels. It aids the absorption of calcium and promotes bone mineralisation. Dietary sources include oily fish, daily produce, eggs, and fortified margarines and spreads. However, most vitamin D is produced by the action of sunlight on 7-dehydrocholesterol in the skin. Vitamin D status can be compromised in older people due to age-related changes in the metabolism of vitamin D. In addition, older people often experience reduced exposure to sunlight and can therefore make less of the vitamin through skin synthesis.

Dietary consumption of vitamin D in respondents was poor, with 96.8 per cent of interviewees not meeting their vitamin D requirements through diet alone (Table 9.5). However, as the MNA results indicate, 89 per cent of clients are mobile outside their home and are likely to obtain some of the vitamin through skin synthesis. This figure, however, is arbitrary and would vary depending on time spent outside. Therefore dietary sources of vitamin D should be regularly consumed and meals-on-wheels organisers should aim to supplement their food and menu rotation with vitamin D-rich foods.

9.4.4 Iron

Iron is a mineral, necessary to carry oxygen in blood and muscle. It is mainly found in red meat, offal, wholegrain cereals, dried fruit, egg yolk and fortified breakfast cereals. The occurrence of low iron among older people is often due to reduced food intake and gastrointestinal blood loss, seen in conditions such as peptic ulcers, diverticulitis, and haemorrhoids. In general dietary intakes of iron among older people are usually adequate (Irish Nutrition and Dietetics Institute, 1990; Lipschitz, 1991). Average iron intakes among the meals-on-wheels clients assessed were low, with 31.7 per cent not consuming the RDA. These individuals may, therefore, be at risk of fatigue or anaemia. Iron-rich foods should be regularly included in meals-on-wheels rotations; haem iron sources, such as red meat, should be included at least three times a week, and non-haem iron sources, such as green leafy vegetables and pulses, should be included daily.

9.4.5 Calcium

Calcium is a mineral required in considerable amounts by the body for the maintenance of the skeleton; 99 per cent of the body's calcium is found in bones and teeth. There is also a small amount in the blood where it is used in membrane transport, muscle contraction, nerve transmission and blood clotting. The main sources of calcium are dairy products, dark green leafy vegetables and tinned fish.

Calcium absorption has been shown to decline with age (Tucker, 1995). There is, however, controversy as to whether additional calcium in old age can prevent osteoporosis, as many other nutrients influence bone health (FSAI, 2000). The RDA for older people is 800mg. The average intake among respondents was 666mg and 74.6 per cent of subjects did not meet the RDA. There appears to be a need for higher calcium intakes among the meals-on-wheels clients. Calcium can be incorporated into the meals-on-wheels rotation through the use of milk-based sauces and milk-based desserts, such as ice-cream, cream, custard, milk puddings and yoghurts. Such inclusions would also increase the protein and energy contents of the meals. Dark green leafy vegetables can also be incorporated as the vegetable portion to provide a small amount of additional calcium.

9.4.6 Folate

Folate is an important B vitamin used in methylation reactions in the synthesis of deoxyribonucleic acid (DNA) and ribonucleic acid (RNA), and plays a crucial role in cell division. Sources include offal, green leafy vegetables, fortified cereals and pulses.

Folate deficiency is common among older people, often associated with low overall energy intakes (Russell, 1997). Other factors, such as polypharmacy, alcoholism and the prolonged cooking of foods, also adversely affect the folate status of older people. The folate requirement for those aged 65 and over is 300µg per day. The average intake among the meals-on-wheels clients assessed was 190µg and 90.5 per cent of respondents did not consume their RDA. Folate can be increased in the diet of older people. As discussed, green leafy vegetables should be included regularly as the vegetable portion of the meal. This could provide extra folate, iron and calcium. As folate is a water-soluble B vitamin, care should also be taken not to overcook these vegetables or cook them in large volumes of water.

9.4.7 Fibre

Dietary fibre describes the constituent of carbohydrate that cannot be digested in the human small intestine. It is sometimes referred to as non-starch polysaccharide (NSP). Adequate dietary fibre is necessary to maintain bowel movement and function. It is important in the prevention of constipation (and associated conditions) and bowel cancer. Sources of dietary fibre include wholemeal bread, wholemeal pasta, wholegrain rice, cereals, pulses, dried fruit and vegetables. There are no current Irish recommendations for dietary fibre intake among the older population, however in the UK, intakes of 18g NSP (equivalent to 24g dietary fibre) per day are recommended to increase stool weight. This study found that the average NSP intake among respondents was 9.6g (ranging from 1.4g to 19.7g). Analysis of the meals also showed they were quite low in dietary fibre. Therefore, extra efforts should be made to increase the dietary fibre content of the meals; fibrous vegetables such as peas, beans, Brussels sprouts and broccoli should be included regularly as vegetables, and again should not be over-cooked. Efforts should also be made to include wholegrain rice and wholemeal pasta for meals-on-wheels clients who would be open to trying such options. Desserts should contain fruit and dried fruit on a regular basis.

Table 9.5: Average intake and percentage of clients meeting RDA

Nutrient	RDA	Average Intake	Percentage of sample meeting RDA
Vitamin D	0-10mg*	2.49mg	3.2%
Iron	9mg-10mg	7.81mg	31.7%
Calcium	800mg	666mg	25.4%
Folate	300µg	190 µg	9.5%
Dietary fibre**	18g	9.6g	3.2%

*depending on time spent outdoors

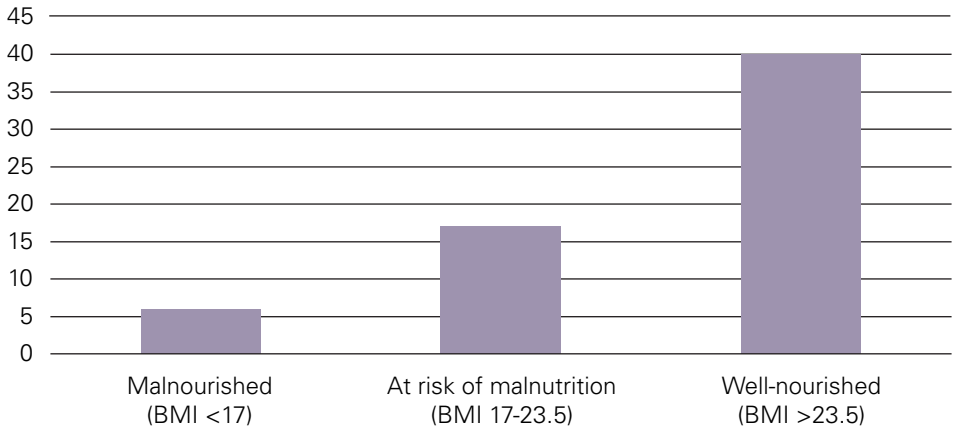
** UK Dietary Reference Value based on the analysis of non-starch polysaccharide (18g NSP=24g dietary fibre).

9.5 Nutritional Status of Meals-on-Wheels Clients

The MNA was used in conjunction with the 24-hour dietary recall in order to provide a holistic overview of the nutritional status of meals-on-wheels clients. The MNA can be used both as a screening and as an assessment tool for identification of malnutrition among older people, depending on the questions asked and the measurements taken.

The results of the analysis show that the majority of meals-on-wheels clients assessed (63.5 per cent) were well-nourished. However, a significant minority (27 per cent) were at risk of malnutrition and almost one in ten (9.5 per cent) had frank protein-energy malnutrition. These clients are at risk of decreasing intake and weight loss, and ideally should be monitored to avoid deterioration in their nutritional and health status.

Figure 9.1: Nutritional status of meals clients (n=63)



While there were no significant differences between the nutritional status of individuals based on the number of meals they received per week from meals on wheels ($r = -.202$, $N = 63$, $p = .112$), the number of years they had used the service ($r = .051$, $N = 48$, $p = .732$) or whether or not they thought food was expensive ($t(50) = 1.03$, $p = .309$), a significant difference was found in the nutritional status of men and women ($t(61) = 2.248$, $p = .028$). On average, men had a higher nutritional status than women (25.0 and 22.8 respectively). The reason for this was unclear, although it is possible it is related to the different attitudes between men and women towards food, outlined in Chapter Eight, i.e. men tended to eat whatever they were given and women invested more of themselves in meal times.

When asked what they thought of their own nutritional status, more than three quarters (77.8 per cent) of respondents believed that they had no nutritional problems (see Table 9.6).

Table 9.6: Self-reported nutritional status

	N	Percentage
Malnourished	4	6.3%
Uncertain of nutritional state	10	15.9%
Having no nutritional problems	49	77.8%
Total	**63**	**100%**

The Body Mass Index (BMI) of each individual was also calculated. BMI is a measure of an individual's weight in relation to their height. The average BMI of those assessed was 25.8kg/m^2 (SD ± 5.4). Table 9.7 shows that 33 per cent were overweight and 19 per cent were obese.

Table 9.7: BMI of respondents

BMI	Description	N	Percentage
<18.5 kg/m^2	Underweight	2	3.2%
18.5 – 24.9kg/m^2	Healthy weight	28	44.4%
25 – 29.9kg/m^2	Overweight	21	33.3%
>30kg/m^2	Obese	12	19.1%
Total		**53**	**100%**

These results are broadly similar to those of Corish and Kennedy's (2003) study, which found that 35.9% of apparently healthy free-living Irish elderly had a BMI within the healthy range. However, Corish and Kennedy found that 66% of older free-living people were either overweight or obese, perhaps indicating that those who receive meals-on-wheels find it harder to access food than those who have a greater level of support in or autonomy over preparing meals.

One in three respondents ate less than three meals a day (see Table 9.8).

Table 9.8: Number of meals usually eaten daily

No. of meals	N	Percentage
1	8	12.7%
2	13	20.6%
3	42	66.7%
Total	**63**	**100%**

9.6 Summary

This chapter presented the findings of the analysis of a sample of eight meals used by Irish meals-on-wheels services and the results of the 24-hour dietary recalls and Mini Nutritional Assessments carried out with 63 meals clients. It is important to note that the small sample sizes and the purposive sampling technique used mean that the results are not generaliseable to other meals-on-wheels services.

The results of the analysis of the sample of meals indicated that the nutritional content of the meals adhered to the US guidelines, whereby organisations must supply clients with one-third of the recommended daily intake of energy and protein. However, the average meal contributed 25 per cent or less of the RDA for vitamin C, vitamin D, folate and calcium.

The 24-hour dietary recall showed that, on average, meals-on-wheels provided clients with almost 33% of their dietary allowance for energy, which is the amount required by the United States Elderly Nutrition Program. However, meals-on-wheels provided clients with 42% of their actual daily energy intake. This implies that other meals eaten throughout the day are not providing some respondents with sufficient energy to meet the RDA. Similarly, meals-on-wheels provided clients with 33% of the recommended dietary allowance for protein but 52% of their actual daily intake. Again, this implies that some clients are relying too heavily on meals-on-wheels to meet their protein requirements.

The results from the 24-hour dietary recalls also showed that only a small number of respondents had one-third of the recommended dietary intake of Vitamin D, iron, calcium, folate and fibre met within a typical day.

The majority of those assessed were well-nourished. Just over one-quarter were at-risk of malnutrition and almost seven per cent were mal-nourished. Less than half (44%) had a healthy weight, while 3% were underweight, 33% were overweight and 19% were obese. These results were broadly similar to previous research which measured the weight of a sample of community-dwelling older people.

Chapter Ten

The Role and Future Development of Meals-on-Wheels in Ireland

Chapter Ten

The Role and Future Development of Meals-on-Wheels in Ireland

10.1 Introduction

Meals-on-wheels is an important service for many community-dwelling older people and people with disabilities in Ireland. However, this study has shown that the service has a number of shortcomings that limit the benefits of the service and point to the need for greater investment in and support for the service nationally. This chapter summarises the main findings of the study and outlines the authors' recommendations for the future development of the service.

10.2 Main Findings

10.2.1 Organisation of Services

The organisation of meals-on-wheels services in Ireland varies considerably from organisation to organisation. While the majority of organisations providing meals-on-wheels are voluntary organisations and registered charities, some are statutory service providers and others have no formal legal status. The organic way in which meals-on-wheels services developed means that some counties have very few services.

While the thirteen organisations from which staff of meals services were selected were not representative of all meals-on-wheels services in Ireland, trends could be seen whereby organisations supported by a Board of Management; run by a co-ordinator with experience in community of business development; where the majority of staff were paid (typically larger organisations), tended to operate more smoothly, had higher standards with regard to food safety and tended to be more client-focused. Conversely, organisations that relied predominantly on volunteers and few staff (typically smaller organisations) tended to be 'crisis-led', and were not in a position to take all the steps necessary for ensuring optimal service provision. However, it was

clear that it was the time and resource limitations that prevented the client-focused approach; co-ordinators of such organisations were typically frustrated with their inability to do more for their clients.

As will be discussed further below, this has led to an overall deterioration in the service in some organisations. As was shown in Chapter Two, many of the difficulties experienced by meals-on-wheels services in Australia have been resolved through the establishment of the Australian Meals on Wheels Association and its six regional bodies, which have provided support to meals-on-wheels services and has also given them a forum in which they can discuss common problems (Cox, 2007).

10.2.2 Staffing and Training

While most meals-on-wheels services have at least one paid employee, the majority of organisations rely heavily on volunteers to prepare and/or deliver the meals. Many also rely heavily on initiatives, such as the Fás CE Scheme, the future of which is currently unclear. The low cost of volunteers and subsidised employees have been central factors in keeping the cost of meals to clients so low to date. However, given the difficulties in recruiting and retaining volunteers experienced by many organisations, it is likely that meals will increasingly be delivered by paid employees. Indeed, many coordinators interviewed considered paid drivers preferable to volunteers, as they were more reliable in terms of turning up for their shift.

Perhaps more worrying is the likelihood of many voluntary coordinators retiring from the service in the short to medium term, with many suggesting it would be difficult to find a replacement. It is unclear whether a strategy or plan for ensuring the future viability of services has been drawn up by the Department of Health and Children or the HSE. The likely additional cost of staffing the meals-on-wheels sector cannot be ignored and points to the need for a strategic approach for the development of the service as a whole.

The analysis of the meals-on-wheels service covering much of Northern Ireland discusses the advantages and disadvantages of using only paid drivers. Employing drivers creates more opportunities for the provision of training and also results in the need for fewer staff, given the longer hours each individual works. However, in Northern Ireland, drivers typically have little time to spend with each individual, given the high volume of meals they deliver each day (see Appendix Five).

Findings from the qualitative data suggest that the current level of training provision for staff and volunteers is low overall. While those involved in the preparation of

meals are legally obliged to undergo health and safety training, there is currently little evidence of any provision of training for drivers, who play an important role as frontline staff, as they provide clients with some level of social contact and security, alerting relevant authorities in an emergency. Indeed, few of the drivers interviewed appeared to have awareness of any protocol in place of what to do in an emergency situation and several did not fully recognise the benefits of the social element of the service. Compulsory training given to each of Domestic Care's drivers covers the procedures for emergency situations, as well as customer care, basic hygiene and manual handling, perhaps a useful model for further investigation within the Republic.

10.2.3 Referrals, Eligibility and Availability

There is currently no uniformity in the referral systems for meals-on-wheels services in Ireland, and criteria for availing of the service vary from area to area. This may result in an individual being refused the service. In addition, the pathway to the service varies from area to area. Few of the organisations appeared to promote the service actively among those who may need it. While this is most likely due to the limited capacity of organisations to cater for increased demand, it may result in socially isolated individuals finding it difficult to access the service. The social role played by meals-on-wheels in the lives of clients highlighted in Chapter Seven reinforces the social aspects of food outlined in Chapter Two. It is important that meals-on-wheels providers remember that attitudes to food and mealtimes can alter as individuals age and personal circumstances change (Lumbers, 2006; Davidson, Marshall and Arber), and that a thoughtfully planned and tasty meal may encourage individuals to eat. It is also noteworthy that clients interviewed for this study did not appear to see meals-on-wheels as a source of 'stigma' per se, (i.e. associated with connotations of welfare or charity) found by Garavan *et al.* (2001) and O'Hanlon *et al.* (2005). Instead, any initial reluctance to avail of the service among those interviewed was a difficulty in accepting their declining independence. Bullington (2006) and Gooberman-Hill and Ebrahim (2007) noted similar findings in their studies on the psychological process of ageing and use of services respectively.

The high number of clients interviewed who volunteered for the service or had been referred by a friend or family member involved in its operation further highlights the need for a formal system to be put in place, with a standard needs assessment form used by trained PHNs or needs assessors. Such a system should not be used for meals-on-wheels only; a system where meals-on-wheels are offered as an element of a care package would support the integration of meals-on-wheels with other community-based services. It should also be noted that meals-on-wheels may be availed of temporarily, e.g. when an individual has been discharged from hospital but

has not fully recovered from an illness/injury. As such, a system to review a client list should be put in place. In addition, as is currently the case in other countries, services other than meals-on-wheels are used to prevent older people from becoming at risk of malnutrition. The United States' Elderly Nutrition Programme also provides older people with training on cooking, nutritional screening and counselling (Administration on Aging, 2003a).

10.2.4 Nutrition

Due to the research design used for this study, it was not possible to ascertain whether meals-on-wheels help to improve the nutritional status of clients. However, it is clear that meals-on-wheels play an important role in maintaining older Irish people and some people with disabilities in their own homes. The results of the nutritional assessments also show that, in and of themselves, meals-on-wheels are providing clients with an adequate supply of the recommended dietary allowance for energy, although the level of protein given is perhaps too high in some cases, suggesting an over-reliance on meat, with a need for more vegetables and a better variety of food. The significantly higher nutritional status among male clients, compared with women, also needs to be taken into account by service-providers, although further investigation should be carried out in order to ascertain the reasons behind the finding. While studies carried out in other countries such as Australia and the United States indicated that meals-on-wheels recipients elsewhere can be below par (Asp and Darling, 1988; Stevens *et al.*, 1992), monitoring and evaluation of services has greatly improved in these countries in recent years, highlighting the need for more regulation in the Irish context.

Having meals-on-wheels available seven days a week, in which two meals per day are available (i.e. a main meal and a tea/supper) as well as appropriate snack foods, and having established regulations on the nutritional content of meals, may help to improve the nutritional status of many clients (such as the need for services to provide clients with at least one-third of their daily recommended energy intake, Administration on Aging, 2004a). Meals providers also need to bear in mind issues with regard to meal utilisation, whereby the proportion of the food consumed may not necessarily equal the amount of food delivered (Fey-Yensan *et al.*, 2001). Service providers should perhaps note that soup and desserts have been found to be the best utilised components of delivered meals (Fogler-Levitt *et al.*, 1995).

Given the difficulties faced by this group in accessing food and cooking meals, ensuring that the nutritional content of meals-on-wheels is adequate is paramount. However, the nutritional content of the sample of meals assessed for this study

indicated that meals-on-wheels services may be failing to provide clients with some vital nutrients, including vitamin C, vitamin D, folate and calcium. This gives further credence to Share's (2005) analysis of meals-on-wheels providers in the North West of Ireland and highlights the need for guidelines or minimum standards to be set by the government in this regard. It is clear that regulations are needed with regard to the nutritional content of meals-on-wheels and the rotation of menus to ensure clients of the service remain well and healthy.

In addition, given that over a quarter of those interviewed were at risk of malnutrition and over six per cent were malnourished, the results suggest that meals-on-wheels clients would benefit from being offered meals seven days a week, with an option to avail of more than one day per week. Where necessary, meals of modified consistency should also be provided. The high level of obesity perhaps suggests either a degree of food poverty among clients or a lack of adequate nutritional education among older people living in their own homes, perhaps a role that meals-on-wheels could fulfil. In addition, clearer nutritional guidelines and sample menus should be drawn up by qualified dietitians in the HSE to guide meals-on-wheels organisations.

10.2.5 Health and Safety

Overall adherence to health and safety legislation by meals-on-wheels services was very high. This perhaps highlights how enforced legislation can play an important role in helping organisations to meet minimum standards, particularly when those enforcing the legislation are expected to play a supportive and educational role, as is the case with the Environmental Health Office of the HSE. Levels of health and safety training for staff involved in the preparation of food was high, according to the survey data and few of the case study organisations mentioned very negative experiences with health inspectors. However, testing is not currently carried out on meals once they have left the kitchen. Given that periods of up to three hours can pass between the time meals are cooked and delivered, with more time passing before food is consumed, there is perhaps a need for an alternative approach in the system used to cook food to be investigated. Hutchin (2006) noted signs of resistance to change with regard to complying with inter alia health and safety legislation among Dublin-based providers perhaps highlights the need for more training and support for service providers with regard to this issue.

Other aspects of health and safety, namely the safety of drivers and clients, do not appear to have been prioritised by many meals-on-wheels services, most likely as a result of the difficulties in sourcing volunteers and staff. None of the thirteen

organisations from which staff were interviewed used any formal procedures to vet drivers, such as obtaining Garda clearance; indeed, a number of co-ordinators mentioned that they would try and source volunteers anywhere they could. Conversely, no training is given to drivers on managing potentially dangerous or threatening situations from meals clients. Given the vulnerability of both drivers and, to a greater extent, clients, this is an issue that should be prioritised by all services.

10.2.6 Social Role of Meals-on-Wheels

One of the benefits of the meals-on-wheels service as seen by its clients was the social role it can play. Several studies have shown that eating alone may lead to a loss of appetite (Shahar *et al.*, 2001; Locher *et al.*, 2004; Davidson, Marshall and Arber, 2007). However, this present study indicated that contact with drivers can act as a powerful substitute for an eating companion. Many appreciated the visit from drivers and looked forward to the chat at each delivery. The fact that drivers did not stay long when dropping off the meal did not appear to bother respondents to a great extent. Many were also acutely aware of the security element of the visit, with four noting that they had been found by drivers after having fallen.

However, just a small proportion of meals providers surveyed noted in response to an open-ended question that providing clients with social contact was one of the main aims and objectives of their service. For their part, the voluntary drivers interviewed were aware of the importance of the social aspect of the service and indicated that the contact with clients was one of the aspects of volunteering that they enjoyed the most. However, many stated that they could not afford to spend long with each individual, as the rest of the meals in their car were getting cold, giving further grounds for the need for an alternative cooking method, such as cook-chill meals to be investigated. It is also clear that some drivers did not recognise the benefits of the social aspect of the service and did not have the skills to recognise changes in the health status of clients, highlighting the need for greater training in this area.

10.2.7 Client-Centred Approach

Meals-on-wheels services in Ireland are not adequately structured to prioritise the needs of clients. The majority of services do not have a formal feedback system in place, which has led to many clients feeling unhappy about various aspects of the service, but not in a position to record their comments. It appeared that some co-ordinators did not use the complaint as an opportunity to review the service, but instead saw those who complained as 'trouble-makers'.

Few meals-on-wheels services operate in Ireland seven days a week. Indeed, more than four in every five services operate between two and five days per week, with clients still sourcing some of their main meals elsewhere. This reduces the contribution meals-on-wheels services can make to support older people to remain at home. In addition, several clients felt that the irregular delivery time of their meals limited their independence, as they had to remain at home until the meal was delivered. Many of these issues are as a result of the limited capacity of the organisations, also noted by Share (2005) and Hutchin (2007). Few have time to take on board the issues raised by their clients and develop the service accordingly. Any further development of the meals-on-wheels service needs to ensure that organisations have the capacity to make it more client-focused.

10.2.8 Funding

Sourcing funding remains one of the biggest problems facing meals-on-wheels services in Ireland, noted by over three in every five organisations surveyed. Funding difficulties may in part be responsible for many of the shortcomings of the service including the quality of the food produced, limited training opportunities for staff and the time available to coordinators to develop the service.

Organisations received an average of between €1.28 and €1.47 per meal from the HSE in 2006. The majority of organisations received little money from fundraising or donations and instead received most of their other funding through charges imposed on clients. Few coordinators interviewed were aware of other funding streams in Ireland and an analysis of their criteria revealed few opportunities for meals-on-wheels services to boost their income.

10.2.9 Meals-on-Wheels Services in the Continuum of Health and Social Care Services

Several studies carried out on community-based health and social services for older people in Ireland have highlighted need for greater cohesion between services, including day services, the home help service, statutory providers, such as PHNs and voluntary organisations.

A number of those interviewed used both meals-on-wheels services and attended a day service. This provided them with more meals per week than would have been the case had just meals-on-wheels been available. In addition, the day service provided opportunities to make friends and socialise. It was clear from the interviews with clients that some might benefit from attending a day service in addition to availing of meals-on-wheels.

The lack of cohesion between meals-on-wheels and other services can have negative consequences for clients. Greater cooperation between services would provide opportunities for the various community services, including inter-agency training, the development of more holistic care plans and advocacy for those in need of greater support.

10.2.10 Relationship with the HSE

Support for meals-on-wheels services from the HSE varies from region to region. For example, HSE South employs community development workers who provide meals-on-wheels services with practical support. However, this position does not exist in the other three regions, leaving meals-on-wheels coordinators with limited support or assistance. Such findings corroborate Hutchin's (2006) study which indicated that Dublin-based meals-on-wheels providers feel that the lack of governmental support available to them is a significant barrier in terms of the smooth operation of the service.

As the HSE considers meals-on-wheels as one of the domiciliary services available to eligible older people, it has a responsibility to ensure the future viability of the service. Planning, management and financial support from the HSE is necessary to ensure that the future development of meals-on-wheels services occurs in a more balanced, uniform and streamlined way, and is in a position to meet the likely growth in demand for the service.

10.3 Options for the Future Development of Meals-on-Wheels in Ireland

The benefits of meals-on-wheels for clients, volunteers, carers, and communities are clear. However, it is also clear that improvements are needed, given that meals-on-wheels services in Ireland have developed organically, and the quality observed in many falls short of what might be expected of such a service. Organisations providing meals-on-wheels in Ireland are currently underfunded, and rely on a diminishing group of volunteers to operate the service, and the majority receive limited practical support from the HSE. This has resulted in difficulties for meals-on-wheels services, with many struggling to manage their current workload, standards varying from area to area and a lack of satisfaction among some clients about the quality of the meals. In addition, while the majority of voluntary organisations go to considerable lengths to provide all those in need with the service, they are under no obligation to do so. As such, greater support from Government, and, in particular, the HSE, is necessary in order to ensure that meals-on-wheels services in Ireland are of the highest standard.

Demand for meals-on-wheels is likely to increase significantly in the medium- to long-term, with a corresponding increase in the diversity of needs and tastes among future clients. As voluntary coordinators retire over the coming years, many anticipate that it will be difficult to find a suitable voluntary replacement. Indeed, many assume that the HSE will step in and employ a full-time coordinator to ensure that the service continues. If this is done in the absence of strategic planning for the service, an opportunity will be lost to ensure all clients and potential services have access to a service that offers value for money and is of the highest standard.

Outlined below are three options for the future development of meals-on-wheels in Ireland. The three models are based on the management and ownership structures of the services, and on the consequent level of funding likely to be available within each option.

Common to each model would be the introduction of a set of minimum standards with regard to the nutritional content of meals and a greater emphasis on the social aspect of the service. Given the difficulties faced by drivers in keeping meals warm once they leave the kitchen, there is a case to be made for cooking systems to be investigated that take into account food safety and the needs of clients in terms of taste, flexibility and ease of use. Meals should also be provided on a seven day per week basis, with an option for the provision of an evening meal. In addition, given the important role that they play as front-line staff, training for drivers, either voluntary or paid, should be mandatory in order to ensure that they can recognise when the health status of clients is deteriorating. Training should also include manual handling, customer care skills and procedures for emergency situations. In addition, standard eligibility criteria and referral procedures should be drawn up at national level, with training provided to those that play a role in referring people to the service. Such criteria should take account of the role played by meals-on-wheels in providing respite for carers and reducing the need for shopping or meals preparation for spouses of those in need of meals-on-wheels.

10.3.1 Model One: Improving the Status Quo

One option for the future development of meals-on-wheels services in Ireland would be a recognition of the local, voluntary nature of the services: current ownership structures would continue whereby the voluntary nature of the service would prevail, with minimum standards, support and supervision playing a more important role.

In order to ensure those in need of the service receive it, the HSE would need to undertake a mapping exercise, drawing up boundary lines with each area covered

by one service. Where an area is not currently serviced, the HSE should support the development of a new service. The introduction of a formal referral system and standard eligibility criteria could help to ensure that all those in need could access the service. In order for this model to be viable, the HSE would need to put in place a strategy for when voluntary coordinators step down and cannot be replaced.

Under this model, meals-on-wheels services would continue to cook their own meals (after investigating alternative cooking systems that aim to improve the taste and temperature of food). Regulations would be put in place to ensure that HSE dietitians had involvement in the development of menus and monitoring of services from a nutritional perspective. Minimum training for those preparing the meals would be required to ensure they meet the nutritional requirements of all clients, including those with special dietary requirements. Client feedback would be obtained by through anonymous surveys, with assurances that complaints and feedback would be welcome and would not result in any negative repercussions for clients, would, in fact, help to improve the service for all clients.

A Meals-on-Wheels Association of Ireland could be established to raise the profile of meals-on-wheels services, encourage more people to use the service, help recruit volunteers and provide training. The Association could be funded through membership fees and by the HSE. As all meals-on-wheels services should have liability insurance coverage, the Association could either provide such coverage or negotiate a package with insurance companies.

Finally, if the meals-on-wheels service is to continue to operate on this footing, a regular independent review process is required and financial audits should also be carried out by the HSE.

While this study has shown that many smaller meals-on-wheels organisations are often not operating in such a way as to guarantee optimal quality, this also appears to be as a result of a lack of financial and practical support at local and national level. As such, this model would only be viable if significant additional support was provided by the HSE. The principal benefits of this model include retention of institutional knowledge along with greater support for service providers, maintenance and support for volunteerism, and some upgrading of the service in terms of minimum standards. In addition, meals-on-wheels would continue to be a local response to local needs. However, if this model were to be sustainable, significant financial investment would be required, particularly if an alternative cooking system (such as the cook-chill method) were introduced, and fixed costs, such as petrol and electricity continue to increase. Funding could be obtained from the HSE, through

(increased) client charges and from other funding sources, such as those already used by meals-on-wheels services and various funding streams for community and voluntary organisations in Ireland.

10.3.2 Model Two: 'Competitive Outsourcing'

The second model is based on the principle of economies of scale. Under this model, the HSE would contract out the preparation and distribution of meals to organisations and companies that were deemed most competitive, following a tendering process. Such a model is already in place in many parts of the UK, including Northern Ireland (see Appendix Six) In the case of Northern Ireland, a single for-profit provider has secured all of the competitive contracts tendered out to date. However, it is also possible to organise competitive outsourcing in a way that results in contracts being awarded to several organisations, both for- and non-for-profit. Furthermore, it would be possible to separate the production and delivery components of the service so that the meals were prepared by a small number of (large) organisations or companies, and distributed by a large number of (small) organisations or companies. This latter model would naturally necessitate the adoption of an alternative cooking method.

Model two has the potential to lead to cost reductions as it relies on the principles of economies of scale and competitive advantage. It could be stipulated that anyone deemed in need of the service, based on objective criteria, would automatically be referred, with all referrals being made by the PHN or another qualified professional working for the HSE. In addition, contract holders could also be obliged to give clients a choice of meals every day, as is currently the case in Northern Ireland, with all menus agreed by community dietitians to ensure that the specific nutritional requirements of clients are met.

Given that organisations may lose money delivering meals to sparsely populated areas, it may be the case that the tendering out of services would need to ensure that the geographical boundaries would make it cost-effective for each organisation to provide the service. In Northern Ireland, tender documents have stated that providers must provide meals to all those deemed eligible, regardless of the area in which they live.

Perhaps one of the disadvantages of this approach is the potential loss of the social and community aspects of the service.

10.3.3 Model Three: Restructuring of Community and Voluntary Organisations

A third possible option for the future development of the meals-on-wheels service in Ireland would be an amalgamation of the main benefits of Models One and Two. This would involve a restructuring of service provision to make better use of existing services, among community, voluntary and statutory providers. This would be similar to the Australian model (Appendix One).

Currently, meals-on-wheels services operate in many areas using parish boundaries. These boundaries could be expanded so that a smaller number of services could operate out of a larger catchment area, with a full-time paid coordinator in each area, funded by the HSE. This would allow existing services to combine their resources and ease the burden on coordinators to source volunteers. Under this model, delivery of meals would remain wholly voluntary. Recruitment would be significantly easier as coordinators would have greater skills and more time to develop an adequate volunteer-base, supported by a Meals-on-Wheels Association of Ireland.

However, the cooking of meals would be similar to that of Model Two. A small number of centralised, HSE-operated kitchens (one or two in each of the four HSE regions) would provide meals for all of the meals-on-wheels services operating within a set area. A system could then be set up whereby paid drivers could deliver meals to each of the local areas, which could then be delivered to clients by voluntary drivers.

This approach would have many advantages. It would represent greater value for money for tax-payers, as well as ensuring that the necessary investment is channelled into service provision. It would provide organisations with greater support from the HSE. It would ensure the continuation of the voluntary element of the current system, thus developing social capital in local areas, as well as retaining institutional knowledge built up over the years. It would also ensure that the work currently being carried out by organisations that adhere to international best practice could be maintained. This approach would also be beneficial for clients of the service, as they would receive meals of a higher quality, and would have greater autonomy over the meals provided. In addition there would be more scope for developing more meaningful client-driver relationships.

The principal disadvantage of this model would be an increase in the number of HSE staff, which may prove problematic, given the current cap in public sector staff employment. In addition, the transfer of responsibility of meals-on-wheels to the HSE would add additional pressure on an organisation that has gone through significant structural changes in recent years, which may have implications for its ability to adequately manage meals-on-wheels services. Table 9.1 summarises the details of the three options.

Table 10.1: Alternative Models for the organisation of meals-on-wheels services in Ireland

	Improving the Status Quo	Competitive Outsourcing	Restructuring of Community and Voluntary Organisations
Overview	Current ownership structures continue: the voluntary nature of the service prevails, with minimum standards, support and supervision playing a more important role.	The HSE would contract provision out to most competitive provider(s).	Community and voluntary organisations manage the service, with boundaries redrawn to amalgamate services thus providing a smaller number of services. Meals cooked in small number of HSE-operated kitchens.
Aims/ Objectives	Nutrition and social visit seen as equally important.	Mainly nutrition; social aspect secondary (but would depend on the way contracts are drawn up).	Nutrition and social visit seen as equally important.
Ownership	Retain current ownership structures (run by voluntary sector organisations), supported to a greater extent by the HSE.	All services provided by one or more private or voluntary organisations (provided they were deemed competitive and competent).	Paid HSE staff coordinating a volunteer-run service.
Coverage	Defined geographical boundaries put in place in line with HSE areas. New services established with support of HSE to ensure all of Ireland is covered.	Possibility of one large company or organisation expanding to country-wide presence but more likely that a number of providers would operate, subject to ongoing competitiveness and passing reviews and inspections.	Defined geographical boundaries put in place in line with HSE areas. New services established or expansion of existing services to ensure all of Ireland is covered.

	Improving the Status Quo	Competitive Outsourcing	Restructuring of Community and Voluntary Organisations
Service Details	Possibility of using an alternative to the provision of hot meals to be investigated; meals available to all those in need, in all areas, on a seven days per week basis.	Possibility of using an alternative to the provision of hot meals to be investigated; meals available to all those in need, in all areas on a seven days per week basis, with a choice of meals given. Potentially providing more than one meal a day.	Possibility of using an alternative to the provision of hot meals to be investigated; meals available to all those in need, in all areas on a seven days per week basis, with a choice of meals given. Potentially providing more than one meal a day.
Nutritional Aspects	Menus must be reviewed and monitored regularly by HSE-employed dietitians.	Menus must be reviewed and monitored regularly by HSE-employed dietitians.	Menus must be reviewed and monitored regularly by HSE-employed dietitians.
Health and Safety	Employment of all food preparation staff conditional on completion of Level 4 FETAC course. Basic training for all delivery staff and regular inspections from HSE EHOs.	Employment of all food preparation staff conditional on completion of Level 4 FETAC course. Basic training for all delivery staff and regular inspections from HSE EHOs.	Employment of all food preparation staff conditional on completion of Level 4 FETAC course. Basic training for all delivery staff and regular inspections from HSE EHOs.
Staffing	As per current set-up, a mixture of paid and voluntary staff.	Preparation and delivery of meals undertaken by paid staff.	A mixture of paid and voluntary staff.

	Improving the Status Quo	Competitive Outsourcing	Restructuring of Community and Voluntary Organisations
Staff Training	Some level of training given to all delivery staff, both voluntary and meals preparation. As above, intensive health and safety training for those involved in food preparation.	Training for delivery staff in customer care skills, manual handling, health and safety, compliance with emergency procedures and emergency procedures. As above, intensive health and safety training for those involved in food preparation.	Training for delivery staff in customer care skills, manual handling, health and safety, compliance with emergency procedures and emergency procedures. As above, intensive health and safety training for those involved in food preparation.
Client Input	Formal and informal feedback systems in place, with recognition given to client reluctance to complain.	Formal and informal feedback systems should be in place, with recognition given to client reluctance to complain.	Formal and informal feedback systems should be in place, with recognition given to client reluctance to complain.
Inspection and Evaluation	Services reviewed by HSE on a regular basis.	Independent reviews conducted on a regular basis.	Independent reviews conducted on a regular basis.
Liability Insurance Coverage	Mandatory.	Mandatory.	Mandatory.
Referral System	Formalised: with referral by PHNs or other qualified HSE staff designated to carry out the role, using a standardised referral form based on need.	Formalised: with referral by PHNs or other qualified HSE staff designated to carry out the role, using a standardised referral form based on need.	Formalised: with referral by PHNs or other qualified HSE staff designated to carry out the role, using a standardised referral form based on need.

	Improving the Status Quo	Competitive Outsourcing	Restructuring of Community and Voluntary Organisations
Funding	Significant increase of both revenue and capital funding (for refurbishment of kitchens) from HSE; increase client charges.	Level of funding from HSE maintained in line with inflation; client charges increased in line with inflation, with extra subsidisation from HSE for those on low incomes.	Initial increased investment from HSE; funding from HSE increased in line with inflation; client charges increased in line with inflation.
Advantages	■ Service remains a local response to local needs. ■ Volunteerism continues to thrive, supported by a Meals-on-Wheels Association of Ireland. ■ Standards of meals improve with staff training and better support from the HSE. ■ The social aspect of the meals remains a priority. ■ Ensures universal coverage.	■ Independently monitored. ■ Delivery of chilled food reduces risks to clients. ■ Guaranteed minimum standards countrywide. ■ Ensures universal coverage. ■ Economies of scale with fewer food producers. ■ Potential for further loss of volunteerism in the community.	■ Significant cost savings, compared with Model One. ■ Guaranteed minimum health and safety standards. ■ Ensures universal coverage. ■ Greater training and support so organisations can plan strategically to meet increased demand. ■ Training ensures organisations have optimal feedback system. ■ Additional funding gives organisations more ownership over food choices.

	Improving the Status Quo	Competitive Outsourcing	Restructuring of Community and Voluntary Organisations
Disadvantages	■ Standards of the service may continue to vary from service to service, if ownership is mixed. ■ Service will be more expensive for clients. ■ Reliance on volunteers may reduce time available to spend on service planning and development.	■ Decline in volunteerism. ■ Possibility that drivers will have little time to spend time with clients. ■ Uncertain that clients would find the meals more appetising. ■ Lack of recognition of better services in operation.	■ Savings would not be as significant as for Model Two. ■ Introducing more HSE staff may be difficult given public sector cap.
Additional Comments	A Meals-on-Wheels Association of Ireland should be established to raise the profile of meals-on-wheels in Ireland, encourage more people to use the service, help recruit volunteer and provide training. The Association could be funded through membership fees from meals-on-wheels services and by the HSE.	The HSE should give adequate time and support to voluntary bodies to prepare for changeover; support them to change their focus from meals provision to befriending/ respite services; maintain their funding. Fewer food production kitchens will mean lower costs.	A Meals-on-Wheels Association could also benefit services. This model is an amalgamation of the principal benefits of Models One and Two.

10.4 Recommendations

All three of the models outlined above have advantages and disadvantages. Whatever model is put in place, much work needs to be done to ensure that meals-on-wheels services meet the needs of clients and provide them with a quality service. In addition, it is important to note that meals-on-wheels should not operate in a vacuum; day services and home help are also vital to allow older people and people with disabilities to remain living in their own homes for as long as possible. Box 10.1 outlines the criteria that should be met by providers of meals-on-wheels services in the future, regardless of the ownership and organisation of services.

Figure 10.1: Summary of general recommendations

1. Meals-on-wheels should be offered to all those deemed to be in need based on objective criteria; nobody should be refused the service for reasons of age, income or geographical location.
2. Meals-on-wheels services should have universal coverage, i.e. they should be available to all those in need, country wide, on a seven days per week basis, including public and other holidays.
3. All meals-on-wheels services should be guided by a client-centred approach, i.e. clients should have input into the service. At a minimum, this should take the form of an anonymous feedback system and the provision of a choice of meals for clients.
4. Further research should be carried out to examine alternative cooking systems that take into account food safety and the needs of recipients in terms of taste, flexibility and ease of use.
5. The social role played by meals-on-wheels should be recognised in a formal way by training delivery staff and volunteers to communicate with clients and to recognise the signs of need for additional health and social services.
6. All services should recognise the benefits of providing training for all staff, paid and voluntary, in customer care skills, manual handling, health and safety, and emergency procedures.
7. All services should develop and follow procedures for emergencies, such as clients not answering the door in unusual circumstances or other emergencies.
8. Provision of training in nutritional risk screening is needed for PHNs or other relevant staff.

9. Mandatory nutritional guidelines/regulations for organisations providing meals for older people should be introduced.
10. Meals-on-wheels services should be better integrated with other health and social care services.
11. The possibility of introducing services that could provide an alternative form of support to those in need of nutritional support, such as cooking classes or assisted shopping, should be considered.
12. Client confidentiality should be maintained by service providers at all times.
13. Independent monitoring and evaluation of services should be completed on a regular basis, with regard to compliance with health and safety legislation, referral procedures and nutrition guidelines (or legislation).
14. The Government should legislate for mandatory liability insurance coverage for all meals-on-wheels services.
15. The benefits of increasing fees for clients should be considered.
16. A Meals-on-Wheels Association of Ireland should be established if a number of services continue to provide meals.
17. Greater recognition should be given to volunteer drivers, e.g. through the payment of expenses or a stipend, as well as fuel allowances.
18. Services should prepare for the likelihood of greater diversity in the client base.
19. A mandatory universal referral system for use by PHNs and other designated HSE personnel should be introduced, with regular reviews of the client list.
20. In recognition of the possible reluctance of clients to use of the service, the HSE and/or service providers should endeavour to publicise the benefits of the service.
21. The possibility of providing a nutritional education and counselling programme for all older people living in their own homes should be considered.
22. In order to facilitate service-planning, a national database of client should be maintained.

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Appendix One

Appendix One

Elderly Nutritional Program, United States of America (USA)

The Older Americans Act, 1965, authorises grants to states for community planning and services programmes, as well as for research, demonstration and training projects in the field of ageing (Administration on Aging, 2004a). In 1968, the Elderly Nutrition Program (ENP) was introduced under the Act to provide grants to State agencies to support congregate and home-delivered meals to those aged 60 and over. Other nutrition services also receive grants under the Act, including nutrition screening, education (e.g. learning to shop and planning and preparing nutritious, affordable meals, and counselling (Administration on Aging, 2003a). ENP and nutrition services accounted for 40 per cent of total grant funding under the Act for 2004 ($714.5 mn out of $1.798 bn) (O'Shaughnessy, 2004). Funding is provided by a variety of bodies, including Federal Government (through the Older Americans Act), the United States Department of Agriculture (which provides supplemental support) and other funds from state, county and city sources, as well as private donations and contributions from clients themselves.

ENP was designed to delay institutionalisation of older people by providing improved nutritional intake and opportunities for social contact. It is targeted at those with the greatest physical, economic and social needs; one of the requirements is that a person must be home-bound to receive a free home-delivered meal (HDG Consulting, 2004). The objectives of ENP are to provide the opportunity for older people to live their years in dignity by:

- providing healthy appealing meals
- promoting health and preventing disease
- reducing malnutrition risk and improving nutritional status
- reducing social isolation and increasing social interaction
- linking older adults with other community-based services, such as physical activities programmes, community health or case management services
- providing an opportunity for meaningful community involvement, such as through volunteering (Administration on Aging, 2003a).

The Older Americans Act requires that each meal must provide at least one third of the recommended daily dietary allowances for older people. Each meal must also be appealing to older adults and take into account specific dietary needs due to health

or medical conditions, cultural preferences or religious beliefs. Food service providers must be in compliance with all State and local health laws regarding the safe and sanitary production, service and delivery of meals (Ponza *et al.*, 1996).

ENP was evaluated in both 1992 and 1996. The 1996 study, using a multiple methods approach (interviews with service providers and users, observation, nutritional food assessments and analysis of programme administration data), found that ENP played an important role in participants' overall nutrient intake. Other studies have shown that participants are more likely to be better nourished and achieve higher levels of socialisation than non-participants (Administration on Aging, 2003a; Lin, 1999); that the programme is highly rated by clients (Administration on Aging, 2003b); and acts as an effective national framework for preventative nutrition interventions (Millen *et al.*, 2002). Many organisations funded by ENP have developed innovative initiatives to ensure that their clients are well cared for, such as the provision of delivery of meals for the pets of some clients in central Virginia. In addition, several organisations have started to deliver breakfast, as well as lunch, to clients. This has resulted in significantly higher nutrient intake for those receiving both breakfast and lunch compared with those receiving lunch only, providing further evidence of the nutritional benefits of meals-on-wheels (Gollub and Weddle, 2004).

However, ENP is not without its shortcomings. Concerns have been raised over the lack of nutritional education for those who use the service, the lack of flexibility in terms of meal delivery times, limited diversity in the food provided, and limited cultural diversity among staff and volunteers (Hutchings and Tinsley, 1990; Stanford, 1990; Ponza and Wray, 1990; Roe, 1994; Burt, 1993).

However, perhaps the most serious shortcoming of ENP is the fact that it supports only the poorest in society, leaving many of those arguably in need without access to the service.

The New South Wales Meals-on-Wheels Association, Australia

The New South Wales (NSW) Meals-on-Wheels Association is a regional representative body established in 1989 that advocates for its members' interests, devises service development projects (in areas such as nutrition, multicultural food, food safety and securing future volunteers) and offers organisational development programmes (in areas such as training, fundraising and human resources issues). It is run by a voluntary management committee comprising of nine representatives from the organisation's membership and four external members invited to contribute their special expertise. The organisation receives its funding from the Australian Government's Home and Community Care (HACC) Program, as well as through fundraising initiatives.

It offers members access to a community insurance scheme and operates a fund for financially disadvantaged meals-on-wheels clients in the region. The Association has 670 members; 210 of which are organisations serving a total of 4.5 million meals to 20,000 clients each year.

The organisation works to resolve the problems faced by meals-on-wheels organisations in NSW, such as sourcing new volunteers, meeting the changing needs of clients and meeting increased demand for the service through the development of innovative projects, liaising with policy-makers and raising the profile of the service. Some of the innovative projects in the NSW area include:

- school link – a project in which school pupils prepare birthday cards for meals-on-wheels clients and receive education about meals-on-wheels. Information on meals-on-wheels is sent home to their parents with a view to attracting new or future volunteers. Parent helpers are also involved in meal delivery
- state-wide food forums – meetings between meals-on-wheels agency representatives to discuss policy and practical issues and to share new ideas
- future of volunteering project – a research project carried out in collaboration with other volunteering agencies to examine likely developments for volunteering in the future
- dementia nutrition project – meal provision plus a volunteer who spends extra time with clients with dementia
- food safety road show – training for food services and assistance with drawing up food safety plans

Meals-on-Wheels services, State of Victoria, Australia

A recent review of home and community care (HACC) programme food services in the State of Victoria in Australia provides a general overview of meals-on-wheels services in Victoria (HDG Consulting Group, 2004). The study established that the proportion of older people accessing the service increases with age: from 4.8 per cent for those aged 70 to 75 years, to 6.5 per cent for those aged 75 to 79 years, to 8.7 per cent for those aged 80 and over. Seventy-one per cent of meals clients are aged 75 or older. For the oldest age group, accessing meals services is a relatively common experience; a fact that probably enhances the legitimacy and lessens any stigma attached to the service. In fact, the report contains no references to 'stigma' or 'embarrassment', suggesting that these are not serious considerations in the Victoria context.

In 2002-2003, commonwealth and state funding subsidised 4.4 million meals in Victoria, distributed through 103 HACC food service providers to some 30,000 eligible clients. The government of Victoria provide a subsidy of AUD 1.20 per meal (indexed annually), plus AUD 2,060 per annum for each day centre at which community meals are provided. In addition to these subsidies, meals provision is funded through client fees that vary from AUD 3.40 to AUD 6.00 per meal and agency contributions. In all, only 16 per cent of funding is public, with 66 per cent being derived from user fees and 17 per cent from agency contributions. Total direct expenditure for 2002-2003 amounted to AUD 33 million.

In terms of public expenditure, the HACC food services programme is highly cost-effective. For every AUD 1.20 of direct subsidy, AUD 6.30 is garnered from other sources. This allows a 'multiplier effect' that enables seven times the level of service that would be possible with the subsidy alone. This multiplier effect would be even higher if indirect costs, such as a client assessment, capital equipment investment and maintenance were included.

A very high proportion of providers (66 per cent) contract out the production of meals, primarily to health service providers in rural areas and private contractors in urban areas. Some two-thirds of providers that use contractors stated that they are faced with the issue of increasing prices. Whereas competitive tendering goes some way towards controlling prices in urban areas, in rural areas there is often a sole provider that is consequently in a monopolistic position. Only one-quarter of food service agencies in Victoria cook their own meals.

In contrast to meal preparation, the delivery of meals is largely carried out by volunteers. Among the food service agencies in Victoria, almost 60 per cent use volunteers to deliver meals, 14 per cent use paid workers and the remainder use a mix of paid and volunteer workers. However, the use of volunteers in delivery is decreasing and many agencies have to recruit paid workers for this task.

Some services use a variety of strategies to target new and non-traditional sources of volunteers, such as local businesses, banks and schools. Areas with paid volunteer coordinators are more likely to have developed systematic volunteer recruitment and support strategies.

In order to comply more easily with food safety regulations, the majority of providers have moved to the cook-chill practice. This has also enabled them to introduce broader delivery timeframes and to operate with a greater degree of flexibility. However, a minority of providers are adamant that hot meals are the superior

alternative. The report acknowledges that the costs and additional administration necessitated by the implementation of food safety regulations have been significant and largely shouldered by agencies themselves. However, the majority of providers are now in full compliance with these regulations.

Almost half of the agencies offer a choice of main courses. Most providers have set-price menus but 10 per cent offer low cost and high cost options. The providers reported that both food and social contact were equally important for 60 per cent of clients, while food was more important for 22 per cent and social contact for 18 per cent. There is a concern on the part of some providers that, especially in the cases where social interaction rather than health reasons is the primary reason for take-up of the service, delivered meals can unintentionally reinforce a sedentary lifestyle.

Considerable assistance and guidance is given to providers in complying with nutritional guidelines. The *HACC Program Manual* lists the recommended food services to assist in achieving the nutritional standards.

The demand for the food services has declined in some areas, which can be attributed to the increased availability of convenience foods from supermarkets and other sources. Changing tastes and preferences may also have played a role in this development. The cost of supermarket convenience meals is still 2 or 3 times higher than the cost of a HACC meal but this may not be a sufficient deterrent/attraction for some older people. It is important for food services to monitor and understand such developments in order to prevent a situation where their service is radically out of step with the preferences of older people and people with disabilities.

Domestic Care, Northern Ireland

Domestic Care is a private company options established in 1993 in order to provide meals-on-wheels to those in need in Ulster Community Trust. It is operated by a board of five directors, selected on the basis of share ownership, corporate or clinical governance skills, or knowledge of the marketplace. It also operates two nursing homes in Northern Ireland and homecare services in some areas.

Since 1993, Domestic Care has expanded into seven of the eleven (old) Health Trust areas in Northern Ireland, having been selected by competitive tender, following a successful completion of a pilot project in some areas. In each area, Domestic Care has replaced the voluntary organisations that were providing meals-on-wheels. The company is currently in negotiations to expand the service into areas it does not cover.

Each Request for Tender document stipulated a number of objectives that tendering companies would have to meet. The stipulations put forward by the North and West Belfast Trust (now part of the Belfast H and SC Trust) were as follows:

- take all reasonable measures to ensure the Trust complies with its statutory responsibilities under the food hygiene/safety legislation
- minimise the level of risk exposure to the Trust through its community meals service
- ensure a safe product produced on premises audited for food safety by appropriately trained and qualified staff
- ensure meals are transported to the clients' homes under controlled conditions which satisfy the temperature control regulations
- ensure clients receive a choice of meal and eating time
- ensure provision of a nutritionally sound community meals service which is reflective of local eating habits, current Government nutritional recommendations and good practice
- ensure there is equality of opportunity in the community meals service and that therapeutic, ethnic and cultural dietary requirements are accommodated.

In addition, the successful organisation was required to provide meals to all who needed them, regardless of their address or accessibility. Given these stipulations, few voluntary organisations that had been providing meals-on-wheels in the area had the capacity to develop the structures of the service they provided to meet them, and ultimately, Domestic Care was the sole organisation that responded to the request for tender.[14]

Clients are referred to the service on the basis that they meet one of the following criteria:

1. the individual is unable to prepare themselves a meal for physical reasons (level of functioning/mobility) or mental reasons (dementia/depression/mental illness) or emotional reasons (bereavement, loss of partner)
2. no other person is available to assist with and cook a meal
3. a Carer is assessed as requiring relief from meal preparation on 2-3 occasions per week.

14 Brian Barry, 2003, Report on the Implementation of Fresh Cooked Chilled Meal Service. North and West Belfast Health and Social Services Trust, 12th May, 2003.

Domestic Care now provides all meals-on-wheels to clients in four of the five Health Trust areas in Northern Ireland and is in negotiations with all four of these Trusts to extend the service into areas it had not previously covered before the redrawing of the Trust areas earlier in 2007. Expansion into two older Trust areas, Causeway, and Newry and Mourne is expected to take place soon.

Meals are provided seven days a week, with Sunday's meal delivered on Saturday. Service provision on Sundays is typically less than the other six days. All of the meals are cook-chilled. The company currently provides a total of 23,000 main meals and 3,000 supplementary meals per week resulting in excess of 1.1 million contacts a year. This will increase to 27,000 and 4,000 respectively when the company extends its service, resulting in 1.4 million client contacts a year. Domestic Care also supplies lunches to nursing homes, luncheon clubs and day centres for older people. The company has almost 6,000 clients at present. On average, clients receive approximately 4.9 main meals per week, with 12.5 per cent also in receipt of an evening meal.

The company has 50 drivers to cover 43 routes. Some drivers in urban areas deliver up to 100 meals a day, in vans owned and maintained by Domestic Care. Each van is refrigerated to ensure meals are kept at the optimum temperature. Meals are delivered between 8.30 a.m. and 1.00 p.m. Drivers are paid between £12,878 (€18,967) and £14,112 (€20, 786) per annum, depending on hours worked. They are recruited through job agencies or newspaper advertisements and are required to give two business references. Before commencing employment, each driver undergoes a training course, which includes basic hygiene, manual handling, customer care, skills on overcoming difficult situations and trips accompanying senior drivers. Drivers are also required to complete a health and safety examination. All drivers undergo an annual review and a bi-annual performance assessment, and are supervised by a transport manager and assistant manager as well as two senior drivers. The cook-chill method is used, which means that drivers do not need to rush to deliver meals to clients. Drivers are required to carry out a 'safe and well' check on clients, which means that they must meet each client face-to-face. Protocols have been agreed with the Trusts where the client is not seen, the driver is unable to gain access or the client is found unwell. In these circumstances, the driver does not leave until help arrives and a system is in place to assist with delivering meals to the rest of the clients on the route. Domestic Care are careful about the staff they recruit to deliver meals, endeavouring to ensure that each individual is suitable and personable. All drivers carry photographic ID at all times.

The cost of the meal to the client varies according to Health Trust area, ranging from £1.20-£2.00 (€1.77-€2.94). The amount Domestic Care receives from each Health

Trust varies, although some clients who are not subsidised by the Trust (as they were not referred), pay the full cost of the meal, offered at £3.89-£4.30 (€5.76-€6.36).

With regard to the nutritional component of the meals, the menu changes completely every 12 weeks and rotates on a three-weekly basis. Both a lunch and evening meal menu are offered to clients every day. For lunch, clients are offered a choice of four main courses; two of which are meat-based, one of which is vegetarian, while the fourth choice is always a salad. Clients are also offered a choice of three desserts. All lunches come with a container of orange juice. Three choices are also offered for the evening meal. All of the menus are prepared in consultation with community dietitians and aim to ensure clients have a balanced diet. Kosher meals, pureed meals, diabetic meals and a variety of other special dietary requirements are also catered for. A separate sandwich menu is also provided to those who don't require a full meal every day (e.g. for those who attend luncheon clubs).

All meals are prepared in a privately-operated kitchen, contracted by Domestic Care, to provide meals according to the standards set out by the various Health Trusts. The kitchen provides meals solely to clients of the NHS, including meals-on-wheels clients, day centres and hospitals subsidised by the health service. The kitchen meets EU health and safety standards and is also the only STS-accredited catering facility responsible for supplying meals to NHS clients in Northern Ireland.[15] Clients are assessed to ensure they are capable of reheating the meals adequately, either in the oven or in a microwave. Domestic Care staff also carry out an annual check on each client's fridge to ensure their food is being stored at the correct temperature.

Clients are surveyed bi-annually, using a written questionnaire, to ascertain their level of satisfaction with the service. Response rates are usually high and are often in excess of 60 per cent. The level of satisfaction has been consistently high (c. 90 per cent), with any matters arising from the surveys being dealt with promptly. Clients are asked to give their name and address on a voluntary basis.

The service is monitored in a number of ways:

a) formal contract review and quarterly meetings

b) external inspection – Domestic Care is independently audited by STS Solutions, the agency contracted to inspect all NHS food production/services. Loss of registration would result in the loss of all contracts

15 STS (Support, Training and Services Plc.) is a company set up to accredit services supplying meals to NHS clients (among others) to its own standards.

c) the company's own internal quality system with formal reviews and audit trails

d) vans are calibrated six-monthly for temperature control, and are subject to daily records and inspection

e) systems are in place to ensure portion consistency at the production facility and also through internal audit process

f) a quarterly committee agrees the next menu cycle to ensure compliance with nutritional guidelines.

The provision of meals-on-wheels by Domestic Care is one of a range of services offered to older people throughout Northern Ireland to enable them to remain living in their own home. Day services and luncheon clubs are well-established in Northern Ireland and homecare packages are designed for individuals by the NHS.

Appendix Two

Appendix Two

Principles of Hazard Analysis and Critical Control Point (HACCP)

Principle 1: Conduct a hazard analysis.

Organisations determine the food safety hazards and identify the preventive measures to control these hazards. A food safety hazard is any biological, chemical or physical property that may cause a food to be unsafe for human consumption.

Principle 2: Identify critical control points.

A critical control point (CCP) is a point, step or procedure in a food process at which control can be applied and, as a result, a food safety hazard can be prevented, eliminated or reduced to an acceptable level.

Principle 3: Establish critical limits for each critical control point.

A critical limit is the maximum or minimum value to which a physical, biological or chemical hazard must be controlled at a critical control point to prevent, eliminate or reduce to an acceptable level.

Principle 4: Establish critical control point monitoring requirements.

Monitoring activities are necessary to ensure that the process is under control at each critical control point.

Principle 5: Establish corrective actions.

These are actions to be taken when monitoring indicates a deviation from an established critical limit. The final rule requires an organisation's HACCP plan to identify the corrective actions to be taken if a critical limit is not met. Corrective actions are intended to ensure that no product injurious to health or otherwise adulterated as a result of the deviation enters commerce.

Principle 6: Establish record keeping procedures.

The HACCP regulation requires that each organisation maintain certain documents, including its hazard analysis and written HACCP plan, records documenting the monitoring of critical control points, critical limits, verification activities and the handling of processing deviations.

Principle 7: Establish procedures for verifying the HACCP system is working as intended.

Verification ensures that the plans do what they were designed to do; that is, they are successful in ensuring the production of safe product. Organisations should validate their own HACCP plans. Verification also ensures the HACCP plan is working as intended. Verification procedures may include such activities as review of HACCP plans, CCP records, critical limits, and microbial sampling and analysis.

Source: Rushing and Ward, 1995

Appendix Three

Appendix Three

Questionnaire for Meals-on-Wheels Services

Social Policy and Ageing Research Centre,
Third Floor,
3 College Green,
Trinity College,
Dublin 2

Dear

A Study to investigate the role and future development of the meals-on-wheels service for older people in Ireland.

The Social Policy and Ageing Research Centre (SPARC), Trinity College Dublin, is currently carrying out a research project on behalf of the National Council for Ageing and Older People (NCAOP) on the provision of meals-on-wheels and community meals for older people within Ireland. To date, very little research has been carried out on these important services from an Irish perspective, particularly as to how each service could be developed to achieve its full potential.

This survey is directed at all organisations that provide **meals-on-wheels** to older people. For comparative purposes, a short section on community meals provision is also included and we would also encourage all organisations providing meals within a **day centre, health centre or a day hospital** to fill out the questionnaire.

I would be grateful if you would complete the attached questionnaire and return it to me in the envelope provided.

It should take approximately 25 minutes to complete the questionnaire. All information you provide will be held in the strictest confidence and your organisation will not be identifiable in the final report. If you have any questions regarding the questionnaire, please do not hesitate to contact me.

I would like to reiterate that the purpose of the survey is to help to improve the meals-on-wheels service in the future and to better facilitate your work in this critical area of service provision for the older population.

Thank you for your assistance.

Regards,
Ciara O'Dwyer
Research Fellow

Organisation Profile Form

For a Study of the Meals -on-Wheels Service in Ireland
by the Social Policy and Ageing Research Centre, TCD
Commissioned by the National Council for Ageing and Older People

Social Policy and Ageing Research Centre

SECTION A – CONTACT DETAILS

1. Name of Organisation		2. Year established	
3. Address			
4. Telephone No		5. Fax No	
6. E-mail		7. Website	
8. Contact Person			
9. Position		10. Contact No	
11. Local Health Office Area			

12. Catchment area of organisation's activities (i.e. do you target a specific area, town, city or county)? *(Please tick one box only.)*

Neighbourhood/Parish		Please name:	
Village/Townland		Please name:	
Town		Please name:	
City/County		Please name:	
Other		Please give details:	

13. Does your organisation provide meals to individuals' homes, within a centre (e.g. day centre) or both? *(Please tick one box only.)*

To individual's homes only		PLEASE COMPLETE SECTION B (below)
Within a Centre only		PLEASE COMPLETE SECTION C (go to Page 4)
Both		PLEASE COMPLETE SECTIONS B AND C (below)

SECTION B – MEALS -ON-WHEELS (HOME DELIVERY SERVICE)

NOTE – THIS SECTION REFERS ONLY TO HOME DELIVERED MEALS

14. Which of the following refer clients to the meas -on-wheels service most often? Using the numbers 1 -4, please put the following in order, where 1 is the most common source of referral and 4 is the least common. *(Please mark N/A where a referral source is not applica ble to your organisation)* :

GP		
Public Health Nurse		
Social Worker		
Family/Friends/Neighbours		
Self-referral		
If other please specify		

15. Do clients have to meet certain conditions before being allowed to use the service (e.g. be a certain age)?

Yes	☐ →	**GO TO Q. 16**
Sometimes/It depends	☐ →	**GO TO Q. 16**
No	☐ →	**SKIP TO Q. 17**

16. If **YES** or **SOMETIMES,** tick all that apply and provide details in brief in the box below:

Age	☐	Please give details	
Disability	☐	Please give details	
Income	☐	Please give details	
Living alone/no other support available	☐	Please give details	
If other please specify	☐	Please give details	

17. How many people are currently on the meals-on-wheels (home delivery service) waiting list? ☐

18. For approximately how many weeks would an individual remain on the waiting list? ☐ (weeks)

19. How many individual clients does the meals-on-wheels service currently have? ☐

20. On what days does the meals-on-wheels service operate? *(Please tick all that apply.)*

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

21. Approximately how many meals in total are prepared each day for home delivery?

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

22. Does the service operate on bank holidays and other public holidays?

Yes ☐ No ☐

23. What meals does the service provide on a typical day? *(Please tick all boxes that apply.)*

Breakfast	☐
Lunch (midday meal)	☐
Dinner (evening meal)	☐
Tea (light evening meal)	☐
Snacks	☐

24. Please estimate the percentage of meals-on-wheels clients that are:

a.	Male		%	Female	%	(Total = 100%)
b.	Under 75 years old		%	Over 75 years old	%	(Total = 100%)
c.	Living alone		%	Living with family	%	(Total = 100%)
d.	Housebound		%	Mobile outside home	%	(Total = 100%)

25. Are clients charged for or asked to contribute to the meals-on-wheels delivery service?

Yes ☐ → **GO TO Q. 26** No ☐ → **SKIP TO Q. 28**

26. **If yes,** approximately what percentage of the clients pay? *(Please tick one box only.)*

1%-24%	☐
25%-49%	☐
50%-74%	☐
75%-99%	☐
100%	☐

27. How much does each client pay/contribute per meal (approximately)? € ☐

28. Do you consult with clients about their meal preferences?

Yes	☐	Please give details
Sometimes/It depends	☐	Please give details
No	☐	Please give details

29. Are the meals provided to individuals' homes hot, cold or frozen or is a choice provided? *(Please tick one box only.)*

Hot ☐ Cold ☐ Frozen ☐ Choice provided ☐

30. Are individuals given a choice of meals each day? *(Please tick one box only.)*

Yes	☐	Please give details
Sometimes/It depends	☐	Please give details
No	☐	Please give details

31. Do you cater for special dietary requirements?

Yes ☐ → **GO TO Q. 32** No ☐ → **SKIP TO Q. 33**

32. **IF YES**, for which ones? *(Please tick all that apply.)*

Low sodium	☐	Gluten-free	☐	Diabetes	☐	Low fat/low cholesterol	☐
Vegetarian	☐	Chewing/swallowing difficulties	☐	Allergies	☐	Other	☐

If other please specify

33. Does your organisation use a menu rotation/cycle system? (i.e. a series of menus repeated at regular intervals)

Yes ☐ ⇒ **GO TO Q. 3 4** No ☐ ⇒ **SKIP TO Q. 3 5**

34. If yes, how often does the menu rotate (**approximately**)? *(Please t ick one box only .)*

- On a weekly basis ☐
- On a fortnightly basis ☐
- On a monthly basis ☐
- Other ☐ Please give details

35. Does a dietician or another nutrition expert have any input into the menu?

Yes ☐ No ☐

36. What percentage of your staff/volun teers have completed :

- A food hygiene safety training course? ☐ %
- A training course on nutrition? ☐ %

37. Does your organisation have a system in place for taking feedback/complaints from clients?

Yes ☐ No ☐

38. What are the broad aims and objectives of your meals -on-wheels service?

IF YOUR ORGANISATION :

Provides meals within a centre	COMPLETE SECTION C (below)
Does not provide meals within a centre	SKIP TO SECTION D (Go to Page 6)

SECTION C – MEAL PROVISION WI THIN A DAY/HEALTH CENTRE (i.e. on -site meal service)

THIS SECTION REFERS ONLY TO MEALS PROVIDED TO OLDER PEOPLE WITHIN A DAY/HEALTH CENTRE

39. Please rank from 1 -4 the main sources of referral of clients to the Centre , where 1 is the most common referra l source and 4 is the least common *(please mark N/A where a referral souce is not applicable to your organisation)* :

- GP ☐
- Public Health Nurse ☐
- Social Worker ☐
- Family/Friends/Neighbours ☐
- Self -referral ☐
- If other please specify ☐

40. Do clients of the Centre have to meet certain conditions before being allowed to use the service (e.g. be a certain age)?

Yes		Please give details	
Sometimes/It depends		Please give details	
No		Please give details	

41. Please estimate the percentage of clients that are:

a.	Male		%	Female		%	(Total = 100%)
b.	Under 75 years old		%	Over 75 years old		%	(Total = 100%)
c.	Living alone		%	Living with family/friends		%	(Total = 100%)
d.	Housebound		%	Mobile outside their home		%	(Total = 100%)

42. For how many people in total does the Centre currently provide meals?

43. Do you provide a transport service for your clients?

Yes	
For some clients	
No	

44. How many people are currently on the Centre's waiting list?

45. On average, for how many weeks would an individual remain on the waiting list? (weeks)

46. Are clients charged for or asked to contribute to the meals provided within the Centre?

Yes **GO TO Q. 33** No **GO TO Q. 34**

47. Are individuals given a choice of meals each day?

Yes

No choice Choice given

SECTION D – BACKGROUND DETAILS

THIS SECTION TO BE COMPLETED BY ALL ORGANISATIONS

48. What is the legal status of your organisation? *(Please tick all that apply.)*

Registered Charity			
Public Sector (HSE)			
Limited Company			
No Formal Status		Please give details	
Other		Please give details	

49. How many staff work for the meals provision service?

Paid (full time)	
Paid (part time)	
Voluntary (full time)	
Voluntary (part-time)	
TOTAL	

50. Please indicate the amount of funding that your organisation received in 2006 from the different sources listed below:

	Meals-on-Wheels	Community Meals Day/Health Centre	TOTAL
HSE	€		
Other public bodies	€		
Fundraising/Donations	€		
Charges/Contributions	€		
Other	€		
If other, please provide details			

51. Does your organisation have insurance to cover any of the following? *(Please tick all that apply)*

Transportation (i.e. motor insurance)	
Premises	
Staff (i.e. liability coverage)	
Service (i.e. liability coverage)	

52. Does your organisation receive any non-financial support from other sources (eg advice or training)?

53. What do you perceive to be the biggest challenges to the future development of your organisation? Using the numbers 1-5, please put the following in order of preference, with 1 as the most preferable alternative and 5 as the least.

Recruiting new volunteers	
Recruiting new (paid) staff	
Securing adequate levels of funding	
Sourcing insurance coverage	
Paying for insurance coverage	
Complying with health and safety regulations	
Meeting increased demand for the service	
Other	

54. Who do you think should be responsible for funding the meals-on-wheels services? Using the numbers 1-3, please put the following in order of preference, with 1 as the most preferable alternative and 3 as the least.

State	
Community/voluntary organisations	
Families	
Other	

If you have any other comments to make regarding the issues raised in this questionnaire please include them in the space provided below.

THANK YOU FOR YOUR HELP

Appendix Four

Appendix Four

Interview Guides

MOW Service Provider (Organiser/Manager) Interview

Background Details

What is your title in this organisation?

Could you please very briefly describe what your role entails?

How long is the organisation in operation?

Can you tell me a bit about how it started originally?

What is the geographical coverage of the service?

How is the overall management structure of the organisation (e.g. Management committee, Board?)

What are the overall goals and aims of the organisation? [Action Plan? Mission Statement?]

Referral System

Who refers people to your service?

Do you use eligibility criteria?

[If yes] What are they?

Who decides whether or not someone is eligible? How strictly are such guidelines adhered to?

In general, do you make any attempts to persuade anyone who is reluctant to avail of the service?

[If yes] How?

How frequently do individuals refuse to take up the service?

How often has this happened?

What are the typical reasons people would not avail of the service?

Have you taken any measures to minimise the occurrence of refusals?

How do you ensure people in your catchment area are aware of your service (e.g. advertising, contacting other key community service providers?)

Can you estimate the proportion or number of older people in the area who you feel need the service but are not accessing it?

Operational Details

[Check that information obtained via postal survey is accurate e.g. you prepare X meals per day, the organisation is in operation X days a week, geographical coverage].

Can you tell me about the benefits and shortcomings of operating a small/large organisation in an urban/rural area.

Meals Clients

[check postal survey data:] How many people receive meals altogether? How many are currently on a waiting list? To what extent are you able to meet demand for this service in your area?

Can you describe in greater detail the type of people that you supply with meals? (age, gender, mobility).

Have the characteristics of the people receiving meals changed over time?

What do you think are the things that your clients like the most about the service?

In your opinion, how satisfied are your clients with the service? Food? Level of social interaction?

Staffing: Employees and Volunteers

Does the organisation employ anyone i.e. paid workers? If yes, how many, and did you have any difficulties registering as an employer? If no, would you like to be able to employ someone?

Do you use people on the JI or CE schemes?

[Where relevant] How do you source paid staff?

Do you have any volunteers? If yes, how many?

What methods do you use to source and recruit volunteers?

How easy or difficult is it to recruit volunteers? Has this changed over time?

How satisfied are you with the volunteers?

Can you briefly describe the type of staff and volunteers in the organisation? (age, gender, other key characteristics).

Have any of the staff undertaken training programmes? What kind? (Nutrition? Food preparation? Hygiene? Safety? Issues related to older people?)

How confident are you that the meals provide your clients with all of the nutrients they should have in their main daily meal?

Meals: Preparation, Content, Delivery

Please describe briefly the meals that you produce/provide.

Can you describe the ways in which you try to ensure the nutritional needs of clients are met?

In what way, if any, are special dietary requirements met?

Have you ever received advice from a dietitian regarding the menu?

Have you ever received advice from a dietitian, doctor or similar regarding the factors that affect older people's appetite and ability to eat?

How satisfied are you with the kitchen in which the meals are cooked?

In what way does your organisation work to meet hygiene standards?

How are meals supplied to clients? (receptacle? vehicle?)

How much time would drivers typically spend with each client?

Do you have any mechanism in place to ensure that the clients eat the whole meal and eat it straight away, or store and heat it appropriately if delivered cold?

Client Feedback

How much input do clients have into the menu? The operation of the service?

Do you have a complaints/feedback system? (Formal? Informal?)

Insurance and Protocols

Can you describe the (different) type(s) of insurance coverage that you have? What are the main issues, if any, in relation to availability and cost of insurance cover?

Do you have any system in place to ensure that your staff are safe (from allegations, attacks etc.)?

Do you have any protocol for reporting anything alarming about the meals clients to police or to other service providers? E.g. Signs of ill health or nobody answering the door?

Relationship with Other MOW Services and other Homecare Service Providers

Can you describe your relationship with the HSE?

Can you describe your relationship with the PHN or GPs? (i.e. main referral sources)

Can you give me an idea of the extent of communication or contact you would have with other meals on wheels providers in your area?

Do you have any contact with the EHO?

How satisfied are you with the level of support you receive from the HSE?

Funding

Can you describe how the organisation sources funding to run the meals-on-wheels service?

How satisfied are you with the level of funding the service receives (all sources)?

In your opinion, how should meals on wheels be funded?

Can you tell me a little bit about your overheads?

[check postal survey data:] Do you feel that the amount you charge your clients for meals is appropriate? Have you received any feedback from clients about the cost of the meal? Is this feedback generally positive or negative?

Overall Views on the Organisation

Can you describe some of the best aspects of your organisation?

Can you describe some of the aspects you feel need to be improved?

Have you ever carried out a review of the service, or has the service been evaluated in any way?

What are the biggest challenges facing your organisation?

Are there are factors that may help your organisation perform better in the future?

Recommendations for the Future

What are the biggest difficulties or barriers the organisation faces at the moment?

Do you have any recommendations for the future development of meals-on-wheels in Ireland?

Any suggestions for meeting unmet need in the area?

Final Comment

Thank you.

MOW Volunteer/Employee Interview

All: Pathway into Employment/Volunteering

Are you are volunteer or a paid employee?

How long have you been working/volunteering for this organisation or other similar organisations?

Why did you decide to start working/volunteering in this organisation?

How many hours per week do you work/volunteer?

What are your main tasks?

All: Purpose, Benefits and Acceptability of MOW

What is, in your view, the central purpose of this MOW organisation?

What are, in your view, the most important benefits of meals-on-wheels to clients?

Why do you think some older people are reluctant to take up MOW?

Do you think you personally would use meals-on-wheels if you ever needed them? Why/why not?

All: Views on the MOW Organisation

Can you tell me what you think of the organisation overall?

What do you think it does particularly well? What do you think it could improve on?

What would help the organisation to work better?

Employees and Volunteers Involved in Delivery of Meals

How many people do you deliver meals to?

How well would you say you know the people you deliver meals to?

How long would you typically spend with each client?

In your opinion, how much of a difference does the social interaction with you make to the clients' day?

Do you tend to pick up on any personal matters or problems in the course of interacting with the clients? Do you sometimes act on these? *(e.g. by recommending a course of action if client not feeling well etc.)*

What are the biggest challenges you encounter in delivering the food? (e.g. traffic, ensuring your safety and the safety of clients)

How do you overcome these?

Kitchen Staff and Volunteers

How would you describe in general terms the food that you prepare? (If necessary, probe: is it. home-like cooking, innovative, traditional, catering to a wide range of tastes?)

Do you participate in menu planning? If yes, how do you go about planning the meals?

Would you like to change the menu(s)? If yes, how? What would be required to make these changes?

What do you enjoy about the preparation of these meals, or about working in this kitchen?

Is there anything that you do not enjoy about the preparation of these meals, or about working in this kitchen?

Have you ever been on a nutrition course? If not, would you like to attend such a course?

Have you ever been on a food hygiene and safety training course? If not, would you like to attend such a course?

All: Recommendations for the Future

Do you have any recommendations for how meals on wheels should be provided in the future?

Do you think there is a problem with securing sufficient numbers of volunteers for this service in the future? If yes, what could be done about it?

Who do you think should be getting meals on wheels? (ie select few or available to everyone?)

Do you think the right people are getting the service at the moment? How do you think we could ensure that the right people get the service in the future?

Final Comment

How satisfied are you with what you have personally achieved through working/ volunteering?

Would you like to add anything else?

Thank you.

Current Client Interview

Use this schedule with individuals who are *already receiving MOW.*

General Food Shopping, Preparation and Consumption

[Please note that data about typical food intake during a 24-hour period – breakfast, lunch, dinner, snacks – are collected by the Research Assistants with backgrounds in nutrition so there is no need to compile a record of food intake in this interview.]

Let's start by talking about buying, preparing and eating food in general – later on in the interview will focus on MOW specifically but for now let's keep it general, so think of all sources of food and not just MOW.

Grocery Shopping

Do you do your own food shopping?

[If respondent gets help with food shopping] Who is/are the helper(s)?)

Can you tell me a little about a typical grocery shopping trip? *[Ask regardless of whether respondent goes him/herself or someone else goes on his/her behalf. If necessary, probe: Where – corner shop or supermarket? Walking or by car? Is shopping straightforward or are there any difficulties or barriers (high shelves, narrow aisles etc.)?]*

Do you find groceries expensive? Are there any food items that you find particularly expensive or unaffordable? How much do you usually spend on your groceries every week?

Food preparation

Thinking about the meals and snacks other than the ones you receive through MOW, do you prepare these meals and snacks yourself or does someone else help you?

If someone helps, who is/are this person/these people?

Eating

Do you usually eat alone or with someone else? If with someone else, who is it/are they?

Where do you usually eat?

Do you usually enjoy meal times?

Thinking of your overall food consumption, do you feel it gives you a well-balanced, nutritious diet?

Meals-on-Wheels

Next, I would like to focus on MOW specifically.

Pathway to Service

Could we please talk about how you first started to receive meals-on-wheels.

How did you first hear about the meals-on-wheels service in your local area?

How long afterwards did you take up MOW?

[If relevant] Was it your decision to look for the meals-on-wheels service or were you approached by somebody else? Who was the person who first approached you and recommended that you take up MOW?

Before being offered the service, were you aware that it was available in this area?

Why do you think you were offered the service?

How did you feel when the service was offered to you?

Why did you decide to take up MOW?

How long have you been receiving MOW?

What type of meal(s), do you receive from MOW? [times per week, type of meal(s)]

On what days do you receive MOW?

Are meals-on-wheels delivered on bank holidays and other public holidays?

[If not] What do you do eat instead on those days?

Views on the Meals on Wheels Service

I would next like to ask you about your opinions, positive and negative, of the meals-on-wheels service that you receive.

What do you think of the MOW service overall?

What aspect(s) of the service do you like the most?

What aspect(s) of the service do you not like?

How happy are you with the quality of the meals?

Could you tell me about a meal or an occasion of receiving a meal (from MOW) that was particularly nice?

Could you tell me about a meal or an occasion of receiving a meal (from MOW) that was not so nice or disappointing? *[If does not like the food or has been disappointed with food]* How often do you receive food that you don't like?

Is there any way to tell the staff/volunteers what food you like and don't like?

Which do you feel is a more important part of the service, the chat with the driver or the meal itself?

Payment for Meals-on-Wheels

Do you pay anything for the meals you receive?

If yes, how much? Do you think that is an appropriate level of payment?

Social Aspects of Meals-on-Wheels

Do you tend to have a chat with the person who brings in your meals?Is it usually the same person, or is/has there been change in the person who delivers your meals?

How much time would the driver usually spend with you when he/she comes?

Do you know anyone else who uses the service?

Do you know anybody who you think might benefit from MOW but doesn't use it? Why do you think they are not getting the service?

Difference MOW has Made

Has MOW made any difference to the amount or type of food you eat?

Has MOW made any difference in your attitude towards food?

Has MOW made any difference for you socially? *[e.g. importance of having the meal distributor call in, chatting etc.]*

Change Over Time in Food Consumption and Preparation

Thinking of the way you take your meals or the amount or kind of cooking that you do, have there been any major changes over time? *[If necessary, probe, with sensitivity, into: impact of marriage/widowhood/remarriage on food consumption and preparation]*

Recommendations for the Future

What do you think could be done to make MOW more appealing or user-friendly?

Do you think the right people are getting the service at the moment?

[If no] How do you think we could ensure that the right people will get the service in the future?

Use of Other Services and Other Social Contacts

Do you use any other community services at the moment? *[GP, home help, personal care attendant, day centre etc.]*

Are there any other community services that you are currently not getting would be interested in?

Do you have much contact with any family members or friends?

[If yes] How often do you see them?

How satisfied are you with that level of contact?

Do you have any neighbours that you are close to?

[If yes] How often do you see them?

How satisfied are you with that level of contact?

Personal Details

Do you live alone?

If yes, how long have you been living alone?

If living with other person(s), who is this/are these?

What is your age?

Final Comment

Would you like to add anything else?

Thank you.

PHN/GP Interview Guide

Role in Referring Older People to Meals-On-Wheels

Could you please briefly outline the criteria you use to determine an individual's need for meals-on-wheels?

Have you thought about using MNA or similar formal assessment tools? *[Why/why not?]*

How often do individuals have reservations or refuse to take up meals-on-wheels, when you suggest the possibility?

Do you think that being referred to a meals-on-wheels service is a sensitive issue for individuals? For everyone or just some people? Anyone in particular?

Do you make any attempt to persuade those who are reluctant to avail of the service? If yes, how do you go about doing so?

Is there a system in place for you to advise or provide further assistance to meals on wheels services, should the service provider become worried about the health of an individual you referred to the service?

Extent of Need for Meals-on-Wheels

Roughly, what proportion (percentage, number per month) of your older client base do you refer to MOW services?

How often, in your experience, does it happen that individuals are put on a waiting list for this service?

Can you estimate the level of unmet need, if any, for MOW services in your area (approx. percentage of older population and number of older people in the area who need the service but are not accessing it currently)? Please explain how you arrive at this figure.

Background/Additional Information

What percentage of your client base is made up of older people? (i.e. 65+)

What do you think of the current level of health and social service provision for older people in the area?

Views on Meals-on-Wheels

Approximately how many MOW service providers operate in your area?

Can you give me an idea of the extent of contact you have with MOW provider(s) in your area?

What are your views on the local MOW service(s)?

What are your views on the MOW services in general in Ireland at present?

What do you feel the meals on wheels services do particularly well?

What are the biggest shortcomings of the meals on wheels services?

Do you feel that the level of support for MOW services from public sources is adequate?

Recommendations for the Future

Could you please outline any ideas or suggestions you may have for developing and improving MOW services? What are the biggest opportunities facing local meals on wheels organisations?

What are the biggest threats facing local meals on wheels organisations?

Final comments

Thank you.

Appendix Five

Appendix Five

Observations from a sample of meals-on-wheels organisations

	MOW 1	MOW 2	MOW 3
Menu rotation	Yes but no specific rotation	5-week rotation	Weekly rotation
No. of choices per day	1	2	2
Courses provided	3- soup, main meal & dessert	2- main meal & dessert	3- soup, main meals & dessert
1- main meal	2- main meal & dessert		
Special Dietary Requirements Catered for	No	Diabetic/ gluten-free/ coeliac/ vegetarian	Diabetic/ coeliac/low-fat/swallowing difficulties
Preferences catered for	Yes	Yes	Yes
Hot/cold/frozen meals	Hot	Cook-chill	Hot
No.of meals/week	6 Mon-Sat	4 per week (2 meals delivered 2 days/week)	5 Mon-Fri
HACCP/Food Hygiene Course	Yes	No-meals collected from local hospital	Yes
Nutritionist/Dietitian input into menu	No	Yes – dietitian in hospital	No

MOW 4	MOW 5	MOW 6	MOW 7	MOW 8
4-6 week rotation	Weekly rotation	Weekly rotation	Weekly rotation	Weekly rotation
1	1	1	2	1
2- main meal & dessert	3- soup, main meal & dessert	2- main meal & dessert		
No	Diabetic/ gluten-free/ low-fat/low sodium/ vegetarian/ swallowing difficulties	Diabetic	Diabetic	No
No	Yes	Yes	Yes	Yes
Hot	Hot	Hot	Hot	Hot
2 Tue & Thurs	5 Mon-Fri	5 Mon-Fri	7 Mon-Sun	6 Mon-Sat
Yes	Yes	Yes	Yes	Yes
No	Yes	Yes	No	No

The box below gives a sample 5-day menu used by one of the organisations above.

Sample menu: Meals-on-Wheels (Service 5)

Monday
Vegetable soup

Roast lamb
Mashed potato (with milk and butter)
Carrots & swede

Jelly and cream

Tuesday
Chicken Soup

Roast beef
Gravy
Mashed potato (with milk and butter)
Peas & carrots

Rice pudding

Wednesday
Mushroom soup

Pork chop
Apple sauce
Mashed potato (with milk and butter)g
Mixed vegetables

Berries and custard

Thursday
Vegetable soup

Boiled ham
Mashed potato (with milk and butter)
Cabbage

Semolina

Friday
Chicken Soup

Donegal Catch
White sauce
Mashed potato (with milk and butter)

Stewed apple and custard 85g

Preference and dietary requirements catered for

Terms of Reference

Terms of Reference

The functions of the Council are as follows:

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

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

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

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