INTRODUCTION

Global prevalence of obesity has doubled since 1980 (Institute for Health Metrics & Evaluation, 2017) and continues to rise sharply (Jaacks, 2017). Rising prevalence of obesity in older populations represents a significant public health challenge (Peralta et al., 2018) and is associated with a number of chronic diseases, including type 2 diabetes (Dewan & Wilding, 2003); hypertension (Redón et al., 2008); coronary heart disease (Villareal et al., 2006); stroke (Wildman et al., 2003); metabolic syndrome (Goodpaster et al., 2005); osteoarthritis (Silverwood et al., 2015); cancer (Freisling et al., 2017); and higher mortality due to COVID-19 (Klang et al., 2020). Obesity can also lead to reduced mobility (Villareal et al., 2004) that may exacerbate frailty/impair quality of life (Giuli et al., 2014). Impairment to functional ability in older people can require increased support with activities of daily living (Chou et al., 2012) which can precipitate the prospect of care home admission to address this need (Zizza et al., 2002).

Obesity is generally identified by measuring body mass index (BMI). Individuals whose BMI is ≥30 kg/m² are classed as obese (Tsigos et al., 2008). Research focusing on obesity in care homes, primarily USA-based, shows that prevalence of BMIs over 30 kg/m² in this sector is increasing significantly (Felix et al., 2015; Zhang et al., 2019). Prevalence of older residents with obesity in care homes in Europe, including the UK, is difficult to estimate as data are limited, although a study of residents' BMI data in Germany and Austria reported the presence of at least 16% obesity (Valentini et al., 2009). An estimate of the proportion of older residents with obesity can also be gained from Veronese et al.'s (2015) meta-analysis which included care homes in Europe, Asia, USA/Canada and Australia and...
found that approximately 10% of residents were obese. In the United Kingdom (UK), the British Association for Parenteral and Enteral Nutrition (BAPEN) has completed nutrition screening surveys in care homes. The most recently undertaken (2011) found that 11% of the 522 residents surveyed had a BMI ≥30, compared to 9% of 584 residents in 2008. BMI between 25 and 29 also increased from 25% to 32% in that period (Russell & Elia, 2015). However, these surveys were primarily focused on investigating malnutrition associated with low weight/BMI, therefore discussion about the implications of obesity in care homes was not provided.

Despite increases in care home admittance of older people with obesity, research in the USA highlights several challenges to admittance. These include increased demand for staffing due to high levels of residents’ dependence regarding mobility, dressing, personal hygiene and nutrition support (Felix et al., 2009, 2010; Harris-Kojetin et al., 2016; Rose et al., 2007). Also, care home premises may lack the additional space needed to support older residents with obesity (Felix et al., 2016). Additionally, lack of specialist moving/handling equipment, resources and training to support residents with obesity impacts staff’s ability to provide effective personal care; e.g. continence care, mobility support and effective weight-management interventions (Bradway et al., 2010; Felix et al., 2016; Marihart et al., 2015). These challenges also impact on the financial costs of care since caring for residents with obesity is significantly more costly than that for non-obese residents (Marihart et al., 2015). As a consequence of these challenges, Miles et al.’s (2012) study of care transitions from hospital to care homes found 80% of care homes unable to accommodate people with obesity. This generally results in delays in discharge from hospital (Popejoy et al., 2012) which can lead to further deterioration in functional status due to limited opportunities for ambulatory activity in hospitals (Fisher et al., 2011) and high hospital costs. This suggests that there may be health/economic advantages associated with improving access to care homes for older people with obesity who require ongoing care support.

While much research has been conducted in the USA highlighting challenges generated by rising levels of obesity in older people and ramifications for care homes, few studies have explored obesity in the context of care homes for older people in England. It was therefore considered appropriate to seek staff’s views/experiences to gain early understanding of this phenomenon in the context of English care homes, including staff perceptions of care home admittance and the challenges/facilitators to provision of person-centred care (PCC) for older people with obesity.

### 1.1 Purpose of this article

This article reports on care home staff’s views/experiences of the prevalence of obesity in care homes, and challenges/facilitators associated with any rise in applications for placements. The article reports on one aspect of a wider study that explored care home staff’s views/experiences of caring for residents with obesity.

### What is known about this topic

- Rising prevalence of obesity in older populations represents a significant global public health challenge.
- Despite this, few research studies have explored obesity in the context of care homes for older people in England.
- Focus of research in UK care homes has been predominantly on provision of person-centred care (PCC) to non-obese people.

### What this paper adds

- Despite growing recognition of the value of PCC, relatively little guidance is available on the use of PCC strategies for managing obesity. Three principal facilitators of PCC are presented.
- Given continuing/widespread trends towards rising prevalence of obesity in this population, the findings have broader translational potential.
- Need for accurate recording of both the numbers of older people with obesity who apply for admittance to care homes and numbers whose applications are accepted.

## 2 | METHOD

This study was located in North East England – a region with one of the highest rates of adult obesity in the UK (NHS Digital, 2020). Two academic researchers based at a North East England University undertook the study, which aimed to explore care home staff’s experiences/views of caring for residents with obesity. The research team felt that this study’s exploration of shared meanings/understandings within organisational/policy/cultural contexts reflected Crotty’s (1998, p. 42) view, ‘that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context’. This supported the rationale for adopting a qualitative methodology situated within a constructivist paradigm.

COREQ guidelines were used in reporting this study.

### 2.1 Participants

For convenience, all care homes providing care for older people that offered nursing student placements to the University were invited via email to participate (n = 78). These care homes were located across North East England, covering three counties. This facilitated recruitment of staff in the busy context of care homes (Davies et al., 2014). It also offered the advantage of accessing participants used to working in partnership with the University and with whom a bond of trust was pre-established. Individuals’ self-disclosure/
candidness tends to be natural when trust is established – essential when asking participants to discuss the difficulties/challenges of caring (Krueger & Casey, 2000).

Response rate to the invitation was low - only seven care homes replied and agreed to participate. This reflected that not all care homes provided care for people with obesity, and it was also considered to reflect judgements potential participants made about the feasibility of committing time seldom readily available in the context of busy care homes to include participation in the study. Care home managers agreeing to participate were invited to indicate convenient dates/times for focus group interviews. Managers contacted all staff due to be working on those dates/times, providing them with study information sheets which explained the purpose of the study and what participation involved, emphasising that participation was voluntary, and that deciding not to participate would not affect staff's employment in any way. Staff were given time to read the information sheet/contact the researchers with any questions before deciding. Those agreeing to participate were required to provide written consent. Inclusion criterion for staff was: 'they must have supported residents with obesity during care activities, e.g. admissions to care homes, dietary management, personal care,' etc. Recruiting participants with a range of care responsibilities maximised discussion about all aspects of caring for older residents with obesity. In total, 33 staff members consented to participate (Table 1). As an exploratory study using focus groups to comment on management of obesity within care homes, it was not deemed necessary to collect further demographic data. All participants were assigned pseudonyms to preserve anonymity.

2.2 | Data collection

Qualitative data were collected via focus group interviews conducted at each care home. Focus group interviews are appropriate for exploratory studies of new topics/new contexts. Findings can inform subsequent studies using mixed-methods/quantitative methodologies. Focus groups are also appropriate as a vehicle for involving care home practitioners, facilitating discussion from the full range of perspectives of the diverse roles/professions of staff working in this setting (Richardson & Rabiee, 2001). In addition, the type/range of data generated through social interaction of the focus group are often deeper and richer than those obtained from 1:1 interviews (Thomas et al., 1995).

Two researchers were involved in data collection. Focus group size ranged from 2 to 8 participants. Interview questions explored care home staff’s views/experiences of older people with obesity, including assessment for their admittance; care practices; challenges/facilitators; prevalence of obesity in care homes; policies and practice guidelines for managing older people with obesity; access to resources/levels of support from other health/social care professionals; recommendations for improving support. Interviews lasted no longer than one hour but afforded time to record participants’ in-depth reflections/descriptions of their experiences/views.

2.3 | Data analysis

Qualitative analyses were conducted of the audio recordings made during focus group interviews. Audio recorded data were transcribed verbatim and open coded by individual members of the research team. This allowed elucidation/description of participants’ experiences, while creating meaningful themes. Thematic analysis was chosen, as it is a method for organising/analysing/reporting patterns/themes) within data that minimally organises and describes data set in rich detail (Braun & Clarke, 2006). Analysis was data-driven, rather than theory-driven. The 6-phase guide to conducting thematic analysis (ibid) was used: familiarisation with the data; generating initial codes; organisation of initial codes into patterns to generate themes; reviewing themes; defining/naming themes; interpretation. During this process, all transcripts were independently coded by another team member and the outcomes compared with the original coding to validate themes (Appendix S1A contains examples of how themes/codes/quotes were linked). The themes which emerged from data analysis were more residents with obesity; and the challenges of providing care for older residents with obesity.

2.4 | Ethical approval

Ethical approval for this study was granted by the host University's Faculty of Health and Life Sciences Research Ethics Committee.

3 | FINDINGS

3.1 | More residents with obesity

Most participants proposed more residents with obesity were being admitted to their care homes:

W1 (RN): 'I’ve been involved in care on/off for about 20 years... and there never used to be as many [residents with obesity].'

Some participants particularly noted increases in numbers with levels of severe/extreme obesity, commenting that more intense care is required for this group:

D1 (Manager): ‘There are more and more clinically and morbidly obese people, and they have required a lot of care’.

Participants noted increases in enquiries about possible admittance to care homes by people with extreme obesity (BMI ≥40) who may require bariatric equipment:

S1 (Manager): ‘...there’s been an increase in the number of enquiries for people who are classed as “bariatric”’.

Participants suggested as more older people with obesity are requiring care home support, care homes need to adapt to account for this resident group:

D1 (Manager): ‘The marketplace in the care home is changed and it is because there are more and more clinically and morbidly obese people’.
Some participants reported concerns not only regarding the emergence of obesity as a significant issue for care homes, but also that this issue warranted greater recognition by care providers and health/social care authorities. These participants proposed that the extent of obesity in the older population requiring care home admittance needs to be acknowledged and care homes should have bespoke support to ensure PCC for them. Without this acknowledgement and support, participants were concerned that some admittances were inappropriate:

S1 (Manager): ‘Personally, [we need] acknowledgement that we do have obese residents within the group and that’s not acknowledged by anybody. It doesn’t matter where you look – whether it’s with the company and the support staff or whether it’s the health authority and it’s going through the admittance or to discharge...’

TABLE 1 Participants’ details

| Focus group (each group based in a separate care home) | Participant (Participants in each focus group based in the same care home) | Role |
|-------------------------------------------------------|--------------------------------------------------------------------------|------|
| 1                                                     | A1 Manager                                                               |      |
|                                                       | A2 Deputy manager                                                        |      |
|                                                       | A3 Chef                                                                  |      |
| 2                                                     | B1 Manager                                                               |      |
|                                                       | B2 RN                                                                    |      |
|                                                       | B3 Chef                                                                  |      |
| 3                                                     | W1 RN                                                                    |      |
|                                                       | W2 Student nurse                                                         |      |
| 4                                                     | D1 Manager                                                               |      |
|                                                       | D2 RN                                                                    |      |
|                                                       | D3 RMN                                                                   |      |
|                                                       | D4 Chef                                                                  |      |
|                                                       | D5 Healthcare assistant                                                 |      |
| 5                                                     | S1 Manager                                                               |      |
|                                                       | S2 RN                                                                    |      |
|                                                       | S3 RMN                                                                   |      |
|                                                       | S4 Chef                                                                  |      |
|                                                       | S5 Healthcare assistant                                                 |      |
|                                                       | S6 Student nurse                                                         |      |
| 6                                                     | P1 Manager                                                               |      |
|                                                       | P2 Healthcare assistant                                                 |      |
|                                                       | P3 Healthcare assistant                                                 |      |
|                                                       | P4 RN                                                                    |      |
|                                                       | P5 RN                                                                    |      |
|                                                       | P6 Chef                                                                  |      |
| 7                                                     | R1 Manager                                                               |      |
|                                                       | R2 RN                                                                    |      |
|                                                       | R3 RN                                                                    |      |
|                                                       | R4 RN                                                                    |      |
|                                                       | R5 Older person specialist nurse                                         |      |
|                                                       | R6 Older person specialist nurse                                         |      |
|                                                       | R7 Healthcare assistant                                                 |      |
|                                                       | R8 Chef                                                                  |      |
would impact on safety in the event of an evacuation: staircases
to take them in because it’s not fair. Bringing somebody in, then
to intense/complex care needs (Royal College of Occupational
The health/safety concerns raised are noteworthy, as is the ac-
accommodate larger wheel chairs. Other participants recognised the need
for a review of where older residents with obesity were situated
within the care home to take better account of/facilitate emergency
evacuation:

P1 (Manager): ‘I think you’d have to keep those people [with obe-
sity] on the middle floor where the evacuation is [held]’.

Participants also recognised how this challenge had recently
been met, but emphasised that this required changes to the way care
homes are constructed:

D1 (Manager): ‘Newer buildings that are purposely built have
patio doors out onto garden areas that are all very flat’.

3.2 | Facilitators to care home admittance for older
residents with obesity

Participants’ responses indicated that facilitating PCC in care homes
relied on access/availability of three key types of resources/facili-
ties: (a) Building design and environment (b) Equipment and furniture
(c) Staffing.

3.2.1 | Building design and environment

A number of participants proposed that care home buildings, par-
ticularly those built in previous decades, were not designed for car-
ing for residents with levels of morbid obesity (BMI ≥35) and that
this was an emergent issue which needs to be recognised:

B2 (RN): ‘Who could’ve predicted 20 years ago we were going to
have an obesity epidemic where we’re going to need bigger rooms,
more equipment?…No one was to foresee that’.

Many participants noted that building/environmental design
represented a key factor when making decisions about whether PCC
could be met:

W1 (RN): ‘…the doors aren’t deemed to be wide enough. The
beds…would have to be assembled in the bedrooms…to get special-
ist equipment through those doors – it wouldn’t happen’.

Where people with obesity were admitted, this necessitated
wholesale adjustment to normal moving/handling procedures to
overcome care homes’ building/design limitations and achieve PCC:

R2 (RN): ‘There’s a problem with the width of the doors…this lady
had a bariatric wheelchair, but it wouldn’t actually fit through the
door…they had to hoist her out of the bedroom into the corridor
before they could put her into the chair’.

Participants also indicated that the requirement for bariatric
equipment impacted on residents’ personal space-limiting accom-
modation of personal furniture/items. This hindered opportunities
to personalise residents’ rooms, impacting on residents’ quality of
life and made implementation of PCC problematic:

S1 (Manager): ‘While it’s lovely to have everything from home,
we cannot keep it in there because we haven’t got room to get the
hoist in. Or… “my Dad wants to sit beside the window so he can see
out”… Well, actually, that’s no good because we can’t get the hoist
over there’.

Environmental considerations were important to participants;
however so too were safety requirements, for example, some par-
ticipants expressed concern that caring for residents with obesity
would impact on safety in the event of an evacuation: staircases
too narrow and lifts unusable because they could not accommo-
date larger wheel chairs. Other participants recognised the need
for a review of where older residents with obesity were situated
within the care home to take better account of/facilitate emergency
evacuation:

P1 (Manager): ‘I think you’d have to keep those people [with obe-
sity] on the middle floor where the evacuation is [held]’.

Participants also recognised how this challenge had recently
been met, but emphasised that this required changes to the way care
homes are constructed:

D1 (Manager): ‘Newer buildings that are purposely built have
patio doors out onto garden areas that are all very flat’.

3.2.2 | Equipment and furniture

Many participants reported moving/handling equipment used in
their homes was not adequate to support care needs of residents
with extreme obesity levels (BMI ≥40) who have limited mobility. Some suggested that this was a barrier to admittance.

A1 (Manager): ‘If somebody came and I assessed somebody
and weighed them and our equipment wouldn't handle them, then
I wouldn't be able to take them in because we couldn't meet their
needs’.

Some participants proposed that they do not admit older peo-
ple with obesity to avoid a situation where residents become settled
in the care home, only to subsequently require transfer elsewhere.
These decisions were based on care homes’ perceptions that there
was a high risk associated with people with obesity regarding care
homes’ ability to meet their needs. They felt insufficiently equipped
to provide PCC to this population group. Moreover, staff were con-
cerned that this might culminate in older people with obesity being
excluded:

A1 (Manager): ‘So...if I had anyone over the mark...I wouldn’t be able
to take them in because it’s not fair. Bringing somebody in, then
having to move them on...it’s a massive change coming into a care
home anyway. Rather than bringing somebody in and then saying,
“sorry, you have to leave because we cannot manage you.” It’s just
not fair on anybody’.

In England, specialist equipment provided for care home res-
idents requiring the 24-hr care of registered nurses is funded by the
care provider, unless residents require ‘continuing care’ due
to intense/complex care needs (Royal College of Occupational
Therapists, 2019). Residents who do not require 24-hr nursing care
have their income means tested with the outcome determin-
ing whether residents or the local authority fund their specialist
equipment (Cromarty, 2018). Most participants indicated that the
cost of buying specialist bariatric furniture/equipment presents
a financial challenge for care homes offering 24-hr nursing care,
restricting care homes’ capacity to deliver PCC to older people with obesity.

P1 (Manager): ‘We have to have special beds, mattresses, everything...that’s a huge cost. Special chairs—that’s an extra cost...it’s equipment really...£3,000 a mattress...£4,000 for a bariatric bed...we’ve got one [resident with obesity], but we wouldn’t be allowed another one...we might have to decline...because of the cost’.

3.2.3 | Staffing

Most participants proposed that more staff would be required to accommodate additional needs of residents with obesity/deliver effective and safe PCC:

W1 (RN): ‘Obviously, from a health and safety perspective, you do need...maybe two extra people – just to make it safe for the individual’.

Some participants suggested that clinical care activities can also be challenging when caring for residents with extreme obesity because of the requirement for extra staff/time to manoeuvre/support residents’ limbs – ensuring that care upholds residents’ dignity and residents feel reassured:

W2 (Student nurse): ‘A procedure like a catheterisation is a lot more complicated when somebody is obese’.

W1 (RN): ‘To get someone safely up because their legs have gone...and they can’t stand again – we’ve had to actually stand on the back of the toilet because it’s the only place they can lean to actually get leverage’.

Many participants suggested that caring for residents with obesity is more than usually physically demanding/time-consuming:

P1 (Manager): ‘And it’s heavy on the staff when you think about all the moving and handling’.

S5 (Care Asst): ‘It’s heavy, and it’s time-consuming’.

Some participants underlined the importance of ensuring sufficient staffing levels to evacuate residents with obesity in an emergency:

P1 (Manager): ‘We’ve got the special evacuation slide mats. But it would take [extra] staff to get [residents with obesity] down because you would have to keep a hold...It’s getting them downstairs...the amount of people we would have to pull’.

Some manager participants struggled to admit residents with morbid obesity (BMI ≥35) because of the potential cost of providing extra staff to support them. For residents requiring 24-hr nursing care, unless they are eligible for continuing care, care providers are responsible for funding extra resources. Many manager participants stated that their employers could not afford to fund extra staff and that other funding bodies were reluctant to fund additional staff:

S1 (Manager): ‘So, if they’re not going to fund extra carers, I can’t afford to put them in’.

Supporting residents with obesity requiring transfer to hospital also required extra external staff/equipment/resources. Participants suggested that this has both financial cost and timing-of-care implications because services need to be coordinated in a timely manner to ensure that extra ambulance staff are available:

D1 (Manager): ‘We have to ring the ambulance crew. And tell them two crews [are required]’.

4 | DISCUSSION

This article explored staff’s views/experiences of the prevalence of obesity in care homes, and challenges/facilitators associated with any rise in applications for placements. Respondents noted recent rises in applications by older people with obesity; however, it is not possible to draw conclusions from a qualitative study based in one region of England. Locating precise data on prevalence of obesity in care homes is difficult to obtain, as there is no requirement by care homes to record data on numbers of older people with obesity who are turned away. Given the currently high rates of obesity among older people in England (35% prevalence: adults aged 55–74; 26%: adults aged 75+) (Conolly et al., 2019), it seems probable the numbers who will apply for care home admittance will rise. This prediction is given credence by recent policy changes among some care homes in England to ensure that new-build care homes include construction of specialist bariatric rooms (Carehome.UK, 2014). In view of the far-reaching implications for care homes of rises in obesity in older people which this article discusses, it is important that data are recorded on both the numbers of older people with obesity who apply for admittance to care homes and numbers whose applications are accepted. Accurate measures of the scale of this phenomenon is critical to ensure that care providers/health/social care authorities’ response is proportionate to demand and appropriate to meet the bespoke needs of this population group. This also requires the development of a clearer understanding of these clients’ needs. However, Harris and Castle (2019) concluded that limited evidence exists regarding the complex challenges of obesity in care homes, warranting further investigation of this emergent issue.

Participants in our study were keen to emphasise all care home clients’ entitlement to receive the same high standard of PCC. There is consensus that PCC equates with bespoke quality care (Royal College of Nursing [RCN], 2009) achieved by treating the patient as a unique individual (Redman, 2004) and promoting a high level of care that puts people at the centre (Manley et al., 2011). Staff in this study strove to maintain these principles, recognising PCC as a hallmark of good practice. However, they also expressed concern that while older people with obesity often required tailored care, achieving this in practice presented three principal challenges which staff felt conflicted about: (a) the appropriateness of building design and environment, (b) accessibility and affordability of equipment and furniture and (c) level of staffing. According to staff’s own views, these challenges in particular hindered care homes’ ability to provide PCC to people with obesity. These broad categories are similar to those previously reported by US studies (e.g. Felix et al., 2016); however, a paucity of information exists regarding their impact on PCC in care homes in England.
Building and environmental design were identified challenges. The majority of participants in our study indicated that care homes lacked adequate space. Furthermore, that design was inappropriate for accommodating specialist equipment/furnishings required to support the care of residents with obesity. In addition, participants voiced concerns that they were restricted trying to honour residents’ personal preferences, for example, letting residents choose window views or furnishing personal spaces to make them more homely. A potential issue is minimum single-room size in care homes in England is dictated by regulations laid down almost twenty years ago (DOH [Department of Health], 2003) that stipulate 12 m² (excluding bathroom). This represents relatively limited space for people with obesity to live comfortably, and staff to work safely, and contrasts with minimum room size regulations in other countries, for example, some regions in Austria, where room dimensions for all residents are double this size (Nies et al., 2013). Policy in England dictating minimum room size may be outdated, requiring revision to take account of any rise in the number of older people with obesity and their potentially higher demand for care home placements. Policy change is also necessary to comply with current care home building regulations for new care homes, requiring care providers to account for accessibility (Croner-i, 2019). Dutta et al. (2018) propose that achieving comfortable/homely/safe/functional environments for residents with obesity would necessitate ‘complete architectural overhauls’ (p. 188). According to Gray and MacDonald (2016), renovating existing structures seems the most likely short-term solution, alongside changes to long-term planning to ensure that new builds are specifically designed to accommodate older people with obesity. However, any renovation to ensure space and safety for residents with obesity, as well as for the staff, remains problematic due to the costs involved (Shield et al., 2014).

Participants further suggested that care homes might find it difficult to justify the significant additional costs associated with purchase of specialist equipment to meet the bespoke needs of older people with obesity. Costing analysis by Dutta et al. (2018) (see Appendix S1B) reported that most commonly equipment to help manage residents with obesity: bariatric beds/wheelchairs/trolleys/weighing scales/specialised air mattresses/overhead lifts/slings/hoists, when combined with the necessity for larger bathrooms make the estimated cost of accommodating residents with extreme obesity £38,000(+) per resident. In circumstances where the care home sector is dominated by for-profit providers (corporates and small businesses combined) whose business models rely on competitive, financialised practices (Burns et al., 2016) and where such business models are far from unique to England, care homes may more widely struggle to access this additional level of funding. Strategic and systemic reforms, including exploration of new ways of funding care of older people, may be required to ensure future provision of PCC in care homes for all who need it.

An additional challenge to care homes’ ability to provide PCC care for older people with obesity is staffing. This study found that staff increases may be necessary, for example, to support mobilisation. Some participants also suggested that clinical care activities can be challenging and sometimes difficult to carry out in ways that respected and upheld residents’ dignity and made residents feel reassured. Recruitment may also need to focus on staff who specialise in care for older people with obesity, for example, carrying out clinical activities such as catheterisation. The need to increase staffing levels in care homes represents a challenge likely to be commonplace given that even small increases in BMI from ‘normal weight’ (18.5 ≤ BMI < 25) may lead to the requirement of two-person, rather than single staff assistance (Harris et al., 2018). In general, care needs tend to increase as BMI increases (Apelt et al., 2012) and Kosar et al. (2018) noted how a higher level of obesity is associated with intensive personal care assistance in nursing homes. A related issue concerns how care homes augment staffing levels to ensure the safe practice and excellence that is fundamental to PCC (Ross et al., 2015), for example, some participants highlighted the important need to ensure sufficient staffing levels to evacuate residents with obesity in an emergency. Our study found that additional staffing/enhanced skills may also be an issue that needs to be addressed by external agencies, for example, facilitating ambulance crews’ transfer of older people with obesity to hospital. Ultimately, bespoke care of older people with obesity in residential care is likely to require more intensive staffing (Harris et al., 2018).

Despite this, participants in our study reported concerns regarding care homes’ capacity to increase their workforce. This represents a more widespread challenge, as care homes currently face an international trend for high attrition rates for direct care workers and providers struggle to attract/retain registered nursing staff (McGilton et al., 2014).

McGilton et al. (2014) suggest that part of the problem with recruitment is that long-term care policy in relation to staffing has failed to respond to a demographic shift that has seen increases in the numbers of people with complex medical conditions currently seeking care home placement. There may also be the need to investigate more specifically how this demographic shift is impacting (a) on numbers of people who not only have complex health conditions but also obesity as a contributory/exacerbating factor (b) on numbers of older people with obesity seeking care home placements. While older people with obesity are recognised as an ‘at risk’ population with potentially urgent health care needs (Elagizi et al., 2018), how these needs can be met by care homes has largely been overlooked. Urgency to address this deficiency is also driven by the fact that in England, as well as the wider context of Europe, current health/social care policy favours promotion of domiciliary care, rather than residential/institutionalised care (Deusdad et al., 2016). While such policies may be well intentioned (Spasova et al., 2018), there is nonetheless the danger that these will lead to inevitable declines in provision of residential institutions at a time when demand may be increasing, including for bespoke PCC care for people with complex health conditions made more complex by obesity (Rosin, 2008). In the UK, health and social care policy continues to remain resolutely focused on the health risks associated with non-obese older people and their weight loss (Public Health Agency, 2014). It is important...
that this bias does not detract from the increasing need to support older people with obesity (Thompson et al., 2020) and ensure that they have the same level of access and entitlement to bespoke PCC within care homes as non-obese people.

While this study highlights some of the principal challenges care homes face in providing bespoke PCC, particularly the additional costs likely to be incurred to address present deficiencies in building design/environment, improve accessibility/affordability of equipment/furniture and augment levels of staffing – as well as how current health/social care policy adds to these challenges – it needs to be borne in mind that people with obesity have more hospitalisations (Han et al., 2009) and longer lengths of stay relative to people without obesity (Schafer & Ferraro, 2007). This can lead to chronic deterioration of patients’ functional status (Tarride et al., 2012) and exert a cumulative impact with further, future hospital admissions and longer subsequent durations of stay (Schafer & Ferraro, 2007) that combine to make hospitalisation, as a main alternative to care home admittance, not only very costly (Tarride et al., 2012) but also inappropriate.

Finally, despite high awareness among care home staff of the challenges in providing bespoke PCC care to older people with obesity and staff’s best efforts to overcome these, participants in our study expressed concern at the reticence at a higher corporate level to acknowledge obesity as an important issue. This raises the fundamental issue of who will take responsibility for the care of older people with obesity. Arguably, this leads to a broader issue that lies beyond the scope of this study concerning not only how the issues raised here are addressed by care home providers, but at a macro level, how they will be tackled by health/social care providers and governments. Discourse should focus on the best ways to manage long-term health of older people with obesity and prolong their quality of life. While focus may often be on how nurses/carers can achieve best practice in terms of caring for people with obesity, this places the onus of responsibility on staff and possibly overlooks the crucial question of how policy can be drawn up and systems designed/funded to support staff to deliver high-quality PCC.

4.1 | Recommendations

Given the continuing/widespread trend towards rising prevalence of obesity in older people, there is a need to more carefully/accurately record both the numbers of older people with obesity who apply for admittance to care homes and numbers whose applications are accepted. This is required to assess the true scale of this phenomenon in different regions and ensure a commensurate response that includes adequate care home provision locally for older people with obesity applying for admittance.

There is also a need to re-examine guidance on the use of PCC strategies for the management of obesity that also takes account of the three principal facilitators of PCC presented here. Additionally, there is a much broader need which extends beyond the scope of this study to examine the crucial question of how policy can be drawn up and systems designed/funded to support staff to deliver high-quality PCC in care homes – particularly given the disadvantages, both economically and on health grounds, over hospitalisation as a main alternative to residential care.

4.2 | Strengths of this study

• Preliminary guidance on how PCC strategies to manage obesity can be facilitated by addressing three principal challenges.

• The need is highlighted for recording of both the numbers of older people with obesity who apply for admittance to care homes and numbers whose applications are accepted to accurately assess local needs regarding care home provision/access.

• Given the continuing/widespread trend towards rising prevalence of obesity in older people more globally, the findings have broader translational potential.

4.3 | Limitations of this study

• Findings based upon the responses of a small number of care home staff located in one region of England. Further research is required to consider the views/experiences of potential and actual care home residents with obesity.

• Future research is required to move beyond this exploratory study to examine more comprehensively how policy can be drawn up/systems designed/funded to support staff to deliver high-quality PCC in care homes.

• Future research is required to consider the patient/cost–benefit analysis of facilitating good-quality care in care homes for older people with obesity against the patient/costs associated with their long-term hospital placement.

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CONFLICT OF INTEREST

There are no conflicts of interest presented by this paper by any of the authors.

AUTHOR CONTRIBUTIONS

MP reviewed the full texts, assessed the risk of bias, conducted data collection, extracted the data and wrote the manuscript. JT conducted data collection, contributed to the analysis, critically reviewed the content of the manuscript and contributed to revision/submission of the manuscript. All authors have approved the submitted version of the manuscript.
REFERENCES

Apelt, G., Ellert, S., Kuhlmeier, A., & Garms-Homolova, V. (2012). Temporal and structural differences in the care of obese and non-obese people in nursing homes. Pflege, 25(4), 271–283.

Bradway, C., Miller, E., Heivy, A., & Fleschner, I. (2010). Continence care for obese nursing home residents. Urology Nursing, 30(2), 121–129.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Burns, D., Cowie, L., Earle, J., Folkman, P., Froud, J., Hyde, P., Johal, S., Jones, I. R., Killett, A., & Williams, K. (2016). Where does the money go? Financialised chains and the crisis in residential care. Centre for Research on Socio-Cultural Change (CRESC) Public Interest Report. http://hummedia.manchester.ac.uk/institutes/crest/research/WDTMG%20FINAL%20-01-3-2016.pdf

Carehome.UK. (2014). Growing number of care homes developing specialist bariatric rooms for obese people. https://www.carehome.co.uk/news/article.cfm/id/1565071/growing-number-care-homes-bariatric-rooms-obese

Chou, C. H., Wang, C. L., & Wu, Y. T. (2012). Effect of exercise on physical function, daily living activities, and quality of life in the frail older adults: A meta-analysis. Archives of Physical Medicine and Rehabilitation, 93(2), 237–244.

Conolly, A., Craig, S., & Gebert, S. (2019). Health Survey for England 2018 obesity and overweight in adults and children. Health and Social Care Information Centre.

Cromarty, H. (2018). Adult social care funding (England): Briefing paper CBP07903. House of Commons Library. https://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf

Croner-i. (2019). Construction safety in care homes: In-depth. https://app.croneri.co/topics/construction-safety-care-homes/indep th?product=137

Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process. Sage.

Davies, S. L., Goodman, C., Manthorpe, J., Smith, A., Carrick, N., & Iliiffe, S. (2014). Enabling research in care homes: An evaluation of a national network of research ready care homes. BMC Medical Research Methodology, 14(1), 47.

Deusdad, B. A., Pace, C., & Anttonen, A. (2016). Facing the challenges in the development of long-term care for older people in Europe in the context of an economic crisis. Journal of Social Service Research, 42(2), 144–150.

Dewar, S., & Wilding, J. P. (2003). Obesity and type-2 diabetes in the elderly. Gerontology, 49(3), 137–145.

DOH (Department of Health). (2003). Care homes for older people: National minimum standards care homes regulations (3rd ed.). Stationery Office.

Dutta, S., Jain, K., & Siddharth, V. (2018). Retrofitting healthcare facilities for bariatric patients: A cost analysis study in a public sector hospital of a developing country. Bariatric Surgical Practice and Patient Care, 13(4), 185–189.

Elagizi, A., Kachur, S., Lavie, C. J., Carbone, S., Pandey, A., Ortega, F. B., & Milani, R. V. (2018). An overview and update on obesity and the obesity paradox in cardiovascular diseases. Progress in Cardiovascular Diseases, 61(2), 142–150.

Felix, H. C., Bradway, C., Ali, M. M., & Li, X. (2016). Nursing home perspectives on the admission of morbidly obese patients from hospitals to nursing homes. Journal of Applied Gerontology, 35(3), 286–302.

Felix, H. C., Bradway, C., Chisholm, L., Pradhan, R., & Weeck-Maldonado, R. (2015). Prevalence of moderate to severe obesity among US nursing home residents, 2000–2010. Research in Gerontological Nursing, 8(4), 173–178.

Felix, H. C., Bradway, C., Miller, E., Heivy, A., Fleschner, I., & Powell, L. S. (2009). Staff time and estimated labor cost to bathe obese nursing home residents: A case report. Obesity and Nursing Home Working Paper Series, (1).

Felix, H. C., Bradway, C., Miller, E., Heivy, A., Fleschner, I., & Powell, L. S. (2010). Obese nursing home residents: A call to research action. Journal of the American Geriatrics Society, 58(6), 1196–1197.

Fisher, S. R., Goodwin, J. S., Protas, E. J., Kuo, Y. F., Graham, J. E., Ottenbacher, K. J., & Ostir, G. V. (2011). Ambulatory activity of older adults hospitalized with acute medical illness. Journal of the American Geriatrics Society, 59(1), 91–95.

Freising, H., Arnold, M., Soerjomataram, I., O’Doherty, M. G., Ordóñez-Mena, J. M., Bania, C., Kampman, E., Leitzmann, M., Romieu, I., Kee, F., Tsilidis, K., Tjønneland, A., Trichopoulou, A., Boffetta, P., Benetou, V., Bueno-de-Mesquita, H. B. A., Huerta, J. M., Brenner, H., Wilsgaard, T., & Jenab, M. (2017). Comparison of general obesity and measures of body fat distribution in older adults in relation to cancer risk: Meta-analysis of individual participant data of seven prospective cohorts in Europe. British Journal of Cancer, 116(11), 1486–1497.

Giuli, C., Papa, R., Bevilacqua, R., Felici, E., Gagliardi, C., Marcellini, F., Boscarn, M., De Robertis, M., Mocchegiani, E., Falloia, E., & Tirabassi, G. (2014). Correlates of perceived health related quality of life in obese, overweight and normal weight older adults: An observational study, BMC Public Health, 14(1), 35.

Goodpasture, B. H., Krishnaswami, S., Harris, T. B., Katsiaras, A., Kritchevsky, S. B., Simonsick, E. M., Nevitt, M., Holvoet, P., & Newman, A. B. (2005). Obesity, regional body fat distribution, and the metabolic syndrome in older men and women. Archives of Internal Medicine, 165(7), 777–783.

Gray, L., & MacDonald, C. (2016). Morbid obesity in disasters: Bringing the “Conspicuously invisible” into focus. International Journal of Environmental Research and Public Health, 13(10), 1029.

Han, E., Truesdale, K. P., Taber, D. R., Cai, J., Juhaeri, J., & Stevens, J. (2009). Impact of overweight and obesity on hospitalization: Race and gender differences. International Journal of Obesity, 33(2), 249–256.

Harris, J. A., & Castle, N. G. (2019). Obesity and nursing home care in the United States: a systematic review. The Gerontologist, 59(3), e196–e206.

Harris, J. A., Engberg, J., & Castle, N. G. (2018). Obesity and intensive staffing needs of nursing home residents. Geriatric Nursing, 39(6), 696–701.

Harris-Kojetin, L., Sengupta, M., Park-Lee, E., Valverde, R., Caffrey, C., Rome, V., & Londond, J. (2016). Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. Vital & Health Statistics. Series 3, Analytical and Epidemiological Studies, (38), x–xii.

Institute for Health Metrics and Evaluation. (2017). Global Burden of Disease Study 2015: Global obesity and overweight prevalence 1980–2015. IHME.

Jaacks, L. (2017). Global trends in adult body mass index (BMI). SOURCES: NCD-RisC, 2017. Worldwide trends in body-mass index, overweight, obesity, and from 1975 to 2016: A pooled analysis of 2416 population-based measurement studies in 289.9 million children, adolescents, and adults. The Lancet, 390(10113), 2627–2642.
Kfang, E., Kassim, G., Soffer, S., Freeman, R., Levin, M., & Reich, D. (2020). Severe obesity as an independent factor for COVID-19 mortality in hospitalized patients younger than fifty. *Obesity, 28*(9), 1595–1599.

Kosar, C. M., Kosh, K. S., Gozalo, P. L., & Mor, V. (2018). Higher level of obesity is associated with intensive personal care assistance in the nursing home. *Journal of the American Medical Directors Association, 19*(11), 1015–1019.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research*. Sage.

Manley, K., Hills, V., & Marriott, S. (2011). Person-centred care: Principle of nursing practice *Nursing Standard, 25*(31), 35–38.

Marilant, C. L., Brunt, A. R., & Geraci, A. A. (2015). The high price of obesity in nursing homes. *Care Management Journals, 16*(1), 14–19.

McGilton, K. S., Boscart, V. M., Brown, M., & Bowers, B. (2014). Making tradeoffs between the reasons to leave and reasons to stay employed in long-term care homes: Perspectives of licensed nursing staff. *International Journal of Nursing Studies, 51*(6), 917–926.

Miles, J., Anderson, D. P., Engelke, M., Kirkpatrick, M. K., Porjes, M. L., Waters, W. G., Watkins, F. R., Pokorny, M. E., & Rose, M. A. (2012). Barriers to transition of obese patients from hospital to community. *The American Journal of Managed Care, 18*(6), e234–e237.

NHS Digital. (2020). *Statistics on obesity, physical activity and diet, England, 2020*. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet-england-2020/part-3-adult-obesity-copy

Nies, H., van der Veen, R., & Leichsenring, K. (2013). Quality measurement & improvement in long-term care in Europe. In *A good life in old age? Monitoring and improving quality long-term care* (p. 229). OECD Health Policy Studies. OECD Publishing.

Peralta, M., Ramos, M., Lipert, A., Martins, J., & Marques, A. (2018). Prevalence and trends of overweight and obesity in older adults from 10 European countries from 2005 to 2013. *Scandinavian Journal of Public Health, 46*(5), 522–529.

Popejoy, L. L., Galambos, C., Moyal, K., & Madsen, R. (2012). Challenges to hospital discharge planning for older adults. *Clinical Nursing Research, 21*(4), 431–449.

Public Health Agency. (2014). *Nutritional guidelines & menu checklist for residential & nursing homes*. http://www.efad.org/media/1351/nutritional_guidelines_and_menu_checklist_march_2014.pdf

Redman, R. W. (2004). Patient-centered care: An unattainable ideal? *Research and Theory for Nursing Practice, 18*(1), 11–14. https://doi.org/10.1891/rtnp.18.1.11.28057

Redón, J., Cea-Calvo, L., Moreno, B., Monereo, S., Gil-Guillén, V., Lozano, J. V., Martí-Canal, J. C., Listerri, J. L., Aznar, J., Fernández-Pérez, C., & Investigators of the PREV-ICTUS Study. (2008). Independent impact of obesity and fat distribution in hypertension prevalence and control in the elderly. *Journal of Hypertension, 26*(9), 1757–1764.

Richardson, C. A., & Rabiee, F. (2001). ‘A Question of Access’ – An exploration of the factors influencing the health of young males aged 15–19 living in Corby and their use of health care services. *Health Education Journal, 60*, 3–6.

Rose, M. A., Baker, G., Drake, D. J., Engelke, M., McAuliffe, M., Pokorny, M., Pozzuto, S., Swanson, M., Waters, W., & Watkins, F. (2007). A comparison of nurse staffing requirements for the care of morbidly obese and non-obese patients in the acute care setting. *Bariatric Nursing and Surgical Patient Care, 2*(1), 53–56.

Rosin, O. (2008). The economic causes of obesity: A survey. *Journal of Economic Surveys, 22*(4), 617–647.

Ross, H., Tod, A. M., & Clarke, A. (2015). Understanding and achieving person-centred care: The nurse perspective. *Journal of Clinical Nursing, 24*(9–10), 1223–1233.

Royal College of Nursing (RCN). (2009). *Measuring for quality in health and social care: An RCN position statement*. Royal College of Nursing.

Royal College of Occupational Therapists. (2019). *Care homes and equipment: Guiding principles for assessment and provision*. Royal College of Occupational Therapists Press.

Russell, C., & Ella, M. (2015). *Nutrition screening surveys in care homes in the UK*. BAPEN (The British Association for Parenteral and Enteral Nutrition). https://www.bapen.org.uk/pdfs/nsw/care-homes/care-homes-uk.pdf

Schafer, M. H., & Ferraro, K. F. (2007). Obesity and hospitalization over the adult life course: Does duration of exposure increase use? *Journal of Health and Social Behavior, 48*(4), 434–449.

Shield, R. R., Tyler, D., Lepore, M., Loosie, J., & Miller, S. C. (2014). “Would you do that in your home?” Making nursing homes home-like in culture change implementation. *Journal of Housing for the Elderly, 28*(4), 383–398.

Silverwood, V., Blagojevic-Bucknall, M., Jinks, C., Jordan, J. L., Protheroe, J., & Jordan, K. P. (2015). Current evidence on risk factors for knee osteoarthritis in older adults: A systematic review and meta-analysis. *Osteoarthritis and Cartilage, 23*(4), 507–515.

Saposka, S., Baeten, R., & Vanhercke, B. (2018). Challenges in long-term care in Europe. *Eurohealth, 24*(4), 7–12.

Tarride, J. E., Haq, M., Taylor, V. H., Sharma, A. M., Nakhai-Pour, H. R., O’Reilly, D., Xie, F., Dolovich, L., & Goeree, R. (2012). Health status, hospitalizations, day procedures, and physician costs associated with body mass index (BMI) levels in Ontario, Canada. *ClinicoEconomics and Outcomes Research (CEOR), 4*, 21. https://doi.org/10.2147/CEOR.S24192

Thomas, L., MacMillan, J., McColl, E., Hale, C., & Bond, S. (1995). Comparison of focus group and individual interview methodology in examining patient satisfaction with nursing care. *Social Sciences in Health, 1*, 206–220.

Thompson, J., Parkinson, M., & Collery, R. (2020). Care home staff’s experiences and views of supporting the dietary management and choices of older residents with obesity. *International Journal of Older People Nursing, 15*(4), e12343. https://doi.org/10.1111/ijopn.12343

Tsigos, C., Hainer, V., Basdevant, A., Finer, N., Fried, M., Mathus-Vliegen, E., Micic, D., Maislos, M., Roman, G., Schutz, Y., Toplak, H., & Zahorska-Markiewicz, B. (2008). Management of obesity in adults: European clinical practice guidelines. *Obesity Facts-The European Journal of Obesity, 1*(2), 106–116. https://doi.org/10.1159/000126822

Valentini, L., Schindler, K., Schlafter, R., Bucher, H., Mouhieddine, M., Steiningher, K., Tripamer, J., Handschuh, M., Schuh, C., Volkert, D., Locsh, H., Sieber, C. C., & Hiesmayr, M. (2009). The first ‘nutritionDay’ in nursing homes: Participation may improve malnutrition awareness. *Clinical Nutrition, 28*(2), 109–116.

Veronese, N., Cereda, E., Solmi, M., Fowler, S. A., Manzato, E., Maggi, S., Manu, P., Abe, E., Hayashi, K., Allard, J. P., Arentd, B. M., Beck, A., Chan, M., Audrey, Y. J., Lin, W. Y., Hsu, S. H., Lin, C. C., Diekmann, R., Kimyagarov, S., ... Correll, C. U. (2015). Inverse relationship between body mass index and mortality in older nursing home residents: A meta-analysis of 19,538 elderly subjects. *Obesity Reviews, 16*(11), 1001–1015.

Villareal, D. T., Banks, M., Siener, C., Sinacore, D. R., & Klein, S. (2004). Physical frailty and body composition in obese elderly men and women. *Obesity Research, 12*(6), 913–920.

Villareal, D. T., Miller, B. V., III, Banks, M., Fontana, L., Sinacore, D. R., & Klein, S. (2006). Effect of lifestyle intervention on metabolic coronary heart disease risk factors in obese older adults. *The American Journal of Clinical Nutrition, 84*(6), 1317–1323.

Wildman, R. P., Mackey, R. H., Bostom, A., Thompson, T., & Sutton-Tyrrell, K. (2003). Measures of obesity are associated with vascular stiffness in young and older adults. *Hypertension, 42*(4), 468–473.

Zhang, Y. S., Saito, Y., & Crimmins, E. M. (2019). Changing impact of obesity on active life expectancy of older Americans. *The Journal of Gerontology: Series A, 74*(12), 1944–1951.
Zizza, C. A., Herring, A., Stevens, J., & Popkin, B. M. (2002). Obesity affects nursing-care facility admission among whites but not blacks. Obesity Research, 10(8), 816–823.

SUPPORTING INFORMATION
Additional supporting information may be found online in the Supporting Information section.

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