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An exploration of the challenges of providing person-centred care for older care home residents with obesity

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Abstract

The aim of this study was to explore care home staff's views on the prevalence of obesity in older people and how well prepared they were for any rise in applications for placements. Thematic analysis was used to analyse focus group interview data collected from seven care homes/33 participants in N.E. England. Findings revealed rises in demand by older people with obesity for care home admittance, consistent with rising prevalence of obesity in this demographic nationally. Findings also highlight implications of rising prevalence of obesity in older people, particularly care home staff's ability to deliver person-centred care (PCC) and the importance of appropriate support/recognition of this as an emergent issue to be addressed at a higher executive level and by health/social care authorities. Ways of ensuring PCC are discussed. Given continuing trends towards rising prevalence of obesity in this population, the findings possess broader translational potential.

KEYWORDS

care homes, challenges and facilitators, obesity prevalence, older age, person-centred care

1 | 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

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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'

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

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

processes – obesity is never acknowledged by anyone...acknowledgement that it's there and that the problem's not going to go away, but to increase needs to be recognised'.

S3 (RMN): 'There needs to be consideration of a different way of management for that person. Greater acknowledgement and support'.

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/facilities: (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, particularly those built in previous decades, were not designed for caring 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 specialist 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 accommodation 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 participants 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 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 obesity] 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'.

The health/safety concerns raised are noteworthy, as is the accompanying need for greater recognition of how outmoded building design/environment potentially impacts on care homes' ability to provide PCC for older people with obesity.

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 people 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 concerned 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 residents 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 determining 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' ($18.5 \leq \text{BMI} < 25$) 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 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.

DATA AVAILABILITY STATEMENT

The data sets generated during and/or analysed during the current study are available from the corresponding author on reasonable request.

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SUPPORTING INFORMATION

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

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