Descriptive title. Exploring staff perceptions and experiences of volunteers and visitors on the hospital ward at mealtimes using an ethnographic approach

Concise title. Volunteers and visitors at mealtimes

Author names, qualifications, affiliations and mailing addresses.

Ella OTTREY BNutrDietet, BNut(Hons)^{1,2}

Claire PALERMO BSc, MNutDiet, PhD¹

Catherine E. HUGGINS BSc(Hons), PhD¹

Judi PORTER BAppSc, MHthSc, PhD^{1,3}

1. Department of Nutrition, Dietetics and Food, Monash University, Level 1, 264 Ferntree Gully Road, Notting Hill, Victoria 3168, Australia
2. Dietetics Department, Eastern Health, 5 Arnold Street, Box Hill, Victoria 3128, Australia
3. Allied Health Clinical Research Office, Eastern Health, 5 Arnold Street, Box Hill, Victoria 3128, Australia

Email addresses, contact telephone numbers and twitter usernames.

Ella Ottrey (corresponding author), ella.ottrey@monash.edu, +61 3 9902 4270

Claire Palermo, claire.palermo@monash.edu, +61 3 9902 4270, @ClairePalermo

Catherine Huggins, kate.huggins@monash.edu, +61 3 9902 4270

Judi Porter, judi.porter@monash.edu, +61 3 9902 4270, @JudiPorter_

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- 2) drafting the article or revising it critically for important intellectual content and
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MRS. ELLA OTTREY (Orcid ID : 0000-0002-2979-548X)

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DESCRIPTIVE TITLE

Exploring staff perceptions and experiences of volunteers and visitors on the hospital ward at mealtimes using an ethnographic approach

CONCISE TITLE

Volunteers and visitors at mealtimes

ABSTRACT

Aims. To explore multiple perspectives and experiences of volunteer and visitor involvement and interactions at hospital mealtimes. In addition, to understand how the volunteer and visitor role at mealtimes is perceived within the hospital system.

Background. Mealtime assistance can improve patients' food intake and mealtime experience. Barriers to providing mealtime assistance include time pressures, staff availability and inadequate communication. Volunteers and visitors can encourage and assist patients at mealtimes. There is a lack of evidence on the relationship between hospital staff, volunteers and visitors.

Design. A qualitative, ethnographic approach.

Methods. Sixty-seven hours of fieldwork were conducted on two subacute wards within an Australian healthcare network in 2015. Mealtime practices and interactions of hospital staff, volunteers and visitors were observed. Sixty-one staff, volunteers and visitors were interviewed in 75 ethnographic and semi-structured interviews. Data were inductively and thematically analysed.

Results. Three key themes emerged: "help" – volunteers and visitors were considered helpful when they assisted patients at mealtimes, supported wellbeing and aided staff-patient communication; "hindrance" – staff perceived visitors as negative presences when they inhibited patient progress

and impacted staff work practices; and “reality of practice” – visiting hours, visitor engagement in patient therapy and communication between staff, volunteers and visitors were important practical considerations of mealtime involvement.

Conclusions. The findings show how and why volunteers and visitors can be helpful and unhelpful at hospital mealtimes on subacute wards. More research on the role and contribution of volunteers and visitors on hospital wards will inform future practice in healthcare settings.

Relevance to clinical practice. This healthcare organisation should continue to encourage volunteer and visitor involvement at hospital mealtimes. More effort is needed to educate visitors about patients’ therapeutic goals and the importance of nutrition. The working relationship between hospital staff, volunteers and visitors should be strengthened to improve nutritional care.

KEYWORDS

Hospital, mealtime assistance, nursing, qualitative study, visitors, volunteers.

What does this paper contribute to the wider global clinical community?

- This study provides evidence on the nature of the relationship between hospital staff, volunteers and visitors with regards to mealtimes on two subacute wards.
- The findings indicate that volunteers and visitors can be helpful when they support patient care at mealtimes, and conversely, unhelpful when they inhibit patient progress and impact staff work practices.
- More organisational support through training, education and communication between staff, volunteers and visitors may extend volunteer and visitor engagement and contributions to patient mealtimes.

INTRODUCTION

Obtaining adequate nutritional intake is essential to enhance recovery of hospitalised patients, yet presents a significant challenge. While the provision of mealtime support can improve patients' food intake and mealtime experience, there are often barriers (i.e. staffing and communication) to providing this support on hospital wards (Manning et al., 2012). Unpaid mealtime assistants, such as volunteers and visitors (i.e. patients' family, friends and carers), could be a valuable resource for providing mealtime support, however there is little evidence or guidance on how to best harness this resource. Underutilised or inadequately trained volunteers may in fact be viewed negatively by hospital staff.

Hospital malnutrition and decreased food intake present a significant burden for patient outcomes and healthcare costs globally (Agarwal et al., 2013; Corkins et al., 2014; Correia, Perman, & Waitzberg; Hiesmayr et al., 2009; Khalatbari-Soltani & Marques-Vidal, 2015). Increasing evidence of the prevalence and consequence of hospital malnutrition has prompted the investigation of a wide range of strategies to improve food intake, such as communal dining (Baptiste, Egan, & Dubouloz-Wilner, 2014), puree food moulds (Farrer, Olsen, Mousley, & Teo, 2016), protein-enriched hospital menu (Munk, Bruun, Nielsen, & Thomsen, 2017) and protected mealtimes (Porter, Haines, & Truby, 2017).

Mealtime assistance is another strategy that has received much attention in recent times. This has been in recognition of the ageing and frail hospital population (Bagshaw et al., 2014; Joosten, Demuynck, Detroyer, & Milisen, 2014), known challenges associated with opening food and beverage packaging and self-feeding in hospital (Bell et al., 2013; Tsang, 2008), and staffs' limited time and resources (Eide, Halvorsen, & Almendingen, 2015; Ross, Mudge, Young, & Banks, 2011). Studies have shown that 31-52.5% of patients need assistance at mealtimes (Palmer & Huxtable, 2015; Westergren, Karlsson, Andersson, Ohlsson, & Hallberg, 2001; Young et al., 2016). Mealtime assistance programs aim to improve patients' access to and consumption of meals in hospital by enlisting trained or untrained staff, volunteers and visitors to help patients at mealtimes. This can be achieved through encouragement and assistance with mealtime tasks, such as setting up meal trays, opening drinks and cutting up food (Age Concern England, 2007; Best & Summers, 2010; Martinsen & Norlyk, 2012).

BACKGROUND

Published systematic reviews have explored the effectiveness of mealtime assistance, including programs that utilise volunteers. Reported benefits include improved nutritional intake (Edwards, Carrier, & Hopkinson, 2017; Green, Martin, Roberts, & Sayer, 2011) and satisfaction (Green et al., 2011; Howson, Sayer, & Roberts, 2016). Evidence for an effect on dietary intake was inconclusive in

the review by Howson et al. (2016), whilst the meta-analyses of Tassone et al. (2015) favoured the provision of mealtime assistance. Original research has also found that volunteer involvement at mealtimes enables staff to complete other tasks (Roberts et al., 2014) and contributes to cost savings (Buys, Flood, Real, Chang, & Locher, 2013). Less evidence is available on the visitor role at mealtimes in hospital. Published studies describe how patients' family can assist by providing food to supplement the hospital menu (Naithani, Whelan, Thomas, Gulliford, & Morgan, 2008), and how all visitors can assist by supporting protected mealtimes programs (Edwards et al., 2017; Palmer & Huxtable, 2015). One Australian study investigated feeding assistance, identifying that visitors spend a comparable amount of time assisting patients with this task as volunteers (Manning et al., 2012).

Studies investigating mealtime assistance have acknowledged factors that inhibit success, including staff time pressures and/or availability (Heaven, Bamford, May, & Moynihan, 2013; Manning et al., 2012; Martinsen & Norlyk, 2012; Robison et al., 2015; Tsang, 2008; Walton et al., 2013) and communication of need for mealtime assistance (Manning et al., 2012; Robinson et al., 2002). Research exploring the patient viewpoint emphasises the need to overcome these barriers, identifying that patients are dissatisfied with the lack of mealtime support, yet are reluctant to ask for help (Naithani et al., 2008). When mealtime assistance is requested by patients, requests can remain unfulfilled and responsibility deflected to others (Jessri et al., 2011; Xia & McCutcheon, 2006).

Although patients are known to value volunteer input at mealtimes (Manning et al., 2012; Roberts et al., 2014; Robison et al., 2015), commentaries have identified their drawbacks, with volunteers considered a short-term solution and inadequate for patients with complex needs (Eberhardie, 2009; Handley & Squire, 2009). Little empirical research has explored the perspectives and experiences of hospital staff, volunteers or visitors in relation to mealtime assistance. There is a need to better understand the relationship between these groups and how they integrate on the ward to identify opportunities to strengthen the system of nutritional care in hospital. We have previously identified complexity at hospital mealtimes, with numerous departments, personnel and processes involved in delivering nutritional care (the authors, 2017). Understanding how volunteers and visitors are involved at mealtimes and their interactions with hospital staff is needed, especially for nurses who are at the healthcare organisation-patient-family interface. This may help to inform future practice around positive engagement of volunteers and visitors at mealtimes, ensuring negative behaviours are minimised (i.e. mealtime interruptions) and positive behaviours are fostered (i.e. encouragement to eat). It may also promote future success of mealtime assistance programs, ensuring benefit to hospital staff, volunteers, patients and their families.

METHODS

Aim

The purpose of this research was to explore multiple perspectives and experiences of volunteer and visitor involvement and interactions at hospital mealtimes. In addition, to understand how the volunteer and visitor role at mealtimes is perceived within the hospital system.

Design

An ethnographic approach was used to explore participants' perspectives and experiences of volunteer and visitor involvement at mealtimes, and to examine their mealtime practices and interactions in a naturalistic environment. This research investigated mealtimes using a whole-of-ward approach to comprehensively understand mealtime phenomena, as occurring within the broader healthcare and foodservice systems. Study design and conduct was informed by the work of anthropologists experienced in ethnographic research (Angrosino, 2007; Fetterman, 2010), including how to enter the field and interact with participants.

Sample/Participants

One subacute ward each from two sites within a large, metropolitan Australian healthcare network were purposively selected for this study. Patients were typically admitted to these wards for geriatric care or rehabilitation, i.e. after a stroke or fracture. Both wards employed an interprofessional team of clinical (i.e. nursing, medical, allied health) and support service staff (i.e. foodservice staff, cleaners, porters, ward clerks) and shared an inclusive approach towards visitors. A volunteer program operated on one ward, where a team of 12 volunteers were rostered to attend from mid-morning to mid-afternoon on designated days of the week. All volunteers completed training on the scope of their role before commencing on the ward. As part of their role, volunteers were encouraged to engage with patients through conversation and activities, and to provide mealtime assistance. They also completed other tasks as requested by ward staff.

Unique identifiers were assigned to 154 hospital staff, volunteers and visitors involved in this research. There were others who were observed but not given unique identifiers, such as transient staff members (i.e. maintenance personnel, pathology nurses, after hours coordinator) and visitors (i.e. groups of relatives, children). Staff were from a wide range of professions, including nursing, medical, allied health, food and support services, and administration. Their level of experience ranged from student to highly experienced practitioners. Volunteers were those involved in the volunteer program. Visitors included family members, friends and carers of admitted patients. Eligibility criteria enabled all staff, volunteers and visitors present on the study wards at mealtimes to be observed, and where verbal consent was provided by English speaking participants, to be

interviewed. Those expressing reluctance to be observed were excluded. Potential interviewees were identified by observation and by nomination from other participants, as is common in ethnographic research (Liamputtong, 2013). Leaders from key professions involved in nutritional care were purposively sampled to participate in an interview, including nurse unit and associate nurse unit managers, dietetic and facility services managers.

Data collection

The first author conducted 67 hours of fieldwork over three months in 2015. The first author was a clinician with lived experience of hospital foodservice systems and the challenges associated with optimising patients' food intake, and was not employed on the study wards. Data were collected using observation, ethnographic and semi-structured interviews. The focus of observation was on mealtime practices and interactions, including those between hospital staff, volunteers and visitors. Observations were made at each of the three main meal times, across seven days of the week. Data were recorded as hand-written field notes, fully reconstructed into 112 pages of typed field notes. Observation conduct and documentation was informed by a published framework (Spradley, 1980).

A total of 75 ethnographic and semi-structured interviews were used to ascertain mealtime perspectives and experiences from 45 staff (including six leaders), five volunteers and 11 visitors. Some participants were interviewed on more than one occasion to clarify or follow up a comment, resume an interrupted conversation, or explore change in perspective over time. Some interviews were conducted as group interviews. Ethnographic interviews were opportunistic and conversational in nature, and were conducted face-to-face on the study ward. Topics of discussion included hospital and mealtime role, mealtime environment, and barriers and enablers to involvement at mealtimes. Ethnographic interviews were audio-recorded where possible, with participants' consent, and transcribed verbatim. Thirty-four interviews were not audio-recorded as requested by the participant or due to spontaneous conversation, in which case, data were recorded as hand-written field notes. Semi-structured interviews with leaders took place on the study ward or in their office, and followed an interview guide (the authors, 2017). These interviews ranged from 16-83min (average 42min), were audio-recorded with participants' consent, and transcribed verbatim.

Data analysis

Data analysis started during fieldwork, where the first author reflected upon observations and interviews, and made interpretations about the data. Interpretations were checked through further observations and interviews, until the research questions could be answered. Field notes and interview transcripts were analysed inductively and thematically through the process of immersion,

coding and categorising to illuminate themes (Braun & Clarke, 2006). The goal of data analysis was to build a description of hospital staff, volunteer and visitor perspectives and experiences with regards to mealtime assistance. The second author independently coded a sample of field notes (approx. 10%) and interview transcripts (approx. 5%), then conferred with the first author on the coding framework and emerging themes. NVivo Pro (Version 11) data management software and memos assisted data analysis.

Ethical considerations

Directors of nursing, allied health and support services provided their support for this research. Participants were aware of the study through posters, staff information sessions and direct liaison with the first author. Ethics approval was provided by the healthcare network (LR76/2015) and university (CF15/2929 - 2015001205) human research and ethics committees.

Rigour

Trustworthiness of this research was supported by an extended period of fieldwork, using a combination of data collection techniques and maintaining a reflective journal (Angrosino, 2007). Sampling two wards from two different sites and including participants from a wide range of professions enabled findings to be compared and contrasted (Liamputtong, 2013). Credibility and dependability of the findings was supported by co-coding a data subset and presenting participants' quotations and field note extracts, with transferability promoted by thick description (Geertz, 1973).

RESULTS

Volunteer and visitor involvement and interactions at hospital mealtimes, and perceptions of their role are explored through three key themes: "help"; "hindrance"; and "reality of practice". These findings shed new light on the relationship between hospital staff, volunteers and visitors specific to mealtimes, describing how and why volunteers and visitors help or hinder patient mealtimes.

Theme 1: Help

Visitors supported patient care by providing patients with food and nourishment. Staff encouraged and appreciated visitors bringing in favourite, familiar or culturally appropriate foods for patients to supplement the hospital menu, acknowledging the nutritional and wellbeing benefit that these foods offered.

"[About patients of Asian background], in their home, they normally have the rice and the soups. But in this environment, it's like Western meals. Elderly, especially elderly patients, they are not eating much... So when they bring their home meals – the rice or the soups –

then they have more. It's good for the patients... If [they] have a good meal, they have good feelings." (AJ, nurse)

Young male visitor is sitting on the bed, with elderly female patient in her chair. Can smell something delicious. Array of little plastic pots on the patient's meal tray containing brightly coloured dishes in green, white, orange, red. "Curry with roti", the visitor explains with a broad smile. The patient adds, laughing, "A bit tastier than the hospital food!" (Field note extract, 10th September 2015, 6:00pm)

Visitors were observed to facilitate shared dining experiences, often eating their own food while sitting with the patient at mealtimes. Carers were observed to attend at mealtimes to feed patients, as they would outside of hospital.

With one hand she [V9, visitor] spoons supplement drink into the patient's mouth while he lies in bed. In her other hand is a face washer, used to wipe up the spillage after each mouthful. One spoon of liquid in, wipe spoon across lips to collect drips, wipe one side of jaw to the other. Methodically repeats every mouthful. Are you a family member? V9, "No, I'm one of his carers! No hospital staff can feed him, so we [carers] come in, breakfast, lunch and dinner..." She tests the temperature of the soup on her wrist. Explains that it might still be a bit hot for the patient. She proceeds to feed the patient dessert, with one tablet pressed neatly into the centre of each spoonful. (Field note extract, 3rd September 2015, 5:25pm)

Volunteers and visitors were viewed by staff as being helpful in supporting patients' wellbeing. This was achieved through social interaction with patients, their ability to comfort, settle or cheer patients, and by providing company and prayer. Volunteers spoke about how they spent time "listening to their stories". Furthermore, staff and visitors themselves identified that visitors were able to provide stimulation and a sense of the outside, which was seen by staff as necessary in adjusting and preparing patients for discharge.

"We love family coming in to help with mealtimes. Absolutely love it... It's such a supportive experience for the patients to have their own family in here... It's almost like a comfort for the patients" (CB, nurse)

Middle-aged man [V10, visitor], "I come in and sit with him [the patient]. Tell him stories. Keep him company. Bring a newspaper. Tell him what is happening. (Field note extract, 14th September 2015, 5:30pm)

Nursing and allied health staff explained how it was important for family members to be involved in all aspects of care, including nutritional care. They described how visitors helped patients with meal-related activities, such as menu completion, retrieving items from the ward fridge, cutting up food, and encouraging and feeding patients, which was a “huge help” for nurses. Nurses described how volunteers assisted at mealtimes by helping patients if they needed and by supervising those eating their meal in the dining room. Volunteers were observed to work closely with foodservice staff at lunchtime, proactively moving through the ward in front or behind the meal trolley, observing how patients were managing their meal, offering their assistance and helping to adjust tray table heights, set out cutlery, remove plastic wrap and deliver napkins.

“Being volunteers, we like to be useful. We don’t like to stand around wondering what to do!” (VOL1, volunteer)

Nurses, allied health and foodservice staff described how visitors were a useful source of information on patients under their care. Visitors were reported to provide staff with detail on how the patient was managing at home, services received or required, care wishes, food intake and dietary needs, including special diets, food and fluid modification.

Nurses also described how visitors assisted them to communicate with patients, particularly those who were confused, resistant to care or of non-English speaking background. Visitor presence and involvement helped nurses to complete tasks that they needed to do with or for these patients. Volunteers were reported to assist with communication by updating communication boards in patients’ rooms.

Theme 2: Hindrance

Staff described how visitors could inhibit patient progress at mealtimes by taking over and distracting patients from eating their meals. This was reported to impact patients’ independence, skills practice and nutritional intake, slowing their recovery. Nurses and dietitians told how they needed to intervene in these situations to increase visitors’ awareness of mealtimes, and emphasise the importance of food and eating.

“You’ve got to stop them from taking over to allow the patient to start feeding themselves, or looking after their fluids themselves, or whatever their care is.” (SH, nurse)

“We’ll tell them if they are being distracting, or we’ll say, “Oh, its lunchtime. Happy for you to go in, but can you just be aware its lunchtime, and just give them some encouragement?”” (DT1, dietitian)

Foodservice staff explained how conflicting information from visitors impacted their job role. For example, when family members over-ruled patients' menu selections, or when there were disagreements amongst family members about patients' food or meal preferences. Foodservice staff described how they negotiated these "family barriers" by liaising directly with the patient.

"The best way to resolve it, is to firstly see if the patient themselves knows what they want! Going to the source is a good idea. That's what I'm supposed to do." (MM4, foodservice staff)

Visitors were also seen as negative influences when they questioned staff actions as a result of not understanding the operational requirements of the foodservice system. This was particularly relevant for foodservice staff, whose work practices, such as meal delivery and collection, were bound by tight schedules. One foodservice leader described how their staff had to "fight to justify" to visitors why they needed to remove unfinished meals after a certain amount of time to protect patient safety. Volunteers were not reported or observed to be a hindrance to patient care or staff work practice at mealtimes.

Theme 3: Reality of practice

Different views about visiting hours and what these constituted were identified. Staff reported official visiting hours were 8am-8pm, however that visitors were welcome any time, within reason. Nurses explained how visiting hours depended upon patients' therapy timetables, in which case, they suggested that visitors phone ahead before arriving on the ward. Staff reported lunch, dinner and weekends were popular times for visitors to attend.

Visitors were observed to enter the ward and walk purposefully and directly to the patient's room. Other visitors first called by the nurses' station to report their attendance or ask for directions, where their presence was observed to be inconsistently acknowledged.

Staff actively encouraged visitors to attend the ward at mealtimes to improve the patient experience and their recovery, irrespective of whether a volunteer program was in operation. Staff recognised that visitor presence added to the sense of busyness on the ward, where up to 25 visitors were observed present at any one mealtime. However, staff admitted that this did not impact them, being "quite used to it". Volunteer attendance was understood by staff to depend on volunteer availability and the roster system, with their presence on the ward seen to be inconsistent hour by hour and day to day. Foodservice staff were observed to be flustered when they could not locate a volunteer when one was needed. Volunteers were clearly identifiable by their shirts that were embroidered with the title, "Volunteer".

Staff emphasised the need to educate and reinforce the patients' therapeutic goals and importance of nutrition to visitors. This was particularly relevant for nurses and allied health staff, who wanted visitors to support patients to achieve their goals. One dietitian revealed that close family members were more likely to understand goals of care and the importance of therapy than friends, who may infrequently visit. Observation data confirmed high levels of family member engagement at mealtimes.

He [V11, visitor] is sitting in a low chair beside her [the patient], watching her eat lunch... She struggles with a particularly large piece of chicken. He kindly prompts, "Think you might need to use your knife to cut that up... There you go!" She reaches for the knife with her left hand. He adds reassuringly, "Now the fork normally goes in your left hand and the knife in your right". He assists in rotating the knife in her right hand, pointing the blade downwards. "How's that? Off you go!" (Field note extract, 11th August 2015, 12:30pm)

Communication about patients' food intake and dietary needs was found to be lacking at times between staff, volunteers and visitors. For example, family members reported not knowing what patients ate when they were not there. Foodservice staff explained that extra meals for visitors participating in trials of care were not always ordered by nursing staff. Foodservice staff and volunteers reported their insights into patients' food intake or need for mealtime assistance were not always welcomed by staff. One volunteer explained how this has improved over time after reporting feelings of tension to management, who responded by educating staff about the volunteer role.

"We find now there's a different attitude. They [staff] say hello to us. They smile. They accept us more because they know what we're doing there... They've got better awareness and also familiarity." (VOL1, volunteer)

Some visitors explained how they felt compelled to attend due to inadequate staffing and provision of care. This was primarily identified on the ward that did not have a volunteer program.

Wife [V8, visitor] of [patient of Chinese background] is washing her dishes in the sink in the corridor. I ask if she visits every day. V8, "Yes. He [the patient] needs me. Not enough nurses to look after patients. Now, six [patients] for each [nurse]. Tonight, three [nurses] for 30 beds! Not enough! The other [patients] can do by self, but not my husband. He needs me." (Field note extract, 1st September 2015, 5:45pm)

Two older female visitors [V6, V7] in Room 6 enquire about my research. I explain that I am looking at mealtimes on the ward. V6, "That's the biggest problem... I'm here with my husband... I'm here watching. He can feed himself. I watch him swallow to make sure that he swallows properly. He has a few mouthfuls, then drinks a little to wash it down. You see, the problem is, the food is put down in front [of the patient] and is forgotten. I've seen this a lot. I wouldn't want this for my husband. That is why I am here 10, 11 hours every day." (Field note extract, 15th August 2015, 5:25pm)

In contrast, nurses from both wards emphasised how they would be able to set patients up for their meal if volunteers or visitors were not present.

DISCUSSION

This study explored multiple perspectives and experiences of volunteers and visitors on the hospital ward at mealtimes, including how the volunteer and visitor role is perceived within the hospital system. We found that staff viewed volunteers and visitors as assets, welcoming their support and contributions to patient care at mealtimes. Staff also perceived visitors as negative influences when they inhibited patient progress and impacted staff work practices. This transpired from visitors' lack of understanding of patients' goals of care and operational requirements of the foodservice system, such as the meal ordering process and meal collection schedules. Volunteers and visitors described their role as enriching the patient experience and their recovery, and for visitors, to bridge perceived gaps in patient care provided in hospital. Practical considerations of volunteer and visitor presence and involvement were identified, including visiting hours, visitor engagement in patient therapy and communication between staff, volunteers and visitors. Our study is the first to show how and why volunteers and visitors can be helpful and unhelpful to patients and staff at hospital mealtimes.

The extent of the evidence on the hospital staff-visitor relationship is based on research in intensive care (Al-Mutair, Plummer, O'Brien, & Clerehan, 2013; Olding et al., 2016), where family member presence and involvement is viewed favourably, including with tasks like feeding (Al-Mutair et al., 2013). The staff-visitor and staff-volunteer relationship has not been explored in depth on other hospital wards where patients' condition and needs may differ, nor has the relationship been investigated specific to nutritional care where volunteer and visitor contributions extend beyond feeding patients. Our study fills these gaps by illuminating how hospital staff view and interact with volunteers and visitors at mealtimes, contextualised within the broader foodservice and healthcare systems. This is important because teamwork and communication are known to underpin mealtime conduct, which is further influenced by factors including awareness and attitude, environment and atmosphere, and leadership (Ottrey, Porter, Huggins, & Palermo, 2017). The findings of this study

provide direction to staff, particularly nurses who are located at the interface between patients, and volunteers and visitors, by highlighting the varied ways that volunteers and visitors can support and enrich nutritional care and the patient experience at hospital mealtimes. Furthermore, exploring staffs' negative perceptions and experiences helps to identify opportunities for service improvement, including the need for better education and engagement of volunteers and visitors at mealtimes.

Similar to other work (Marco et al., 2006), staff found visitors were a useful source of information on patients under their care, including patients' situation and needs. The nature of the patient population on the study wards may have contributed to this finding, where patients were typically elderly, and included those with cognitive and hearing impairments, and those of non-English speaking backgrounds.

Volunteers were found to prioritise the provision of assistance at mealtimes in this study. Rather than waiting for patients to ask for help, volunteers proactively rounded the ward, observing how patients were managing their meal and offering help. This approach appears warranted in light of patients' reluctance to request assistance (Naithani et al., 2008). Volunteers' performance may be bolstered by their training (Green et al., 2011) or may be inherent to their character, with volunteers known to find reward in their experience and involvement at mealtimes (Manning et al., 2012; Robinson et al., 2002).

Nurse involvement to train and support volunteers and family members to deliver mealtime assistance has been suggested (Edwards et al., 2017). Understanding how volunteers and visitors are perceived by nurses may help to build capacity to improve nutritional care. This is through awareness and recognition of existing attitudes and experiences, positive or negative, and the nature of the staff-volunteer and staff-visitor relationship to inform future practice. In this study, visitors (i.e. family and friends visiting patients they knew) were more commonly identified as being unhelpful at mealtimes than volunteers. On the ward that operated the volunteer program, this may be explained by the number of visitors present at mealtimes outweighing that of volunteers, volunteer training or limited staff-volunteer interaction. Irrespective, it may be important for healthcare organisations and staff, particularly nurses, to focus on educating and training visitors to increase their understanding of the foodservice and healthcare systems, and promote their positive contributions at mealtimes (Jones, 2011). Formal guidance may help to define visitors' contributions at mealtimes and promote patient safety, such as policies on visitors bringing in food from outside the hospital and the storage of such items (Dean, 2012). Opportunity also exists to enhance volunteer contributions at mealtimes through greater staff-volunteer communication. This may be achieved through nutrition-specific handover with the nurse in charge at the start and end of the

volunteer shift, notifying ward staff of volunteer availability each shift, and encouraging increased liaison between ward staff and volunteers of mealtime issues and solutions. Volunteer efforts could also be focused towards patients at risk of malnutrition. Leadership, particularly from nurse unit managers and volunteer program coordinators, will be critical to improve staff-volunteer communication.

Future research should investigate new ways to engage visitors in nutritional care, for example through pamphlets, posters, video clips or kitchen tours. Evaluation of these strategies should be conducted to determine intervention effectiveness in supporting visitors to help rather than hinder patient mealtimes. Qualitative or quantitative evaluation methods may be used to investigate outcomes including visitor satisfaction, patient quality of life, positive and negative mealtime interruptions, and food intake. Clarification is also needed on how hospital staff should mediate visitors' helpful and unhelpful involvement at mealtimes and how this should be communicated, such as general reminders or targeted feedback. Finally, strategies to strengthen the staff-volunteer relationship should be explored, given the role that volunteers can play in improving food intake. Greater inclusiveness and teamwork may be promoted through engagement (i.e. staff-volunteer introductions and shared use of staff tea rooms) and education (i.e. role clarification) strategies.

Limitations

This study was conducted on two hospital wards with a subacute focus, thus findings may not be transferable to other healthcare settings, such as acute hospital wards, long-term or aged care facilities. Staff, volunteers and visitors were aware of the researcher's presence, as such may have altered their interactions or behaviour from their usual practice. However, typical ethnographic strategies were followed, such as prolonged engagement in the field and explaining the nature and purpose of the researcher's presence to those requesting this information. Data were limited to that collected via observation and interview; no quantitative data collection techniques were used. Patient perspectives were not sought as part of this research, and volunteer perspectives were limited to the ward where the volunteer program was in place.

CONCLUSION

The findings of this study provide evidence on the relationship between staff, volunteers and visitors at mealtimes on two hospital wards, highlighting how and why volunteers and visitors can be helpful and unhelpful to patients and staff. There are numerous opportunities for volunteers and visitors to be involved at hospital mealtimes, providing support to hospital staff who may be time- and resource-limited. More organisational support at this healthcare network through training,

education and communication may extend the engagement and contributions of volunteers and visitors to enrich nutritional care and the patient experience in hospital. More research on the role and contribution of volunteers and visitors on hospital wards will inform future practice in healthcare settings.

RELEVANCE TO CLINICAL PRACTICE

This healthcare organisation should continue to encourage volunteer and visitor involvement at hospital mealtimes to advance patient care and the healthcare experience. More effort is needed to educate visitors about patients' therapeutic goals and the importance of food and eating to enhance their engagement with nutritional care. The working relationship between staff, volunteers and visitors should be strengthened to fully realise volunteers' and visitors' capacity to help address hospital malnutrition and decreased food intake.

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Author/s:

Ottrey, E;Palermo, C;Huggins, CE;Porter, J

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