

# [Free literature review on the research](https://assignbuster.com/free-literature-review-on-the-research/)

[](https://assignbuster.com/)[Technology](https://assignbuster.com/essay-subjects/technology/), [Development](https://assignbuster.com/essay-subjects/technology/development/)

Recent studies have established that people do not mind their eating habits. They do not know the dangers either associated with poor eating habits, or are just ignorant to the fact that healthy eating is paramount to healthy societies. However, poor eating habits should not be confused for malnutrition (Krahn and Lengyel, et al. 2011). The major problem associated with poor eating habits is obesity, which exposes people to diseases such as hypertension, coronary artery diseases and diabetes. These are very threatening diseases that have very simple origin-poor eating habits-but also have simple solutions - proper dietary measures.

After noticing the trend of the residents’ increasing overweight, I decided to conduct a survey on the probable reasons that might be responsible for such a scenario. First, I sought to establish the eating habits of these residents and the places they get their food. Upon finding out that most of these residents get their food from a local cafeteria, I decided to visit the cafeteria over lunch-hour to establish the menu. I approached the lead cook of the cafeteria who informed me that he has been working in that cafeteria for around five years, which gave me the confidence that he would be in a position to explain the eating habits of his customers (Flynn and Liang, et al. 2010).   
The lead cook provided me with the day’s menu and it had-it-all - these residents would obviously be obese if they took these meals on a daily basis. There was list of hotdogs, French fries, and ice creams, among others on the menu for lunch. This even made my worries worsen. When I asked if they served these on their own choices or if their customer had an influence on what should be cooked for them, the lead cook informed me that, the meals were prepared on the customers’ demand. I did not believe this until I further interviewed two of their clients, one a male in his early 70s and the other a woman whom I approximated could be close to her 60s, who were also overweight. Both my respondents confirmed to me that they were comfortable with the meals provided at the cafeteria and that did not have any problems with their body weights. The male respondent further informed me that he would not go for a day without at least two or three hotdogs in his meal.   
After gathering the above information on the residents of the area surrounding the nursing home for which I work as a nurse, I felt that I had a responsibility to control the current situation. I realized that the major problem was not with the workers since they only prepared the foods that are requested for by the residents. I had to initiate a change in the patients’ diet in order to reduce their chances of contracting diet related diseases such as hypertension among others. However, the workers also had a responsibility to create awareness to their client on the dangers associated with unhealthy eating habits and propose to them alternatives diets that could be equally beneficial.

## The change

Therefore, I realized that the best means of initiating a change was through utilizing the knowledge of the workers and their influence on their clients. The most influential worker according to my research was the lead cook. The major reason that attracted my attention to the problem was the overweigh adults that were either in our nursing home or out in the neighborhood.

## The model for change

I adopted John Kotter’s change model since I considered it most appropriate in solving this issue of obese residents (Stragalas, 2010). The first phase of the model was to establish the urgency of the change. I realized that quite a good number of the population were increasingly growing overweight, therefore, a swift action had to be taken to combat this problem. Secondly, creating a coalition was necessary. I realized that I could not implement the change on my own, but with assistance from other departments in the home. These departments included the cafeteria staff, the home management and the nursing department. After forming the coalition, we had to develop and share a clear vision so that we could be able to assess our activities in relation to the attainment of the desired goals, which was to combat obesity and its related diseases.   
Empowerment was the next course of action. All the involved individuals and groups of individuals had to be equipped with relevant information in relation to the dangers of poor diet and the advantages of healthy eating habits, and the need for a change. After empowering the involved persons, we decided to implement the change; we printed leaflets on healthy eating habits, effects of poor diet, and the need for a change on the eating habits of the residents. After printing and circulating these articles, we conducted an awareness creation forum introducing substitute meals for the one we considered as ‘ hazardous’ and explained the best preferred meals for a healthy living.   
The second last phase of the change model was very challenging; most of the residents did not immediately take up the change positively. They were very conservative and could not easily change their tastes and preferences. This was expected from the start of the change process, therefore, we consolidated and kept moving on. I never gave up. Finally, we had to review our short-term achievements and rewarded those who were not resistant to the change within the short-term process (Eide, & Allen, 2012). We viewed that this could persuade others into buying the idea of change.

## The elements of change plan

Just like any other change process, this case was not exceptional. There were three elements in the change process.   
- Readiness to change   
As a nurse, I was ready to commence with the change process since I am well equipped with the knowledge required to convince the residents on the dangers associated with poor eating habits and the need to change these habits. After consulting with the management of the home, they promised to support the idea with the required resources and to oversee the implementation of the change process.   
- Barriers to change   
Habit is usually the hardest to change. From the routine things that we do that form part of our daily activities that eventually become habits. Eating habits are not easy to change since they are considered addictive (Anderson, and Siems et al. 2012). In this case, the residents were not willing to change their eating habits since they did not see anything wrong with their weight and did not have the need to watch these weights. The cafeteria workers in the earlier stages did not see the importance of implementing the change since according to them; their customers did not have a problem with either the food they cook or their weights.   
In my opinion, watching weights has great effects on population. A healthy population means an increased productivity. On the other hand, sick population implies that they would not have enough time and energy to contribute to production, but most of their time would be spent trying to treat the diseases. Therefore, ensuring proper eating of the residents would be economically helpful and medically recommendable.

## The role of the nurse leader in directing the change

As a junior staff in the nursing department, I had to seek permission from the nurse leader in order to take this course of action. It was the responsibility of the nurse leader to grant me permission and to oversee my activities in ensuring that the values and ethics of nursing are abode by. Any other person in the nursing department who intended to take part in the change process also had to seek approval of the nurse leader (Nagi and Williams, 2012). The other important role of the nurse leader was to coordinate the activities of the team involved in the change process with the home administration and the residential. The nurse leader was the link between the different entities in the change process.

## Communication and collaboration strategies

Communication and collaboration strategies that were used were dependent on the nature and need for communication or collaboration and the involved parties (Wilson, and Rochon et al. 2012). For instance, when dealing with the residents, the cafeteria staff, and the other members of the nursing department, I employed the use of horizontal communication. This was because I considered them to belong to the same level. In reference to collaboration at this level, the nurse leader was important in ensuring that all the activities of the nursing department are well coordinated. The lead cook also organized his team very well in their duties that were related to this discipline.   
In dealing with the management, there was an upward communication (Lunenburg, 2011). Different departments of the team forwarded their requirements to their departmental heads, which were responsible for passing this information to the nurse leader whose responsibility was to inform the management.

## Advantages of the change

According to the United States Department for Agriculture, a healthy diet helps reduce the susceptibility to diseases related to diets. In this case, for instance, people who took those lunches from the cafeteria had their weights too high, this made them susceptible to diseases such as hypertension. The other advantage associated with this change is economical. The costs of treating the diseases related to obesity are too high compared to the cost of implementing a balanced diet that avoids these scenarios (Grandjean, 2012).

## Disadvantages

According to my assessment, in the short-term effect, several residents would stop buying from the cafeteria in search of others that stock the products that they want. This negatively affects the suppliers of the cafeteria by reducing amounts they supply. The cafeteria would also realize reduced profits since their customers would not immediately adapt to the change. The workers will feel reduced motivation towards work since just a few customers would be coming to the cafeteria.   
However, it should be noted that these are just short-term effects, but with persistence of the implementers of the change process, the residents would understand the need for healthy diets, and that the idea benefits them most. The cafeteria would soon regain its customers who would be coming to purchase of substitutes and complements of the meals they previously demanded.

## References:

Stragalas, N. (2010). Improving Change Implementation. OD Practitioner, 42(1), 31-38.   
Eide, C. K., & Allen, C. D. (2012). The More Things Change, Acquisition Reform Remains the Same. Defense Acquisition Research Journal: A Publication Of The Defense Acquisition University, 19(1), 99-120.   
Anderson, K. and Siems, L. et al. (2012). Group counselling improves quality for patients with limited health literacy. Quality In Primary Care, 20(1), 5-13.   
Wilson, R. and Rochon, E. et al. (2012). Examining Success of Communication Strategies Used by Formal Caregivers Assisting Individuals With Alzheimer's Disease During an Activity of Daily Living. Journal Of Speech, Language & Hearing Research, 55(2), 328-341. doi: http://dx. doi. org. ezproxy. apollolibrary. com/10. 1044/1092-4388(2011/10-0206)   
Krahn, V. M. and Lengyel, C. O. et al. (2011). Healthy Eating Perceptions of Older Adults Living in Canadian Rural and Northern Communities. Journal Of Nutrition In Gerontology & Geriatrics, 30(3), 261-273. doi: http://dx. doi. org. ezproxy. apollolibrary. com/10. 1080/21551197. 2011. 591270   
Lunenburg, F. C. (2011). Formal Communication Channels: Upward, Downward, Horizontal, and External. FOCUS On Colleges, Universities & Schools, 6(1), 1-7.   
Nagi, C. and Williams, M., et al. (2012). A Multidisciplinary Approach to Team Nursing Within a Low Secure Service: The Team Leader Role. Perspectives In Psychiatric Care, 48(1), 56-61. doi: 10. 1111/j. 1744-6163. 2011. 00310. x   
Flynn, L., Liang, Y. et al. (2010). Effects of Nursing Practice Environments on Quality Outcomes in Nursing Homes. Journal Of The American Geriatrics Society, 58(12), 2401-2406. doi: 10. 1111/j. 1532-5415. 2010. 03162. x   
Grandjean, A. (2012). Dietary intake data collection: challenges and limitations. Nutrition Reviews, 70S101-4. doi: http://dx. doi. org. ezproxy. apollolibrary. com/10. 1111/j. 1753-4887. 2012. 00545. x