Older people’s experiences of their kitchens: dishes and wishes

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A new study is investigating the life-long and contemporary experiences of kitchens of 48 people over 60 years of age. The research includes detailed questionnaire interviews asking people about their experiences of living in their current kitchen. This paper presents the initial quantitative results of people’s experiences, needs and wants from their current kitchens. This includes problems experienced with activities of daily life in the current kitchen, changes that have been made or are planned to be made to the current kitchen to increase usability in older age, coping strategies and examples of design that have been found to be really useful to older people.

Introduction

The population is ageing. In the United Kingdom in 2006, 11million people were over the official retirement age, currently 60 years for women, 65 years for men (Office for National Statistics, 2005). It is estimated that, worldwide, by 2050 the number of people aged 60 years and over will be 2 billion (World Health Organisation, 2008). For many people, the kitchen is the centre of the home, a place with influence on individual health and well-being. Previous work conducted by members of the research team has allowed some comment on the relationship between space, design and individual behaviour (Kellaher, 2002; Percival, 2002), and how the built environment can form an important aspect of self-identity in older people (Peace et al, 2006). The kitchen was found to be a source of quality of life issues for older and disabled people (Oliver et al, 2001).

A new study, the Transitions in Kitchen Living project, funded by the New Dynamics of Ageing programme (sponsored by the ESRC) aims to provide a historical understanding of the physical/material, social and psychological environment of the kitchen guided by life events, as well as a contemporary understanding of the current kitchen examining role, function and design. This paper presents the findings of the second of two interviews conducted with older
people, concerning their use of their current kitchen and any changes they have made, plan to make or would like to make to their current kitchen as they get older.

**Methods**

In the Transitions of Kitchen Living project, 48 participants were recruited with the aim of ensuring an even spread of people in each of the age ranges 60-69, 70-79, 80-89 and 90+ years, with a ratio of 2:1 of women to men (to reflect the fact that proportionally women live longer than men. Peace et al, 2007).

Ethical approval was sought and obtained from both the Human Participants and Materials Ethics Committee at The Open University and the Ethics Advisory Committee at the University of Loughborough. All interviews were recorded on a digital recorder, with the participants’ permission (one participant did refuse to be recorded, and that interview was recorded by means of a note-taker accompanying the interviewer). Prior to the main trials pilot trials, were conducted with 6 participants in Loughborough, Bristol and London, and the questionnaires and protocols were refined in response to comments and the experience of conducting these pilot trials.

Prior to meeting with participants, each was sent an information sheet detailing the aims of the project and their role in it, a short ‘tick box’ questionnaire to collect demographic data, and a ‘housing history’ form, in which they were asked to write down brief details (house type, house age if known, year moved in) for each home they had lived in during their life. If participants were unable or unwilling to complete these prior to the trials taking place, they were completed by the interviewer during the course of the first interview. All participants were interviewed twice, in their own homes, with each interview lasting no more than an hour. The first interview consisted of an oral history investigation into the person’s experiences of kitchens through their life course, from the first kitchen they could remember (typically as a young child) through to their current kitchen. This interview consisted of open-ended prompts from the interviewer, with the participant encouraged to talk about any and all aspects of each kitchen that were of interest to them.

The second interview was conducted subsequently to the first or on a return visit, depending on the preference of the participant. If the second interview was to be conducted on a return visit, participants were asked if they would like to use a provided digital camera to take photographs of any particular aspects of their current kitchen that they liked or disliked, or incidents that occurred before the second interview. If the interviews occurred immediately after each other or the person was unable or unwilling to take photographs themselves, then photographs were taken during the second interview by the interviewer, with the participant suggesting what should be photographed (this seemed to suit most participants). A note was made for all photographs of what the picture
contained, and why it had been taken. Either after or during the second interview the interviewer also drew a sketch diagram of the current kitchen, including taking measurements of room dimensions and also dimensions of any non-standard apparatus (ie non-standard work-surface heights). Light meter readings were taken, both with lights off and lights on, in the kitchen at the surface most commonly used for preparing food, at the edge of the sink, and at the kitchen eating area (where one was present). A measure of the external light levels was also recorded.

The second interview itself consisted of a semi-structured interview, with the interviewer having a recording sheet on which they could tick the relevant boxes and jot notes if required, although the interview was recorded as well for further detail if needed. Questions concerned the current kitchen, physical abilities and any issues that cause problems for the participant currently, anything they had changed in the kitchen as they have aged, any changes they would like to make or imagine they may want to make as they get older.

Results

At the time of writing 40 new trials have been completed (26 women and 14 men), with the final 8 booked in. Table 1 indicates the ages and genders of the current sample. Thirty-eight participants were of white British ethnic origin, with two participants who were Asian or Asian British.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Men</th>
<th>Women</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69 years of age</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>70-79 years of age</td>
<td>1</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>80-89 years of age</td>
<td>3</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>90+ years of age</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>13</td>
<td>27</td>
<td>40</td>
</tr>
</tbody>
</table>

When asked if they needed any help completing daily tasks, one participant needed help with most tasks, seven participants said that they needed help with ‘some tasks’, and three participants had an occasional helper (typically a family member or friend) who was on call when help was needed.

Fifteen participants reported ‘yes’ to having problems with reaching (up or down) to items in the kitchen. Three participants (including some who responded that they had ‘no problems’ with reaching) mentioned using a grabber or ‘hooking’ items that were out of reach, and six other participants said they use a step or stool to reach high items.
Twelve participants reported having problems with dexterity. Problems included reduced dexterity, reduced strength/weakness of grip, numbness in the hands and fingers and arthritis. Difficulties with dexterity were reported to affect the following tasks: opening jars, cans and bottles (6 participants), lifting pans or dishes (1 participant), turning knobs/taps (1 participant). Eight participants mentioned using a ‘gadget’ or strategy such as running the jar under hot water, to assist them in opening jars, cans and bottles.

Three participants reported having problems with preparing food. One participant reported pain when peeling and chopping while another stated that their hands were not strong enough for lots of food preparation. A further individual had frozen meals delivered and used a microwave oven to cook/reheat them. Thirty two participants stated that they did not have problems preparing food and cooking meals. However of those 32 participants, 3 participants also stated that although they did not have problems they did engage in different strategies to make the task easier, these including using ready meals if they were particularly tired, and sitting to prepare food and other kitchen tasks. A total of four participants mentioned using ready meals on a regular basis, and another said that they cooked large batches of food so they could freeze the rest in meal-sized containers and then just use them as required. Of the 37 participants who had a microwave, six reported using the microwave mainly for defrosting or reheating meals or simply rarely at all. Three participants reported having problems using the microwave, with problems with the height of the microwave, transporting hot food out of the microwave, or getting the cooking time wrong and burning food.

Thirty participants stated that they cooked meals for themselves ‘everyday’ or their partner cooked. The large majority of these ‘cook everyday’ participants described themselves as able to get about their houses independently without the use of aids (23 participants) and six reported having to use a stick, frame or hold onto furniture. The 30th participant who cooked everyday was a wheelchair user. Six participants reported cooking their own meals ‘some days/occasionally’. All six described themselves as able to get about their house independently without the use of aids. Of the four who never cooked for themselves, two were independent and two used stick, frame or held on to furniture.

Table 2 summarises the number of participants and the meal times that participants cooked for ‘everyday’ or ‘some days/occasionally’.

<table>
<thead>
<tr>
<th>Meal time</th>
<th>Number of participants that cooked a hot meal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>5</td>
</tr>
<tr>
<td>Lunch time</td>
<td>14</td>
</tr>
<tr>
<td>Late afternoon</td>
<td>3</td>
</tr>
<tr>
<td>Evening</td>
<td>31</td>
</tr>
</tbody>
</table>

Note: (n exceeds 40 as some participants cooked more than once a day).
Sixteen participants ate at least some of their meals in the kitchen whilst 20 ate in other rooms (four did not answer this question). Ten participants said that they ate off a tray on their knees or at the arm chair.

The majority of participants had no problems with washing up or loading/unloading the dishwasher. Eighteen participants had a dishwasher and a further 3 explicitly mentioned that their spouse did most of the washing up. However three participants did report problems with washing up, with one reporting that their dishwasher was a bit too low for comfort, and the other two participants stating that they could only do small amounts of (hand) washing up at a time and had to be careful.

Only one participant reported having a problem with making hot drinks. They reported having difficulties lifting the kettle and so had adopted a strategy of sliding the kettle to and fro because it was too dangerous for them to lift it (due to risk of dropping it). However, other participants did mention other coping strategies for making hot drinks, including one person who used a small lightweight kettle, another participant used a microwave instead of a kettle, and a third person had bought a cordless kettle to avoid the risk of getting tangled in the cord.

All participants had a bin for general waste somewhere in the kitchen, with only two participants reporting problems with disposing of rubbish. Three participants mentioned having a bin for compostable materials in the kitchen, and all participants said they recycled rubbish. Different local authorities have different schemes for what is recycled and whether this is done with provided bags, boxes or bins, so responses varied accordingly. However, participants seemed generally enthusiastic about recycling, with three participants taking items that the local authority did not offer a collection service for to local recycling areas themselves. Two participants did mention some confusion over what to put in which bags, which might not be that surprising given the variety of bags/bins available.

When asked what aspects of their current kitchen they particularly liked, twenty seven participants commented. These comments included issues with natural light in the kitchen (4 participants), space in the kitchen (not too big, everything easy to reach, 5 participants), storage space (4 participants), ease of cleaning tiled/lino floor (2 participants), mid-level appliances (4 participants). Other aspects each mentioned by one participant included: plenty of work surfaces, having a self-defrosting fridge, the general layout, and having a double sink.

Fifteen participants said they had already made adaptations to their kitchens to make life easier for them. Changes made included having a dishwasher installed (possibly slimline or worktop ones for smaller kitchens), automatic kettles, lighter irons, increasing lighting, having more plug sockets installed, having a water filter tap fitted, having lever taps fitted, having a fan fitted in the window,
and pull-out shelves in cupboards. When asked if there were any changes they
would like to make in the future to make life easier as they get older, participants
mentioned replacing the flooring to make it easier to clean, getting a dishwasher,
getting a self-cleaning oven, having shallower drawers, knocking down the wall
to convert current space to include a wet room with laundry facilities (next to the
kitchen), more plug sockets fitted, move items/appliances lower to make
reaching them easier, and fitting revolving units in corner cupboards for easier
access. Eleven participants mentioned disliking the size of their kitchen and/or
the amount of storage space. Cleaning or opening/closing the kitchen windows
was a problem for six participants, while poor lighting was raised as an issue by
four participants. Getting access to appliances, cupboards and the sink caused
problems for four participants, and maintenance issues such as defrosting the
freezer were a problem for one participant. A lack of plug sockets was cited as a
problem by one participant.

Discussion

Whilst the current Transitions In Kitchen Living project aimed to include the
views of ethnic minorities as well as white British people, in reality finding older
participants of different ethnic origins proved more challenging. The two British
Asian participants needed a family member to act as interpreter for the trials to
take place, which may have impacted to a degree on the results of their
interviews. No other ethnic groups were represented, which is something that
could be addressed in future work. The project also intended to have equal
numbers of participants in each decile band (60s, 70s, 80s and 90s years of age),
but finding participant over the age of 90 was another challenge to the project.
Overall it was possible to get a sample that roughly reflected the aim of
achieving a 2:1 ratio of women to men, with 27 women to 13 men in the sample
to date.

Of the four participants who responded that they ‘never cook’ two participants
had physical difficulties, while the other two appear had the cooking done by
their partner, so inability to cook is not always due to physical
constraints/problems but may be due to allocation of tasks to different members
of the family/couple. The use of pull-out shelving units, revolving units or
similar devices were found to be very popular or desired by the participants,
enabling easier access to corner cupboards in particular. Kitchen windows were
a problem for several participants, with the main problem being reaching to open
or close the window. Kitchen windows are typically located in the wall behind
the sink, with the opening section at the top of the window, requiring the person
to leave over the sink and work surface and then reach up to the latch. If the
window opened from the bottom, with the latch at the bottom, the person would
only have to reach over the sink / work surface in order to open the window and
ventilate the room.
Conclusions

The kitchen is an area of the home that carries great significance for a number of people, especially older people, and can be seen as the ‘hub’ or heart of a home. As people age, their abilities and needs can change, and their kitchen may no longer be as accessible or appropriate to their needs. The study has shown that older people experience a variety of difficulties performing basic activities of daily life in their kitchens, such as making a hot drink or cooking their own dinner. Whilst there will always be some people who will need some assistance in these daily tasks, for others it is possible that adaptations to the design and layout of their kitchen or the appliances within it could make life easier for them on a daily basis, both currently and in the future. The study is ongoing, and will combine the findings of the review of people’s current kitchens with information gained in the oral history interviews into people’s memories and experiences of kitchens through their life course. The project aims to develop guidance for older people, occupational therapists, kitchen designers, and other interested parties that provides an understanding of user requirements for inclusive kitchen designs, as well as archive materials on the changing nature of kitchen usage during peoples’ lives.

Acknowledgements

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References


