Theo yêu cầu của khách hàng, trong một năm qua, chúng tôi đã dịch qua 16 môn học, 34 cuốn sách, 43 bài báo, 5 sổ tay (chưa tính các tài liệu từ năm 2010 trở về trước) Xem ở đây

DỊCH VỤ DỊCH TIẾNG ANH CHUYÊN NGÀNH NHANH NHẤT VÀ CHÍNH XÁC NHẤT

Chỉ sau một lần liên lạc, việc dịch được tiến hành

Giá cả: có thể giảm đến 10 nghìn/1 trang

Chất lượng:Tạo dựng niềm tin cho khách hàng bằng công nghệ 1.Bạn thấy được toàn bộ bản dịch; 2.Bạn đánh giá chất lượng. 3.Bạn quyết định thanh toán.

Tài liệu này được dịch sang tiếng việt bởi:

www.mientayvn.com

Từ bản gốc:

https://drive.google.com/folderview?id=0B4rAPqlxIMRDUnJOWGdzZ19fenM&usp=sharing

Liên hệ để mua:

thanhlam1910_2006@yahoo.com hoặc frbwrthes@gmail.com hoặc số 0168 8557 403 (gặp Lâm)

Giá tiền: 1 nghìn /trang đơn (trang không chia cột); 500 VND/trang song ngữ

Dịch tài liệu của bạn: http://www.mientayvn.com/dich_tieng_anh_chuyen_nghanh.html

Patients' nutritional care in hospital:
An ethnographic study of nurses' role and patients' experience

Final report

May 2005

Jan Savage RN, BSc (Hons) PhD
&
Cherill Scott RN, MA, MSc
RCN Institute
20 Cavendish Square
London W1G 0RN

Commissioned by NHS Estates

CONTENTS

Acknowledgements

Executive Summary…………………………………………………………………… i

SECTION 1: BACKGROUND..…………………………………………………………… 1

1. Introduction

1.1 Nurses' role in nutritional care: the changing policy context

1.1.1 Decline in nurses' managerial authority

1.1.2 Re-defining the 'proper functions' of a nurse

1.1.3 Recent measures and their implications for nursing

SECTION 2: RELEVANT LITERATURE………………………………………………… 7

2.1 Nurses and nutritional care

2.2 Patients' experience

2.3 Waste and the organisation of food delivery systems

2.4 Nutrition and clinical outcome

2.5 Summary

SECTION 3: THE STUDY

…………………………………………………………………. 12
3.1 Research aims
3.2 Research approach
3.3 Choice of research site

3.4 Sampling
3.4.1 Criteria for selecting patients for observation and /or interview
3.4.2 Criteria for selecting ward staff for observation and/or interview

3.4.3 Criteria for selecting other Trust staff
3.5 Methods of data collection

3.5.1 Observation on the ward
3.5.2 Semi-structured interviews
3.5.3 Documentation
3.5.4 Invited attendance at meeting of Trust's Nutrition Committee
3.5.5 Visits to hospital kitchens
3.6 Data analysis
3.7 Transferability of findings

3.8 Rigour
3.9 Ethical issues
3.9.1 Obtaining informed consent

3.9.1.1 From patients, for observation of care and interviews
3.9.1.2 From staff, for observation of care and interviews:
3.9.2 Ensuring potential participants did not feel coerced into being involved.
3.9.3 Ensuring confidentiality
3.10 Project timetable
SECTION 4: THE STUDY SITE …………………………………………………………… 20
4.1 The overall context
4.1.1 The trust
4.1.2 City hospital
4.1.3 Catering services across the trust
4.1.4 Assessment of the quality of food

4.2 Relevant information catering, dietetic and nutritional issues within the trust
4.2.1 Hospital report on catering and dietetics
4.2.2 Nutrition committee
4.2.3. Manual on Nutrition Support
4.2.4 Nutrition support team
4.2.5 Essence of care benchmarking
4.2.6 Protected mealtimes
4.3 The organisation of catering services

4.3.1 The cooking and reheating of food

4.3.2 Menu cards
4.4 Food choice and diets

4.4.1 The new menu
4.4.2 Special diets
4.4.2.1 Culturally appropriate diets
4.4.2.2 Therapeutic diets
4.4.2.3 High profile diet
4.4.3 Nutritional supplements
SECTION 5: BACKGROUND INFORMATION ABOUT THE WARD…………… 26

5.1 Description of Mary Seacole ward

5.1.1 Patient profile

5.2 The organisation of nursing staff

5.2.1 Shifts
5.2.2 Staffing levels
5.3 Ward routine
5.4 Challenges
5.4.1 Particular nutritional issues associated with the ward's patients

SECTION 6: FINDINGS ABOUT THE CONTEXT OF CARE…………………… 30
6.1 Trust priorities
6.2 Budgets

6.2.1 Nursing budgets
6.2.2 The budget for food
6.3 Interdepartmental and inter-professional working
6.4 Interdepartmental and interdisciplinary contributions to nutritional care

6.4.1 Medical
6.4.2 Nursing
6.4.3 Dietetic
6.4.4 Speech and language therapy
6.4.5 Modern matron

6.4.6 Housekeeper
6.4.7 Domestic
6.5 Implementation of the Protected Mealtimes initiative

6.6 Trust-wide views on the quality of hospital food

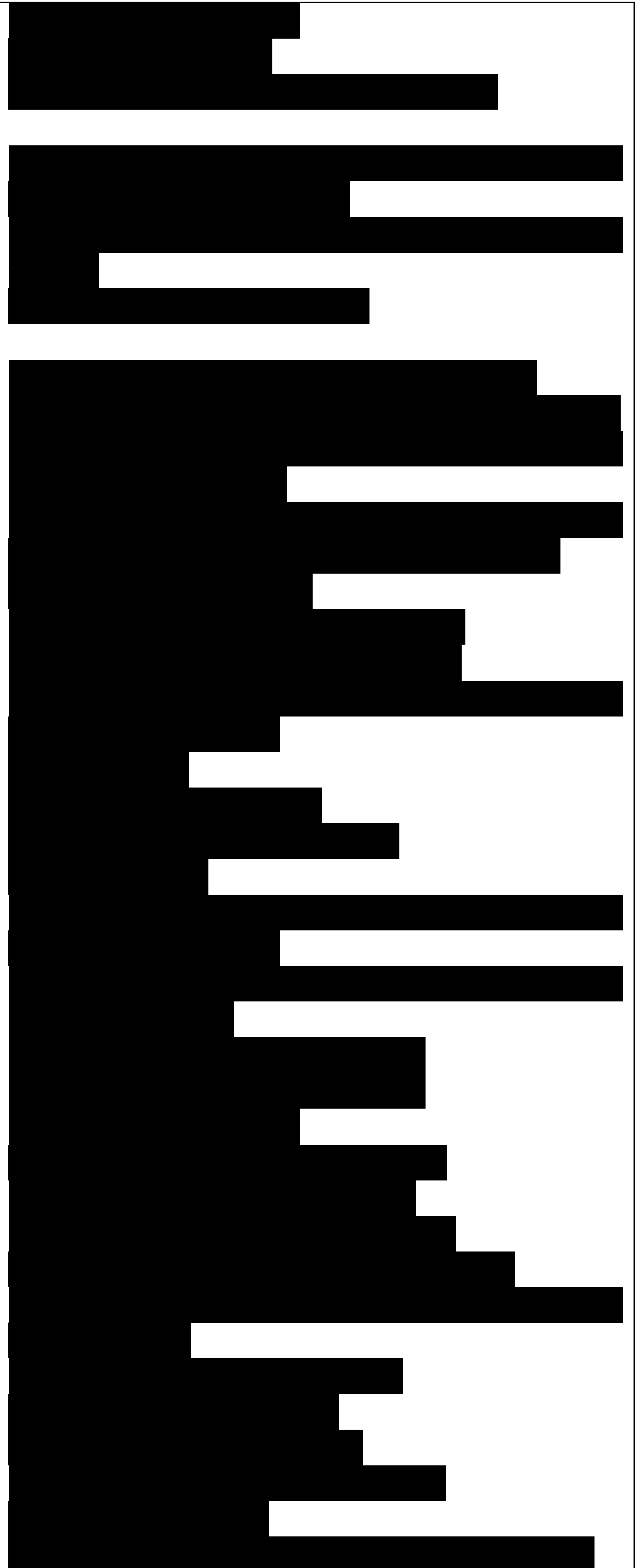
6.7 Health and safety issues in the trust
6.7.1 Restricted access to kitchens
6.7.2 Restrictions on reheating food
6.7.3.Restrictions on the use of ward refrigerators
6.7.4.Restrictions on the use of blenders in ward kitchens

SECTION 7: FINDINGS: NURSES' INVOLVEMENT IN NUTRITIONAL CARE ... 41
7.1 Broader issues
7.1.1 Nursing practice

7.1.2 Nursing morale

7.1.3 The views of ward staff on the quality of food

7.1.3.1 Regeneration
7.1.3.2 Limited choice
7.1.3.3 Fresh fruit and vegetables
7.1.4 Budget



7.1.5 The views of the ward's patients on the quality of food

7.1.6 The quality of nutritional care on Mary Seacole ward
7.1.6.1 Staff views

7.1.6.2 Patients' views

7.1.7 Managing complaints
7.2 The provision of nutritional care
7.2.1 Assessment and referral

7.2.1.1 Dysphagia screening

7.2.1.2 The nutritional screening tool
7.2.2 Nurses' involvement in the provision of food

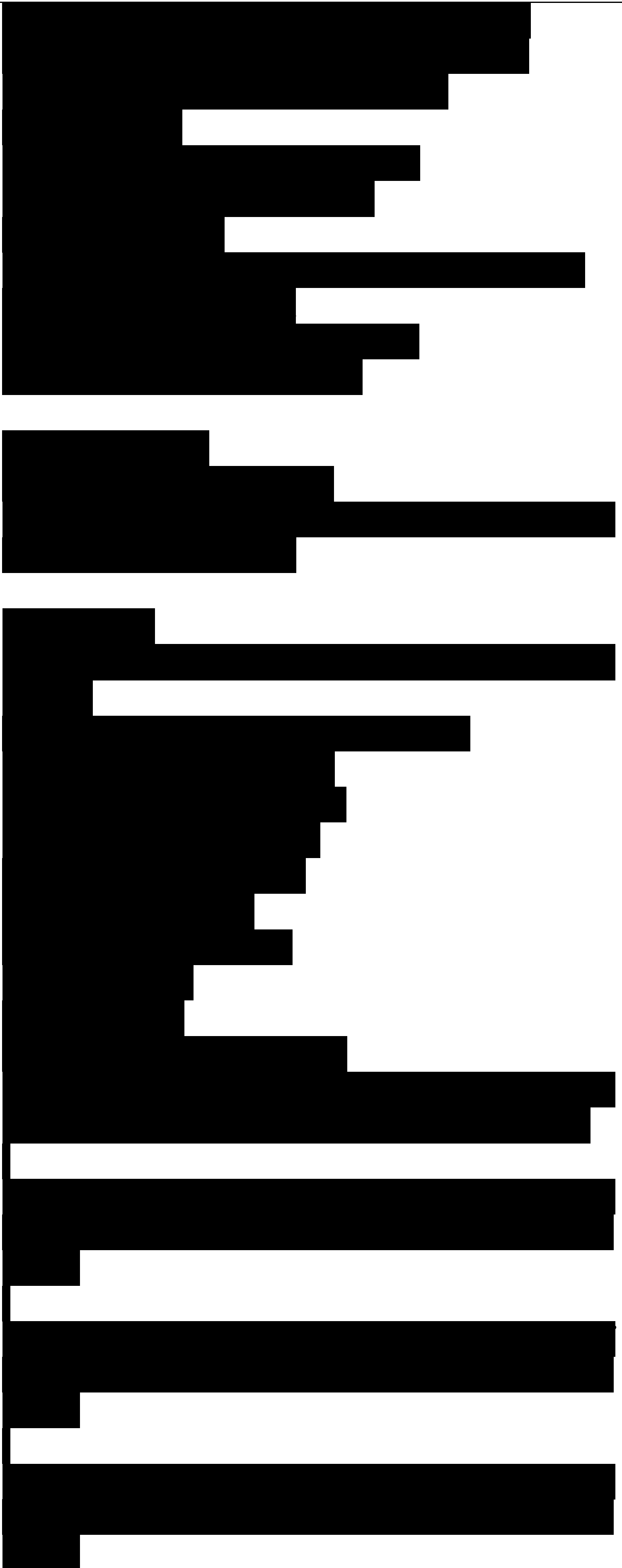
7.2.2.1 Ensuring supplements
7.2.2.2 Snacks
7.2.2.3 High profile menu
7.2.2.4 Ensuring special diets

7.2.3. Menu cards
7.2.3.1 Patients' views on menu cards
7.2.4 Nurses' role in Protected Mealtimes
7.2.4.1 Impact on nurses' hours of work
7.2.4.2 System for food service

7.2.4.3 Speed
7.2.4.4. Conflicting priorities

7.2.4.5 The serving of food
7.2.4.6 Presentation
7.2.4.7 Patients' views of protected mealtimes
7.2.5 The feeding of patients
7.2.6 Tempting patients to eat

7.2.7 The monitoring of food intake
7.2.7.1 Documentation
7.2.7.2 Interview data
SECTION 8: CONCLUSION AND RECOMMENDATIONS……………………



…. 59
8.1 Conclusions
8.1.1 The influence of 'top down' initiatives
8.1.2 The significance of nutrition
8..1.3 Organisational systems
8.1.4 Nurses' authority
8.1.5 Staff morale
8.1.6 Cross-team working
8.1.7 Protected Mealtimes
8.1.8 Ward housekeepers
8.1.9 Complaints
8.1.10 Training
8.2 Limitations of the study
8.3Recommendations………………………………………………………………….. 64

REFERENCES ………………………………………………………………………… 66

GLOSSARY ………………………………………………………………………… 70

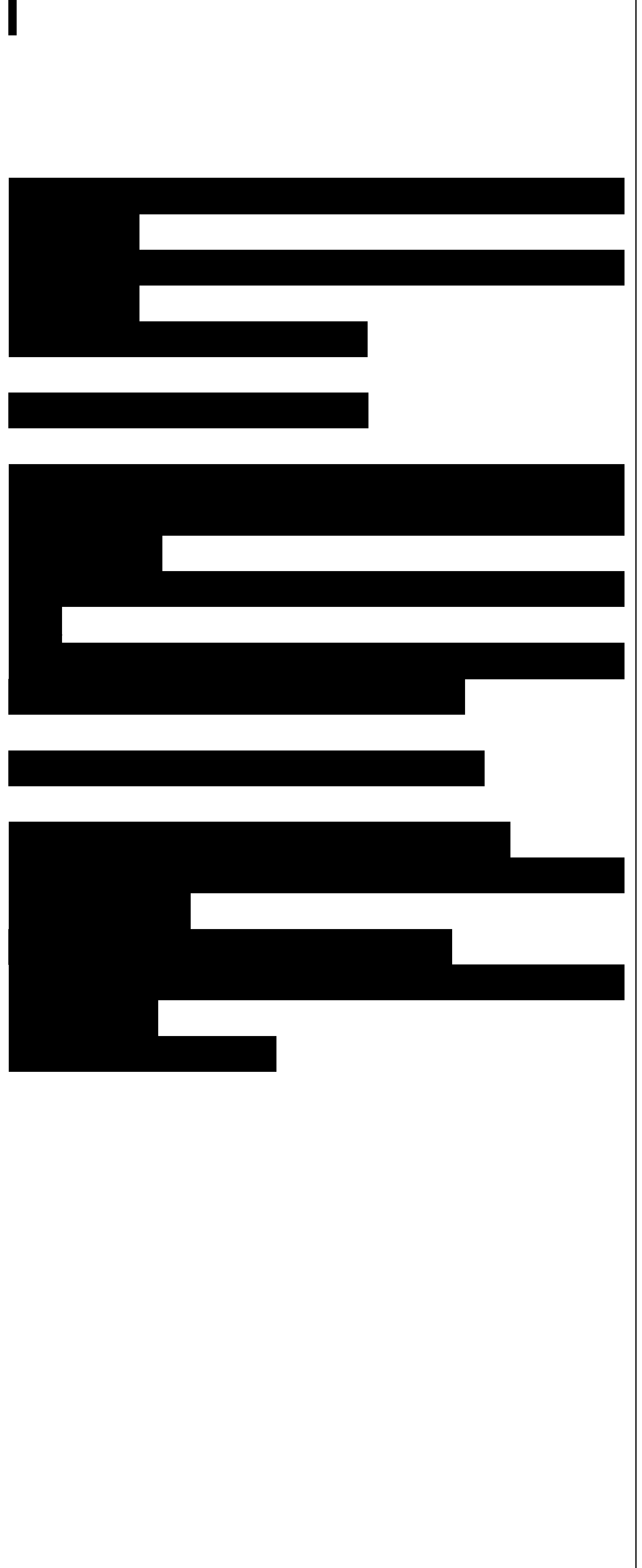
APPENDICES ………………………………………………………………………… 71

Appendix 1: Details of staff interviewed
Appendix 2: Details of patients interviewed
Appendix 3: Examples of menus
Appendix 4: Menu of supplements
Appendix 5: Results of Essence of Care audit (food and nutrition)

Appendix 6: Duties of night staff
Appendix 7: Nursing care plan: Eating and drinking – at risk of malnutrition

Appendix 8: Overall assessment process

Appendix 9: Nutritional screening tool
Appendix 10: Protected mealtimes checklist



Appendix 11: New food chart

Appendix 12: Nursing notes

Acknowledgements

We would like to thank members of the NHS Estates/RCN Institute PEAT/Better Food Programme liaison group for their support and guidance on the project. We also thank members of staff and patients from 'Trust X', for their help in arranging access, or their involvement in the research. We are particularly indebted to the staff of 'Mary Seacole' ward, for their co-operation and forbearance. We hope that we have managed to convey some of the complex issues that they face, without effacing their achievements and the good heart they bring to their work.

Executive Summary

1. Previous research has established that the nutritional status of hospitalised patients can be compromised by a number of factors, including the failure to detect poor nutrition, poor recording of information about patients' nutritional status (such as weight loss), poor referral systems, fragmented working practices, inadequate educational or training programmes, inadequate ward staffing and confusion over who has the primary responsibility for patients' nutrition.

phân tán

việc

chăm sóc cho

2. The nature and extent of nurses' involvement in nutritional care has varied over time. By the mid- twentieth century, matrons and senior nurses had relinquished direct managerial control over catering and other housekeeping functions in hospitals. It proved difficult for senior nurses to retain influence

over standards of service provision, particularly following the widespread ‘contracting out’ of catering and domestic services; at the ward level there was some blurring of the roles and responsibilities of nurses and non-nurses in the preparation and serving of food, and helping those patients who could not manage to eat unaided. (The provision of housekeeping staff to help nurses to concentrate on their clinical responsibilities – as originally suggested in the Salmon Report, 1966 - never materialised.) Recent policy, such as NHS Estates’ Better Hospital Food Programme and Protected Mealtimes initiatives, along with the requirement for NHS trusts to appoint ‘modern matrons’ and ward housekeepers, have once again focused attention on the potential contribution of nurses to nutritional care.	người trong vấn đề
3. This study was funded by NHS Estates to explore nurses’ involvement in nutritional care following anecdotal evidence that, despite initiatives to improve their experience of eating in hospital, patients’ nutritional needs were often poorly met.	dựa theo một số bằng chứng về việc
4. The study was undertaken by researchers from the Royal College of Nursing Institute, using an ethnographic approach to study in depth the different factors affecting nurses’ involvement in nutritional care. For the purposes of the study, the term ‘nutritional care’ was taken to mean a patient-centred, co-ordinated, multi-disciplinary approach to meeting individual needs for food and fluids. Because the researchers wanted to understand nurses’ role in the fundamental aspects of nutritional care, they focused on patients who were taking food or fluids by mouth rather than those receiving enteral or parenteral care. The research proposal was peer reviewed by the RCN Institute research projects sub-committee and approval was given by the relevant Multi-	tiếp cận theo hướng đa ngành để thỏa mãn nhu cầu của từng cá nhân về thực phẩm và chất lỏng

site Research Ethics Committee. All participants in the study gave their signed consent to observation of care and/or interview. The project was funded for nine months (April – December 2004) and the fieldwork took place over four and a half months (July – mid-November). During this time, the researchers completed ten periods of observation of practice, each lasting up to four hours. Semi-structured, recorded interviews were conducted with 20 members of staff from the ward and the wider trust, and with ten patients, selected to cover a range of ages, ethnic backgrounds, diagnoses and lengths of stay. The researchers also studied relevant documentation relating to the trust's strategy for nutritional care and to care planning at ward level. Based on this information, the full report contains detailed descriptions of the organisational context within which nutritional care took place. Analytical coding of notes from observations of practice and the interview transcripts generated thematic categories for the organisation of the study findings.	Đạo đức (trong) nghiên cứu có sự khác biệt về tình trạng bệnh trust về kế hoạch điều dưỡng cấp tình hình tổ chức để sắp xếp
5. The NHS trust in which the research was conducted provided district general services to its local population and specialist tertiary care for patients across a wide geographical area. It managed three hospitals; the one in which the study took place had just under 700 beds. The local population faced huge medical and social problems, with a higher burden of ill health than most other areas. It was ethically and culturally diverse, and included a high proportion of people for whom English was a second language. The trust achieved disappointing ratings in the most recent (2004) PEAT inspections of food and food services.	tiến hành nghiên cứu tổng quát cấp khu vực các ở mức độ thứ ba cho các bệnh nhân trên một khu vực địa lý rộng lớn Tổ chức này quản lý ba bệnh viện Đây là nơi có tính đa dạng văn hóa và sắc tộc có một số lượng lớn người
6. The ward on which most of the fieldwork was carried out was a 27-bedded general medical ward that has a challenging mix of	nặng có

patients (both male and female), from a variety of ethnic and social backgrounds, many of them requiring intensive nursing and medical care. Language problems were often a barrier to good nurse: patient communication. The ward was suggested by senior nurses in the trust because it had been involved in piloting Protected Mealtimes, and because they thought the ward team had an interest in improving nutritional care. It had no ward housekeeper in post, but it did have a nutrition link nurse (the first in the hospital) who had a strong interest in this aspect of nursing care.	và điều dưỡng
7. The trust's commitment to nutritional care was demonstrated in several ways: its enthusiasm to be involved in the research; the publication of a detailed manual on nutrition support; the establishment of a nutrition committee and nutrition support team; and the early implementation of the Protected Mealtime initiative. However, nutrition was routinely subordinated to other trust priorities, such as the requirement to meet targets associated with star ratings. There was concern that 'top down' initiatives such as Protected Mealtimes, seen to be predominantly concerned with aesthetics, were prioritised over 'bottom up' initiatives designed by clinicians to improve the therapeutic potential of nutrition. Budgets were also perceived to be a problem: nursing budgets were expected to cover the costs of certain domestic items and the salaries of ward housekeeping staff. The trust's budget for food, per patient per day, was not generous, although comparable with other NHS hospitals. Catering staff found it difficult to get approval for expenditure on kitchen equipment. It was not always easy for staff from different functions to collaborate on the development of new menus. The introduction of Protected Mealtimes across the trust was generally welcomed, although on some wards (notably surgical wards) it had posed some logistical	sớm triển khai sáng kiến theo kiểu từ trên xuống từ dưới lên bác sĩ lâm sàng đề xuất của vào cỡ cảm thấy họ khó nhận được Việc hợp tác của các nhân viên từ các phòng ban khác nhau để phát triển thực đơn mới cũng không dễ dàng ở trust làm nảy sinh

difficulties for medical staff. Health and Safety policies, for example those concerning the nurses' use of microwave ovens to heat food brought in from outside the hospital, were seen to undermine nurses' and relatives' attempts to encourage patients to eat. Finally, there was no clear way of complaining about the quality of food or food service: comments on quality were dealt with a range of trust staff including nurses, Patient and Public Involvement officers, and catering staff such as Patient Services supervisors.	cho được nhiều người trong trust xử lý nhân viên của Patient and Public Involvement
8. The study identified the key responsibilities of the ward nursing team in relation to nutritional care as: • initial nutritional assessment, monitoring and referral to specialist staff where appropriate;	phân bổ nhân viên đến nơi phù hợp
• screening for dysphagia at times when speech & language therapists are not available (eg at weekends); • implementing the advice of dieticians and speech & language therapists; • helping patients to complete menu cards; • ensuring that patients received their chosen meal, including special diets; • serving breakfast, and other meals with the help of domestic staff; • providing snacks (such as toast and tea) for patients who cannot eat a full meal; • helping to feed any patients who need it; and • organising nursing work around protected patient mealtimes	kiểm tra âm ngữ trị liệu ngày âm ngữ trong bệnh viện
9. The researchers found that, despite the commitment of nurses on the study ward to good nutritional care, there were inconsistencies in nursing assessment, care	

plans and monitoring (such as the recording of food intake or weight). Several factors were identified that affected the ability of ward nursing staff to perform well in all areas of nutritional care. First, the rapid throughput of patients, along with high dependency levels, meant that nurses had to prioritise aspects of patient care (with activities such as monitoring food or fluid intake given low priority); they had little time to talk to patients and get to know them properly; and worked long hours without breaks. Second, the language and documentation of nursing handover sessions suggested that nurses were under pressure to follow a medical and technical model of care, rather than one focused on the fundamentals of nursing care. Third, ward staff felt they could do little to mitigate any problems with the quality and choice of food on offer, or the shortcomings of the hospital's food production or delivery processes. Fourth, nurses had to manage conflicting demands: for example, the pressure on wards to meet trust performance targets by admitting patients from A&E as quickly as possible tended to over-ride the aim of protecting mealtimes. Fifth, there was no ward housekeeper in post who might support nurses by, for example, chasing up missing food orders or help patients to complete menu cards. Sixth, there was room for greater co-operation across hospital teams, such regular feedback on levels of monitoring food intake. Lastly, patients on the ward had mixed views about the quality and variety of food on offer, and the manner in which it was served, some being very critical and others much more appreciative. They did not hold nurses responsible for problems with food, but neither were they aware that the hospital's 'modern matrons' had the authority to deal with their concerns in this area.	mức độ tiêu thụ Nghiên cứu đã xác định được một số yếu tố tốc độ tiêu thụ thức ăn nhanh của bệnh nhân những vấn đề về trong việc đảm bảo việc hợp tác giữa các nhóm trong bệnh viện cần phải cải thiện thêm nhiều quan điểm khác nhau lại khen ngợi liên quan đến
10. Findings of the study are not generalisable	

in the sense used by quantitative research. Instead, the aim was to provide rich description that allows others to identify issues applicable to their own situation. Bearing this in mind, a number of recommendations are identified at national, cross-trust and local level with the aim of improving standards of nutritional care:	có thể cho trường hợp của mình cấp
Recommendations to policy makers and NHS management o to consider ways in which clinical staff can be involved in developing the criteria on which star ratings are based; o to consider ways of empowering NHS staff to prioritise and focus on important elements of care that currently do not attract star ratings; o to ensure that the training and post-graduate education of nursing and medical students provides clinicians with sound knowledge for the assessment and, where appropriate, improvement of patients' nutritional status, as an integral part of all patient care;	một số cách để nhân viên y tế có thể tham gia xây dựng tiêu chuẩn xếp hạng dựa trên sao vị trí với tư cách
o to give further consideration to, and guidance on how to maximise the potential of modern matrons and ward leaders to improve nutritional care;	hoạt động
o to consider ways of ensuring that ancillary staff such as domestics working both for the NHS and for external contractors have parity of pay, conditions of work and staff development, to help improve morale and efficient working. Recommendations to all hospital trusts o to develop a clear, whole-trust strategy for nutritional care, including a standardised screening tool, adequate training for its use, and guidelines for referral where necessary.	công bằng trong khảo
Recommendations to the study trust	

o to consider setting up a cross-trust nutritional care team (for example, akin to the tissue viability team) that advises on patient care where nutritional screening produces a score below 6, but complex problems are identified or suspected;	nhưng đã xác định được nhiều vấn đề phức tạp nảy sinh hoặc còn đang nghi ngờ
o to set up a cross-discipline working group to consider the specific training associated with nutritional care required as a standard element of staff development/induction; o to augment training in the use of the nutrition screening tool by providing more guidance on the range of stress factors influencing nutritional status; o to clarify, and publicise, systems for the ordering and supply of special diets and supplements; o to consider establishing a new catering dietician role to focus on the delivery of appropriate food to patients with special dietary requirements; o to set up a cross-trust working group to examine health and safety policies, their interpretation and implications, with a view to increasing the ability of ward staff and others to respond to patients' nutrition need; o to take measures to establish the authority of modern matrons to challenge cross-trust practices impacting on patient care (including nutritional care) and explore ways of raising the profile of the matron as a conduit for nursing concerns; o to consider ways of reducing pressure on nursing staff, such as the wider introduction of ward housekeepers, the development of new roles, and the provision of additional help from facilities staff at mealtimes such as breakfasts;	thành liên nghành thành phần tiêu chuẩn đến việc thiết lập ý nghĩa trong các hoạt động liên trust đầy khó khăn giải tỏa đưa vào khoa nhiều người dọn dẹp hơn
o to set up a working group to agree guidance for the trust-wide implementation of the ward housekeeper role, including job	thành

description, sources of funding, line management and time frame;	
o to encourage cross-team dialogue on nutritional care through joint training or staff development workshops;	
o to ensure that information about the times and principles of Protected Mealtimes is made available to all relevant trust staff, and that this includes clarification of the trust's position on managing conflicting priorities (such as the need to observe Protected Mealtimes and the need to admit patients as necessary from A&E);	
o to streamline, clarify, and publicise, the system for making complaints about food and food service, and how these complaints are to be acted upon;	
o to review and, if appropriate, streamline the process and documentation for initial nutritional assessment/screening by ward nurses by considering, for example, the advantages of integrating nursing assessment of a patient's ability to eat and drink with the trust's nutritional assessment tool;	ghi nhận lại những tích hợp với
o to clarify understanding of the remit of registered nurses and whether they are essentially concerned with fundamentals of care, such as assisting patients to eat, or whether nurses primarily supervise care, and concentrate more on technological interventions.	
11. The study has identified a number of areas where further research is needed:	
o an exploration of the current role of modern matrons with respect of their responsibilities for promoting and ensuring nutritional care (Department of Health 2003b);	
o a national study of how the ward housekeeper role has been implemented looking at how the role is developed, funded and managed in different contexts, perceptions of the role and its impact, and barriers to	trong đó chú ý đến các vấn đề như xây dựng vai trò, cấp quỹ và quản lý trong các điều kiện khác nhau, nhận thức về vai trò và tác động của nó, và những khó khăn trong

implementation;	quá trình triển khai;
o a in-depth study of cross-cultural beliefs about food and its social role, including a consideration of the significance of family or carer involvement in providing food and help with feeding, and the ways in which some food contributes to patient identity and social wellbeing.	
SECTION 2: RELEVANT LITERATURE	
2.1 Nurses and nutritional care	
Nurses are not solely responsibility for nutritional care but they play a potentially significant role in patient feeding and the identification of vulnerable patients (Holmes 1999). The British Association for Parenteral and Enteral Nutrition (BAPEN 1999) recommended that nurses hold primary responsibility for the nutritional care of in-patients. It argued that food should be served by nurses, supported where necessary by other grades of staff trained for this purpose (such as ward hostesses or care assistants). BAPEN also recommended that nurses should ensure assistance with eating, the provision of special utensils where required, and the monitoring of patients' food intake.	đã đề xuất các y tá cần phục vụ thức ăn trong khi những nhân viên khác đã được đào tạo chuyên môn thì hỗ trợ nếu cần thiết bệnh khu hoặc trợ lý đề xuất
Coates's (1985) study of nurses' involvement in nutrition found only a small percentage of written nutritional information about patients was accurate, and nutritional assessment by nurses was essentially a matter of measuring patient weight. Whether or how nurses helped patients to eat varied. Nurses spent considerable time feeding patients (up to 30 minutes) if there were the staff available to do this (occasionally one nurse might simultaneously feed a number of patients). Helping a patient eat could be a skilled job if	dinh dưỡng được ghi lại đánh giá dinh dưỡng bằng cách y tá thực hiện chăm nhiều một

the patient was reluctant, or had difficulty in chewing or swallowing. There was no clear evidence that the mode of organising care influenced patients' dietary intake. However, all wards in the study were operating with fewer nurses than recommended for the methods of nursing organisation in use and therefore deficiencies in nutritional care might there be attributable to a chronic shortage of nurses.	khó tính Chưa số lượng y tá ít hơn con số vì vậy những quy cho thiếu hụt số lượng trong thời gian dài
More recently the RCN has made clear its concern that a fall in the number of registered nurses on hospital wards and inconsistencies in the basic training of nurses posed threats to the nutritional status of hospital patients (RCN 1996). The Department of Health commissioned work to identify the blocks to ensuring good nutritional care and to provide examples of good practice (Bond 1997). Yet studies have continued to highlight problems in this area. A Nursing Times survey, for example, showed very low levels of recording food intake or routine weighing of patients on admission, on acute wards (Wood 1999). Although nurses have shown a greater interest in nutritional care than some other groups of health professionals, they do not always have the appropriate knowledge to underpin this (Council of Europe 1992). Research in Scotland (Harris and Bond 2002) involving nurses and chief dieticians indicated concerns in relation to nutrition screening tools, referrals, education/training and the relationship between staffing levels and feeding. In response, a Best Practice Statement on nutrition assessment and referral was developed with recommendations covering five areas: admission to hospital; nursing management of nutritional care, screening and documentation, criteria for nutritional referrals, and education and training.	nêu lên một số gương điển hình cấp tính kiểm tra phân bổ trình độ nhân viên kinh nghiệm tốt nhất phân bổ phân bổ

2.2 Patients' experience	
McLaren et al (1997) and Holmes (1999) identified a number of issues associated with hospitalisation that could influence patients' eating behaviour, including: • impaired appetite due either to the effects of physical disease causing difficulty with swallowing, or to feelings of anxiety or depression;	giảm thèm ăn do
• removal from familiar environment/alien surroundings of the hospital ward • different routines; • uncertainty about what will happen; • unappealing institutional meals; • inflexible hospital systems which make it difficult to make alternative provision for patients who have missed meal-times; • regulations preventing the preparation of additional meals or snacks in ward kitchens; • delayed referrals for dietetic advice.	
Patients' experience of food may also vary for socio-cultural reasons. For instance, Mennell et al (1994) point to the importance of the social context and aesthetics of food, with the choice of food, methods of eating, preparation, number of meals a day, size of portions being culturally shaped (Fieldhouse 1986). In addition, food can act as a code to convey messages about, for example, social hierarchies, or the social inclusion or exclusion of groups or individuals (Douglas 1997). The study by Edwards and Nash (1997) for example, found that food waste was greatest on those wards caring for elderly patients (over 65 years), hinting that perhaps the needs of this group had been marginalised.	
Research over many years has identified consistent patient dissatisfaction with aspects of hospital food such as unhelpful menus carrying poor descriptions of the dishes on offer problems with the timing of food	không hài lòng

delivery; the presentation and temperature of food; and the size of portions, while systems for complaints were complex (NHS Estates 2004). Coates (1985) found that patients might be left to feed themselves despite having difficulty lifting the lid covering their meal; some lost substantial amounts of food in feeding themselves; and one patient in the study was found to have swallowed the 'cling film' used to cover his or her plate. More recently, an audit of care for 70 elderly patients found that, according to criteria used by ward staff, 14 patients needed help with feeding but only two were adequately fed, and 14 patients required help with cutting food, but help was given to only 10 patients (Bactawar 1999). In addition, three patients would have benefited from adapted cutlery but no such cutlery was available. Eleven patients ate very little food, and four ate no food at all, yet none were offered supplements or any alternatives to the basic hospital diet. At the same time, numerous activities such as doctors' rounds; social worker visits; drug rounds; physiotherapy assessment; dieticians' visits; bed making; and patient transfer assessment, took place at mealtimes. Such disruption may not only impact on patients' food intake, but can have more subtle effects. Research suggests, for example, that patients' perceptions of their social world, the control they can exercise over this, and the extent to which they can take responsibility for aspects of their care can impact on their health (Douglas and Douglas 2004). The NHS Plan (DoH 2000) aimed to address these and other concerns, and improve the contribution of food to patients' overall experience of hospitalisation. Under the Better Food Programme, for example, it set out the government's commitment to a 24 hour catering service with a new NHS menu, and prompted the introduction of independent Patient Environment Action Teams (PEATs) to review hospital food standards.	hệ thống đánh giá

2.3 Waste and the organisation of food delivery systems	
Dissatisfaction with hospital food is one reason why patients do not eat the food provided in hospitals. Waste also results from inflexible food delivery systems. A study of nine NHS wards, for example, found high levels of waste in all sites, with waste higher in wards catering for patients over 65 years of age (Edwards and Nash 1997). This was less evident where meals were plated on the wards (rather than pre-packaged), and staff were able to respond flexibly to patients' needs (which might have changed since food was ordered). The study found that waste was linked to the fact that food was often delayed, or served in poor condition (aesthetically and nutritionally), because of lack of staff or because medical or domestic routines took priority over patients' need to eat.	phổ biến hơn ở
2.4 Nutrition and clinical outcome	
Specific diseases can prompt inherent nutritional problems, most commonly malnutrition. For example, chronic obstructive airway's disease is associated with a high incidence of protein calorie malnutrition (Hunter et al 1981). Infection may increase patients' nutritional needs because of an increase in metabolic rate (Coates 1985). Cancer may cause an increased metabolic expenditure requiring an increased nutritional intake yet the patient may feel less able to eat due to nausea, pain or obstruction of the gastro-intestinal tract (Coates 1985). After a cerebral-vascular accident, patients with weakness or paralysis can be susceptible to nutritional problems because of difficulties with handling cutlery, or chewing food (Coates 1985). Other variables, in addition to or in spite of their primary disease, may also affect nutrition. Loss	căn bệnh ban đầu

of body fluid (such as through diarrhoea, vomiting, wounds, blood loss) can deplete nutrients such as electrolytes or nitrogen. Surgery or trauma such as accidental injury can significantly affect body metabolism; the metabolic response to trauma has been shown to correlate with the magnitude of injury and result in both a proportionately increased metabolic rate and increased energy requirements (Elwyn et al 1981).	liên
A range of studies in the 1970s indicated that up to 50% of patients hospitalised for more than two weeks were affected by malnutrition, and were at risk of higher rates of morbidity and mortality and longer hospital stays (for example, Hill et al 1977; Bistrian et al 1976). More recent work confirms that medical and surgical patients with malnutrition experience higher rates of complications than patients who are adequately nourished (McCamish 1993; Potter et al 1995). The potentially-reversible effects of malnutrition include reduced muscle power and mobility with increased likelihood of deep vein thrombosis and pressure sores (Holmes et al 1987). Wound healing can be delayed (Windsor and Hill 1988). Tolerance to therapies such as chemotherapy or radiotherapy may be reduced (Holmes 1997), while increased complication rates and longer length of stay lead to increased costs of hospital care (Larsson et al 1990; Lennard-Jones 1992)) and increased admission rates (Tierney et al 1994). A report from the King's Fund suggests that potential improvements in nutritional care could lead to savings of £226 million a year (Lennard-Jones 1992).	
Iatrogenic malnutrition – that is, malnutrition as a consequence of hospital diet, hospital processes and shortcomings – has long been an important factor in determining the outcome of illness. Butterworth (1974) highlighted the role of U.S. hospitals in the development of patient malnutrition, prompting a flurry of research in	

this area in both the USA and UK. Weisnier et al (1979), for example, found that 75% of medical patients admitted with normal nutritional status were found to have depleted nutritional reserves after a time in hospital. Similarly, a study of underweight hospital patients suggested that although their food intake had been adequate prior to admission, in hospital their intake fell to only 70-80% of their needs (Johnston 1980). In Coates's (1985) study, all patients taking an ordinary hospital diet were consuming less energy and some, less protein, than the DoH (then DHSS) recommendations. 70 out of 93 patients in her study were unable to meet requirements for energy and protein from diet alone and were therefore using body stores to address the deficit. More recently McWhirter and Pennington (1994) drew attention to the continuing presence of hospital-related malnutrition, and the Association of Community Health Councils (1997) showed that many hospital patients were receiving too little food to stave off hunger. Hospital diets have been found to be, at best, adequate for maintenance of nutritional status, but not repletion. (Holmes 1999).	trong đã bị suy dinh dưỡng của hơn vài người trong có liên quan đến được cho là tối đa cũng
In a study published in 1985, a number of circumstances that contribute to iatrogenic malnutrition were identified including:	
• lack of nutritional awareness, with research suggesting that nutritional problems in hospital are often unrecognised • the low status of nutritional care, where short-term interventions such as surgery are given more credence than long-term and more subtle forms of therapy such as nutrition, which tends to get categorised as "just a 'hotel service' and hence not worthy of the attention of health professionals" (Bond 1988, p27)	

• priority of treatment, where restricting food or fluid intake for diagnostic procedures, or medical rounds may contribute to a patient's compromised nutritional status	khi làm
• lack of communication between the nurse and patient, or between members of the health care team, can contribute to nutritional neglect • confusion over responsibility for nutritional care, as it potentially falls within the remit of doctors, nurses, dieticians and pharmacists (Coates 1985).	
More recently, the Council of Europe (2002) has identified the main problems that underpin malnutrition in hospitals in the UK as: • lack of flexibility in food service • inconsistency in the assessment of nutritional status and food intake • lack of understanding of the importance of nutrition in hospital care • lack of information about practical ways of improving food intake in hospital • poor quality hospital food • an increasing number of older people with complex food needs.	
2.5 Summary	
The nutritional status of hospitalised patients can be compromised by a number of factors, primarily the failure to detect poor nutrition, confusion over who has primary responsibility for patients' nutrition; poor recording of data about patients' nutritional status (such as weight loss); poor referral systems; fragmented working practices; inadequate educational or training programmes; and inadequate ward staffing. Recent initiatives such as the Better Hospital Food programme may provide the basis for improving patients' experience of food but, without nursing involvement, they may not deliver patient satisfaction or ensure	phân tán

appropriate nutritional care. In the next chapter, we describe the design and implementation of a study that sought to take account of the many different factors that may currently affect nurses' involvement in this aspect of care.

SECTION 4: THE STUDY SITE

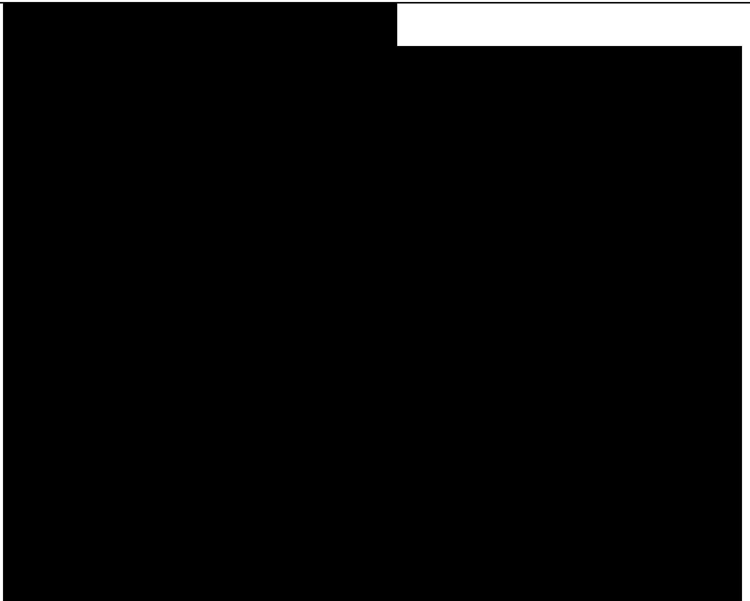
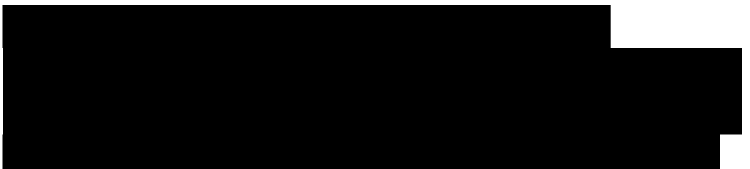
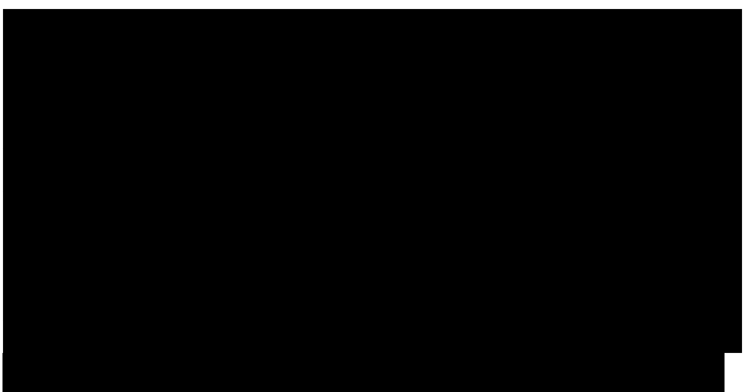
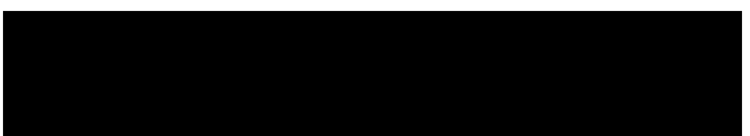
4.1 The overall context

This section gives a brief description of the trust and then the hospital in which our study ward was located, the catering services that the trust provides and relevant performance indicators.

4.1.1 The trust

Research took place on Mary Seacole ward, a general medical ward within City hospital, part of an inner city teaching trust (Trust X). The trust, established for over 10 years now, provides district general hospital services to its local population and specialist tertiary care for patients across a wide geographical area. It has an annual budget of £400 million pounds. In the year prior to our study, the trust provided care for approximately half a million patients and employed about 7000 members of staff. There are approximately 1000 in-patient beds across the trust. Clinical services are delivered across eight directorates. Our study was located within the Medical and Emergency directorate, which covers general and emergency medicine, specialist medicine, accident and emergency services, trauma, infection and immunity services.

Trust X has a good reputation for clinical services, supported by low mortality ratios. In the most recent government star ratings assessment, it was rated 'medium' overall on the patient focus dimension.

4.1.2 City Hospital The hospital is which our study took place has just under 700 beds. It has ageing facilities, and is located in a deprived inner-city borough. The local population faces huge medical and social problems, with a higher burden of ill health than other areas. A high number of patients are affected by tuberculosis, diabetes, heart disease and cancer, and malnutrition is common. The local population is ethnically and culturally diverse: the largest ethnic groups are white British, Bangladeshi, Somali, Irish, Afro-Caribbean, Turkish, Jewish and Vietnamese. The population incorporates a large – often non-English speaking - refugee population who tend to present late for treatment.	
4.1.3 Catering services across the trust The trust has three main sites for in-patient services. For historical reasons, they do not all function in the same way with regard to the organisation of catering services.	
At two hospitals (City and St Cecelia), food is provided by a centralised production unit (CPU) located some miles away, while the third hospital (Crosskeys) has an on-site kitchen providing a plated food service to the wards. Catering and domestic staff at Crosskeys hospital are employed by the trust, while in the other hospitals, such staff are employed by an independent contractor.	
According to the trust's facilities manager, the CPU provides meals for 1000 patients (2000 meals per day) plus staff. This is addition to the local provision of meals for 300 patients at Crosskeys hospital, plus staff.	
The trust's clinical governance report for 2002-2003 (the most recent one available) gave details of the five main categories of	

complaints received. Complaints about food or nutrition were not among these main categories.

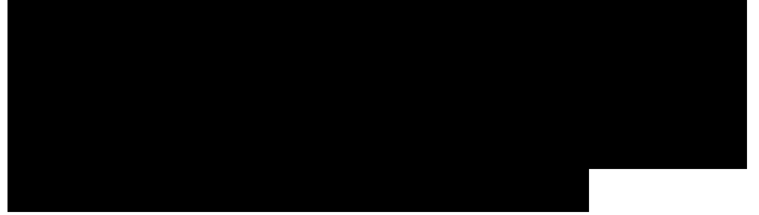
4.1.4 External assessments of the quality of food

PEAT scores for food attributed to the different sites within the trust are as follows:

Hospital	Catering system	PEAT score 2002	PEAT score 2003	PEAT score 2004
City	CPU, with staff contracted out	amber	amber	'poor'
St Cecelia	CPU, with staff contracted out	amber	green	'poor'
Crosskeys	in-house	green	green	'poor'

(For an explanation of PEAT scores, see p9, Footnote1.)

According to a press release from the Department of Health pre-dating our study (DoH 2003c), almost 90% of acute hospitals provided access to drinks and light refreshments 24 hours a day; 71% of hospitals provided snack boxes for patients who missed meals or required something lighter; and 66%

of hospitals offered patients additional snacks on at least two occasions per day. City Hospital was represented in these figures. However, at the time, City was not included in the 60% of hospitals that, according to the DoH, offered at least three new 'chef's hat' dishes on its menu. The National Patient Survey carried out by the Picker Institute in 2004 included a question on how patients rated the hospital's food. Although responses varied widely, the trust scored poorly overall, both in comparison to the scores for other indicators of quality (such as cleanliness), and in relation to the scores for food achieved by other trusts. Our trust was on the border of being amongst the 20% of worst performing trusts.	

Bản báo cáo này là kết quả của một dự án xem xét các vấn đề về chế độ và cách phục vụ ăn uống. Được thực hiện năm 2003, bản báo cáo cho rằng sau đợt đánh giá của PEAT trước đây, bệnh viện đã hoàn toàn tuân theo chuẩn của chương trình *Thức ăn bệnh viện tốt hơn* về khía cạnh cung cấp đủ món ăn "nón bếp trưởng" trên thực đơn cho bệnh nhân. Họ khẳng định rằng vòng thực đơn (3 tuần tại thời điểm báo cáo) có thể được điều chỉnh để đưa ra nhiều lựa chọn hơn nữa cho bệnh nhân nằm viện lâu ngày. Bản báo cáo cũng chỉ ra nhu cầu chuẩn hoá kích cỡ khẩu phần ăn, cho phép các chuyên gia dinh dưỡng thực hiện các phân tích về dinh dưỡng có ý nghĩa và giúp y tá theo dõi lượng thức ăn bệnh nhân tiêu thụ. Bệnh viện đã ghi nhận việc bệnh nhân không được phép lựa chọn phần ăn nghiền nhừ, và tiến hành cải thiện tình trạng này đối với những bệnh nhân gặp vấn đề nhai nuốt thức ăn. Những bệnh nhân như vậy phải nhờ vào chuyên khoa về âm ngữ, và thức ăn nghiền nhừ chỉ có thể được đặt qua một chuyên gia dinh dưỡng sau khi đánh giá. Điều này làm cho việc cung cấp thức ăn cho bệnh nhân mất nhiều thời gian. Tương tự như vậy, những chế độ ăn chữa bệnh phải được chuyên gia dinh dưỡng đặt, và như một hệ quả của hệ thống này, họ phân bổ thời gian cung cấp thức ăn/phục vụ ăn không cân đối. (Xem Mục 6.3 những nhận xét trong bản báo cáo về tác động qua lại giữa những nhóm khác nhau trong The Trust)

do giám đốc điều dưỡng và chất lượng đương nhiệm làm chủ tịch thành lập giải quyết những vấn đề này

đưa ra

Bệnh viện đã gấp rút cho ra đời tài liệu này do họ thấy rằng

biên soạn vào

đối với

được mọi người biết đến với tên là

chứ

không phải những hình thức cung cấp dinh dưỡng phổ biến

lâu dài kiểm soát

lớn tuổi

Họ phụ trách khoảng

chỉ những bệnh

nhân thích hợp mới được mở thông dạ dày

soát

sống của

đề xuất từ triển khai (đưa vào)

trong khoảng thời gian từ

phác họa các hệ thống phân phối thực phẩm cơ bản cho bệnh nhân Hoạt động trong thực tế của những hệ này như thế nào đề cập đến sau ở

không phải do công ty bên ngoài cung ứng

làm việc ở bộ phận chuyên

dẫn đến việc phải dẹp bỏ các nhà bếp trong bệnh viện đã từng cung ứng các bữa ăn trước đây

theo chúng tôi được biết

một khu riêng để nấu

phụ trách

Khi nhân

viên và y tá khu vực đẩy các xe chứa

chính xác

trong bảng thực đơn ngày trước đó

Thức uống nóng được cung cấp vài lần mỗi ngày

cho phép các bệnh nhân có nhu cầu đặc biệt nhiều lựa chọn hơn cần tư vấn

triển khai

người phục vụ sẽ đưa lên từng món ăn và sau đó dọn đi

tăng khả năng lựa chọn lên gấp ba lần hiện tại

tính chất đa dạng của số lượng thực khách mà trust phải phục vụ sẽ không gây ra nhiều khó khăn

Tất nhiên, nhân viên luôn muốn tiết kiệm chi phí do đó đưa vào

Bệnh nhân có thể yêu cầu riêng những món này
không phải lúc nào họ cũng

tại đây xem bữa ăn nào đã có
người của

theo kiến nghị của những người giám sát việc phục vụ bệnh nhân chúng ta cũng nên phục vụ những yêu cầu đặc biệt nếu một bệnh nhân nào đó không thể ăn theo thực đơn chính
Những yêu cầu này do người giám sát dịch vụ bệnh nhân xem xét những người này sẽ thảo luận với bệnh nhân về yêu cần và sở thích của họ Sau đó, những lựa chọn thay thế cá nhân hóa do người giám sát đề xuất sẽ được một chuyên gia dinh dưỡng phe duyệt

thỏa mãn nhu cầu
lượng tiêu thụ
do bộ phận phân phối của bệnh viện đặt
Lượng

Như sẽ trình bày trong phần sau mà đã từng
vấn đề

quan điểm của họ về việc

thông qua

lệ thuộc vào

đã phân biệt rõ

lực lượng nhân viên chuyên môn

như đã đề

cập trước đây

kiểm

soát

tham gia

hiện nay
nhân viên

y tá ngày càng cao mọi người ngày càng đánh giá cao hơn
trong

ưu tiên nhiều

là

của

gánh nặng
chúng ta vẫn chưa biết được
những vấn đề như thế có được giải quyết khi bệnh nhân xuất viện hay
không

bị chi phối bởi sự luân chuyển
nhanh bệnh nhân
đã nói
rất nhiều thứ cần phải tập trung
các
tiêu chuẩn ghi nhận cao

chi
phối sẽ quyết định sự phân bố nguồn lực

không đủ

vượt mức

Chúng ta thấy rằng

khi

và liên bộ

được tư vấn

hỗ trợ rất nhiều

hoàn toàn

giám sát nhận xét

bà đã bác sĩ
đến gặp bệnh nhân vào giờ ăn trưa có thực sự cần thiết không

một số nhân viên điều dưỡng vẫn băn khoăn về việc triển khai
sáng kiến giờ ăn an toàn việc mình phải làm thêm
hoặc giám sát

việc này không chỉ của

trong một số trường
hợp

tham gia vào

liệt kê ý kiến của

người ta thường quan tâm đến
việc chọn lựa cần mở rộng hơn

cho dù

theo

Một số nhà lâm sàng đã cho qua những chỉ trích về thức ăn phục vụ cho bệnh nhân vì cho rằng nhân viên phục vụ đang gặp nhiều khó khăn

về

họ xem bữa ăn ở đây là

cho do các nhà bếp tập trung nấu

dẫn đến việc
cá viên

cho thấy

chín

Chuyên gia dinh dưỡng

đánh giá cao chuyên gia dinh dưỡng đang làm việc cùng họ

các y tá thường hay gặp

cũng có nói đến chẳng hạn như

có lĩnh vực nào trong chăm sóc dinh dưỡng cho bệnh nhân cần y tá tham gia nhiều hơn không

thấy có

cho

tinh tế hơn

Patients' nutritional care in hospital: An ethnographic study of nurses' role and patients' experience	Chăm sóc dinh dưỡng cho bệnh nhân trong bệnh viện: Một nghiên cứu dân tộc học về vai trò của y tá và trải nghiệm của bệnh nhân
CONTENTS	MỤC LỤC
Acknowledgements Executive Summary…………………………………………………………… i SECTION 1: BACKGROUND..………………………………………………………… 1 1. Introduction 1.1 Nurses' role in nutritional care: the changing policy context 1.1.1 Decline in nurses' managerial authority 1.1.2 Re-defining the 'proper functions' of a nurse 1.1.3 Recent measures and their implications for nursing SECTION 2: RELEVANT LITERATURE……………………………………………… 7 2.1 Nurses and nutritional care 2.2 Patients' experience 2.3 Waste and the organisation of food delivery systems 2.4 Nutrition and clinical outcome 2.5 Summary SECTION 3: THE STUDY ……………………………………………………………… 12 3.1 Research aims 3.2 Research approach 3.3 Choice of research site 3.4 Sampling 3.4.1 Criteria for selecting patients for observation and /or interview 3.4.2 Criteria for selecting ward staff for observation and/or	Lời cảm ơn **Tóm tắt dự án** .... i PHẦN 1: BỐI CẢNH .. .. 1 1. Giới thiệu 1.1 Vai trò của y tá trong chăm sóc dinh dưỡng: bối cảnh thay đổi chính sách 1.1.1 Giảm thẩm quyền quản lý của y tá 1.1.2 Xác định lại "những chức năng thích hợp" của y tá 1.1.3 Các đánh giá gần đây và tác động của chúng đối với hoạt động điều dưỡng PHẦN 2: TÀI LIỆU CÓ LIÊN QUAN .... 7 2.1 Y tá và hoạt động chăm sóc dinh dưỡng 2.2 Trải nghiệm của bệnh nhân 2.3 Xử lý chất thải và tổ chức hệ thống phân phối thực phẩm 2.4 Dinh dưỡng và tác động lâm sàng 2.5 Tóm tắt PHẦN 3: NGHIÊN CỨU .... 1 3.1 Mục tiêu nghiên cứu 3.2 Cách tiếp cận nghiên cứu 3.3 Lựa chọn địa điểm nghiên cứu 3.4 Lấy mẫu 3.4.1 Tiêu chuẩn lựa chọn bệnh nhân để quan sát và / hoặc phỏng vấn 3.4.2 Tiêu chuẩn lựa chọn cán bộ khu vực để quan sát và / hoặc phỏng vấn

interview	
3.4.3 Criteria for selecting other Trust staff	3.4.3 Tiêu chuẩn lựa chọn nhân viên đáng tin cậy khác
3.5 Methods of data collection	3.5 Các phương pháp thu thập dữ liệu
3.5.1 Observation on the ward	3.5.1 Quan sát tại bệnh viện
3.5.2 Semi-structured interviews	3.5.2 Phỏng vấn bán cấu trúc
3.5.3 Documentation	3.5.3 Ghi nhận
3.5.4 Invited attendance at meeting of Trust's Nutrition Committee	3.5.4 Tham gia cuộc họp tại Ủy ban Dinh dưỡng Ủy Thác
3.5.5 Visits to hospital kitchens	3.5.5 Thăm nhà bếp bệnh viện
3.6 Data analysis	3.6 Phân tích dữ liệu
3.7 Transferability of findings	3.7 Mối quan hệ giữa các phát hiện
3.8 Rigour	3,8 Tính nghiêm ngặt
3.9 Ethical issues	3,9 Vấn đề đạo đức
3.9.1 Obtaining informed consent	3.9.1 Nhận được bản chấp thuận tình nguyện tham gia nghiên cứu
3.9.1.1 From patients, for observation of care and interviews	3.9.1.1 Từ quan điểm bệnh nhân, quan sát quá trình chăm sóc và phỏng vấn
3.9.1.2 From staff, for observation of care and interviews:	3.9.1.2 Từ quan điểm nhân viên, quan sát quá trình chăm sóc và phỏng vấn:
3.9.2 Ensuring potential participants did not feel coerced into being involved.	3.9.2 Đảm bảo những ứng viên tiềm năng không cảm thấy bị ép buộc tham gia.
3.9.3 Ensuring confidentiality	3.9.3 Bảo đảm bí mật
3.10 Project timetable	3.10 Lịch trình dự án
SECTION 4: THE STUDY SITE …………………………………………………………… 20	PHẦN 4: VỊ TRÍ NGHIÊN CỨU 20
4.1 The overall context	4.1 Bối cảnh chung
4.1.1 The trust	4.1.1 Sự tin tưởng
4.1.2 City hospital	4.1.2 Bệnh viện thành phố
4.1.3 Catering services across the trust	4.1.3 Các dịch vụ ăn uống dựa trên sự tin tưởng
4.1.4 Assessment of the quality of food	4.1.4 Đánh giá chất lượng thực phẩm
4.2 Relevant information catering, dietetic and nutritional issues within the trust	4.2 Các thông tin về việc phục vụ, ăn kiêng và các vấn đề dinh dưỡng trong niềm tin
4.2.1 Hospital report on catering and dietetics	4.2.1 Báo cáo của bệnh viện về vấn đề phục vụ và dinh dưỡng
4.2.2 Nutrition committee	4.2.2 Ủy ban Dinh dưỡng
4.2.3. Manual on Nutrition Support	4.2.3. Hướng dẫn về hỗ trợ dinh dưỡng
4.2.4 Nutrition support team	4.2.4 Nhóm hỗ trợ dinh dưỡng
4.2.5 Essence of care benchmarking	4.2.5 Bản chất của tiêu chuẩn chăm sóc

4.2.6 Protected mealtimes	4.2.6 Các giờ ăn an toàn
4.3 The organisation of catering services	4.3 Việc tổ chức các dịch vụ ăn uống
4.3.1 The cooking and reheating of food	4.3.1 Nấu ăn và hâm nóng thức ăn
4.3.2 Menu cards	4.3.2 Bảng thực đơn
4.4 Food choice and diets	4.4 Lựa chọn thực phẩm và chế độ ăn
4.4.1 The new menu	4.4.1 Thực đơn mới
4.4.2 Special diets	4.4.2 Chế độ ăn đặc biệt
4.4.2.1 Culturally appropriate diets	4.4.2.1 Chế độ ăn thích hợp với văn hóa
4.4.2.2 Therapeutic diets	4.4.2.2 Chế độ ăn điều trị
4.4.2.3 High profile diet	4.4.2.3 Chế độ ăn profile cao
4.4.3 Nutritional supplements	4.4.3 Bổ sung dinh dưỡng
SECTION 5: BACKGROUND INFORMATION ABOUT THE WARD…………… 26	PHẦN 5: THÔNG TIN CƠ BẢN VỀ KHU VỰC 26
5.1 Description of Mary Seacole ward	5.1 Mô tả khu vực Mary Seacole
5.1.1 Patient profile	5.1.1 Hồ sơ bệnh nhân (những đặc trưng về bệnh nhân ở đây)
5.2 The organisation of nursing staff	5.2 Tổ chức nhân viên điều dưỡng
5.2.1 Shifts	5.2.1 Những chuyển đổi
5.2.2 Staffing levels	5.2.2 Quy mô nhân viên
5.3 Ward routine	5.3 Những thói quen trong khu vực
5.4 Challenges	5.4 Những thách thức
5.4.1 Particular nutritional issues associated with the ward's patients	5.4.1 Vấn đề dinh dưỡng đặc biệt liên quan đến bệnh nhân trong khu vực
SECTION 6: FINDINGS ABOUT THE CONTEXT OF CARE…………………… 30	PHẦN 6: KẾT QUẢ VỀ BỐI CẢNH CHĂM SÓC 3
6.1 Trust priorities	6.1 Ưu tiên về Niềm tin
6.2 Budgets	6.2 Ngân sách
6.2.1 Nursing budgets	6.2.1 Ngân sách điều dưỡng
6.2.2 The budget for food	6.2.2 Ngân sách cho thực phẩm
6.3 Interdepartmental and inter-professional working	6.3 Hoạt động liên ngành nghề
6.4 Interdepartmental and interdisciplinary contributions to nutritional care	6.4 Các đóng góp liên ngành và đa lĩnh vực cho chăm sóc dinh dưỡng
6.4.1 Medical	6.4.1 Y tế
6.4.2 Nursing	6.4.2 Điều dưỡng
6.4.3 Dietetic	6.4.3 Dinh dưỡng

6.4.4 Speech and language therapy	6.4.4 Liệu pháp giọng nói và ngôn ngữ
6.4.5 Modern matron	6.4.5Nữ y tá trưởng hiện đại
6.4.6 Housekeeper	6.4.6 Quản gia
6.4.7 Domestic	6.4.7 Nội bộ
6.5 Implementation of the Protected Mealtimes initiative	6.5 Triển khai sáng kiến bữa ăn an toàn
6.6 Trust-wide views on the quality of hospital food	6.6 Quan điểm hoàn toàn tin tưởng vào chất lượng thực phẩm bệnh viện
6.7 Health and safety issues in the trust	6,7 Vấn đề sức khỏe và an toàn trong quá trình ủy thác
6.7.1 Restricted access to kitchens	6.7.1 Hạn chế quyền vào bếp
6.7.2 Restrictions on reheating food	6.7.2 Các hạn chế về hâm nóng thực phẩm
6.7.3.Restrictions on the use of ward refrigerators	6.7.3.Hạn chế việc sử dụng tủ lạnh trong khu vực
6.7.4.Restrictions on the use of blenders in ward kitchens	6.7.4.Hạn chế về việc sử dụng máy xay sinh tố trong nhà bếp khu vực
SECTION 7: FINDINGS: NURSES' INVOLVEMENT IN NUTRITIONAL CARE ... 41	PHẦN 7: KẾT QUẢ: Sự tham gia của Y TÁ TRONG CHĂM SÓC DINH DƯỠNG ... 41
7.1 Broader issues	7.1 Các vấn đề rộng hơn
7.1.1 Nursing practice	7.1.1 Hoạt động điều dưỡng
7.1.2 Nursing morale	7.1.2 Tinh thần Điều dưỡng
7.1.3 The views of ward staff on the quality of food	7.1.3 Quan điểm của cán bộ khu vực về chất lượng thực phẩm
7.1.3.1 Regeneration	7.1.3.1 Tái tạo
7.1.3.2 Limited choice	7.1.3.2 Lựa chọn hạn chế
7.1.3.3 Fresh fruit and vegetables	7.1.3.3 Trái cây tươi và rau quả
7.1.4 Budget	7.1.4 Ngân sách
7.1.5 The views of the ward's patients on the quality of food	7.1.5 Ý kiến của bệnh nhân trong khu vực về chất lượng thực phẩm
7.1.6 The quality of nutritional care on Mary Seacole ward	7.1.6 Chất lượng chăm sóc dinh dưỡng ở khu vực Mary Seacole
7.1.6.1 Staff views	7.1.6.1 Quan điểm của Nhân viên
7.1.6.2 Patients' views	7.1.6.2 Quan điểm của bệnh nhân
7.1.7 Managing complaints	7.1.7 Quản lý khiếu nại
7.2 The provision of nutritional care	7.2 Cung cấp chăm sóc dinh dưỡng
7.2.1 Assessment and referral	7.2.1 Đánh giá và giấy giới thiệu
7.2.1.1 Dysphagia screening	7.2.1.1 Kiểm tra tình trạng khó nuốt
7.2.1.2 The nutritional screening tool	7.2.1.2 Các công cụ kiểm tra dinh dưỡng
7.2.2 Nurses' involvement in the provision of food	7.2.2 Sự tham gia của Y tá trong quá trình cung cấp thực phẩm

7.2.2.1 Ensuring supplements	7.2.2.1 Bảo đảm nguồn bổ sung
7.2.2.2 Snacks	7.2.2.2 Các bữa ăn qua loa
7.2.2.3 High profile menu	7.2.2.3 Thực đơn profile cao
7.2.2.4 Ensuring special diets	7.2.2.4 Đảm bảo chế độ ăn đặc biệt
7.2.3. Menu cards	7.2.3. Bảng thực đơn
7.2.3.1 Patients' views on menu cards	7.2.3.1 Ý kiến của bệnh nhân về bảng thực đơn
7.2.4 Nurses' role in Protected Mealtimes	7.2.4 Vai trò của Y tá trong bữa ăn an toàn
7.2.4.1 Impact on nurses' hours of work	7.2.4.1 Tác động đến giờ làm việc của y tá
7.2.4.2 System for food service	7.2.4.2 Hệ thống dịch vụ thực phẩm
7.2.4.3 Speed	7.2.4.3 Tốc độ
7.2.4.4. Conflicting priorities	7.2.4.4. Những ưu tiên cạnh tranh
7.2.4.5 The serving of food	7.2.4.5 Sự phục vụ thực phẩm
7.2.4.6 Presentation	7.2.4.6 Trưng bày
7.2.4.7 Patients' views of protected mealtimes	7.2.4.7 Ý kiến của bệnh nhân về giờ ăn an toàn
7.2.5 The feeding of patients	7.2.5 Cho bệnh nhân ăn
7.2.6 Tempting patients to eat	7.2.6 Khuyến khích bệnh nhân ăn
7.2.7 The monitoring of food intake	7.2.7 Giám sát lượng thức ăn
7.2.7.1 Documentation	7.2.7.1 Ghi nhận
7.2.7.2 Interview data	7.2.7.2 Dữ liệu phỏng vấn
SECTION 8: CONCLUSION AND RECOMMENDATIONS………………………. 59	PHẦN 8: KẾT LUẬN VÀ KIẾN NGHỊ 59
8.1 Conclusions	8.1 Kết luận
8.1.1 The influence of 'top down' initiatives	8.1.1 Sự ảnh hưởng của sáng kiến "từ trên xuống"
8.1.2 The significance of nutrition	8.1.2 Tầm quan trọng của dinh dưỡng
8..1.3 Organisational systems	8.1.3 Các hệ thống tổ chức
8.1.4 Nurses' authority	8.1.4 Thẩm quyền của Y tá
8.1.5 Staff morale	8.1.5 Tinh thần nhân viên
8.1.6 Cross-team working	8.1.6 Làm việc phối hợp
8.1.7 Protected Mealtimes	8.1.7 Giờ ăn an toàn
8.1.8 Ward housekeepers	8.1.8 Quản gia khu vực
8.1.9 Complaints	8.1.9 Khiếu nại
8.1.10 Training	8.1.10 Đào tạo
8.2 Limitations of the study	8.2 Hạn chế của nghiên cứu
8.3 Recommendations…………………………………………………………. 64	8.3 Đề nghị 6
	THAM KHẢO

REFERENCES ………………………………………………………………………… 66	……………………………………………………………… 66
GLOSSARY ………………………………………………………………………… 70	THUẬT NGỮ ……………………………………………………………… 70
APPENDICES ………………………………………………………………………… 71	PHỤ LỤC ……………………………………………………………… 71
Appendix 1: Details of staff interviewed Appendix 2: Details of patients interviewed Appendix 3: Examples of menus Appendix 4: Menu of supplements Appendix 5: Results of Essence of Care audit (food and nutrition) Appendix 6: Duties of night staff Appendix 7: Nursing care plan: Eating and drinking – at risk of malnutrition Appendix 8: Overall assessment process Appendix 9: Nutritional screening tool Appendix 10: Protected mealtimes checklist Appendix 11: New food chart Appendix 12: Nursing notes	Phụ lục 1: Thông tin về nhân viên tham gia phỏng vấn Phụ lục 2: Thông tin về bệnh nhân tham gia phỏng vấn Phụ lục 3: Ví dụ về thực đơn Phụ lục 4: Thực đơn bổ sung Phụ lục 5: Các kết quả cơ bản thu được qua hoạt động đánh giá quá trình chăm sóc (thực phẩm và dinh dưỡng) Phụ lục 6: Nhiệm vụ của nhân viên làm việc ban đêm Phụ lục 7 Kế hoạch chăm sóc điều dưỡng: Ăn uống khi có nguy cơ suy dinh dưỡng Phụ lục 8: Quy trình đánh giá tổng thể Phụ lục 9: Công cụ tầm soát dinh dưỡng Phụ lục 10: Những mục cần kiểm tra đối với một bữa ăn an toàn Phụ lục 11: Biểu đồ thực phẩm mới Phụ lục 12: Một số ghi chép trong hoạt động điều dưỡng.