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Patients' nutritional care in hospital:  
 An ethnographic study of nurses' role and patients' experience  
 Final report  
 May 2005  
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### 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.

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

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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.

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.

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-

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chứng về việc

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.

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.

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

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

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

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.

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

và điều dưỡng

kiến

sớm triển khai sáng

xuống

theo kiểu từ trên

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.

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;
- 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

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

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được nhiều người  
trong trust xử lý  
nhân viên của  
Patient and Public Involvement

phân bổ nhân viên đến nơi phù hợp

kiểm tra  
âm ngữ trị liệu  
ngày

âm ngữ

trong bệnh viện

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

quan điểm khác nhau  
nhiều

khen ngợi  
liên quan đến  
lại

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:

#### 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;

- o to give further consideration to, and guidance on how to maximise the potential of modern matrons and ward leaders to improve nutritional care;

- 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.

#### Recommendations to the study trust

có thể cho trường hợp của mình cấp

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

hoạt động

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trong

khảo

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;

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;

o to set up a working group to agree guidance for the trust-wide implementation of the ward housekeeper role, including job

nhưng đã xác định được nhiều vấn đề phức tạp nảy sinh hoặc còn đang nghi ngờ

thành liên ngành thành phần tiêu chuẩn

đến việc thiết lập

ý nghĩa

trong các hoạt động liên trust đây khó khăn

giải tỏa

đưa vào khoa nhiều người dọn dẹp hơn

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;

- 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

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ghi nhận lại những  
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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;

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 responsible 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.

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

quá trình triển khai:

[Redacted]

[Redacted]

[Redacted]

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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

đinh dưỡng được ghi lại đánh giá dinh dưỡng bằng cách y tá thực hiện chăm một nhiều

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.

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.

khó tính  
Chưa

số lượng y tá ít hơn con số  
vì vậy  
những  
quy cho  
thiếu hụt số lượng  
trong  
thời gian dài

nêu lên một số gương điển hình

cấp tính

kiểm tra  
phân  
trình  
bộ  
độ nhân viên

kinh nghiệm tốt nhất  
phân bộ

phân bộ

## 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;
- 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

giảm thèm ăn do

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.

### 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 gastrointestinal 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

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cần

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).

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

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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).

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)

trong  
đã bị suy dinh dưỡng  
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có liên quan đến  
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• priority of treatment, where restricting food or fluid intake for diagnostic procedures, or medical rounds may contribute to a patient's compromised nutritional status

• 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

khi làm

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.

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#### 4.1.2 City Hospital

The hospital in 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.

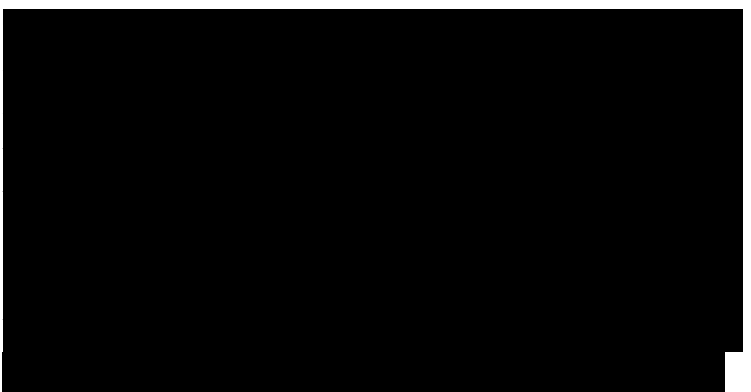
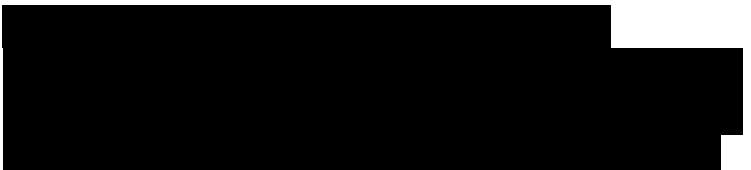
#### 4.1.3 Catering services across the trust

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%

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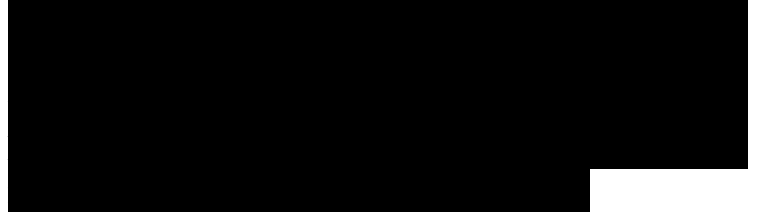
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[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

[REDACTED]

[REDACTED]

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.

