Improving patient nutrition through simple initiatives

**AUTHOR** Siân Watkins, MA, BSc, DipN, RN, is matron (medicine) Norfolk and Norwich University Hospital NHS Trust.


Nutrition is an important aspect of patient care and sometimes simple changes can make a significant difference. Initiatives such as Essence of Care and protected mealtimes can be used to improve patients’ nutritional intake. While simple initiatives can often involve more work than expected, the final outcome and benefits for patients justify the time spent.

Adequate nutrition is particularly important in hospital patients. Up to 40 per cent of those admitted to hospital are underweight (Audit Commission, 2001) and many lose weight while in hospital. It is estimated that up to 60 per cent of hospital patients are clinically malnourished (Malnutrition Advisory Group, 2003).

Although malnutrition is commonly thought of as affecting people who are underweight, the condition is defined as an imbalance between nutritional needs and intake. Since this includes consuming too much as well as too little, people who are obese are also considered to be malnourished.

**Background**

In recognition of the importance of nutrition, *The NHS Plan* (Department of Health, 2002) included the improvement of hospital food as one of its targets. This led to the Better Hospital Food project in 2002, while one reason for the introduction of modern matrons in the health service was to give them responsibility for patient nutrition and the implementation of Essence of Care patient-focused benchmarks (DoH, 2001) – one of which relates to food and nutrition.

At the Norfolk and Norwich University Hospital NHS Trust the catering service is provided by a private contractor, which has worked in partnership with the trust to improve the quality of service for patients. As part of the commitment to improve patients’ experience of food and nutrition, a number of initiatives have been undertaken within the trust. These resulted from patient feedback, Essence of Care benchmarking and nurses questioning existing practice.

**Reintroducing toast**

One of the trust’s initiatives was to reintroduce toast for patients, which it had provided for breakfast until it moved to a new site three years ago, when it was decided the practice should stop. Although there was an extensive menu for breakfast, informal comments from patients suggested that they would like the option of toast, while a visit by Age Concern to one medical ward for older people led to feedback indicating that the patients missed the ability to have toast and requesting that it be reintroduced.

This led to a pilot project to test the uptake of toast before costly new toasters were bought for all wards. Initially, four medical wards for older people took part in the four-week trial, in which toast was made available and patients (n=300) were asked for their opinion about this service.

The feedback was positive – 64 per cent (192) of patients were satisfied, 20 per cent (60) were dissatisfied and 16 per cent (48) said they did not mind (Fig 1). Comments from those who were dissatisfied showed that this was largely due to the fact that the toast was prepared in the trust’s central kitchen and delivered to the wards wrapped in foil. While this was done to retain the heat, it caused the toast to lose its crispness and become chewy.

The catering service was asked to develop this project to inform the trust of its cost and time implications. A decision was made to purchase toasters and add toast to the breakfast menu. While this may not seem a significant change patients have enjoyed the smell of toasting bread, which has stimulated the appetites of many, and the choice has proved popular.

All other options remain on the breakfast menu including cereals, porridge, prunes and grapefruit segments. However, instead of plain bread served with preserves that was previously available, patients can now have it toasted.

**Dry sandwiches**

Patient feedback on the catering service is collected by questionnaire and by listening to patients. Some of the issues they raised have been addressed relatively easily. For example, patients and nurses in the oncology day unit repeatedly commented on how dry the sandwiches were for patients receiving chemotherapy. The treatment affects oral mucosa and the ability to enjoy food in many instances. One of the chefs suggested condiments such as...
tomato sauce or salad cream be made available for patients and that salad garnish served with the sandwiches could be another source of moisture. The suggestion was implemented and proved popular with the patients.

The trust’s matrons also met the catering manager to discuss the sandwich service as a whole, as patient feedback showed the sandwiches were unpopular in their current presentation. After some deliberation it was suggested the sandwiches be served on a plate rather than in plastic containers, cut into quarters to make them easier to pick up, and served with a salad garnish. This change made them far more popular with patients and was an easier option to implement than seeking an alternative sandwich supplier.

Working in partnership
Initially the trust adopted the Better Hospital Food menu (NHS Estates, 2002). However, some of the dishes, such as green Thai chicken curry, proved unpopular with many patients. Feedback identified that they missed more traditional options such as cottage pie, so the menu was amended accordingly, with input from the dietitians.

A further update was made more recently after ward sisters, charge nurses and matrons were asked to ascertain what type of meals would be most appropriate for the patient group on their ward.

The catering department then devised two menus – a traditional and a modern one – for wards to select from. Although many of the meals were available on both menus the modern menu included a selection of dishes to appeal to the more adventurous palate, while the traditional menu retained the meals that appeal to the majority of patients when they are ill.

A ward sister on a medical ward for older people and the matron for medicine had a discussion about improving nutrition for patients who would prefer a small bowl of soup – which is a common request. As a result the matron, dietitians and the catering service are exploring ways in which nutritious soups can be served to patients whose appetite is poor but who may manage soup. Although proprietary products are available, we are hoping to provide ‘home-made’ soup with high nutritional value.

These issues demonstrate that different departments working in partnership can improve the patient experience.

Identifying at-risk patients
The food and nutrition benchmark from Essence of Care (DoH, 2001) was used to examine practice in many wards within the trust. As a result of the benchmarking within medicine, some further work has been undertaken.

The first requirement under food and nutrition is for screening and assessment to be undertaken to identify patients’ nutritional needs, the benchmark of best practice being that nutritional screening progresses to further assessment of all patients who are identified as being ‘at risk’. A development initiated in response to this requirement was the introduction of signs and red napkins for patients who, using the trust nutritional assessment, are deemed to be at risk.

One ward within medicine for older people was identified to run a pilot project as the ward sister had a keen interest in patient nutrition and was eager to support the development. At-risk patients had been identified and, although steps were being taken to address their needs, it was thought that there was room for further improvement.

Implementation of the ‘red tray initiative’ (Bradley and Rees, 2003) was discussed. However, instead of supplying red trays to at-risk patients it was decided to use red napkins as tray liners. These were placed on the usual trays for patients and signified to catering personnel that they should not remove the trays until the nurse caring for that patient had documented the amount of food eaten. Patients were given letters to explain the scheme and if they did not want to be included they were asked to inform the nursing staff.

A suggestion to use signs above the bed to identify patients who had special food requirements caused debate as there were concerns regarding treating patients differently. Initially a red star was going to be used but this was not thought appropriate so the ward staff designed a sign using a red knife, fork and spoon. All patients are given a nutritional assessment on admission to the ward and those who are identified as being at risk are given the red tray liner, sign and a food chart.

Data was collected prior to the introduction of the

**REFERENCES**


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tray liners and nursing documentation was checked to ascertain how thoroughly patients’ nutritional needs were being documented and what measures had been taken to meet these needs. The signs were designed for display at the bedside, red napkins purchased and food charts made available in case of increased demand.

Data collection after the introduction of the project revealed that food was put within easy reach of the patients in all instances. Initially, nursing staff were not present on the ward when food was being served but this was pointed out to the ward sister who alerted the ward staff. There was subsequently an increased nurse presence on the ward assisting patients to eat and drink. The number of food charts in patients’ health records increased after the scheme was introduced, so the measure increased awareness of food and nutrition.

A number of nutrition-related issues were identified for one patient, but he remained reluctant to eat any of the food put out for him. He was encouraged by different members of staff to eat his meals but he continued to decline. In this instance it had to be acknowledged that patients are free to choose not to eat and, although every effort can be made to ensure they receive nutrition, ultimately it is their own choice.

Protected mealtimes
While collecting the data for this project, it became apparent that there was a significant amount of activity in the ward area around mealtimes. It should be noted that ensuring patients are fed is one of many demands on nurses’ time.

Florence Nightingale was perhaps the first to recognise the value of protected mealtimes, in which all other ward activity ceases. Whether this can be achieved or sustained in the modern health service is debatable as nurses are expected to address multiple patient needs and there are times when other tasks take priority over nutrition. It was thought that evidence on protected mealtimes (Hospital Caterers Association, 2004; Baker, 2003) and the experiences of other hospitals that have set up protected mealtimes could be applied.

A number of factors have influenced consideration of this initiative:
- Open visiting can prove distracting when visitors arrive at mealtimes;
- The number of staff who visit the patients in the course of a day seems to be steadily rising;
- Wards have become busy places, while dining rooms have been abolished so patients eat their meals at the bedside.

These factors can make it difficult for patients to enjoy a meal in the ward environment. They may be interrupted while eating by members of staff, or visitors may sit watching them eat their lunch, which can make some people feel uncomfortable. Admittedly, some relatives come specifically to help the patient to eat by feeding them, encouraging them to eat or, in some instances, eating with them as they have done for many years at home. In addition, nurses’ roles have become more complex and they have additional responsibilities that can take them away from direct patient care.

Initially two wards were willing to undertake a trial in which the lunchtime period was protected, as this is the main hot meal of the day. The ward sisters supported the idea and communicated the information to their staff. The clinical governance department also expressed support, as did a superintendent physiotherapist.

Communication to other areas of the hospital was vital to ascertain the impact of the initiative on their workload and the smooth running of patient care. Although we wanted to enhance patient nutrition, we did not want to compromise other aspects of the patients’ care. It was important that catering personnel on the wards were given the same information so they were aware of what we were trying to achieve.

Data was collected by observation during the pilot period and this showed a large amount of activity around the ward when the catering trolley appeared. However, working in partnership with the catering personnel and nursing staff ensured the pilot continued and other wards are now participating.

Conclusion
Although the patient nutrition initiatives developed within the trust may seem relatively simple, they have involved a significant amount of work. However, they have improved patient care and emphasised the importance of patient nutrition to nursing and catering staff.

Essence of Care has underpinned much of what has been addressed, which is ideal as it focuses on the fundamentals of practice that form the foundation of high-quality patient care. While nursing and catering staff had worked cooperatively in the past these initiatives have enabled them to understand each other’s role in greater depth and the issues they both face. Both teams are keen to improve the service for patients.

There is clearly more work required from nurses to ensure patients receive adequate nutrition, which is so important for their recovery. Permitting 40 per cent of patients to suffer from malnutrition would imply that we have not fulfilled our duty of care. Working collaboratively appears to be one way to ensure we do not fail our patients and that we are able to achieve sustainable results. Malnutrition in patients remains a source of concern within the trust and will no doubt continue to receive attention in the years to come. ■