Improving the nutritional care of patients in hospital

AUTHORS Rick Wilson, BSc, SRD, is director of nutrition and dietetics at King’s College Hospital, London; Caroline Lecko, RGN, is modern matron, neurosciences, King’s College Hospital, London.

The provision of good nutrition has long been recognised as essential for hospital patients and ensuring patients received adequate food used to be a key nursing responsibility. However, changes in the preparation and delivery of hospital food and in the nurse’s role have reduced nurses’ control over their patients’ diet. This article reports on the progress of the Better Hospital Food programme, which was implemented to improve food services and give back more control over food to nurses.

The importance of food in the care and treatment of hospital patients has been championed by the nursing profession for many years. Nonetheless it is still a neglected branch of nursing. The Salmon Report (1966) on senior nursing staff structure is widely believed to have diminished the importance of nutritional care as a key nursing role, so much so that the UKCC (now NMC) wrote to all registered nurses reminding them of their responsibilities in this area.

Until the 1960s most hospital food was delivered to the ward in bulk and nurses were responsible for serving it to the patients. Ward sisters regarded the serving of food as an important nursing duty. Ensuring that every individual patient’s food and nutritional requirements were met was regarded as core to good care and treatment.

More recently, developments in food service have removed some of this control from nurses. The distribution of pre-plated food has reduced their control over food provision. Food hygiene and health and safety regulations have reduced the amount of food readily available on the ward and nurses’ ability to prepare food for patients as and when they need it. Nurses could easily find themselves responsible for nutritional care but powerless to deliver it in the modern ward environment.

Catering in hospitals

Food service in hospitals in the early part of the 20th century was rather hit and miss and not regarded as warranting any degree of funding until the start of the Second World War. Rationing in 1939 brought a new awareness of nutritional needs and funding – this resulted in hospitals receiving the food rations of their inpatients.

In 1945 the government recommended hospitals employ professional catering managers. Professional chefs – largely recruited from the armed services – were appointed.

The King’s Fund created its own catering advisory service for hospitals and in 1954 its School of Hospital Catering was opened at St Pancras Hospital, London. Over the following decades food service technologies improved.

It could be argued, however, that the link between food service and the provision of nutritional care was being eroded. While food service became more professional, nursing became more technically demanding and many nurses were glad to hand over responsibility for food provision.

In the 1990s nurses began to realise that they may have given away responsibility for nutrition. McWhirter and Pennington (1994) noticed that many patients were admitted to hospital already in a malnourished state. Alarmingly this was not noticed in most cases and up to 70 per cent became even more malnourished while in hospital.

Better Hospital Food

The NHS in England launched the Better Hospital Food programme in May 2001 (NHS Estates, 2005). Hospitals were given six requirements to meet:

- To implement a 24-hour food service consisting of a ward kitchen service for light refreshments, snack boxes and light meals;
To meet or exceed acceptable standards in the range of meals offered in the mealtimes service;
- To use an NHS Menu design template;
- To use a specially designed snack box in the 24-hour catering service;
- To move the day’s main meal to the evening;
- To use a range of recipes devised for the NHS.

The project’s steering group, chaired by food critic and broadcaster Loyd Grossman, includes representatives of patient groups, the catering and hospitality industry, the food industry, nursing, dietetics and academia. Implementation of the six requirements was regarded as phase one of the project and progress since 2001 has been rapid.

Hospital food services are inspected annually as part of patient environment action team (PEAT) visits and are classified as red, yellow or green (Table 1). Red classification indicates poor (unacceptable) service, yellow is acceptable and green good. Only hospitals that have implemented all six requirements can attain a green classification. There are still 480 hospital sites in England with some work to do. This year PEAT inspection becomes part of patient environment action team (PEAT) visits and is classified as red, yellow or green (Table 1). Red classification indicates poor (unacceptable) service, yellow is acceptable and green good. Only hospitals that have implemented all six requirements can attain a green classification. There are still 480 hospital sites in England with some work to do. This year PEAT inspection becomes part of the function of the Commission for Healthcare Inspection and Audit in England and Wales.

Standards for the modernisation and reform of food services and nutritional care in hospitals have also been set in Scotland and Wales (NHS Quality Improvement Scotland, 2002; National Assembly for Wales, 2001).

**Protected mealtimes**

Improving food and nutritional care standards does not just involve implementing change across the NHS. It also requires the development of a series of small, practical ideas that will lead to lasting change and influence patients’ experience of hospital food. One idea being promoted in the Better Hospital Food programme is protected mealtimes.

The aim of protected mealtimes is to ensure that ward activity is reduced to a minimum so that patients can take their meals in a peaceful and calm environment. A key aim is to enable staff to devote time to the meal service and assist those patients needing help to eat.

The significant number of malnourished patients in hospitals should give cause for concern to all involved in health care delivery. McWhirter and Pennington (1994) reported that up to 40 per cent of patients being admitted to hospital were undernourished and that this figure increased for patients who had been in hospital for more than one week. Further studies conducted by Stratton and Elia (2000) identified that this situation had remained unchanged.

Failing to address this problem has vast implications for hospital trusts and patients. Despite the availability of effective treatment, malnutrition often goes unrecognised and untreated (Kelly et al, 2000) leading to worse outcomes, prolonged hospital stays and increased costs. There are obviously many reasons why patients do not or cannot eat in hospital but one of those cited by patients is that their mealtimes are being interrupted by ward activity such as cleaning, ward rounds and medicine rounds and by having to leave the ward for diagnostic investigations.

Patients have also experienced difficulties in obtaining assistance to eat their meals when needed. Observational audits conducted in hospitals across the country at mealtimes have demonstrated that the general level of clinical activity is not reduced at mealtimes and there is increasing concern that interrupted mealtimes not only reduce patients’ enjoyment of their meal but also have a detrimental effect on nutritional intake.

Ensuring patients are able to eat their meals is the responsibility of the whole health care team. However, nurses can play a fundamental role in ensuring patients can have their meals in an environment that is conducive to eating. Protected mealtimes allow nurses to focus on the meal and patients’ nutritional needs.

Nurses can be instrumental in driving the Better Hospital Food initiative. They can increase the potential for their patients to benefit nutritionally from their food and to enhance their patients’ experience while in hospital. Nurses can also take a lead in making nutrition a priority in ensuring quality of care in their trusts.

Many professional organisations support the concept of protected mealtimes. The Royal College of Physicians (2002) says doctors can help to promote better nutrition by ensuring that – as far as possible – mealtimes are not interrupted by ward rounds or by routine tasks that could take place at other times. The Essence of Care (Department of Health, 2001) food and nutrition benchmark also recommends the curtailment of inappropriate activity such as cleaning and ward rounds at mealtimes.

Implementing protected mealtimes requires organisational change if it is to be successful. At King’s College Hospital in London staff have found that board-level support is essential.

The trust has published 10 key guidelines for wards regarding protected mealtimes, and these

**TABLE 1. RESULTS OF FOOD SERVICE INSPECTION IN PEAT HOSPITAL VISITS**

<table>
<thead>
<tr>
<th></th>
<th>RED</th>
<th>YELLOW</th>
<th>GREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>15</td>
<td>554</td>
<td>118</td>
</tr>
<tr>
<td>2003</td>
<td>0</td>
<td>480</td>
<td>365</td>
</tr>
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**REFERENCES**


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
Guided reflection

Use the following points to write a reflection for your PREP portfolio:

- List the main points the article makes about nutrition;
- Write about how this article could have helped you optimise the nutritional care of a patient;
- Describe what action you will take to follow up this article.

**Table 2. Benefits of Protected Mealtimes at King’s College Hospital**

<table>
<thead>
<tr>
<th>Benefits for Patients</th>
<th>Benefits for Staff</th>
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<tbody>
<tr>
<td>- Patients can have hot food</td>
<td>- Nurses have been able to regain control of the ward environment</td>
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<tr>
<td>- Individualised food service/nutritional care</td>
<td>- They have been able to regain control of patients’ mealtimes</td>
</tr>
<tr>
<td>- Wards have a ‘restaurant’ feel at mealtimes</td>
<td>- They have permission to make their patients’ nutrition their priority during mealtimes and to leave other responsibilities until later</td>
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<tr>
<td>- Wards are quieter/calmer environments in which to enjoy meals</td>
<td>- Staff like the new system</td>
</tr>
<tr>
<td>- No blood tests or examinations occur</td>
<td>- Teamwork and communication have improved as a result of the new system</td>
</tr>
<tr>
<td>- Commodities are removed or emptied</td>
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<tr>
<td>- Safer, managed nutritional care can be given</td>
<td></td>
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<tr>
<td>- All staff can be informed of patients’ needs</td>
<td></td>
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<tr>
<td>- Better communication is possible</td>
<td></td>
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</tbody>
</table>

have been signed by both the director of nursing and the medical director:

- Protected mealtimes take place between noon and 1pm;
- Nurses will prepare the areas around patients beforehand – for example bedside tables will be cleared, commodes and urinals will be removed;
- Nurses will ensure patients are positioned appropriately and safely;
- Visiting will be restricted during the protected mealtimes, with the exception of carers who assist in feeding and supervising patients at mealtimes;
- Where possible patients will not leave the ward for non-urgent investigations;
- Routine ward rounds will not take place during the protected mealtimes;
- Nursing staff should not perform routine medicine rounds during the protected mealtimes;
- All non-essential clinical activity will stop during the protected mealtimes;
- Nurses will assist in the meal delivery service;
- Every effort will be made to make mealtimes enjoyable and nutritionally successful for patients.

Table 2 illustrates the benefits of protected mealtimes identified at the trust.

**The Council of Europe resolution**

The Council of Europe (2003) resolution on food and nutritional care in hospitals makes over 100 recommendations for improvement. These cover all areas, including:

- The preregistration and postregistration education of health care professionals;
- Nutritional risk assessment;
- Responsibilities of health care professionals;
- Nil-by-mouth orders;
- End-of-life decisions about nutritional support;
- Provision of contracted-out food services.

Eighteen countries, including the UK, are signatories to this resolution and are committed to drawing up and implementing national recommendations on food and nutritional care in hospitals based on the principles and measures set out in the resolution.

Irish hunger strikers undergoing prolonged total starvation in the 1980s lost a mean of 38 per cent of their weight after 60 days. A relationship between the degree of weight loss experienced and reduction in organ function, immune status, wound healing and muscle strength was found. It was concluded that a rapid weight loss of 5–10 per cent causes clinically significant organ function changes, that a weight loss of 35–40 per cent is associated with a 30 per cent risk of death and that survival beyond 50 per cent weight loss is unlikely (Allison, 1992; Allison, 1995).

This demonstrates the importance of ensuring hospital patients, most of whom are already debilitated and many of whom will experience reduced appetite, have adequate nutritional intake to prevent them deteriorating and to enhance their recovery. This involves not only providing appropriate and appetising food but also ensuring patients are able to eat that food, and that ward activity and their environment do not distract them or cause them to lose their appetite.