The nurse’s role in patient nutrition and hydration

In this article...

- How nutrition and hydration needs became overlooked
- Stipulations of the NMC’s revised code of conduct
- How nurses can ensure they comply with the Code

There is no specific mention of nutrition and hydration in the previous version of the code (Nursing and Midwifery Council, 2008), so why has it become necessary to be so specific in this new version? Why are nurses being advised that they could be held to account for not providing adequate access to nutrition and hydration. And how can we demonstrate that we have provided appropriate care if asked?

Previous shortcomings
Nutrition and hydration have been increasingly discussed in national media. Various organisations have attempted to set standards for nutritional care, including charitable association BAPEN (Brotherton et al, 2012) and the Department of Health (2010), and organisations such as the Patients Association have highlighted the shortcomings experienced by patients and their families in healthcare environments (2013, 2012). Unfortunately, during this process, the role that registered nurses play – or do not play – in helping patients meet this most fundamental aspect of care has led to strong criticism.

Inadequate nutrition and hydration in care settings is not a new problem. In 1859, Florence Nightingale remarked in her Notes on Nursing:

“Every careful observer of the sick will agree in this that thousands of patients are annually starved in the midst of plenty, from want of attention to the ways which alone make it possible for them to take food.”

More than 150 years later, the Parliamentary and Health Service Ombudsman stated (2011):

“It is incomprehensible that the Ombudsman needs to hold the NHS...
to account for the most fundamental aspects of care: clean and comfortable surroundings, assistance with eating if needed, drinking water available.”

**Where did it go wrong?**
To understand why nurses do not appear to be addressing patients' nutritional and hydration needs as is expected of the role, it is necessary to look back at recent history and explore the changes surrounding nutrition and hydration in hospitals.

**The nursing role**
In the late 19th and 20th centuries the hospital matron was the head of nursing staff, and also responsible for the kitchen and housekeeping staff. Indeed, many nurses undertook related tasks such as cleaning, providing food and laundry care. However, as hospitals grew in size and complexity, many of these aspects were taken over by non-nursing staff, supervised by senior nurses (Savage and Scott, 2005).

At the time of the Salmon report (Salmon, 1966), nursing staff were still very much involved in all activities relating to nutritional care. This included helping patients to order meals, arranging special diets and taking meals to patients who could not sit at the ward table. Staff would monitor what patients had eaten and drunk, and, in some hospitals, make sandwiches for them for afternoon tea, as well as preparing breakfasts such as boiled eggs and toast. This continued in many hospitals until the mid-1980s.

However, in 1968, a Standing Nursing Advisory Committee report argued that it was no longer appropriate for nurses to spend time on “hotel services” to the detriment of their rapidly expanding “therapeutic role” and “technical nursing” skills (Central Health Services Council?, 1968).

The most time-intensive of these “hotel services” were considered to be:
- Distributing food and drinks at mealtimes;
- Collecting and clearing meals;
- Preparing patients’ food and drinks (except special diets).

The committee recommended that these tasks be undertaken by non-nursing staff, such as ward housekeepers, which essentially confirmed that nutritional care of the patient was not an important nursing consideration. The same report also failed to highlight the important role of nutrition in the recovery process, or mention supervision or feedback of care provided by housekeepers to nursing staff.

By the 1980s, with the loss of crown immunity and the outsourcing of hospital catering to private companies, food in hospital had become a financial issue and the extent to which nurses could influence the standards of food provided to patients was limited.

**Staffing levels**
The Griffiths report of 1983 led to a change in the focus of the NHS: it needed to be management led. Budgets, resource allocation, strategic decisions and reports on performance became key themes, and clinical managers were replaced with general managers, who had little or no NHS experience (Day and Klein, 1983). At the same time, with the loss of rostered students on the wards and the widespread failure to provide housekeeping teams, nurses began to struggle to provide all aspects of patient care.

A King’s Fund report stated that lack of nursing supervision at mealtimes could leave a patient’s poor nutritional intake unnoticed and, as such, uncorrected, which would put the patient at an increased risk of developing malnutrition (Lennard-Jones, 1992). Lennard-Jones also suggested that malnutrition was often unrecognised because nurses and doctors were not used to looking for it.

This report was later supported by McWhirter and Pennington’s 1994 report, which highlighted that in an acute hospital of 500 beds, 40% of inpatients were found to be already malnourished on admission, and a further two-thirds of all patients studied had lost weight during their hospital stay.

Two years later, the issue was exacerbated by the falling number of nurses. The Royal College of Nursing suggested that,

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**BOX 1. THE MID STAFFS INQUIRY: NUTRITION AND HYDRATION ISSUES**

The inquiry into care failures at Mid Staffordshire Foundation Trust found:
- Inappropriate food given to patients in light of their condition
- Patients’ meals placed out of reach and taken away, even though they had not been touched
- Patients given no encouragement to eat
- Relatives and other visitors denied access to wards during mealtimes
- Visitors having to assist other patients with their meals
- No water available at the bedside
- Water intake not monitored or encouraged
- Problems with not addressed adequately
- Lack of monitoring and appropriate records of fluid balance and nutritional intake

Source: Francis (2010)
Discussion

although 37,000 registered nurses qualified in 1983, it expected that figure to drop by between 8,000 and 9,000 by 1997-98 (RCN, 1996). It also suggested the “registered nurse’s role with regard to feeding is not clearly prescribed”. Yet no guidance was offered on how to clarify the nursing role in nutrition.

As a result of the RCN’s report, the chief registrar of the UK Central Council for Nursing, Midwifery and Health Visiting (the predecessor to the NMC) wrote to every trained nurse in the UK to remind them that they had a responsibility to ensure the nutritional needs of their patients were met. Unsurprisingly, the Association of Community Health Councils for England and Wales (1997) reported nurses as stating that:

- They did not have time to help patients to eat;
- There did not seem to be anyone taking responsibility for nutrition at ward level.

Despite the fact that nutrition and hydration were recognised as problems in the 1990s, little progress appeared to have been made until a 2006 report by Age Concern. This stated that older people in hospital and their relatives were extremely concerned by nurses’ apparent lack of interest in helping them to eat and drink. It found that, despite a wealth of guidance and standards, malnutrition and the provision of poor nutritional care in hospital still seemed to be a huge problem.

As a result, in 2007 the RCN launched its extremely successful Nutrition Now campaign (bit.ly/RCNNutritionNowCampaign). Supported by both the National Patient Safety Agency and Age Concern, it aimed to empower trusts to improve the nutritional care they gave patients.

The situation today

In 2010 Age Concern (now rebranded as Age UK) issued its second report, which suggested that the nutrition and hydration needs of older people in hospital were still unmet (Age UK, 2010). Groups such as BAPEN and the RCN reacted to this with a flurry of reports and guidance, while the government asked the Care Quality Commission to make unannounced inspections of 100 hospitals in England to explore dignity and nutrition. The inspector reported that “a fifth of hospitals were not delivering the care that met the standards the law said people should expect (Care Quality Commission, 2011).

However, staffing still seemed to be the main reason nurses gave for not helping their patients to eat and drink: three out of four reported not having the time to talk to older hospital patients and many said they were so rushed they could not help patients to eat (RCN, 2012). The RCN’s report found that, typically, one registered nurse is expected to look after nine older patients who may be frail, acutely ill and have complex medical needs.

It can be argued that it is not solely the nurse’s responsibility to ensure patients receive adequate nutrition and hydration, but, as the professionals who are with patients 24 hours a day, we are in the best position to ensure our patients receive appropriate care and attention.

Other members of the multidisciplinary team – dietitians, catering staff, speech and language therapists, and medical staff – are vital components of patients’ overall nutritional care, but nurses are the ones who must ensure appropriate care is provided. Even if they are not directly helping the patient to eat and drink, and have allocated the task to another member of the ward team, registered nurses are responsible for ensuring each patient receives timely and appropriate nutritional care that is accurately documented and monitored.

Unfortunately, while many areas provide good standards of nutrition and hydration care, it is still not universal – as was highlighted in the report of the inquiry into care failings at Mid Staffordshire Foundation Trust (Francis, 2010) (Box 1). The report highlighted that, despite all the recommendations made and standards published, good nutritional care was not embedded in every healthcare organisation (Francis, 2010).

In 2013, an independent review of the Liverpool Care Pathway made a number of recommendations to improve end-of-life care, one of which was to develop an individual care plan that included food and drink intake and should be agreed, supported and delivered with compassion (Department of Health, 2013). This stemmed from reports from relatives who told the review body of their experiences – their family members did not have their nutrition and hydration needs met appropriately during their last hours – and raised their concerns that, in some cases, patients suffered needlessly through lack of adequate nutrition and hydration.

BOX 2. AVOID MAKING ASSUMPTIONS: CASE SCENARIOS

- Joan Smith, 16 metres in height and weighing 78 kg, is admitted to your ward/nursing home for assessment. Your visual assessment says she is obese. You calculate her body mass index (BMI) to be 30.5, confirming she is in the obese range.

**Question 1: Based on this information alone, what should be your plan of care for Mrs Smith?** Your initial thought may be that you do not need to worry about Mrs Smith’s nutritional state. Indeed, you may think she needs to lose weight. If you factor in that she has, for example, pressure ulcers, has mobility problems caused by pain in her knees and finds it difficult to shop for food or make meals at home, the picture changes.

**Question 2: With this additional information, how should you change your original plan of care?** Although Mrs Smith is obese, she has more immediate health issues that need to be addressed in which nutrition and hydration play an integral role: the healing of her pressure ulcers. In addition, managing her pain more effectively may improve her mobility, and initiating a referral to appropriate social services may make it easier for her to obtain appropriate food at home.

- Gerald Thomson is 79 years old. He is 1.88 metres in height and weighs 64kg. His BMI is calculated to be 18.1, making him underweight.

Mr Thomson insists on having porridge every night for his evening meal but is seen to eat little else throughout the day.

**Question 1: Should you try to change Mr Thomson’s diet or work around his individual choices to increase his nutritional intake?** Involving Mr Thomson in decision making to improve his nutritional or fluid intake is likely to be more effective than dictating to him what you think he should do and when you think he should do it.

**Question 2: What additional action could you take to try to improve Mr Thomson’s nutritional intake?** A nursing assessment should be holistic, and nutrition and hydration may be affected by pain that is not adequately managed, constipation, changes in routine and environment, an inability to read or understand menu choices, and food dislikes. You should complete a full assessment to ascertain the reasons behind Mr Thomson’s low food intake.
In response to this report, was Leadership Alliance for the Care of Dying People published One Chance to Get it Right (2014), it stated registered nurses’ responsibilities in nutritional care as to:
» Be able to assess and monitor nutritional and fluid status;
» In partnership with patients and their carers, formulate an effective plan of care to ensure people receive adequate food and fluid;
» Identify when nutritional status worsens/signs of dehydration and act to correct them;
» Ensure appropriate assistance is available to enable people to eat and drink;
» Ensure people unable to take food by mouth receive adequate fluid and nutrition to meet their needs.

The issues discussed above explain why the NMC has included nutrition and hydration as part of the fundamentals of care in the revised code and reinforces the importance of the nurse’s role in patients’ nutritional care.

The revised code
The first section of the revised code, Prioritise People (NMC, 2015), states that nurses must treat people as individuals and uphold their dignity. To achieve this, nurses should:
» Treat people with kindness, respect and compassion;
» Make sure they deliver the fundamentals of care effectively;
» Avoid making assumptions, and recognise diversity and individual choice;
» Make sure that any treatment, assistance or care for which they are responsible is delivered without undue delay;
» Respect and uphold people’s human rights.

Using these five statements as a basis, how can we, as nurses, ensure we are upholding the code when dealing with our patients’ nutrition and hydration needs?

Treat people with kindness, respect and compassion
The DH has dedicated an entire document to compassion in nursing practice (DH, 2012) and outlines six fundamental values – known as the “six Cs”: care, compassion, competence, communication, courage and commitment. It suggests that, to meet the six Cs, there should be:
» Clear leadership at every level;
» Clear expectations for all staff to manage performance, champion change and create an environment where staff are not afraid to speak out;
» Training and development for all staff;
» A culture where people are encouraged to “go the extra mile” and challenge current practice to improve the quality of care provided to patients;
» A working environment that enables staff to deliver the best care for people;
» A clear communication strategy and collaborative workforce.

Each of these statements can be applied to the provision of nutrition and hydration to patients.

Good leadership is required to have a clear awareness of who is providing what care and to whom. As an example, patient mealtimes can be chaotic if staff are unaware which patients require special diets, thickened fluids or assistance to eat. Clear communication between all staff involved in patient mealtimes is essential. Changes in the level of care required or referrals needed may be missed if they are not communicated effectively to the appropriate person.

Staff who have not been trained in nutritional care may not realise the significance of, for example, a “red tray” (issued to patients who need assistance with eating or drinking, or whose dietary intake is being monitored), how to safely help someone to eat or drink, or what issues they should feed back after a meal.

Deliver the fundamentals of care effectively
Nutrition and hydration are fundamental to life, and, as such, consideration must be given to the nutrition and hydration needs of every patient in the nurse’s sphere of responsibility, even if they are nil by mouth.

Effective care can only be provided if the patient’s needs have been fully assessed. Assessment should begin at the first consultation, be that in a GP surgery, outpatient department or hospital ward. Nursing assessment should comprise:
» A full medical history, including social issues/support (if appropriate);
» Completion of a nutrition screening tool.

Once the assessment stage is completed, an individualised care plan should be made, documented and communicated to all those involved in caring for that patient. If additional support is needed, appropriate referrals should be initiated.

Avoid making assumptions and recognise diversity and individual choice
It is easy to make an assumption about a person’s nutritional status and ability to manage their nutrition and fluid intake orally, based on first appearance. Two fictional scenarios look at how our assumptions can affect the nutritional care we provide to patients (Box 2).

Exploring the two cases in more detail, it becomes clear that, although nurses are not providing direct assistance to help their patient to eat, their role is essential to avoid incorrect assumptions, and to recognise and address problems to improve nutritional intake.

Ensure that any treatment, assistance or care for which you are responsible is delivered without undue delay
As discussed earlier, registered nurses must retain responsibility for intervention, even when they have been delegated to an unregistered member of staff including healthcare assistants, volunteers, housekeepers, or members of domestic staff. As responsible professionals, registered nurses are expected to...
coordinate the nutritional care of patients in their sphere of responsibility even if they do not provide the care directly.

On completion of the nursing assessment and screening process, a plan of care for each individual patient must be developed, even if it is to identify that the patient does not need any specific nursing assistance. It is the registered nurse’s responsibility to monitor and review the plan of care, making changes as the patient’s clinical condition changes. It is also the nurse’s responsibility to communicate those changes to other staff members involved in the patient’s care. Consider the scenario outlined in Box 3.

Respect and uphold human rights

Human rights violations relating to nutrition and hydration include issues such as:

» Refusing to help patients to eat or drink when they are unable to help themselves;
» Leaving food or drinks out of reach;
» Not providing adequate oral hygiene;
» Leaving patients in soiled or wet clothing after a meal;
» Not helping patients to obtain food outside mealtimes;
» Not making appropriate referrals when a need has been identified;
» Providing personal care in preparation for, or after, a meal in view of other people;
» Making meal choices without including the patient.

None of the issues highlighted are difficult to address. All that needs to be done is the following:

» Recognise the need;
» Identify and coordinate who is providing the necessary aspect of care;
» After the intervention, feed back to a designated person – usually the registered nurse – who has responsibility for that patient to inform future care.

When difficulties providing appropriate care are recognised, it is the responsibility of the registered nurse to identify how that issue needs to be addressed and who needs to be involved to address it. When delegation is required, the nurse must provide information and instruction to ensure appropriate care is provided and feedback given. When there is a lack of knowledge, understanding or ability to provide appropriate care, education or mentoring must be initiated. When other personnel need to be involved, a referral must be made to the appropriate health or social care professional to instigate further assessment or support.

BOX 3. DELIVER CARE WITHOUT DELAY: CASE SCENARIO

Nora John is a 63-year-old woman with multiple sclerosis. Nursing assessment and nutrition screening has highlighted that she is unable to eat without assistance. She does not have the strength in her arms to raise cutlery to her mouth. As the only registered nurse on the ward, you are unable to dedicate the time necessary to help Mrs John directly, so you delegate the task to a healthcare assistant.

Question 1: What details do you provide to the HCA to ensure they have the appropriate information to provide safe care to Mrs John? An integral part of the delegation process is to provide the HCA with the appropriate information to enable them to undertake the task safely. This may include consistency of diet required, level of assistance required, risks and patient expectations. You should also make it clear to the HCA what information must be fed back to you about Mrs John’s nutritional and fluid intake, including any problems or difficulties.

Conclusion

It should be clear that including nutrition and hydration in the revised NMC code does not involve additional work for nurses. The new code is far more detailed than previous versions and provides clear guidance about what is required of them. The specific mention of nutrition and hydration can be viewed in two ways – as a reminder that nurses have not addressed patients’ nutrition and hydration needs adequately in the past, or as reinforcement that nursing has a vital role to play in the nutritional care of patients. Whatever your take on it, the code came into force on 31 March 2015 and must be adhered to. The new conditions will become part of the revalidation process for every nurse registering in the UK, which is scheduled to start in April 2016. NY

References

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