Hungry in hospital essay sample

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The Hungry in Hospital report concerns the importance of food in relation to nutrition, and how nutrition is important when people are ill in terms of the healing process. It explores how food is therefore part of a patient's treatment, the reputation of hospital food, and suggests that health is being seriously affected when people in hospital do not eat or drink enough. The aims and recommendations of the report highlight the importance of nutrition in hospital, why patients leave hospital undernourished, it examines whose role is it to feed patients.

The Hungry in Hospital report was written in January 1997, the rationale in choosing this particular report stems from a mixture of personal patient experience and now, a decade later, the concerns of the report are evident in everyday practice in my role as a student nurse. The report highlights factors that may contribute to a patient not eating and drinking in hospital, this paper will examine several of these issues, together with the impact malnourishment has on recovery from illness, and whether it is, or ought to be the role of the nurse to feed patients.

The issues examined will relate to a surgical ward within a local trust. Hospital catering is an essential part of patient care. Patients need nutritious, appetising food that they are able to eat in order to aid their recovery. If patients do not maintain an adequate dietary intake they may become malnourished, this increases the risk of delayed healing, (Williams & Leaper 2000). Malnutrition may be defined as bad nutrition, and applies to " any condition caused by excess or deficient energy or nutrient intake, or by an imbalance of nutrients". Whitney, Cataldo & Rolfes 1994). The report highlights undernutrition as delaying recovery from illness or surgical or

medical intervention, and further suggests it may be life threatening as it can cause complications in illnesses. The latter statement is supported by findings from the " Royal College of Physicians (2002) which states acutely ill patients are more likely to die if undernourished" and also by " Holmes (2003) who implies undernutrition increases the risk of mortality".

PEM (Protein energy malnutrition) and deficiency of energy and trace nutrients, leads to the wasting condition known as malnutrition or undernutrition, it is the most common form of undernutrition in hospital. (Pinchcofsky-Devin & Kaminski 1986). The report introduction emphasises the significance of nutrition when people are ill. Healing requires increased energy demands and an adequate calorie intake from a balanced diet is essential to maintain and promote good health. It provides the nutrients needed by the body cells, a nutrient is any substance that is digested, absorbed and utilised to promote body function (Wilson and Waugh 1996).

Some nutrients are essential nutrients which means the body can not make the substance, therefore it must be obtained from the diet. Nurtients include carbohydrates, protein, fats, vitamins, mineral salts and water. Carbohydrates provide energy and heat, proteins are made up from amino acids which are used for growth and repair of body cells and tissues. A diet deficient in protein synthesising nutrients such as vitamin C compromises tissue integrity, making it easier to damage and delays wound healing (Fletcher 1996).

Fats produce chemical energy and heat, and act as an insulator through the subcutaneous layer, they also transport the fat soluble vitamins A, D, E and

K. Vitamins are essential for normal metabolism and health and are either fat soluble as above or water soluble such as vitamin B complex and C. Water makes up about 70% of body weight in men and 60% in women (Hinchcliff et al 1996) large amounts of water are lost in sweat, urine and faeces. When eating and drinking normally the loss is balanced, where diet and hydration are impaired dehydration occurs and can have serious consequences.

It is vital that a patients nutritional needs are properly met, When sufficient intake is not maintained the body looks for alternative sources and skeletal muscle tissue will be broken down. (Casey 2003). In the case of surgical patients “ any wound places increased metabolic, and consequently nutritional demands on the patient, which may or may not be met depending on the size and duration of the wound, the amount of exudative loss, and the nutritional status of the patient before the surgery”. (Collins 1996).

One long stay patient undergoing continuing surgical debridement for extensive venous leg ulcers was aware that her poor nutritional status was having an effect upon wound healing. However her reluctance to eat arose from drug induced nausea, and clinical depression following the recent death of her husband. The report states that “ many patients, particularly those who have been in hospital for extended periods of time leave hospital in an under nourished state”. A finding which is supported by McWhirter & Pennington (1994) citing “ 70% or more are malnourished on discharge”.

It is difficult however to find other supporting evidence from literature sources to substantiate this statement, therefore questioning the validity of figures which are nine years old as being relevant today. By contrast, The

Audit Commission (2001) cites “ studies with findings of up to 40% of adult patients becoming malnourished during their stay”. This figure may be a more accurate and reliable indication of the extent of malnutrition today, as indicated in the hungry in hospital report.

During my practice placement it was the protocol for any patient requiring assistance to be helped with their meals, all patients were encouraged to eat and drink, food and fluid charts were documented each meal time. It would seem probable that the patient referred to would possibly have left hospital in an undernourished state pertaining to her sociocultural aspects, but based on my placement experience I would disagree with the quoted figures indicating the percentages of malnourished patients.

The report contains several recommendations, one of which is “ the strengthening of staff training to emphasise the importance of nutrition in recovery from illness”. I feel this recommendation to be a valid recommendation, as based on my practice placement experience it is largely unqualified staff who assist patients at meal times and many may not be aware of the importance of nutrition. “ Arrowsmith (1997) indicates the importance of better nutritional education to enable staff to recognise malnutrition”. When uneaten food is removed it is often assumed that the person is just not hungry, an easy assumption for unqualified staff to make.

Largely this is then documented but if not brought to the attention of the nursing staff documentation serves no purpose. The inherent danger in this kind of situation is outlined in the report and may be viewed as one of its strengths. This is substantiated by the Department of Health (1995)

indicating “ there must be a locally agreed policy for keeping written records of the proportion of a meal eaten by a patient, and a system for reporting this information to the nurse responsible for the patient’s care. ” If all staff understood the importance of nutrition in recovery from illness the incidence of undernutrition could be greatly reduced.

Lennard-Jones (1992) indicates the “ importance of this stating the focus to be on illness rather than nutrition, as patients are cared for by many healthcare professionals in different disciplines, no one group accepts responsibility for, or anticipates nutritional problems”. Nursing staff may identify patients at risk of nutritional problems but if this information is not communicated to all members of staff involved in serving food and collecting trays it serves little purpose. The cost of such training would surely be worthwhile when offset against the cost of long stay patients where poor nutrition was affecting recovery and healing.

A further consideration could also be the cost to the NHS of treating patients needing re-admission following undernourishment upon discharge. This is supported by Tierney et al (1994) who indicate “ unacceptably high incidence of undernutrition in hospitals increases re-admission rates. ” The report highlights the issue of who should be responsible for ensuring that patients eat and drink in hospital and outlines the nurses’ role in meeting the needs of nutrition as defined by the Royal College of Nursing.

The responsibilities of the nurse should be to make sure that the patients’ nutritional needs are met, preferences identified, patients are in a correct position to eat or drink and any lack of appetite is monitored and acted on

where necessary, but the responsibilities of the role do not include feeding patients”. (Royal College of Nursing 1996). The report suggests that a lack of role definition has lead in part to nurses not being involved with assistance at meal times, but a reduction in the number of registered nurses together with shortages of staff are also contributing factors.

It suggests numbers of registered nurses have fallen dramatically stating only 9, 000 nurses were due to qualify by 1997/8. Harris (2002) claims that the “ current shortage of nurses is almost half a million in the United Kingdom”. By contrast the Royal College of Nursing whilst not denying there is still a serious shortage of nurses, welcomes the fall in nursing vacancies with three thousand or more nurses returning to practice, or training to return. (Royal College of Nursing 2001).

Outlined also in the report is the suggestion that nursing staff have pressure to undertake more ‘ pressing’ or ‘ glamorous’ duties and this could prevent providing assistance with feeding. During my placement, lunch times on the ward were certainly very busy with nursing staff facing contesting demands. At times there would be only one qualified nurse covering fifteen patients, with the responsibility for a lunchtime drug round, a constantly ringing telephone and the writing up in Kardex ready for handover to colleagues on the next shift.

Assisting patients to eat and drink did not form a regular part of the nurse’s role on the ward identified, although approximately one third of patients required some form of assistance. It was seen to be the role of the auxiliary, student, cadet nurses and ward-aid assistants to distribute, assist and

document feeding. On several occasions food charts were not documented, presumably each person ‘ assuming’ someone else would do it. This was mentioned to staff by the ward sister, but no clear guidelines were given.

I took it as my personal responsibility that if I removed a tray I documented accordingly, but other staff did not always do so. The report recommendation for definition of roles and responsibilities as previously outlined is further supported by this evidence. The only exception to nurses not being involved with feeding was a female patient with dysphagia, (difficulty in swallowing) who was to be fed by ‘ trained staff only’. The report identifies the issue implemented by the Department of Health (1995) that patients “ needing assistance with eating and drinking must be helped whilst their meals are hot and appetising”.

On several occasions the patient identified had her meal left on the bedside tray for long periods of time, waiting for a qualified nurse to assist her. Subsequently the food was often cold and unappetising when offered to her, and it was frequently documented that she was eating very little and had a poor appetite. In reality if the food had been given whilst it was still hot, and the nurses had more time to spend with her instead of constantly rushing, she would possibly have eaten more.

As a result the patient had a naso-gastric tube inserted causing her great distress which could possibly have been avoided.. This I feel is an instance which reinforces the report’s recommendations that patients needing assistance must be helped whilst their meals are hot and appetising. Conversely, a barrier to implementing the recommendation is the shortage

of trained nurses, the report acknowledges this with a short paragraph. This barrier is supported by the instance above, that staff shortages do prevent nurses from offering assistance at meal times.

No provision is included in the recommendations of the report for addressing this issue, and this therefore could be viewed as a weakness, failing to properly address this vitally important issue. The NMC Code of Professional Conduct (2002) states that as " a registered nurse or midwife you must: protect and support the health of individual patients and clients", in my opinion this includes ensuring patients maintain an adequate nutritional intake, whether by means of careful monitoring or by providing direct assistance at meal times.

Although nurses cannot accept sole responsibility, they can and should play a central role in patient feeding. Recognition of the risk of undernutrition must rest with nurses" (Holmes 2003). Several authors call for better nutritional education to enable staff to recognise malnutrition. (Arrowsmith 1997, RCP 2002). The report recommends that roles and responsibilities of staff at meal times must be clearly defined by the Department of Health. A statement reiterated by the (Audit Commission 2001) and the (Royal College of Physicians 2002) indicating that nutrition should be accepted as a team responsibility.

Role definition regarding staff at meal times would provide a focus for responsibility, would ensure patients requiring assistance received it, and nutrition of all patients was adequately monitored. This recommendation I feel is valid and would have a direct outcome in improving nutrition in

hospital. The report focuses on barriers which may prevent a person from eating such as inappropriate food, timing of meals, positioning, utensils and physical problems. Any one of these could result in malnourishment but often patients experience several barriers collectively.

The positioning of food for example “ It is not uncommon for food to be placed outside the patient’s reach and later removed untouched” (Davies 2002) this scenario sounds unthinkable in today’s modern care environment, I have witnessed this recently. Food being left on the bedside tray out of reach of an elderly patient, all that was required was for the tray to be moved and placed across the bed where it was accessible. Unfortunately it was not realised until the trays were being collected, by this time the food was cold and the patient ate only a little of the desert.

On a separate occasion a patient with spinal compression and paralysis from the chest downwards had his breakfast left in a similar position without the lid being removed, staff ‘ assumed’ his tray was finished with and collected it in. He informed me when I was ready to begin washing him that he had no breakfast. I made toast and helped him to eat it, but it was a poor substitute for breakfast for a seriously ill patient. These scenarios and other similar ones are evident in extracts of the report, which have been taken from interviews with relatives particularly of elderly patients.

Both these incidents confirm the findings of the report and further establish a recommendation of the report that “ Those patients needing assistance with eating and drinking must be helped whilst their meals are hot and appetising. ” In examining the responsibilities of the nurse the report

indicates that where necessary patients should have special equipment to help them eat. This finding is substantiated by Davies (2002) who states, " eating may present an insurmountable obstacle for patients with a physical disability, and various aids can help in such situations".

The report indicates that as part of " budget cutting exercises" Occupational Therapy Departments no longer provide equipment for use on wards, only on discharge. There is little evidence from literature searches to support this indication, on the contrary during my placement a patient was assessed by the Occupational Therapist and provided with an angled spoon to facilitate independent eating. Unfortunately this method of help was not entirely successful, as after use the spoon was washed and placed in the ward kitchen drawer, on numerous occasions it was forgotten and not given to the patient at meal times.

This mirrors the report's contents on positioning of food, food cannot be eaten if left in an inaccessible place or manner. Likewise it is a waste of resources to provide special equipment and subsequently leave it in a drawer at mealtimes. The focus of the report is to disseminate information collected surrounding the various issues of why people can not, or do not eat in hospital and are therefore Hungry in Hospital. The issues discussed are all interrelated and have a direct effect on each other.

Whatever the figure, people in, or leaving hospital malnourished is a serious cause for concern and is the basis for the report. The report recommends clearly defined roles and strengthening of staff training, in opposition to this is the issue of staff shortages which is mentioned in the report, but no

attempt is made to address this issue in the recommendations. A highly trained nurse or assistant who is quite clear of her role in preventing malnutrition, will not be effective in her role if she has no time to do her job properly because the ward is short staffed.

Hospital food has a history of criticism, according to Girling (2002) " criticising NHS food is almost a national pastime". It is suggested that the problem of malnutrition in hospitals has been known about, but in effect ignored for the better part of forty years. As outlined in the report the responses from Community Health Councils and members of the public gave cause for real concern that some people are not eating and drinking enough in hospital.

A major criticism of the report must however be the basis for its' foundation, responses and statements from relatives and Community Health Councils, rather than factual evidence based research. The impact of the report has been to publicise these concerns and has lead to action being taken in line with the recommendation that the " Department of Health must take these accusations seriously and investigate the problem". As a result the NHS Plan (DOH 2000) " included food in hospitals as a major target for improvement".

It is evident to me from my practice placement experience that nutrition, and feeding patients in hospital is still an area for concern. As stated , whilst some areas of the report are lacking factual evidence it is however in my opinion, an interesting report on a very poignant subject with valid recommendations. Some of these have been implemented in part, and evidenced in practice, such as an initial assessment made of food and fluid

intake but others have yet to be acted upon. Food, after all “ Can be the least expensive form of treatment”. (Cryer 2002).