



# **Organisation of Food and Nutritional Support in Hospitals**

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## Foreword

There has been considerable discussion about where the burden of responsibility lies for providing nutritional care to patients. Doctors, nurses and dietitians and other health care workers have produced their own local or national documents, outlining their individual roles and responsibilities. In reality, nutritional care is a multi-disciplinary responsibility, and an integration of workforce activities is absolutely essential. Without coordinated and complementary efforts of different health care workers the result may be poor, even if individual disciplines excel. It is like an orchestra in which individuals musicians have excellent talents, but they do not play at the same time and in the same spirit as other members of the orchestra. It seems that there are two challenges that face us. The first is to encourage excellence within professions and the second is to make the professions work together in the most efficient and integrated manner. BAPEN is unique in that it developed from a wide range of disciplines interested in nutrition (nurses, doctors, dietitians, pharmacists, scientists, patients, and others). Therefore, it was appropriate for BAPEN to have taken lead in producing its first national report *Organisation of Nutrition Support in Hospitals* in 1994, with input from multiple disciplines under the chairmanship of Dr DBA Silk. This acted as a model that influenced practice in the UK. However, as new guidelines and standards have been produced, and the organisational infrastructure of the National Health Service has changed, the way different health care workers need to operate and interact with each other has changed. Many standards and guidelines focus on achieving the end point. This report focuses on the process by which that end-point can be achieved. BAPEN is therefore delighted to support and congratulate Professor Jeremy Powell-Tuck and his committee for their excellent work in updating the report, emphasising even more than before the importance of the multi-disciplinary approach, which is at the heart of BAPEN's mission, and for producing a user friendly web-based information resource, which is now available to a much wider audience than our previous reports.

Professor Marinos Elia

Chair of BAPEN

August 2007

## 1 Introduction

Organization of food and nutritional support relates nutrition services with all other services provided in a hospital. In whatever shape the organisational plan is viewed, it is about delivering appropriate nutritional care to all patients. Several key websites provide valuable guidance and this website will help you find these. We aim to give you ideas whether your hospital has an advanced service suitable for providing care to many specialist units, or whether you are just setting out for the first time to try to meet the NICE guidelines. We expect few, perhaps no, hospitals to fulfil all these aspirations – but if the website helps you to develop your service a little bit more it has achieved its aim.

Since the publication of the first edition of the first edition of “Organisation of Nutritional Support in Hospitals” [1] and “Hospital Food as treatment [2], a large number of important political drivers have emerged which seek to influence nutritional care in hospitals. This is greatly to be welcomed. The purpose of the present document is to

- Collate existing initiatives and drivers and enable easy access to them
- Provide a framework for their implementation
- Consider where further advances can be made
- Provide an *aspirational* model for *progressive* improvements in the delivery of nutritional care in hospitals

## 2 External Recommendations and Reports:

*These can be accessed directly from our interactive website – or follow the hyperlinks from this text.*

A series of documents, papers and recommendations from many organisations, including the first edition of “Organisation of Nutritional Support in Hospitals” published in 1994 by BAPEN, have been highly influential; governments have been responsive to them. This can be seen in the guidance now emanating from government both at European and national levels aimed at improving the nutrition of hospital patients. From the dimension of the UK, the publication of the NICE clinical guideline 32 “Nutrition support in adults” provides a particularly opportune moment to re-examine the BAPEN report on organization of food and nutritional support in hospitals.

In **Resolution ResAP (2003) 3 the Council of Europe** recommends that the governments of member states draw up and implement national recommendations on food and nutritional care in hospitals based on the following headings:

## **1. Nutritional assessment and treatment in hospitals**

*1.1 Nutritional risk screening 1.2 Identification and prevention of causes of undernutrition 1.4 Ordinary food 1.5 Artificial nutritional support*

**2. Nutritional care providers** *2.1 Distribution of responsibilities for nutritional care in hospitals 2.3 Education and nutritional knowledge at all levels*

**3. Food service practices** *3.1 Organisation of hospital food service 3.2 Contract food service 3.3 Meal service and eating environment 3.4 Food temperature and hygiene 3.5 Specific improvements in food service practices to prevent undernutrition*

**4. Hospital food** *4.1 Hospital menus and diets on medical indications 4.2 Meal pattern 4.3 Monitoring of food intake 4.4 Informing and involving the patient*

**5. Health Economics** *5.1 Cost-effectiveness and cost-benefit considerations 5.2 Food service and food wastage costs*

The full resolution is reproduced at <https://wcd.coe.int/> .

**Nutritional Screening** should be routine for all patients unless specific opt-outs are agreed as hospital policy (see NICE guidelines below). BAPEN recommends the use of the MUST [http://www.bapen.org.uk/must\\_tool.html](http://www.bapen.org.uk/must_tool.html)

Within the UK, nutrition has been included in government drivers for modernising the NHS and for improving patient focused care. These have started with hospital food, concentrating first on food quality in the **Better Hospital Food** initiative:

[http://195.92.246.148/nhsestates/better\\_hospital\\_food/bhf\\_content/introduction/home.asp](http://195.92.246.148/nhsestates/better_hospital_food/bhf_content/introduction/home.asp)

and then creating **protected mealtimes** for patients:

[http://195.92.246.148/nhsestates/better\\_hospital\\_food/bhf\\_content/protected\\_mealtimes/overview.asp](http://195.92.246.148/nhsestates/better_hospital_food/bhf_content/protected_mealtimes/overview.asp).

**Patient Environment Action Teams** (PEATs) assess the cleanliness of individual healthcare facilities on a yearly basis. Each PEAT comprises NHS managers and staff, patients and representatives from patients' groups.

Initiatives have progressed to bedside management of nutrition through “**Essence of care: patient-focused benchmarks for clinical governance 2003**”. The latter includes eight areas of which one, “food and nutrition”, is most relevant here. The factors considered in this relate to nutritional screening, assessment and care planning,

and go on to consider standards for provision of food which are highly relevant to hospitals and care/nursing homes:

<http://www.dh.gov.uk/assetRoot/04/12/79/15/04127915.pdf> .

In Scotland a report entitled **Food, Fluid and Nutritional Care in Hospitals** revised in September 2003, set out standards that are “achievable but stretching” by which performance in the provision of food, fluid and nutritional care in NHS Boards throughout Scotland could be assessed:

[http://195.92.246.148/nhsestates/better\\_hospital\\_food/bhf\\_downloads/nutrition/scotland\\_food\\_fluid.pdf](http://195.92.246.148/nhsestates/better_hospital_food/bhf_downloads/nutrition/scotland_food_fluid.pdf).

The standards given in this are as follows:

- 1 Each NHS Board has a policy, and a strategic and co-ordinated approach, to ensure that all patients in hospitals have food and fluid delivered effectively and receive a high quality of nutritional care.
- 2 When a person is admitted to hospital, an assessment is carried out. Screening for risk of undernutrition is undertaken, both on admission and on an ongoing basis. A care plan is developed, implemented and evaluated.
- 3 There are formalised structures and processes in place to plan the provision and delivery of food and fluid.
- 4 Food and fluid are provided in a way that is acceptable to patients.
- 5 Patients have the opportunity to discuss, and are given information about, their nutritional care, food and fluid. Patient views are sought and inform decisions made about the nutritional care, food and fluid provided.
- 6 Staff are given appropriate education and training about nutritional care, food and fluid.

The **Royal College of Nursing** has examined the nursing practice of nutritional care at ward level demonstrating in an observational report the complexities of trying to respond to these initiatives:

<http://www.rcn.org.uk/downloads/research/institute/PatientsNutritionalCareInHospital.doc>

The study identified a number of areas where further research was needed:

- an exploration of the current role of modern matrons with respect of their responsibilities for promoting and ensuring nutritional care (Department of Health 2003b);
- 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 implementation;
- an 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.

The **Royal College of Physicians** [3] has emphasised the medical responsibilities in nutritional care which include awareness of nutritional problems and how to manage them, nutritional screening and documentation of nutritional status, discouragement of obesity. The College recommended that hospitals should have a multidisciplinary nutrition steering group to develop policies and have explicit protocols and standards for nutritional management. Doctors should play an active role in a multidisciplinary support team for the care of complicated undernutrition. Regular audit was recommended and those responsible for clinical governance were advised to identify nutritional as an important aspect of clinical practice involving caterers and many health care disciplines. The College emphasised and sought to catalyse the needs for medical undergraduate and continuing professional training in nutrition.

Much of the political emphasis to date has been on the routine assessment of patients' nutrition on or before admission to hospital, and the development of a care plan employing principally good food provision supervised at the bedside by motivated nurses who understand the importance of nutrition in speeding recovery. If there has been somewhat less political recognition of the role of artificial nutrition in those who cannot eat or absorb enough to maintain an adequate nutritional state or in critically illness, this has been redressed by publication of **evidence-based reviews** such as that published by Stratton, Green and Elia "Disease-related malnutrition, an evidence-based approach to treatment"[4], the British Society of Gastroenterology "Guidelines for enteral feeding in adult hospital patients [5], ESPEN "ESPEN Guidelines on Enteral Nutrition" [6] and on artificial nutritional support in the publication of the **National Institute for Health and Clinical Excellence Guidelines** on Nutrition Support in Adults.

ESPEN website: <http://www.espen.org>.

NICE Summary guideline: <http://www.nice.org.uk/pdf/CG032NICEguideline.pdf>

NICE full guideline: <http://www.nice.org.uk/pdf/cg032fullguideline.pdf>

NICE guidance sets out key clinical and organisational priorities for implementation:

*Clinical:*

Appropriately trained professionals screen and assess all patients on admission or at first attendance to out patients

Consider use of nutritional support in those who are malnourished or at risk of malnutrition.

*Organisational:*

All healthcare professionals should receive appropriate nutritional education and training.

Healthcare professionals should ensure that people who need nutritional support should receive coordinated care from a multidisciplinary team.

All acute hospital trusts should employ at least one specialist nutrition support nurse

All hospital trusts should have a nutritional steering committee working within the clinical governance framework

### 3 Core Objectives:

These have clinical, humanitarian, environmental and psycho-social dimensions:

- Appropriate nutrient intake for all hospital patients bearing in mind their nutritional status, their length of stay and (changes in) their clinical situation.
- Good food, acceptable to the patient bearing in mind tastes, culture, religion, age, and making allowance for illness.
- A pleasant environment conducive to enjoyment of food and suitable for various states of health and disease, with food able to be delivered to patients flexibly according to their needs in sites such as the ward, ward common room, or a patient restaurant.
- Encouragement of a social component to eating to aid psychological recovery:
- Safe and effective artificial feeding
- Pre-admission nutritional support when possible
- Discharge planning and continued community and out-patient nutritional care.

#### Philosophy:

The first of these objectives seeks to achieve *appropriate* nutrient intake which implies early nutritional assessment and estimation of requirements. It also implies the use of the *simplest, safest, most cost-effective means of nutrient intake acceptable to the patient*. It will encompass food, nutritional supplements (including snacks, sip feeds, vitamin and minerals), enteral and parenteral nutrition. It *does* need to be acceptable to the patient, particularly in the context of artificial feeding.

The second demands good hospital catering and an awareness of social and religious constraints on food intake. It takes account of changing taste in relation to disease and its treatment.

The third depends upon an understanding of how to achieve an environment conducive to a good appetite and the enjoyment of food and might imply investment in/development of patient restaurant facilities or other innovations.

The fourth gives regard to the importance of food as a social activity vital in the maintenance of patients' morale and psychological independence and well being.

The fifth emphasises excellent multi-professional care in the delivery of safe artificial feeding – "first do no harm".

The sixth reminds us that nutritional management is not a quick fix, and requires continuing care, often amounting to recommendations for changes in the patient's lifestyle.

### **Specialist Units and Hospitals large and small.**

Hospitals may be small and specialist and deal predominantly with a single group of patients (care of the elderly, cardiac, respiratory, gastrointestinal, ENT, urological etc) or they may be large institutions, often comprising more than one hospital under unified management, and providing general and specialist care in a variety of units each with their own distinct mix of patients. Hospital strategy needs to provide a framework for nutritional care which can be adapted to fulfil patients' needs in all such units. It must therefore recognise a need for special arrangements in each specialist setting. A balance has to be achieved between central standardisation and unit-based delivery of care to a group of patients with special needs.

In the first edition of "Organisation of Nutritional Support in Hospitals" the multidisciplinary approach to nutritional support was emphasised by recommendation of a two tier structure: there was to be both a Nutrition Steering Committee and a Nutrition Support Team. The concept of a multidisciplinary/multi-professional approach was strongly advocated. While this is an important aspiration, it is apparent that this alone is not enough; nutritional care must be provided for all patients through *institution/hospital-wide* commitment. Nutrition committees and teams function principally to foster and co-ordinate such commitment and to aid its development - they cannot themselves deliver care to all patients. Their educational and organisational role is therefore paramount. What is needed is achievement of a *culture* orientated towards excellent nutritional management which pervades throughout a hospital's clinical workforce. This depends upon coherence between many semi-autonomous clinical groupings and upon a desire by all to achieve this, together with an understanding of the benefits of doing so. There needs to be an *acceptance of responsibility for nutritional care by all healthcare professionals especially all doctors and nurses.*

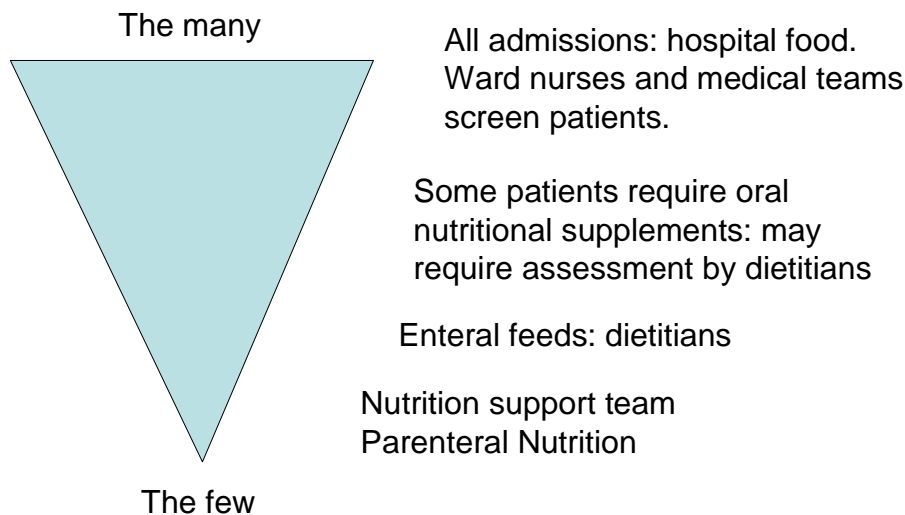
## **4 Organisation**

The fundamentals of good nutritional care lie at the bedside, with ward nurses supervising patients' choice from good food presented by imaginative and technically competent hospital catering services. The nurses play an important role in assessing their patients' nutrition and nutritional needs, helping them to choose appropriately, making them comfortable and assisting them in feeding, using the expertise of other professionals including physiotherapy and occupational therapy if required. They can help create the right environment for an enjoyable meal. The patient's medical team needs also to assess the patient and appreciate the benefits of nutritional management, supporting and motivating the nurses in this. An understanding of the patients' ingestive, absorptive, metabolic and excretory physiology should allow an informed approach to appropriate nutritional support. Fundamental, too, is the support of catering, medical and nursing services by qualified dietitians, through more detailed nutritional and dietary assessment, advice on recipes, food choice and monitoring, special diet supervision, choice of supplements and the prescription of, and assistance with, enteral nutrition when required. A multi-professional nutrition support team (NST) is required to provide safe and cost-effective artificial nutritional support in the minority of patients who need it. The NST supports the dietetic and nursing teams by providing specialist nutrition nursing, dietetic and pharmacist input and medical liaison, in order to optimise metabolic care of some of the sickest patients in the hospital, employing the parenteral route when necessary. The multiprofessional team

of doctor, specialist nurse, dietitian and pharmacist can do much to co-ordinate the nutritional function of ward nurses, ward dietitians, ward pharmacists and other doctors in the delivery of an organised nutritional strategy. The Nutrition Support Team functions for the most part through such links. Such a team may have special responsibility too for patients requiring long term, home parenteral nutrition. A “Lean” approach to organisation may be worth considering in order to maximise the efficiency by which patients rapidly receive appropriate nutritional management (“value-adding activity”) while “non-value-adding activity” is minimised:  
[http://www.leanuk.org/articles/lean\\_thinking\\_for\\_the\\_nhs\\_leaflet.pdf](http://www.leanuk.org/articles/lean_thinking_for_the_nhs_leaflet.pdf)

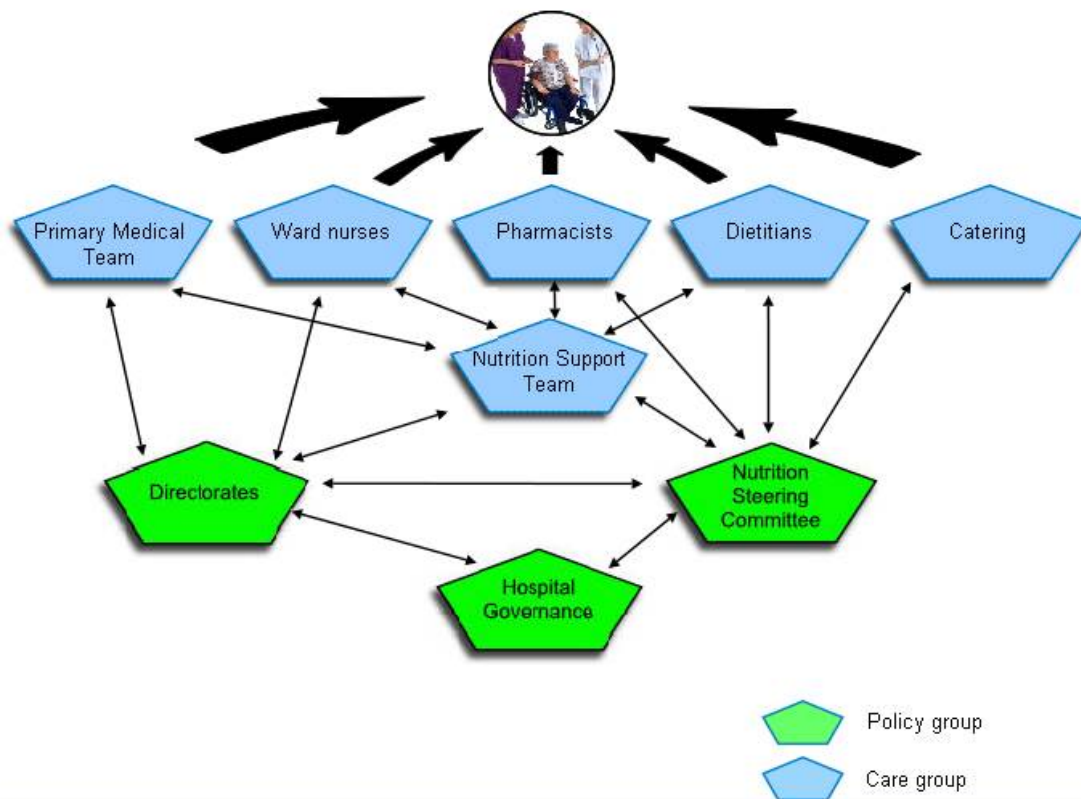
The provision of nutritional support can be seen as an inverted triangle in which the majority have their needs met by hospital food, a smaller number need supplementation or sip feeds, still fewer need tube feeding and just a small minority need parenteral nutrition. The diagram indicates who might be involved in supervising such approaches:

### From food to parenteral nutrition

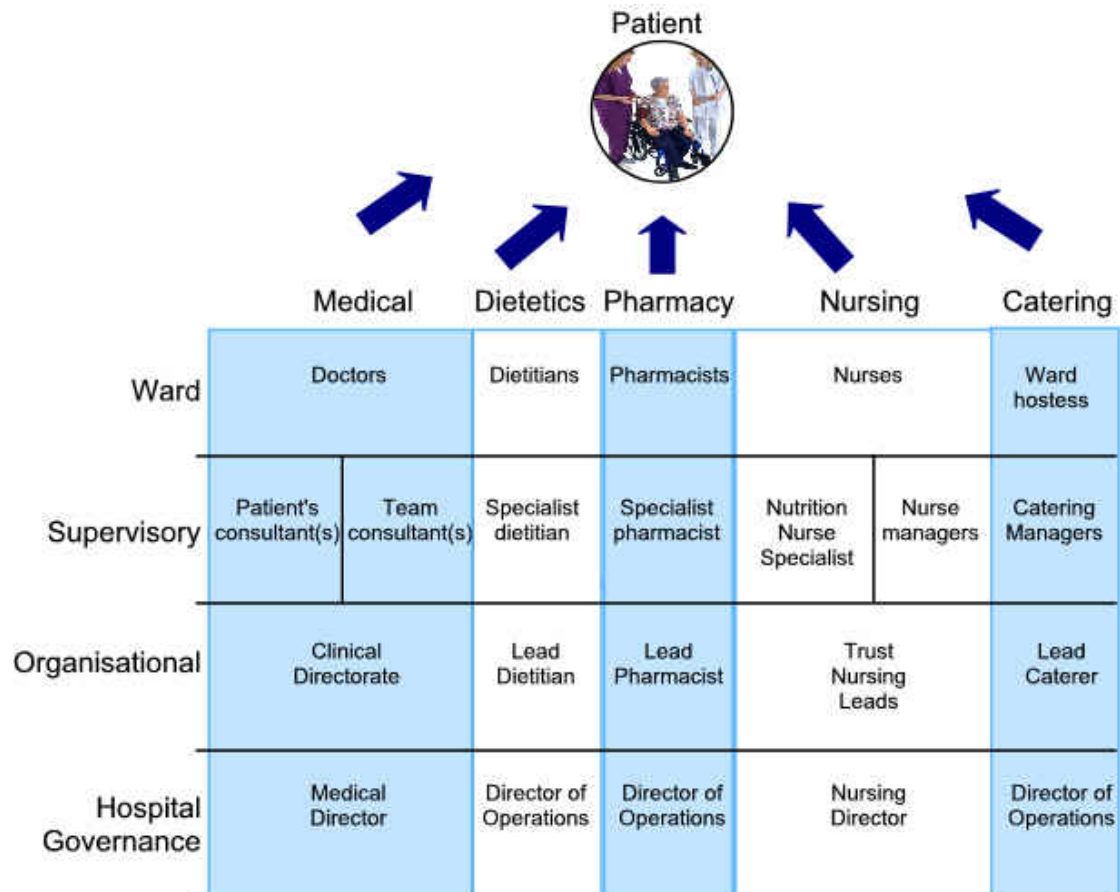


Delivering excellent nutritional care across the many specialist units of a large, complex hospital requires co-ordination. Standards must be set and audited, education and training delivered, equipment chosen and procured, and this must all co-ordinate with other governance, including, for example, infection control and risk management. This is the reason why a supervisory Nutrition Steering Committee is needed and why it must be multi-professional. Nutritional support is therefore delivered via catering, ward nurses and the patient’s medical team, supported by specialist advice and an authoritative, specialist-derived management structure which fosters excellence and responsiveness to external drivers. A Nutrition Support Team (NST) brings together, in a group which is seen to be primarily supervisory but nonetheless functional at ward level, the expertise of at least a doctor, nurse, dietitian and pharmacist with specialist skills in nutrition support. If all patients are to have nutritional screening and a nutritional plan, it is self evident that this cannot be delivered by a single small NST. The role of this team (and others) in nutritional

education and training is therefore emphasised. There should be an over-arching nutrition policy for the whole hospital, which can be used, with appropriate adaptation, at individual ward and specialist unit level. Specialist unit and ward nutrition policy must be in concordance with hospital policy. Staff moving from one unit to another within the hospital should recognise a uniformity of approach. How all these pieces of the jigsaw fit together is shown in the diagram below



Organisation can be seen in another dimension. Hospital services can be viewed as a series of columns providing support for each front-line service:



On the accompanying website this diagram is used to show where groups such as the nutrition support team and the hospital steering committee sit in this structure.

## 5 Who delivers what?

### 1 Patients.

In many countries patients and their relatives retain considerable responsibility for feeding themselves in hospital. While bringing cooked/prepared food in is neither expected nor generally possible in the UK principally because of concerns over food hygiene expressed through the Food safety Act 1990

([http://www.opsi.gov.uk/acts/acts1990/Ukpga\\_19900016\\_en\\_1.htm](http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900016_en_1.htm)), it is nonetheless good if the patient and their relatives take a positive approach to improving their nutrition.

How?

- 1 Know your weight and height when you go into hospital and think what your usual weight is.
- 2 Make sure someone weighs and measures you when you are admitted to hospital.
- 3 Tell the hospital about your dietary needs and cultural preferences
- 4 Be aware that good nutrition speeds recovery
- 5 Know that illness changes appetite and taste
- 6 If you are not eating enough tell your nurse or doctor
- 7 If you've lost weight think about drinks and snacks at home as well as in hospital: milk, cakes biscuits for example. Good nutrition shouldn't stop when you leave hospital.

- 8 Visit <http://www.eatwell.gov.uk/> but remember that when you've lost a lot of weight "healthy eating" may not be your major priority at first.
- 9 Sometimes people need artificial feeding via a feeding tube placed through their nose into the stomach. Sometimes people need to be fed through a vein. Your hospital should have specialist services organised to supervise these procedures efficiently. Ask about them.

## *2 The Hospital Nutrition Steering Committee:*

Brings together senior managers from many disciplines including nursing, catering, dietetics, pharmacy, medicine & surgery. It may appropriately be chaired by the Head Nurse or a senior figure within the hospital who can provide natural links with Governance and the Board. It may benefit from having sub-committees – for example Research and Development, Screening, Specialist Services, Catering.

Its remit is across the whole hospital or institution. It:

- 1 Oversees and advises the hospital on all aspects of nutrition, including screening and assessment, catering and food, supplements, enteral and parenteral nutrition – for in-patients and out-patients.
- 2 Scrutinises, develops and co-ordinates hospital nutritional policy in response to external and internal drivers through research and audit.
- 3 Agrees standards for screening, assessment and monitoring; food provision and nutritional support
- 4 Co-ordinates delivery of excellent nutritional support in all units, specialist or general.
- 5 Co-ordinates and monitors appropriate education and training programmes for all staff.
- 6 Liaises with specialist units and if necessary encourages, supports and develops specific needs for nutritional care delivery within them
- 7 Supports at least one multi-professional nutrition support team which includes at least one nutrition nurse specialist
- 8 Oversees the coordinated procurement of supplies relevant to nutrition
- 9 Oversees management of food for staff
- 10 Advises on provision of commercial food outlets on hospital premises
- 11 Is answerable through a governance committee to the hospital board

## *2 Nutrition Support Team(s) (NST)*

Is multi-professional and should include (at least) doctors, nutrition nurse specialist(s), dietitian(s) and pharmacist(s). It should be a role model for multi-professional working. It brings together nutritional experts from medicine/surgery, nursing, dietetics and pharmacy who can co-ordinate the contributions of each of these specialties into coherent nutritional support. It manifestly cannot do all the ward delivery of nutritional care itself, but serves to organise it and enhance it. It becomes particularly involved when there are problems requiring complex artificial nutritional support, especially parenteral nutrition. It may have a specialist role in supporting Home Parenteral Nutrition. The dietitian and pharmacist need to be senior staff and will have a supervisory role within their departments. The team's operational focus is the safe provision of artificial nutrition but it also has a wider educational remit. It:

- 1 Maintains itself as the principal source of evidence-based information about nutritional assessment and support
- 2 Liaises closely with Nutrition Steering Committee (see above)
- 3 Fosters and provides education, training and research in nutritional screening, assessment, monitoring and nutritional support, for nurses, medical students, doctors, dietitians, pharmacists and managers.
- 4 Develops and audits practical standards of care and organises approaches to nutritional screening, assessment, monitoring and artificial nutrition (eg catheter sepsis rates).
- 5 Is a focus for a multi-professional approach to artificial nutrition and provides co-ordinated medical, pharmaceutical, nursing and dietetic advice on request
- 6 The NST assesses suitability of different feeding routes and advises on alternative treatment options. It particularly directs nutritional care of patients receiving parenteral nutrition or in transition between enteral and parenteral.
- 7 Links to expert capabilities for intravenous catheter and gastrostomy insertion and assists in developing standards for such procedures.
- 8 Provides advice on supplies procurement
- 9 Supports dietitians, particularly in complex enteral feeding cases
- 10 Researches all aspects of artificial nutrition

### 3. Nutrition Nurse Specialist

- 1 Coordinates Nutrition Support Team with nursing care in general
- 2 Develops safe and practical nursing techniques with respect to nutrition policy through research and audit
- 3 Is a clinical expert in the assessment of nutritional needs and the delivery of treatment.
- 4 Provides advanced technical skills in relation to naso-gastric feeding, Percutaneous Endoscopic Gastrostomy, Radiologically Inserted Gastrostomy and Peripherally Inserted Central Catheters.
- 5 Provides specific training in these skills for nurses, patients and carers.
- 6 Contributes to nutrition education in a broader sense – nursing, medical staff and students
- 7 Advises, with others, on nutrition support policy, linking with the Hospital Nutrition Steering Committee to help develop a coordinated strategy, including issues regarding risk management and ethical decision making
- 8 Links with specialist units to foster good nutritional care.
- 9 Advises on and assists in the procurement of equipment
- 10 Out-patient nutritional support – liaison with community nurses, patients and carers
- 11 Maintains records
- 12 Participates in and often leads audit
- 13 Direct patient advocacy and care – out-patient HEN, HPN. Here the role may come to be seen as that of *care manager* for nutritional support patients.

### 4. The Nutrition Support Team Doctor(s):

Nutrition teams need medical involvement, at both consultant and more junior levels. Some patients may be cared for under the consultant's primary care, though most will usually be under the principal care of another team.

The doctor(s):

- 1 Assess critically the nutritional needs and approach in the context of the patient's clinical condition and treatment.
- 2 Have a critical awareness of nutrition's impact on quality of life and clinical outcome
- 3 Have a detailed insight into diagnosis and medical management and how aspects of nutrition relate to these
- 4 Provide a conduit through which Nutrition is linked to the broader hospital medical consensus and teaching.
- 5 Co-ordinate with endoscopy and other gastrostomy-insertion services.
- 6 Maintain links with catheter-insertion services
- 7 Have the expertise to critically appraise a parenteral or enteral nutrition prescription.
- 8 Provide expertise in fluid balance therapy
- 9 Support and conduct nutrition-related audit and research
- 10 Promote the development and maintenance of the Clinical Nutrition Support Team(s) via business planning in hospital and in liaison with Primary Care Commissioning Trusts.

*5. The Nutrition Support Team Dietitian and the Department of Nutrition and Dietetics:*

The Nutrition Support Team Dietitian needs to be a senior figure within the Department of Dietetics. He/she provides a vital operational and organisational link between the Team and the Department. The Department:

- 1 Maintains itself as the principal source of evidence-based information on food and nutrition and is an important contributor on nutritional assessment and support
- 2 Supervises and supports dietitians and dietetic assistants
- 3 Provides nutritional advice and expertise in all units of the hospital, including Catering.
- 4 Liaises closely with Nutrition Steering Committee and the Nutrition Support Team(s)
- 5 Participates in education and training
- 6 Assesses diet and nutrition in more detail than a basic screen.
- 7 Provides dietetic advice tailored to individual patient's needs
- 8 Tailors food and supplements to special dietary/nutritional needs
- 9 Supervises, analyses and interprets dietary records and recalls.
- 10 Prescribes or helps prescribe enteral feeds and supplements, liaising with doctors, nurses and the nutrition support team
- 11 Is "part of the ward" – understands wards and patient problems in order to help solve them
- 12 Liaises with clinical staff including ward nurses, SALT, doctors, occupational therapists and social workers etc
- 13 Advises about enteral feeding techniques
- 14 Advises about parenteral nutrition in liaison with Nutrition Support Team
- 15 Provides community liaison and care (extended roles –links with NNS)
- 16 Provides out patient nutritional care and follow up

*6. The Nutrition Support Team Pharmacist and the Pharmacy:*

Pharmacy is the home base of the Nutrition Support Team pharmacist and will provide input to nutritional care of patients via ward pharmacists, procurement and

via drug advisory services. The NST pharmacist links patient care with pharmacy aseptic services and external, often industrial, suppliers particularly in the context of parenteral nutrition.

1. Assists with pre-admission clinic and ward based identification of nutritionally at risk patients.
2. Advises on parenteral nutrition composition and compatibilities
3. Makes safe additions to standard parenteral feeds or tailor-makes feeds according to the patient's individual requirements using aseptic technique according to national policy.
4. Ensures that parenteral nutritional solutions are compounded appropriately and are suitable for use. This may be via an in-house aseptic unit or outsourced (pharmacy are responsible for audit of external suppliers).
5. Appropriately qualified pharmacists may prescribe parenteral feeds, fluids and other necessary therapy.
6. Assists with monitoring of parenteral feeding
7. Liaises with home care companies for HPN and patients
8. Assists in PCT liaison for funding of HPN and high cost drug therapy
9. Assists with audit of PN usage and service
10. Contributes to nutrition education
11. Advises on drug-nutrient and nutrient-nutrient interactions
12. Advises on drug delivery via naso-enteric and enterostomy tubes and unblocking parenteral and enteral nutrition delivery systems.
13. Purchase and contract for parenteral (and in some cases, enteral) nutrition products and on local formulary content of nutrition-related products.

#### *7. Catering services*

- 1 Control catering budget and contract: food, beverages and snacks
- 2 Choose and order ingredients
- 3 Develop recipes and menus taking into consideration dietetic advice and patients' age, culture religion and medical condition
- 4 Prepare food to approved standards
- 5 Deliver food to wards, patients and staff restaurants
- 6 Serve food to patients at ward level (hostesses)
- 7 Provide snacks
- 8 Maintain and supervise food hygiene at all times
- 9 Consider development of patient restaurants or other novel food delivery/outlets
- 10 Control cost and monitor waste
- 11 Audit and develop service delivery

#### *8. Ward nurses*

Are the crucial "final common pathway" of nearly all patient-centred, ward-based care. For Nutrition they should adhere to standards set by Hospital Nutrition Steering Committee which may be adapted locally by Specialist Unit governance. They work in close co-operation with the patient's principal medical team and the nutrition support team. Together with them they:

- 1 Maintain an ongoing policy towards the nutritional support of patients which has continuity in the context of staff turnover.

- 2 Employ routine nutritional screening including assessment of nutritional risk and the ability of the patient to eat.
- 3 Maximise use of available facilities and options to achieve enjoyable, psychosocially beneficial, nutritionally effective meals and food intake.
- 4 Take responsibility for individual patient's food intake and co-ordinate a protected mealtimes policy at ward level.
- 5 Help with food choices
- 6 Help with feeding as appropriate
- 7 Monitor/keep records of food intake when necessary
- 8 Are alert to unsafe feeding
- 9 Provide food, and in conjunction with dietitians, supply artificial nutritional supplements
- 10 Provide expert safe delivery and monitoring of artificial nutritional support.
- 11 Deliver enteral and parenteral nutrition skilfully, closely following hospital protocols and guidance
- 12 Monitor enteral and parenteral nutrition – fluid balance, blood/urine glucose, diabetic charts, microbiology
- 13 Prevent (cross) infection.
- 14 Liaise with patient and patient's relatives
- 15 Employ timely discharge planning and liaise with the community.

#### *9. Patient's primary medical/surgical team*

Must play a co-ordinating role between nutritional and other medical and surgical treatments and ensure that their patients receive excellent nutritional screening, assessment and care.

- 1 Acknowledges the importance of the involvement of all doctors/surgeons in nutritional care as, for example, emphasised by the Royal College of Physicians and PMETB.
- 2 Develops, fosters and encourages an awareness of the benefits of appropriate nutritional management and treatment, before during and after hospital admission, whether surgical or medical.
- 3 Considers the patients' mental and physical ability to eat, the integrity of gastrointestinal function including motility, digestion and absorption, the metabolism and excretory function in the context of a diagnosis.
- 4 Prescribes treatment, taking into consideration drug nutrient interactions, surgical needs etc
- 5 Takes note of and applies nutritional screening, and assesses and monitors nutrition employing clinical, biochemistry/haematology/microbiology information. Includes documentation of nutrition-related issues in records.
- 6 Decides in liaison with NST, nurses, dietitians etc on the optimal approach to each patient's nutritional needs and ensures informed consent.
- 7 Liaises with patient and patient's relatives: provides major source of information to patient and relatives in respect of all aspects of treatment, including nutrition.
- 8 Leads on ethical decisions in conjunction with NST and ward nurses, taking into consideration family/carer views including interpretation of advance directives.
- 9 Includes nutritional aspects of care in plans for discharge and out-patient follow up

10 Includes nutrition when liaising with primary healthcare professionals.

*10. Other specialist teams:*

A major challenge in organising excellent nutrition support is to bring groups together in a common cause to provide the highest quality nutritional care for the patient. It is a major challenge for a clinical team to organise in such a way that it works efficiently with other teams with subtly differing agendas.

Each specialist area in a large hospital may have its own governance, structure and nutrition protocols but these must be in line with overall hospital or institutional policy.

Nutrition Support services link importantly to :

- Radiology (central line insertion, Radiologically Inserted Gastrostomy insertion),
- Endoscopy (Feeding tubes, Percutaneous Endoscopic Gastrostomy, Percutaneous Endoscopic Jejunostomy insertions) will be crucial to practice organisation.
- Speech And Language Therapy will be crucial allies in the care of patients with (potentially) unsafe swallow.
- Nurse led catheter insertion services may link directly or indirectly with nutrition nurse specialists. Liaison over policy development will be vital.
- Infection control team and microbiology: particularly relevant to parenteral nutrition – there needs to be tight coherence in policies.
- Biochemistry services
- Home enteral or parenteral feeding services

**6 Priorities for setting up de novo.**

Aspirational concepts can be daunting to the new-comer. This guide is designed to help all hospitals, expert or otherwise in nutritional support, to improve their services. In what order of priority might services be developed? The following is a suggested order of priority:

- 1 “Essence of Care” – nutrition benchmarking
- 2 Implementation of “Better Hospital Food”
- 3 Implementation of “Protected Mealtimes”.
- 4 Establish/strengthen Department of Dietetics
- 5 Establish Steering committee
- 6 Create a functioning nutrition support team
- 7 Appoint a nutrition nurse specialist
- 8 Develop out-patient services and home and community care
- 9 Develop and formalise education and training.  
Nurses, doctors, medical students, pharmacists etc
- 10 Develop specialist teams – eg for catheter insertion etc

***The most important thing is to establish a culture of nutritional awareness in all areas of clinical practice.***

## 7 References

1. Silk DBA, ed. *Organization of nutritional support in hospitals*. 1994, BAPEN: Maidenhead. 35.
2. Allison SP, e., *Hospital Food as Treatment*. 1999, BAPEN. p. 48.
3. Physicians, R.C.o., *Nutrition and Patients: a doctor's responsibility*. 2002, Royal College of Physicians of London: London. p. 92.
4. Stratton RJ, Green CJ, and Elia M, *Disease-related malnutrition*. 2003, Oxford: CABI Publishing. 824.
5. Stroud, M., H. Duncan, and J. Nightingale, *Guidelines for enteral feeding in adult hospital patients*. *Gut*, 2003. 52 Suppl 7: p. vii1-vii12.
6. Valentini L, et al., *ESPEN guidelines on enteral nutrition*. *Clinical Nutrition*, 2006. 25(2): p. 1-360.

## 8 Appendices

### Appendix 1

**Responsiveness:** Engagement of Nutrition committee and NST with staff in all clinical environments – develop workshops with the theme

“How does nutrition affect your patients and what can we do together to deliver practically in your environment?”

Engagement with patients: balance between nutritional services and primary carers. Team should not usurp or undermine role of primary medical and nursing teams – it should support them.

**Discipline:** Who monitors, who delivers? How is pride in good practice maintained and rewarded? How is poor practice ironed out?

## **Appendix 2**

**Education and Training:** The nutritional care of each and every patient can only be addressed if a significant number, and preferably all, of the health professionals caring for that patient understand the advantages of maintaining good nutrition. Health professionals then need the (a) basic education to understand the importance of nutrition in health care and (b) training in how this is to be implemented in specific clinical situations. A major role of nutritional experts will be to foster education and training.

### ***Organisation of Nutritional Education and Training.***

For nurses, doctors, pharmacists, dietitians.

Undergraduate  
Postgraduate  
Generalist  
Specialist

May be in hospital, in school or college or from a specialist society Nutritional societies or Royal Colleges:

Private – books, journals, internet  
Ward-based  
Seminars, lectures, case presentations and tutorials  
Problem based learning  
Distance learning

Try to use available facilities appropriately and cost-effectively. National and International conferences are vital for making contacts and for disseminating knowledge, but they are not necessarily the best way to learn basics. Try the available websites or explore what is going on more locally through the BAPEN website.

### **Appendix 3**

#### **Development Plan for Specialist Nutrition Support Nursing at Barts and the London NHS Trust - an example.**

##### **Key elements of specialist nursing practice (1)**

- 1 Demonstrates advanced nursing skills in assessing and meeting the physical and psychosocial needs of patients within the specialty.
- 2 Facilitates nursing practice, acting as a change agent in adjusting boundaries and communicating and implementing innovations.
- 3 Provides education, a consultative service and clinical leadership within the specialty.
- 4 Adopts a holistic and collaborative approach for nursing drawing on aesthetic, personal and ethical knowledge.
- 5 Utilises and prioritises research in everyday practice.
- 6 Promotes and monitors the implementation of quality and clinical effectiveness.
- 7 Uses complex reasoning, critical thinking, reflection and analysis to inform assessment, clinical judgment and decisions.

##### **Generic core competencies for specialist nursing**

Leadership; the specialist nurse as a role model; working in multidisciplinary teams; challenging professional boundaries; NHS policy on advanced scope of practice; clinical audit; research; managing change; the use of clinical guidelines; ethical frameworks and critical decision making; risk management; staff and patient teaching; patient advocacy.

Acquisition is a dynamic process which takes place over time, prioritized through objectives agreed with the nurse's manager.

##### **The scope of Nutrition Support Nursing**

This section describes the specific objectives for the role of Nutritional Nurse Specialist (NNS).

The NNS functions as a member of the Nutrition Team. Neither work in isolation and this framework also provides opportunity for promoting shared vision, within the team and between the team and the wider hospital community.

Evidence of achievement of objectives, anonymized where necessary, may be used to create an individual portfolio of practice, which demonstrates to managers and colleagues the scope of specialist nursing. The suggested assessment methods described in the framework are based on those suitable for a newly appointed, inexperienced NNS.

The level of evidence provided for assessment of competencies, necessary to achieve objectives, will be measured against the Trust grading criteria for specialist nurses and form the basis for progression within the post.

Suggested levels:

Basic: Descriptive, with some evidence of analysis

Intermediate: Deeper level of analysis, with recommendations for practice development.

Advanced: Evidence of practice development, including changes to patient/organizational outcomes.

**Note** The Nurses and Midwives Council are expected to publish criteria for advanced nursing practice in late 2006.

## 1 CLINICAL PRACTICE

Objective	Competencies	Acquisition	Assessment Method
<p>1.1 Be an effective member of the Nutrition Team.</p>	<p>Know: the Nutrition Team philosophy and model of practice, explicit roles and responsibilities of team members, team timetable, methods of communication between team members and the wider hospital, agreed outcome measures and reporting.</p> <p>Know the reason for different models of Nutrition Teams in different clinical settings.</p>	<p>Multi-disciplinary Nutrition Team meeting.</p> <p>Visit to other Nutrition Teams.</p>	<p>Written reflection or presentation on the effectiveness and problems inherent in different team models.</p>
<p>1.2 Undertake the NNS role in the weekly nutrition round and clinic.</p>	<p>Know the needs of patients and colleagues.</p> <p>Plan to ensure that necessary skills, equipment, policies and patient information literature are available to ensure effective management of the round and clinic.</p>	<p>Shared practice with mentor.</p> <p>Visit to NNS's in other trusts.</p>	<p>Observation by manager.</p>
<p>1.3 Perform nursing assessments of patients needing nutritional support, plan and evaluate care in collaboration with nursing and other colleagues on the wards and</p>	<p>Know: the underpinning theory and practice of nutritional support, the problems of integrating nutritional care into the total nursing and medical care of the patient,</p>	<p>Shared practice with mentor - bedside teaching and nursing ward rounds shared with ward staff.</p>	<p>Care plans.</p>

departments.	the needs of ward and departmental nurses and how they might be supported, the relationship between the specialist nurse and established ward and departmental teams.		
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1.4 Co-ordinate patients nutritional management with other diagnostic and therapeutic interventions to ensure a holistic approach and smooth journey of care.	Understand the clinical structure, relationships and culture of the Trust	Discussions with nurse manager and other specialist nurses.	Case presentation.
1.5 Ensure the safe effective insertion and management of venous and enteral access devices.	Know the Trust policy for selection, purchase, insertion and management of venous and enteral access systems and current research based evidence.  Skills in relation to the insertion and management of these devices, so as to meet patient and Trust needs.	Review current written guidelines, policies and procedures.  Obtain views of patients and other clinicians regarding any policy associated problems.  Evaluate compliance through audit.  Shared practice with mentor, bedside teaching.	Policies based on current evidence.  Audit presentations.
1.6 Perform venepuncture and peripheral venous cannulation.	According to Trust Policy.	Review own peripheral cannulation and venepuncture skills.	According to Trust policy.

		Trust training programme.	
1.7 Be an effective patient advocate.	Knowledge of ethical principles, models and their application in clinical practice, particularly in relation to commencing and withdrawing nutritional support.	Review own knowledge base and personal beliefs regarding the purpose of healthcare.  Discussions with members of Clinical Ethics Forum. External courses and visits. Audit	Case and or audit presentation.
1.8 Prepare patients for home parenteral nutrition (HPN).	Know: the pathophysiology of intestinal failure, its causes and their nursing and medical management, the British Association for Parenteral and Enteral Nutrition (BAPEN) 'Home Parenteral Nutrition: Quality Criteria for Clinical Services and the supply of nutrient fluids and equipment'  Skills required to meet the BAPEN standards.  Understand the implications of a chronic illness diagnosis.	Personal study.  Discussions with patients receiving HPN.  Attendance at conferences and courses  Practice with mentor	Discharge and follow up documentation.

## 2 TEACHING

Objective	Competency	Acquisition	Assessment methods
2.1 Encourage and support the acquisition of knowledge and skills, in relation to clinical nutrition, in other healthcare professionals	Teaching skills.  Know: how to take advantage of teaching opportunities during clinical practice, the problems of teaching peers and those from other disciplines, how to manage and undertake such teaching.	Teaching courses  Shared practice with mentor	Teaching qualification  Education packages and presentations
2.2 Effectively teach complex skills to the acutely sick patient requiring home parenteral nutrition.	Skills in patient teaching  Knowledge of the reasons for and methods of HPN	Review current practice and its research base.	Patient education material.

## 3 RESEARCH AND DEVELOPMENT

Objective	Competencies	Acquisition	Assessment method
3.1 Further the development of good nutritional care throughout the Trust.	Know: the Trust Essence of Care (EoC) programme, the NNS's role in nutrition benchmarking, the Trust nutrition policies.	Discussions with those responsible for leading EoC topics.  Review Trust policies.  Attend the Trust Nutrition Strategy	According to outcome measures decided by the Committee.

		Committee.	
<p>3.2 Undertake evidence based practice development to improve patient outcomes.</p>	<p>Audit skills.</p> <p>Critical appraisal of research and its translation in Trust policies</p> <p>Know: the audit process within the Trust, how to use audit outcomes, critical incidents and risk assessment to identify research and development opportunities and how to turn these into safe, effective Trust policies.</p>	<p>Discussions with Trust lead for Clinical Governance.</p> <p>Study a successfully implemented audit action plan within the Trust.</p> <p>Private study</p>	<p>A completed audit cycle.</p>
<p>3.3 Meet the specific demographic and healthcare needs of patients treated at the Trust</p>	<p>Knowledge of the profile of patients treated at the Trust, their cultural and religious needs.</p>	<p>Observation.</p> <p>Trust policies and training.</p>	<p>Specific needs have been incorporated into Trust nutrition support policies.</p>

#### 4 MANAGEMENT AND ORGANISATION

Objective	Competencies	Acquisition	Assessment method
4.1 Take a pro-active role in strategic planning for nutritional care within the Trust.	Understand the NNS's role in strategic planning and how strategy is formed in NHS Trusts.	Discuss with Senior Nurse Managers and other specialist nurses.	Describe the way in which strategic decisions are made.
4.2 Co-ordinate the discharge and ongoing care of patients requiring home parenteral nutrition.	Understand the clinical and financial implications of the primary/secondary care interface, both locally and on a national scale.  Know the role of the homecare company and its staff.  Know how to maintain effective communication between all parties, to ensure patients needs remain foremost.	Discussions with patients.  Visit to homecare company.  Visit to PCT commissioners and Trust finance officers.	Documentation of practice.

#### 5 PROFESSIONAL DEVELOPMENT

Objective	Competencies	Acquisition	Assessment method
5.1 Undertake practice which reflects current clinical and professional research based evidence.	Knowledge of current research and the role of professional organizations.	Reflect on own knowledge and skill and with nurse manager identify objectives and training needs.	Review of objectives.

### References for appendix 3

1 Adapted from: Good Hope Hospital Trust (1999) Specialist Nursing – Clarifying and Strengthening their Contribution and United Kingdom Council for Nursing, Midwifery and Health Visiting (1999) Higher level of practice pilot standards, London: UKCC



