LEADING ARTICLE

Proper hospital nutrition as a human right

Jens Kondrup\textsuperscript{a,b}

\textsuperscript{a}Nutrition Unit 5711, Rigshospitalet, 2100 Copenhagen, Denmark  
\textsuperscript{b}Department of Human Nutrition, Royal Veterinary and Agricultural University, Frederiksberg, Denmark

ESPEN is strongly encouraging the national societies to implement the resolution on Food and Nutritional Care in Hospitals, as adopted by the Committee of Ministers of the Council of Europe in November 2003.\textsuperscript{1} The Committee of Ministers is the decision-making body of the Council, consisting of the foreign ministers of the member countries, or their ambassadors. The main aims of the Council are to reinforce democracy, human rights and the rule of law and to develop common responses to political, social, cultural and legal challenges, based on the Declaration of Human Rights from 1948. The Council of Europe also hosts the European Court of Human Rights in which cases concerning human rights can be raised against a state by individuals, associations or other contracting states.

This particular resolution was accepted by the 18 member states of the Partial Agreement in the Social and Public Health Field, i.e. Australia, Belgium, Cyprus, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

The introduction to the resolution outlines the background for the initiative: (a) access to a safe and healthy variety of food is a fundamental human right, (b) proper food service and nutritional care in hospitals has beneficial effects on the recovery of patients and their quality of life, (c) the number of undernourished hospital patients in Europe is unacceptable and (d) undernutrition among hospital patients leads to extended hospital stays, prolonged rehabilitation, diminished quality of life and unnecessary costs to health care.

Therefore this resolution recommends to the governments of the member states to (a) draw up and implement national recommendations on food and nutritional care in hospitals based on the principles and measures set out in the appendix to this resolution (see below), (b) promote the implementation and take steps towards the application of the principles and measures contained in the appendix, in fields where these are not the direct responsibility of governments but where public authorities have a certain power and (c) ensure the widest possible dissemination of this resolution among all parties concerned, particularly public authorities, hospital staff, primary health care sector, patients, researchers and non-governmental organisations active in this field.

The appendix to the resolution consists of some 100 specific recommendations in a number of categories: nutritional assessment and treatment, responsibility and education of staff, hospital food and food service practices and health economics. In each category, the role of the level of government/health authority versus the level of hospital/department/patient is specified. The recommendations were proposed by a large European expert group, based upon the information gathered from health authorities of all member states in a report which preceded the resolution.\textsuperscript{2}

Some of the key recommendations at the level of government/health authority are: (1) Standards of practice for assessing and monitoring nutritional risk should be developed. (2) The definition of disease-related undernutrition should be universally accepted and used as a clinical diagnosis and hence treated as such. (3) Good practice to ensure the intake of ordinary food by the patients should be documented. (4) Standards of practice for initiation, monitoring and termination of all artificial nutritional support should be developed. (5)
The authorities’ responsibility with regard to nutritional care and support, and food service systems, should be acknowledged. (6) Nutritional risk screening, assessment and monitoring should be included in the accreditation standards for hospitals. (7) A continuous postgraduate education programme for all staff should be implemented. Clinical nutrition should be recognised as a specialised discipline by medical schools. Clinical nutrition should be included or improved in the education of physicians and nurses. The education of dieticians should be set at the highest undergraduate level. (8) National guidelines and standards for food provision in hospitals should be established. Food service contracts should be sufficiently detailed and they should cover special diets on medical and personal indications, energy and protein dense menus and provision of snacks and/or meals at ward or near-ward level. The Clinical Nutrition Service should be given the responsibility for ensuring that the contract reflects nutritional standards.

These key recommendations will help the level of government/health authority to evaluate the adequacy of nutrition activities in individual hospitals and also help the authorities to evaluate unfortunate individual cases. It is quite obvious that future students of medicine, nursing or dietetics need to be educated in this area but since universities and nursing schools are moving very slowly in this direction, it is a clear responsibility for the authorities to draw the attention to the fact that these are required competencies of the medical staff in the future.

Key recommendations at the level of hospital/department/patient are: (1) The nutritional risk of all patients should be routinely assessed either prior to or at admission. This assessment should be repeated regularly during hospital stay. (2) Identification of a patient at nutritional risk should be followed by a treatment plan including dietary goals, monitoring of food intake and body weight, and adjustment of treatment plan. (3) The food intake of patients at nutritional risk and receiving nutritional support should be registered by means of dietary records. (4) "Nil-by-mouth" regimes, overnight fasting and bowel-cleansing protocols with dietary restrictions should not be used routinely; the literature should be reviewed in order to assess which procedures may require such regimes. (5) Medical and nursing patient records should contain information about each patient’s nutritional status. (6) Physicians, pharmacists, nurses, dieticians and food service staff should work together in providing nutritional care, while the hospital management should give due attention to such co-operation. The responsibility of different staff categories with respect to nutritional care and support, and food service should be clearly assigned. (7) Immediate feedback from the patients to the kitchen and ward staff in relation to liking or disliking of the food served should be encouraged. (8) Snacks and nourishing drinks between meals should be available and be offered on every ward. (9) Hospital managers should take into account the potential cost of complications and prolonged hospital stay due to undernutrition when assessing the cost of nutritional care and support. Steps should be taken to reduce documented wastage of food and artificial nutrition products.

These key recommendations will assist the hospitals and departments in establishing the main steps of providing nutrition support. Their successful implementation has the potential of improving the efficiency of the hospital service by reducing length of stay and rate of complications, or severity/cost of complications. In addition, it will make the patient comfortable to see that basic needs are taken care of and thereby reduce the likelihood of complaints over unfortunate nutritional events. To some doctors, the specific recommendations may be seen as overlapping with the traditional right of "Doctor’s order" but it should be remembered that the resolution is based on a Human Rights concept. Also within nutrition should the Doctor’s order be compatible with this.

ESPEN has given a high priority to this area. Screening methods to be used in the community, in hospitals and among the elderly were recently endorsed by ESPEN. In recent years, Clinical Nutrition has published a number of papers providing insight to these problems and their possible solution. A study describing all patients present in the hospital found that 70% of the patients did not reach a reasonable recommended intake. In most cases, this was not related to the disease or treatment but rather to inadequate meal service e.g. lack of choices and/or inadequate taste. A study reported that about 25% of a random sample of hospital patients from various units ate nothing or very little in the hospital, and that a large part of those who had no appetite also considered food in hospital to be only moderately important, pointing to the role of patient education. Other studies have shown that a patient-oriented improvement in hospital food increased intake and decreased wastage while a broad non-obligatory staff training did not. A study of nutritionally at-risk patients during their entire hospital stay suggested that the main causes for inadequate nutritional care were the lack of
management’s instructions to deal with the problems, the lack of elementary knowledge with respect to dietary requirements and ignorance about practical aspects of the hospital’s food service, while patient-related aspects and the system of food service itself only contributed to a small degree. It seems obvious that the problems to be dealt with, and their solution, will vary from one patient category to the other. Therefore, the recommendations given in the appendix to the resolution is useful as a check-list when improvements are being prepared.

Finally, recommendations for future research and development is recognised as a third level in the appendix. The resolution is based on today’s knowledge which is seen as sufficient to act, but it is also realised that much more work is required to optimise the effort. Key areas of future research are: (1) Studies should be undertaken to develop and validate simple screening methods, aimed for use in hospitals and primary health care sector. (2) Randomised trials and systematic reviews should be performed to evaluate the effect of nutritional support on clinical outcome, including physical and mental condition. In particular, randomised trials evaluating the effect of ordinary food on clinical outcome should be given high priority. (3) Studies should be undertaken to evaluate the effect of energy and protein dense menus on food intake and patient outcome. These topics also relate to the primary cause of undernutrition in hospitals: the disease processes leading to increased, or changed, nutritional requirements and at the same time leading to a decrease in appetite. These recommendations could serve as suggestions for public and private funding organisations that may consider supporting the development of this truly multi-disciplinary field in the years to come.

References