Exploring the Nutritional Needs of Older People in a Hospital Environment: The Educational Perspective

Report for the Changing Ageing Partnership (CAP)

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1. INTRODUCTION

The aim of this study is to investigate the role of healthcare education in promoting interest in and understanding of nutritional care for the older person in a hospital environment and to determine ways in which this might be improved. The study will contribute to the *Improving Quality of Life* agenda of the Changing Ageing Partnership (CAP). The study will also draw attention to the importance of maintaining and raising the quality of nutritional care for the older person in a hospital environment.

One important way in which the healthcare workforce is shaped is through the education frameworks of the various healthcare professions, which determine the knowledge, skills and attitudes necessary to become, and maintain status as, a practitioner. In order to raise the profile of any area of clinical practice it is essential it is given appropriate recognition in programmes of education. In this case, to ensure that at all stages of the education continuum healthcare students and practitioners are equipped with appropriate knowledge and skills to deal with the complexity of nutrition in older people. Furthermore, there is evidence to suggest that pre-qualification healthcare education in particular, needs to be developed to attract more students into this vital but low profile area of healthcare (Age Concern, 2006).

2. BACKGROUND

2.1 Nutrition and the older person

With a growing ageing population (Office of National Statistics, 2007) it is more important than ever to ensure their needs and care are adequately addressed by health services. It is imperative that older people have appropriate care in hospital and a good diet and positive eating experience are essential to aid their recovery from illness and any related treatment or surgery. 'Nutrition is the bedrock of good care and recovery from illness - older people are at particular risk of malnutrition and will struggle to respond to treatment or recover well if they are malnourished' (Potter, 2008).

Whilst nutrition is primarily defined within a medical discourse through dietary, biochemical and clinical indicators, the patient's nutritional intake can also be related to sensory, psychological and social aspects (Amarantos et al. 2001). Therefore, adequate nutrition is not only dependent on healthy meals but on the mental health and subjective well-being of the patient. For example, whilst meal times are an essential part the patient's hospital stay they can also stimulate satisfaction and pleasure and are thus a basic level of patient care (Blades, 2000). Furthermore, meals may also provide security, meaning, order, and structure to an elderly patient's day in hospital. They may 'imbue that person with feelings of independence, control, and sense of mastery over his or her environment; and provide opportunities for making food choices' (Amarantos et al. 2001:55). These quality of life aspects of nutrition are particularly important for older people in a hospital setting as changes in emotional well-being are often associated with disease, ageing and fluctuations in functional status (ibid).

Poor nutritional status among older people is well documented (ENHA, 2005). Nutritional status has increasingly been associated with variety of morbid conditions including cancer, heart disease and dementia among in persons over the age of 65 (Wells and Dumbrell, 2006). Older adults who live in institutions are more likely to be malnourished whilst those living in the community are more likely to be overweight (British Nutrition Foundation). It has been reported that 40% of older people are malnourished on admission to hospital (ENHA, 2005; Age Concern, 2006; and DHSSPS, 2007;) with six out of ten older people at risk of becoming

malnourished, or their situation getting worse whilst in hospital (ENHA, 2005). Older patients who are malnourished have longer stays in hospital, require more medication, are more likely to suffer from infections (DHSSPS, 2007) and have an increased risk of death (Pirlich et al., 2005). In comparison, excessive food consumption combined with a lack of exercise may result in obesity. Diabetes, cancer, cardio-vascular diseases, and premature death are often associated with obesity (Amarantos et al., 2001).

The health care costs of malnutrition have been estimated to exceed £7.3 billion per year (considerably more than obesity). Over half of this cost is expended on people aged 65 years and above (DHSSPS, 2007), and with increasing numbers of people in this age group, this figure could rise further, unless action is taken to address the issues of malnutrition among patients and poor dietary experiences whilst in hospital.

2.2 Monitoring Nutrition

According to the European Nutrition Health Alliance (ENHA) malnutrition is common, under-recognised and under-treated – thus it is a prime candidate for screening (Elia et al 2005 cited ENHA 2005: 5). Although there are several guidelines which advocate the use of systematic nutritional screening it is far from universally adopted (Elia et al. 2005 cited ENHA: 5). Furthermore, nutritional support is of low priority among treatment and evaluation priorities (Morley, 1991; Mowe et al., 2006) and as a result many older people are inadequately screened upon admission. In a survey conducted by the RCN (2007), 28% of nurses stated that there was not a requirement in the nursing documentation to record a nutritional assessment whilst 25% said patients were not assessed for malnutrition on admission to hospital or on first appointment in the community (RCN, 2007). In 2008 the British Association for the Parental and Enteral Nutritional (BAPE) found that although most hospitals (89%) reported that they had a screening policy, weighing on all wards was carried out in less than half. This inconsistent application of assessment of malnutrition can result in the failure to intervene by the use of nutrient supplements and change in diet.

An effective way to monitor nutrition is by continual weighing and by observing and recording changes in weight (The Caroline Walker Trust, 1995). A validated tool for

measuring under and over-nutrition is the Malnutrition Universal Screening Tool (MUST). It calculates the risk of malnutrition by taking into account the BMI score[1], changes in weight which are unplanned within the past 3-6 months, and, if the patient is acutely ill combined with having no nutritional intake for more than five days. It is important to note that difficulties in measuring height and weight can result in misleading BMI scores, which may misclassify older people who are at risk from malnutrition. Therefore, other indicators of malnutrition may be more effective such as weight loss, leaving food on the plate and illness (The Caroline Walker Trust, 1995).

2.3 Causes of poor nutrition

The reasons for malnutrition are well documented. Malnutrition in the older person during a hospital stay can be attributed to a number of factors including; the quality of hospital food; lack of appropriate food; and most notably, the absence of help with eating and drinking. Furthermore, Blades (2000) identifies a number of additional factors including: the lack of knowledge of malnutrition among doctors and nurses; patients away for tests at meal times; budgeting constraints for catering managers; unfamiliar food; illness of the patient; changes in taste due to patient's illness; increased nutritional requirements; changing population of patients; the logistical considerations of having to deliver food to wards from the catering department; and finally, ordering in advance from menus. Poor nutritional status can also be linked to disability and vice-versa. Those who are malnourished are more likely to suffer disability and those who are disabled are more likely to be malnourished (Amarantos et al., 2001).

In the UK, a recent survey by the Healthcare Commission (2007) revealed that almost half (46%) of adult patients surveyed reported that the quality of hospital food was either 'fair' (31%) or 'poor' (15%). This rating is the same as that reported in the 2005 survey, indicating no improvement in the quality of hospital food over a two year period. The 2007 survey also revealed that 23% of patients reported only being offered a choice of food 'sometimes' (16%) or 'never' (7%) (Healthcare Commission, 2007). Furthermore, the recent Age Concern report

[1] BMI is used to measure a person's healthy body weight based on their height.

documented personal testimonies of older patients receiving food which was inappropriate in terms of the patient's cultural or religious beliefs. It was also reported that patients were offered food which they couldn't eat; for example patients who required pureed food and did not receive such, subsequently couldn't eat their meal and the tray was removed without them having had any suitable food. Individuals also reported receiving specific foods items they could not eat, despite making their dietary requirements known to hospital staff (Age Concern, 2006).

Perhaps one of the most well documented issues in relation to nutritional status for older people whilst in hospital is the lack of assistance with eating and drinking. The 2007 inpatients survey revealed one in five patients reported not having received sufficient help with eating and drinking, whilst a further 20% report to only received enough help 'sometimes' (Healthcare Commission, 2007). Furthermore, the 'Hungry to be heard' report by Age Concern, reports extensively on individual cases where patients and their families highlighted the absence of help with eating and drinking as a major cause for concern in the overall quality of care for older people during their time in hospital (Age Concern, 2006).

Other issues related to poor nutritional status of older people include complicated medical histories; difficulty in diagnosing routine conditions; the interaction of medication with the diet (Lewis, 2008) and difficulties with swallowing (Sheth and Diner, 1988).

2.4 Nutritional training and practice among nurses and doctors

Statements regarding the responsibility of doctors and nurses for nutritional care refer to patients of all ages. For example, the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC) (1997) stated that nurses are responsible for ensuring that patients in hospital are adequately fed. Their responsibilities also include nutrition screening, monitoring of the nutritional state, assistance with eating and completion of menus, identification of those who need special diets and co-ordinating other health professions such as dieticians, occupational therapists and doctors in the nutritional care of the patient (RCP, 2002). Since then the Nursing and Midwifery Council has developed 'Essential Skills Clusters' which are skills statements set out under a number of broad headings that

complement some of the NMC's outcomes and proficiencies contained within the 'Standards of proficiency for pre-registration nursing education'. Within 'Nutrition and Fluid Management' patients/clients can trust a newly registered nurse to: Assess and monitor nutritional status and formulate an effective care plan; assess and monitor fluid status and formulate an effective care plan; provide an environment conducive to eating and drinking; ensure that those unable to take food by mouth receive adequate nutrition and; safely administer fluids when fluids cannot be taken independently.

In comparison, doctors should understand the clinical importance of a balanced diet, of patients being under – or over weight or of being deprived of nutrients and to recognise nutritional deficiency or excess (RCP, 2002). The GMC (2009) have developed education protocols which may equip medical students to meet these responsibilities. They state that as part of diagnostic procedures medical students are expected to be able to make an assessment of the patient's state of nutrition. This includes an evaluation of their diet; their general physical condition; and measurement of height, weight and body mass index. The graduate should also be able to apply to medical practice biomedical scientific principles, method and knowledge relating to nutrition. For foundation level doctors, the requirements for knowledge of the nutritional care of patients increase. At this level doctors must demonstrate a number of skills including, to name a few, preparing a nutritional care plan when appropriate and being knowledgeable in the effects of poor nutrition (GMC, 2009).

The Intercollegiate Group on Nutrition is a group of the Academy of Medical Royal Colleges. The group have proposed learning objectives for the undergraduate medicine nutrition curriculum. They state that all newly qualified doctors should be able to assess nutritional status and understand the consequences in health and disease for all stages of life and for both over- and under-nutrition. They also state that newly qualified doctors should be safe and competent to advise on diet and physical activity in health and disease and manage over- and under-nutrition in: primary, secondary and tertiary care; clinical and public health settings; and in practical and ethical dimensions (www.icgnutrition.org.uk). However, currently it is not compulsory for medical schools to incorporate these proposals.

The training of medical and nursing staff in regards to both nutrition and the care of older people is particularly important in the recognition, treatment and prevention of poor nutritional status among older people in hospital. There is little specific criticism of the nursing and medical curriculum with regard to the nutritional care of *older* patients. However the importance of the education of health professionals in regards to the nutritional care of all patients is well documented. For example, the ENHA (2005) state that it is imperative that health professionals become aware of the prevalence of malnutrition and are educated about detection and prevention. They also state that 'health professionals need more training in dealing with malnutrition, and expert nutrition organisations need to have a greater role in evaluating and determining the training of health professionals. Professional bodies should influence curriculum development in nutrition training for health professionals' (ENHA, 2005: 8).

The ENHA (2005) go on to note that inadequate professional nutritional training for doctors and nurses is a key issue with malnutrition in general being given little attention in current undergraduate medicine or nursing curricula. For example, Johnston et al (2008: 217) found that:

> Overall the reported adequacy of training, teaching time and core area coverage in nutrition appears to be low in UK undergraduate course. Student training and satisfaction appears to be greater in courses with a higher priority... In order to have adequately trained doctors, it is imperative to increase the amount, depth and priority of nutrition in medical school's curriculum and assessment processes.

In an earlier publication, Seiler (2001) commented that more attention should be paid to malnutrition by treating it as a disease in its own right and including it in the training of doctors and nurses. Additionally, Palmer (1998: 931) has noted that 'unfortunately the subject of nutrition has not been extensively included in the curriculum of either nurses or doctors and therefore many have continued to practice in ignorance.' Palmer (1998) goes further to suggest that nutritional problems within a healthcare setting can be attributed to an under-educated workforce, responsibility for nutrition being placed on junior, less experienced members of hospital staff and a lack of recognition among nurses for the responsibility for nutrition among the patients.

Poor educational training with regard to nutrition among all hospital staff is one barrier (amongst others) to effective nutritional care of patients including those of older ages. However, physicians' education contains few lessons on nutrition and teaching has fallen behind the ever advancing nutritional research (Beck et al., 2001). Furthermore, a lack of interest in geriatric nursing and medicine (Lewis, 2008) may contribute to a diminished level of care and interest in the dietary needs of older people.

2.5 An interprofessional approach to the nutritional care of older patients

It is vital that those who provide nutritional care to older people in hospital are able to recognise, and make use of those people who can improve the standards of nutritional care. Interprofessional communication, for example, between doctors, nurses, dieticians, occupational therapists may help to tackle the problem head on. The RCP (2002) state the importance of good communication between hospital and primary care teams if continuity of nutritional care is needed.

Nutritional care is more than just monitoring weight and feeding the patient, it is about 'informing the patient, preparing the patient, motivating the patient, urging or feeding the patient, and other aspects of doing and showing care i.e., the food culture amongst all staff members of the hospital), is essential in relation to the food chain' (Beck et al., 2001: 457). Beck et al (2001) use the term food chain to demonstrate that nutrition begins from catering and menu selection, to medical and nursing care, to the support of additional professions such as occupational therapists. The importance of the recognition of interprofessional communication when improving nutritional standards within the hospital setting is illustrated by Blades (2000: 227). She provides a comprehensive list of those involved in the nutrition of hospital patients ranging from medical and nursing staff to speech therapists and catering managers.

Furthermore, it is not only hospital staff who play a vital role in the nutrition of older people in hospital. Others such as relatives and carers can assist by encouraging the patient to eat, by bringing in additional food and by helping the patient to choose suitable foods from the menu (Blades, 2000). By recognising the role of family, friends and carers, the nutritional care of older patients can be significantly improved.

2.6 Tackling the problem

Considering the range of causal factors and effects of poor nutrition among older people in hospital, it is obvious that this issue must be tackled head on, by nursing and medical staff. In 2007 the Royal College of Nursing (RCN) carried out a survey amongst its staff and found that 81% believed patient nutrition as a clinical issue is "extremely important" while 92% said they would support a campaign by the RCN to raise awareness of nutrition and its benefits (RCN, 2007). This suggests that for some time the need to address the issue of nutrition has been recognised but it remains a key issue.

The issue of nutrition in hospital has been given greater impetus in recent years through campaigns such as the Royal College of Nursing's 'Nutrition Now' campaign and Age Concern campaign, 'Hungry to be heard'. The Council of Europe and a number of other collaborators also put forward a food and nutritional care resolution which forwarded a number of food recommendations which member governments, including Northern Ireland, should implement and promote in both public and private health sectors. These recommendations are outlined in the '10 key characteristics of good nutritional care in hospitals' document.

At a local level, the DHSSPS (2007) has published its own guidelines: '*Get your 10 a day! The Nursing Care Standards for Patient Food in Hospital*' in collaboration with the DHSSPS Directorate of Nursing and Midwifery and the Royal College of Nursing as a Northern Ireland response to the RCN's national *Nutrition Now* campaign. The guidelines are 'designed to provide a framework within which patients, relatives and carers can participate in shaping the way that food and drink is offered and taken, and to promote multidisciplinary working with nurses, healthcare assistants, dieticians, catering staff and speech and language therapists and others working towards the common goal of improving the patient experience of food and mealtimes in hospitals' (DHSSPS, 2007).

As with any issues relating to health status, appropriate intervention brings considerable benefits. The guidelines published by DHSSPS and Age Concern, if implemented effectively, will help to improve the eating experience of older people in hospital and ultimately improve their overall nutritional and health status. The obvious benefits include a quicker recovery period for the patient, a shorter stay in hospital and the reduced need for medication, of which the latter two would have considerable financial implications. However, such guidelines will only be effective if fully embraced by both medical and nursing staff who are trained appropriately to deal with the complexity of nutrition in older people.

2. METHODOLOGY

2.1 Research Question

The purpose of the research is to assess the contribution made by pre and post qualification healthcare education in Northern Ireland to nutritional care of the older person in a hospital environment and to examine how this can be improved.

2.2 Research design

The design of the research is a multivariate qualitative approach. Qualitative research is guided by the depth of understanding obtained from the information rich cases, as opposed to quantitative research which focuses on generalizations for larger populations (Sandelowski, 1995). The study used a qualitative approach to enable the exploration of multiple perspectives and the emergence of key themes. There were four stages involved in the collection of data for analysis. These are listed below.

1. Interviews/conversations with older patients about their hospital experience of diet and nutrition.
2. Mapping the pre and post qualification education provision for medical and nursing students with regard to nutrition and the older person
3. One focus group with medical students and one focus group with nursing students in their final year of study to discuss their knowledge, skills and attitudes with regard to nutrition in care of the older person in a hospital setting.
4. Interview with a key informant from medicine and nursing responsible for curriculum development in an education institution.

The study was conducted in the Belfast and Western Health and Social Care Trust and involved only the professions of medicine and nursing. This was to ensure a representative sample of patients, students and those responsible for curriculum development in Northern

Ireland, without making the study prohibitively large. The sample included Northern Ireland's two major teaching hospitals and universities.

The first stage involved interviews with older people within a hospital setting. 16 interviews were carried out in a hospital in the Belfast Health and Social Care Trust and 11 in a hospital in the Western Health and Social Care Trust among those who had given informed consent to participate in the study. Certain inclusion and exclusion criteria applied to the selection of participants for this stage of the research. Those inpatients who were deemed suitable to participate in the research were: those who were aged 65 and over who could give informed consent to participate in the study; those aged over the age of 65 who were able to feed orally and; those aged 65 and over with a score of 1 or 2 using the Malnutrition Screening Tool (MUST)[2]. Inpatients were excluded from the opportunity to participate in the study if they were deemed by their consultant to be too unwell physically and/or mentally to participate in the study, but were proxy consent is unavailable and/ or if they had not undergone a MUST assessment.

The interviews with older people can be described as semi-structured. Semi-structured interviews are those which have pre-defined questions, yet allow significant opportunity for the respondent to discuss their answers with the researcher. The interview focused on various aspects of nutritional care such as the provision of meals for a specialist diet, religious or cultural beliefs which prohibit the consumption of certain foods, whether or not they can eat 'normal food', the appetite of the patient, snacks and type of drinks received, missed meals, timing of meals, and their overall eating experience. The subsequent questions dealt with whether or not they have been weighed each week when in hospital, whether or not they have been seen by a dietician during their hospital stay, the use of nutrient supplements, assistance with meals, placement of trays within reach of the patient, and the provisions of necessary utensils.

During the mapping stage the researcher sought to identify the extent of pre and post qualification education and training for medical and nursing students in relation to the older

[2] Score 1: Medium risk of malnutrition; Score 2: High Risk of Malnutrition.

person. Data was collected from the pre and post qualification curriculum documents provided by two universities. Post qualification data was also collected from the Belfast and Western Healthcare and Social Care Trusts.

Interviews were then conducted with two key informants who had some responsibility for educational policy with regard to the medical and nursing staff working with older people in a hospital environment. The interview questions with key informants focused on:

- Current education provision in relation to nutrition and the older person
- The gaps in knowledge and skills based on the experiences of older people in hospital
- The level of priority given to this area of healthcare

Before the interview, the key informants were informed about the research project. They were also given a copy of the interview schedule as some of the question required the informant to be up-to-date on the policies which guide the curriculum in relation to nutrition. Allowing the participant to prepare for the interview meant that the interviewee was informed thereby increasing the accuracy of the results. Interviews were organised and conducted privately to ensure the anonymity of the interviewee.

Finally, one focus group with medical students (n=4) and one focus group with nursing students (n=9) in their final year of study was conducted to discuss their knowledge, skills and attitudes with regard to nutrition in care of the older person in a hospital environment. The interview questions arose from the key themes drawn from the analysis of the interviews with older inpatients and the key informants. The students were given the chance to discuss the adequacy of the current education provision, their knowledge of nutritional needs of older people in hospital, whether or not they felt that their skills were adequate or if further development was required, and finally, their attitudes to nutritional needs of older people in hospital (i.e. level of interest; priority area/ relevance/importance).

Participation in the focus groups was voluntary. Students were given an information leaflet and when the required number of students agreed to take part in the study a time and location convenient to the students to conduct the focus group was set up. Consent was obtained and interviews were recorded and transcribed.

2.3 Analysis

The interviews with older people, key informants and the focus groups were analysed using grounded theory (Glaser and Strauss, 2006). This approach refers to theory or explanation which is built 'from the ground up'. Therefore, rather than testing a hypothesis, grounded theory refers to the construction of a theory based on the collection of data. A pre-requisite of the approach is that the data 'fits' the theory (Glaser and Strauss, 2006). In other words the data must be able to adequately explain the phenomenon at hand. The approach has been described as an objective, unbiased method of data collection and analysis (Charmaz, 2003).

Grounded theory refers to the methods for the analytical stage of the research process rather the methods for data collection. The analysis of the data is based on the system of coding. These codes are not predefined, but rather, are a set of themes which emerge from the researcher's interpretation of the data. Codes are recognised after the researcher reads and re-reads the interview transcripts.

Once all stages of the analysis were completed the results were linked together to provide an informative account of the contribution made by pre and post qualification healthcare education in Northern Ireland to nutritional care of the older person in a hospital environment. This approach to analysis is described by Moran-Ellis et al. (2006: 55) as involving separate methods, separate analysis, and theoretical integration. Although data were collected during separate stages of research the results were integrated so that knowledge produced by different methods was blended into a coherent account.

2.4 Ethics

The research has ethical approval from the Office for Research Ethics Committees Northern Ireland (ORECNI). Informed consent was obtained from all research participants and was based on their full understanding of the purpose of the research, the nature and extent of their involvement and how their data will be used. The interviews and focus groups were recorded and participants were made aware of this at the commencement of the interview/focus group

and written consent obtained for the audio recording. All interview participants were made anonymous.

4. RESULTS

4.1 Results of interviews with older people

The results of the interviews with older people can be categorised under six major themes:

- Appropriateness of hospital food
- Quality of hospital food
- Assistance during mealtimes
- Family involvement
- Professional involvement
- Overall well being

Each of these themes is discussed in the sub-sections below.

4.1.1 Appropriateness of hospital food

In relation to normal eating habits

Patients' comments about their normal eating habits suggested that many older patients had a varied diet prior to their admission to hospital. Some older patients relied on family members or carers to prepare their food and others prepared their own meals at home.

> *Summertime I'd have salads or something tasty, Thai or something...My daughters you see would cook for - have been cooking for me, one of my girls-she does a lovely lasagne* [A10]

> *Well in the morning I usually have porridge and just tea and toast and then maybe about eleven o'clock or so my niece was helping me and we would have a cup of tea and a buffet like cake or sandwich and then at lunch time we would have*

potatoes and vegetables sometime and just different you know.... my house was salad (pause) salad (pause) salads ((laughs)) and (pause) and I never lost the taste for salads....maybe and a bit of chicken and we'd eat very well [A05]

[Interviewer: what about then for your evening meal would you cook a meal for yourself about six o'clock...]

... I do meat on a Sunday...and maybe on Tuesdays a wee bit of fish or maybe Wednesday do a bit of chicken...Try to vary it as much as I can

[Interviewer: Yes of course okay and do you prepare that for yourself?]

Yes...Chicken and broccoli pie...[B10]

Comments from other patients reflected fairly simple tastes and a set routine when it came to the food they would normally eat at home.

[Interviewer: What would you normally cook for yourself?]

A mixture (pause) like stews...and pork pieces ...and pork chops....

[Interviewer: right alright and then would you have anything in the afternoon?]

Well the afternoon I suppose is mostly the same thing (pause) a little bit of sandwich[A03]

Cornflakes in the morning...A cup of tea and a bit of toast...At dinner the girl that looked after me used to bring me round two wee sandwiches (pause)....And at night she would have brought me a dinner round [B16]

The majority of older patients who participated in interviews indicated that the food on offer in hospital was fairly similar to the food they would normally eat at home. None of the patients indicated that the food on offer in hospital was different to their normal diet. However a number of patients did state that they simply ate whatever food was provided for them.

Oh much the same...

[Interviewer: What would you normally have for breakfast at home for example?]
I have porridge and I have porridge in hospital [A08]

[Interviewer: What would you have for breakfast?]

Oh porridge

[Interviewer: Porridge okay and would you have tea?]

Tea and toast, tea and pancakes or something...That's what I have when I'm in hospital. [A10]

Toast...I would definitely have toast

[Interviewer: you would have toast?]

and a boiled egg or something

[Interviewer: ok and what about lunch time, what would you normally have about twelve or one o'clock each day?]

Normally just something simple too I don't know really I just take whatever is produced for me. [B05]

Meeting dietary needs

The majority of patients did not state any special dietary requirements in relation to food they could not eat. A small number of patients stated specific medical conditions, for example diabetes, recovery from surgery or stroke which required particular attention to their diet. In those cases, some patients indicated that their dietary needs were met during their stay in hospital.

[Interviewer: Is there anything that you can't eat for any particular reason?]

No there's nothing...I can eat just anything or...and everything [B12]

I'm not on a diet at all but any food that I have has to be pureed basically...

[Interviewer: Right okay and is that since you've had the stroke?]
Since I had the stroke or if it's not pureed it's fed through a tube [A09]

I'm a diabetic

[Interviewer:...And are there any foods that you can't eat or anything that you need to avoid?]
Just sugary food I can't eat the sugary food...when you're diabetic... But that's ... I can eat most ... can eat most things [B15]

Some patients, when probed further talked about foods they preferred not to eat. There was little indication that their personal tastes were voiced to hospital staff.

I kind of had ...[to] go for something that's as soft here for example I can get roast turkey and a roast [unclear]...you know

[Interviewer: ((laughs)) do you find these things are too tough for you]

Yes

[Interviewer: Are there alternatives on the menu that you can choose?]
Yeah [B09]

[Interviewer: is there anything that you can't eat because it makes you unwell?]

fatty stuff ...I'm a light eater [A02]

[Interviewer: ((laughs)) okay and are there any foods that you can't eat for any particular reason?]

No (cucumbers) are the only thing ...cucumbers you know the green thing ...I eat them but they repeat on me ((laughs)) [A03]

In relation to normal eating times

Comments from patients demonstrated that there was variation in terms of when patients normally ate their main meal. Some older patients ate their main meal at lunchtime whereas others ate their main meal later in the day. Many comments, however, indicated that older patients had a routine for their mealtimes.

> *see I was always used at home with my dinner in the evening...with a light lunch...here I find they bring your dinner at lunchtime*
>
> [Interviewer: that's right (pause) you get your main meal quite early in the day (pause) your main meal at 12]
>
> *I'm not eating it so well...cause it's so much* [A04]

> *we are quite regular the girl comes about... in the morning at seven, seven thirty, half nine and ten...and then she comes at night (pause) no she comes at lunchtime, half twelve usually and her main one* [B03]

Many of the older patients who participated in interviews were happy with the timing of meals during their hospital stay. Other patients stated that timing of hospital meals were not ideal in relation to their normal eating times. However the majority of patients indicated that whilst the times of meals may not be the most appropriate for them, they were content to fit in with the mealtimes set by the hospital.

> [Interviewer: And do you think that you get your meals at the right time of day, for example if you get your main meal at lunch time is that the right time for you or would you prefer it in the evening?]
>
> *At the right time of day twelve o'clock* [A06]

[Interviewer: Do you think that's the right time, some people like their evening meal at five o'clock?]

Well I think it's up to yourself, it's up to people to eat whenever they feel like it and I mean you can't time meals in a hospital there's too many people at it [A08]

[Interviewer: So would you like to have your main meal then in the evening whilst you're in hospital if you could?]
Well they do have it ... no they don't-it's supper ....Oh I'm easy it doesn't matter which way and which time...And if you don't ... if you can't eat it you just leave it so it all depends on how you feel [B14]

[Interviewer: Thinking in particular where you get your main meal at lunchtime and for some people they take their main meal in the evening and that's a bit of a change for them-How do you feel about that?]

No... no...no

[Interviewer: Do you have any difficulty with that or are you happy to have your main meal at lunchtime as opposed to the evening?]

No I just go with the flow [A10]

Portion sizes

The majority of older patients interviewed felt that the portion size of meals prepared during their hospital stay was too big in relation to their appetite. Patients were given a choice of portion size when placing their food orders; however the small portion was too large for some of the older patients. Many patients also spoke of their diminished appetite citing various reasons such as illness, old age or lack of physical activity.

Oh they've been far too big and I mark off small, you know on the menu...And they mustn't read it, because it's a man's dinner...I say oh that's a man's dinner, to me because I was always was small with my food. [B14]

[Interviewer: Would you say that you have received the right amount of food during your time in hospital?]
Goodness...Too much food.
[Interviewer: Do you find that off-putting at all that there's too much food? Or do you just leave what you don't eat?]
Well I leave it sometimes...but I ask for small portions, I never get them [A11]

[Interviewer: Do you feel that you need any other snacks do you need anything more in hospital is there anything else you would prefer to have?]
No I think you're well fed in here [A03]

[Interviewer: Do you think you've had enough food?]...
I can eat it or sometimes I can't eat it you know what I mean?
[Interviewer: Oh is that because you just don't feel like it...?]
It's the pain and I can't [B02]

You know it's just that it doesn't sort of fit me you know
[Interviewer: Is that really mostly because of the fact that you, you're just not as mobile at the moment?]
I'm not [B09]

A small number of patients considered the amount of food on offer in the hospital as appropriate to their needs.

[Interviewer: Is the amount of food that you're getting- is it too little? Is it just about right or is it too much?]

What I get- it does me [A07]

[Interviewer: You feel it's the right amount of food for you or is it too much or too little or is it just about right?]
Just about right I'd say [A08]

In addition to portion size, patients talked about the amount of snacks available to them. For many patients, whilst snacks were offered to them at various times during the day, they did not feel they were always necessary.

> [Interviewer: Are you able to get any snacks in hospital, for example are you able to get something mid morning or mid afternoon if you feel like you need it?
>
> *I never did need it...because we get quite a lot.* [B08]

> *Well [I] like eating chocolate or eating you know a bun or something like that you know I never felt the need to*
>
> [Interviewer: You haven't, you haven't felt hungry?]
>
> *No* [B10]

In addition older patients who took part in the interviews felt that there was a good choice of snacks available to them. A small number provided examples of instances when if they required anything they asked hospital staff to accommodate their needs. Others expressed a different view, suggesting that the selection of snacks and timing of snacks between meals was determined by the hospital menu rather than the needs of the patients.

> *I only snack in the morning with my egg and toast I always had a banana...and in hospital say when they, when the catering staff, you can get bananas here if you want but so far I haven't...I haven't asked for any* [B13]

> [Interviewer: Say for example you wanted some fruit or something you know you fancied something different?]
>
> *Fruit would be on the menu*
>
> [Interviewer: Right okay that's an option for you?]
> *Dessert anyway* [B15]

Choice available

Comments from some older patients indicated that they were satisfied with the variety of food available whilst they were in hospital.

> *...Great choice on the menu. I wouldn't have that choice at home, if it came to it I wouldn't have the choice but I was just saying...the food is beautiful...up here I have the choice...the food is really beautiful.* [A05]

> *I've discovered now I can have an omelette in here....they do quite nice like a real omelette they turn it over in half...with beans too.* [A04]

A small number of patients were less content with the food available in hospital. Some patients conveyed their frustration with the lack of freedom in relation to personal choice and limited food choices. Others were dissatisfied with the requirement that patients were expected to make food choices twenty four hours in advance.

> *At home it's my own choice when I want it ...I like it as I want it ...when I feel like it I take it.* [A03]

> *But then they ask you you see for the following day and then the day comes you forget what you've ordered.*
>
> [Interviewer: you might've felt like it on a Tuesday but by the time it comes on Wednesday you may not feel like it?]
>
> *it's the same thing at home...but they've got to cater for a lot of people you see...you know I sort of have to pick what suits me. I would get my fish with cabbage...I prefer peas with it. I'm not being fussy*

[Interviewer: No no I understand but just some of the things are not to your taste not how you would put them together?]

No they don't know [A04]

I would definitely have toast...and a boiled egg (pause) or something...normally just something simple too. I don't know really, I just take whatever is produced for me [B05]

4.1.2 Quality of Hospital Food

Positive comments

The majority of patients stated that they were satisfied with the food available and enjoyed the food available during their hospital stay. There were a small number of positive comments in relation to the quality of hospital food. Positive aspects of hospital food included enjoyment of particular dishes, the variety of food and the knowledge of when meals were being served.

You know with the food and all we get, oh aye (pause) I says "oh (pause) the food's great like" you know [I – aha] I would describe it as all (pause) all good you know [B12]

I can't complain much about the food (pause) you know what I mean [B04]

The best thing I've eaten here and I'm not going to tell you how I got it was a melon, I got a bit of a melon yesterday and the day before and you'd have just thought it was right and dead on for me [B16]

And yes (pause) the food is very pleasant...whenever I eat in here...couldn't be beat [B08]

It's marvellous here you get your breakfast in the morning, tea at 10 o'clock, your dinner -tea in the evening here supper whatever you call it...tea again at 8 and tea before you go to bed [A03]

Negative comments

A small number of patients interviewed mentioned some negative experiences of hospital food. It is interesting to note that most of the comments were related to drinks rather than the food provided as part of their overall eating experience.

The hospital one's dreadful sometimes it's, it's all a mass of meat and potato stuck together oh...what they do not that I would, I've never put, I would never put vegetable in my Irish stew when I made it at home.[A08]

I'd like drinking at meals I like to eat and I don't stop when I say a drink you know a lemonade...I don't like tea after a meal. [A02]

There's a - I don't know whether there's one there - its supposed to be a supplement and they make it up into a drink...And it tastes yucky.[A09]

But no yucky orange hospital orange yuck

[Interviewer: Do you not like it?]
Oh yuck [A09]

4.1.3 Assistance during mealtimes

Assistance eating meals

Comments from older patients indicated that there were different levels of assistance required during mealtimes. This ranged from patients requiring no assistance to patients having their meals pureed or fed via a tube.

[Interviewer: Do you need any help with your meals at all?]

None at all [A01]

But again they would cut it for me because ...on the ward if you need help there's no problem in getting it.

[Interviewer: Who would normally provide that help for you? Would it be the nurses or the nursing assistants?]

One of the nurse assistants, she keeps her eye that everybody gets their meals and that they are eating them...Then there is always an auxiliary or somebody on you know...As long as it's cut then they can leave me and I can just eat it then. [A11]

And the nurse would ... and there was meat on the plate, chicken...the nurse would ... cut it for me...cut it up in wee bits for me. She would do that, anything I want cut, the nurse would cut up for me. [B15]

Many of older patients' comments indicated that they preferred to 'manage' their mealtimes without assistance. Those older patients who required help expressed their frustration at not being able to do things they would have been able to do prior to their admittance to hospital.

[Interviewer: Do you need any help with your meals at all? Do you need anyone to help you cut your food or anything like that?]

No I can manage. [B14]

[Interviewer: Do you need any help with your meals at all?]

No thank God [B08]

[Interviewer: Although you've been having your food pureed are you able - well now that you're starting to have your food pureed are you able to feed yourself or do you need any help eating your food..?]

Most of the time I can manage myself. [A09]

[Interviewer: Whenever you did have difficulty and you needed assistance...could you maybe just describe that?]

Only one word-frustration....Upset.

[Interviewer: And would I be right in saying that was because previously you were able to do this and then in a fairly short period of time suddenly you couldn't

That's right. [A10]

There's a time when I'm incapacitated...the nurses....tolerate me

[Interviewer: right, do you find it takes you a little longer now that you just have use of one hand?]

Um [agreement]

[Interviewer: But you prefer to do it yourself is that correct?]

Um [agreement] [A02]

I was quite ill..I've been very ill after it was one complication and another

[Interviewer: okay and did the nursing staff then help you with your meals?]

Yes they were very good (pause) very patient [A04]

Utensils available

The majority of patients who were interviewed stated that they were provided with the appropriate utensils with their meals. Additional utensils required by patients during mealtimes included a straw for drinking and special cutlery with gripped handles.

[Interviewer: For example, if you needed a spoon or a straw?]

...No, no I have everything.

[Interviewer: You have everything that you need?]

It comes on the tray...with a (bell) and a napkin [A04]

I have a straw.

[Interviewer: Is there always a straw available for you when you need it?]

Oh aye-I've got a draw full there [A11]

I had special cutlery...I was coming on then to get a grip you know. Those shiny ones are not so good but the grey...It's slightly - it's a slightly ribbed effect that gives you [A10]

There was also an indication that patients were making do with utensil provided with their meals, rather than asking for additional help. However some patients were proactive when it came to requesting help and of staff asking whether they needed additional utensils for their meals.

You use the ones that have been provided for you...and if I can't reach it I try and use the spoon on the tray. No big deal. [A10]

The tea this morning that I had, I had the straw...I've been able to do. But it doesn't always come with...

[Interviewer: Okay and would you ask for a straw if it wasn't?]

I think I will ask for one. [A09]

I don't need anything at all - the last time they come round they want to know do I need a (straw) [A03]

[Interviewer: Do you have that if you need it?]

S- sometimes have to request that [A06]

Timing of meals

The majority of patients were satisfied that they had not missed meals during their hospital stay and were given adequate time to finish their meals. Some patients who had missed their meals commented that their meal was given to them when they returned to the ward.

[Interviewer: at lunchtime and you've missed your lunch because you've been out of the ward?]

No, no, I think they would keep it for you -you know they're very good [B14]

[Interviewer: Have you ever missed any of your meals during your time in hospital?]
Not really because if you're away down to get x-rayed or scanned or anything your food's there when you come back like you know...it's always kept for you, you know.
[Interviewer: Okay and is it always, if it was your main meal do you find that it's always hot enough?]
Oh it's hot enough-they see to that [A01]

[Interviewer: Has your meal ever been taken away before you've had an opportunity to finish it?]
Oh no, They leave it there you know for ages...I'm glad to see it gone (pause) because ...I've eaten enough. [B14]

A small number of older patients reported problems with their food when they had missed meals due to tests. One patient commented that their food was overheated; another patient felt that they waited too long for the missed meal and when it came it was cold.

As soon as we were going out the door the dinner was coming up... I come back and they warmed it up in the microwave and brought it back.
[Interviewer: Okay and how was it?]
A wee bit (boring) it was too long in the mic. [A03]

And that lady over there had no meal. I had no meal so we had to sit for half an hour waiting until they brought something and now my tea was poured it was stone cold by time the fella come up. I got a big chunk of ham. It come straight out of the freezer and that was sitting on my plate...It was frozen...They'd picked that up to anybody on the ward frozen.... but we were having if for half an hour but the tea was frozen you couldn't have drank it

[Interviewer: Did you get an alternative?]

No! I had to take what...was brought to me. [B01]

Accessing meals

In relation to accessing their meals on the food trolley, most patients interviewed were able to reach their meals. If they were unable to reach their food, they were happy to ask for assistance.

[Interviewer: Do you find that your little table here and your food tray-is that always within reach for you?]

Oh it is yes...If it's not I just call a nurse and she brings it over to me [A08]

[Interviewer: Is your tray always close enough to you?]

Yeah, sometimes you know it wanders...it goes over but then if they come in I'll just say to them ... (there's) always somebody there that I can (ask) no problem really ... but you can understand if they're busy doing things and somebody comes and calls them...to do something else then maybe the tray you know it's away (pause) just that I couldn't reach but I have a buzzer.

[Interviewer: And you get the assistance that you need?]

It's not intentional...just by accident but not often [A04]

[Interviewer: Can you always reach your tray?]

Oh yes

[Interviewer: Its never been too far away from you?]

They bring it over for me. [B02]

Very odd times like if it's not always I say to whoever brings it "do you mind turning the trolley around or bring it a wee bit nearer me"...Or something like that so it...it's hard here, you can't, it's sort of funny you know er...someone always helps you if you need it. [B10]

Willingness to ask for help

The willingness of older patients to ask for help during mealtimes in hospital was a common theme in many of the interviews. Some of the patients were happy to ask for help when needed, however it was also indicated they may not be proactive enough when seeking help.

[Interviewer: Do you need any assistance with your meals at all?]
No so far I have been able to eat them alright...a bit cumbersome but I get through it so
[Interviewer: What do you mean now about being a bit cumbersome?]
You are not comfortable....I am not comfortable sitting in the bed...I am not comfortable sitting, your hands are shaking so much. [B13]

Most of the time but they know now that I can feed myself...
[Interviewer: Can you always reach that at meal times?]
Not always
[Interviewer: And what would you do if it wasn't within reach?]
Hit the bell or they get a shout
[Interviewer: So you would ask for assistance?]
Yes [A09]

[Interviewer: Would you ask someone to help you?]
Well ...you don't have to ask for help... they're just up and down and say "are you all right what else do you need now" , "do you need" so this place here is just absolutely great . I'm only speaking for ward. [A05]

Comments from interviews also highlighted the need for some older patients to retain a level of independence during their hospital stay. Thus a small number of patients were reluctant to ask for help.

> [Interviewer: Do you need any of the Nurses to help you with your food... to help cut it up for you?]
>
> *No, I'm alright....I don't want to get it handed to me alright.* [B03]

> [Interviewer: Do you feel you need to ask for any help with your meals?]
> *No, the girls have offered-they have offered to help, they have offered to help ok, they have definitely offered help...I am trying to be a wee bit more independent...I think that's most of my problem, I was too bloody independent.* [B13]

4.1.4 Family involvement

Bringing food in

The most significant role for family and/or carers was bringing food into the hospital. The food they brought into hospital would typically include, fruit, drinks and biscuits (snacks). During interviews patients were happy with the additional food brought in by family members however some felt that the food already provided in hospital was adequate and there was little requirement for additional snacks.

> *Well they they're bringing those mixed foods you know they be different fruits in, you get them in Sainsbury's, you know the container with the different fruits or sometimes they just bring me banana or the little small oranges.* [A08]

> *They bring me juice...They bring me fruit as well.* [A10]

> [Interviewer: Do any family members bring you any snacks at all?]

I tell them not to bring anything here at all. I've no time to eat anything else...you're eating from when you get up in the morning till you go to bed [A03]

He would bring me things if I wanted but I always tell him I don't want anything...because I get enough here [B03]

I tell them not to... because I get plenty...He might bring a little lemonade, he brings me too much lemonade [B08]

Preparation of meals/Assistance with meals

Comments from older patients also highlighted the role of family members/carers in terms of preparation of meals prior to their hospital stay. Some of the patients relied on family members/carers for most of their meals.

And at dinnertime my daughter (pause) two daughter in laws...they were...feeding me as fast they could feed me. [B13]

And my son usually comes daily and cooks the main meal...like to keep busy...Always used to it. [B08]

I have a girl who does my food meals you see...she comes in. [B03]

Well somebody would help with it, I couldn't do it myself...NAME is my niece...she's looking after everything. [A05]

4.1.5 Professional involvement

Involvement of dietician

The majority of patients who were interviewed stated they had not seen a dietician and didn't feel they needed their advice. Those who had been visited by a dietician did not have much detail on their discussion, other than advice on a supplementary drink. Indeed there was some confusion over whether some of the older patients had seen dietician or not.

[Interviewer: And have you seen a dietician at all during your time in hospital?

No-I never was talking about that. [A06]

[Interviewer: And have you seen a dietician at all since you've been in hospital?]
No I don't think I need a one. [B14]

[Interviewer: Have you seen a dietician at all during your time in hospital?]

Oh I have- yes

[Interviewer: what did you talk about?...]

About special drinks that she had...little vitamin supplement drinks

[A08]

[Interviewer: have you talked to anyone who specialises in food and diet?]

I couldn't, different ones have been with me...Dieticians

and that sort of thing different ones have been with me you know...what to eat and what not to eat and all this sort of thing you know...I mean it is hard to go by, you just have to take sometimes what people -what they bring you, you know in hospital and in your nursing home...you can't pick and choose. [B04]

[Interviewer: Did you give her a history of what your appetite had been like and what you had been eating?]
Oh I think I did. [B13]

[Interviewer: Have you seen a dietician during your time in hospital? Have you talked to anyone about your food?]

There was a lady up but I don't remember, she just was a lady [A07]

Involvement of nursing staff

The role of nursing staff did not feature highly in discussion around patients eating experience during their hospital stay. However a number of patients did make positive comments about the helped provided by the nursing and auxiliary staff as part of their overall hospital experience.

They are so good and so caring and looked after me from top to bottom. All the nurses, the doctors, everyone...They are with you, you ring and they come...they respond. [A11]

But again they would cut it for me because (it) is very good you know on the ward if you need help there's no problem in getting it...One of the nurse assistants she keeps her eye that everybody gets their meals...And that they are eating them...Then there is always an auxiliary or somebody on you know (pause) [A10]

Monitoring by professionals

There was a mixed response from patients in relation to the monitoring of their eating experience by hospital staff. A significant number of older patients commented that they were not weighed during their stay in hospital.

[Interviewer: Have you been weighed each week during your time in hospital?]
No not, not at the beginning. I haven't this last two weeks, well I was so ill I couldn't. I think I wasn't out of bed. [A04]

I don't think I was weighed when I came in here. [B04]

[Interviewer: Have you been weighed since you came into hospital?]
Yesterday, got weighed yesterday
[Interviewer: Okay so is that the first time during this stay in hospital?]

Yesterday yes. [B15]

[Interviewer: You're underweight...were you weighed once or twice during your time]
I've forgot you see...there's once when you're, when you're admitted. [B01]

Interventions initiated by professionals

A small number of patients commented on interventions by professionals in relation to diet and eating experience of older patients. Consultation with dieticians or other health professionals for some patients resulted in the prescribing of vitamin supplement drinks.

[Interviewer: Have you been taking those [supplement drinks] during your time in hospital?]

Oh I have yes...I have the Doctor prescribed those at home for me...before I went to the hospital she prescribed them. [B13]

They have wee sorts of food supplements in here and I can't take the small ones I don't like them.

[Interviewer: Now are those little supplement drinks?]

Yes (pause) Suck through a straw...They come back up again.

[Interviewer: Would you vomit them back up again]

Mhm [agreement] [B16]

4.1.6 Overall wellbeing

Diet/appetite

Patients who participated in interviews were asked if they thought that the food served in hospital would help them get better whilst they were in hospital. The majority of patients

recognised that food would help them get better. Patients also commented they were eating to facilitate their recovery so they could ultimately return home.

[Interviewer: Do you think that the food you're eating will help you get better?]

Well I am getting better....the doctors and the consultant were here yesterday morning and they said "I'm going in the right direction. [A09]

[Interviewer: Do you think that the food you're eating will help you get better?]

Well that depends now- it can make me better- yes [A06]

[Interviewer: And is there anything in particular you think will be important for your recovery?]
Good and substantial dinners you know....Good soup or broth or whatever you want...
You know down to earth food you know....Wholesome food (pause)
[Interviewer: Do you mean things like meat and vegetables?]
That's right yes that you can digest (pause) [B07]

[Interviewer: Do you think that the food you eat will help you get better - do you think eating well is important for your health?]

Oh aye it is -everybody said so, eat well....I mean it (pause) it (pause) it'd keep me around...You need it in that sense. [A07]

[Interviewer: How would you describe your appetite at the moment?]

Bad....I'm eating to get out [A02]

Some patients acknowledged that their appetite was not good. They cited a variety of reasons for their lack of appetite such as their illness, old age and general lack of interest in food.

It was the diarrhoea and all that after the operation, you know one thing and another...

it seemed to put me off food altogether... they give me-not sure what do you call it, not liquidised.

[Interviewer: Was it pureed –yes?]

But then I got so much I got really sick [A04]

Well it's not as good as it was but then you don't expect it to be good when you're this age -Do you?...No it was quite good so it was though it was less too...a couple of years now .... I'll say to my daughter "I'm never hungry"...You know where you feel like a meal... I don't. [B14]

My appetite has improved a lot...since I have come in here.
[Interviewer:...how would you describe your appetite before you were admitted to hospital?]
I just had no interest in food...none whatsoever...I was eating, occasionally I felt like a steak burger... I was eating nothing unless, I was very fond of poached egg, toast....I just went off it completely
[Interviewer: How long would you say you have been feeling off your food for?]
Oh about I would say four weeks [B13]

Well put it this way, I wouldn't say it's great since I've been in hospital...Well in the first ...way that...it's full of antibiotics, two I was running a temperature you see and that puts you off [B09]

Overall eating experience in hospital

Patients were generally very positive about their eating experience during their hospital stay. Many patients however did state that their illness and general lack of appetite did impact on their overall eating experience in hospital. Furthermore, a small proportion of patients indicated that in terms of the food provided in hospital they simply ate what was provided for them.

You couldn't say anything else about it, Especially if you've an appetite you know if you're not having a good appetite many's the time you try things you don't even like if you're hungry...But other than that it's quite good food [B14]

[Interviewer: Yes just overall if you would think about, you know?

Well I don't...

[Interviewer: Overall your food and what you've been eating in hospital -how would you describe it?]

I don't see anything wrong with the food in the hospital [A08]

[Interviewer: If you think about the whole experience how would you describe it?

Oh god you get everything (pause) it's lovely ...and I'm sure they're cooking for your benefit I would say that's probably (good). [A03]

[Interviewer: How would you describe your overall experience?]

I've no experience, I just...I eat...And I enjoy it because-that's always good there. [A07]

I try to take just whatever they bring me, you know [B04]

Overall hospital experience

The interviews with older patients also highlighted generally positive views of their hospital stay. Many patients referred to the excellent care and help given by the hospital staff. Similar to much of the discussion, there was an indication that older patients may have felt reluctant to make a fuss in terms of needing help whilst in hospital.

Well I can't fault the care I'm getting in the hospital and the nurses are very good and very nice [A08]

Oh no you couldn't -they do a lot, they're patient they're nice... they have a nice attitude. [B08]

[Interviewer: Great is there anything else you would like to add about your food?]
there's not a thing...and the staff is excellent...and the night staff too...I don't how they put up with it. [B13]

Suggestions for improvements

There were very few comments from patients in relation to how the eating experience in hospital could be improved. Comments from the patients related to more flexibility in terms of how their meals were served, greater choice from the menu and the size and portions provided. However the majority of comments indicated older patients preferred to fit in with the hospital routine and not make a fuss.

[Interviewer: Is there any improvements at all you think that could be made?]

Give me less

[Interviewer: Is there anything else that you can think of?]

I'd like (another) drinking at meals I like to eat and I don't stop...when I say a drink you know a lemonade...I don't like tea after a meal. [A02]

Oh they've been far too big and I mark off small, you know on the menu...And they mustn't read it, because it's a man's dinner...I say oh that's a man's dinner, to me because I was always was small with my food. [B14]

it's the same thing at home...but they've got to cater for a lot of people you see...you know I sort of have to pick what suits me. I would get my fish with cabbage...I prefer peas with it. I'm not being fussy

[Interviewer: No no I understand but just some of the things are not to your taste not how you would put them together?]

No they don't know [A04]

What more can I say about it, I get my breakfast, my tea...anything I want I get it and ...how can I complain, I just couldn't could I, I couldn't tell you something different. [A05]

I suppose -this is not a hospital, this is more like a hotel. [B12]

[Interviewer: No improvements?]

At least I hope I haven't been giving trouble you know...and like you know the work that they do you'd have to be dedicated let me tell you. [A10]

[Interviewer: And do you think is there anyway it could be improved at all? If there was anything ?]

Well personally speaking I wouldn't want to pressurise anybody...because they'd use some commonsense you know?...and those men are just wonderful (pause) very nice. [B08]

4.2 Nutrition Education in Nursing and Medical Curricula

Pre and post nursing and medical curriculum which devotes teaching time to nutrition are displayed in the tables below. Relevant medical and nursing policy and governing bodies which dictate the curriculum in regards to nutrition are included below in each table.

Table 4.2.1 Pre-qualification nursing

Nursing Curricula	Institution	Year of Study	Teaching Session	Course / Module Content
Pre-qualification nursing[a]	A	Year 1	1hr	***Nutrition Theory (1)*** • psychosocial and cultural significance of food • psychosocial, cultural and politico-economic factors influencing food consumption and eating behaviours • evolution of food consumption patterns and eating behaviours • implications of present day food consumption patterns and eating behaviours for health
			1hr	***Nutrition Theory (2)*** The composition of nutrients and a balanced nutritional intake: • function and source of dietary nutrients • concept of dietary reference values • nutrient deficiency diseases and the principles of healthy eating • contribution of healthy eating to health throughout the life span

			1hr	***Promotion of Healthy Eating*** Contribution of healthy eating to health throughout the lifespan, including: • current public health concerns related to diet • current healthy eating guidelines • establishing life ling healthy eating • current strategies to support healthy eating and improve public health
			2hrs	**Practical: Feeding the patient.** Students would get experience of what it is like to be fed by a nurse. Students are blind-folded whilst being fed different types of food such as yogurt.
		Year 2	1hr	***Nutrition Assessment in Practice*** • actual and potential problems that may arise with patient nutrition in different care settings • nurse's professional responsibility for patient nutrition • factors to be considered in nutritional assessment/screening and care planning • best nutritional screening/assessment practice
		Years 1,2 and 3	-	***Placement*** Mentor assesses each student 3 times per year. Students must meet their nutritional skills as identified in their portfolio. Nutritional skills must always be met before the student can pass their placement. The skills in the portfolio are those as identified by the NMC essential skills clusters. Also concerns gastric, peg feeding etc.

	B	Year 2	3x2hrs	***Clinical Nutrition (1)*** • definition, extent and risk factors associated with malnutrition • types and consequences of malnutrition • assessment of nutritional status / use of nutritional screening tools • prevention and early detection of nutritional deficits • use of oral supplements • nutritional support and dietary guidance **Nutrition in Older People** • malnutrition in older people • malnutrition risk factors – physical, psychological, socio-economic, nutritional • nutritional concerns and requirements • managing nutritional problems ***Clinical Nutrition (2)*** • discussion of 2 case studies using two nutritional screening tools • enteral feeding ***Clinical Nutrition (3)*** • nutritional management of diabetes mellitus • nutritional support in renal failure

[a] The Nursing and Midwifery Council has developed 'Essential Skills Clusters' which are skills statements set out under a number of broad headings that complement some of the NMC's outcomes and proficiencies contained within the 'Standards of proficiency for pre-registration nursing education'. Within 'Nutrition and Fluid Management' patients/clients can trust a newly registered nurse to:

- Assess and monitor nutritional status and formulate an effective care plan
- Assess and monitor fluid status and formulate an effective care plan
- Provide an environment conducive to eating and drinking
- Ensure that those unable to take food by mouth receive adequate nutrition
- Safely administer fluids when fluids cannot be taken independently

Note: Pre-qualification nursing is comprised of 50% theory and 50% practical work. During placements students also gain practical experience of nutritional care of older people.

Table 4.2.2 Post-qualification Nursing

Nursing Curricula	Institution	Year of Study	Teaching Sessions	Course / Module Content
Post-qualification Nursing	A	Certificate in Health Studies	3hrs	***Renal Nursing*** As part of the programme of Continuing Professional Development, the Renal Nursing course comprises three modules: Nephrology nursing; Nursing in a Haemodialysis context; and Principles and practices of paediatric haemodialysis nursing. Within this module a renal dietician delivers a teaching session in which students explore nutritional issues relevant to the care of a renal patient. The session includes a discussion of 'nutritional' case studies from renal practice
		MSc	Small Part of a 3hr teaching session	**Advanced Biomedical Science** As part of 3hr teaching session students learn about cellular metabolism, lipids and nutrients
		BSc (Hons) or Postgraduate Diploma in Specialist Practice	3hr	**Specialist Practice in Nursing: Nursing Care for Older People** Focuses on assessment of the older adult some of which would contain information on nutritional assessment.

	B	PGDip/MSc	n/a	**Distance Learning Course: Interdisciplinary Dementia Studies** Module: Approaches to Dementia Care:- Few paragraphs relating to nutrition and the person with dementia.
		Postgraduate Short Course or Specialist Practice Nursing Course)	1hr lecture	**Multi-disciplinary stroke care module** 1 Lecture/Skills session provided by a dietician in relation to nutrition and the person with stroke
		Postgraduate Short Course or Specialist Practice Nursing Course)	1.5 days	**Stroke Nursing Module – (Postgraduate Short Course or Specialist Practice Nursing Course)** 1.5 days relating to swallowing screening and stroke

	The Beeches Nursing	n/a	5 day course	***Nursing Older People**** • Physiology and psychology of ageing • Therapeutic interventions necessary in the nursing care of older people • Legal and professional issues that are relevant in the nursing management of older people • Discussion of evidence based practice pertinent to this specialist field • Significance of psycho-social and sexual aspects of nursing older people • Skills required to assess individual needs of older people • Reflection on principles of teaching and learning specific to the older person • Appreciation of the importance of multidisciplinary team collaboration in the care management of older people
	Nursing Education and Development Consortium North and West		9 x 1hr 1hr	**Training Programmes:** ***Malnutrition Universal Screening Tool*** ***Diabetes Nursing***

* This course has not been delivered for two years due to the lack of uptake. The course will be reviewed in summer '09 with the view to offering a different version in 2010.

Table 4.2.3 Pre-qualification Medicine

Medical Curricula	Institution	Year of Study	Teaching Sessions	Course / Module Content
	QUB	Year 1	Semester 1 and 2	Whilst there are no specific lectures devoted to nutrition during year 1, nutrition is embedded within a variety of different compulsory modules. Year 1 is a foundation upon which the rest of the course is built. The modules in it provide an introduction to genes, molecules and processes which allow cells to form tissues and organs which in turn form functional systems which operate in people. For example, the module *Cell and Molecular Biology*[1] includes the elementary treatment of structure and metabolism of carbohydrates, lipids, proteins and nucleic acids, vitamins and co-enzymes.
			Student Selected Components	***Diet and its relationship to colorectal cancer***
			4 hours teaching time per week	In this module students are expected to demonstrate how diet and lifestyle factors are related to the incidence of colorectal cancer. In particular, students should be able to describe the role of dietary micronutrients in health and disease and analyse the role of micronutrients as modulators of colorectal cancer development. Students also have the opportunity to discuss issues such as public awareness of the link between diet and colorectal cancer; adopting a healthier diet; functional foods and dietary supplements; establishing dietary interventions to reduce cancer in the general population.

Pre-qualification Medicine[a]				***Micronutrients in health and disease***[2] This module introduces students to micronutrients and the role they may play in a range of diseases including cardiovascular disease and cancer. On completion of this module, students should be able to: • Recognise the potential contribution of environmental factors to disease development • Describe the types of study used to study the contribution of environmental factors to disease and critical analysis of these studies • Describe in detail at least one group of micronutrients and how they might influence the development of a particular disease
		Year 2	2 lectures and 2 tutorials devoted to nutrition	***Systems Course 1***[3] Introduction to epidemiology and public health The nutrition element of this module encompasses 2 lectures and 2 tutorials. In week 3 of the module, students receive a lecture on nutrition and energy expenditure which includes: • Role of major nutrients in growth and development • Nutritional assessment surveillance methods • Definition of overweight and obesity • Inappropriate nutrition and health • Role of macro and micronutrients in cardiovascular disease, obesity, diabetes and cancer • Epidemic of overweight and obesity in industrialised and some transitional societies • Public health strategies to improve nutrition and levels of physical activity In week 4, students receive lecture and tutorial on obesity, considering obesity trends among US adults between 1985 and 2002.

			Student Selected Components 6hrs teaching time per week.	***Contentious issues in nutrition[4]*** This module is designed to examine the controversial, and sometimes unresolved, nature of nutrition science in a way with an emphasis on self-directed learning and will, ultimately give students an appreciation of the complex relationship between diet, health and disease. In doing so, students are expected to critically appraise the scientific evidence relating to a particular area of nutrition science. ***Exercise and applied physiology*** This module encompasses the follow nutrition element: • The basic components of a healthy diet • The fuels used in different types of exercise and their relative contributions • The additional nutritional requirements of training • Sports where malnutrition is common and the consequences of this
		Year 3	 20-30min	In year 3, specialties within medicine and surgery include cardiology, endocrinology and nephrology, which are linked to nutrition. In cardiology, no formal nutrition education is provided as part of the course, with a limited focus on nutrition in nephrology. The nutritional aspects of endocrinology are described below. ***Clinical Practice*** **Endocrinology** Paediatric dieticians deliver a 20-30min teaching session, with question and answer session as part of a multidisciplinary team teaching approach on paediatric diabetes.

			<u>Student Selected Components</u>	
			12 hours average teaching time per week	***Nutrition and cancer prevention*** This module requires students to: • Critically appraise the scientific evidence relating to a particular area of nutrition/diet/physical activity and cancer prevention • Summarise in writing and present orally their appraisal of the evidence relating to their assigned topic
			11 hrs average teaching time per week	***Global Health: Global health issues*** Within this module there is a lecture on 'Malnutrition', which includes: • Understanding what malnutrition is • Appreciation of the global trends in malnutrition prevalence • Description of how malnutrition can be prevented or treated
		Year 4	1 hr Lecture	***Ageing Well and Ageing Long*** Within the module 'Ageing and Health' there is a lecture on 'Ageing Well, Ageing Long' which focuses on factors which contribute to 'successful ageing'. Nutrition is emphasised as an important part of ageing well. The lecture includes: • The effects of the interaction between genes and nutrition and successful ageing in terms of the disposition to certain diseases among the oldest old.

				• The relationship between omega 3 fats and autoimmune disease, heart disease and chronic disease susceptibility among older people • The relationship between certain foods and the prevention of disease in old age.
			Small part of 1hr Lecture	***Bone Disease*** As part of the module 'Ageing and Health' students are taught about various bone diseases. Part of this lecture focuses on the effect of inadequate vitamin D on the development of bone disease.
		Year 5		**Clinical Attachment** During their medical attachment in final year, medical students are required to demonstrate skills in history taking, which in some cases will require knowledge and understanding of diet and nutrition. Students placed within Geriatric Medicine must visit an OT Department. OTs may discuss the difficulties older people may have when using utensils. Students must also visit a speech therapist where it is possible they will discuss problems of swallowing which is applicable to the nutritional needs of patients.
			Clinical Projects[5]	
			2004-5	**Does the nutritional status of elderly people depend on their depression score? A comparison between Scarborough, Tobago and Belfast.**
			2005-6	**Malnutrition in children: audit of WHO guidelines**
			2008-9	**Audit: ensuring elderly inpatients in Belfast City Hospital are nutritionally screened on admission using 'Malnutrition Universal Screening Tool**

[a]**General Medical Council (GMC) – *Tomorrow's Doctor***

Tomorrow's Doctor set out the knowledge, skills and behaviours medical students must demonstrate by the time they graduate. They must be able to demonstrate certain skills before they proceed to the Foundation Programme. *Tomorrow's Doctor* sections the expected learning outcomes for undergraduate medical students under three headings: the doctor as a scholar and scientist; the doctor as a practitioner and; the doctor as a professional.

- Under the heading of the doctor as a scientist it is stated that 'the graduate will be able to apply to medical practice biomedical scientific principles, method and knowledge relating to: anatomy, biochemistry, cell biology, genetics, immunology, microbiology, molecular biology, nutrition, pathology, pharmacology and physiology (GMC, 2009: 16). Furthermore, when applying to medical practice the principles, method and knowledge of population health and the improvement of health and healthcare they are expected to be able to discuss the role of nutrition in health.

- As part of diagnostic procedures doctors are expected to be able to make an assessment of the patient's state of nutrition. This includes an evaluation of their diet; their general physical condition; and measurement of height, weight and body mass index.

[1] Module renamed 'Cells Tissues and Organs' in 2009

[2'] Micronutrients in health and disease' did not run in 2009-10 due to staff on leave.

[3]Systems Course 1 was discontinued in 2009 and is now incorporated into the first year modules: *Clinical Skills and Experience, Principles of Disease and Treatment* and the 2nd year modules: *Concepts in people and populations* and *Physiological Basis of Clinical Practice*.

[4]The SSC 'contentious issues in nutrition' did not run in 2009-10 due to lack of uptake from students.

[5]A clinical project is a student selected component. The project may be a specific research project, a literature review or clinical audit. All students are required to carry out a clinical project.

Table 4.2.4 Post-qualification Medicine

Medical Curricula	Institution	Year of Study	Teaching Session	Course / Module Content
Post-qualification medicine[a]	Northern Ireland Medical and Dental Training Agency	Foundation Year 1		***History taking*** F1 doctors are required to consider the impact of poor nutrition. At F1 level core competences and skills includes recognition of the importance of nutritional factors F1 doctors must demonstrate knowledge and skills, attitudes and behaviours to ensure basic nutritional care. Knowledge: • Effects of disease on nutritional requirements • Impact of poor nutrition on susceptibility to disease • Metabolic response to injury, sepsis, starvation • Complications of over- and under-nutrition • Safety issues regarding nutritional care Attitudes/behaviours • Make nutritional care a routine part of daily practice Core Competences and Skills • Take an adequate nutritional history • Perform a basic nutritional screen • Identify major nutritional abnormalities • Prepare a nutritional care plan when appropriate

		Foundation Year 2		In addition to the above, F2 doctors are expected to demonstrate the following core competences and skills: • Describe options for nutritional support • Refer appropriately to a dietician or nutrition team

[a] **General Medical Council (GMC) - *New Doctor***

Provisionally recognised doctors are required to demonstrate the outcomes as set by the General Medical Council (GMC) *New Doctor* document in order to be eligible to apply for full registration. The content of these outcomes is set by the *Foundation Programme Curriculum* as published by the Academy of Medical Royal Colleges Foundation Programme Committee. The course content for Foundation Level 1 and Foundation Level 2 can be found in the *Foundation Programme Curriculum* available at www.foundationprogramme.nhs.uk

Note

The Intercollegiate Group on Nutrition provide courses and education on nutrition primarily for medical practitioners. Foundation level doctors may have the opportunity to participate in such courses. The first course to be developed is: *The Intercollegiate Course on Human Nutrition - Evidence Based Clinical Nutrition*. The specific aims of the course are:

- To enable doctors to extend their knowledge of nutritional principles
- To bring together sub-specialities to study nutrition in relation to disease processes and across boundaries of care
- To encourage the application of effective nutrition in relation to the promotion of health and in the treatment of disease

The course balances nutritional concepts and supporting science with practical examples, real life experience, and cases relevant to all participants.

4.3 Nursing Education: Results of the interview with nursing key informant and focus group with final year nursing students

The following section presents the results of the nursing key informant interview and the focus group with final year nursing students. The results were categorised using four key themes:

- Emphasis placed on nutrition and the older person in the nursing curriculum
- The education and training of nurses in the nutritional care of older patients
- Changes in the nursing curriculum in relation to the nutritional care of older patients
- The nutritional care of older people in hospital

Each of these themes is discussed in the sub-sections below.

4.3.1 Emphasis placed on nutrition and the older person in the nursing curriculum

The nursing key informant indicated that nutritional care of all patients, including older people, is assigned a high level of priority within the nursing curriculum. Each student must be able to demonstrate their knowledge of the nutritional requirements of patients, as outlined in the Nursing and Midwifery Council (2007) 'Essential Skills Clusters'. Students must also demonstrate core skills which relate to assessing the weight and height of patients upon admission.

> *They (students) have to demonstrate knowledge and understanding of patients' nutritional requirements. [KI 1]*

> *We emphasise to our students that yes, you do have to have the patient's weight for other reasons, i.e. to calculate dosage of medicines, etc, but you also if you're concerned about a patient and the weight loss, obviously weight would be a factor they'd have to look at. [KI 1]*

the curriculum obviously has to reflect nutrition and assessment in particular. So we have included a lot of detail on assessment of the patient and assessment of nutritional needs. And when the students are out on placement, they are exposed to an assessment chart (MUST), looking specifically at nutritional needs for patients. [KI 1]

The emphasis placed on nutritional care within the nursing curriculum is supported by comments from the nursing student focus group. The nursing focus group recognised that there has been an emphasis on the nutritional care of *adult patients* which was taught directly and embedded within other aspects of their training which they were expected to apply to older patients.

We got like a nutrition lecture but all the other lectures we've had on different sort of like chronic illness or say Parkinson's Disease or Alzheimer's it's been broken down in the nursing care into activities of daily living, so we've always addressed eating and drinking in particular conditions. [NS 1]

Additionally, the participants of the nursing focus group recognised that they held responsibility for ensuring older patients received adequate nutritional care.

We do take responsibility for that. [NS 5]

We're with the patients 24/7 and so – yeah, we can see what they're eating 24/7. [NS 3]

We have a responsibility to understand it [nutrition], not just to give it [responsibility for nutrition] to someone else. We have to try and understand basically what the dietician is doing. [NS 2]

I think we have to have a well rounded knowledge of an awful lot of things. Whereas the dietician can concentrate – like the physio concentrates on things and I do think there needs to be a dietician input in the care. But I think we need to have a bit more

knowledge ourselves of keeping it up on a daily basis. Because the dietician might come twice a week to a ward. [NS 1]

4.3.2 The education and training of nurses in the nutritional care of older patients

Current provision

Comments from nursing students suggested that the training they received in nutrition was not significantly concerned with older people. However, they did indicate that they were taught about the nutritional care of adult patients which they associated with learning about how to care for the nutritional needs of older patients. The students commented that the training they received regarding nutritional care of adult patients was basic and was not continued throughout three years of the nursing degree.

> *First year we had a big nutrition lecture, we had like three of them and then we had tutorials that went with it, but – it's been mentioned in everything but it's kind of just on a PowerPoint – points of nutrition and it's not been huge details. [NS 4]*
>
> *I think it was very basic, I think, the stuff in first year. I don't really think – I did PE and HE in school and I don't really think it taught me anything more than that, and that was at GCSE. And I don't think it kind of built much on that. And there is like even in practice and stuff, but I don't think it was that great, you know. You talk about eating and drinking as one of the activities of living, but apart from mentioning it it doesn't really – [NS 2]*
>
> *Yeah, that's how I feel. I don't think we've had great training in nutrition ... Apart from lectures in the beginning, like that's – they touch on nutrition and then that's – they leave it. You know, it's not taught necessarily, not since our lectures in first year. [NS 3]*
>
> *It was kind of as if it was common sense that obviously people need to eat and people need to get nutrition. That was kind of what we got with it. [NS 4]*

Nursing students commented on a number of things they considered would improve the current nursing education provision with regard to nutritional care of all patients including older people. These included an in depth and continued approach to nutritional training throughout the nursing degree. They also stated that nursing education needs to be more direct with regard to nutrition. In other words, lectures, practicals and tutorials need to be explicit in ways to deal with nutritional issues in a hospital setting. They called for additional practicals on alternative forms of feeding and pointed to the importance of being assessed on their knowledge of nutrition.

Have practical classes on Peg tubes, nasal gastric tubes, you know. [NS 1]

I think like directing a module on – start with the basics of nutrition, looking at – not just the food plate, but looking at all the macro nutrition as well, because that plays such a big role in a lot of our patients. [NS 2]

I think – like we were saying we have these lectures in first year. First year was two years ago, they should be continued through first year, second year and third year. And I find that it would have been helpful when we were doing like integrated nursing care to – you know when we had – we did PowerPoint presentations and somebody would do the pharmacology, somebody would do immunology, a nutrition section on each of those would have been handy. Because then you could apply it to specific illnesses. [NS 3]

And if you look, we had weeks where we concentrated on certain conditions and we had lectures and tutorials and everything on those conditions. I think we should have at least a week on nutrition and go into depth on it and kind of – exactly what is needed for every kind of condition as well, because you need to have different nutritional intake for wounds healing and things like that. [NS 1]

Be assessed on it as well. We've never actually been assessed on nutrition. So for some people that's the only stimulus to really learn it, if you know you're going to get an exam on it. We've never had an exam on it. [NS 3]

You miss lectures, you know, people don't get to attend lectures for whatever reasons, if they miss that lecture there's no practical on it, they don't get anything about it at all. [NS 4]

There's no exam on it, then that's gone. [NS 3]

I think there needs to be like a proper module on nutritional science, assessed at the end of it along with practicals and tutorials and like a proper nutritional kind of class [NS 2]

Additionally, the nursing students involved in the focus group were particularly concerned with their lack of knowledge of the MUST tool.

MUST assessment. [NS 3]

Yeah, a practical class on that [Must tool], how to correctly assess patients. [NS 1]

And the teachers quite like using like a tool for like assessing nutrition like the MUST, but we never had a lecture on it or anything [NS 2].

Unless you have a placement that use it and use it well, you know – [NS 2]

Yeah. I knew what it was, but I didn't know how to calculate the score or anything like that. [NS 1]

I think that's probably an indication of what level of education we got on it, we knew what it was and what it was for, we didn't really – [NS 2]

Know how you use it. [NS 1]

There was no in depth look at it at all like, it was just mentioned. [NS 1]

An interprofessional approach to nutritional training

The nursing key informant was positive about a multi-professional approach to educating students about the nutritional care of older people in a hospital setting. It was indicated that those involved in nursing training in relation to nutrition draw on the knowledge of other professionals within specialist areas of health care.

we would bring in other professionals to teach into modules, for example in the community module we would always bring in the community team or people from the community team so that the student is exposed to experts from the community team Now you have the word dietician here, but I'm honestly not sure whether we bring a dietician in. We bring people in like the stroke specialist nurse the continence advisor ... I know that some of our students may have been exposed to the dietician in the clinical area because for some of their assignments they have to do a care plan ... but as part of that they might want to go and speak to the dietician on placement, find out what their role is etcetera, particularly with regards to alternative methods of feeding. When patients have had a peg tube inserted the person who can best advice

them is the dietician. So they see the collaboration there between doctors and the dietician in terms of the feed. So yes, we do bring in other professions. [KI 1]

However the respondent recognised that there is room for improvement and discussed the benefit of incorporating a wider range of professionals into the training.

The dietician is probably not one that ranks the highest. We bring in the tissue viability nurse, continence advisor, I think we should also be bringing in the dentist for example [KI 1]

Those participating in the nursing focus group agreed that interprofessional work is important in the nutritional care of older people in a hospital setting. They stated that an interprofessional approach to care was emphasised during their training although they believed the extent to which it was emphasised depended on those teaching the session, with younger staff more likely to have encouraged it.

[Interviewer: What about when you're learning about nutrition? Do you think the lecturers encourage an interprofessional approach?]

Yeah.[NS 5]

The opinion is kind of a bit more old school, kind of want to keep everything in nursing, you know. Have you heard that, like you know, with – oh, they're giving everything away to – [NS 2]

Yeah.[NS 5]

I think it would depend who you had, because it was the smaller classes. Remember we went through all the different things, I think it would depend on who you had as your teacher. [NS 6]

I don't agree with that, but I've heard a couple of the older lecturers say that. [NS 2]

Like they think it's the job of like the front line nurse to do everything. [NS 1]

To do everything, yeah. [NS 2]

However, some of the students felt that their training should teach them how to make use of other professionals in a hospital setting.

But I don't know whether they would have encouraged in lectures to talk to the people you've suggested, like occupational therapists and speech and language and social workers. I don't know if that would be – [NS 3]

Just some of the resources maybe that they signposted us towards, those would, so maybe indirectly. [NS 5]

That they haven't said – yeah. [NS 6]

Not so much specifically relating to nutrition I don't think. [NS 3]

Again, all that's sort of through the portfolio, it's sort of saying liaising with. [NS 5]

But there again, it's kind of all – they should say it out front, especially if you're getting a good base grounding in it, it shouldn't be kind of hidden in other avenues. It should be there and, you know, you need to do this. [NS 1]

4.3.3 Changes to the nursing curriculum

The nursing key informant recognised that it would be beneficial to spend more teaching time on the topic of the nutritional care of the older person and ideally to include an additional module in the nursing curriculum which focuses solely on the topic of nutrition.

[Interviewer: do you think that (nutrition being threaded throughout the undergraduate nursing degree) is sufficient in dealing with -]

Eating and drinking is linked throughout the element but there is not a module on nutrition. So I suppose if I was asking for the ideal curriculum, I would like a module

on nutrition, and nutritional needs of the patient and the actual science behind it ... so there's a lot of things, yes, that we could do with an actual nutrition module.[KI 1]

The nursing key informant indicated that although there are no plans to implement such a module there are plans to create a module which focuses on the older person within which it would be possible to devote teaching time to the topic of nutrition. The key informant stated that a separate module on the older person would allow students to learn about the nutritional care of older people in an in-depth way.

It's probably not going to be one specific (module) on nutrition, but there will be a module on the older person, which will highlight more on the nutritional needs of the older person. That's been talked about in light of as I say, the NMC review, so we anticipate there will be more of a focus on the older person and ultimately nutritional needs [KI 1]

The key informant stated that there are a number of barriers to setting up modules which relate solely to nutrition and/or older people. These barriers include time and space and the need to meet other NMC essential nursing skills. Furthermore in order to change the current curriculum and increase the amount of teaching time devoted to the nutritional care of older people it would be necessary to seek the approval of nursing governing bodies. For example, the curriculum is guided by the Nursing and Midwifery Council (NMC) and would be sensitive to any new policies or reports released by for example the Royal College of Nursing (RCN) or the Department of Health.

[Interviewer: You talk about taking a module for nutrition and for older people, what are the barriers of setting up those modules?]

Because we have other modules that we must put in. So for example, we have to have biomedical sciences we have to have nursing, we have to have sociology. So there's things that we have to have in from the NMC ... We are governed by what the NMC are saying must go into the curriculum. It has to be 50/50, 50% theory, 50% practice. And that's directed by the NMC. We also have directives from the EC, European

community, saying that they have to have so much mental health, learning disability, and children's exposure. [KI 1]

To overcome such barriers the respondent indicated that it would may be possible to implement teaching on nutrition within non-compulsory modules. However, issues such as lack of funding and the reliance on staff initiative to introduce such modules would need to be addressed to bring this about.

We are trying to introduce student selective components in our curriculum, and nutrition could be a module that you could have as student selective. [Interviewer: So selective means optional?]

Yes it does....maybe set it up as a selective and, you know, even if you only have one or two people who select it in the first instance they go away and say, that was really good ,and provide positive evaluations and more students are likely to select it in the next

[Interviewer: Sure, sort of like a trial run first and then...]

Yes, absolutely, yeah. But again, the difficulties with that or the barriers is you have to run that on your todd (own). Because you have to believe in it, your not going to get money to do it initially, you have to run these projects sometimes on your own. Not on your own, but you know what I mean, sort of try to do it within the parameters to prove that there is a need for this. [KI 1]

4.3.4 Nutritional care of older people in hospital

Knowledge of the Nutritional Care of Older Patients

The results from the interview with the key informant indicated that students are taught to deal with different situations which might arise when caring for the nutritional needs of older patients. The key informant stated that students are taught to deal with many of the issues by using individual assessments. For example, the informant indicated that students are encouraged to treat each patient individually and encourage the patient's involvement in his or her own care and these aspects should be addressed using such assessments.

> *Well, things like – I mean, we would – from the older person perspective, we would encourage students to assist the person to choose from the menu for example. You know, and to go through what's available, so they are picking what they want. We would also say to them things like, to say, you know when the food is in front of the person and if they need assistance, to ask, what would you like next? Rather than just assuming ... I mean, the focus should be on the assessment of patient's needs, whether they be older people or not, that you have to look at it individually, and each person is an individual and they have an individual assessment. So we take it from that angle. [KI 1]*

The respondent again emphasised the role of patient assessments to inform the hospital staff about various nutritional requirements, for example, if utensils were inappropriate or if patients preferred to certain foods or to eat their meals at different times of the day

> *That would come out in the assessment, this assessment that is done when the patient is admitted to hospital. And under that there is a part looking at nutritional needs and diet and their likes and dislikes, so it comes in under that. [KI 1]*

The respondent also explained that students were expected to understand the role of family participation in the nutritional care of older patients. The informant stated that communication skills would be the key area of nursing education which would deal with this aspect of care.

...We encourage our students to recognise the family input from the point of view of – and I'll go back to the SBAR again, but if they are making a clinical decision about a patient, and the clinical parameters suggest that the patient is ok we always encourage them to say to the patient's relative, how do you think for example their father is looking today ... They might say, well, I don't think they look terribly well ... and we always emphasise, you always take on board what the relative is saying, because they know the patient much better that you. [KI 1]

The nursing focus group indicated that although students are taught how to interact with the patient's family it is not related directly to the nutritional care of older people.

You're taught how to deal with them but not in relation to nutrition, yeah. You do get taught how to interact with families and things, but where nutrition is concerned you don't get told how to approach them, you know, ask them what their normal eating habits would be, if they would like to come up and feed and things like that, you don't get taught any of that. [NS 3]

The students indicated that they were aware of different aspects of nutritional care of older people in a hospital setting. They discussed ways in which they would ensure a patient received nutritional care including using individual assessments, recognising weight loss, involving the patients family, understanding poor appetite, encouraging patients to eat, assistance with feeding and involving other professionals.

You know when you're admitting someone there's like a wee section for their appetite, and generally you just say, how's your appetite, and they say good, and you tick good and that's it, isn't it? [NS 1]

And you'd ask them [if they've lost weight] and they're not sure and you're having to look at clothes and things to see if they're too big for them. [NS 6]

... families quite often come up at mealtimes if that's allowed, you're generally not allowed, it's hectic at mealtimes, but if there's a patient who's not eating sometimes the family will be allowed up because they'll feed the patient and then they'll have lots of time... [NS 3]

I guess it depends on what's the cause of it, why they're not hungry. If they're on antibiotics and that's making them feel sick all the time – [NS 2]

Yeah, as long as they're eating something. And quite often with elderly patients who have lost their appetite, they like sweet things, and it would be, well, if she'll eat an ice cream – you might be feeding elderly patients ice cream all the time because it's all they're eat. [NS 3]

You do [approach other professionals] with OTs and things like that, because they're assessing are they actually able to and – and the speech and language therapist if their swallow is – [NS 5]

Comments from the focus group suggested that it was during placement, i.e. working in wards with patients, that students learned most about the nutritional care of older people in a hospital setting.

I have to say I think personally we did get a grounding, a little bit in nutrition, but it is from placements that you pick it up moreso than – when you're out there doing it and seeing the patient. Which is – for an awful lot of lectures as well it's hard to kind of put it into reality until you are. But you get to go out and be with the dietician as well

and certain things, so you kind of pick up different things from different professions. [NS 1]

Barriers to transferring knowledge of nutritional care of older patients to a hospital setting

Although the students were knowledgeable about various aspects of nutritional care there were certain barriers when applying this knowledge to a practical setting. The barriers to transferring their knowledge to the care of older people in a hospital setting included catering difficulties, a medical rather than nutritional approach to health problems, lack of time to ensure patients were eating, conflict of nutritional care with other responsibilities, and their perception of the low priority for nutrition on the wards.

The orange juice, they all love the orange juice, but you can only get it in the morning. [NS 4]

And I mean, it's pureed meals ... You're mortified giving them to people. It looks like they've just been slopped out. They used to come in wee shaped portions so they at least resembled the food that they were supposed – like broccoli would be in a broccoli mould and meat would be in a sort of chop sort of shape. At least it looked remotely palatable. But apparently that's too expensive. [NS 3]

Well, in hospital there's hospital food, I mean, everyone knows isn't great and there's not a lot of choice for – you know, sometimes patients don't like what's on the menu and then they just said, I'll just not having anything. And the other problem is – which was never addressed in the first year which I have come across in placement with a family member is people with dietary requirements aren't catered for in hospital. [NS 5]

But there's never a whole lot done in hospital about malnutrition I don't think. Like if you feel someone's mal – you know, malnourished, they're referred to the dietician and the dietician writes them up for Fortisip, that's it. [NS 1]

That's what I was going to say, yeah. [NS 3]

And then they're forgot about, oh the dietician has seen them and they're getting Fortisip so they're all right. And that's not enough. [NS 1]

It comes down to staffing as well, you know, you're expected to do all this other stuff, you know, but you don't get it done, and why didn't you get it done, because I was feeding someone, it wouldn't really go down, you know, on a lot of the wards. [NS 2]

And the priorities daily, yeah, it wouldn't be up there on kind of the top. It should be and I think if you were putting together – like for example, for our management, I think we did put nutrition on there and it was quite high up, but on a daily basis, on a ward level, it wouldn't have been something that would have been as high up in priority of care. [NS 3]

Well, I don't know, that's just my exp – obviously at mealtimes and things like that and you fill out the charts and things, but you are more kind of – I have to get this done, I have to get that done. [NS 3]

I think everyone agrees it's a priority and it's really important but in reality, you know, we're not really given the resources or the time to kind of really tackle it. [NS 2]

But it's fair enough like being taught all that and being taught in depth nutrition, but it sounds as if from the way everyone is talking that the real problem is the food in the

hospital. If you can't get it you can't apply your knowledge, if you know what I mean. If pantries are closing and silly things like that and they're not getting their fruit and veg, what's the point in knowing it if you can't put it into practise. [NS 1]

The nursing key informant also recognised that the structural organisation of hospitals can cause significant barriers which may prevent nursing students from applying their knowledge in a practical setting. The respondent stated that nursing students were often faced with standardisation of care within a hospital setting which prevented students from applying an individual approach to care.

It (patient assessment process) can be very prescriptive, for want of a better word, in terms of what you ask, but it's meant to be individual to the person. Currently there's a group of people within the Belfast Trust looking at care planning at the moment, because we recognise there are problems with that as well. We went through a stage where we were teaching this but the students went on placement and they were introduced to what were called core care plans; they were standardised. So there are issues around care planning that have to be teased out. [KI 1]

Interprofessional care

The nursing key informant indicated that there are several cultural barriers to nurses interacting with other professionals within the hospital setting when caring for the nutritional needs of older patients. These include a reluctance to communicate directly with other health care professionals; other healthcare professionals not doing likewise with nursing students and; lack of team working ethos.

[Interviewer: Do you think there are any barriers to that sort of activity, in terms of the nurses interacting with other disciplines?]

Yes I think sometimes the barriers exist in the nurse's own head. Because they don't think for a moment that they could maybe speak to – you know, they'll go and read the notes, so the person coming in to see the patient will go and see the patient and then

will write in the notes. And my experience is the student will go and look at the notes but will not speak to the person before they leave the ward and say, you know, I'm looking after Mrs So and So, so tell what is your opinion? That is difficult to get sorted I would say ... And equally so the person coming in, whether they be the phsyio, the dietician, whoever, they have to get in their head that I should be speaking verbally to the nurse as well as writing this in the notes. And I think even if they have very little to say, you know, but the fact that they are saying, I'm part of this team, so I want to speak to the nurse in charge or whatever. Not just appearing on the ward, writing and off they go. It's not a criticism but I think it could improve the whole kind of notion of who's involved in this care. [KI 1]

Comments from the focus group indicated that students were able to approach and make use of other professionals in a hospital setting.

[Interviewer: How would you feel about maybe approaching another professional in the hospital in terms of providing nutritional care for older people?]

You do with OTs and things like that, because they're assessing are they actually able to and – and the speech and language therapist if their swallow is – to make sure that they're actually safe to – [NS 5]

[Interviewer: So you would actively seek out other professionals?]

Yes. [NS 5]

And social worker as well, because you don't what their background is at home, if they – you know, who they have at home looking after them, if they need some sort of – because they mightn't be able to prepare food themselves and that's the simplest way of doing it. [NS 4]

However, the comments from the focus group indicated that there were significant cultural barriers when approaching other medical staff such as doctors when providing nutritional care for older people. The reason for this was the student perception of power differentials and the belief that doctors are more concerned with medicating than with nutritional care.

You feel more on a power with professionals I think than with medical staff, they can be intimidating and sometimes you can think medical staff would be less interested in nutrition and more interested in medicating or, you know – but – other professionals are much more approachable for nurses. [NS 3]

4.4 Medical Education: Results of the Interview with a Medical Key Informant and the Focus Group with Final Year Medical Students

The following section presents the results of the interview with the medical key informant interviews and the focus group with final year medical students. The results were categorised using four key themes:

- Emphasis placed on nutrition and the older person in the medical curriculum
- The education and training of the medical profession in the nutritional care of older patients
- Changes in the medical curriculum in regards to the nutritional care of older patients
- The nutritional care of older people in hospital

Each of these themes is discussed in the sub-sections below.

4.4.1 Emphasis placed on nutrition and the older person in the medical curriculum

The priority placed on nutrition and the older person within the medical curriculum is not clearly defined. The medical key informant stated that the policy which guides the medical curriculum in relation to nutrition is broadly defined through the GMC policy document '*Tomorrow's Doctors*'. It is the responsibility of teaching staff to interpret the document as they see fit and to use their judgment to include nutrition within the curriculum when it is both relevant and appropriate. The respondent stated that responsibility is placed upon course directors to develop the curriculum to meet the priorities within their specialist areas.

> *Those (Tomorrow's Doctors) guidelines are quite general and the rationale for that is that each medical school can interpret them and deliver them in the way they think is fit for their local circumstances. In relation to specific topics like for example nutrition, we wouldn't have any specific set of guidelines that we would issue for staff. We would expect staff as they're designing the curriculum to use their judgement as appropriate and to include information about nutrition where they think it's relevant and appropriate. [KI 2]*

We give each of the course directors and course co-ordinators a certain degree of autonomy and we expect them to include in the course things that are priorities within their specialist areas [KI 2].

The medical key informant also indicated that doctors play a very small role in the nutritional care of the patient and nutritional care is often viewed as '*out of their area' [KI 2]*. It is not therefore relevant for medical students to learn about many of the issues raised by the interviews with older people. For example, the respondent indicated that the doctor would assign low priority to the nutritional care of the patient as it is commonly viewed to be the responsibility of other healthcare professionals.

At the level of providing nutrition I think the perceived – the view of the doctor would be that that is the responsibility of the dietician ... They would probably provide general advice about nutrition but at the actual level of putting together a menu plan, which is what the dietician does, that would not be seen as being the role of the medical professional [KI 2]

Medical students similarly indicated that relatively little of their curriculum is concerned with the nutritional care of older people.

Geriatrics placement maybe, we get a little bit, we get – I vaguely remember something about a MUST screening tool, but that's about it, I couldn't tell you what's in it. [MS 1]

I can't remember any specific lecture there's been on nutrition or emphasis on nutrition. [MS 2]

It's definitely not emphasised as part of our curriculum. [MS 3]

There isn't one [priority]. Pretty low. [MS 4]

They also indicated that they did not hold direct responsibility for the nutritional care of older patients. Yet they stated that they thought that they should be well informed in this respect.

It should be because that's vital in getting better [MS 1]

It would do no harm, yeah. [MS 4]

In getting better from everything they have to get fed or they can't – you know, they're not going to make any progress. [MS 1]

I probably should have more of an awareness but it's not something that I would look for. But maybe I should. Well, I probably should be. [MS 1]

Furthermore, data from the medical focus group indicated that the general topic of nutrition is not seen as a priority area among medical students. Other reasons for lack of interest include time demands placed on the students and the assumption that much of nutrition is 'common sense'. The students suggested that nutrition fell lower on medical students' list of priorities as many are examination driven and they believed that nutrition was unlikely to be assessed in an exam.

Well, I would see it as well, but, you know, demands on our time as well, you sort of – a lot – we've got to sign in to so much things that maybe in our view we feel aren't necessary and are things that are an absolute waste of time. So when you've got demands on your time like that you sort of will pick and choose what you feel is going to help you in the immediate. It's more to do with time demands. [MS 3]

And I think also some people will be like, oh nutrition, that's just common sense. I think a lot of people would have that attitude. And would be like, common sense, you know, if they've lost a significant amount of weight, if their BMI is low or if they're a cancer patient or they're an elderly patient, you know, I think a lot of people will be like, you know – because we've never actually been – it's never emphasised, you will be examined on how to assess the nutritional status of this patient [MS 2]

And that's the problem, we are so examination driven, we really are. If it's not coming up in the exam we don't care. I'm not speaking for myself but I'm speaking for a lot of people. [MS 4]

4.4.2 Education and training of medical students in the nutritional care of older patients

Current provision

The medical key informant indicated that the aim of the undergraduate medical curriculum is to produce safe and competent foundation doctors. In order to satisfy this expectation there may be little opportunity to prioritise nutrition over other essential skills. However, the respondent felt that the current level of priority in the curriculum given to nutritional care of older people was probably sufficient.

That's difficult to gauge and I think, as with everything in a curriculum you can probably teach a lot more about everything but its trying to prioritise and making sure that we produce a safe and competent foundation doctor. I think you know if we a had a six year course we probably would devote more time to all of these things so it's just getting a balance...And I think we probably are satisfied with what we have at the moment in relation to the nutritional care of the elderly. [KI 2]

The respondent felt that the current approach to incorporating the topic of nutritional care of older people into the medical curriculum was sufficient for two reasons. Firstly, as the guidelines stated within the GMC policy document *Tomorrow's Doctors* are broad, teaching staff have the opportunity to take on board any national initiatives which might impact health and well-being. This in turn has lead to the development of the curriculum in response to recent national guidelines on nutritional topics such as obesity.

...I think yes it is appropriate because we have changed the focus and certainly talking to colleagues, a lot of what's been covered in relation to nutrition has changed

in recent years in response to things like obesity and in sort of national guidelines and national information about, as I say particularly obesity but that tends to be the approach that medical schools take about everything, that you rely on the expert judgement of the people designing the curriculum and also that they respond appropriately to any national initiatives that might impact on health and wellbeing. [KI 2]

Secondly, there was an expectation that specialist issues such as nutrition in the elderly would also be picked up at a postgraduate level.

... I think that its at the point that we – we can cover and we can introduce students to basic concepts at an undergraduate level but I think its to recognise that their training doesn't stop at the end of five years. There is an opportunity for additional training. [KI 2]

Whilst the respondent was aware of the Intercollegiate Group on Nutrition[3] their aims are not currently incorporated into the undergraduate medical curriculum. The respondent indicated that recommendations are received from various organisations and incorporating every recommendation into the curriculum would make it heavily swayed towards topics which are of current national interest when the priority in the medical curriculum is to ensure that each new doctor has the basic skills to practice medicine.

If we incorporated all those recommendations we would maybe have a curriculum that would focus on things that were of current national interest and that's a concern that every medical school has. So we take all of these national guidelines and we discuss them at a committee like the UMEC and teachers can then implement them as they see fit and I think that's the approach that medical schools have because we've a vast range of things that we have to cover and it is a five year course and we have to make sure we're covering the basic. [KI 2]

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[3] See page 7 for the aims of the Intercollegiate Group on Nutrition

The medical key informant suggested that students have the opportunity to learn about nutrition through Student Selected Components (SSCs). There are currently six SSCs which incorporate the topic of nutrition. The respondent stated that a topic covered in a SSC is not necessarily excluded from the core curriculum but takes a '*different*' and '*in-depth*' approach. Furthermore, SSCs are aimed to give a student an opportunity to study a topic which is of interest to them. The respondent indicated that there are a number of barriers to using SSCs as a way to teach the topic of nutritional care. The first limitation of SSCs is that only a small number of medical students will receive this training.

> *Not every student is exposed to teaching and that's why initially the GMC said that it had to be something that wasn't part of the core teaching curriculum. So yes there is that risk that if you say that it's delivered exclusively as part of an SSC programme then only a narrow range of students will receive this training. [KI 2]*

Secondly, the respondent indicated that many students select an SSC based on the way it is assessed.

> *If you talk to students about how they select their student selected component they look at how it's assessed ... And they go for modules with what they perceive as the light touch for assessment ... [KI 2]*

Finally, the respondent indicated that SSCs are generally chosen by students based on their interest. This means that students might not necessarily choose topics devoted to nutrition. However the respondent stated that those SSCs which relate to nutrition are no more or no less popular than other SSCs.

> *...Students for example who are interested in paediatrics will do things that focus on children and early stages of the life cycle. Students who are interested in exercise, physiology, sports medicine will also do something in relation to nutrition because they will see that as being relevant. So there are certain trends and certain patterns*

but again they're not any more popular than modules that we offer on other topics. [KI 2]

Data from the focus group with medical students similarly indicated that SSCs were often chosen based on the type of assessment and their level of interest in the topic.

I think it's a bit variable as well, because when we came through the student selected components the method of assessment was different. So very often I would have chosen some of my selected components on the type of assessment that was involved. [MS 3]

No dissertation.[MS 2]

Yeah, well, I always ended up with massive dissertations but – so that would have – there's too many other issues really rather than just the sort of subject choice that you couldn't really look and say, well, people aren't interested in nutrition, it maybe would have been other things they were looking at as well. But they're more standardised now. [MS 3]

More interested in assessments.[MS 2]

Overall the medical students were somewhat convinced that SSCs may be effective in providing nutritional training. They stated that the topic of nutrition would not necessarily dissuade them from choosing such a SSC, but they recognised that only a small number of students are likely to receive nutritional training in this way.

[Interviewer: Do you think that those SSCs would be – are an effective way of teaching nutrition?]

Probably would be. I think a short course in it probably wouldn't do any harm. I always do take quite a lot of SSCs. [MS 1]

It's only going to be a certain number of people, it's not going to be the whole year, it's only going to be a small number. [MS 4]

But I suppose if you had one doctor on a ward who has a vague idea, then that can pervade a wee bit. [MS 1]

It wouldn't have put me off doing one, I think I just happened to chose things that I enjoyed. If I could avoid presentation I would, I'd rather do an essay. But other people are the complete opposite. [MS 4]

Interprofessional approach to nutritional training

The data from the focus group with medical students indicated that they thought an interprofessional approach to nutritional care would be effective. They maintained that due to other time pressures their responsibility for nutritional care should be shared.

Well, shared responsibility because we can't be entirely – but it has to be teamwork [MS 1].

The medical key informant indicated that, to a large extent, there is no interprofessional approach to education in relation to nutrition. A lack of staff awareness and encouragement from supervisors were seen as the primary reasons for this. However, working as part of a wider team is encouraged from the beginning of the course and during the student's clinical training medical students are advised to refer the patient to other health professionals when appropriate.

The respondent stated that an interprofessional approach to care is difficult to encourage among medical students for cultural and practical reasons. At a practical level interaction among medical students would occur most often with nurses and there is limited opportunity

for engagement with other healthcare professionals particularly when considering the nutritional care of older people.

Team working is encouraged right from the outset and when they start their clinical training which predominately starts in year three, they are advised quite strongly to work as part of the team and where appropriate defer to other health care professionals but I think at an undergraduate level most of their interface in a clinical setting would be with nurses. They may encounter, maybe a diabetic care nurse who would again have some nutritional advice when they're doing their primary care but again that will depend on practice that they're in whether or not that practice has a diabetic care nurse linked to it. So yes they are encouraged but I think it's opportunistic and it depends on you know who they see at a particular time during a placement but I think nurse would be their primary source of information. [K2]

At a cultural level, the respondent stated that many students may have a negative perception of interprofessional education which is exacerbated by a lack of encouragement from their supervisors.

I think just the general barriers that you get and I think maybe a general negative perception among students in particular that inter-professional education is not a valuable experience and maybe sometimes some of the clinical supervisors not encouraging it either. [K2]

...there are cultural barriers to embedding IP [interprofessional education] in the programme. [K2]

4.4.3 Changes in the medical curriculum in regards to the nutritional care of older patients

There are no major plans for changing the way nutrition is taught within the medical curriculum in Northern Ireland. Additionally, there are no new plans to implement new modules which relate to older people and/or nutrition within the curriculum. The main barrier to providing a greater focus on nutrition within the medical curriculum is the availability of time and space.

> *I suppose its curriculum congestion and making sure that we are producing somebody who has a general understanding of a vast range of topics in relation to medicine and as I said earlier that they can practice as safe, competent foundation doctors. So the main barrier is I think, time and getting balance within the curriculum and making sure that we can reflect everything that we need to cover in the five years of the programme. [KI 2]*

Medical students were also cautious about the addition of new subjects in what they perceived as an already over-crowded curriculum. However they indicated that they thought nutrition was important, that it should be taught throughout the course but as a compulsory component or else it would be ignored. An interprofessional approach was also advocated. Furthermore, they felt that nutrition should be assessed in order to encourage students to learn about the topic.

> *Teach nutrition. I think you'd have to be very careful about your approach. I mean, as I say, we have got a really over stuffed curriculum, it's full of nonsense these days. It really is. And you would have to be quite careful. It would have to be a compulsory thing, it would have to be something that people got signed into, because otherwise they would not come, I'm just telling you that. And it would be best if it was inter professional. Absolutely. [MS 4]*

The medical key informant indicated that there were some areas in the current medical curriculum that could be developed. First by incorporating an interprofessional approach to nutritional care within the medical curriculum.

> *Probably the inter-professional aspect and maybe creating awareness of what other members of the health care team can contribute to the patient's information and support in relation to nutrition and health. [KI 2]*

Second to determine the level of general knowledge students have about nutrition prior to their admittance to the medical degree.

> *I think sometimes of this anecdote if I'm talking to students that perceptions of food and food values and things can be a little bit at odds at what I would expect fro somebody coming into health profession programme. [KI 2]*

> *So I think you know, its – the two areas are maybe opportunities for learning about what other members of the health care team can offer and secondly knowing what our student actually already know about food and nutrition generally' [KI 2].*

4.4.4 The nutritional care of older people in hospital

Knowledge of the Nutritional Care of Older Patients

The medical student focus group indicated that students viewed themselves as having limited knowledge of how to deal with the nutritional needs of patients. One medical student commented that they were 'embarrassed' by their lack of knowledge with regard to the nutritional care of older patients.

I'm actually quite embarrassed by this, I really am. [MS 2]

If dieticians decided to leave, all of them en mass, I'm sure the patients on the ward would flounder because we wouldn't know what to do. We could have a go but it wouldn't – [MS 1]

Which is not good for people who train for five or six years in physiology and science and healthcare, like that's just not okay. [MS 2]

Additionally, the medical students had limited knowledge of nutritional screening tools.

I know they [nutritional screening tools] exist, that's about as far – I couldn't tell you what would be on them. [MS 4]

I have no idea about them to be honest. [MS 2]

And actually I know about the MUST tool, I'm thinking now, is because a group in the year above me did that as their clinical project and came back to present it. And I was in geriatrics and that's how I remember it more. Because thinking about it now, maybe we didn't have anything else in geriatrics apart from that. [MP 4]

I don't think we did. [MS 2]

However, the medical students had some awareness of alternative methods of feeding due their ability to prescribe such a method of care.

> *We probably actually know more about that than – [MS 2]*
>
> *Yeah, if it can be prescribed and it can be read in a textbook, yeah, we're on it. [MS 1]*
>
> *Complications of a Peg tube and all that stuff. [MS 3]*
>
> *But I'm not sure that I would to be honest know what to do if it blocked or if, you know – I could have a go. And I'm not sure I'd know how to deliver it. Again, that would be more the remit of the nurses, so that's probably something that could be addressed. I know that it existed and a patient could have it but – [MS 1]*

The medical students also agreed that they had little or no experience of dealing with the nutritional needs of older patients.

> [Interviewer: Have you had any experience of dealing with older people in hospital in terms of nutrition at all?]
>
> *I've seen people leave food and I've never seen anything being said, oh Mrs X hasn't eaten for the last few days, it's just put in front of them and goes away. And that's what I've seen. I don't know, maybe someone does follow that up, but – [MS 1]*
>
> *If there was some sort of assessment that could be done on the patient, something in the notes that this patient needs help with feeding, does that happen? I don't know. Is there notes made that people are aware of – [MS 3]*
>
> *Sometimes you have things like INO charts where you can say what they – but it's more for fluids and – but they have – I think they've recently started those things where there is a nutritional thing and they write what they had for breakfast, lunch and dinner. They have started those, but I haven't seen that in every hospital. [MS 2]*

Barriers to transferring knowledge of nutritional care of older patients to a hospital setting

The medical key informant stated that student doctors did not necessarily receive first hand experience of the way older peoples' nutritional needs are taken care of. This was due to their absence on the wards during visiting and meal times. For example, the respondent suggested that student doctors might not always be aware of the role of the family in the nutritional care of older people, in particular, the way in which visitors often brought food and drink to the patient.

> *And I think that maybe a lot of the doctor's actually aren't aware of it (family bringing food to the patient) because they're not on the wars at visiting time. The nursing staff probably see more of it. Students may or may not be on the – if it's evening time the students are not on the wards. They may see it during an afternoon visiting time but I think that there is maybe a lack of awareness among the medical profession that that's a practice that is starting to - come through [KI 2]*

The medical students indicated an additional reason for their lack of experience of dealing with the nutritional needs of older patients was that they were unsure as to whether or not the scope of their responsibilities covered nutritional aspects.

> *From a medical perspective it is obviously but I just mean as a level of a junior doctor, what say do we – what do we do? What is our role? [MS 3]*
>
> *I wouldn't say it's well defined. I know our responsibility is for patient care and putting them at the centre of everything we do, so obviously nutrition is going to be a huge aspect of that. And it's a human right at the end of the day as well. I just don't know. [MS 1]*
>
> *I suppose in your head at the back of your mind you're thinking someone else is dealing with this, the dietician is sorting this out. [MS 2]*

I think we're very much focused on pathology, aren't we? We're focused on what's wrong and how can we fix it. But we don't really think about optimising normal. [MS 1]

Interprofessional Care

Data from the medical focus group indicated that students thought that it would be beneficial to be aware of any nutritional issues a patient might be experiencing and that interprofessional communication was key to achieving this. Furthermore they stated that it would aid the practice of patient centred care.

It would be good even, I suppose like you said, on a ward round to at least ask, and how is this patient? Have they been eating well? If someone would – I don't know if that would be in nursing notes, because you do get dieticians will write in the notes, but maybe only once a week depending on what the problem is. [MP 4]

Part of the problem is – I've recently been on placement in medicine in the [said hospital]. And the F1 [foundation level 1 doctors] said that they're quite often doing bloods and doing the ABGs and the procedures of patients without actually knowing what their medical condition is, it is actually at that level, never mind what their nutritional status is, never mind what their religious, spiritual needs maybe, there's nothing beyond [he's broke his arm]. So – which is not great. There has been a shift in focus away from the patient. Especially at junior levels. [MP 1]

It would be good even, I suppose like you said, on a ward round to at least ask, and how is this patient? Have they been eating well? If someone would – I don't know if that would be in nursing notes, because you do get dieticians will write in the notes, but maybe only once a week depending on what the problem is. [MP 4]

Data from the focus group with medical students indicated that they perceived the current level of interaction between doctors and nurses with regard to nutrition to be very low. They reasons suggested to explain this were communication and cultural barriers.

> [Interviewer: So would you interact with the nurses in terms of nutrition?]
>
> *We do for other things but not that I've even seen for nutrition. [MP 1]*
>
> [Interviewer: Never?]
>
> *We have some prescribing classes and they're increasing the focus on inter professional education at [said university] as part of the new course. But yeah, I think there's still a barrier there. [MP 1]*
>
> *Yeah, there's an us and them sometimes. [MP 3]*
>
> *Yeah, very much. [MP 1]*

The medical students believed that an interprofessional approach to medical training would be the best way to address such issues.

> *The whole IPE thing has really only started like in recent years. And I think it's really good. [MP 3]*
>
> *It's brilliant, yeah. [MP 2]*
>
> *Really good. And I think for the years below us they should increase those sessions. [MP 3]*
>
> *But do you think they intend to? [MP 1]*
>
> *Because you need to know people's roles and remits and you don't know that until you have the time to try it out, like the sort of simulator things that we do, to know what a nurse actually can do and what's the boundary of her job and when we pick up after it, that's useful to know. [MP 3]*

5. DISCUSSION

This study has explored the nutritional needs of older people in a hospital environment from an educational perspective. Using a number of methods this study has drawn together the perspectives of older people, nursing and medical students, and those responsible for the delivery of the healthcare curriculum.

5.1 Issues in nutritional care as identified by older people

Appropriateness of Hospital Food

The interviews suggested that the majority of older patients had well established eating patterns prior to admission to hospital. Many also relied on family members or carers to provide their meals on a regular basis. The amount of hospital food was adequate for some of the patients however many felt that the portion size was too big to meet their needs. Similarly some older patients acknowledged that whilst there was a wide choice of food and snacks on offer they would have liked more freedom in terms of when and what they could eat. Comments from older patients indicated that they were reluctant to voice their concerns about the appropriateness of hospital food, despite the food available and timing of meals being different from their normal routines. It may be that older patients were hesitant to complain if their needs were not being met unless hospital staff specifically asked or were aware of particular dietary needs. There was also a sense that any dissatisfaction with hospital food was connected to the absence of personal choice/freedom during their hospital stay.

Quality of Hospital Food

Older patients who participated in interviews were fairly satisfied with the quality of hospital food. However few patients talked specifically about their enjoyment of the food or indeed aspects of hospital food they did not enjoy. This absence of commentary on the quality of hospital food may be due to a number of factors such as their illness, lack of appetite or unwillingness to make a fuss whilst in hospital.

Assistance with mealtimes

Comments from older patients reflected different needs in relation to assistance required during mealtimes. Overall older patients felt satisfied with the help provided during mealtimes in relation to accessing meals and utensils provided for meals. There were a small number of patients who had experienced difficulties when they had missed meals. Many of the older patients' comments indicated a reluctance to seek out assistance and a preference to be more independent and 'manage' mealtimes on their own. Furthermore patients who needed help expressed frustration at not being able to do things on their own and considered their needs an additional burden on hospital staff. Their comments would suggest that in terms of meeting patient's needs it may be that their needs should be more explicitly sought and facilitated in ways which recognise the desire of patients to retain some independence.

Family Involvement

Family and carers had a key role supplementing meals in the hospital by providing additional snacks such as fruit, biscuits and additional drinks. Family members and carers were also important in relation to the provision of meals prior to patients' admittance to hospital. Analyses of older patients' comments highlighted the importance of family members and carers in supporting older patients' mealtimes both in and outside hospital. In order to enhance the overall mealtime experience for older patients it may be appropriate to seek the advice of those family members and/or carers involved in the preparation of meals.

Professional Involvement

The interviews indicated that not all older patients were visited by a dietician during their hospital stay. There was also some confusion over whether some of the older patients had seen a dietician or if their weight was being monitored. Older patients spoke very positively about care provided by nursing staff as part of their overall hospital experience. The limited discussion around any interventions by hospital staff would suggest that older patients may not be fully aware of all the professionals involved in their care and of any follow up treatment related to their diet.

Overall Wellbeing

In general most of the older patients who participated in interviews felt that the food they were eating in hospital would help them get better and were positive about their eating experience in hospital. Many patients accepted that their eating experience was affected by their lack of appetite due to their illness and a variety of other reasons. However there was also an indication that older patients may be reluctant to voice any concern, preferring to fit in with hospital mealtime routines and menus.

Older patients overall wellbeing in relation to their eating experience highlights the difficulties in meeting the needs of older patients who have a diminished appetite and/or are in recovery from illness but are reluctant to speak up when their needs are not met or if they have concerns about their dietary requirements in hospital. In terms of meeting their needs hospital staff should engage in approaches to ensure a more positive eating experience in hospital such as increased monitoring of weight, greater inter-professional communication, notation of food consumed and discussions with family members/carers in addition to listening to older patients.

5.2 Nursing education for nutritional care

Although nutritional care of patients is assigned a high level of priority within the nursing curriculum, a limited amount of teaching time is devoted to the topic of the nutritional care of older people in a hospital setting. Nutrition and the older person is taught at institute 'B' within year 2 of the undergraduate nursing programme across a two hour session. The session provides an introduction to nutrition in older people and includes physical and psychological risk factors, nutritional requirements, deficiencies and related diseases. It focuses on malnutrition (including a definition, prevalence, causes, types and consequences), assessment of nutritional status, nutritional screening tools and nutritional supplements.

Various other aspects of nutritional care are incorporated into the curriculum at both institute 'A' and 'B'. At institution 'A' nutrition education is delivered within years 1 & 2 of the undergraduate nursing curriculum. 'Nutritional Aspects of Care' lectures, taught during year

1, include the psychosocial, cultural and politico-economic factors influencing food consumption and eating behaviours and function, source and use of nutrients in the diet. Students receive a further lecture which focuses on healthy eating guidelines, establishing good dietary patterns, recognising the effects of poor dietary intake on health and current strategies to support healthy eating and improve health status. The 'Nutrition Assessment in Practice' lecture taught in year 2 includes nutritional difficulties in the care setting, nurses' role in providing nutritional care and conducting a nutritional assessment. Students also gain practical experience of nutrition when they are asked to feed each other whilst blindfolded which teaches students what it is like to be dependent on another for food and drink.

At institute 'B' nutrition is taught using case studies (which students received in advance of the lecture) based around nutritional screening tools. Students are also taught about alternative feeding methods and related patient care. An additional session is used to teach the nutritional care of patients with diabetes and renal failure. This lecture includes management of these conditions and nutritional support and advice for patients. Nutrition education is delivered using a blended approach to learning, where students have on-line access to teaching material prior to the lecture and are required to prepare activities to discuss in class with feedback.

Students gain meaningful experience of nutrition theory on clinical placements. It is here that students interact directly with patients in a hospital or care setting. Clinical placements make up half (18months) of the three-year undergraduate nursing degree. During their placement each student is assigned a mentor who oversees, guides and assesses the student in regards to their ability to meet a range of nursing skills. It is here that students must demonstrate their ability to meet the 'Nutrition and Fluid Management' skills as set out in the NMC 'Essential Skills Clusters'. For example, students must show their ability to carry out a patient assessment on admission which includes recording the weight of the patient. Furthermore, they must demonstrate knowledge and understanding of a patient's nutritional requirements. They are assessed on their ability to undertake a nutritional assessment using a recognised risk assessment tool, to prepare food and fluids and feed a dependent patient. They must be able to monitor patient nutrition and fluid intake, undertake naso-gastric tube insertion aspiration. They are also expected to liaise with a dietician, and to show knowledge of polices and protocols in relation to alternative methods of feeding and fluid replacement.

Nutrition is incorporated into a limited number of specialist courses during post qualification nursing training. For example, whilst renal nursing would explore nutritional issues relevant to the renal patient, stroke nursing modules would focus on problems with swallowing. Nutrition also plays a small part in the post-graduate nursing courses in relation to older people. Although there have been a number of additional nursing short courses which provide training in regards to nutrition and/or the care of older people there has been little or no focus on the nutritional care of older people in a hospital setting. Furthermore, the numbers who receive additional specialist training is dependent on the numbers interested in taking up the course along with the continual provision of such courses from year to year.

The results suggest that nursing students are taught about nutrition in general and are expected to be able to apply their knowledge of nutritional care to older people as and when appropriate. Although it was assumed that the nursing students were largely able to do this, there were aspects of pre-registered training which the focus group data indicated could be improved. This included increasing the depth of knowledge of nutrition in relation to older people in the event of a dietician not being available. It would also be beneficial to increase the number of practical sessions in relation to the MUST tool and alternative methods of feeding. The results also indicated that nursing students would prefer a more direct and explicit approach to education in relation to nutrition and the older person instead of it being 'hid in other avenues'. For example, the focus group commented that whilst they were able to approach other professionals to seek their input on the nutritional care of older patients, they felt that their training did not explicitly promote this as a core skill.

The comments from older people suggested that those involved in their care must be able to possess a number of additional skills which are absent from teaching sessions relating to nutrition. For example, the results indicated that it would beneficial to patients if those involved in a their care were able to recognise and deal with a number of issues including: recognising when a patient is in distress or not happy with the food or drink; determining if patients would like to retain their independence during meals; understanding the eating habits of the patient prior to admission to hospital; and being able to involve the family in nutritional care. As suggested by the nursing key respondent, many of these issues can be addressed

through other aspects of training such as communication skills. However, it is essential that educators ensure and not assume that such skills are transferred to this environment.

An interprofessional approach to the nutritional care of older people also emerged as an important aspect of nursing training. The results of the study indicate that this aspect could be addressed by focusing on improving communication between different members of the hospital team, addressing cultural barriers among different professions and by including a broader range of specialists used to teach nursing students about potential nutritional issues among older people. The importance of interprofessional nursing education for the care of older people is recognised by the Department of Health (2001: 31) who stated that:

> Inter-professional curriculum development and shared learning, at both pre-registration and post-registration levels, could facilitate communication among the different professional groups responsible for the care of older people. Education should focus not only on courses for individuals, but also on the development of teamwork in practice.

The nursing key informant suggested that the nutritional care of older people could be embedded within a module devoted to the care of older people. Such a module may offer an opportunity to increase teaching time on the issues raised above. However, there are barriers to overcome before implementing such a module. For example, changes in the curriculum must not take teaching time away from other essential areas and must have NMC approval. Additionally, there is the potential of optional modules to provide undergraduate nursing students with skills in relation to the nutritional needs of older people in a hospital setting. There are obvious barriers to such an approach including lack of funding and the reliance on staff initiative to set up such modules. In addition, unless nutritional care of older people is offered as a core module not all students will have the opportunity to learn these skills. Nursing curriculum developers need to give fuller consideration to whether this area should be designated as core skills and made available to all.

Finally, there are organisational barriers within a hospital setting which could be adapted to facilitate students learning experience. Nursing students participating in the focus group

emphasised that it was often difficult during placements in a hospital setting to apply their knowledge of nutritional care to the care of older people. One of these barriers included catering difficulties. For example, the students recognised that the older patients enjoyed drinking orange juice but were only able to give them a small amount due to catering budgets. Additionally, students commented on the quality and appearance of pureed food. Other barriers included a medical rather than nutritional approach to health problems, lack of time to ensure patients were eating, conflict of nutritional care with other responsibilities, and a low priority for nutrition on the wards. According to Savage and Scott (2005), a possible contributor to these barriers is that whilst the Salmon Report (1996) suggested that housekeeping staff should be provided to help nurses to concentrate on their clinical responsibilities these recommendations never materialised. Instead NHS policies such as Protected Mealtimes and the appointment of 'Modern Matrons', whose roles include ensuring the patient's nutritional needs are met, have increased the expectation that nurses contribute to the nutritional care of patients. Therefore nurses are expected to have dual responsibilities, both clinical and daily care, which may conflict in a hospital setting. As a result, depending on hospital protocols nutritional care may be subordinated to other nursing priorities. Therefore both the NHS and university education need to work together to optimise learning opportunities for nursing students on placement.

5.3 Medical education for nutritional care

A limited amount of teaching time is devoted to the nutritional care of older people within the medical undergraduate curriculum. As part of the core syllabus students are taught about nutrition within the fourth year module devoted to medical aspects of ageing. Within this module, one hour is devoted to understanding how the nutritional effects of certain foods impact on the health of people in later life. Within this module, a small amount of time is also devoted to the effects of certain nutrients on bone disease.

Medical students learn about various other aspects of nutrition throughout their degree. The inclusion of nutrition education in the medical curriculum varies across each year and tends to be delivered in subject specific areas. Whilst there is no specific lecture devoted to nutrition during year one, nutrition is embedded within a variety of other compulsory modules. For

example, the functioning of carbohydrates, lipids, proteins and nucleic acids, vitamins and co-enzymes as influential factors in the functioning of genes and molecules are included in the course content. Students are also introduced to the Family Attachment Scheme in year one which requires students to be aware of the importance of health promotion in the community, which encompasses dietary intake. However, the emphasis within this scheme is communication skills and learning about the effects of a disease on both the patient and the family members. During year two students learn about obesity trends and the role of nutrients in growth, development and various diseases. In year three students are introduced to more specialized subject areas including cardiology, endocrinology and nephrology, all of which are linked to nutrition. However, there is no focus on nutrition in cardiology, a limited focus in nephrology and a small amount of teaching time devoted to paediatric diabetes in endocrinology.

The topic of nutrition is also included in some Student Selected Components (SSCs). Here, students are given the opportunity to learn about various issues in relation to nutrition. However, these modules are not compulsory and students must choose five SSCs during phases two and three of the curriculum. Those SSCs which focus on the topic of nutrition include D*iet and its Relationship to Colorectal Cancer*; *Contentious Issue in Nutrition*; *Exercise and Applied Physiology*; *Nutrition and Cancer Prevention* and; *Global Health: Global Health Issues*. Whilst the teaching time varies for each of the SSCs, students are also expected to dedicate forty-eight hours per semester to private study for each SSC. The numbers of students taking these courses range from five to twenty, therefore, not all newly qualified doctors will receive this training. Furthermore, SSCs depend on staff availability and student take-up. In the academic year 2009-10, two of these modules *Contentious Issues in Nutrition* and *Micronutrients in Health and Disease* did not run for such reasons.

Students are also required to prepare and present a project in phase five on an aspect of clinical medicine which is of interest to them. Over the course of five years three students chose to prepare a project on the topic of nutrition.

There are no immediate plans to increase the amount of teaching time devoted to the topic of nutritional care of older people in a hospital setting. There are a number of reasons to explain

this. First, the primary goal of the medical degree is to produce safe and competent foundation doctors and in order to satisfy this goal there may be little opportunity to prioritise nutrition over other essential skills. Second, there is an expectation that the specialist topics such as nutrition and older people are more appropriate at a postgraduate level. Unfortunately this study only examined the views of undergraduate medical students and thus further research would be required to examine the views of postgraduate medical trainees about their experiences and knowledge of nutritional care of older people.

The results of the focus group with undergraduate medical students suggested that they were not confident in their knowledge of the nutritional care of older people. There are two possible reasons for this. First there was a lack of clarity as far as the students were concerned about the scope of their responsibilities in relation to nutritional aspects of care. This may be a reflection of both limited practical experience and limited compulsory teaching time in relation to the nutritional care of older patients. The students felt that relatively little of their curriculum was concerned with nutrition particularly in relation to nutrition and older people and is not given high enough priority. The medical key respondent explained that students do not learn about various aspects of nutritional care as it is often deemed as out of the area of the medical curriculum. The results from the medical student focus group indicated that students rarely receive first hand experience of the nutritional care of older people in a hospital setting. On a simple, practical level this was because students were rarely on the wards during meal times. Increasing learning in a practical setting may be one answer to this problem.

Second, the medical students believed it to be unlikely that the topic of nutrition would be assessed in an examination at undergraduate level. As a result they felt that many medical students may perceive nutrition as a ‘soft subject’ or something which can be understood using ‘common sense’. The students stressed that they are examination driven and thus the time they spend studying the topic of nutrition in general falls lower on their list of priorities due to an already crowded curriculum. The importance of assessment cannot be ignored and medical educators cannot ignore the direction in which their choice of assessment drives students. If nutritional care of patients and elderly patients in particular is to be taken seriously then it needs a place in the curriculum and in practical skills assessments.

Another way to improve learning in this area would be by using an interprofessional approach. An interprofessional approach emerged throughout the course of the study as an important factor when considering the improvement of medical training in regards to the nutritional care of older people. This was also highlighted in the focus group with final year medical students. They stated that responsibility for the nutritional care of older people in a hospital setting should be 'shared' amongst the team. For example, medical students felt that their responsibility for nutritional care of older people was in conflict with other responsibilities on the ward. However, through better communication with other hospital staff the students felt that patient centred care would improve. Communication and interprofessional education were emphasised as an important factor in achieving this.

6. CONCLUSION

Using comments from older people in a hospital setting the study recommends that hospital staff should continue to encourage and progress practices which promote a positive eating experience such as increased monitoring of weight, notation of food consumed, greater inter-professional communication, and discussions with family members/carers in addition to listening to older patients.

The findings of this study suggest that the current amount of nursing and medical teaching time devoted *directly* to the topic of the nutritional care of *older people* in a hospital setting is minimal in Northern Ireland. Although medical and nursing students learn about various aspects of nutrition throughout their degree they indicated that they would prefer a greater focus on nutrition and older people in the curriculum using an interprofessional approach across a wide range of disciplines.

The study also indicated that certain hospital practices concerning the nutritional care of older patients could be adapted to facilitate students learning experience. Students encountered a number of problems when transferring their knowledge of nutrition to older people in a hospital setting. For nursing students, these included catering procedures, lack of time to ensure patients were eating, conflict of nutritional care with other responsibilities, a medical rather than nutritional approach to health problems and a low priority for nutrition on the wards. For the medical students, these difficulties included interprofessional barriers, conflict with other responsibilities on the wards and uncertainty in their role for nutritional care.

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