

The European view of hospital undernutrition

Beck, Anne Marie; Balknas, U; Camilo, M; Furst, P; Gentile, M; Hasunen, K; Jones, L; Jonkers-Schuitema, C; Keller, U; Melchior, J; Mikkelsen, Bent Egberg; Pavcic, M; Schauder, P; Sivonen, L; Zinck, O; Øien, H; Ovesen, L

Published in:
Nutrition in Clinical Practice

Publication date:
2003

Document Version
Early version, also known as pre-print

[Link to publication from Aalborg University](#)

Citation for published version (APA):

Beck, A. M., Balknas, U., Camilo, M., Furst, P., Gentile, M., Hasunen, K., Jones, L., Jonkers-Schuitema, C., Keller, U., Melchior, J., Mikkelsen, B. E., Pavcic, M., Schauder, P., Sivonen, L., Zinck, O., Øien, H., & Ovesen, L. (2003). The European view of hospital undernutrition. *Nutrition in Clinical Practice*, 18.

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal -

Take down policy

If you believe that this document breaches copyright please contact us at vbn@aub.aau.dk providing details, and we will remove access to the work immediately and investigate your claim.

Caring for Undernourished Patients in an Orthopaedic Setting

Atika Khalaf, Vanja Berggren and Albert Westergren

Nurs Ethics 2009 16: 5

DOI: 10.1177/0969733008097986

The online version of this article can be found at:

<http://nej.sagepub.com/content/16/1/5>

Published by:



<http://www.sagepublications.com>

Additional services and information for *Nursing Ethics* can be found at:

Email Alerts: <http://nej.sagepub.com/cgi/alerts>

Subscriptions: <http://nej.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations: <http://nej.sagepub.com/content/16/1/5.refs.html>

>> [Version of Record](#) - Dec 22, 2008

[What is This?](#)



CARING FOR UNDERNOURISHED PATIENTS IN AN ORTHOPAEDIC SETTING

Atika Khalaf, Vanja Berggren and Albert Westergren

Key words: ethics; experiences; nursing; nutrition; orthopaedic patients; undernourishment

This study elucidates the nursing of undernourished patients as experienced by eight registered clinical nurses and five nursing assistants by using content analysis. The participants' narratives describe the inner perspective of caring for undernourished patients, known in Sweden as 'the thin ones'. Categories identified were: frustration in nursing, joy in nursing and that undernourishment is taboo. The taboo was narrated as feelings of guilt and shame. Frustration in nursing could be seen as feeling stressed, exposed, lonely, powerless, helpless, and being torn between demands and needs. Joy in nursing was experienced when creating a trusting relationship, promoting pleasure in the meal situation and working with respect for each individual's life-style and context of life. Understanding staff members' views is important when implementing guidelines as well as in the teaching situation in order to identify where staff stand with regard to knowledge and attitudes.

Background

Undernourishment is a widespread problem in Swedish hospital care, affecting about 30% of patients.¹ There is presently ample knowledge of how undernourishment can be prevented and treated. However, little is known about staff attitudes to nursing undernourished patients.

The negative consequences of undernourishment caused the Council of Europe to adopt a resolution in 2003 with recommendations to Member States about nutritional management in hospitals.² This resolution means that all patients admitted to hospital should be screened for undernourishment, and that those with at-risk signs or manifest undernourishment should be further assessed. For optimum implementation of this type of recommendation, it would be valuable to know what staff attitudes are about caring for undernourished patients.²

The causes of undernourishment are complex and it is sometimes found that they are related to both individual and organizational factors.^{3,4} Results from a European

Address for correspondence: Albert Westergren, Kristianstad University College, SE-291 88 Kristianstad, Sweden. E-mail: albert.westergren@hkr.se

study⁵ showed multiple and complex reasons for undernourishment. These included a lack of clearly defined responsibilities, an absence or lack of sufficient education, inadequate knowledge about patients, lack of co-operation between different staff groups, and lack of involvement by hospital management personnel.⁵ In a Swedish study² the target group for administering a questionnaire included doctors, nurses and dietitians. Attitudes to and procedures for nutritional treatment in hospital care were studied in relation to the Council of Europe recommendations. Eighty-eight percent of the respondents said screening of nutritional status should be made on admission to hospital. Only 22% said that such screening was actually carried out on admission. The survey showed that Swedish hospital care does not follow the Council of Europe recommendations for nutritional treatment.²

Among elderly patients undergoing acute hospital care, those in orthopaedic wards have been shown to have the highest prevalence of undernourishment.⁶ In Sweden, falls are the most common cause for hospital care and are dominant among elderly people.⁷ Patients with hip fractures are most often elderly and frail.⁸ On admission to hospital, 56% of the patients with hip fractures were in the at-risk zone for undernourishment and this figure rose to 68% after 2–3 weeks.⁸ There is a lack of interview-based studies in orthopaedic settings focusing on nurses' experience of caring for undernourished patients. A deeper understanding of staff attitudes and experiences is important for the implementation of nutritional guidelines. It is also important for the identification of facilitating and hindering factors in nutritional care.

Aim

The purpose of this study was to explore nurses' and nursing assistants' experience of and ethical reflections on nutritional care for undernourished patients.

Method

In order to gather the respondents' experiences an inductive qualitative approach with an interview-based procedure was chosen,⁹ followed by content analysis.¹⁰

Context

At a hospital in southern Sweden having four orthopaedic wards, the ward used for this study specialized in caring for patients with leg and arm fractures. In 2006, a total of 809 admissions were registered on this ward, where approximately three nurses and six nursing assistants work during the day shift. The number of inpatients per day varies, but there are 22 beds and two spare beds in each ward. There are no local guidelines on how to handle nutrition on these wards.

Sample

A purposive sample¹¹ of respondents was selected in collaboration with a nurse specialized in nutrition. The sample consisted of registered clinical nurses ($n = 8$) and nursing assistants ($n = 5$) (Table 1).

Table 1 Respondents' demographic characteristics (*n* = 13)

Characteristic	No.
<i>Sex</i>	
Female	12
Male	1
<i>Age (years)</i>	
22–31	5
32–41	5
≥42	3
<i>Profession</i>	
Registered clinical nurse	8
Nursing assistant	5
<i>Total job experience (years)</i>	
0–10	8
11–20	3
≥21	2
<i>Job experience in current department (years)</i>	
0.5–5	11
≥6	2

Human participant protection

The study was approved by the orthopaedic ward's manager (January 2007) and by the ethics council of Kristianstad University (ER2006–56). The nurse with special expertise in nutrition selected and informed potential respondents about the study, both orally and in writing. All were contacted and given further information before finally consenting to participate. They received information about confidentiality and the possibility of withdrawing from the study, and that the interviews would be tape-recorded, encoded and kept separate from the identifying list.

Data collection

The study commenced with a pilot stage of three interviews. These were carried out in order to examine and develop the thematic areas that were to be the focus for the interviews.¹¹ The pilot interviews were followed by seven semistructured interviews, and three more interviews were undertaken in order to validate that no further variation or additional content came to light. All interviews took place in a quiet room on the ward; they were recorded and transcribed verbatim. All 13 interviews were included in the analysis and were the basis of the results.

Analysis

Latent content analysis was chosen in order to clarify deeper or latent meanings in the text.¹⁰ Both manifest and latent content analysis include an interpretation of the text material, although they vary with regard to interpretation depth and abstraction level.¹²

The texts were first read several times by all three authors in order to gain an overall understanding of the data. On the basis of this first naive reading, distinguishing

patterns emerged from the texts. These preliminary thoughts and reflections on the text content constituted the first results and were recorded in the margins and used throughout the remaining stages of the analysis. Step by step, the material was discussed and analysed, keeping the aim of the study in mind. 'Meaning units' were then identified and those with similar content were organized into specific areas, again keeping the study aim in focus. The meaning units were checked and analysed critically on the basis of their manifest and latent content. Comparisons were made with respect to similarities and differences to obtain a deeper understanding of the underlying text for the latent content analysis. The meaning units were condensed; that is, the sentences were shortened while preserving the core.¹⁰ Subcategories were created to enable sorting of the analysed material. In the last stage, the subcategories were linked together into three main categories that expressed the latent content. After each reading, the three researchers came together and compared their individual analyses.¹³

Results

The respondents' narratives were very extensive, and several patterns of their experiences of undernourishment and ethics in orthopaedic care in Sweden were identified. These experiences fell into three main categories: to be frustrated in nursing; to experience joy in nursing; and that undernourishment is taboo. Internal variations were identified as subcategories (Table 2).

In the narratives, an undernourished patient was generally portrayed as 'the thin one', for example: 'low-fat endowed, thin, undernourished', 'a very thin lady', 'dehydrated thin and eats poorly', and 'they are like small baby birds'. Three different kinds of patients were described in the narratives with regard to prognosis and treatment: healthy younger patients; previously healthy older patients with or without a DNR (do not resuscitate) order; and patients receiving palliative care. A decision for DNR is taken in consultation with the patient and/or relatives. The respondents often reflected on their actions and decisions in relation to how they would like to be treated themselves in similar situations. In all the narratives, it emerged that it is not easy to weigh patients on arrival in the ward because of mobility limitations related to the fractures.

Table 2 Nursing staff's experiences of care for undernourished patients on an orthopaedic ward

Category	Subcategory
<i>To be frustrated in nursing</i>	Organization-related stress To be exposed and lonely Experience of powerlessness and helplessness Experience of being torn between demands and needs
<i>To experience joy in nursing</i>	Create a trustful relationship Promote pleasure in the meal situation Respect for each individual's life-style and context of life
<i>Undernourishment is taboo</i>	Experience of guilt

To be frustrated in nursing

Many of the narratives described work situations in which frustration was experienced. This was expressed differently, depending on whether problems were related to the organization, co-operation with other staff, or the patient. Shortcomings in the organization were associated with the experience of stress. Poor co-operation was portrayed as experiencing being helpless and powerless. Similar experiences of powerlessness or helplessness were also described in relation to patients. Ethical conflict in nursing caused feelings of being unable to make decisions.

Organization-related stress

A central issue in all narratives was the experience of stress. This was associated with organizational factors. A well-functioning organization was experienced as facilitating care for patients' nutrition. It seemed to be easier to accept and to explain responsibility when the staff could relate their actions to clear guidelines that were followed by all staff. When there were no guidelines for responsibility, certain basic nursing aspects could fail. The result was described as inefficiency when some of the staff worked in their own ways and did not follow guidelines.

Perhaps you overlook that this patient needs some additional monitoring during meal-times ... you expect that the patient will eat alone and it turns out later that the patient hadn't eaten anything, and then [pause] you take away the tray and go on without asking why she had not eaten.

Some respondents thought that much is done on an organizational level regarding nutrition for 'thin' patients, and that it is the staff's responsibility and obligation to keep their knowledge updated regarding nutrition.

It emerged in the narratives that there was often a focus mainly on the 'broken bone' or the urgent trauma, and that nutrition was forgotten before the operation, while pain and mobilization were the focus after surgery.

The broken leg was primarily the focus, and then the nutrition aspects could perhaps be forgotten ... they will be up on their feet the day after in order to be mobilized, so that they can be discharged within a week and then perhaps one does not get so far with nutrition.

Waiting for surgery did not make patients' nutritional status any better, particularly when they already had a poor starting point nutritionally. Several respondents described how patients could wait and fast with only an incomplete intravenous infusion for up to three or four days while waiting for surgery.

There was often a need for nutritional follow up when patients went home but links to organizations to implement this were lacking. The poor follow up of undernourished patients' nutrition after discharge home was often experienced as a worry for the respondents, but not an obstacle to good nursing on the ward. At the same time, some said that the organization lacked competent assistance from a dietician.

When patients are thin and undernourished, we give them lots of energy food here, and then they go home and we know that it goes back to the same with nutrition ... I wish

that it would be easier, that one could do follow ups on thin patients after they go home, because I know that I cannot really keep in touch.

Most participants experienced that the short hospital stay hampered optimal nutritional nursing ('I can never expect to get the patients well nourished during the short time they are here') so the stress and the lack of time related to understaffing was regarded as the main reason why they felt frustrated and lacking in their care.

If there is overcrowding, one has no time, feels stressed, and then has to give priority to things. But if I do not have time to do something, I must ensure that it gets done ... but the stress may not interfere as much as the lack of responsibility.

Other respondents expressed that on certain days several patients may need help with feeding, which caused them to feel stressed.

To be exposed and lonely

Experiences of loneliness were common in relation to inadequate co-operation or because it was difficult to change old habits. Most respondents felt that nurses were mainly responsible for the care of orthopaedic patients' nutritional needs. They described a feeling of loneliness and abandonment due to the lack of support from other colleagues.

By accepting help from others in the ward, you avoid this feeling of despondency of 'I just do not have the energy' because you must of course help each other.

Some lacked help from colleagues from other professions.

Aggravating factors for nursing have to do with the routines we have and how it works between me and other professionals, mainly doctors and nursing assistants.

Other participants indicated that most colleagues had an understanding of each other's duties.

The respondents said that they sometimes made proposals on how patients' nutritional status could be improved but, for various reasons, they were not met with enthusiasm.

The nursing assistants tried to order chocolate pudding and ice-cream ... but when they came back for the next shift, the pudding and the ice-cream were finished and it was perhaps not only the patients who had eaten them.

Experience of powerlessness and helplessness

Powerlessness and helplessness were described in relation to the patients. All the respondents shared the experience that most patients on the orthopaedic ward were older and that they did not recover completely after surgery. It also emerged that age and incomplete recovery, and the patients' other medical conditions and social situation before arrival at the hospital, contributed to the development of undernourishment.

A crucial factor in the narratives was that the patients' own wishes should be the starting point for all nutritional intervention. At the same time, a feeling of helplessness arose when patients' wishes contradicted the staff's desire to help them through their illness towards recovery.

If a patient does not want to eat, you have to respect that. It is the patients who make a choice; you cannot force the patients to do something they do not want to do. It is ethical for me to accept what the patient wants.

Nursing care became complicated when a patient did not want to collaborate. The staff could however coax patients instead of forcing them to eat.

You can never force patients to do something, but you can coax them and try to persuade them, and come up with some good reasons why they should eat.

Patients who could communicate more easily and were physically active were more manageable. However, patients with DNR orders, and those who were confused or had dementia, were three groups whose nutrition caused difficult ethical dilemmas because the staff believed that patients have the right to make their own decisions.

DNR to me means that one does not do anything; no measures are taken in case of cardiac arrest. It is not palliative care, but it is of course important that they get nourishment, but if they do not want to eat then I cannot force them.

Experience of being torn between demands and needs

Linked to loneliness and powerlessness was the difficulty encountered when conflict arose between the staff's wish to fulfil their nursing duty to meet patients' need for good nutritional status and the desire to let patients decide.

Most often, the patient agrees to eat something anyway. I have never experienced that someone has totally refused food without being really sick, but certainly, sometimes it feels like one forces it on them [pause] even though they actually do not want to eat.

Many respondents considered patients' wishes to be the starting point for all nursing work regarding nutrition.

Ethical problems in nursing caused a feeling of being torn between implicit or explicit demands expressed by different people.

A thin woman is weak and so it is easier to listen to stronger relatives. But even though you have to bear in mind that it is up to the individual lying there, and that she still has her own thoughts, feelings and desires, you actually need to go back to yourself and think: 'How would I like to be treated?' You should listen to the patient, that's what you want of course. Even though one becomes old and frail, one still has a lot inside that is important and worthy. But this is of course very difficult. When you work in health care, you want to care for and help others. That can be done in many different ways. It may be that it would be best to care for her inner needs, what is best for her.

The difficult situation mentioned above often led to delayed decisions because not all decisions could be made by the lead nurse; it had to be discussed with colleagues from other professions first.

We have had a patient who needed tube feeding, but it took three weeks before he got it. I still believe that it is not the nurses and nursing assistants on the ward who can and should prescribe tube feeding and parenteral nutrition.

To experience joy in nursing

In the narratives it emerged that nursing care was often carried out with joy when the staff felt less stressed and had the possibility to create a trustful relationship with patients, promote pleasure in the meal situation and work with respect for each one's life and situation.

Create a trustful relationship

The narratives contained rich descriptions that trust in the staff created a safer environment for patients. All respondents had an understanding of patients' situation when they were not motivated to eat. This situation could therefore be helped when someone else assisted them when it was difficult with a particular member of staff. It also emerged that if patients trusted the staff's knowledge, then nurses could be given the authority to influence patients' situation.

You have great power to influence. They do what we tell them to do ... in a positive way, so these small ladies who have never eaten, eat like they never did before ... because they know that we know what we are doing.

A few respondents experienced that it was easier to reach certain patients if staff were determined and reliable, while others thought that nursing became easier when the 'chemistry' worked between patients and staff. The respondents described that they could not build a relationship with all patients. Patients noticed if nurses only did their job or if they did it with joy and passion.

Patients cannot trust those who are unable to create an environment that makes patients feel at ease. They know that you care, that you are not just doing your job.

Promote pleasure in the meal situation

Despite the lack of time and the experience of stress, many respondents stated that it is very important to create a pleasant meal situation that stimulates the 'thin' patients to eat and thus achieve good nutritional status.

I think it is important that you take it easy when you eat and that you give yourself time and sit down with the patient and talk a little and make the meal a pleasant experience, and that you do not only focus on the need for the patient to eat a certain amount so that it almost becomes a demand on the patient. Instead, you try to create a pleasant atmosphere and get the patient to eat as much food as possible.

Several respondents emphasized the importance of aesthetic values in a meal to make it easier and more pleasant for patients to eat.

When you come in with a tray, it needs to look good, because 'you eat with the eyes' too. You lay the table nicely and you don't just throw the cutlery down, but you place them neatly on the napkin.

One statement also contained reflections on older patients' loneliness at home and whether that could diminish their appetite.

I think that old people are very lonely. They sit alone and only eat in order to eat. I do not think this is much fun, because they should eat in order to enjoy the food.

Several respondents experienced that there were cultural differences concerning food that would be important to consider, for instance ordering special food for those who are vegetarians.

Other factors were to ensure that patients are free of pain before mealtimes and were sitting comfortably at the table.

Respect for each individual's life-style and context of life

It emerged from the narratives that a sign of respect for an individual's needs was to see the people in the present situation in their lives. Comments to the effect that 'life takes its toll' (in Swedish: 'Åldern tar ut sin rätt') and 'many older patients had perhaps eaten poorly all their life' were used in order to reflect on an individual patient's present life. The respondents commented on the large portions that were offered to patients. They also believed that patients became stressed over the documentation of fluid and food intake.

We work with our fluid charts and patients get stressed by the fact that each little millilitre they drink is documented. I believe that they get stressed over this and feel pressure to eat.

The combination of loneliness and attitude to food, as well as age, could be contributing factors to undernourishment.

The mere fact that they are older perhaps means that they become undernourished. When they are at home, they do not have the energy to stand and prepare food, do not have the energy to go out shopping for the same reason, and do not think of their mealtimes in the same way either ... and then I believe it has a lot to do with their attitude; they are old, so they think they can eat what they want.

Undernourishment is taboo

The respondents said that undernourishment did not develop or occur on the ward. Such statements indicated that patients were often undernourished or at risk of undernourishment before they were admitted. Experiences of guilt and feelings of self-accusation were expressed, often leading to a denial of the existence of an

undernourishment problem, or at least a projection of the problem to other settings. These denials stem from ethical tension between patients' needs and demands to keep patients well nourished.

Experiences of guilt

The narratives indicated that the occurrence of undernourishment on the ward was seen as shameful, and that the staff could be blamed for it.

Nobody wants to talk about it. It is only when there are very clear cases, such as when an extremely thin patient is admitted ... but it is probably only obvious cases that get noticed.

A few respondents saw patients' age and disease as reasons why they became undernourished on the ward or emphasized that undernourishment on the ward was a rare problem.

Most patients eat what they should. It is not common that they are undernourished, and most often they are undernourished already when they are admitted.

Various experiences of guilt and accusation were made in care situations when different requirements and needs stood against each other.

Then I feel guilty (pause) for having contributed to continued malnutrition, and it does not really feel ethically correct for me, but it is not ethically correct to force feed either.

The respondents meant that undernourishment did not develop during a patient's stay in the hospital. Instead, the worst that could happen was that the patient could end up in a vicious circle.

They do not stay here long enough to enable us to notice a fatal weight loss, at least regarding their appearance, as we do not weigh them, but they can of course end up in a vicious circle here.

Another ethical problem that worsened the staff's guilt feelings was that they were in between patients' wishes and relatives' expectations.

The relatives see that they languish more and more. It is difficult to explain, but we cannot force feed them.

There were strong moral viewpoints in relation to the development of undernourishment on the ward.

I think that if a patient has been admitted and has not been undernourished, but becomes undernourished on an orthopaedic ward, I think that is scandalous.

I think that people should never have to starve to death, I think it is most unethical ... it sounds absolutely terrible that people become undernourished in hospital.

Discussion

When the respondents defined or put into words what undernourishment meant, they often used the expression 'the thin ones'. However, it is important to be aware that thin people may also be well nourished, for example, if they have had a thin or low-fat body composition for their entire lives. Even a person who is overweight can be undernourished.

The different values of nutrition

The nursing staff lacked security in their work with patients' nutrition, which in turn had lower priority than other nursing tasks because the staff knew that their initiatives were not followed up by someone with specialist nutrition skills. In the main category 'to feel frustrated in nursing', it was obvious that the respondents experienced stress and feelings of loneliness and powerlessness in their daily work, resulting in feelings of frustration. In the subcategory 'organization-related stress', respondents expressed feelings of helplessness and abandonment when there were no links to an organization for further follow up of patients' nutritional status after discharge from hospital. Johansson *et al.*² emphasized the importance of collaboration between different professionals to combine medical, nursing and nutritional issues and make them an operational entity. Follow up should ideally be carried out by a dietician attached to the orthopaedic ward or the municipality, but no such contacts were made during the study.

Besides food intake, the ambience of a meal is also important. Studies^{14,15} have shown that nutrition is an important part of both nursing and medical treatment, and they stress the importance of observing the eating process. In Furåker's study¹⁶ staff spent less than half of their work time in direct contact with patients and organizational factors influenced this time. Other studies¹⁷⁻²¹ have shown that education is the most important factor that can motivate staff to introduce new procedures caring for undernourished patients and make it easier to detect those in the at-risk zone.

Respect for the patient's autonomy

The respondents in this study emphasized the need to respect patients' wishes. This perspective was prioritized over the requirement to meet patients' need for a good nutritional status and was described by the subcategory 'an experience of being torn between demands and needs', which can apply to ethical dilemmas connected to nutritional care. The narratives reflected the need for both a biomedical perspective and a humanistic approach to decision making. Wulff and Götzsche²² concluded that human nature has two sides, which must both be taken into account during the clinical decision-making process. The biomedical perspective is built on a theoretical component and empirical component. The humanistic perspective is a combination of empirical-hermeneutic and ethical components. Several of these components were highlighted in the present study. When respondents expressed a desire to fulfil their nursing tasks (i.e. to ensure that patients had a good nutritional status) this reflected the biomedical and theoretical components. A desire to respect patients' wishes reflects the humanistic and ethical components. According to Wulff and Götzsche,²²

today's western cultures are characterized by the idea that people are autonomous individuals in that they are able to make moral choices and act in accordance with these choices. This means that patients not only expect to receive the correct treatments but also esteem, respect and loving care.

When nursing staff's desires to provide good nursing care stand against patients' wishes to decline the care offered, tensions arise and the staff feel they are split between various needs and demands, as demonstrated in the results. The experience of incongruity can be seen as a description of the staff's feeling of being in the middle of an ethical dilemma. This is seen as an imbalance between the biomedical and humanistic perspectives in clinical decision making, for example, between 'no patient is allowed to become undernourished' and 'the patient does not want to live any more'. Autonomy demands that all people have an obligation to respect each other's decisions.²³ In this study good care meant to respect patients' wishes, even at the cost of a deteriorating nutritional status. Thus, autonomy was prioritized before other ethical principles.

Denying undernourishment

In this study, the respondents said indirectly that undernourishment is taboo and causes them feelings of guilt, shame and denial. They thought that undernourishment was not common among the patients on the ward. They believed that most of the affected patients had already been either in the at-risk category for undernourishment before admission or became undernourished owing to old age, morbidity and surgery, or a combination of these factors. Other studies have confirmed the nurse participants' reflections about what may cause patients to become undernourished.^{8,24,25} There are, however, no studies that can directly support a statement that the occurrence of undernourishment on a ward is taboo and linked to feelings of guilt and shame. Further research on this matter is important in order to understand better and to come closer to the nursing staff's experiences of nutritional care. If nursing staff tend to underestimate, or even deny, the occurrence of undernourishment on their own unit, it may be difficult to motivate them to attend training and other initiatives that aim to change existing nutritional practices.

Joy in nursing

In the main category 'to experience joy in nursing' it was seen that the respondents could experience joy in many ways, such as by promoting a pleasant atmosphere around food, creating a trustful relationship with patients and working with consideration for individual patients' present situation. A literature search of relevant scientific databases yielded only one study²⁶ that explicitly concerned nursing staff's experience of joy in nursing. Factors similar to those identified in the present study could contribute to experiences of joy and satisfaction in nursing work. For example, creating a good relationship with patients engenders feelings of joy and satisfaction,²⁶ and joy is important in creating a pleasant and aesthetically appealing mealtime ambience.^{27,28} Joy in nursing is an important issue for further research in order to stimulate nursing personnel to carry out their duties with passion and desire.

Conclusion

On the basis of the results, various explanations can be found regarding reasons for the development of undernourishment and for the failure to follow existing guidelines for screening patients' nutritional status. Explanations such as organization-related stress, a lack of joy in nursing, and denial of the existence of undernourishment on the ward were revealed. Understanding insiders' views is imperative when implementing guidelines for care, as well as in teaching situations, where it is important to establish rapport with staff in relation to their knowledge and attitudes.

Standards of nursing care will benefit from acknowledging the results of this study, which show that patients need to be seen, met, supported and respected by the health care system on an individual level and in their own life situation. On an organizational level, collaboration concerning nutrition among different groups of health care staff should be prioritized.

Limitation

It should be kept in mind that this study addressed the issue under discussion on one ward in one hospital, and that individuals will have their own levels of competence and morality.

Declaration of interest

The third author (Albert Westergren) is supported by the Swedish Research Council and the Skane County Council's Research and Development Foundation.

Atika Khalaf, University Hospital, Malmö, Sweden.

Vanja Berggren and Albert Westergren, Kristianstad University College, Kristianstad, Sweden.

References

- ¹ Socialstyrelsen. (National Board of Health and Welfare.) Nutritional treatment must be on a par with other medical treatment. (*Nutritional treatment must be on a par with other medical treatment.*) *Läkartidningen* 2001; **98**: 4724–25 (in Swedish).
- ² Johansson U, Larsson J, Rothenberg E, Stene C, Unosson M. Svenska sjukhus klarar inte Europarådets riktlinjer. (Swedish hospitals do not meet European Council guidelines.) *Läkartidningen* 2006; **103**: 1718–24 (in Swedish).
- ³ Beck AM, Balknäs UN, Camilo ME *et al.* The European view of hospital undernutrition. *Nutr Clin Pract* 2003; **18**: 247–49.
- ⁴ Saletti A. *Kommunernas kost- och nutritionsarbete. (Dietary and nutritional work in Swedish municipalities.)* Stockholm: Socialstyrelsen (National Board of Health and Welfare), 2003 (in Swedish).
- ⁵ Beck AM, Balknäs UN, Furst P *et al.* Food and nutritional care in hospitals: how to prevent undernutrition; report and guidelines from the Council of Europe. *Clin Nutr* 2001; **20**: 455–60.

- ⁶ Allan DJ. Adding food for thought. Structuring nutritional support for elderly trauma patients. *Prof Nurse* 1993; **8**: 632–37.
- ⁷ Socialstyrelsen. (National Board of Health and Welfare.) *Fallolyckor vanligaste orsaken till vård. (Falls are the most common accidents requiring health care.)* Stockholm: Socialstyrelsen, 2004 (in Swedish).
- ⁸ Nematy M, Hickson M, Brynes AE, Ruxton CHS, Frost GS. Vulnerable patients with a fractured neck of femur: nutritional status and support in hospital. *J Hum Nutr Diet* 2006; **19**: 209–18.
- ⁹ Svensson PG, Starrin B. *Kvalitativa studier i teori och praktik. (Qualitative studies in theory and practice.)* Lund: Studentlitteratur, 1996 (in Swedish).
- ¹⁰ Berg BL. *Qualitative research methods for social sciences.* New York: Allyn and Bacon, 2001.
- ¹¹ Polit D, Beck CT, Hungler BP. *Essentials of nursing research methods, appraisal, and utilization.* Philadelphia, PA: Lippincott, 2006.
- ¹² Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2003; **24**: 105–12.
- ¹³ Kvale S. *Den kvalitativa forskningsintervjun. (The qualitative scientific interview.)* Lund: Studentlitteratur, 1997 (in Swedish).
- ¹⁴ Mowe M, Bosaeus I, Rasmussen HH, Kondrup J, Unosson M, Irtun O. Nutritional routines and attitudes among doctors and nurses in Scandinavia: a questionnaire based survey. *Clin Nutr* 2005; **25**: 524–32.
- ¹⁵ Westergren A, Unosson M, Ohlsson O, Lorefält B, Hallberg IR. Eating difficulties, assisted eating and nutritional status in elderly (> or = 65 years) patients in hospital rehabilitation. *Int J Nurs Stud* 2002; **39**: 341–51.
- ¹⁶ Furåker C. Direkt omvårdnad mindre än hälften av arbetet. (Nurses' everyday activities in hospital care.) *Vårdfacket* 2006; **10**: 63–64 (in Swedish).
- ¹⁷ Rasmussen H, Kondrup J, Staun M, Ladefoged K, Kristensen H, Wengler A. Prevalence of patients at nutritional risk in Danish hospitals. *Clin Nutr* 2004; **23**: 1009–15.
- ¹⁸ Bruun LJ, Bosaeus I, Bergstad I, Nygaard K. Prevalence of malnutrition in surgical patients: evaluation of nutritional support and documentation. *Clin Nutr* 1999; **18**: 141–47.
- ¹⁹ Sanchez LAM, Moreno-Torres HR, Perez CAJ, Orduna ER, Medina T, Lopez MC. Malnutrition prevalence in patients admitted to a rehabilitation and orthopaedic surgery hospital. *Nutr Hosp* 2005; **20**: 121–30.
- ²⁰ Hallström I, Elander G. A comparison of patient needs as ranked by patients and nurses. *Scand J Caring Sci* 2001; **15**: 228–34.
- ²¹ Hallström I, Elander G, Rooke L. Pain and nutrition as experienced by patients with hip fracture. *J Clin Nurs* 2000; **9**: 639–46.
- ²² Wulff HR, Götzsche PC. *Den kliniska beslutsprocessen. (The clinical decision process.)* Lund: Studentlitteratur, 2000 (in Swedish).
- ²³ Beauchamp TL, Childress JF. *Principles of biomedical ethics*, fourth edition. New York: Oxford University Press, 1994.
- ²⁴ Eiman M. *Kvalitetsutveckling avseende nutrition vid Ortopediska kliniken. (Quality development of nutrition at the orthopaedic clinic.)* Malmö Universitets-sjukhuset MAS, 2005 (in Swedish).
- ²⁵ Chen CC, Schilling LS, Lyder CH. A concept analysis of malnutrition in the elderly. *J Adv Nurs* 2001; **36**: 131–42.
- ²⁶ Jackson C. The experience of a good day: a phenomenological study to explain a good day as experienced by a newly qualified RN. *Accid Emerg Nurs* 2005; **13**: 110–21.
- ²⁷ Pfeiffer NA, Rogers DA, Roseman MR, Jarema LC, Reimann A, Combs-Jones D. What's new in long-term dining? *N C Med J* 2005; **66**: 287–91.
- ²⁸ Gustafsson K, Sidenvall B. Food-related health perceptions and food habits among older women. *J Adv Nurs* 2002; **39**: 164–73.