FAGFELLEVURDERT RESEARCH

Interaction between nurses and doctors is important for the nutritional status of nursing home patients

For nurses to be able to attend to their patients' nutritional status in the best possible way, they need a regular nursing home do ctor who knows the nutritional wishes and needs of individual patients.

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SAMMENDRAG

Background: The nutritional work carried out in nursing homes constitutes necessary and important health care. In many nursing homes, the nutritional work forms part of a collaborative procedure that involves a number of disciplinary groups and professionals. Research and monitoring have found that between 20 and 60 per cent of patients in nursing homes are undernourished.

Objective: The study examines how nurses interact with the nursing home doctor. This topic has received little attention in research.

Method: The study has a qualitative design and involves the analysis of focus group interviews with nurses whose duties include hands-on patient care. The analysis is based on Malterud's approach to analysing data, involving the reading of the text as a whole, meaning units, categorisation and abstraction before the findings are summarised.

Results: The level of cooperation between nurses and the nursing home doctor impacts significantly on the nutritional work carried out in nursing homes. Patients and their relatives are reassured when the nursing home doctor raises the subject of nutrition on admission, informs them of expected developments and is familiar with the patient's wishes and needs. Similarly, nurses need a nursing home doctor who knows the nutritional wishes and needs of individual patients, and who checks up on the nutritional work on the ward.

Conclusion: The experiences of the nursing home nurses suggest that collaboration with the nursing home doctor is an important factor for the institution's nutritional work. Good cooperation promotes medically sound nutritional treatment of nursing home patients.

The provision of medically sound nutritional treatment requires competence and follow-up on all levels within the health and care service (1). In the primary health service, we are currently witnessing a major re-structuring process which focuses on multi-disciplinary initiatives and flexible job descriptions.

While patient safety is accentuated, rationalisation and cost-cutting initiatives are intended to provide good health services for the benefit of the general population (2, 3). Local authorities invest in quality-improvement packages and evidence-based practices are prioritised in nursing homes.

Patients in nursing homes are elderly and their clinical situation is often complex. Most patients need help to have their basic needs fulfilled, including their nutritional needs (4, 5). The nutritional work carried out in nursing homes therefore constitutes health care that is both necessary and important.

> **«Most patients need help to have their basic needs fulfilled, including their nutritional needs.»**

There is a link between functional capability and health, and people's nutritional status is closely associated with their functional capability (6, 7). Research and monitoring have exposed shortcomings in routines for identifying and following up undernourished patients in hospitals as well as in nursing homes (1, 8).

Nutritional work in nursing homes

In many nursing homes, nutritional work is carried out in collaboration between several disciplinary groups and professionals (9). The nursing home doctor has the overall responsibility for the medical examination, diagnosis and treatment, while the nurses are responsible for implementing initiatives and ensuring that the patients' intake of food and drink is sufficient (9). The nursing home doctor is responsible for the patients' medical care but often has no supervisory function in relation to the nursing home (10).

The nature of the interaction between the nursing staff and the doctor will therefore impact on patient safety. The Norwegian Directorate of Health points out that good interaction among the parties involved is required for nursing home patients to have their nutritional needs fulfilled (9). The exact group of people and disciplines involved at each nursing home may vary with the size of the home and the patient's needs.

The study's objective

Having conducted searches in SveMed+, PubMed and CINAHL, we found no articles that discussed the cooperation between doctors and nurses with respect to nutritional work carried out in nursing homes.

Consequently, this article highlights the role of the doctor in the nutritional work carried out in nursing homes. We approached our data material with the following question in mind: ‘How do nurses perceive the nursing home doctor’s role with respect to the nutritional work?’

Method

The study has a qualitative design and involves an analysis of focus group interviews. We chose focus groups because they allow the participants’ experiences to be shared and discussed. This type of interview encourages different views, attitudes and perspectives that shed light on how nurses perceive their day-to-day experiences in nursing homes (11).

Sample and situation

We recruited our informants by contacting the management of the nursing homes, who in turn selected appropriate candidates. The inclusion criteria were defined as nurses whose duties included hands-on patient care, and who had at least three years’ experience of nursing for residents with a dementia diagnosis.

A total of 15 nurses from seven nursing homes in four different counties took part. The informants had between four and 25 years of nursing experience from nursing homes, and we conducted four focus group interviews. We chose to have three to four participants per group in order to encourage them to expand on their viewpoints.

Data collection

The interviews were conducted in the autumn of 2013. The main question was as follows:

‘Talk about episodes or experiences and ethical dilemmas you have encountered in your work with undernourished residents in nursing homes’.

The interviewer was specifically tasked with presenting the purpose of the interview and promoting positive group dynamics and interactions among the participants during the interview (12).

We took an open-ended approach because we wanted to explore the informants' personal experiences and thoughts regarding the nutritional work carried out in nursing homes. We made use of follow-up questions and sentence repetition to clarify and verify statements. The duration of interviews was between 55 and 110 minutes. All interviews were recorded on tape and transcribed verbatim.

Data analysis

The analysis is based on Malterud's (12) approach to analysing data material, which in turn is a modified version of Giorgi's (13) phenomenological analysis. We started by individually reading the whole material to gain an overview, before we went on to look for meaning units that were later categorised by allocating codes. We worked together on the coding and the content abstraction before synthesising the significance of our findings (11).

The interview focused on ethical dilemmas encountered in relation to nutritional work. In the course of this exercise, the doctor's role in the collaboration with the nurses clearly emerged. Against this background, we conducted a secondary analysis of the material in order to gain a deeper understanding of the nurses' perception of the role played by the doctor with respect to nutritional work.

Ethical considerations

All participants received written and verbal information about the study and its objective. We emphasised the fact that participation was voluntary, and that the participants could withdraw from the study at any time. All information in the transcribed material has been anonymised, and the informants were given fictitious names. The study has been approved by the Norwegian Centre for Research Data (NSD).

Results

Three of the findings that were key to our analysis could all be related to the role played by the nursing home doctor with respect to nutritional work: the doctor's contact with the patients, with the nursing staff, and with the patient's family. Translated quotes from the interviews have been put in quotation marks.

Contact with patients

The nurses described their nutritional work in nursing homes as demanding. It was particularly challenging when patients lost weight or refused to eat. The informants talked about patients who had lost their appetite, a shortage of staff at mealtimes, limited nutritional knowledge and inadequate documentation. Some of them also talked about insufficient follow-up of the patients' nutritional needs, and they felt that the quality of the nutritional work was unsatisfactory.

The nursing home doctor's knowledge of the individual patient was important. The informants stressed the significance of the nursing home doctor working in partnership with the ward by familiarising themselves with the patients' situation and ascertaining and following up their nutritional status:

'She [the doctor] doesn't look at things merely from the medical perspective, it's as if she is looking more to people's overall situation.'

This approach might appear to be obvious, but in order to interact with patients, doctors would have to familiarise themselves with and listen to patients individually. At two of the nursing homes, the nutritional situation was routinely discussed with the doctor during the admission interview with the patient.

This made it easier to form a picture of the patients' relationship with food and their wishes and needs at later stages. Sometimes the nurses found that the doctor was more interested in the patient's medication list than in their nutritional status and overall situation.

Patients listen more to the doctor

Whenever the nursing home doctor discussed the nutritional situation with the patient, the informants felt that patients would listen more carefully to the doctor's recommendations than to their own. The doctor's say-so was perceived to be 'more important' than the nurses' say-so. This meant it was essential for the doctor to know patients well and to be able to relate to them with ease.

Several informants mentioned that the follow-up of patients was much better if there was a regular doctor who knew the individual patients. Moreover, it was important for the doctor to enjoy talking to elderly people. One of them said:

'So it's important that we have a doctor who is regular, who enjoys talking to the elderly, [who] sort of takes pleasure in it, and when that's not the case, then things are difficult.'

The difficulties often arose when the patients lost weight or stopped eating, or when their condition was noticeably deteriorating. Several informants described situations where hospitalisation could have been avoided if the doctor who had been called had been better acquainted with the patient.

Familiarisation with the patients' wishes and needs

The informants gave examples suggesting that the annual medication review should involve more than merely reviewing and monitoring the patient's medication list. Doctors should be willing to take the time to familiarise themselves with the patient's wishes and needs. Doctors who asked to see patients to talk to them, were given a completely different insight into their life situation than doctors who restricted themselves to a medication review in the staff duty room:

'We have introduced a medication review, and at that point we review the overall health situation. […] Both the nurse and the doctor talk to the patient and the family, and they [the patient and the family] talk about all sorts of things, and they bring up the question of how things will progress even at that stage.'

Just over half the nurses found that doctors were well informed about patients. Doctors in small nursing homes did not necessarily know their patients better than doctors in large nursing homes; it was more a matter of personal interest and continuity than nursing home size.

Collegial cooperation

The nurses considered the nursing home doctor to be an important fellow contributor to the institution's nutritional work. In several focus groups, the nursing home doctor was described as a good collaborative partner, both in terms of assessing the patient's nutritional situation and in terms of implementing nutritional initiatives:

'I think our doctor is really good, she is so nice, ascertains that sort of thing beforehand, and talks to the relatives and to us about what is going to happen, and then she writes it all down in the patient's records.'

The nurses saw it as their role to make sure that patients receive sufficient food and drink according to their own wishes and needs, and to discuss things with the doctor if they came across difficulties in the nutritional work.

The doctor’s role was that of an important discussion partner. The doctor’s willingness to be present and to get to know the patients and the staff on the ward impacted significantly on the nature of the collaboration and the nutritional work.

Close contact with the doctor means better nourishment

The informants listed close contact with the doctor as a nutrition-improving factor, and the fact that ‘he [the doctor] drops by to check if there are any particular concerns whenever he calls in at the nursing home’. The fact that the nursing home doctor focused on the individual patient’s nutritional status when he visited the home, was important for the other staff on the ward to also focus on nutrition.

Whatever receives the doctor’s attention when he visits, will also receive the nurses’ attention. If the nursing home doctor did not concern herself with nutrition, then the subject would sometimes be considered less important by the rest of the staff.

«Whatever receives the doctor’s attention when he visits, will also receive the nurses’ attention.»

If the nutritional collaboration with the doctor worked well, the informants felt that it was less demanding for them to face challenging nutritional situations because they dared to show their uncertainty and to raise issues they felt unsure about. One informant particularly mentioned how important the nursing home doctor had been to her when, as a newly trained nurse, she found herself in a dilemma with respect to a patient who no longer wanted to live and refused to eat:

'The doctor gave us a little help in that process, and then he says [the doctor]: 'Allow her to go through the process she has embarked on.'

Her cooperation with the doctor gave the nurse the re-assurance she needed to accept the patient's wish not to eat, and it also helped her to see the situation in a new light.

Good communication has an impact

Several nurses pointed out that their nutritional work was made easier by good communication, discussions about the nutritional situation on admission, and on-going nutrition-related record-keeping. The informants described a monitoring system that could involve a gap of several days between the doctor's visits. Good cooperation was therefore essential to ensuring that the nurses were confident about expected developments and the path ahead:

'We want a doctor who knows what's what, who knows who I am talking about.'

Good cooperation could also prevent hospitalisation if the patient deteriorated or stopped taking any sustenance, because the nurses knew the wishes of the patient and the doctor.

«We want a doctor who knows what's what, who knows who I am talking about.»

Nurse

Several nurses described their own reluctance to contact the out-of-hours emergency service because they were worried about exposing the patient to excessive treatment and hospitalisation by a doctor who did not know the patient:

‘And sometimes we ring the out-of-hours emergency service, and then the guys there are unable to access the doctor’s module, which means the attending doctor won’t be able to read what’s been described, and then it’s a matter of starting up with this, that and the other.’

The informants found their contact with the out-of-hours emergency service to be challenging if the attending doctor was unable to access the patient’s medical records.

Contact with relatives

The nurses described conversations with the patients’ relatives as an important part of their nutritional work in nursing homes. They pointed out that family members are concerned about the nutritional situation for their loved ones, and could be anxious about patients eating too much or too little. Several nurses reported that the nursing home doctor was taken more seriously and commanded more authority than themselves during conversations with patients’ relatives about food and drink:

‘They take more note of what the doctor says, I believe, for we can say whatever we want, but then you’re only a nurse. But if a doctor says the same thing, then it’s sort-of right.’

The informants described how important it was for the nursing home doctor to be willing to set aside time to talk to the patients' relatives and to show an interest. If nutrition had been raised as a topic during the admission interview it was easier for the family to relate to the nursing home's guidelines if the patient were to refuse food, or if the patient's life was nearing the end. This prepared them for what was to come, and enabled them to play a part in the patient's own process.

Two nurses used the concept 'family-centred medicine' and felt this expression was commonly used at the nursing home:

'We call it family-centred medicine, that they have been so fixated on their mother dying from thirst that we have inserted an intravenous line just to make things easier for the relatives.'

Explaining the final stage

If the doctor explained to the relatives what the patient's last days would be like, as part of the nursing home's routine, it was more likely that the relatives would accept the patient's end-of-life process.

Several informants talked about how many relatives worried that the nurses were killing their loved ones if they did not offer food and drink to patients who did not want to eat or who could not muster the energy. The reason was that they did not understand the patient's process. One of the nurses compared the dying process to a wilted plant on the window ledge:

'It's no use watering the plant if it has shrivelled up, and that's how it is with our bodies as well.'

This was an image the relatives understood, but they often refused to accept the situation until they heard it from the doctor. Consequently, it was important for relatives to feel that the doctor and the nurses had a joint approach to the patient's nutritional problem.

Discussion

This study shows that nurses believe a collaborative partnership with the nursing home doctor is important for the patients' nutritional treatment and status. The nurses carry the day-to-day responsibility for the nutritional work, while the nursing home doctor has a key function as a dialogue partner for the nurses, the patients and their relatives.

Furthermore, it is important that the doctor knows and takes an interest in the individual patients, their relatives and the nurses on the ward. If the patient's nutritional status is discussed during the admission interview and when doctors do their round, all parties will be prepared and can focus on the patient's path ahead.

Assessing the nutritional need

Good nutritional practices in nursing homes require nursing staff and doctors to work together to establish and continually assess whether the patients' nutritional needs are met by the meals provided. They also need to follow up as required and document the patients' nutritional status (8, 9).

The nurses' responsibilities include an assessment of the nutritional situation as well as appropriate follow-up initiatives. They are also tasked with obtaining assistance from other qualified personnel if required. The doctor, however, has overall responsibility for the medical examination, diagnosis and treatment (1, 9). This distribution of responsibilities requires constant interaction and a systematic review of the patient's nutritional status.

Inadequate nutritional expertise has been identified among health care personnel (9, 14) and among Norwegian nurses (15, 16). Mowe et al. show that doctors and nurses in Scandinavia have insufficient knowledge about nutrition, and that good nutritional practices are dependent on a good level of nutritional knowledge (17).

The World Health Organization points to a shortage of targeted courses on nutrition for health care personnel, and emphasises that nutritional work must be integrated at local level (18).

The need to keep professionally updated

It is worrying that nurses fail to keep professionally updated within the area of nutrition. All nurses have an independent function which involves a professional, ethical and personal responsibility for their own actions and assessments (19). This includes a personal responsibility for keeping professionally updated on research, development and documented practices within the areas of nutrition and geriatrics.

Furthermore, they should help ensure that new knowledge is applied in practice. It is also worrying if the World Health Organization is correct in pointing to an inability to integrate nutritional work at individual nursing homes and in the service provision to individual patients (18).

If doctors and nurses enhance their nutritional expertise, they will find it easier to cooperate and focus on the nutritional work in nursing homes (18). Task distribution, patient base, nutritional competence, professional development, service user involvement and adaptation are also important factors that impact on their ability to cooperate with respect to the patient's nutritional status (20).

«It is worrying that nurses fail to keep professionally updated within the area of nutrition.»

There is a need for roles and responsibilities to be clearly distributed between doctors and nursing staff on each ward, and a good collaborative climate is important. It may be worth noting that the nurses who contributed to our study consider the doctor's rounds and the doctor's discussions with the patients and their family to be important arenas for collaboration that provide opportunities to clarify expectations, roles and responsibilities.

For patients, sound nutritional treatment of a high standard means the provision of individual assistance adjusted to the patient's needs (1). If the nurses have inadequate nutritional expertise and there is no dialogue or interaction between nurses and doctors, then the required level of nutritional safety and quality will be difficult to achieve.

Increased focus on nutritional work

The informants report varying degrees of involvement from nursing home doctors with respect to the patients' nutritional situation. It is however a matter for concern that the nurses afford less attention to the patients' nutritional needs if this is not specifically raised during the doctor's visit to the home.

Leirvik et al. (21) show that nurses in nursing homes are not particularly focused on nutritional work because other nursing tasks take priority. Pressures of time and a multitude of tasks are the reality of today's nursing homes. Nevertheless, we query how nurses can overlook the patient's need for nourishment, as all nurses have a professional responsibility to fulfil the patient's basic needs (7, 22).

The patient's nutritional status is an important part of the patient's overall treatment, and the nurses in the study stressed this point. They also emphasised that good cooperation with the nursing home doctor could prevent hospitalisation and excessive treatment if the patient's condition deteriorated or if they refused to eat.

A survey of patients admitted to hospital from nursing homes in the area around Bergen concluded that the homes did not have satisfactory procedures for the medical assessment made by doctors prior to hospitalisation. It also appeared that the decision-making processes in relation to hospitalisation were inadequate (23), a point also made by the nurses in our study.

Strengths and weaknesses of the study

The study's strength is its focus group interviews with nurses from different parts of the country. All informants have many years' experience and represent nursing homes of different sizes. The data have been processed by both the first and second author, and there is consensus with respect to the analysis and the results.

It may be a weakness that we never asked the focus groups specifically about the role of the nursing home doctor in relation to their nutritional work. Nevertheless, the interaction with the doctor is clearly raised during the interviews. We therefore feel it is important to highlight the need for good cooperation between nurses and doctors in order to achieve the best possible standard of nutritional care for nursing home patients.

Conclusion

This article explores the nurses' perception of the role played by the nursing home doctor with respect to the nutritional work. The main finding is that the interaction between nursing staff and doctors impacts significantly on the nutritional status of nursing home patients.

To be able to attend to their patient's nutritional status in the best possible way, the nurses need a regular nursing home doctor who knows the patients' individual nutritional wishes and needs, and who takes an interest in and checks up on the nutritional work carried out on the ward.

Nurses, patients and relatives all feel more re-assured when the nursing home doctor interacts with the nursing staff and discusses the expected development with patients and their family. As life is nearing its end, it is particularly important that both nurses and doctors know the patient's wishes and needs.

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