COUNCIL OF EUROPE- COMMITTEE OF MINISTERS

Resolution ResAP (2003)3 on food and nutritional care in hospitals

(Adopted by the Committee of Ministers on 12 November 2003
at the 860th meeting of the Ministers' Deputies)

1. The Committee of Ministers, in its composition restricted to the Representatives of Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland and the United Kingdom, member states of the Partial Agreement in the Social and Public Health Field,

2. Recalling Resolution (59) 23 of 16 November 1959 on the extension of the activities of the Council of Europe in the social and cultural fields;

3. Having regard to Resolution (96) 35 of 2 October 1996, whereby it revised the structures of the Partial Agreement and resolved to continue, on the basis of revised rules replacing those set out in Resolution (59) 23, the activities hitherto carried out and developed by virtue of that resolution; these being particularly aimed at:

a. raising the level of health protection of consumers in its widest sense, including a constant contribution to harmonising – in the field of products having a direct or indirect impact on the human food chain as well as in the field of pesticides, pharmaceuticals and cosmetics – legislation, regulations and practice governing, on the one hand, quality, efficiency and safety controls for products and, on the other hand, the safe use of toxic or noxious products;

b. integrating people with disabilities into the community: defining and contributing to the implementation at European level of a model of coherent policy for people with disabilities taking into account the principles of full citizenship and of independent living; contributing to the elimination of all barriers to integration, whether psychological, educational, family-related, cultural, social, professional, financial or architectural;

4. Considering that the aim of the Council of Europe is to achieve a greater unity between its members for the purpose of facilitating their economic and social progress;

5. Considering that access to a safe and healthy variety of food is a fundamental human right;

6. Bearing in mind the beneficial effects of proper food service and nutritional care in hospitals on the recovery of patients and their quality of life;

7. Bearing in mind the unacceptable number of undernourished hospital patients in Europe;

8. Bearing in mind the fact that undernutrition among hospital patients leads to extended hospital stays, prolonged rehabilitation, diminished quality of life and unnecessary costs to health care;

9. Bearing in mind the Parliamentary Assembly Recommendation 1244 (1994) on food and health;

10. Having regard to the First Action Plan for Food and Nutrition Policy of the WHO European Region
(2000 – 2005),

11. Recommends that the governments of the member states of the Partial Agreement in the Social and Public Health Field, having due regard to their specific constitutional structures, national, regional or local circumstances, as well as economic, social and technical conditions:

a. draw up and implement national recommendations on food and nutritional care in hospitals based on the principles and measures set out in the appendix to this resolution;

b. promote the implementation and take steps towards the application of the principles and measures contained in the appendix, in fields where these are not the direct responsibility of governments but where public authorities have a certain power or play a role;

c. ensure the widest possible dissemination of this resolution among all parties concerned, particularly public authorities, hospital staff, primary health care sector, patients, researchers and non-governmental organisations active in this field.

Appendix to Resolution ResAP(2003)3

1. Nutritional assessment and treatment in hospitals

1.1 Nutritional risk screening

i. The assessment of nutritional risk should take into account nutritional status and the severity of disease.

ii. The nutritional risk screening method should be evidence based, in order to secure the identification of patients who may benefit from nutritional support.

iii. The nutritional risk screening method should be easy to use and simple to understand.

iv. The influence of age, growth and sex should be taken into consideration when the nutritional risk of the patient is determined.

v. The nutritional risk of all patients should be routinely assessed either prior to or at admission.
This assessment should be repeated regularly (intervals depending on the level of nutritional risk) during hospital stay.

vi. Studies should be undertaken to develop and validate simple screening methods, aimed for use in hospitals and primary health care sector.

vii. Identification of a patient at nutritional risk should be followed by a thorough nutritional assessment, a treatment plan including dietary goals, monitoring of food intake and body weight, and adjustment of treatment plan.

viii. Standards of practice for assessing and monitoring nutritional risk/status should be developed at a national and European level.

1.2 Identification and prevention of causes of undernutrition

i. The multiple causes of disease-related undernutrition should always be considered for every patient.

ii. The use of medications and combinations with side effects of anorexia, nausea and other gastrointestinal symptoms, drug-nutrient interactions or alterations of taste and smell should be well grounded and avoided as much as possible while physicians and nurses should be aware of these side effects.

iii. "Nil-by-mouth" regimes, overnight fasting and bowel-cleansing protocols with dietary restrictions should not be used routinely; the literature should be reviewed in order to assess which procedures may require such regimes and for those investigations/procedures requiring dietary restriction the exact period of restriction should be determined.

iv. The definition of disease-related undernutrition should be universally accepted and used as a clinical diagnosis and hence treated as such.

1.3 Nutritional support

i. Nutritional support as part of the treatment of patients should be considered systematically.

ii. The nutritional treatment plan should be reviewed and adjusted if appropriate on at least a weekly basis, by means of information about the patient's nutritional intake, weight change and other relevant nutritional and clinical variables.

iii. Nutritional support should be properly targeted to the individual patient. The volume of artificial nutrition infused and any discarded should be carefully documented.

iv. No patient should receive artificial nutritional support without proper evaluation of indications, risks and benefits, informed consent of the patient as well as close supervision of side effects.

v. Specific immune-modulating formulas should be limited to those patients who may benefit from them in the light of available randomised trials.

vi. Patients in need of nutritional support should receive such treatment before admission (where possible), at the earliest opportunity during hospital stay and after discharge.

vii. Medical and nursing admission, discharge and outpatient records should contain information about each patient's nutritional status, and physical and mental condition in relation to food intake.

viii. Randomised trials and systematic reviews by specialists in clinical nutrition should be performed to evaluate the effect of nutritional support on nutritional status, clinical outcome, and physical and mental condition.

ix. Randomised trials evaluating the effect of ordinary food on clinical outcome should be given high priority.

x. Standards of practice for the assessment and dietary management of patients with dysphagia should be developed at national levels as appropriate. National descriptors for texture modification should be developed.

1.4 Ordinary food

i. Ordinary food by the oral route should be the first choice to correct or prevent undernutrition in patients.

ii. Good practice to ensure the intake of ordinary food by the patients should be studied and documented. The practice of documenting and assessing intake of ordinary food by the patients identified as at nutritional risk is essential.

iii. Sip feedings should not be used as a substitute for the adequate provision of ordinary food, and should only be used where there are clear clinical indications.

iv. Artificial nutritional support should only be started when the use of ordinary food fails or is inappropriate.

1.5 Artificial nutritional support

i. Standards of practice established and implemented for initiation, safe delivery, aseptic handling techniques, line care, monitoring and termination of all artificial nutritional support should be developed at national and European level.

ii. Standards of practice should be developed for the initiation, preparation, education, equipment provision, and safe delivery and monitoring of patients discharged on home nutritional support.

2. Nutritional care providers

2.1 Distribution of responsibilities for nutritional care in hospitals

i. The Department of Health, Regional Authorities and each Hospital management should acknowledge their responsibility with regard to nutritional care and support, and food service systems.

ii. Hospital management, physicians, pharmacists, nurses, dieticians and food service staff should work together in providing nutritional care, while the hospital management should give due attention to such co-operation.

iii. The responsibility of different staff categories with respect to nutritional care and support, and food service should be clearly assigned.

iv. Hospitals should develop appropriate structures to set standards for nutritional care and support especially in relation to costs, contract specifications, nutritional risk screening and audits, and to implement these standards through the control, supervision and audit of nutritional care and support.

v. Nutritional risk screening, assessment and monitoring should be included in the accreditation standards for hospitals.

2.2 Communication

i. Organisational research should be conducted to assess and improve the co-operation between different staff groups.

ii. Food service personnel, ward staff and patients should develop, test and implement forms for menu ordering.

iii. Regular contacts between ward and food service personnel should be established.

iv. One or more representatives in each ward and at the kitchen should be designated to have primary responsibility for communication and information in nutrition-related issues.

v. Regular contacts between the hospital and the primary health care sector should be established.

2.3 Education and nutritional knowledge at all levels

i. A continuous education programme on general nutrition and techniques of nutritional support for all staff involved in the feeding of patients should be implemented.

ii. Clinical nutrition should be included in under- and post-graduate education of physicians.

iii. Chairs in clinical nutrition should be established.

iv. Clinical nutrition for both adults and children should be recognised as a specialised discipline by medical schools. The teaching should cover preventive as well as therapeutic aspects of nutritional care and support.

v. The education of nurses in clinical nutrition, with special emphasis on nutritional risk assessment, monitoring, and feeding techniques, should be improved.

vi. The education of clinical and general dieticians at national levels should be set at the highest undergraduate level to enable all European dieticians to assume a more central role in nutritional care and support.

vii. The education of administrative dieticians should be upgraded, especially in the field of management.

viii. The education and training of hospital food service managers/supervisors should differ from hotel management by preparing them to cater for sick people

ix. Special focus should be placed on the nutritional training of non-clinical staff members, e.g. part-time care assistants and ward housekeepers and the definitions of their area of responsibility.

x. Special emphasis should be given to educating and informing the public (including patients) regarding the importance of good nutrition.

xi. European initiatives on clinical nutrition education should be encouraged.

xii. Co-operation between clinical nutrition societies in different countries should be expanded.

3. Food service practices

3.1 Organisation of hospital food service

i. The responsibilities and accountabilities for hospital nutrition among health care professionals and hospital management should be clearly assigned.

ii. A food service policy should be adopted and implemented at hospital or regional level.

iii. Hospital managers should give proper attention to food service policy and nutritional support.

iv. All hospital staff – clinical and non-clinical – should acknowledge food service as an important part of the treatment and care of patients.

3.2 Contract food service

i. Guidelines and standards for out-sourcing hospital food service should be developed.

ii. Contracts should be sufficiently detailed and they should cover special diets on medical and personal indications, energy and protein dense menus and provision of snacks and/or meals at ward or near-ward level. They should also cover texture-modified menus for the management of dysphagia.

iii. The cost for adequate contract monitoring should be built into the contract.

iv. The Clinical Nutrition Service/Department, the Nutritional Steering Committee, the Nutritional Support Team or an adequately qualified person should be given the responsibility for ensuring that the contract reflects nutritional standards.

3.3 Meal service and eating environment

i. The serving system should be adjusted to the patients' needs taking into consideration their physical and mental condition. This often requires different serving systems.

ii. All patients should have the possibility to choose their eating environment.

iii. All patients should have the possibility to sit at a table when eating their main meals.

iv. The hospital-eating environment should be improved with a focus on surroundings and the presence of personnel and free from unpleasant smell/odours.

v. Adequately trained personnel should be available to assist patients with mental/physical feeding difficulties and suitable modified equipment should be available when required to aid/facilitate independent feeding.

3.4 Food temperature and hygiene

i. All patients should receive hospital food, which has been stored, prepared and transported in such a way as to ensure the hygiene, safety, palatability, gastronomy, and nutrient content of the food at a high level.

ii. All hot meals should be served at temperatures around 60-70° C.

iii. The Nutritional Steering Committee, the Nutritional Support Team or an adequately qualified person should be responsible for the hygienic aspects of food service.

iv. The kitchen and ward staff should receive proper education in food hygiene while the hygienic control of hospital food production should be used to engage hospital management in the wider concept of hospital nutrition.

3.5 Specific improvements in food service practices to prevent undernutrition

i. Standards for food service systems, based on patient needs rather than hospital needs, should be developed.

ii. Regardless of which serving system is used, close collaboration between the patient, relatives and the nursing, dietetic and food service staff is required to get the patient to eat.

iii. The provision of meals should be flexible and individualised. All patients should have the possibility to order food and extra food at any time and be informed of this possibility.

iv. Menus should be specifically targeted to different patient categories.

v. Proper feeding-aid should be provided.

vi. Successful measures to prevent undernutrition should be given publicity.

4. Hospital food

4.1 Hospital menus and diets on medical indications

i. Good practice should be established through the development of national guidelines and standards for food provision in hospitals to meet the needs of all categories of patients including diets on medical indications, and vegetarian, texture modified and energy and protein dense menus.

ii. Studies should be undertaken to evaluate the effect of energy and protein dense menus on food intake and patient outcome.

iii. A range of dishes enriched in energy and protein should be available in every hospital aimed at patients with disease-related undernutrition.

iv. The physician should always be aware of the nutritional status of patients and only prescribe diets with scientifically documented effects.

v. The health care personnel should be aware of the patient's use of "alternative diets" and the influence these might have on the nutritional status.

vi. Immediate feedback from the patients to the kitchen and ward staff in relation to liking or disliking of the food served should be encouraged.

vii. The nutrient content, the portion size of the food and food wastage should be audited annually.

viii. The nutrient sufficiency of a menu should be documented already at the planning stage. The Clinical Nutrition Service/Department, the Nutritional Steering Committee, or the Nutritional Support Team or an adequately qualified person, should be given the responsibility for ensuring that the menu reflects nutritional standards.

ix. A database on nutrient content of meals/menus and portion sizes should be established in each food service department to be made available for the purpose of assessing nutritional adequacy of menus and monitoring of patients' food intake.

x. Research should be conducted to generate more reliable data on nutrient losses with different food service systems.

4.2 Meal pattern

i. Serving hours should be reviewed to ensure that there is sufficient time between each meal to allow for in-between snacks in the morning, afternoon and late evening.

ii. Mealtimes should be spread out to cover most of the hours spent awake.

iii. Interruption of patients' meal times by ward rounds, teaching and diagnostic procedures should be minimised.

iv. Snacks and nourishing drinks between meals should be offered when appropriate and be available on every ward.

v. The involvement of relatives in serving meals to patients should be encouraged, when appropriate.

vi. The use of sip feedings should be properly targeted and a protocol for the distribution and supervision of sip feeds should be developed and implemented.

4.3 Monitoring of food intake

i. The personnel on the wards should be trained in how to monitor food intake.

ii. The food intake of patients should be noted by means of a semi-quantitative system.

iii. Tray collection should be supervised closely to enable monitoring of patients' food intake.

iv. The level of food intake should be used to assess the patients' need for nutritional support.

v. The food intake of patients at nutritional risk and receiving nutritional support should be registered by means of dietary records.

vi. Information from the kitchen and the menu nutrient database regarding portion size and energy content of hospital food should be available to aid ward personnel in the monitoring of patients' food intake.

vii. The information about patients' food intake should be used to develop appropriate, target group specific menus.

viii. Studies should be undertaken to develop and validate simple food recording methods.

4.4 Informing and involving the patient

i. The positive role of nutrition as treatment should be made known to the public to engender general awareness and support.

ii. On admission or before admission patients should be informed about the importance of good nutrition for their successful treatment.

iii. Adequate information in written and oral form should be given to patients regarding available dishes and foods.

iv. Dishes should be described accurately so that patients have a reasonable idea of what to expect.

v. Patients should receive information regarding the nutrient composition of different foods and drinks.

vi. Patients should receive help and guidance in ordering food by the ward staff.

vii. Patients should be involved in planning their meals and have some control over food selection.

viii. Patients should be able to receive a menu, which is in accordance with their age, religious, ethnic or cultural background.

ix. Methods to assess patient satisfaction should be developed and implemented.

5. Health Economics

5.1 Cost-effectiveness and cost-benefit considerations

i. Calculations of cost-benefit and cost-effectiveness of nutritional support should also be made at hospital level.

ii. Calculations of cost-benefit and cost-effectiveness of nutritional support should involve experts in health economics.

iii. When estimating the cost-benefit and cost-effectiveness the choice of nutritional support should be considered.

iv. When estimating the cost-benefit and cost-effectiveness of nutritional support, outcomes should include functional capability and life satisfaction of patients.

5.2 Food service and food wastage costs

i. The influence of food service practice on food wastage should be examined.

ii. Flexibility with regard to the patient's menu choice and serving size should be ensured.

iii. When assessing the cost of different food preparation systems, the patient's satisfaction with the food served should be considered.

iv. The food budget should be valued as part of the budget spending on clinical support and treatment services.

v. Hospital managers should take into account the potential cost of complications and prolonged hospital stay due to undernutrition when assessing the cost of nutritional care and support.

vi. Steps should be taken to reduce documented wastage of food, sip feedings and artificial nutrition products.

6. Definitions

Artificial nutritional support

Administration of specially formulated liquid nutrients through a tube directly into the gut (enteral nutrition) or into a vein (parenteral nutrition).

Diets on medical indications

A prescribed allowance of food or nutrients provided via the oral route and used in the treatment of specific diseases, e.g. lipid lowering diet, diabetic diet, and energy reduced diet.

Disease-related undernutrition

A state of insufficient intake, utilisation or absorption of energy and nutrients due to individual or systemic factors, which results in recent or rapid weight loss and change in organ function, and is likely to be associated with a worse outcome from the disease or the treatment. Undernourished patients can be overweight or obese according to their body mass index (BMI).

Energy and protein dense menu

A menu with a high nutrient density, due to use of food products with a high fat and protein content.

Food service

A system in which meals are produced and served for hospital patients, in a professional context. The system includes the food service premises, the production and distribution technology, and human resources involved in management, production, distribution and serving.

Hospital food

The meals served at hospitals – including diets on medical indications.

Nutritional assessment

A comprehensive evaluation of nutritional status, including one or more of these: medical history, dietary history, physical examination, anthropometrical measurements and laboratory data.

Nutritional care

The basic duty of providing adequate and appropriate food and drinks and/or artificial nutrition to the patient.

Nutritional risk

The risk for nutrition-related complications to the disease or the treatment.

Nutritional risk screening

The process of identifying characteristics known to be associated with nutrition-related complications. Its purpose is to detect patients at risk who may experience an improved clinical outcome when given nutritional support.

Nutritional Steering Committee (NSC)

An advisory committee consisting of staff from all disciplines, including the management involved in the nutritional care of the patient.

Nutritional support

Assessment of current nutritional status, estimation of nutritional requirements, prescription and delivery of appropriate energy, macro- and micro-nutrients, electrolytes and fluids (in the form of ordinary hospital food (first choice), sip feedings and/or artificial nutrition), monitoring the former in the context of clinical status and ensuring that the most optimal feeding route is used at all times. Nutritional support is part of the medical treatment and its purpose is to improve or maintain a patient's nutritional status and hasten and improve recovery.

Nutritional support teams/units (NST)

A multidisciplinary team/unit with expertise in nutrition, which is involved in nutritional support, whose remits varies according to local circumstances, interest and resource allocations. Usually takes active part in nutritional support, and serves in a quality control capacity, standardising practice, gathering new information and educating other health care professionals.