Patient nutrition is too important to be delegated to unpaid support staff

The art&science article on the role of dining companions in supporting nursing care (June 17) raises many interesting issues and it is good to see that NHS trusts are focusing on nutrition support.

There is one caveat. However much we camouflage it with terms such as ‘dining companions’ or ‘feeding assistants’, volunteers are still unpaid support workers. They are a short-term solution to a bigger long-term problem.

Nutrition support is not an add-on. Like drug administration and wound care, it is fundamental to patient wellbeing. Nurses and healthcare assistants need education and training in nutritional assessment and assisted eating and feeding techniques.

We would not delegate intravenous drug administration or wound care to volunteers. As general or specialist nurses, we all need to remember that nutrition is therapy for every patient we meet.

Christine Eberhardie, Sutton, Surrey

NUTRITIONAL ASSISTANTS ARE EFFECTIVE BUT HAVE LIMITATIONS

Helen Brown and Lucy Jones (art&science June 17) highlight the key role of nurses in the nutritional status of patients and acknowledge the difficulties and barriers we face.

As nutritional link nurses for the acute and rehabilitation stroke unit at Nottingham University Hospitals NHS Trust, our role is to make sure that members of staff can meet the nutritional needs of all their patients.

The introduction of nutritional assistants on a paid basis in some hospital trusts has had a positive effect and it will be interesting to see if audit outcomes show that the nutritional status of patients has improved as a consequence.

But, given the complex nutritional requirements of many patients who have had a stroke, it may prove difficult to introduce nutritional assistants in stroke units.

Natalie Handley and Jaime Squire, by email

TASTY FOOD ALONE WILL NOT SOLVE NUTRITION PROBLEMS

I read with interest that celebrity chef Heston Blumenthal is involved in a project to improve the taste of hospital food, and boost the nutrition of older patients and those with long-term conditions (news June 17).

His knowledge and experience could help hospital caterers to look at nutrition in an innovative way. This project will hopefully enhance our knowledge of how tastes change with age and how medication can affect taste and appetite, as well as providing practical solutions.

But let us not forget other important factors in improving the diet of older people in hospitals. Helen Brown and Lucy Jones, for example, highlight the role of dining companions in supporting nursing care (art&science June 17) – evidence that tasty food will not solve the problems we face by itself.

Brigid McKevith, registered dietician and public health nutritionist, by email

LOOKING AFTER NURSING STUDENTS IS TIME WELL SPENT

Joanne Hardy looks back to her first day on the ward and says it felt like her first day at school (career development June 3). It taught her to notice new patients and students on placements, and help them feel comfortable.

In our trust we try to look after all our students. We listen to them and appreciate their feedback. On my ward students are given a morning’s
induction. This is backed up by a booklet on the ward hours, learning opportunities and contact numbers.

The induction allays their initial worries and concerns, encourages our students to feel part of the team and helps them to settle.

The ward is extremely busy and time is precious. But my colleagues and I feel that this time is well spent and feedback from the students backs this up. We must remember that these are our nurses of the future and we need to support them.

Bev Goose, by email

ENFORCE SAFETY GUIDELINES TO PREVENT NEEDLESTICK INJURIES
An RCN poll in November 2008 revealed that 48 per cent of nurses in the UK have been injured by a needle or sharp at work (news June 17). Nurses continue to be at risk, even though safer needles and sharps are available at no extra cost.

The needlestick injury prevention guidelines being formulated for introduction across the European Union are aimed at preventing the incidence of injuries. The framework is expected to contain measures to promote education and training, improve risk management, modify unsafe working practices and promote the safe use and disposal of needles and sharps.

I welcome the call from health unions to adopt the guidelines immediately, rather than wait for them to be legally formalised. Any delay will lead to more lost working time, emotional trauma, litigation and compensation.

Rick Dean, by email

TIME TO BE PROACTIVE AND ADOPT EUROPEAN MEASURES
The RCN and Unison are calling for the immediate adoption of the European Union’s needlestick injury prevention guidelines (news June 17). The UK is behind many other countries in injury prevention, including the United States. We have no formal guidelines to ensure that the NHS is obliged to take action to prevent needlestick injuries, especially with regard to introducing safer equipment such as needleless injector connectors and safety cannulae.

A resolution from the RCN IV therapy forum calling for the introduction of safety devices was accepted at RCN congress a number of years ago.

Despite support for the resolution, a chapter on needlestick management in the Blue Book for NHS employees and the recent RCN publication, Needlestick Injuries: The Point of Prevention, nothing proactive has occurred until now.

The European guidelines should be welcomed into clinical practice sooner rather than later.

Lisa Dougherty, RCN IV therapy forum chair, by email

ACCUSSION THAT NURSES ARE DESENSITISED IS HARMFUL
Dame Chris Beasley, the chief nursing officer for England, claims that nurses may have become desensitised to mixed-sex wards (news June 17).

Professor Beasley reiterates a familiar claim that nurses are unable to comprehend the wider implications of their role. To state that busy nurses can become desensitised to patients’ concerns is speculative and professionally harmful.

The reality of nursing is that a heavy workload forces us to prioritise; the immediate demands of clinical care inevitably dominate. This does not mean nurses are desensitised to patients’ anxieties about mixed-sex accommodation.

Instead of criticising nurses, it would be helpful if Professor Beasley were to recognise nurses’ sensitivity to the potential difficulties experienced by patients accommodated in mixed-sex wards, as evidenced by initiatives such as the RCN’s dignity campaign.

Her comments reflect a worrying tendency to question nurses’ abilities to comprehend the bigger picture.

Chris Chaloner, by email

NURSES’ HANDS ARE TIED IN ADDRESSING MIXED-SEX WARDS
I read with interest the news story, ‘CNO criticises “desensitisation” to mixed-sex wards’ (June 17). There are so many targets in the clinical setting that nurses have to achieve, but sometimes these slip out of our hands.

Bed managers and directorate managers also have targets from A&E and need to ensure that patient trolley waits do not exceed four hours. Side rooms have to be found for patients with meticillin-resistant Staphylococcus aureus and outliers are often difficult to keep track of.

More and more is asked of nurses today. How do managers feel, too, when their hands are tied by targets? And is enough being done in terms of listening to the voice of our patients – the reason we are all working in the healthcare setting in the first place?

Jane Brown, clinical risk facilitator, by email

RENAME HCAs AS NURSES AND WE CAN BE CALLED MANAGERS
Further to previously published letters on nursing as a graduate-only profession, at last we are beginning to see where this will lead (news June 17). NHS Employers predicts that nursing is set to become a smaller, elite workforce that will oversee the work of an increasing number of healthcare assistants (HCAs).

Why are we allowing our profession to be handed over to others? What is the point of nursing students working long and hard to obtain degrees, only to then supervise HCAs as they carry out the jobs the nurses have been expensively trained to do?

I say let’s go the whole hog and rename HCAs as nurses and replace the title ‘nurse’ with ‘HCA manager’ or ‘support staff manager’.

Governments always go for the cheapest option, so watch this space as regulated, well-managed and co-ordinated HCA training becomes the new nurse training and nurse graduates compete for fewer and fewer of these ‘elite’ posts.

Claire Leathem, Belfast