

ORIGINAL RESEARCH

Nurses' and other healthcare professionals' representations of malnutrition among patients in a psychiatric setting: The missing link between knowledge and practice?

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Received: December 19, 2014

Accepted: March 8, 2015

Online Published: March 17, 2015

DOI: 10.5430/jnep.v5n5p103

URL: <http://dx.doi.org/10.5430/jnep.v5n5p103>

ABSTRACT

Nurses play an important role in identifying nutritional risk among their patients and in referring them to the physician or the dietician. However, systematic screening is rare, mostly because of lack of time and awareness among nurses, which lead to suboptimal detection of malnutrition. But studies also showed nurses' positive attitudes towards nutritional care and a good level of knowledge about malnutrition. The goal of this study was to qualitatively examine the social representations of malnutrition among caregivers working in a large psychiatric hospital. Three trained dietitians conducted semi-structured, one on one, 30-minute interviews using an open-ended 7-item guide. The sample included 8 psychiatric nurses, 8 nursing aids and 8 physicians. Each interview was audio-recorded and transcribed verbatim. Content analysis was performed and social representations were structured around the four main concepts that emerged: 1) Images and personal definitions of malnutrition, 2) Knowledge, 3) Professional practices and 4) Professional training. Most respondents shared the image of extreme thinness to describe malnutrition. Theoretical knowledge was found to be good, but the respondents failed to relate it to their patients, apart from cases of anorexia nervosa. It seems that caregivers' social representations of malnutrition are incompatible with the signs displayed by patients at nutritional risk. This could contribute to explaining why nutritional risk assessment is rarely performed routinely. Social representations on malnutrition should be taken into account when addressing issues about screening for malnutrition.

Key Words: Malnutrition, Social representations, Psychiatry, Healthcare professionals

1. INTRODUCTION

Hospital malnutrition is a widely recognised problem. Prevalence varies from 20% to 50%, depending on the age of the patients, their condition and comorbidities.^[1-4] Common

consequences of malnutrition are delayed recovery, weakening of the immune system and risk of increased hospital stay.^[1,2,5]

International^[6] and European^[7,8] guidelines recommend rou-

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tine screening to improve early identification of patients at risk of malnutrition, as well as protocols for the management of nutritional risk. However, it has been shown that screening is rarely performed systematically.^[9] A large European audit on nutrition, the so-called “Nutrition Day”, showed that systematic nutritional screening was performed in 21% to 73% of the participating units.^[10] In a Scandinavian study on more than 4500 nurses and physicians, only 16% to 40% of the patients were screened, depending on the country.^[11] In this same study, 95% of the participants attributed a very high importance to nutritional screening and dietary intake evaluation,^[11] however only 25% reported difficulties identifying patients with nutritional therapy needs.^[12]

When asked about the reasons of the low rates of nutritional screening, the nurses most frequently mentioned not only their lack of time due to large number of tasks to perform, but also the prioritisation of those tasks.^[9,13] Their attitude towards screening and nutrition was generally positive^[14-17] but its priority was lower than that of the other care-related activities.^[9]

To our knowledge, there are no data focussing on nutritional risk amongst patients hospitalized in psychiatric hospitals or wards. However, these patients’ pathology could be related to insufficient or inadequate dietary intake, and their long-term or repetitive hospitalisations could affect their nutritional intake. In older patients, cognitive problems and dementia increase the risk of malnutrition.^[3,18] There is no evidence that screening for nutritional risk is more frequent than in other settings. One study showed that when nurses in psychiatry were relying on their own judgment to identify patients with a nutritional risk, they identified 50% of the cases only.^[19]

There seems to be a contradiction between the importance attributed to malnutrition and screening, and the actual practices. Instead of assessing knowledge, generally reported as good,^[12,13,17] this study therefore focused on the representations of malnutrition held by nurses and other caregivers working in a psychiatric setting. The purpose of this study was to explore nurses’, nursing aids’, and physicians’ social representations (SR) of malnutrition, and to identify the possible missing link between their theoretical knowledge and actual screening practices for malnutrition risk.

The link between SR and behaviors has been studied and formalized in the theory of planned behavior model^[20] which offers connexions between beliefs, attitudes, behavioral intentions and actual behaviors. Its applications have shown the validity of this model in various contexts. For our purpose, SR were defined as an interpretative and socially constructed frame already in place, a « déjà-là ».^[21,22]

2. METHODS

The researchers of this study assume a relativist ontological position, meaning that the professional experience of the study population is a social product, ie constructed collectively and potentially influenced by such factors as social, historical and cultural norms and values. Studying SR is one way to understand this construction, as shown by the work of Serge Moscovici.^[23] Knowledge acquired from his ontological position is rooted in individuals’ subjectivity, as opposed to objective findings.^[24,25]

This qualitative study was performed in three wards (including adult rehabilitation, psycho-geriatric care and adults with somatic and psychiatric comorbidities) of a Department of psychiatry of a large University hospital in Switzerland. The three field investigators were invited by the nurse coordinator of each ward to present the study and leave information flyers to their staff. The nurses, nursing aids and physicians (NNAP) interested in participating voluntarily contacted the investigators, who guaranteed confidentiality. Purposive sampling was performed with the aim to include five to eight members of each profession. This number was to be adapted depending on the results, with the recruitment to be stopped if no new information was yielded, and to continue if new representations emerged. Among the interested persons, 24 were randomly selected and invited to participate (8 nurses, 8 nursing aids and 8 physicians) with a similar distribution across wards and professions. No incentive was provided but the professionals were allowed by their management to participate during their working hours. Each participant received formal, written information about the goal and procedures of the study, the confidentiality of the data and the fact that participants could withdraw at any time from the study without giving any reason, and signed an informed consent form. The study complied with the Swiss Federal Law on Research (LRH) but was out of the scope of the Ethics Committee on research involving humans.^[26]

A semi-structured interview guide was established using the input from three Bachelor students in dietetics, two of their professors and one dietician working in the field of psychiatry. Each interview topic was then developed into one to three questions, which were submitted to the same panel plus one nurse specialised in psychiatry. The questions rated as the most appropriate were selected to form a 30-minute interview. Before the start of the study, the interview was tested on three Bachelor students in nursing and one medical student. After some minor adjustments, the final interview guide comprised seven open-ended questions on how the professionals would describe malnutrition and its causes, asking them to think about malnutrition in the context of psychiatry in general, and for their patients in particular. In addition,

the respondents answered close-ended questions about their gender, age, profession and years of professional experience. They were also asked if they had had formal training in nutrition. The data were collected in a one-to-one audio taped interview. Each investigator transcribed their own interviews verbatim, and read the other interview transcripts.

Thematic analysis of content according to Bardin^[27] followed a literal approach, where recurrent themes within the interview transcripts were used to define codes. There was no preconceived hypothesis but instead an inductive coding process,^[28] with a focus on the representations on malnutrition of the respondents.^[29] Each investigator coded the

same number of transcripts, and then all coded transcripts were examined and discussed in the research team in order to reach agreement. The codes were then organized around main themes.

3. RESULTS

SR were similar across professions and units. Four major themes emerged from the data: 1) Images and personal definitions of malnutrition (which was sometimes coupled with “bad nutrition” or “junkfood”), 2) Knowledge, which was mainly related to causes and consequences of malnutrition, 3) Professional practices and 4) Professional training. Table 1 provides representative quotes supporting each theme.

Table 1. Main representations on malnutrition of nurses, nursing aids and physicians working in a psychiatric setting

| Themes | Representative quotes |
|---|---|
| Images and personal definitions of malnutrition | <p>“African children with a big belly and skinny limbs (...)” (308a)</p> <p>“Even if I weren’t a health professional, but even more so since I am, the wasted body, the refusal to eat ... well, me, I am a woman, a mother, a provider, and it calls out to me.”(205i)</p> |
| Knowledge | <p><u>Question:</u> “[...] could you give me some other reasons that may lead to malnutrition?”</p> <p>“[...] Financial problems, a generally precarious living situation, housing problems, having little or no money, not having enough money for basic needs [...]” (302i)</p> <p>“Patients with psychiatric problems or a major depression, a really severe depression, or...or anorexia nervosa, so...there is a range of causes, quite a wide range” (303m)</p> <p><u>Question:</u> “What could the consequences be?”</p> <p>“Well, it is true that the organism deteriorates because of that, in all sorts of ways, and ah well... in the end, one would die, but well you know, the fact is, one dies in the end anyway.” (305a)</p> <p>“Malnutrition can affect the person’s cognitive capacities, and on the psychological side one can be depressed if one is undernourished or malnourished...and there’s the cardiovascular level...The physically manifest effects are numerous, and so are the psychological ones.” (104m)</p> |
| Professional practices | <p>“I see it as a circle...which includes the kitchen [staff], the dieticians, the care-givers, the physician, the patient...so you see, well there is this circle. We all have our duty to help the patient to feed himself or to have a good relationship...well I mean ‘good’ relationship in quotation marks, with eating.” (304i)</p> <p>“Meals are as important as medication, I mean especially in geriatric psychiatry, or actually in all psychiatry really.” (304i)</p> <p>“No, we no longer apply naso-gastric feeding, it is too aggressive, or anyway it is perceived as an aggression, so they...well anyway we’d never get them to consent to it.” (304i)</p> |
| Professional training | <p>“The problem is that the care-givers aren’t very aware of this issue! [...] Malnutrition (...), there are signs, but they aren’t seen, and then when there are very obvious signs people start to worry.” (104m)</p> <p>“This concerns everybody, in our units here in [the psychiatric hospital] or in all medical units, generally I believe that food is the first medication.” (105a)</p> |

3.1 Images and personal definitions of malnutrition

Most respondents shared the image of extreme thinness to describe malnutrition “(...) like African children with a big belly and skinny limbs” (308a), with a terminology suggesting its severity: “developing countries”, “concentration camps”, “poverty”, “marasmus”, “kwashiorkor”, “starvation”, “bulging eyes”. To them, malnutrition was a visible condition “She had lost lots of weight, she was cachectic, as if you could see her bones, and that was something that

made a deep impression on me, when I saw her” (104m); “You can see the skinniness, I mean [they are] deadly skinny” (102i) and the terminology reflected strong feelings “violent in daily life”, “alarming”, “terrifying”, “sad”, “sense of failure”.

For most, malnutrition was described as a void, the absence or the lack of “something”. Some respondents described malnutrition as the lack of “balance between needs and intake”

or inadequate food intake in quantity or quality. In their eyes, malnutrition concerned specific (social) groups: “[patients with] *anorexia nervosa*”, “*older people*”, “*poor people*”, “*alcoholics*”.

When asked about the possibility of the co-occurrence of malnutrition and obesity, the respondents would describe it as « *possible of course, but it is not the first image [that comes to mind]* » (303m). However, they would develop this idea referring to “*overnutrition*” or “*bad nutrition*” described as the intake of “*junk food*”. For the respondents, malnutrition and being corpulent was incompatible. “*I think that usually, with obese people, we don’t think of malnutrition, because they are a bit overweight, people think OK if he’s obese he’s well nourished*” (104m). They also recognized spontaneously their shortcomings on the matter, noting their confusion about the definition of malnutrition as they talked about kids being malnourished because of the intake of junk food. During the interviews, they were relating to two different concepts: the “*undernutrition-malnutrition*” existing in poor countries, and the “*bad nutrition-malnutrition*” in the industrialized countries.

3.2 Knowledge

The knowledge of the respondents was mainly related to causes and consequences of malnutrition. Four such main causes emerged from the data: aging process, socio-economic factors, insufficient intake, psychiatric and other diseases. For each cause, respondents gave details showing theoretical knowledge on the subject. For example, elaborating on the aging process as a cause of malnutrition, they shared “*loneliness*”, “*loss of taste*”, “*lack of exercise*”, “*confinement to bed*” as specific risk factors related to age, but without relating them to the nutritional risk of their own patients. Similarly, for socio-economic factors they shared “*lack of financial means*”, “*insecurity*”, “*budget priorities*”. About insufficient intake, some respondents specified that it was unlikely that it would appear during hospitalization. Diseases related to malnutrition were mostly (but not exclusively) named by the physicians, who used technical vocabulary to explain the physiopathology leading to malnutrition.

The respondents’ knowledge about the type and the consequences of malnutrition was evident as they talked about numerous and severe consequences of malnutrition, which were grouped as somatic disorders (39x), physical capacities (36x), psychic disorders (22x), death (13x), neuropsychological capacities (8x) and physical appearance (6x). It is interesting to note that physical appearance was the least described of the consequences, but the main and most common of the representations of malnutrition. Some respondents mentioned a “*vicious circle*” when describing the interplay

between nutritional and psychological states. This interconnection made it difficult for them to distinguish between cause and consequence of malnutrition.

3.3 Professional practices

The respondents, especially nurses and nursing aids, mentioned the burden of nutritional care: some did not consider the nutritional care as a supplementary burden (“*It is part of the care*”), others said it was time and energy consuming, especially during meals. Most respondents, physicians included, were not able to describe their roles in relation to nutritional care. They delegated the entire nutritional aspects of the care to the dieticians, whose precise role they did not know either. For example, for them, the priority lay in the psychiatric care, and, for some, in some form of intake monitoring: “*Our role, it is more like, well, surveillance, to monitor if the patient eats enough to avoid a situation of malnutrition [...]*” (304i).

They recognized their lack of competence in the appropriate response to give if this monitoring were to reveal a problem related to nutrition. The most frequent response would be to “*call the specialist*” (the dietician or clinical physician). The respondents considered the “*food offer*” at the hospital as abundant but lacking in variety for the meals. Patients received meals and snacks, and could also buy snacks at the cafeteria and vending machines.

Sometimes the respondents needed strategies to cope with “*crisis situations*”, typically a refusal to eat. They described a lack of codified professional practices to deal with this and reported they had to find their own strategies to motivate their patients to eat. They sometimes found themselves feeling aggressive. They would consider naso-gastric feeding only after repeated refusal to eat, as the last (and rarely used) resort. The respondents expressed a deep unease and apprehension of enteral nutrition, which they considered invasive and having a negative influence on the relation with the patient. Some respondents mentioned an evolution in professional practices, saying that “*force-feeding*” was not an option anymore: “*force-feeding is outdated*”. They would not feed the patient “*at all costs*”, the choice of refusing to eat was his own. Abandoning these “*old-fashioned*” practices seemed to have left a void in the professional practices, as the respondents wondered about the line between professional ethics and patients’ rights: “*When do we have to take action when they go on hunger strike?*” Some respondents mentioned that their personal attitudes towards dietary habits impacted their approaches to their patients. For example, a nurse admitted he brought food from the outside to try to make the person eat at least something. Another consequence of the difficulty in finding an adequate response in

a situation of nutritional crisis was the difficulty of dealing with their own emotions, which the respondents described with strong words: “frustrated”, “powerless”, “exhausted”, “desperate”.

3.4 Professional training

A majority of respondents (14/24, 58%) thought that many colleagues, themselves included, would be willing to follow classes on malnutrition if they were offered. Suggested themes were:

- Definitions of malnutrition and the differences between “undernutrition-malnutrition” and “bad nutrition-malnutrition”
- Tools to detect signs of malnutrition
- Causes and consequences of malnutrition, and relationship with psychiatric disorders
- Strategies to prevent or avoid malnutrition, and to treat it when it is present
- Balanced meals (how to compose them)
- Nutritional care of a malnourished patient
- Follow-up and monitoring of measures taken

The respondents felt such classes would have to be both theoretical and practical, and the content should be centred on their own experience and day-to-day work. They said it would be useful to demonstrate the existence of malnutrition in psychiatric settings. Some also mentioned that the title of the classes had to be attractive and avoid the term “malnutrition” which was considered as “too aggressive” by some, or that some would not feel it concerned them. *“I am not sure that people think they are dealing with any malnutrition in psychiatry, so why would they go follow a class?”* (205i)

4. DISCUSSION

The main finding of our study among nurses, nursing aids and physicians was that the representation they had of malnutrition was an image of extreme thinness. The physical signs they recognized as indicating the presence of malnutrition were the very obvious ones. Despite their theoretical knowledge of the main risk factors, including age, isolation and financial insecurity, common among their patients, they did not mention screening for nutritional risk.

The secondary finding was that the respondents did not have a precise idea of their role, nor of the dietician’s role, in the process of nutritional care. The main concern they expressed was the difficulty of dealing with patients refusing any food intake.

Malnutrition goes often unrecognized in hospitals^[30–32] and also affects patients with overweight and obesity,^[33] despite

the fact that nurses perceive themselves as able to identify malnutrition, and rate nutrition screening as important.^[11,34] This apparent contradiction has been explained by lack of time and/or lack of training.^[30,31,35] In our study, time was not mentioned as a major barrier, and knowledge on malnutrition was good.

But our data show that the representations of NNAP on malnutrition may be interfering with their knowledge and therefore affect their behaviour. In our study, NNAP perceived malnutrition as an extreme situation, which can contribute to explaining why screening for it would not be routine. Despite good theoretical knowledge on malnutrition, its causes, consequences and screening methods, their representations seem to overrule cognition in practice. Previous research on decision processes has shown that subjects tend to see themselves as objective and unbiased.^[36,37] Accordingly, the decision to screen for malnutrition would not be made, because of the absence of evidence of malnutrition risk. It is possible that the ideal of thinness as a norm of beauty and good health^[38–40] contributes to the internalization of extreme images to characterize malnutrition, and this could be explored in further research.

Future training of nurses and nursing aids could include, for example, a reflection on their social representations on malnutrition, and decision making exercises based on pictures of patients in addition to clinical data.

Our results suggest that NNAP have a different interpretation than nutrition experts when it comes to identifying malnutrition, as observed by Hall.^[41] Our findings also show that NNAP find it difficult to define their own and others’ roles in nutrition. Developing interprofessionality between NNAP and dieticians could contribute to a better mutual understanding of their respective roles, which is key to good collaboration.^[42] Direct interactions and collaborative practice could also help to reconcile different views on malnutrition.^[43] Interprofessionality, referring to “two or more members of different healthcare professions working together to solve problems or to provide services”,^[44] has been identified as an effective response to resource limitation^[42] and previous research has shown good results on patients’ outcomes.^[44,45] A survey among 6000 doctors and 6000 nurses showed an association between the number of ward visits performed by the dietician and the focus on nutrition of doctors and nurses. Also, the nurses and doctors not working regularly with clinical dieticians were less aware of how to cooperate with them and how to use their expertise.^[46] Encouraging interprofessionality might contribute to remedy the divergence observed in our study between knowledge and representations on malnutrition. This could lead to better provision

of services,^[42] and therefore offer an alternative to the “systematic screening” policy^[16] which seems unrealistic when most hospitals hire less health care staff to face shortage in funding.

Our study had some weaknesses. The main bias was that the participants were all volunteers and probably more interested by the theme of nutrition. However, we have reasons to think that this did not greatly affect our results, as most of the eligible personnel were interested and participants were drawn at random. Another limitation could be related to social desirability, as the interviews were led by dietitians. Finally, our results cannot be generalized on a statistical basis, but only on a theoretical basis, as expected in a qualitative study.

The strengths of this study were that the researchers transcribed their own interviews, developing familiarity with the data and contributing to the quality of the analysis,^[47] and the large set of data.

5. CONCLUSION

The goal of this study was to explore the representations that nurses, nursing aids and physicians in a psychiatric setting had of malnutrition, in order to better understand the reported contradiction between practices (low screening rates) and knowledge about nutrition (usually good). Caregivers' representation of malnutrition can contribute to explain why nutritional risk assessment is rarely performed systematically. Our results suggest that representations of malnutrition might be incompatible with the signs displayed by patients who are at nutritional risk, and therefore interfere with systematic screening. The study results offer a new perspective to experts addressing malnutrition screening issues, focussing on improving caregivers' awareness of signs of malnutrition and on more interdisciplinarity.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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