



Research report

Hungry in hospital, well-fed in prison? A comparative analysis of food service systems[☆]Nick Johns^{a,*}, John S.A. Edwards^b, Heather J. Hartwell^b^a School of Management, College of Management and Technology, Walden University, 100 Washington Avenue South, Suite 900, Minneapolis, MN 55401, USA^b Foodservice and Applied Nutrition Research Group, Bournemouth University, Poole, Dorset, BH12 5BB England, United Kingdom

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ABSTRACT

Meals served in prisons and hospitals are produced in similar ways and have similar characteristics, yet hospital patients are often at risk of being undernourished, while prisoners typically are not. This article examines field notes collected during nutritional studies of prison and hospital food service, which confirmed the difference in nutrient intake claimed by other authors. A comparison of food service processes and systems showed that the production of meals and the quality leaving the kitchen was similar in both types of institution. However, the delivery and service system was found to be much less coherent in hospital than in prison. Transport and service of hospital food were subject to delays and disruptions from a number of sources, including poor communication and the demands of medical professionals. These meant that meals reached hospital patients in a poorer, less appetising condition than those received by prisoners. The findings are discussed in the light of previous work and in terms of hospital food service practice.

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Introduction

Published evidence (Edwards, Edwards, & Reeve, 2001; Edwards, Hartwell, Reeve, & Schafheitle, 2007; Hartwell, Edwards, & Beavis, 2007; Hartwell, Edwards, & Symonds, 2006) suggests that prisoners' food intake is more adequate for their needs than that of hospital patients, but little is known of the background or causes underlying this phenomenon. This paper examines and compares factors which may be influencing the food intake of prisoners and hospital patients.

The prison system's custodial responsibility requires that inmates receive a diet sufficient to maintain them, while its public responsibility means that this must be done on a minimal budget. Therefore in most countries, the quality of the prison diet, which might otherwise succumb to budgetary pressures, is controlled through national legislation (Brisman, 2008), for example in the UK it comes under the Prison Service Order 5000, which interprets the UK Department of Health's dietary reference values (DRVs) into

practical food terms (Blades, 2001). In 2000 UK prisons moved from a "ration scale" system, where prisoners were given set meals, to a menu system offering a range of choice at every meal. Prisoners in most European and US prisons can purchase supplementary food items from internal shops, but for security reasons, they cannot receive food brought in from outside.

Prisoners tend to look forward to mealtimes, which punctuate the daily routine with "high points" of varied activity (Valentine & Longstaff, 1998). However, the food and service express the penal experience, through bland monotonous quality, rigid timing and contrast with what prisoners would normally eat at home (Brisman, 2008; Smith, 2002) and for these reasons, most inmates express dissatisfaction with prison food (Dodd & Hunter, 1991; HMSO/OPCS, 1994; Smith, 2002; Ugelvik, 2011). Many consider that their diet changes on entering prison (HMSO/OPCS, 1994) and that they get too many calories for too little exercise (Valentine & Longstaff, 1998). The management of prison catering is important for maintaining morale, minimising disruption and avoiding riots, since collecting food from the prison service counter provides an opportunity for contact between inmates and a potential focus for trouble (Brisman, 2008; Valentine & Longstaff, 1998).

Hospitals generally have no custodial duty towards their patients, and medical treatment dominates the concept of care. As with prisons the catering budget is under public scrutiny and food and nutrition are subject to national guidelines, which focus on nutritional quality and on the food delivery system (Hartwell & Edwards, 2003; Mahoney, Zulli, & Walton, 2009; Porter & Cant, 2009).

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Many hospitals, including those in non-Western countries offer a range of menu choices (Jessri et al., 2011; Porter & Cant, 2009). On the other hand, the service and consumption of food often conflicts with medical rounds, diagnostics and treatments, and it is sometimes considered to hinder the institution's "proper" business of treatment (Hickson, Connolly, & Whelan, 2011; Jessri et al., 2011). Like prisoners, hospital patients look forward to meal times, since they mark the passage of time, and conversations with (non-medical) food service staff offer a brief escape from medical matters (Johns, Hartwell, & Morgan, 2010). Despite this, the quality, timing and delivery of hospital meals tend to accentuate patients' awareness of their absence from home (Johns et al., 2010) and as in prison, food is frequently a cause for complaint and dissatisfaction (Johns et al., 2010). Unlike prisoners, patients can receive food brought in from outside by friends and relatives. Hospitals also have shops that sell food items, but the scope is limited, since facilities are rarely available for patients to heat their own food (Hickson et al., 2011; Jessri et al., 2011; Johns et al., 2010).

Various studies have reported inadequate intake of energy and macronutrients, especially carbohydrates, among hospital patients, although dietary protein and most micronutrients tend to be adequate (Barker, Gout, & Crowe, 2011; Gallagher-Allred, Voss, Finn, & McCamish, 1996). Often patients' nutrition is poor on arrival and those most undernourished on admission tend to show the greatest rate weight loss during their hospitalisation (McWhirter & Pennington, 1994). Inadequate nutrition may lengthen patients' hospital stay by 50%, an average of 6 days, and triple mortality rates (European Nutrition for Health Alliance, 2008). Jeejeebhoy (2003) notes that hospital under-nutrition is not generally caused by disease-related factors and concludes that it must be due to low food intake.

In contrast, Edwards, Edwards, and Reeve (2001), Edwards, Hartwell, Reeve, and Schafheite (2007) report that the prison diet generally provides adequate amounts of energy, protein and most micronutrients. They found minor deficiencies in vitamin D, zinc, selenium, manganese and iodine, and sodium levels exceeded maximum recommendations, findings that are also consistent with studies in the UK and USA by Lester et al. (2003) Eves and Gesch (2003) and Collins and Thompson (2012). In addition to desirable nutrients, prison diets tend to contain higher than recommended levels of cholesterol, sodium, and sugar (Collins & Thompson, 2012; Edwards et al., 2001, 2007). Thus whilst prison diets cannot be unreservedly described as "healthy", prisoners appear to receive adequate energy, an appropriate balance of macronutrients and a reasonable intake of most micronutrients.

Prison and hospital catering are generally designated "institutional food", a term which has not been clearly defined in the academic literature. The following outline provides the elements of a definition for the present discussion. Institutions generally have some other motivation than feeding their population, which tends to be expressed in the food, the service and the situation in which the food is eaten. The quantity and quality of institutional food is under strict Governmental control, yet recipients tend to perceive the food as bland in taste, texture and temperature and the service as ill-timed and perfunctory, no matter how grateful they are to receive it. The quality of institutional food generally expresses the dominant national culture, and may not be entirely appropriate for minority groups (Valentine & Longstaff, 1998). Although one would hesitate to claim these features of institutional food as universal, they have been reported for hospitals, prisons and other institutions in countries as diverse as Norway (Ugelvik, 2011) and Iran (Jessri et al., 2011).

Above all (and despite reflecting the national culture) institutional food is always perceived as differentiating the institution from normal life. The recipients of hospital and prison food are 'unwilling customers', often anxious, frightened or disoriented at

being removed from the emotional security of home. They are surrounded by uniformed, empowered staff in an alien environment where meal times are imposed and the choice of food is often made well before consumption takes place, and there is generally also a loss of privacy. Given the similarity of food provision in the two situations (Ugelvik, 2011, reports that the prison he studied in Norway received its food from the local hospital kitchen), it is surprising that prisoners are substantially better nourished than hospital patients.

Other differences influencing the nutritional needs of hospital patients and prisoners include typical length of stay and nutritional status upon arrival. In prison the length of stay may be months or years, while in most European hospitals it now averages between 5 and 10 days (Beck et al., 2001; Johansen et al., 2004); thus the function of food provision is different. In hospital, long-term maintenance is generally not required, but patients must receive enough food to maximise their rate of recovery and redress poor nutrition that occurred before the hospital stay. Food service in prison is essentially concerned with long-term maintenance. The nutritional status of new prisoners has not been reported, but long-term exposure to prison catering presumably has a normalising effect. In all types of institution there is a humanitarian requirement to provide food in a condition that recipients consider edible and appetising.

The food service system, including ordering, transport, service and the environment where the food is eaten plays an important part in the meal experience and therefore has a significant influence upon food intake (Reilly, Hull, Albert, Waller, & Bringarden, 1987). Allison (1999) notes that effective ordering of hospital food may depend upon the clarity of the menu, the language in which it is written and the system by which orders are collected from patients and communicated to the kitchen. Menu choice and portion control may be inappropriate for patient needs (Rush & Moloney, 1998). For instance smaller, more energy-dense portions may produce greater calorie intake in older patients, who may be deterred by larger portions of carbohydrate-rich food (Stephen, Beigg, Elliott, Macdonald, & Allison, 1997). Transporting and holding institutional meals can render the temperature, texture and colour less attractive, by cooling, warming or drying the food (Hartwell et al., 2007; O'Hara et al., 1997). The service of hospital meals may reduce acceptability through poor presentation, or may make the food less accessible, if it is wrapped or placed outside the reach of the patient (Corish & Kennedy, 2000). The timing of meals may be too rigid, or spread over too long a period, and other aspects of service may be inflexible, for instance there may be no access to snacks and no allowance made for patients returning to the ward after tests or treatments (Jessri et al., 2011; McGlone, Dickerson, & Davies, 1995; Millar, 1998).

The service and consumption of food may be affected by disruptions due to ward rounds or emergencies, by the ward atmosphere, which depends on the level of activity of nurses and other staff (Corish & Kennedy, 2000) and by the medical conditions and behaviour of other patients (Cardello, Bell, & Kramer, 1996). Hickson et al. (2011) examined the effect of protecting mealtimes from medical rounds and other disruptions, finding that although patients valued the protected time their food intake did not increase. Edwards and Hartwell (2004) report that food intake was the same whether patients ate sitting alone by the bed or sitting in bed, but increased by 20% if patients ate together in a group. Food intake is also affected by diseases and medications, which may suppress appetite, cause nausea or distort sensory perception of food. Ethnic background may limit menu choice and reduce food acceptability, and handicapped patients' ability to feed themselves may be compromised by the way food is served or by a lack of available assistance (Corish & Kennedy, 2000). Older patients may be unable to

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