Creating a Great Patient Experience: Improving Care with Food and Nutrition Services

THE GOAL OF EVERY HOSPITAL is to optimize patient health. However, hospitals also must provide a great patient experience to secure future business and referrals. Patient dining, retail foodservice operations, and the integration of registered dietitian nutritionists (RDNs) within the interdisciplinary care team are all important components of the overall patient experience. We review the roles of the clinical RDN and foodservice staff in optimizing patient satisfaction. Information regarding nutrition plan of care, diet order entry, patient-specific education, retail foodservice operations, and an open system model for creating a great patient dining experience are included.

Patients typically have some freedom in choosing a hospital. A 2005 Gallup Poll Panel survey noted the top three consumer reasons for hospital choice are objectively based: "expertise in specific illness/treatment," "history of medical errors," and "doctor referral/doctor's orders."[1] However, additional weighted factors in decision making are subjective: "courtesy of the staff," "appearance of hospital/facility," "recommendation of family/friends," and "amenities (food, parking, etc)." Many consumers are using hospital survey results and comparison websites in choosing a hospital. The data from these surveys and websites often incorporate subjective reports of patient satisfaction. For example, the Centers for Medicare & Medicaid Services (CMS) uses patient experiences (as reported in the Hospital Consumer Assessment of Healthcare Providers and Systems Survey results) as one of its Hospital Compare data measurements. Hospital Compare is a website that allows hospitals to be compared on different performance measures, helping the consumer to make an informed decision on where to seek health care.[2]

Ultimately, regardless of tracking or reporting mechanism, improved patient experiences result in increased future business and financial security for the hospital. The desire to optimize patient experience should be shared by all hospital employees, not just the chief executive officer.

IMPORTANCE OF NUTRITION SERVICES

Quality of health care is typically measured in two metrics: patient outcomes and patient satisfaction. Although achieving optimal patient health outcomes is the primary quality metric, 54% of health care executives report "patient experience and satisfaction" as one of their top three priorities.[3] Food and nutrition services, in cooperation with other service lines, plays an important part in creating a great patient experience. Both foodservice and clinical nutrition operations should be considered when evaluating and working to improve the overall patient experience.

Implementing higher-end dietary upgrades such as on-demand or room service dining has been associated with improved patient satisfaction, oral intake, and physical outcomes.[4] Once a novel approach to patient dining, room service dining has now become standard practice in hospital foodservice operations.

The clinical RDN is an important link between foodservice operations and the patient bedside. Enhancing communication between nutrition services, the patient and the interdisciplinary team can yield improved patient satisfaction. Patients often consume more when they understand dietary restrictions, receive dietary preferences, and approve of the presentation and quality of the food.[5] Patients' understanding of their in-hospital and post-discharge health plans and instructions can prevent hospital readmissions[6] and medication errors.[7] Educating patients on nutrition care requires knowledge of nutrition services, customer relations, health literacy, and the individual patient's care plan.

INPATIENT RDN's ROLE IN SATISFACTION

The inpatient RDN plays a vital role in ensuring that nutrition care is prioritized and communicated between the interdisciplinary team and patient. In fact, most RDNs acknowledge the importance of being proactive and involved as an integral member of the interdisciplinary team.[8] Interdisciplinary round participation is encouraged to ascertain that nutrition goals are appropriately recognized and addressed.[9,10] One option in effectively implementing a nutrition plan is providing RDNs with institutional order-writing privileges. Improvements in quality of care, patient safety, and efficiency, as well as lower health care costs, have been noted when RDNs can create or adjust diet orders.[11] Although the integration of electronic diet order entry via the electronic health record has reduced the risk for diet order transcription errors, diet order entry by an RDN is still more accurate and timely than that of clerical assistants or registered nurses.[12] In 2014, CMS published a final rule allowing RDNs to write therapeutic diet orders independent of a physician order within the parameters of respective state licensure

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and facility bylaws parameters. CMS acknowledges that this privilege "enhances the ability that RDs [registered dietitians] already have to provide timely, cost effective, and evidence-based nutrition services as the recognized nutrition experts on a hospital interdisciplinary team and saves valuable time in the care and treatment of patients, time that is now often wasted as RDs must seek out physicians, APRNs [advanced practice registered nurses], and PAs [physician assistants] to write or co-sign dietary orders."[13] Although the RDN does not need to be involved in every short-term nil per os (NPO) advancement (such as after a minor procedure or test), the RDN adds value to the diet order entry process for patients with complex or evolving nutritional needs.

Once the interdisciplinary nutrition plan and orders are in place, the plan must be relayed to the patient or the patient's family. Patient and family engagement requires proper communication and a sound knowledge base.[14] Optimal interpersonal skills and nonverbal communication (eg, eye contact, touch, and facial expressions) allow the patient and family to feel comfortable speaking with and approaching the RDN with questions. RDNs must be mindful and respectful of educational, cultural, and social boundaries. An enhanced nutrition and medical knowledge base provides patients and families comfort that they are receiving the best nutrition care. The nutrition plan and goals must be clearly delivered in layman's terms. Health literacy can vary widely between health care professionals and patients,[15] and poor literacy can lead to misunderstanding, miscommunication, and negative outcomes. Health care literacy also plays a major role in satisfaction and compliance. If a patient is "NPO," the RDN should explain this means "nothing by mouth" and provide the reasoning behind the diet order (eg, altered gastrointestinal or swallowing function). The RDN must continue to follow up with the interdisciplinary team and patient or family in a timely manner. Follow-ups should include reviews of current nutrition status, any updates to the nutrition plan, and information on next steps to achieving nutrition goals, including diet advancement per gastrointestinal or surgical pathways or swallowing evaluations.

COMMUNICATING ABOUT NUTRITION SUPPORT

If a patient is to receive enteral nutrition or parenteral nutrition, the reasoning, route, and goal of the enteral or parenteral nutrition should be explained to the patient and family (eg, "You will be receiving a liquid nutrition via a tube that enters your nose and goes into your stomach to provide your nutrition needs until your swallowing functioning returns."). If the next step of the nutrition care plan is known, that information also should be communicated to the patient and family (eg, "The speech–language pathologist will continue to assess your swallowing function and advance your diet as able."). Knowledge of the pros and cons of nutrition support is also needed to appropriately answer patient and family questions or concerns regarding nutrition support. The RDN also plays an important role in educating the interdisciplinary team on the appropriateness of nutrition support in end-of-life situations.

ORAL DIETS AND PATIENT SATISFACTION

At the point of initial diet advancement, the RDN should perform a nutrition assessment and provide diet recommendations that coincide with the patient's current medical condition and medical history. Care must be taken to avoid over-restriction of food and beverages, because this can lead to confusion or frustration for the patient as well as insufficient intake required to support recovery.[16]

To encourage adequate intake and compliance with diet restrictions, the care team should provide information as to why certain diet restrictions are in place and how the patient can comply with the established diet parameters. The food and nutrition services team can support this education as needed through a variety of routes such as education provided by RDNs, providing RDN-approved materials to patients and families, and using RDN-approved call center scripting. Education must occur early and be reinforced by the team throughout the hospital length of stay to ensure that the patient fully understands the restrictions and is capable of making appropriate food choices.[17]

PATIENT DINING

Active communication is also required for inpatient menu selections. Meal services differ between organizations, and patients may not receive desired foods if the menu selection process is not explained. To improve patient satisfaction while ensuring foodservice efficiency, some facilities offer up to three types of meal service: nonselect, assist, and room service dining. With a nonselective menu, all patients receive the same meal, often called a "house diet," within set diet restriction parameters based on a rotating menu (often week-long in length). No choice is solicited from the patient. This type of service is indicated in patients who are too ill to place meal orders independently, lack the mental capacity to elicit choice (such as with advanced dementia), or are on diets with very limited choices such as level 1 dysphagia or clear liquid diets. An assist menu service involves a foodservice associate visiting the patient's room and asking what he or she would like to eat for upcoming meal periods. If the patient is unavailable or unwilling to make menu selections at the time of visit, a paper menu may be left at the bedside for patient completion. A foodservice associate may then revisit the patient later to collect paper menus and enter the data into the foodservice software.

Room service dining is the third and often preferred option for meal service. Like hotel in-room dining, room service dining allows the patient to call and place meal orders from a static menu. On hospital admission or diet advancement, the patient and family are provided instructions on how to place a meal order. To ensure diet compliance, all orders should be filtered through the foodservice software, which flags any noncompliant items such as excess sodium with a cardiac diet or insufficient carbohydrates with a consistent carbohydrate diet. The patient should be informed as to why items are noncompliant, to avoid resulting frustration in not receiving requested menu items.