REHABILITATION COMMUNAL EATING

QEII HOSPITAL

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BRISBANE

BASELINE DATA

- Poor oral intake by stroke and rehabilitation patients resulting in reduced participation in therapy, low energy levels, fatigue and poor concentration.

Inadequate nutrition can also result in decrease in mobility, with increased liability to venous stasis, thrombosis, and pressure sore formation, wound healing is delayed. Respiratory muscles weaken and the normal hypoxic respiratory drive is attenuated cardiac function is impaired. The immune system is affected, with increased susceptibility to infection Hospital complication, mortality, and unplanned readmission rates rise, in-patient treatment is prolonged and quality of life may be reduced (Perry, Hamilton, Williams, & Jones, 2013).

- Patient isolation resulting to low mood, low intake, low participation

Adequate nutritional intake is fundamental for recovery and rehabilitation, with potentially devastating effects associated with protein-energy malnutrition. Loss of muscle strength, energy, and body tissue may be followed by mental changes involving depression, lethargy, and anxiety apathy and anorexia may develop (Perry et al., 2013).

AIM OF THIS INNOVATION

Communal eating will allow staff to monitor patients intake, identify those requiring assistance, swallowing issues, low intake thus allowing prompt referral to dietetics and speech pathologists as they are present in the room.

- 90% of patients to have their meals in the dining area
- Reduce malnutrition
- Reduce pressure injuries
- Reduce infection, DVTs
- Reduce length of stay
- Increase endurance as patients walk back and forth the dining area as part of therapy

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KEY CHANGES IMPLEMENTED

- A high number of patients have been complaining of low energy levels, feeling tired and fatigued resulting low participation in therapy. Due to the low number of staff at meal times, it is difficult to monitor all patients nutritional intake.

Eating management difficulties have been found to be common among patients with stroke, with 89% having difficulties in insertion of food into the mouth, inability to locate tray of meals (40%) or to locate items on a meal tray, hoarding food in the mouth (40%), and regurgitation and/or choking of food (36%) (Mizrahi, Arad, Weiss, Leibovitz, & Adunsky, 2013). Higher food intake has been observed among seniors who ate in a dining room regardless of whether they lived at home, in an institution or were hospitalized

- Implementation of communal eating on 4B has encouraged patients to interact with each other, allowed a multidisciplinary approach to patient nutritional intake

KEY CHANGES IMPLEMENTED

- Set up the dining area in an inviting way to encourage patients to come out to the dining room
- Provide brief education sessions on nutritional importance whilst patients are waiting for meals
- Have a nursing staff, speech pathology staff, occupational therapists and dietetics available to patients during mealtimes.
- Involving relatives to have meals with their loved ones

OUTCOMES SO FAR

- Staff visibility monitoring patients intake in real time
- Increased number of patients having meals in dining room 15-20
- Increased participation in therapy
- Patients displaying good energy levels
- Less break down of skin and pressure injuries
- Reduce malnutrition rate
- Prompt referral to dietetics and speech pathology as they are present in the dining area

OUTCOMES

LESSONS LEARNT

- Introducing change is not always easy
- Have a strategy - communication, multidisciplinary team approach
- Know how to sell it
- Review outcomes and feedback results

REFERENCES

Mizrahi, E.-H., Arad, M., Weiss, A., Leibovitz, A., & Adunsky, A. (2013). Eating management and functional outcome of elderly patients with symptomatic ischemic stroke undergoing inpatient rehabilitation: Eating management among stroke patients. Geriatrics & Gerontology International, 13(3), 701-705. doi:10.1111/ggi.12003

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