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Title

Ward culture and staff relationships at hospital mealtimes in Australia: An ethnographic account.

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- 1.1 Study aim: This study was part of a larger research project exploring mealtime culture, environment and social practice from the perspective of staff, volunteers and visitors in subacute care (Ottrey, Porter, Huggins, & Palermo, 2018). The contributions of volunteers and visitors have been reported elsewhere (Ottrey, Palermo, Huggins, & Porter, 2018).
- 2.4 Ethical considerations: Ethics approval was obtained from Eastern Health (LR76/2015) and Monash University (CF15/2929 - 2015001205) human research ethics committees.
- 4 Discussion: We have also shown that engagement of volunteers and visitors may also support positive mealtime experiences and staff work practices (Ottrey, Palermo et al., 2018).
- References:

- Ottrey, E., Palermo, C., Huggins, C.E., & Porter, J. (2018). Exploring staff perceptions and experiences of volunteers and visitors on the hospital ward at mealtimes using an ethnographic approach. *Journal of Clinical Nursing*. 27, e1571–e1579. doi:10.1111/jocn.14318
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ABSTRACT

Nutrition care is a fundamental component of quality healthcare provided to patients in hospital, yet little is known about the staff who deliver this care and their interrelationships, and how this impacts nutrition care. In this ethnographic study on two subacute wards, 67 hours of fieldwork was conducted over three months to explore the relationships, roles and responsibilities of those involved at mealtimes, and influence on meal provision. Data were analyzed inductively and thematically. Three themes describing ward culture and staff relationships emerged: (i) defining mealtime roles and maintaining boundaries; (ii) balancing the need for teamwork and having time and space; and (iii) effective communication supports role completion and problem solving. Lack of appreciation of workflow enablers and barriers degraded working relationships between staff with and without central roles at mealtimes. This study informs healthcare organizations on building a culture that supports interprofessional collaboration in nutrition care in the subacute setting. All staff need to be aware of their and others' mealtime roles and responsibilities to support a coordinated approach.

KEYWORDS

Hospitals, interprofessional relations, meals, nursing, qualitative research, subacute care.

1 INTRODUCTION

Successful healthcare services are built upon effective interprofessional relationships to achieve common outcomes for the benefit of patients. Mealtimes are essential for the physiological and psychosocial health, wellbeing and recovery of hospital patients (The British Dietetic Association, 2017), yet little is known about the individual and teams of staff and their interrelationships that provide meals to hospital patients. This knowledge is needed to inform healthcare organizations, so that they may build a culture that supports staff from different professions to work together and

prioritize mealtimes in hospital, thus promoting quality nutrition care (DiMaria-Ghalili et al., 2014; Iff et al., 2008).

Interprofessional collaboration is the process of bringing different staff groups together to foster effective interaction for the betterment of healthcare (Zwarenstein, Goldman, & Reeves, 2009). Strategies that support interprofessional collaboration amongst healthcare staff have the potential to improve processes and outcomes (Zwarenstein et al., 2009), and may include activities such as interdisciplinary team meetings, case conferences and joint consultations. In relation to nutrition care, interprofessional strategies known to improve quality and safety include parenteral nutrition ward rounds (Hvas et al., 2014) involving doctors, nurses, pharmacists and dietitians, and meal audits (Banks et al., 2017) conducted by dietitians, speech pathologists and foodservice staff.

Research has shown that interprofessional collaboration in nutrition care is yet to be fully realized. An Australian study on barriers to feeding patients in hospital found inadequate interdisciplinary communication and a lack of shared responsibility amongst the healthcare team negatively impacts nutrition care coordination (Ross, Mudge, Young, & Banks, 2011). Another study exploring clinicians' perceptions of practice improvement strategies found different healthcare professions lack a shared understanding of nutrition-related harms (McGrath, Botti, & Redley, 2017). Working in departmental silos has been highlighted as contributing to inefficiencies, and a lack of engagement impacting the sustainability of nutrition care practice changes (Laur, Valaitis, Bell, & Keller, 2017).

Consequently, there have been ongoing calls for greater healthcare team engagement and collaboration in nutrition care (Bell et al., 2018; Stone, 2013). Efforts to achieve this have included novel models of care addressing organizational culture (Tappenden et al., 2013) and interventions like protected mealtimes (Porter, Ottrey, & Huggins, 2017). What remains unclear is the nature of the relationship between staff from different professions who provide meals to hospital patients, whether there is a desire to work together at mealtimes and how this influences nutrition care. There is a need to explore the attitudes, intentions, behaviors and interactions of staff who are involved at hospital mealtimes to inform efforts that aim to improve nutrition care.

1.1 Study aim

This study was part of a larger research project exploring mealtime culture, environment and social practice from the perspective of staff, volunteers and visitors in subacute care (Ottrey, Porter, Huggins, & Palermo, 2018). **The contributions of volunteers and visitors have been reported elsewhere** (Ottrey, Palermo, Huggins, & Porter, 2018). The aim of this study was to explore the relationships, roles and responsibilities of staff involved at hospital mealtimes, and their impact on nutrition care.

2 METHODS

A qualitative, ethnographic approach was considered best for this research (Savage, 2000), supporting immersion on the study wards and providing the opportunity to observe participants' behaviors and ask questions about their experiences (Gobo & Molle, 2017). This promoted an enriched understanding of ward culture and staff relationships at hospital mealtimes, helping to uncover new knowledge on how the healthcare team engages in and works together to deliver nutrition care.

2.1 Sample

A purposive sample of one ward each from two sites within an Australian healthcare network was chosen. The study wards were part of the subacute care program, where patients were admitted for geriatric evaluation and management or rehabilitation. Each ward contained 32 beds and was staffed by a healthcare team that included a wide range of clinical and support service personnel. Meals were plated in the kitchen and delivered to patients on the ward by foodservice staff. Mealtime assistance was provided to patients by nursing staff and/or volunteers. Therapy unrelated to eating was not scheduled at mealtimes, although a protected mealtimes program was not in place. Additionally, nutrition inservices (i.e. malnutrition, therapeutic diets) were conducted by the dietitian as part of staff education.

All staff (including such as engineering, security, TV hire personnel), volunteers and visitors on the study wards during meal service were eligible to participate in the research, unless expressing reluctance or verbally declining to participate. Eligibility criteria for profession, level of professional experience or time spent on the study wards were not set to maximize sample diversity and reflect the real world and practice. Leaders from nursing, dietetic and foodservice departments were invited to participate. Patients were not directly involved in this research.

2.2 Data collection

Fieldwork (67 hours) was conducted by the first author over a three-month period. The first author was a dietitian researcher invested in optimizing nutrition care and with an understanding of the healthcare system, however was not an employee of either study ward (Yanos & Ziedonis, 2006). A combination of observation and interview data collection techniques were used in this study, informed by the work of Angrosino (2007), Fetterman (2010) and Spradley (1980).

Observation was used to learn about the behaviors and interactions of participants at mealtimes. Meal services at breakfast, lunch and dinner were observed on different days of the week to capture diversity in the people present and events that occurred at mealtimes. The first author moved throughout the ward, watching and listening to participants and recording this data as hand-written fieldnotes. Fieldnotes were fully reconstructed as typed fieldnotes (112 pages, single-spaced) after each observation episode. Repeated observations helped participants to feel at ease, reduced the likelihood of changed behavior and enabled evolving interpretations to be checked. Observation continued until patterns were realized.

Interview was used to engage with participants to explore their views and experiences of mealtimes, discover meaning and contextualize observations. Discussion focused on participants' hospital and mealtime role, the mealtime environment, and what helps or hinders mealtime involvement. This helped to illuminate the attitudes and intentions that contribute to ward culture and practice at mealtimes. Key points were relayed back to participants to check understanding and obtain further insight (Creswell & Miller, 2000). Potential interviewees were primarily identified through observation, and to a lesser extent, at the suggestion of other participants. Potential interviewees were approached face-to-face and invited to participate. Interviews were opportunistic, conversational and open-ended in nature. Follow-up interviews were sought by the first author to clarify understanding, or by participants to offer further explanation. Audio recording was used where possible and with participants' consent, and transcribed verbatim. Otherwise data were recorded as hand-written fieldnotes. Semi-structured interviews were conducted with leaders, where discussion also covered

policies, procedures and training that influence mealtimes. These interviews were audio-recorded and transcribed verbatim.

2.3 Data analysis

Data were analyzed using an inductive, thematic approach, focusing on the relationships, roles and responsibilities of staff involved at mealtimes. The first and second authors independently coded a sample of transcripts and fieldnotes, then crosschecked code lists to reach consensus on the coding framework. The coding framework was applied to code remaining data, evolving as data were analyzed. Codes were grouped and summarized, and thematic maps drawn to help identify and analyze patterns (Braun & Clarke, 2006). A multilevel approach to data analysis was taken, with consideration of individual staff, staff from the same profession, then staff from the same site. Data analysis was supported by NVivo data management software, memo-writing and reflective journaling.

2.4 Ethical considerations

Ethics approval was obtained from Eastern Health (LR76/2015) and Monash University (CF15/2929 - 2015001205) human research ethics committees. Support for data collection was obtained from directors of nursing, allied health and support services. Participants were aware of the study through posters, staff information sessions and direct communication with the first author. Participants were identified in fieldnotes using unique codes in place of actual names to protect anonymity.

3 RESULTS

More than 150 participants were involved in this research through observation and/or interview, predominately staff (approx. 90%). Staff were from a wide range of professions, including nursing, medical, allied health (i.e. dietitians, speech pathologists, physiotherapists, occupational therapists, social workers and allied health assistants), food and support services, and administration. Varied levels of professional experience were captured, ranging from pre-registration students to directors. Foodservice staff held positions that included foodservice assistant, menu monitor, chef, supervisor and manager. Staff were employed on casual contracts through to permanent positions. Sixty-one participants were interviewed on at least one occasion (75 interviews in total), including 18 nurses and 14 foodservice staff.

The analysis of observation and interview data revealed three key themes relating to ward culture and staff relationships at hospital mealtimes, and these were: (i) defining mealtime roles and maintaining boundaries; (ii) balancing the need for teamwork and having time and space; and (iii) effective communication supports role completion and problem solving.

3.1 Defining mealtime roles and maintaining boundaries

Both nursing and foodservice staff played a central role in mealtimes on the ward each day. Nurses described the functions of their role, such as needing to input diet codes into the menu system, ready patients for meals, supervise and encourage food and fluid intake, resolve foodservice issues and minimize risk associated with eating, for example by providing mealtime and feeding assistance. Other tasks completed by nurses at mealtimes were medication administration, clinical observations, documentation and toileting patients. Foodservice staff defined the operational aspects of their role,

which were meal preparation, meal tray delivery and collection. Some foodservice staff considered the broader mealtime experience, expressing their role as providing nourishment and joy to patients:

“We don’t push and prod. We don’t hurt them. We feed them. We give them cuppas. We are the happiest people that they see.” (MM3, foodservice staff)

Dietitians, speech pathologists, occupational therapists and allied health assistants were involved with selected patients at mealtimes, undertaking activities directly related to eating, such as meal rounds, swallow assessments, equipment reviews, breakfast and lunch group facilitation. Other allied health professionals, including physiotherapists and social workers, were rarely seen on the ward at mealtimes, and if they were, this was not usually for meal-related activities. One physiotherapist reflected on their limited mealtime involvement:

“I think it would be nice for us as physios to have little bit more of a role at lunch time. I think we can assist in terms of the feeding. It’s just whether that would fit in with the way that we run things, and the way that we structure our therapy and what we can offer in terms of resources. I know the OTs [occupational therapists] run the lunch group... It’s just something we’ve never really been involved with and don’t really have clear direction in terms of what our role would be within that setting.” (PTA, physiotherapist)

The way that staff responded to seeing the meal trolley arrive on the ward offered insight into how they perceive their mealtime role. Nurses’ responses varied from needing to ensure patients were set up for meals, to realizing it was nearly time for their break. For physiotherapists, it was about patient consultations and working out whether there was enough time to conduct one more, or needing to finish up. Similarly, occupational therapists described how the meal trolley signaled that it was time to do administrative tasks, such as documentation.

Delineation of mealtime responsibilities was sought and maintained by foodservice staff, particularly when it came to system issues, such as missing or incorrect diet codes. These issues were seen by foodservice staff as being the nurse’s responsibility to resolve. Similarly, dietitians reported asking nurses to provide mealtime assistance to a patient when this need was identified. Rather than delegating to another profession, nurses were often observed to take on the responsibility of resolving foodservice issues themselves. For example, locating packets of salt or butter if requested by patients, improving meal tray accessibility, and retrieving missing pieces of cutlery.

Patient in room 23/24 mumbles something to YM [nurse] as she enters the room. YM, “Hey?” More mumbling. YM, “You didn’t get one either [a spoon]? Hold on. I’ll go and find one.” Still wearing the medication vest, she exits the room, walks down the corridor in search of a spoon. She returns a minute later, “There you go. That’ll make it a bit easier on you!” (Fieldnote extract, 8:30am on 18th August 2015)

Nursing staff admitted being unsure about the scope of the foodservice staff role when it came to meal accessibility. For example, nurses reported not knowing whether it was the foodservice staff’s responsibility to remove lids, set out cutlery or provide napkins at mealtimes. This lack of role understanding by nurses was reflected by foodservice staff:

“There are some nurses who are really switched on to the role that I have and the importance of it. Others are sort of oblivious to it.” (MM4, menu monitor)

3.2 Balancing the need for teamwork and having time and space

Participants reported that “working together” was important at mealtimes. Examples of intraprofessional teamwork included nurses checking on their colleagues’ patients while they were on break, foodservice staff working in tandem to deliver meal trays, and pairs of occupational therapists or dietitians facilitating breakfast and lunch groups. Examples of interprofessional teamwork were also observed, such as the way that nurses, foodservice and allied health staff (i.e. dietitians, physiotherapists, allied health assistants), and volunteers worked together to facilitate the dining room program.

“You have to support each other; leader with a team and the team who has a supportive leader... It has to be two to tango.” (MIC, nurse)

Leaders from the foodservice department expressed the desire to have “everyone on the same page”, for staff to feel “comfortable” approaching other team members and to have “respect going both ways”.

Both nursing and foodservice staff identified the importance of having time and space to complete the tasks that they needed to do at mealtimes. For nursing staff, this related to the need for uninterrupted time to conduct medication rounds at mealtimes to promote patient safety. For foodservice staff, this was about ensuring the corridors were clear of people and equipment to enable passage of the meal trolley, and protection from interruptions to facilitate timely meal delivery to patients.

“We should have restricted mealtimes. They’re my time. And I’ve told them. I tell doctors, I tell everyone... They should be my time from 12[noon] to 12:45[pm] and from 8[am] to 8:45[am]. They [the patients] should be left alone to eat... No visitors. No phone calls. No doctors. No speech. No physios. Physios walk up and down the hallway at quarter past 12 [12:15pm], and we’re trying to get the Burlodge [meal trolley] through... It’s really dangerous.” (LR, foodservice staff)

There were mixed views from nursing staff on whether medical and allied health staff helped or hindered meal service. This was most clearly seen when comparing weekdays, where numerous medical and allied health staff were present, and weekends, where they were rarely seen. Some nurses reported that it was helpful to have allied health staff around during the week, such as physiotherapists and allied health assistants, to assist with transporting patients to the dining room. Other nurses and foodservice staff described the medical and allied health staff presence as a distraction, contributing to congestion, a sense of busyness and feeling overwhelmed.

“There’s more people [on weekdays]. It’s busier. More noise, doctors, allied health... There’s so many people here. Busy, busy. And they all want to do everything... You’ve got more doctors, they’re doing rounds, and you’ve got OTs [Occupational Therapists], Speech... They’re all here, doing their bits.” (CIC, nurse)

When the desired balance between working together and having time and space was not achieved at mealtimes, nursing and foodservice staff reported feeling under-supported and their workflow interrupted. This contributed to a sense of stress, exasperation and “animosity” within and between staff groups, including those with and without central roles at mealtimes. Perceived time pressures,

patients' level of dependence and cognition, and lack of awareness of other's roles were described by staff and seen to be influencing factors.

“It's very messy and awkward. There's no real structure [to mealtimes]... Everyone's got their own job to do and everyone's concerned about that.” (FSM2, facility services manager)

3.3 Effective communication supports role completion and problem solving

Communication between staff involved at mealtimes was observed to enable the completion of mealtime tasks. Foodservice staff were seen to liaise with nurses to clarify the status of isolation rooms and to identify patients in the dining room. Nurses were observed relaying information to foodservice staff to assist with meal service, such as patient flow (i.e. admissions and discharges), room and diet code changes. Nurses were also seen advising allied health assistants – responsible for transporting patients to the dining room – of patients preferring to stay in their rooms for meals.

Liaison between staff involved at mealtimes extended to those without significant mealtime roles to promote smooth meal service operation and maintain mealtime schedules. Well-developed working relationships between those involved at mealtimes, and an understanding of other mealtime staff's workflow enablers and preferences, were noted to drive this communication.

DT2 [dietitian] and YM [nurse] exchange comments about the lateness of the physiotherapy group, which is still running in the therapy room, appearing anxious that the patients will be late to lunch. MIC [nurse] has also noticed that the group is still running. DT2 comments to MIC, “[LR][foodservice staff] won't be happy if they're not in their rooms!” Admonitory tone. TK [nurse] walks over to the therapy room, knocks on the door, [addresses the therapists running the group], “Sorry! It's lunch time now!” (Fieldnote extract, 12:00noon on 15th October 2015)

Participants described using interprofessional communication to prevent problems from arising at mealtimes. For example, the nurse in charge instructing foodservice staff to delay meal tray delivery if they arrived early on the ward, enabling nurses to finish readying their patients for meals. Similarly, dietitians asking therapists to schedule therapy sessions away from mealtimes, reducing the impact of fatigue on food intake and satiety on therapy participation. Participants identified electronic communication between the ward and kitchen via email or the menu system as ways to ensure patients received suitable meals.

Some problems affecting mealtimes were reported to other professions to be resolved. The communication of patient-related issues was described as supporting enhanced nutrition care, such as nurses requesting allied health input for difficulty feeding or swallowing, or foodservice staff advising the dietitian of poor supplement intake. Reporting system-related issues alerted other professions to errors that could impact meal provision, such as nurses telling foodservice staff that another meal was required, or foodservice staff notifying nurses of missing diet codes in the menu system. Nurses were observed to attend to other foodservice issues on the spot (i.e. items missing from the meal tray), rather than informing foodservices, which was seen to improve the patients' mealtime experience **when they received what they ordered.**

Participants expressed that staff meetings were a useful way to facilitate communication about nutrition care to the healthcare team. Dietitians described using interprofessional team meetings as an opportunity to ensure that nutrition-specific goals were set for selected patients, such as attending the dining room for meals. Meetings involving representatives from foodservices, dietetics and speech were reported to focus on foodservice issues, audit results and system changes.

4 DISCUSSION

This ethnographic study aimed to understand mealtime culture by exploring the relationships, roles and responsibilities of the individual and teams of staff involved with meal provision in hospital. Although numerous professions have input at mealtimes, a lack of understanding and appreciation of each other's roles, **deflection of responsibility to resolve issues**, and conflict between staff wanting teamwork and segregation at mealtimes was identified. These findings provide insight into why effective interprofessional communication and collaboration remains elusive at mealtimes, hampering efforts to improve nutrition care.

High-performing healthcare teams have been described as those that have clear vision and purpose, specific goals linked to outcomes, skilled leadership, regular and effective communication, cohesion and mutual respect between team members (Mickan & Rodger, 2005; Misfeldt, Suter, Oelke, & Hepp, 2017). Glimpses of these qualities were observed in this study, such as how different professions contributed to dining room program facilitation, and how some meal-related issues were reported to another profession to enable their resolution. What appears to be missing, consistent with other research (Ross et al., 2011), is a shared understanding of the importance of mealtimes and how all members of the healthcare team need to contribute. For example, we found some staff were focused on discipline-specific tasks (i.e. completing group therapy), rather than working to support meal service at mealtimes (i.e. ensuring patients were ready to receive their meals). This raises serious doubt as to whether members of the healthcare team see themselves as a team and whether together they are collectively competent (Lingard, 2009) when it comes to mealtimes, even though optimal food and fluid intake will ultimately benefit other treatment goals for patients.

This highlights the need for healthcare services to reinforce the overall vision for quality patient care and shared goals relating to nutrition care, including the provision of nutritious food (Department of Health & Age UK, 2014). This has been modelled in other hospital programs, like falls prevention programs, which are emphasized as everyone's responsibility (Hempel et al., 2013). In an environment of disinvestment in nutrition and dietetic services (Bell et al., 2018), it is critical for all members of the healthcare team to work together to prioritize mealtimes. A more coordinated and collaborative approach at mealtimes may be promoted by establishing forums to discuss the delivery of nutrition care, dedicated interprofessional collectively competent mealtime teams and nutrition champions to enact positive mealtime strategies (Fabbruzzo-Cota et al., 2016; Tappenden et al., 2013). **We have also shown that engagement of volunteers and visitors may also support positive mealtime experiences and staff work practices** (Ottrey, Palermo et al., 2018). Improved reporting systems that elevate mealtime and foodservice issues to higher operational levels may help to drive system-wide practice changes (Tucker & Edmondson, 2003). Reorientation of therapy structures and resources towards mealtimes may facilitate buy-in from professions with limited mealtime involvement, through increased presence, thus potential for communication and contribution, even if unofficial in nature (Lewin & Reeves, 2011).

The responsibility of promoting interprofessional collaboration at mealtimes must also extend to educational institutions. Studies on interprofessional education typically involve healthcare professions, such as medicine, nursing, physiotherapy, occupational therapy, dietetics and pharmacy (Hammick, Freeth, Koppel, Reeves, & Barr, 2007; McKenna et al., 2014; Roberts & Goodhand, 2018), with little attention paid to effective collaboration with support service personnel. The findings of this study support previous reports that foodservice staff are integral to **nutrition care for their role in meal preparation and delivery** (Keller et al., 2014; Ottrey & Porter, 2017), thus should be considered part of the healthcare team. Broadening curricula for healthcare undergraduates, especially nursing and dietetic students, to include working with support service personnel may help to promote preparedness for interprofessional practice in the workplace and foster respect for foodservice staff (Hammick et al., 2007; McKenna et al., 2014).

There were several notable strengths to this research. The first author's background as a **dietitian** researcher provided prior knowledge and experience with healthcare systems, nutrition care and translational research, supporting a greater appreciation of practice challenges and findings with real world relevance (Yanos & Ziedonis, 2006). Applying an ethnographic approach allowed prolonged engagement on the study wards to observe and engage with participants. This enabled an enriched and nuanced understanding of ward culture and relationships at hospital mealtimes, in ways that observation or interview alone could not have provided.

4.1 Limitations

The study's limitations should be acknowledged. Observation primarily focused on behaviors and interactions occurring on the ward at mealtimes. Observation in other locations (i.e. kitchen, team meetings) may have offered further insights into ward culture and staff relationships influencing nutrition care. **The findings are from two subacute care wards within one healthcare network, potentially limiting transferability to other healthcare settings (i.e. acute care) or organizations where mealtime and ward personnel and practices may differ.** Further research into mealtime culture in other healthcare networks is needed to ascertain organizational influence, as is a deeper exploration of the foodservice staff perspective to understand their willingness and capacity to play a greater role in enhancing nutrition care.

5 CONCLUSION

Effective interprofessional collaboration is essential for quality healthcare, but is yet to be achieved at mealtimes **in all healthcare networks**. Healthcare organizations must strive to build a culture that supports staff from different professions to work together and prioritize mealtimes to enrich nutrition care. **Contributions are needed from all team members, where reinforcement of shared goals and reorientation of resources towards mealtimes may support greater staff engagement.** Strategies are needed to help staff clearly understand **their and others' mealtime roles and responsibilities to support a coordinated approach. Greater appreciation of workflow enablers and barriers may strengthen working relationships between staff with and without central roles at mealtimes.**

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Title

Ward culture and staff relationships at hospital mealtimes in Australia: An ethnographic account.

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- 1.1 Study aim: This study was part of a larger research project exploring mealtime culture, environment and social practice from the perspective of staff, volunteers and visitors in subacute care (Ottrey, Porter, Huggins, & Palermo, 2018). The contributions of volunteers and visitors have been reported elsewhere (Ottrey, Palermo, Huggins, & Porter, 2018).
- 2.4 Ethical considerations: Ethics approval was obtained from Eastern Health (LR76/2015) and Monash University (CF15/2929 - 2015001205) human research ethics committees.
- 4 Discussion: We have also shown that engagement of volunteers and visitors may also support positive mealtime experiences and staff work practices (Ottrey, Palermo et al., 2018).
- References:
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