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Letter to the Editor

Way of delivering food in hospital to improve nutrition

To the Editor

Hansen et al. wrote a very interesting paper on a new way of delivering food in hospital by a buffet system.[1] Along with this, the most important aspects that we can detect are the existence in Denmark of widely adopted guidelines to screen people admitted to a hospital with a very reliable tool, as it is the nutritional risk score (NRS-2002),[2] and the availability of three different menus according to special requirements (fat-energy of 30% or 40%) and nutritional risk (fat-energy of 50%).[3] Unfortunately, only 50% of patients at nutritional risk (NRS-2002 $\geq$ 3) ordered the correct menu and interestingly for those taking $<$50% of the energy requirements about 90% came from the main courses.[1] We would like to discuss some points.

The choice of a buffet system in a hospital is not just a way of delivering food but it appears as a promising solution to improve nutritional risk all over Europe. Although in Denmark only a hot course is served (dinner), in many others European countries (e.g. Italy) at least one hot first-course and one hot main course are served both at lunch and at dinner. Accordingly, if the food provided is more tasty, given the trend to take most of the energy from the main courses, oral intake might be consistently increased. This is what we suggested in a recent issue of the journal when emphasizing the precious role of the catering service leading chef in improving nutrition in a hospital.[4]

However, in these countries a buffet system seems to be expensive way, and very difficult to sustain, when costs usually need to be reduced. Thus, although snacks appear scantly consumed, they become an important resource and the use of energy-dense formula might probably be enforced in this catering model. Nevertheless, it should be very interesting to know if Hansen et al. have considered possible external factors biasing the assessment of intakes. It is our experience that, unsatisfied of hospital food, some people like to have some food taken from relatives and not to declare it, fearing to be prohibited to.[5] Accordingly, if patients had some snacks from home they might have refused what was provided by the hospital.

Along with this, it should be recognized that the study by Hansen et al. is more consistently focused on the system used rather than on the features of the population recruited. Indeed, some patients suffer more frequently from conditions affecting normal intake. Geriatrics might experience many problems according to dysphagia and cognition. Orthopaedics, apart from the first days after surgical procedures, usually have less difficulties. Moreover, general medicine patients frequently present with gastrointestinal complications, cancer and so hyporexia/anorexia, thus making intakes compromised. Finally, it should be very interesting to focus on whether people can eat by themselves or need help and if this can increase food intake.[6] Sometimes, feeding can take more than 30 min and fatigue can lead to a suspension of this important appointment.

Future analyses concerned with the systems of food delivery should probably consider also these factors in order to improve nutrition in the population admitted.

Conflict of interest

All authors certify that there are no affiliations with or involvement in any organization or entity with a direct financial interest in the subject matter or materials discussed in the manuscript.

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