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Mealtimes in single-room accommodation: The patients' perspective

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RESEARCH ARTICLE

Why you should read the article

- Mealtime in single-room accommodation is characterized by complexity
- Professional responsibility for the patient's food intake and meal situation is important
- Knowledge of patients' perspectives may guide nurses' approaches to communicating with patients about the importance of the meal for well-being, healing and rehabilitation

Abstract

Aim: To investigate how patients admitted to single-room accommodation experience mealtime situations.
Methods: The study employed an ethnographical phenomenological design using the go-along method. From April to September 2022, 40 hours of meal-related observations and informal conversations with ten patients were completed in a Danish cardiac medicine ward and a vascular surgery ward. Data were analysed using a Ricoeur-inspired method.
Results: Admission to a single-room is not unequivocally excellent or wrong with respect to the patients' experiences of the meal or their perceived appetite. Nevertheless, meals were often referred to as the highlights of the day. Patients were positive about their own influence on their food choices, but they needed to experience professionals talking to them about healthy nutrition. Privacy was greatly emphasised, and most patients chose to eat alone because of their condition. Therefore, eating in the common dining room was seldom chosen. The results are presented in two themes: 1) Beyond the tray: Understanding the significance of meals for patients in single-rooms, and 2) Alone – but not lonely.
Conclusions: Single-rooms allow for privacy during illness and recovery and make it possible to have private conversations about adequate nutrition. Clear professional responsibility needs to be assigned for the meal in single-room accommodation.
Relevance to clinical practice: Knowledge of patients' perspectives may guide nurses' approaches to communicating with patients about the importance of the meal.

Keywords: Nursing; Nutrition; Hospital design; Single-room accommodation; Qualitative research

Introduction

Nutritious food and participating in pleasant meals are important elements of our everyday life. According to the seminal work by the Australian professor Deborah Lupton (1), food and eating practices are central concerns in western societies and relate to the body, self-control, health, consumption and the construction of identity. In addition, well-prepared, healthy food is related to health and to disease prevention (2-3).

Studies show that malnutrition can interact with the immune system, leading to several health-related issues, e.g., increased immobilisation, infection, and risk of cancer, but also to poor wound healing and prolonged rehabilitation (2,4). It is also well known that food intake is closely related to social and cultural contexts. Preparing the meal is often correlated with the family, friends and specific traditions. Thus, psychological aspects are connected to mealtimes.

Lupton (1) stresses that food is fundamental to the individual's sense of self, and that nutrition and the mealtime have strong psychological connotations. It is described in several studies that a mealtime's social environment can result in greater and healthier food intake (5-6).

The present paper focuses on experiences relating to mealtimes in single-room accommodation. We discuss the patients' perspective, and we discuss how professionals may exploit the single-room's possibilities for private conversations.

Background

In nursing care, nutrition has been on the agenda since the end of the 19th century when Florence Nightingale highlighted the importance of adequate nutrition for patients (7). Since then, other nurse theorists have followed in her footsteps, stressing that the intake of food and drink is a basic need (8-9).

Nowadays, the evidence-based framework of nursing Fundamentals of Care (FoC) has emerged from the International Learning Collaborative as a conceptual framework for what nursing is; it points to the importance of being person-centred and fulfilling the patient's needs when providing nursing care. For example, FoC highlights eating and drinking as basic needs in the individual patient's physical fundamental care (10-11).

Despite decades of focus on nutrition and improved conditions for mealtimes, the literature shows that sufficient nutrition and focus on mealtimes remains a problem in nursing care (3,6). The literature shows that achieving sufficient nutrition in a hospital setting is complex as food is often secondary to the main reasons for admittance (3,5-6,12). In a hospital, the mealtimes seem merely to provide nutritional support, without focusing on improving patients' perceptions of hospitalisation (5,13).

According to Beck et al., being admitted to hospital often means that familiar home environments are replaced by unfamiliar surroundings (5). In accordance with the international literature, the authors stress that eating routines in hospitals often differ considerably from patients' usual habits, wherefore patients often choose to eat alone or not to eat at all (3,5-6,12-13). Several of these studies suggest that organisational changes in hospital environment and design may have the potential to address the patient's lack of appetite positively.

Worldwide, hospital design is evolving towards mainly single-room accommodation. The ambition behind increasing the number of single-room accommodations is to incorporate patient-centred care, patient safety and a better economy. Thus, most of the evidence on single-room hospital design suggests that there is neither a significantly beneficial nor a harmful effect of the accommodation change in terms of safety (14-17).

Correspondingly, there is no clear evidence showing the patients' preferences concerning single-room design versus shared-room design. However, a scoping review by Søndergaard et al. (17) suggests that patients experience a homelier environment in single-room hospital accommodation.
As argued, there is a psychological aspect between the environment and the experiences of mealtime. However, to our knowledge, no studies have explored if the experiences of the homely environment in single-room accommodation influence patients' food intake and experiences of mealtimes.
The aim of this study is therefore to investigate how patients admitted to single-room accommodation experience mealtime situations.

Methods

Design and Setting

A qualitative study using an ethnographic phenomenological approach to patients' experiences of mealtimes in single-room accommodation was conducted from April to September 2022. We applied the go-along method (18) to explore patients' perspective. The go-along is an ethnographic phenomenological research tool that draws attention to some of the transcendent and reflexive aspects of lived experience as grounded in place (18-19). We consider the go-along methodology to be valuable in this study because it allowed us to observe the patients while assessing their experiences and interpretations (18). The go-alongs took place in two settings: a cardiac medicine ward and a vascular surgery ward in the same Danish hospital with all single-room accommodations. Ten patients who were hospitalised in single-rooms participated in the study. Regular research meetings were held to discuss the data analysis, sampling methods and data generation.

Participants

Twelve patients in total were invited to participate in the study. Due to personal factors, two participants declined to participate. The remaining ten participants consisted of six females and four males, all of Danish origin. We made efforts to accommodate variation in, for example, gender and age.
We purposefully sampled Danish-speaking patients in single-room accommodation who had experienced mealtimes during their hospitalisation to ensure a useful manifestation of the phenomenon (20). The sample procedure continued as long as we were able to obtain additional new information and until further coding did not add new insights into the themes (21). The head nurses at the hospital wards acted as gatekeepers by identifying and approaching the patients, which meant that we had no relationship with the participants prior to the start of the study.

Data collection

Data were gathered through qualitative go-alongs (18). During the go-alongs, we interviewed, listened and observed, and actively explored the patients' experiences and practices as they occurred (18-19) at the hospital. Inspired by Spradley's (22) grand tour dimensions, the following topics guided our observations: physical places, activities, events, emotions expressed, people involved, physical objects present, what people try to accomplish and what takes place over time. During the mini-tours (22), we asked open-ended questions such as: Can you describe for me how the meal takes place? Can you tell me what a mealtime means to you? The go-alongs at the two hospital wards took place during various mealtimes, including breakfast, lunch, afternoon snack, dinner and evening snack. When possible, conversations with participants were recorded digitally. All recordings were transcribed verbatim.

When the data collector followed a patient during go-alongs outside the single-room, the conversations were not recorded. Instead, the data collector wrote field notes. Thus, data collection in the go-along method also consisted of field notes. The data collectors took notes about what happened, where they were and who was present. The written field notes contained phrases, single words and short sentences written down during the observations and interviews. The notes represented a condensed version of what occurred and were supplemented by written reflections immediately after each go-along.
In total, the notes contained 110 pages of text and were based on 40 hours of meal-related observations and informal conversations. The first and second author, together with a Bachelor student, collected the data between April 2022 and September 2022. To enhance the consistency of data collection concerning the differences in competency levels within the research team, we conducted a targeted education program on the data collection method. This program included 16 lectures covering theoretical and practical elements.

Data analysis

Ricoeur's theory of interpretation served as the inspiration for the method of interpreting the text notes (23-25). Data analysis focused on understanding people in context. We took both the experiences of the patients (what was said) and of the researcher (what was observed) into account and let the language of both sources speak to us about the lived experiences (25). Three analytical phases were involved, and these phases were carried out in a cyclic mode throughout the analysis process (24-25). For a preliminary analysis, the first and second author began a reading of the complete text, which consisted of notes gathered from the observations and interviews, to gain a sense of the whole. An inductive approach was used to understand the patients' experiences of mealtimes in single-room accommodation. During the first phase, we began to formulate thoughts about its meaning for further analysis of the patients' practices and interpretations.

After that, we followed up with a structural analysis. Interpretations and tentative analyses were compared and challenged, and pre-understandings were discussed to identify patterns of meaningful connections, which were thematised into two themes (see table 1). Finally, critical interpretation has the goal of developing new understandings. The themes were re-contextualised in the light of relevant literature (23,25). In presenting the findings, we use examples from specific go-alongs to support the research team's analyses and themes. In the examples, we use "O" to indicate observations and "I" to indicate interviews, followed by an ID number.

Ethics and Informed Consent

All participants were provided with information both orally and in written form regarding the study's objectives. They signed a declaration of informed consent and were ensured anonymity in the published work and confidentiality as far as their identity was concerned. The study was performed in compliance with the Declaration of Helsinki and complies with the Data Protection Committee of the Central Denmark Region (ID number: 1-16-02-10-19). According to Danish law, qualitative studies must be registered only if the project involves the study of human biological material, contains personally identifiable data or is part of a clinical trial (26). Identifiable information about the participating patients was anonymised within the manuscript. The authors have previous experience of conducting qualitative research and analysing qualitative data.

Findings

The findings represent the patients' perspective. Thus, the experiences of meal situations must be seen in the light of being admitted to a single-room. The findings show that admission to a single-room was not unequivocally good or bad in terms of the experience of the meal situation and the patients' perceived appetite and food intake. The study's findings are presented in two themes:

1) Beyond the tray: Understanding the significance of meals for patients in single-rooms
2) Alone - but not lonely.

TABLE 1 An example of a structural analysis regarding the finding: Alone - but not lonely

UNITS OF MEANING (What is said/what is observed).	UNITS OF SIGNIFICANCE (What is being talked about/ what the observation is about).	THEME
"I feel that it is great to have a single-room. It is an absolute luxury. You can always go out and find someone to talk to..." (I-2).	The patient appreciates being able to be alone in the single-room, but at the same time the patient know that there is life/people outside the single-room. Alone is not the same as lonely. Being alone is a luxury.	**Alone - but not lonely**
"I'm a person who likes my own company. I like being social, but only after my need to be by myself is refuelled, and the other way around. It's about balance you know" (I-4).	Being alone is a preference. Being social is optional. It's about balance. The single-room offers the opportunity to both be alone in your own company and socialize outside the single-room.	
Interviewer: "Do you ever feel lonely here in the single-room? Patient: No. Not at all. That is. (...) Well, I think I would have a hard time enduring being here if it wasn't a single-room. (...) I am significantly younger than the average patient on the ward. And that, I think, increases my need to be alone. I don't feel the same way as the others. (...) And then it is better to be alone" (I-7).	The patient chooses to remain in the single-room and prefers not to seek out fellow patients. Being alone is considered a good thing - and the patient does not feel lonely.	

Beyond the tray: Understanding the significance of meals for patients in single-rooms

Patients admitted to single-rooms spoke of the meals as the highlights of the day. The meals were something to which they looked forward. This was explained, among other things, by the fact that the meals were activities that broke up the otherwise often long days during hospitalisation:

"*It may also be because when you are lying in here, there is not much else to do. It is to some extent the highlight of the day (...) Looking forward to the meals (...) It's like when you read a book, there are chapters. The meal is just like the chapters of the day*" (I-4).

The patients found that their appetite was either unchanged or less than normal when hospitalised in single-room accommodation. According to the patients, decreased appetite was not a result of the single-room. Instead, they attributed it to their situation, noting that being in an unfamiliar hospital environment and dealing with the effects of illness affected their desire and energy to eat:

"*... I might not eat that much because I don't really know what's going to happen (...) it's a bit chaotic for me (...) well, I like food, but then, with the symptoms I have, it's not food I think about first, no...*" (I-3).

The patients experienced having offers of more meals during the day than they were used to at home. They were generally delighted with the food offered. For most, the food was similar to what they prepared and served at home. They felt that it was important for their appetite that the meals were familiar. They described that they had a great deal of influence on what they were served during hospitalisation:

"*... they come here* [to the single-room] *and tell you what you can choose from that day. And then you order some food that they bring*" (I-10).

An accessible weekly scheduled meal plan, placed visibly in the dining room, made it possible for the individual patient to find their way around the menu and choose between meals.

The patients did not experience much talk about food as a source of proper nutrition, as a means of achieving well-being and health promotion, or as something that could help them to recover and get well either in the common room or their private room. During meal service, the researchers observed that the introductory conversation was about meal options. Meals were mainly based on the patients' current appetite. In the dining room, they were given the option of saying yes or no to every component of the dish (pasta, sauce, etc.):

"*...The first patient walks into the dining room (...) the nurse presents the food briefly and asks if he would like a small portion of all the options (...) the patient receives his tray and sits down at a table (...) three more patients enter the room. The same procedure occurs at the counter*"(O).

The patients could collect their meals from the dining room and choose to either eat it there or bring the food to their room. The patients did not talk with anyone about the meal. It was often one staff member who served the food and another who cleaned up. As a result, the patients did not experience that health professionals considered their food intake.

Alone - but not lonely

Previous experiences of being hospitalised coloured the patients' expectations and attitudes towards single-room accommodation:

"*I have been admitted to shared rooms so many times... some fellow patients were quite miserable to be with... and some, well, they were so weak, they could hardly talk, and some have acted like crazy. There are just as many different kinds of people who are hospitalised as you meet out in society*" (I-10).

Especially in an acute situation, the patients did not necessarily have the mental capacity to deal with others. Thus, the patients expressed that they appreciated the opportunity to choose between being alone or seeking company:

"I feel that it is great to have a single-room. It is an absolute luxury. You can always go out and find someone to talk to..." (I-2).

"...and "I'm a person who likes my own company. I like being social, but only after my need to be by myself is refuelled, and the other way around. It's about balance you know" (I-4).

However, during previous hospitalisations in shared rooms, some patients had experienced that it was nice having fellow patients as they helped to make the days feel less long. The patients did not express any other reflections about what they might have missed by being in the single-room. There was no consensus among the patients regarding how eating alone in a single-room affected their appetite. Patients emphasised that it was only an advantage having fellow patients if it was someone for whom you had sympathy and with whom you could have a good time. Based on previous experiences, where 'good' fellow patients had made the dining situation more pleasant, a few patients estimated that they would probably have eaten more if they had been in shared-room accommodation. Conversely, some patients had the opposite experience of meals in shared rooms. Concerns were expressed about seeing fellow patients suffering:

"... it's hard not to relate to others getting sick or being unwell, and you lie wondering how unwell they are" (I-7).

They enjoyed eating alone and experienced that the sounds, suffering and smells of fellow patients negatively affected their appetite. Patients mentioned a sense of boredom during admission, often as their condition improved; however, they did not experience loneliness.

The dining room was often mentioned as a place where patients could change their otherwise monotonous day in their single-room. However, only a few patients used the dining room either because they did not want company, were too ill or because the common dining room was not well visited:

"Yes, the first evening, I went to the dining room and sat there alone. There was a man at another table, and I thought that I might as well eat in my own room. If I had to sit alone in the dining room, I might as well sit alone here" [the single-room] (I-9).

The patients who did not find the dining room necessary were often affected by their condition. For example, one patient was too tired, while another found the social part too much for her needs. It seemed that the patients saw fellow patients largely as a possible distraction during hospitalisation and not as expert patients. Lack of desire for company when eating was explained in terms of personal preferences (e.g., introverted personality) and lack of energy to get involved in other people's situations.

A patient told how she had eaten in the common dining room once. Throughout the meal, she was nervous about whether another patient would come and sit at her table and start up a conversation. After this experience, she had not sought out the dining room again:

"I'm pretty sure I'd skip the snacks if I had to eat in the common dining room. I would choose less food so I could finish faster" (I-7).

Observing the evening meal situations in the common dining room gave the impression that dinner was considered the most valued social time. Compared to breakfast and lunch, the sound levels were mostly filled with laughter, stories and conversation rather than soft music and background sounds, i.e., walking, packing trays, etc.:

"... three more patients enter the room (five in total) (...) all decide to sit down after receiving their tray (...) three more patients arrive. They nod and smile at the nursing staff. Go in line. After receiving their tray, they walk to their respective rooms (...) Warm, rich aroma of food in the dining room (...) the room now represents a social area for staff and patients."(O).

During observations, the researchers noticed that the common dining rooms were small, with only a few tables and chairs. In addition, observations indicated that most patients chose to eat in their single-room.

In general, the patients had not thought much about the interior design of the single-rooms. They emphasised that it was, after all, a hospital room that contained the necessary furniture and remedies.
The TV and the view from the room were often mentioned as providing amusement or relaxation. However, no one considered that a more 'homely' interior would influence their appetite or food intake.

Discussion

Peace is more important than sociability

One of our main findings was that patients in single-room accommodation valued the peace and opportunity to withdraw from the company of fellow patients. This was also the case in relation to the meal, where patients could choose to be social during the meal or to eat alone in their room. In our study, patients' choices appeared to be governed by their perceived disease situation. The more chaotic and disturbing the patient experienced hospitalisation and their illness situation, the less energy they had to get involved in other patients' life situations and possible suffering.

A study from 2015 (27) found that older patients preferred to eat alone rather than in communal areas. The patients in our study experienced staying in a single-room as a good thing, and even as a luxury.

A recent Danish study (3) also found that patients perceived staying in a single-room as a luxury. They found that patients' wishes regarding eating surroundings varied, as some found that the presence of other patients' eating could negatively affect their appetite, while in other situations, it was the patients' own discomfort that was a barrier to eating with others. This is in accordance with our findings. It is known that meal experiences are influenced by many factors, including sound, smells, emotions and the food itself (28).

The patients in our study also referred to previous experiences where sounds, smells and fellow patients' suffering had negatively affected their appetite. According to Markovski et al. (29), supervised eating in common dining rooms can improve hospitalised elderly patients' nutritional status. Previous research (30) has shown that patients in shared-room accommodation can learn from, help and informally care for each other.

For some patients, it can be helpful (and even easier) to talk to a fellow patient who has been in the same situation, than, for example, to a health professional or family member who does not have first-hand experience of the disease/ disorder. However, the single-room hospital design made it possible to completely opt out of being with others.

The present study indicated that the patients were not aware of the benefits that social communities during hospitalisation could bring. No one spoke about or requested this. Patients admitted to Danish somatic wards are most often admitted acutely, and the length of stay is short. The average length of stay for 0-64-year-olds in 2018 was 3.7 days, whereas for 65+ year-olds it was 5.3-5.6 days (31).

However, even if interested, the single-room design may complicate patient-patient relationships, as the social gathering must be actively sought outside the single-room.

Likewise, the design of common rooms was not optimal for supporting the framework for a social community and conversations between the patients. For example, the common dining rooms were small with poor space for several wheelchairs at the same table.

Privacy and responsibility

Privacy during hospitalisation was emphasised as something positive from the patients' perspective, which aligns with other patients' experiences (17). The single-room design creates an ideal environment in which nurse-patient communication can take place in an undisturbed and safe fashion (17). However, this privacy comes with responsibilities as well as opportunities. One option in the single-room design is that nurses interact and discuss patients' meals and nutrition.

As our findings indicate, patients have a positive attitude towards their influence and autonomy in choosing what to eat, but they did not experience conversations about proper nutrition. Therefore, there is a missed opportunity to use this private space to support patients' positive attitudes towards the meal and discuss proper nutrition, meals to facilitate their well-being and recovery, and the risk of weight loss in relation to their condition.

Responsibility for utilising the single-room's potential for conversation may lie with hospital staff, but such responsibility is often not coordinated or communicated about clearly among hospital staff. Previous studies have identified a lack of communication and responsibility for ensuring patients' food intake (32-33).

Conversely, when privacy is used correctly, e.g, to talk about serious illness, patients state that it creates a high degree of security and improved patient-nurse relationships (17). Especially in the single-room design, patients have a closer relationship with their nurses, which places great responsibility on nurses. However, it is important that the hospital organisation assigns and prioritises task regarding meals and nutrition rather than expecting it to be part of the nurse's routines.

Without placing such responsibility, it turns out to be everyone's – and thus no one's – responsibility (32). To improve nursing care in single-room design from a nutritional point of view, responsibility must be placed to use the privacy to communicate with patients about their meal preferences and the nutrition needed.

Missed nursing care

Single-room accommodation creates a sense of dignity and ownership for patients, but this increased focus on patient privacy comes with challenges. Søndergaard et al. (17) report on nurses' concern for patient safety in single-room designs, while Feo & Kitson (34) raise the question of whether this movement towards single-room accommodation results in a lack of fundamental care. Fundamental care reflects both limiting damage and optimising recovery, of which attention to eating and drinking is an important part. Patient-centred care emphasises the patient's involvement in decision-making to match their cultural, physical and emotional needs (34).

The patients included in this study did not express dissatisfaction with their autonomy or inclusion in meal decisions, but they did not perceive anyone being responsible for their nutrition either. Neither nutritionists nor nurses commented on their intake or talked about the influence of nutrition on their condition. Meals may have become a fragmented and forgotten basic nursing task, considered only if patients need physical assistance (34).

Nutritional need extends beyond the biological need to stop hunger. Nutritional needs also incorporate psychosocial and relational factors, such as feeling worthy and respected and having company, should be met (34).

A single-room design creates the space to fulfil these needs. Thus, the concept of basic care should be reconceptualised to include a comprehensive view of patients' needs in a single-room design.

Strengths and limitations

The ethnographic phenomenological approach helped us gain a more complete picture of a practice situation as the patients experienced it compared to the data that an interview alone would have produced (18). Furthermore, the go-along methodology made it possible for the data collectors to create a trusting relationship with the participants. This allowed the participants to talk freely about their experiences with and practices in connection with meals during hospitalisation in single-room accommodation. The data acquired inspired from grand-tour dimensions combined with mini-tour questions contributed thematically rich data. Even though the data were collected in two wards at the same Danish hospital, we consider the findings transferrable to similar settings.

We consider the study's interdisciplinary research team a strength, as the team was composed of nutritionists and nurses with practical and academic work experience (three with a PhD degree and one bachelor student). The involvement of three data collectors in this study prompts a discussion on whether it poses a potential drawback, specifically in terms of the possibility that they may be looking for and highlighting different aspects during go-alongs. We have taken steps to address this concern by engaging in continuous discussions about the study's purpose and sharing our experiences with the method throughout the data collection period.

Additionally, there is an apparent difference in academic qualifications within the data collection team, comprising both PhD and bachelor-level members. Despite this contrast, it is noteworthy that the bachelor-level student underwent specialized training to ensure proficiency in conducting data collection using the go-along method.

Conclusion

Based on observations of and conversations with patients, the study revealed that most patients experienced either no change or only a slight decrease in appetite during hospitalisation. They did not find that the single-room hospital design had an impact on their appetite. Privacy during admission was emphasised as something positive from the patients' perspective.
The study indicated that most patients chose to eat alone in their rooms, either because they were unwell, or because they wanted peace and their own company. However, some patients chose to eat in the common dining room to experience a social gathering and have the mealtime stretch out in an otherwise rather long day. Patients did not feel that their food intake would have been different if they had been admitted to a shared hospital room.

The study showed that even though the hospital design with single-room accommodation made private conversations possible, healthcare professionals did not avail of the opportunity to discuss possible mealtime challenges or the importance of sufficient nutrition with patients. We therefore conclude that, although the patients felt satisfied with the hospital's food and their autonomy in choosing the menu, they lacked the nurses' knowledge and communication to understand the importance of the meal for well-being, healing and rehabilitation. In addition, we conclude that nurses must be made aware of the responsibility they have for patients' nutrition, and that attention to the meal is no less important in single-room accommodation than in shared-room accommodation.

Relevance to clinical practice

This study presents a comprehensive understanding of patients' experiences regarding mealtimes in single-room accommodation. Knowledge of patients' perspectives may guide nurses' approaches to communicating with patients about the importance of the meal. Furthermore, this study shed light on the large potential that the hospital design with single-room accommodation provides regarding a person-centered nursing care. The single-room design has been shown to be a context that can improve patient privacy, integrity and modesty regarding nutrition and the mealtime.

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