-HEALTH AND WELL-BEING SCRUTINY COMMITTEE

9th February 2011

POLICY REVIEW: MALNUTRITION IN HOSPITALS – FEEDBACK FROM HOSPITAL VISIT

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide a feedback report to the Scrutiny Committee following a visit to Sunderland Hospital as part of the review of malnutrition and dehydration in hospitals.

2. Background

2.1 The Scrutiny Committee has been pursuing a review of the management of malnutrition and dehydration in hospitals since September. The review was selected following national studies highlighting the risks in hospitals across the country.

2.2 The scope of the review is to study the evidence in City Hospitals Sunderland set against those national studies and best practice guidance.

3. Feedback from Visit

3.1 Members were invited to visit Sunderland Royal Hospital on Friday 21st January and view the arrival, preparation and serving of food to patients.

3.2 The hospital comprises 36 wards/patients feeding points of varying specialities and feeds about 1,000 patients per day.

3.3 The visit began in the Central Assembly and Distribution Unit. The purchase, food storage, assembly, and distribution of ready cooked frozen and chilled meals is undertaken from the unit on behalf of all hospitals within Sunderland.

3.4 Following a review in 1992 the Trust introduced a chilled meal assembly production method which would focus on the ward service and not food production. It was noted that many large hotel chains employ a similar system. The chilled meal assembly process means that food products are purchased directly from companies either frozen/chilled in hygienically sealed units. Purchasing is from mostly from local suppliers including local sources of fresh vegetables and meat and branded products are purchased.

3.5 All meals are assembled in insulated boxes, ready for distribution. The delivery of meals to wards is undertaken by catering staff. Insulated boxes are transported by refrigerated vehicles to drop off points at each location where catering personnel ensure correct distribution to each ward regeneration point. Chilled food is then placed into regeneration ovens/trolleys for the food to be heated to the correct temperature as close to the ward as possible.

3.6 At this point the responsibility transfers to ward staff. It is the responsibility of health care assistants to take the meal trolley and to serve meal to patients. Nursing staff provide individual help to patients if a need is indicated by a red serviette on the patient's food tray.

3.7 Members visited three different wards which were selected to provide a cross section of the needs of patients. The wards visited were C33 Head and Neck, E52 Care of the Elderly and D44 / D43 Trauma and Orthopaedics and the 12 noon food service delivery was observed. All wards operated Protected Meal Times.

3.8 It was highlighted that the needs of patients vary greatly across the wards at the Hospital. This may mean there are different arrangements for meal ordering, with a flexible system to account for other activities going on at the same time e.g. diagnostics.

3.9 The patient's named nurse is responsible for ensuring awareness of how much is eaten by the patient at meal times and throughout the day. This information can be relayed via the health care assistant or ward hostess. Supplementary drinks are used for patients who miss a meal. If a patient has not eaten their food then the nursing staff explore the reasons why and resolve any issues there may be. If a patient does not like the food they are offered then alternative choices are available from the catering department.

3.10 It was emphasised that the catering service can supply a meal at any time 24 hours a day and overall responsibility rests with ward managers. Although facilities are in place for a meal to be ordered outside of meal times, it was questioned if this was being utilised appropriately. It was acknowledged that in some instances this may rely on the patient being proactive and asking for help. Discussion was held regarding patients making sure that they asked for food if they needed it. It was noted that some patients have a tendency not to ask as they do not like to trouble busy staff. It was commented that there may be instances when staff could do more to ensure that patients know they can ask for different food or more food.

3.11 The lunch time menu on D43 and C33 was soup accompanied by sandwiches, (jacket potatoes with various fillings were available on request).

3.12 E52, the Care of the Elderly ward has recently reviewed meal provision and introduced a two course hot meal at lunch time and sandwiches/soup at tea time. This reflects the mealtime habits of older people in the community and seems popular with in-patients.

3.13 Liquid refreshments are offered seven times daily and all patients are supplied with a jug of water and a glass on admission (assuming their condition allows them to drink) and it is refilled twice daily and on request.

3.14 Patients who have delirium and dementia require additional support to tempt and reinforce their need to eat and the red serviette system was seen operating on ward E52 with patients receiving help to eat.

3.15 The Care of the Elderly Ward also operates a luncheon club for one day a week (being extended to daily) ensuring adequate nutrition is provided in a therapeutic environment. This appeared to be very popular and successful at encouraging patients to eat a meal. Staff and volunteers facilitate the club, and they are seen as integral to the patient's rehabilitation by promoting normality as they enable patients to sit at the table with others.

3.16 Homely crockery is used and the table is set with a table cloth, which seems more conducive to successful nutrition. Smaller portions are served and fish and chips were served on the day of the visit.

3.17 During this time social activities also take place, when the patients can either watch movies, play games or do some craft work. The lunch club on E52 has been running approximately two years and just recently received the Board of Governors Award at the Trust's Reward and Recognition Celebration in September 2010.

3.18 On wards D43 and D44, both Orthopaedic wards, the patients appeared to be happy with the choice of food on offer. On these wards all of the food was served and then staff would return to patients who might need assistance, using red serviettes.

3.19 Members visiting this ward also observed the Malnutrition Universal Screening Tool (MUST) on the computer system. MUST is used on wards to identify adults who are malnourished, at risk of malnutrition or obese. Patients are weighed when they are admitted to hospital and then on a weekly basis. Appropriate action will be taken dependent on the score from MUST.

3.20 As the needs of patients varies greatly across wards, staff commented that supervision by the Matron and Ward Manager is key to ensuring patients received adequate food and assistance.

3.21 The food that is ordered for the ward is estimated in advance by the staff (this may be a couple of days in advance). There was concern

over the extent to which patients were able to exercise a wide choice but it was highlighted again, that the provision was there to provide alternative food at the patient's request.

3.22 Members questioned whether relatives and friends could assist during meal times. They were informed that this would not be a problem and if relatives spoke to staff on the ward this could usually be accommodated. Members observed that this may not be common knowledge amongst patients or relatives that relatives are able to come in during meal times and provide assistance and encouragement to patients.

3.23 After the meal is served a questionnaire is given to patients regarding the food provided. The catering department issues an average of 100 questionnaires on a weekly basis. Feedback is collated monthly. If there is a complaint, the hostess would be able to address this at the time. The hostess does record the amount of wasted food but this does not show which patients have not been eating the food. This would be identified through MUST. The extent to which a patient's family would be included in the patient feedback was questioned as it was felt relatives may be more prepared to give an accurate assessment of the patient's eating and needs.

4. Conclusion

4.1 The assembly and distribution of such a large quantity of meals was an impressive operation. It was commented that there was a high quality of food provided. Certainly, the food sampled in the staff restaurant was tasty and nutritious. The staff who assisted with the visit ranging from the catering department to the ward staff were undoubtedly dedicated to providing the best nutritional support and they are to be congratulated on the service provided.

4.2 Aspects of the meals service which raised questions during the visit included:

a) The difference in operational standards from ward to ward and the extent to which patients have the full range of choice on the menu.
b) The extent to which patients are involved in the menu design linked to feedback surveys and best use of information from patient feedback.
c) The involvement of a patients' friends / relatives in supporting encouraging patients to take food and passing on information about patients
d) The availability of snacks / fruit and individualised meals and the extent to which patients ask for food or the patients staff offer.
e) Maintaining, monitoring and using data about malnourished patients.

5. Recommendation

5.1 The Committee is asked to receive this feedback report as part of the evidence for the policy review.

6. Background Papers

Health & Well Being Scrutiny Committee Reports

- Work Programme and Policy Review Report 9 June 2010
- Evidence from City Hospitals Sunderland 10 November 2010

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