Sunderland City Council

**Item No. 4D**

# HEALTH & WELL-BEING SCRUTINY COMMITTEE

## DRAFT FINAL REPORT

## MALNUTRITION AND DEHYDRATION IN HOSPITALS

## Foreword

Over the years hospital food has definitely improved and patients now seem generally satisfied with the food they are given when they are in hospital. Unfortunately hospital food has an image problem. Often, even before tasting any food patients generally expect poor quality.

Yet, I can think of no other organisation where it is more important to serve healthy, wholesome food than in our hospitals. It is important in so many ways – to the recovery of patients, to staff morale and to the atmosphere on the wards. When hospitals serve good food, everyone benefits.

Patients going hungry in hospital is a very emotive subject. During the course of this review there has been much publicity nationally on the continuing issues around food in hospitals and the consequences of not eating properly. The Health Service Ombudsman in February 2011 said that half the people featured in a report about the care of older people did not consume adequate food or water during their time in hospital. At the same time new research confirmed that during winter 2010 a third of all patients admitted into hospital and care homes were at risk of malnutrition, an increase over previous seasonal surveys.

Not eating and drinking in hospitals and the consequences of not doing so affect all groups and all ages of patients, however elderly patients are particularly vulnerable. Age UK Sunderland has been supporting the Hungry to be Heard campaign for several years and supported us during our review.

Dignity and respect for patients have been underlying themes throughout the review and we have considered the level of care given to people in terms of respect and dignity in relation to nutrition and hydration.

We would like to thank Carol Harries and the staff at Sunderland Royal Hospital who provided members with an informative tour of the kitchens and some of the wards and enabled members to observe meal times. Members would also like to thank the patients who provided evidence, Alan Patchett from Age UK, the staff and volunteers at Sunderland LINk, and members of the public who contacted us and shared their views and experiences.

Councillor Peter Walker
Chair, Health & Well-Being Scrutiny Committee

## 1. Purpose of Report

1.1 To provide the Scrutiny Committee with its draft final report following a review of malnutrition and dehydration in hospitals.

## 2. Introduction

2.1 This report looks at why some patients do not eat and drink enough when they are in hospital, what action can be taken and who is responsible for ensuring that they do and finally, makes recommendations to address this very disturbing problem.

2.2 The review focused on food services in Sunderland Royal Hospital. The topic was chosen following significant national media coverage of the implications related to the support and feeding of people in hospital. Following the publication of a report by Age UK, Members were particularly concerned about the support available to older people who have difficulty feeding themselves, and the risk of malnutrition and the implications that this has on the ability to recover from surgery and illness, and fight off infection.

## 3. Aim of the Review

3.1 To review strategies to support the decision-making of health professionals involved in the provision of food and fluids, nutritional support and public health advice and interventions for Sunderland Royal Hospital inpatients in order to manage avoidable malnutrition and dehydration.

## 4. Terms of Reference

4.1 The terms of reference were agreed as:

- To consider the whole process for providing hospital meals;
- To explore issues around the identification of patients who are admitted to hospital malnourished and whether that status has changed on discharge;
- To explore reasons why patients are not eating their meals;
- To establish how patients who find it difficult to feed themselves are supported to do so;
- To evaluate the effectiveness of management, treatment and training programmes relevant to malnutrition and dehydration;
- To explore what happens to monitoring information and how it is used to ensure all people receive the nutrition they require.

## 5. Membership of the Scrutiny Committee

5.1 Councillors Peter Walker (Chair), Christine Shattock (Vice-Chair), Kath Chamberlin (up to December 2010), Jill Fletcher, Anne Hall, Paul Maddison, Tony Morrissey (from January 2011), Sylvia Old, Neville

Padgett, Derrick Smith, Dianne Snowdon, Norma Wright and co-opted member Alan Patchett.

## 6. Methods of Investigation

6.1 The Scrutiny Committee has considered information contained in national guidance and research, taken evidence from all those involved in delivering the food service, visited Sunderland Royal Hospital to see meal times in operation, considered good practice examples from other Trusts, heard from members of the public, and consulted with patients.

## 7. Setting the Scene

7.1 City Hospitals Sunderland is responsible for the provision of the Health Services to the population of the City of Sunderland. The present catchment population is 330,000 and this figure includes the 33,000 for the Easington area.

7.2 There are currently two hospitals within Sunderland, Sunderland Royal Hospital and Sunderland Eye Infirmary, supporting in the region of 956 beds.

7.3 Sunderland Royal Hospital is situated approximately one mile from Sunderland city centre. The hospital is the largest in Sunderland, a mainly acute unit of 934 beds, with approximately 95% average occupancy. It also houses the Trust Headquarters, education centre, residential accommodation, and district laundry and transport services. Adjacent to the hospital is a large health centre and pharmacy store.

7.4 Following a review in 1992 a chilled meal assembly production method was introduced which would focus on the ward service and not food production. A large portion of the meals on the patients and staff menus are purchased from commercial suppliers in a frozen or chilled state in multi-portion containers. Branded products are purchased and there is some purchasing from local suppliers including locally sourced fresh vegetables and meat.

7.5 The hospital comprises 36 wards each one with patients feeding points of varying specialities and a Coronary Care Unit, Intensive Care Unit, Accident & Emergency department, outpatient facilities, treatment and diagnostic services and occupational health department. Some of the feeding areas and wards are some distance from the main central assembly unit.

7.6 Staff from City Hospitals Sunderland Foundation Trust (hereafter referred to as the Trust), representing nursing, catering and nutrition provided evidence to the Scrutiny Committee on how the processes and systems operate from delivery of food, heating the food and feeding the patients. They summed this up as:

- A seamless service from delivery, preparation, serving to the patient
- No requirement for food production equipment
- Significant reduction in equipment maintenance
- Safe and modern frozen/chilled food storage facilities
- Temperature controlled from delivery at hospital to delivery on ward
- Reduced wastage of resources in production and uneaten meals
- Choice at the point of service 'choose with their eyes'
- Hot, fresh food prepared near at point of service
- Improved plate presentation at point of service
- Food and Beverage Policy formulated around the ward with constant patient quality questionnaires.

## 8. Findings

Promoting Health

8.1 The Committee was informed that the prevention of malnutrition is a key priority for the Trust with staff from all relevant areas working together to minimise the prevalence of malnutrition. Research highlighted that good patient nutrition needs to be a priority for everybody from the catering staff through to the chief executive. To achieve that level of priority leadership on good nutrition must be in place and disseminate throughout the organisation.

8.2 The Committee asked questions about the extent to which nurses saw nutrition as an integral part of their job and if nutritional support is delegated to more junior staff. An assurance was given that nursing staff saw nutrition as a critical part of a patient's daily care and that this was a component of their training, however, there is a 10% turnover of staff so messages about good nutrition have to be reinforced repeatedly. There is a greater stability in the matron's posts which helps to reinforce messages at ward level.

8.3 It is recognised that this clearly defined structure, which defines whose responsibility it is to ensure an individual patient has food, wherever they are in the hospital, is essential to good nutrition.

8.4 The Committee invited other good practice Trusts to submit evidence to the review and gathered a number of good practice examples around using information, networking and communication to embed messages about good nutritional care in organisations.

**EAST CHESHIRE NHS TRUST - LEAN Event**
This LEAN event took place 5th November 2009 to explore the oral nutrition process and highlight what works well and which areas could be improved. Over 40 staff from all disciplines attended the event looking at four key areas: Menus, Education, Corporate Policy, Mealtimes.

A lead was nominated for each key area to support the individual projects identified for action within their area. Findings from the key areas were then fed back to complete the overall action plan. Persistence and encouragement were key, as the LEAN event was held over the winter period and the Trust was extremely busy.

All the actions from the LEAN event groups are fed into a nutrition action plan, which continues to be updated and reported back through our patient meals group and clinical nutrition steering group on a bi-monthly basis.

Improvements continue and have included: Increased compliance from 30% - 70% (2008 – 2009) documented MUST screening. To increase compliance still further Key Performance Indicators have been set for the next three years. Results of MUST screening are shown prominently on the wards as part of the 'Knowing How You are Doing' display boards.

- 'Top Tips' Nutrition Newsletter. Includes useful information about nutritional needs for patients and updated information about overall nutrition performance. East Cheshire.
- 'Knowing How You Are Doing' display boards - results of MUST screening are shown prominently on the wards. East Cheshire
- Information of changes and updates - patients, nursing and ward-based staff are informed through Patient Information Booklets, the Trust Intranet, and Nutritional Champions Network. Royal Berkshire
- 'Talking Up Food' - Staff not only use the catering facility but recommend it to others and also talk up food when necessary with patients and relatives. Poole NHS Trust

8.5 During their visit Members observed that the staff they met were undoubtedly dedicated to providing the best support to the patients and they are to be congratulated on the service provided. Patients surveyed were complimentary about the nursing staff and any dissatisfaction in relation to the food service was 'systems' related, not staff related.

8.6 The Committee is aware that the Patient Environment Action Team (PEAT) inspection rated food as excellent yet there are issues that regularly appear in patient feedback surveys that need to be addressed. The National In-Patient Survey 2009 showed that there are aspects of the food service that continue to be of concern for some patients, particularly the issue about patients not being offered a choice of food since this was also a low scoring question for the Hospital in the 2008 survey. As far back as 2006 a survey of patients in Sunderland Hospital by the Patient and Public Involvement Forum[16] (PPI) indicated that 39% of patients responding said they didn't receive a menu in advance or a choice of meal.

8.7 While it was clear to Members that there were continuous service improvements taking place year on year, there were also a small number of recurring messages from patients, particularly around choice where further improvements could be made. Members noted that patient feedback is regularly collected and this would contribute towards further improvements in the few remaining areas of concern.

8.8 Members were encouraged by what they observed on their visit but they were concerned that the good practice they witnessed may not be available on all wards, at every mealtime, round the clock and feedback from patients reflects this. If consistency is lacking, not every patient can be assured that the food system would be 'by the book'.

8.9 To achieve any percentage reduction in the occurrence of malnutrition, ensure best nutritional care across the organisation and for the message of consistency to disseminate throughout the organisation, good nutrition needs to continue to be a key priority at board level.

8.10 Research shows that nutritional care of patients in hospital can suffer from a division of responsibility. To achieve consistency requires decisions to be taken that 'join-up' services structurally so that the organisation is not just reliant on good practice at individual level to make connections and in this way the food service reflects the patient experience in its totality.

8.11 Building on the good practice observed on their visit, Members believe that the embedding of the good practice observed should be extended across all wards in the organisation, and that the Trust should aim to be recognised as a best practice exemplar in this area.

8.12 To support this approach, the Trust provides an opportunity to reward best practice at an annual event which enables those individuals demonstrating particular good practice in nutritional care to be recognised. The Committee would also endorse extending the use of all available communication tools for the promotion of nutrition to keep this as a priority in the minds of everyone all of the time, similar to the 'Wash Your Hands' campaign.

How Information Supports Choice

8.13 Members reviewed whether patients have sufficient information to enable them to obtain food and drink. A choice menu operates on a minimum two week standard cycle. Catering staff are required to ensure that a copy of the menu is available in every patient's bedside locker. Menus are available in large print and menu cards are available in the main entrance. The menu includes advice to patients about catering standards, how to order meals, and healthy eating. Information is included on the menu about help with reading the menu if required.

8.14 Research shows that patient satisfaction is related to the extent that choice of meals is met. A range of suitable information, and assistance with ordering from the menu, if required, and the timing of ordering should support patient choice.

8.15 Information exchange between patients and staff requires the distribution of menus, helping patients with their choice and checking orders. Some patients in the survey had indicated that they had been unable to exercise a choice from the menu.

8.16 The following scenario indicates that information is not always supporting patient choice:

> *"There was no fresh fruit, only fruit crumbles. In the evening, mash and either chicken or beef were the only choice. I never saw a menu."*

8.17 It was highlighted that the needs of patients vary greatly across the wards. This means there are different arrangements for meal ordering, with a flexible system to account for the needs of the ward or other activities going on at the same time, for example, diagnostics. Patient meal ordering is undertaken by nursing staff in conjunction with catering staff. During breakfast, lunch and dinner the catering staff complete the meal order sheet for the following day's requirements.

8.18 However, evidence showed that access to a menu seemed to be a source of contention for some patients. A 2006 survey of patients in Sunderland Hospital by the Patient and Public Involvement Forum[16] (PPI) revealed that 40% of the 26 patients who responded to the poll said they had not seen a menu. The Committee found a similar picture and it was not uncommon for patients to not see a menu at all. Large print menus are currently available on request only although the Committee is aware that improvements are in place to enhance this service.

8.19 It was evident that on some wards ordering is carried out by nursing staff without reference to the patients by estimating in advance which meals they will need on their wards. Patients then choose from the food that arrives on the ward resulting in the likelihood that popular choices run out, although the Committee is aware that ward deliveries start at a different end of the ward on each occasion.

8.20 This practice results in a situation where it is not the patient who is the customer of the food service, but the ward and the individual choice is removed. This can also result in choice going to the bed, and not to the individual patient if they happen to be moved. If patients do not get the food that they would have chosen for themselves there is the likelihood that they will not eat what is available to them as the following illustrates.

*"Trolley's are loaded with whatever is appropriate for the ward. When they used to have individual sheets to tick there was a choice, that's gone. Filling in slips takes time and needs people but is used to work. You can't even request a boiled egg on toast now."*

8.21 Overall, patients are happy with the food service and when they are not, it is known that few patients complain. They do not like to be unkind to staff who are looking after them and they fear there will be some reprisal. Robust information gathering from patients is therefore vital. Feedback is regularly sought from patients in the hospital and the Committee gathered evidence from other hospitals about how they gather vital information from patients:

**Royal Brompton & Harefield NHS Foundation Trust**
"The Catering Department has the complete responsibility for the catering patient meal service and the Catering Host and Hostesses are employed by the department to work at ward level. They give the menu to the patients as well as all meals and beverages. This responsibility to the Catering Department ensures that all patients are fed and nourished which is supported by the red tray system."

**Royal National Hospital for Rheumatic Diseases**

"Patient feedback forms a crucial part in determining our food and drink offerings to our patients. Feedback from patients is achieved at various times and levels ;

- Catering manager walk round – once a month. To ensure direct and face to face contact and feedback from patients.
- Group sessions with Catering team and residential course patients (such as our one month residential courses for AS and Pain Management patients).
- Catering Manager meets with individual patients in cases of special dietary requirements to recognise food allergies and/or ethnicity requirements.
- All in-house patients have ready access to the 'Did you enjoy your meal' feedback folder in our Day room
- All patients are asked to complete the food section as part of our discharge procedure

8.22 The Committee felt that more needs to be done ensure patients have access to a menu and to provide easier access to appropriate versions of the menu e.g. large print, bearing in mind the reluctance for patients to ask for help. This could be a role for volunteers on the ward to increase capacity around the information exchange with patients, or simply more use of the internet and bedside folders.

8.23 The Committee also felt that the role of the catering department could be extended further into the ward to interact directly with patients as the customers of their service.

<u>Availability of Choice</u>

8.24 The menu offers a varied choice of nutritional food - a different soup each day and a choice of sandwiches at lunchtime with a main meal –

dinner and dessert - at supper time. Traditional roast dinner is available on Sunday's. The supper menu includes a total of 25 choices of main meal in any one week including cauliflower cheese, beef goulash, roast pork, fisherman's pie and beef casserole. To offer variety the menu changes for the second week and includes new options within the 25 choices including Cumberland sausage, leek pie, cod in parsley sauce and chicken pasta. However, as already described, patients are not always exercising a choice within the full range of options. This leads to the following scenario:

> *"I did not always get what was ordered. Then offered mince which I dislike a lot. Family then got food as I was very hungry."*

8.25 Availability of menu choices is critical to a successful food service. It is sometimes the case that when people are unwell they feel able to eat only a particular dish. If the dish is readily available there will not be a problem. It was emphasised to Members that the catering service can supply a meal at any time 24 hours a day providing snacks, sandwiches, and salads and a 'Lite Bite' menu is available daily from midnight to 6.00 am. Overall responsibility for meeting patients needs rests with ward managers. Although facilities are in place for a meal to be ordered outside of meal times, it was questioned by Members if this was being utilised appropriately.

8.26 Some patients clearly do use the alternative menu facility however, there is enough evidence of patients feeling they had no access to other food to leave some uncertainty whether patients were aware that food including snacks were available 24 hours a day, seven days a week, as the following patient described.

> *"I would like the option of having snacks, toasties, cup-a-soups or micro-snacks, as I may not always be hungry at designated meal times"*

> *"Would prefer smaller snacks - it's not nice to have big dinners all the time."*

8.27 Patient feedback received during this review includes sufficient evidence to indicate a level of dissatisfaction with choice. The Trust is aware through the national in-patient survey that patient choice of food is an issue that needs to be addressed.

8.28 It was acknowledged that in some instances use of the Lite Bite menu may rely on the patient being proactive and asking for help. It was noted that some patients have a tendency not to ask as they do not like to trouble busy staff. Research shows that there is an institutionalised acceptance that staff are busy and patients don't want to bother them. Members remained concerned that the availability of the full variety on the main menu and also the availability of Lite Bites were not as used

as they could be and information about the food services may require reinforcing.

Meeting Individual Needs

8.29 The simplest way of promoting nutrition is to get a patient to eat more. This may mean meeting individual requirements with frequent small meals, or tempting the patient with favourite foods. Texture and temperature have been found to be most important to hospital patients when judging food quality. Lack of variety can also prevent meals from being appetising. This is particularly the case for patients who are in hospital for long periods of time. Being presented with the same meals can put people off their food. People with dental problems or those who have difficulty swallowing may not be able to eat meals that have been prepared in the standard way so they may need soft or pureed food.

8.30 Appearance and flavour are also important and portion sizes need to vary if there has been a drop in appetite as a result of the ageing process or condition of a patient. Too much food can be off-putting in those circumstances and also creates unnecessary waste. Not enough food for some patients will mean that they go hungry. Patients responding to the survey indicated that, mostly, they were satisfied that appropriate portion sizes were provided. The Committee felt this could be further enhanced with the distinction in choice between small, medium and large portions.

8.31 There was some evidence that, although the ingredients purchased are of good quality, some of the aspects of hospital food that give it its poor reputation are in evidence. Food that is bland and tasteless were common complaints and patients had little control over the flavouring of the food. Tea may be lukewarm and jugs of water are tepid. These are all issues of quality which can be easily addressed, for example by a range of common condiments and sauces being available.

8.32 Evidence showed that the organisation is sufficiently flexible to allow for the optimal circumstances needed for nutritional care in each department with different arrangements in place to cater for differing patient needs. Systems exist for a full range of alternative and special diets including Halal, Kosher, vegetarian and children's menu. Texture modified diets are also available if required.

8.33 However, Members found that some patients with special dietary requirements were not always catered for. There were some aspects individual needs and preferences that patients were more satisfied with than others. On the elderly ward the use of modest portion sizes and the option of the main meal at lunch time and a sandwich meal in the evening seemed to be well-received. Evidence also showed that patients requiring meals of suitable texture were provided with soft food and helped to eat. However, there were examples of patients' needs

not being met. One patient on a salt restricted, fat free diet was offered food she should not have been eating and another patient who could not eat milk was offered it. Access to fresh fruit seemed to be an issue for a number of patients.

8.34 The Trust confirmed that dietetics, catering and nursing staff were working together to ensure a more joined up approach to counter these individual service issues.

8.35 All of the factors which influence the quality of the food – temperature, texture, portion size, preference etc - should define the focus for a hospital food service. Where patients have increased involvement with the food service, such as in the trolley style of delivery where choice is at the point of consumption, satisfaction would be increased. The Trust has recently acquired new trolleys which could go in to individual bays and were hoped to improve the patients' choice.

8.36 Members felt that it is not acceptable to assume that patients are unhappy and choosing not to eat food just because it is impossible to please all of the people all of the time. The provision of a responsive out-of-hours and alternative service, and the full awareness of this service to patients, is essential to deliver the full range of choice.

8.37 The systems in place to enable patient choice and individual need should be reinforced. This should involve improving communication between patients, ward staff and catering staff to an extent that each individual patient can fully exercise choice and have their expectations met.

Environment

8.38 The environment in which meals are served can play an important part in whether or not patients eat their meals. Dining areas, time to eat meals without interruption, and the timing of meals are important factors which influence appetite. An example of good practice operated by the Trust is set out below.

**Lunch Club**

The Care of the Elderly Ward operates a lunch club for one day a week (being extended to daily) ensuring adequate nutrition is provided in a therapeutic environment. 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. 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. The focus is on stimulating a patient's memory, which can improve and encourage dietary intakes. The lunch club has been running approximately two years and received the Board of Governors Award at the Trust's Reward and Recognition Celebration in September 2010

8.39 Any appropriate opportunities for patients to be encouraged to eat meals in the ward day-rooms will provide a familiar and more relaxed eating environment. 27% of patients in the Committee's survey said they would have liked to be able to sit at a table or eat in the company of others. The Committee acknowledged that while this would be physically precluded on some wards, where this is possible, extended use of designated dining areas away from the bed is to be welcomed.

8.40 The Trust operates a Protected Meal Times policy. Protected Meal Times ensure that people are given enough time and support to be able to eat their meals. Protected Meal Times are in operation on the wards and were evident during the visit. There was no evidence that nurses are unable to implement the policy due to pressure from other healthcare professionals and patients reported that they had enough time to eat their meals. The only concern expressed by Members was that there were some patients who would benefit from the presence of relatives during Protected Meal Times. Consideration should be given to a workable system that will allow support from relatives to be combined with protected mealtimes, as one patient commented:

> *"I think it would be good for family and friends to have access at meal times in order to help."*

8.41 On most wards the main meal of the day is served in the evening, with sandwiches in the middle of the day. E52, the Care of the Elderly ward has recently reviewed meal provision following feedback from patients and introduced a two course hot meal at lunch time and sandwiches/soup at tea time. This reflects the mealtime habits of many older people in the community and seemed to be popular with the in-patients.

8.42 The regularity of the timing of meals seemed to be helpful for most patients although there were some who commented about inflexibility of mealtimes as some patients summarised:

> "*Didn't get offered food at later time. Mentioned it would have been nice to have it an hour later."*
>
> *"No appetite because mealtimes too close together."*
>
> *"Not used to meal at 4 pm – it is a bit early." To spread meal times a little could make a difference."*

8.43 Each ward receives three meal deliveries a day, seven days per week for the "just in time" for meal service. There are also 7 drinks rounds with the last one at 7 pm. Delivery and meal serving times are :

| Delivery Time | Ward Delivery Times | | Meal Time |
|---|---|---|---|
| Breakfast Delivery Time | 07:10 | Breakfast | 8.00 |
| Lunch Delivery Time | 10:40 | Lunch | 12.00 |
| Supper Delivery Time | 16:10 | Supper | 17.00 |

8.44 Although this regularity was appreciated by some patients, others found it unhelpful if they weren't hungry at those set times, and as indicated earlier, they didn't understand fully the alternative options available. There were several requests in the survey for more drink, particularly milky drinks at bedtime.

Screening and Assessment

8.45 Effective screening can help detect and treat malnutrition. On admission, all patients should be weighed using the Malnutrition Universal Screen Tool (MUST) within 24 hours and then on a weekly basis. MUST is used to identify adults who are malnourished, at risk of malnutrition or obese. A score of 2 immediately indicates that the patient is suffering from some kind of malnutrition and needs referral to the dietetic service for further advice and management plan.

8.46 Once a referral has been received the dietitian will attend the ward within 24 working hours. They will liaise with appropriate health care professionals and gather initial information about the patient from medical and nursing records. They will then talk to the patient, if possible, to try to find out more information about their usual eating habits including any loss of appetite prior to admission, social issues, and weight loss history.

8.47 It was unclear from the Trust, following questioning in the Scrutiny Committee, what is their level of compliance with MUST. BAPEN in their Nutrition Screening Week survey (winter 2010[13]) reported that malnutrition was found to affect more than 1 in 3 adults on admission to hospitals, and their nutritional status has been shown to deteriorate further during their stay. The Committee was unable to ascertain the number of in-patients currently in Sunderland Royal Hospital who are clinically malnourished, either because they were admitted in a malnourished state or they lost weight during their stay in hospital.

8.48 Overall, Members were concerned that no evidence was available of the data collected in relation to malnutrition and how this was used to ensure patients were well-nourished. It was confirmed to Members that MUST was being reinvigorated and a weight audit was currently

(November 2010) taking place in the hospital to provide a baseline from which to measure future improvements.

8.49 The screening process is a key determinant of information about the patient which will influence their eating during their stay in hospital. It is acknowledged by the Committee that weighing each patient on admission can be a difficult undertaking for a variety of reasons however in planned admissions compliance with MUST should be achieved. It is also important that the patient understands what is happening and why the screening is being done.

8.50 The Board of Directors (through the Clinical Governance Group) should monitor information on the compliance rate with MUST, the number of patients identified as malnourished or at risk of malnourishment and how many are referred to the dietetics service i.e. that all appropriate scores actioned.

8.51 Malnutrition is not just issue for hospitals. Malnutrition may occur in the community prior to admission to hospital. It was outside of the remit of this review to consider the profile of the malnutrition of people in the community as well as in the hospitals. This includes what people such as carers, friends and families should look for, what they can do, and what role the different organisations play in terms of providing advocacy, support, and advice. BAPEN research[13] concludes that "much of the 'malnutrition' present on admission to institutions originates in the community" and whilst nutritional screening is linked to care plans in most institutions this is not routinely followed through into discharge planning. Continuity of nutritional care could therefore be hindered.

8.52 BAPEN recommends that consistent and integrated strategies to detect, prevent and treat malnutrition should exist within and between all care settings. GPs and nurses in the community have in important role to watch for signs of under-nourishment. Ideally every person in a care setting should receive nutritional screening and an appropriate care plan using a recognised nutritional screening tool e.g. MUST.

8.53 The Committee felt that ideally, malnutrition should be recognised and treated before admission. It is recognised that this ideal is impossible to achieve in all cases because many patients are first seen as an emergency, however, for planned admissions information about catering services in advance of admission may be an option.

Assistance

8.54 Patients require assistance for a variety of reasons, for example, they may not be able to sit up following an operation. For some patients, they may not even be aware the food is there unless they are helped. They may need dentures or they may not be able to hold cutlery. If a patient requires assistance then this is offered during all meal times

and can be in the form of patient's being assisted to sit in a specific position to enable them to access their meal; food being cut into bite size pieces; general encouragement to eat and drink; patient's being assisted to eat their meal by being fed by a relative or member of the nursing team.

8.55 If a patients nursing assessment identifies the risk of them becoming dehydrated and/or malnourished, requiring assistance to feed or be prompted to eat, the 'red serviette' system is implemented. This entails the wrapping of cutlery in red serviettes prior to food service and thereby raises staff awareness of the need for assistance.

8.56 Wherever the red serviette symbol is present, staff should make sure that patients know that meals have arrived and provide assistance with the meal. This also ensures that the patient's intake of food and drink is assessed, monitored, and then documented on a food chart. Food charts are available to record the intake patients have consumed in any 24 hour period. This allows the medical, nursing and dietetic staff to assess on a regular basis that the patient is getting the nourishment that they need during their hospital stay.

8.57 The red serviette system was seen operating during Members' visit to the hospital. In the patient's survey, the majority said that nursing staff did encourage them to eat and that they had enough time to eat.

> *"Staff encouraged (me) to eat but seemed at times to be too busy."*
>
> **"***Staff encouraged us to build up strength."*

8.58 It was also recognised that it is important that from the time the meal is placed in front of the patient to the arrival of someone to assist should be limited as any delay will affect the temperature of food and may be a reason why some patients are reporting warm food despite it being heated close to the ward.

8.59 Members remained concerned that if a meal is left uneaten, there is a risk of an assumption being made that patients do not want the food and the meal could be removed. If the red serviette has been lost i.e. fallen of the tray or disposed of, it may not be considered that the patient has been unable to feed themselves.

8.60 Members are aware that the red tray system as an alternative to the red serviette system has been considered but not adopted, largely because of the perceived unappealing visual impact and out of respect for the patient in not drawing too much attention to their needs. However, Members can see that a link can be established between the need for monitoring uneaten food and with patients who need assistance. It was felt that if a red tray system was adopted, and a meal was left uneaten on the plate, the link would automatically be

established between a patient needing assistance and an uneaten meal.

8.61 Some patients also find it difficult to access drinks themselves. They may be too physically weak to lift a jug and pour water into a tumbler or they may be immobilised as a result of surgery or trauma and unable to move from a prone or sitting position without help. One of the visual methods that can be used to ensure assistance is provided to patients are red lids for water jugs. This system highlights to other members of staff that a patient may need assistance with drinking.

8.62 Assistance with feeding inevitably has consequences for capacity on the ward. Attitudes towards the role of volunteers on the ward varies from hospital to hospital. Some hospitals use volunteers under supervision and direction of nursing staff to help with the feeding of patients. Others use volunteers as menu coordinators. There are 300 volunteers throughout the hospital, and currently they do not help to feed patients.

8.63 The role that volunteers might undertake in future is currently being explored by the Trust and the Committee would endorse this approach to providing additional capacity believing that the patient meal service would benefit with the introduction of additional voluntary roles that could be useful and enhance the patient experience.

8.64 Earlier in this report there is reference to the role of families to encourage and to assist their relatives in choosing food and feeding during meal times where it is appropriate to do so. Members observed that this may not be common knowledge amongst patients or relatives that they could come in during meal times and provide assistance and encouragement to patients and this should be highlighted.

Monitoring

8.65 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 will explore the reasons why and resolve any issues there may be. If a patient does not like the food they are offered alternative choices are available from the catering department.

8.66 Through patient consultation Members were aware of a number of instances where patients did not eat their food. 37% of patients said they missed a meal because the food was not to their taste or was unappetising. 27% of patients missed meals because their illness had given them a reduced appetite or were unable to eat because of illness as the following examples illustrate:

*"Medication made it tricky to eat, did try but was tired and had no appetite"*

*"Always tried food but haven't eaten much when I was tired during treatment"*

8.67 The distribution and collection of waste food is shared between the nursing and catering staff. Food wastage is stringently measured by the Catering Department but this was not linked to what each individual patient had eaten. Catering staff do not know the specific needs and requirements of individuals and are not expected to ask patients why they have left a meal. Nurses give out the meal and catering staff clear away, what may be an untouched meal. If there are occasions when uneaten food is not monitored and reported to nursing staff an opportunity is being missed in the way in which staff work together to support people to eat and drink.

8.68 Members felt that the importance of auditing the cause of waste and the use of data to support patients should be rigorous. Written records of the proportion of a meal eaten by a patient should be rigorously maintained together with a system for reporting information about uneaten food to the nurse responsible for the patient's care. Monitoring of nutritional intake needs to be much more robust if the scale of the problem and issues are to be identified and addressed.

8.69 Despite the good practice witnessed with assisting patients, and the regular patient feedback, Members had concerns that there is a silent majority of patients who are not complaining even when they are unable to eat the food.

## 9. Conclusion

9.1 There are a number of reasons why patients may be malnourished in hospital. The Committee has investigated some of the key issues including the screening of patients and assessing whether a patients' nutritional needs and requirements have increased or decreased; missing meals; the need for help with feeding; and unappetising food. Weaknesses in any of these areas could contribute to poor nutrition in hospital.

9.2 Through the visit to the hospital and through direct patient feedback the Committee was aware of ongoing improvements in the meal service which will continue to make everyone's stay in hospital as comfortable and safe as possible.

9.3 While this review has not focused specifically on older patients, in drawing its conclusions the Committee wishes to endorse the Age UK research which concluded with seven steps to improve older patients' nutrition:

a) Listen to us
b) All ward staff must become 'food aware'
c) Hospital staff must follow professional codes
d) Assess us for malnourishment
e) Introduce protected mealtimes
f) Use a red tray system
g) Use mealtime volunteers

9.4 Our conclusions are largely similar to those of Age UK although we have concluded with specific themes which are more particular to Sunderland Royal Hospital. Those themes involve:

a) Building on existing good practice
b) Accountability and monitoring of the state of nutrition in the hospital
c) Improving patient choice
d) Improving communication and the information exchange with patients
e) Raising the profile of good nutrition across the organisation
f) Quality, consistency, rigour and attention to detail

9.5 The recommendations set out below provide actions within those themes which are intended to drive further the improvements already being put in place by the Trust.

## 10. Recommendations

10.1 Consistency in best practice should be developed through an Improvement Plan. This should include timescales to achieve the full and successful achievement of benchmarks of best practice for the Trust to aim to be recognised as an exemplar for nutrition and hydration.

10.2 The Improvement Plan should include actions to achieve the following key recommendations.

1. The structure which clearly defines whose responsibility it is to ensure an individual patient has food needs to demonstrate that it supports the patient's experience in its totality and the patient as the customer of the food service, not the ward, with the individual choice being a key priority.

2. The Trust should review roles and responsibilities to enhance patient choice which includes the role for volunteers and the role of the catering department.

3. To ensure rigorous monitoring the Board should analyse data on:
   - The number of patients identified as malnourished or at risk of malnourishment
   - The compliance rate with MUST
   - Targets to be set for improvement in compliance with screening

- Actioning of MUST scores

4. To support an approach of consistent best practice, the Trust should consider the use all available communication tools for the promotion of nutrition for example, newsletters, bulletin boards, and internet to keep this as a priority in the minds of everyone all of the time, similar to the 'Wash Your Hands' campaign.

5. The Trust should aims to achieve consistency so that patient choice is delivered with access to a menu, easier access to appropriate versions of the menu, and consistent delivery of alternative menu choices.

6. To enhance the eating environment and opportunities for patients to control their enjoyment of a meal, the Trust should consider the use of designated dining areas away from the bed where the physical layout allows this.

7. To enhance the quality of food the following options should be consistently applied and communicated to patients:
   - a range of common condiments and sauces should be available either routinely or on request
   - portion sizes should be offered to patients in small, medium and large sizes
   - milky drinks should be offered to patients in the evenings
   - handy snack boxes of pre-packaged fruit, cheese, biscuits should be readily available to patients.

8. To further enhance assistance to patients a red tray system should be provided to ensure a link between a patient needing assistance and an uneaten meal left on the plate.

## 11. Acknowledgements

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| | |
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| Martin Smits | Poole Hospital NHS Foundation Trust |
| Phil Davies | Robert Jones and Agnes Hunt Orthopaedic and District |

## 12. Background Papers


| | | |
|---|---|---|
| 1. | National In-Patient Survey | CQC (2009) |
| 2. | NHS Plan | Department of Health (2000) |
| 3. | Standards for Better Health | Department of Health (2004) |
| 4. | Choosing a Better Diet: A food and health action plan | Department of Health (2005) |
| 5. | Nutrition Action Plan | Department of Health (2007) |
| 6. | Nutrition Action Plan – End of Year Progress | Department of Health (2009) |
| 7. | Government response to the Nutrition Action Plan Delivery Board end of year progress report | Department of Health (2010) |
| 8. | Essence of Care – Benchmarks for Food and Drink | Department of Health |
| 9. | Standards and Guidelines for Nutritional Support of Patients in Hospital | BAPEN (1996) |
| 10. | Malnutrition Matters: Meeting Quality Standards in Nutritional Care | BAPEN |
| 11. | Improving Nutritional Care and Treatment: Perspectives and Recommendations from Population Groups, Patients and Carers | BAPEN (2009) |
| 12. | Toolkit for Commissioners and Providers in England: Malnutrition Matters: Meeting Quality Standards in Nutritional Care | BAPEN (2010) |

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| 13. | Nutrition Screening Survey in the UK and Republic of Ireland In 2010 | BAPEN (March 2011) |
| 14. | Malnutrition in Hospitals: Hungry to be Heard | Age Concern (2006) |
| 15. | Still Hungry to be Heard | Age Concern (2010) |
| 16. | Health Food Watch Report | Commission for Patient & Public Involvement in Health (2006) |
| 17. | A Positive Approach to Nutrition as Treatment | King's Fund (1992) |
| 18. | Hotel-style room service in hospitals: the new paradigm of meal delivery for achieving patient satisfaction of food service | Journal of the American Dietetic Association 2004 |
| 19. | Guidance about compliance, essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act (2008) | Care Quality Commission December (2009) |
| 20. | Nutrition Support for Adults | NICE (2006) |
| 21. | National Audit of Dementia (Care in General Hospitals) | Royal College Psychiatrists December (2010) |
| 22. | State of Healthcare | Healthcare Commission (2007) |
| 23. | Incidence and recognition of malnutrition in hospital. | McWhirter JP, Pennington CR Br Med. J 1994; 308: 945-948 |
| 24. | Hospital food: a survey of patients' perceptions | Clinical Nutrition 2003 |
| 25. | Care and Compassion? | The Health Service Ombudsman February 2011 |


## 13. Definitions

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| Nutrition | The supplying or receiving of nourishment |
| Malnutrition | The broad term used to describe under or over nutrition, dietary imbalance or nutritional deficiencies. |
| MUST | The Malnutrition Universal Screening Tool used throughout the Trust to screen for malnutrition. |
| Dehydration | An inadequate amount of fluid in the body |

## 14. Appendices

Appendix 1. Hospital Food Survey
Appendix 2. Hospital Visit

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