

Nuffield Trust Series No. 8

A Recipe
for Quality

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CONTENTS

	<i>Page</i>
Foreword	5
Chapter 1	
Summary and Recommendations	8
Chapter 2	
Background to this Report	19
Chapter 3	
Understanding the Problem	21
Chapter 4	
Key Issues to be Tackled	29
Chapter 5	
Recipe for a Quality Service	35
Appendix 1	61
Background, Aims and Methods for this report	
Appendix 2	66
UK Reports and Statements to Date	
Appendix 3	106
Local examples of Good Practice	
References	112

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FOREWORD

Soon after I became Secretary to the Nuffield Trust, Chris Reid asked whether this rather 'high-falutin policy organisation' would have an interest in things which *mattered* to people. In particular he had in mind the role of nutrition in patient care, and the simple but vitally important fact that appropriate food, properly prepared and served, plays a significant part in patient recovery. I had worked with Chris over a number of years in the 1970s when I was Administrator at St Thomas' Health District and he was Assistant Clerk for Hotel Services. Prior to that he had had a distinguished career in the catering industry and was a leading light in recruiting, training and establishing standards, particularly in hospitals. He was also an example of someone who moved from a specialist activity in hospital food to general management. This monograph is dedicated to Chris Reid in recognition of his awareness that things are not as they should be.

In 1963 the Trust produced an authoritative handbook on nutrition in hospitals' so this monograph fits within the tradition of the Trust and is also an example of our current interest in quality. Here are practical solutions to some of the issues facing the health service today: lack of preparation of nurses who have responsibility but no training; medical interest only in high technology patient requirements; managers preoccupied with cost; contractors interested in delivering and removing the plate and the waste.

We are grateful to those who took part in the scoping of this project and in particular to the Worshipful Company of Cooks who helped us develop an appreciation of the scale of the problem. The conclusion -

FOREWORD

that food should be managed as an integral component of clinical care rather than a hotel function - would be how Chris Reid would have seen it and is a recipe for quality.

John Wyn Owen

March 1999

1. Platt BS, Eddy TP and Pellett PL (1963). *Food in Hospitals. A study of feeding arrangements and the nutritional value of meals in hospitals*. London: Nuffield Provincial Hospitals Trust.

The consulting the hours when the patient can take food, the observation of the times, often varying, when he is most faint, the altering seasons of taking food, in order to prevent such times - all this, which requires observation, ingenuity, and perseverance (and these really constitute the good nurse), might save more lives than we wot of...

Remember however, that the extreme punctuality in well-ordered hospitals, the rule that nothing shall be done in the ward while the patients are having their meals, go far to counter-balance what unavoidable evil there is in having patients together...

Remember that sick cookery should half do the work of your poor patient's weak digestion. But if you further impair it with your bad articles, I know not what is to become of him or it.

If the nurse is an intelligent being, and not a mere carrier of diets to and from the patient, let her exercise her intelligence in these things.

Florence Nightingale

Notes on Nursing. 1859

CHAPTER 1

SUMMARY AND RECOMMENDATIONS

SUMMARY

In Britain today, about 40% of adults admitted to hospital are undernourished, and many others become so during their stay in hospital. This is a serious and deplorable state of affairs. Malnutrition increases the risk of complications, lowers resistance to infection, impairs physical and mental functioning, and delays recovery. Apart from the human costs, it adds hundreds of millions of pounds a year to the NHS bill.

For many of these vulnerable patients the problem is hospital food - the limited choice, the way it is served, or the lack of help for those unable to feed themselves properly. Others need additional nutritional support but their plight goes unrecognised or unheeded.

A number of recent publications have highlighted this issue and dealt with various aspects of it - the responsibilities of those involved in preparing, distributing and serving meals, the early identification of inpatients who are malnourished or at risk of becoming so, help with feeding and nutritional support; and the perspectives of patients, relatives and carers.

Our report is intended to complement these by concentrating more on *organisational and management matters*, from ward level upwards, particularly in the context of the Government's emerging quality agenda for the 'new NHS'.

The report reviews recent scientific literature, management handbooks and policy documents covering various aspects of hospital food provision and nutritional care. Additional input has come from interviews and correspondence with a range of key experts and stakeholders, and the proceedings of two seminar-workshops hosted by The Nuffield Trust.

Our findings confirm the urgent need to tackle this issue at all levels of the NHS. We found widespread support for the proposal that hospital food provision should be considered as part of clinical care, with management and accountability through the clinical line. There is a need for clear definitions of roles and responsibilities regarding nutritional care at ward level, for quality assurance, and for coordination at a senior management level within each Trust.

We conclude that food provision should be managed as an integral component of clinical care rather than a 'hotel' function.

Furthermore, we argue that nutritional care provides an ideal, patient-centred, whole-hospital model for refining and evaluating the new clinical governance arrangements being implemented throughout the NHS.

Our recommendations, outlined below, are aimed at all levels of the NHS - the Department of Health and NHS Executive; other national bodies including research funding agencies; health authorities and primary care groups; and hospital NHS trusts.

Notes

Note 1: Although the focus of this report is food and nutritional care in hospitals, many of the issues raised and recommendations made also apply to nursing homes - some to a greater extent because of the generally longer stays in these establishments.

Note 2: Although many of the following recommendations refer to the NHS structure and policy framework in England, the principles apply equally to all parts of the UK.

Note 3: The report is not intended to be critical of any particular group of staff involved in nutritional aspects of hospital care - but rather the general lack of a coherent and coordinated approach at ward, Trust and national level.

RECOMMENDATIONS

TO THE DEPARTMENT OF HEALTH AND NHS EXECUTIVE

1. Food as therapy

Based on the scientific evidence, the provision of nutritious and appetising food must be recognised at all levels of the NHS as a key component of effective high quality hospital treatment. Catering is not merely a 'hotel' function. For many hospital inpatients, notably those already malnourished or vulnerable to malnutrition through frailty, illness or debility, food is a crucial aspect of clinical therapy. Food service, feeding practice and nutritional support should all be recognised as elements within a spectrum of hospital-based 'nutritional care'.

2. Nutritional care in the new quality framework

Ensuring that nutritionally vulnerable patients receive enough food for their needs is a clinical imperative on both effectiveness and quality grounds. The NHS Executive should incorporate nutritional care into all relevant components of the new effectiveness and quality agenda as a matter of urgency.

3. Delivering quality - clinical governance

All aspects of nutritional care - hospital food service, feeding practices and nutritional support - should be embedded in the new clinical governance framework. Nutritional care provides an ideal, patient-centred, whole-hospital model for refining and evaluating the new clinical governance arrangements being implemented throughout the NHS.

4. Assessing performance

A set of robust indicators concerning nutritional care of nutritionally at-risk or malnourished people in hospital to fit the National Performance Assessment Framework should be developed and agreed. This would need to be consistent with similar frameworks being

developed for related aspects of care, e.g. care of older people.

The proposed Commission for Health Improvement should take this approach forward as a matter of priority.

5. Patient and user experience

We recommend that patients', users' and carers' views of hospital food and help with feeding be incorporated into the proposed National Survey of Patients' and Users' Experience as a standing item, and that the findings are considered in tandem with the clinical governance programme.

TO THE NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE

6. Centrally agreed standards

There should be centrally agreed standards for nutritional care.

The proposed National Institute for Clinical Excellence (NICE) should build on the solid base of existing studies in nutritional care and provide a core set of national guidelines and standards. These should be incorporated into all relevant National Service Frameworks.

For example, older people make up a large proportion of nutritionally vulnerable inpatients. The forthcoming National Service Framework for the care of older people recently announced by the Secretary of State for Health¹ should include standards covering the nutritional needs of older people in hospital.

TO THE AUDIT COMMISSION

7. Audit

The Audit Commission should consider the use of an audit of nutritional care as a marker for assessing wider aspects of ward or hospital performance.

SUMMARY AND RECOMMENDATIONS

TO HEALTH PROFESSIONAL BODIES

8. Education and training of health professionals

Increased emphasis and effort must be placed on raising awareness of the importance of food and nutrition among health professionals, particularly doctors and nurses, many of whom are still unaware of the role of nutrition in health and illness. Nutrition must be a more prominent feature of student curricula and qualifying examinations.

Nutrition should be included as a core element of undergraduate and postgraduate medical education, as well as the training of nurses and other key health professionals. The contribution that food and feeding make to hospital care should be a key element of this.

TO RESEARCH FUNDING AGENCIES (INCLUDING THE DEPARTMENT OF HEALTH)

9. Research

Further research is required in this important area of healthcare.

We recommend that research be commissioned in the following areas:

- **the extent of the problem of malnutrition in different groups of vulnerable inpatients, in different types of hospital**
- **identifying best practice approaches already developed in some hospitals**
- **issues concerning access to nutritious food, feeding and nutritional support for different groups of vulnerable inpatients**
- **the clinical outcomes of appropriate feeding and adequate nutrition in different groups of vulnerable inpatients**
- **the cost-effectiveness of appropriate feeding and adequate nutrition in different groups of vulnerable patients**

- **the effectiveness of routine use of validated screening and assessment tools**
- **the perceptions of key stakeholders (including patients and carers) with regard to hospital food and nutrition**
- **evaluation of nutritional care as a model for developing clinical governance**

There is a particular need for a systematic review of the evidence about the consequences of undernutrition, and also a systematic review of trials assessing the effectiveness or cost-effectiveness of different methods of nutritional care.

TO HEALTH AUTHORITIES AND PRIMARY CARE GROUPS

9. Hospital nutrition in Health Improvement Programmes

In *The New NHS* White Paper each Health Authority is charged with leading the development of a local Health Improvement Programme in collaboration with other local partner agencies including Primary Care Groups, Trusts, local authorities, the voluntary sector and the public.

A key principle underlying such programmes is the reduction of inequalities, particularly inequality of access to services. One very practical way to contribute to this would be to help ensure that vulnerable patients have access to nutritious and palatable food and appropriate nutritional support, not only whilst in hospital but also post-discharge.

10. Performance management by Health Authorities

Each Health Authority is charged with ensuring that Trusts deliver on the action plans drawn up in response to performance assessment and agreed with the NHS Executive Regional Office.

SUMMARY AND RECOMMENDATIONS

Hospital food, feeding practices and nutritional support must be made integral to these processes.

12. Healthcare commissioning

Primary Care Groups will shortly begin to take over from Health Authorities much of the commissioning of local health services including hospital services. They will be responsible for developing and agreeing long-term service agreements with Trusts.

Health Authorities and/or Primary Care Groups should include specific quality requirements concerning nutrition (e.g. provision of food, feeding practices, nutritional assessment, nutritional support, and follow-up) in long-term service agreements. Sufficient resources must be allocated to Trusts to enable them to satisfy such requirements.

TO HOSPITAL TRUSTS

13. Board-level commitment

For nutrition to have the status it deserves within the Trust management environment, Trust boards should be fully committed to the notion of food provision being a key component of clinical care and subject to the clinical governance programme.

14. Coordination at senior level

Each Trust should identify a named senior health professional to have responsibility for coordinating nutritional care services across the entire Trust. This officer should be supported by a senior multidisciplinary Nutritional Care Committee. The responsible officer (eg. a senior dietitian, nurse or clinician) would chair this committee and report directly to the medical or nursing executive director on the Trust's management team.

15. Food service

Hospital menus and meals should provide sufficient choice to offer healthy, balanced, appetising nutrition for *all* inpatients. Special attention should be given to the requirements of sick and nutritionally vulnerable patients, and appropriate special therapeutic diets for those who need them should be provided.

Arrangements for distribution and serving should deliver food of a defined standard in terms of nutritional quality, appearance, flavour and temperature, with minimum wastage.

Consideration should be given to adopting bulk-distribution, ward-based plating systems.

Ward staff should have ready access to snack foods between meals for patients who may need it. Nutritionally vulnerable patients (e.g. sick children, frail older people) should be placed in wards with 'kitchen areas', or near-ward kitchens, for preparing special meals or snacks.

16. Catering contracts

There must be agreed guidelines for caterers and an agreed contract monitoring framework. A named senior health professional should be given responsibility for ensuring that the contract reflects nutritional standards (e.g. by adhering to agreed standards or guidelines). This officer should report to the Nutritional Care Committee.

Contracts should include special therapeutic meals and provision of snacks and/or meals at ward or near-ward level.

17. Budgets

Budgets for catering, distribution, serving, feeding and nutritional support must be adequate to achieve the required standards. They must be ring-fenced and held under the heading of clinical services rather than 'facilities' or 'hotel services'. The budget holder should be the

SUMMARY AND RECOMMENDATIONS

named senior health professional responsible for nutritional care, supported by the Nutritional Care Committee.

18. Nutritional screening

As with any clinical intervention, the first step in nutritional care is to assess need. All too often, nutritional screening is simply a perfunctory 'box-ticking' exercise, if performed at all. **Patients who are malnourished or at risk of malnutrition should be identified as early as possible using a simple validated standard screening protocol that is quick and easy to administer by nursing or medical staff and is applied to all patients on admission. A named nurse should be made responsible for nutritional care on each ward or unit, and should ensure that all patients are screened as specified above.**

19. Help with feeding

Delivering food to the patient is one thing - ensuring it is eaten is another. Many patients become malnourished in hospital because they are not given enough help with feeding themselves. For all patients the responsibility for ensuring appropriate and adequate feeding rests with the nursing staff.

Patients who have difficulty feeding themselves should be helped by nursing staff, or, if insufficient nursing staff are available, a system for enlisting the support of relatives, carers or volunteers should be set up.

The nurse designated as responsible for nutritional care on each ward should ensure that patients are eating adequately, with or without help, or if necessary are referred to the dietitian for nutritional support. The nurse should report on this to the medical personnel managing each patient.

20. Nutritional support

Patients found to be malnourished or at risk of malnutrition on initial screening should be referred to a dietitian to have their nutritional

status more rigorously assessed as a baseline. They should be provided with a clear 'nutritional care plan' specifically tailored to their needs as an integral component of their clinical management.

Adherence to the plan should be the responsibility of ward nursing staff, supported by the dietitian and, where appropriate, a multidisciplinary team of other key health professionals - the 'nutritional support team'.

21. Monitoring and audit

Nutritional status

Simple monitoring/audit of nutritional status is crucial. Patients should be weighed and their nutritional status assessed on both admission and discharge. Their weight and nutritional status should also be monitored at predetermined intervals throughout their stay.

Feeding practices

Ward feeding practices should be audited on a random basis. Adequate nutrition could be used as a marker to assess ward performance.

Food intake and wastage

Wastage should be routinely monitored. Nurses should be provided with a tool for rapidly assessing food left on the plate and, where possible, identifying reasons for the wastage using a simple checklist.

Nutritional support

Use of supplements, tube feeds and parenteral nutrition must also be carefully monitored and audited against agreed standards. Appropriate records must be kept. Responsibility for this lies with the named nurse, supported by the dietitian or, where available, the nutritional support team.

SUMMARY AND RECOMMENDATIONS

22. Information and communication

Nutritional status assessments, nutritional care plans, and monitoring and audit results should be coded in a standard way on hospital databases. The information should be accessible by all relevant authorised staff, including the patient's GP and social services care manager (if appropriate).

23. Post-discharge care

In nutritionally vulnerable cases, the nutritional status on discharge, together with a nutritional care plan, should be communicated to the patient's carer, GP and, where appropriate, social services care manager to ensure proper follow-up care.

Communications to the carer, GP and/or social services care manager regarding post-discharge care should be audited as part of the quality framework for hospital nutritional care.

CHAPTER 2

BACKGROUND TO THIS REPORT

In 1992 the King's Fund Centre report, *A positive approach to nutrition as treatment*,¹ reviewed the organisation of food and nutrition services in UK hospitals and made a number of recommendations for improving care. Evidence was presented that malnutrition in hospital patients had both clinical and financial implications.

Subsequently a number of reports have produced recommendations specifically addressing the management of food and nutrition in hospitals. These cover such issues as staff roles and responsibilities, training, standards for hospital food, and the identification and assessment of undernutrition.

Despite this increase in awareness and widespread discussion of the issues, there is little evidence of general improvement in practice, either in the provision and organisation of nutrition care or in the prevalence of malnutrition among inpatients. Recent publications have highlighted the continued confusion of roles and responsibilities over nutrition care,^{6,7} a lack of enforcement of existing guidelines, and a lack of status awarded to the whole area of food and nutrition in hospitals.⁸

Now, with the emergence of a much greater emphasis on quality in the Government White Paper, *The New NHS: modern, dependable*,⁹ and other key policy papers that have flowed from it, in particular, *A First Class Service*,¹⁰ an important opportunity to gain proper recognition for nutrition in hospital has opened up. The growing acceptance of 'food as therapy' allows the issue to be properly regarded as a legitimate part of clinical management and therefore an appropriate element to be embedded in the developing performance assessment and clinical governance frameworks.

* Malnutrition is the broad term used to describe under- or over-nutrition, dietary imbalance or nutrient deficiencies.

** Undernutrition specifically refers to the condition arising from the inadequate provision of nutrients essential for health and growth.

BACKGROUND TO THIS REPORT

This is the focus of the present report. It is widely recognised that there has hitherto been a lack of incentives for Trust managers and clinicians to ensure high quality nutrition for hospital patients, and this in turn has been due largely to the absence of recognition of the importance of the issue by healthcare commissioners and policymakers at the centre. The time has come to include firm policy directives with regard to hospital food and nutrition in NHS Priorities Guidance, quality assurance standards, performance assessment, and clinical governance arrangements throughout the hospital sector.

This report considers *key policy changes* that could be used to achieve this end and makes recommendations to central government, local NHS commissioners and Trusts.

CHAPTER 3

UNDERSTANDING THE PROBLEM

This section briefly reviews evidence concerning the extent of the problem in the UK and its impact on outcomes. It also looks at the potential clinical and resource benefits of nutritious food, help with feeding and adequate nutritional support.

Unfortunately malnutrition is neither a new nor a rare problem in British hospitals. Reports from twenty years ago identified malnutrition as a common occurrence¹¹ and studies of hospital patients consistently report a prevalence of malnutrition of 20-50%.¹²¹³ A recent study of 500 adult patients in five different specialties in a large acute hospital found that 40% were underweight on admission and two thirds of these lost more weight during their stay.¹⁴ A smaller but substantial proportion of children admitted to hospital are underweight - around 15% in most studies.¹⁵¹⁶ However, there is a lack of robust evidence to show the full extent of the problem nationally.

Studies measuring the food and nutrient intakes of patients in hospital show that intakes are often inadequate in terms of energy, protein and various micro-nutrients.¹⁷¹⁸¹⁹²⁰²¹

The effects of undernutrition

The impact of undernutrition on functional and clinical outcomes has been widely investigated and shown to include increased post-operative complications, reduced resistance to infection and decreased quality of life. (Table 1).

UNDERSTANDING THE PROBLEM

Table 1

The effects of undernutrition on clinical and functional outcomes

• <i>Increased post-operative complications</i>
• <i>Increased risk of pressure sores</i>
• <i>Poor wound healing</i>
• <i>Sepsis</i>
• <i>Reduced immune response</i>
• <i>Lowered resistance to infection</i>
• <i>Apathy/depression</i>
• <i>Weakness/immobility</i>
• <i>Reduced muscle strength</i>
• <i>Reduced ability to cough</i>
• <i>Reduced quality of life</i>
• <i>Increased risk of mortality</i>

There is also evidence of a relationship between undernutrition and increased length of stay^{22 23} longer convalescence and rehabilitation and increased re-admission rates.²⁴

Why does undernutrition occur?

Patients may be malnourished on admission to hospital as a result of a variety of disease-related, social or psychological factors. For example, pain, illness, disability, depression, dementia, poverty or social isolation may reduce appetite, access to a nutritious diet, or ability to eat. In

hospital some of these factors may still have an effect but there is also a range of other issues that become important and can further contribute to an inadequate nutritional intake. These are quite separate from any illness or treatment effects.

Examples of hospital influences on nutritional intake

Hospital food

- *nutritional quality*
- *taste*
- *appropriateness (e.g. texture, culturally)*
- *appearance*
- *temperature*
- *portion size*

Hospital routines

- *interruption of mealtimes*
(e.g. ward-rounds, investigations)

Environmental factors

- *suitable cutlery*
- *positioning*
- *social influences*

Other

- *supervision and assistance provided*
- *monitoring of intake*
- *timing of meals*

In practice, malnourished or at-risk patients are most likely to be frail older people, adults or children with mental health problems, learning or physical disabilities, and adults or children with debilitating illness or injury.

UNDERSTANDING THE PROBLEM

Degrees of nutritional risk

Simple screening protocols, applied to all patients on admission, can be used to allocate them to one of three nutritional care pathways according to risk. For example:

- **High risk:** frankly malnourished patients or those who are sufficiently at risk of becoming malnourished that they need nutritional support. Action: refer to the dietitian.
- **Moderate risk:** patients who are not malnourished but who have some risk of becoming so and need some help in choosing a nutritious diet or help with feeding. Action: special attention and monitoring by nursing staff, with support of relatives, carers or volunteers as appropriate.
- **Low risk:** patients who are not malnourished and whose general physical and mental state does not put them nutritionally at risk providing they receive sufficiently nutritious and palatable routine meals. Action: re-screen at weekly intervals by nursing staff.

Providing adequate nutrition in hospital

Maintaining good nutrition is vital for patients' overall wellbeing. For most patients this will mean ensuring that they eat a nutritionally adequate diet whilst in hospital. However, some patients who are malnourished or at risk of becoming so require additional support. This may be in the form of:

- encouraging eating, help with feeding
- providing extra snacks and nutrient dense foods

- nutritional supplements taken orally in addition to meals (e.g. proprietary fortified drinks)
- enteral feeds given via a tube (e.g. nasogastric or PEG (gastrostomy) feeds)
- intravenous nutrition/TPN (Total Parenteral Nutrition) when the intestine cannot be used or its function is inadequate

Providing adequate nutrition by each of these means has been shown to improve nutritional status in appropriate cases: e.g through the appropriate use of highly nutritious hospital food,²⁵ oral supplements²⁶ or other forms of nutritional support.²⁷

THE BENEFITS OF IMPROVING NUTRITION

Outcomes

A number of studies have shown a relationship between nutritional status and clinical outcomes.²⁸ Randomised controlled trials of nutritional support have demonstrated improved outcomes in older people undergoing orthopaedic surgery²⁹³⁰ and reductions in major complications and mortality."² Patients given oral supplements have fewer complications such as pressure sores,³³ wound infections³⁴ and anaemia and lower mortality compared to those that received no supplements.³⁵³⁶

Length of stay

There is also evidence of a relationship between undernutrition and an increased length of stay.³⁷ Patients who are malnourished on admission have longer lengths of stay.³⁸³⁹

UNDERSTANDING THE PROBLEM

Giving nutritional support can reduce length of stay.⁴⁰ For example, trials of supplementary feeding in patients with fractured neck of femur have found lengths of stay reduced by about 40% in the supplemented versus non-supplemented groups.^{41 42} Rehabilitation times were also reduced.

COST IMPLICATIONS

Savings

The King's Fund Centre report⁴³ calculated that providing comprehensive nutrition support would result in a five day reduction in hospital stay for approximately 10% of inpatients. The consequent saving was estimated to be £266 million annually in the UK. A recent audit of about 2500 cases in 20 US hospitals also found substantial reductions in length of stay of those patients who received earlier nutritional intervention.^{44 45} On average, stays were reduced by a factor of one day for every two days the earlier the intervention. The conclusion was that appropriate and timely nutritional support could save a typical large US hospital about \$ 1 million a year.

Undernutrition is associated with an increased likelihood of developing complications which may have significant cost implications. One study showed that the admission of a malnourished patient who experienced a major complication cost as much as four times that of a normal patient with no complication.

Expenditure

When the costs of feeding hospital inpatients by various means are compared, there are large differences. These have implications for the efficient management of nutrition. For example, at one large London teaching hospital, the comparative costs of different feeding systems are:⁴⁶

Hospital food	£ 2.40 per day (for 3 meals and 7 hot drinks)
Supplements	£ 1.00 for each item on average
Tube feeding	£ 10.00 per day on average
Parenteral nutrition	£ 80.00 per day on average

These costs do not take account of the extra clinical risks involved with artificial nutrition, and in particular the cost of dealing with the complications and side effects of parenteral nutrition.

Providing the most appropriate form of nutritional support is also important in this context. There is evidence of the inappropriate and unnecessary use of expensive forms of nutritional support; for example, where TPN is used when enteral nutrition would have been more appropriate.⁴⁷

Wastage

Food wastage may have important clinical and cost implications. There are many factors involved in determining how much food is wasted, ranging from food palatability to portion size, and from the individual inpatients' appetites to availability of help with feeding. Studies of hospital food wastage show high levels of waste. A recent study reported that inpatients were leaving an average of 40% of their lunch and 42% of their evening meal.⁴⁸ This was calculated to lead to an energy deficit averaging 58% for each patient.

A review of the management of clinical nutrition in hospitals looked at the issue of waste of artificial feeds and estimated that substantial savings could be made through the better management of artificial feeding practices, including improving monitoring, providing protocols and more prudent purchasing.⁴⁹

UNDERSTANDING THE PROBLEM

Improved or expanded nutrition services can help cut costs if they are targeted to inpatients at risk, applied early and the benefits recorded.⁵⁰ The best results are obtained in terms of appropriate and efficient use of resources, reduced complications and costs when specialist nutrition support is managed by a specialist multidisciplinary nutrition team.⁵¹⁵² It is estimated that at least two thirds of UK hospitals may have no formal nutrition team responsible for the identification, treatment and monitoring of malnutrition.⁵³

CHAPTER 4

KEY ISSUES TO BE TACKLED

There are a number of major factors that have been identified as contributing to the poor management of nutrition in hospitals. In this section some of these reasons are examined.

Hospital food has a poor image

Patients' and relatives' expectation of hospital food has traditionally been low. Letters written by concerned relatives to their Community Health Councils, and used as the basis for the 1997 report *Hungry in Hospital!*,⁵⁴ indicate that most people do not expect hospital food to be particularly appetising. However, they do expect it to be nourishing and reasonably palatable. The recent report, *Not Because They Are Old*⁵⁵ which focuses on the care of older people in acute hospitals, found that complaints about the food and feeding were paramount.

Providing nutritious food is not regarded as a priority

Managers and clinicians generally do not see catering as playing a particularly important part in the service the hospital is providing.^{56,57} Doctors in particular tend to regard nutrition for patients in hospital as of little importance. This was confirmed in one study where the main reason that doctors gave for not asking patients about their nutrition or weight was that they felt it was unimportant.⁵⁸ In a review of the case-notes of undernourished patients less than half (48%) had any nutritional information documented.^{5*}

Food provision is seen simply as a 'hotel' service rather than an important therapeutic aspect of patients' hospital stay. This image can come both from within and as a result of external perceptions of hospital catering. Consequently, catering departments are usually grouped with general facilities rather than patient care services. This

KEY ISSUES TO BE TACKLED

means that food provision tends to have a somewhat humble profile in the perennial struggle for scarce resources.

Catering staff may not be aware of the importance of providing highly nutritious food to ill patients. Nutrition is not taught on all catering courses and what is taught may be insufficient. Often the emphasis is on 'healthy eating' (e.g. cutting down on fat and sugar), which is usually not appropriate for malnourished or at-risk patients with poor appetites who require energy- and nutrient-dense food.

Doctors and nurses generally have a low awareness and a lack of training and knowledge about nutrition

Surveys looking at the awareness and knowledge of clinicians about nutrition and nutrition management have repeatedly shown that generally awareness is low.⁶²

There could be a number of reasons for this. Firstly, most of today's consultants have had no formal training in nutrition. Current medical students may also be receiving inadequate nutrition education. It has been reported that only a few medical colleges make a serious attempt to teach nutrition at an undergraduate level, and that most final year students know less about nutrition than other branches of medicine." Although some medical schools have developed a clear educational strategy for nutrition these tend to be ones where there are existing nutrition departments.⁶⁴ Nutrition has been described as a 'Cinderella' subject in undergraduate medical schools.⁶⁵

In general, nurses' nutritional knowledge and training have been shown to be inadequate, with widespread deficiencies in the knowledge, communication and co-ordination required to ensure consistent good practice.⁶⁶ However, an increasing number of hospitals now employ nutrition nurse specialists.

Hospital catering departments or contractors work to very tight budgets

Unlike clinical services, there is no powerful voice for catering when it comes to financial control, 'efficiency savings' and the allocation of budgets. So often, when efficiency savings have to be made, catering budgets are squeezed. This inevitably puts the quality of the food service at risk, making it more difficult to achieve or maintain standards.⁶⁷ Food wastage can be a critical factor here. There is an urgent need for 'champions' for catering at a high level within the hospital management structure.

Where catering is contracted out, competitive tendering may threaten quality for the sake of price. This needs to be rectified. Contracting-out also creates difficulties in making food service part of the clinical delivery.

Nutrition is not regarded as a priority at ward level

With increasing pressure on nurses' and other ward staff's time, feeding patients is all too often sidelined as a lower priority activity that gets in the way of 'real' work. This has knock-on effects - a lack of concern about making sure the right meals are ordered; hurried and careless serving of food; rushed mealtimes. Even patients who need help with feeding may be neglected or given cursory assistance because there is something 'more important' waiting to be done.⁶⁸ As for nutritional screening and monitoring food intake, these are widely regarded as 'pie-in-the-sky' ideas - just not feasible on a busy ward - and either ignored completely or done in a half-hearted fashion. Consequently the nutritional status of patients is rarely considered when their case is reviewed.

KEY ISSUES TO BE TACKLED

Issues of responsibility remain confused and unclear

Historically nurses have played a role in feeding patients. However, increasingly complex ward procedures and other demands on their time have meant that many nurses no longer regard helping patients to eat as part of their job. The 1997 report *Hungry in Hospital*?⁶⁹ identified many examples of nurses not assisting patients with feeding or not being present at mealtimes.

In response the UK Central Council for Nursing (UKCC) has issued a statement unequivocally identifying nurses as responsible for ensuring that patients are adequately fed. However, a lack of clarity still prevails. A questionnaire survey of all nurses in one district general hospital found that less than half felt that part of their role was to be responsible for patients' nutrition.

The responsibilities of other groups of staff may be equally confused. For example, there is often confusion over the precise roles and responsibilities of doctors and dietitians with regard to nutritional care and how these relate to the nursing role. The different responsibilities of catering and ward staff in making sure appropriate food is delivered and food wastage monitored may need clarifying. The part played by relatives, carers and volunteers may need to be clearly fitted into the picture.

There is a lack of professional coordination and cooperation

The chain of events that must occur between the patient choosing food from the menu right through to the patient eating the food and/or receiving nutritional support is complex. This 'food chain' requires different individuals and professional groups to link together in a coordinated and seamless manner at each stage. There are many potential pitfalls where a lack of co-ordination and communication can

lead to a break in the chain. This may in part be due to a poor definition of responsibilities.

For example, the separation of managerial and budgetary responsibilities for the provision of 'normal' versus 'special' meals, or food versus supplements and feeds, means there is a segregation of services through different management lines. This tends to lead to poor coordination of nutritional care.

Information for monitoring and audit is not being properly collected, nor being reported to and acted upon by decision-makers and managers

Because of the low profile of catering in the hospital management hierarchy, senior Trust officers tend to marginalise it in making key decisions. The prevailing attitude is that it is a service that 'runs itself' and has little impact on the main thrust of the hospital's role, treating patients. Decision-makers and managers do not know what information is being, or should be, collected, nor how to interpret it or act on it.

There is no shortage of guidance, but it is not being taken up

There is a considerable and growing body of guidance from a variety of sources (which we review in Appendix 2). In general, the approaches being advocated are all consistent and the potential benefits are clearly set out - and yet there is little evidence of the advice being taken up on a wide scale.

KEY ISSUES TO BE TACKLED

There are no formal means of generally enforcing standards and recommendations

Hitherto the hospital quality assurance process has failed to grasp firmly the issue of providing nutritious and palatable food for all inpatients and effective nutritional care for those who are most vulnerable: patient satisfaction surveys have played a small part in improving the quality of catering in many hospitals, but rarely address the aspect of nutritional support and feeding. Hospital accreditation schemes have tended to focus on catering hygiene standards rather than the nutritional content of meals, or the feeding of patients.

Improvements to catering services are perceived as a drain on resources that would otherwise be allocated to patient care

Capital investment in facilities and equipment for a ward-based or near-ward-based service, and revenue costs for extra kitchen staff, may amount to considerable sums which could be used for more specific forms of direct patient care.

However, improvements can often be achieved without the need for extra resources, simply by changing inefficient routines and practices.⁷²

There is a lack of research evidence

We still do not know the full extent of the problem in different types of hospital across the country. We still need to assess the routine use and effectiveness of validated screening, assessment and plate wastage protocols. We need a systematic review of trials of different nutritional interventions. We need more studies of the cost-effectiveness of different models of nutritional care.

CHAPTER 5

RECIPE FOR A QUALITY SERVICE

This section sets out a rationale and 'recipe' for change in the field of hospital food, feeding practices, and nutritional support, including a number of specific recommendations, particularly in terms of policy at national and local level.

Our review of recent reports (a digest of which is given in Appendix 2), shows that there is a wealth of good ideas about how effective nutritional care of hospital inpatients should be organised, coordinated, delivered, supported and audited to the satisfaction of patients, carers, clinicians, managers and commissioners.

The challenge is in putting the best of these ideas into effect through a process of education, motivation, planning, resourcing and performance management.

We believe that, although there are signs that things are moving slowly in the right direction, the time is ripe for a big push. Suddenly, quality is right at the top of the NHS priority list, and hospital nutrition should be firmly embedded in that agenda.

The whole hospital food and nutrition service, from 'menu to mouth', should be an integral part of the new NHS quality framework, with special emphasis on nutritional support for all malnourished or nutritionally at-risk inpatients.

Nutrition in the new NHS national quality framework

In December 1997, the Government White Paper, *The New NHS: modern, dependable*,⁷³ set out a modernisation programme to deliver more consistent and higher quality care for patients.

"The new NHS will have quality at its heart. Without it there is unfairness. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality

RECIPE FOR A QUALITY SERVICE

care when they need it. Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality."

From The new NHS: modern, dependable, 1997

A follow-up consultation document, *A First Class Service: Quality in the new NHS*, (issued in July 1998),⁷⁴ provides a more detailed framework for quality improvement and fair access in the NHS. Its main elements are:

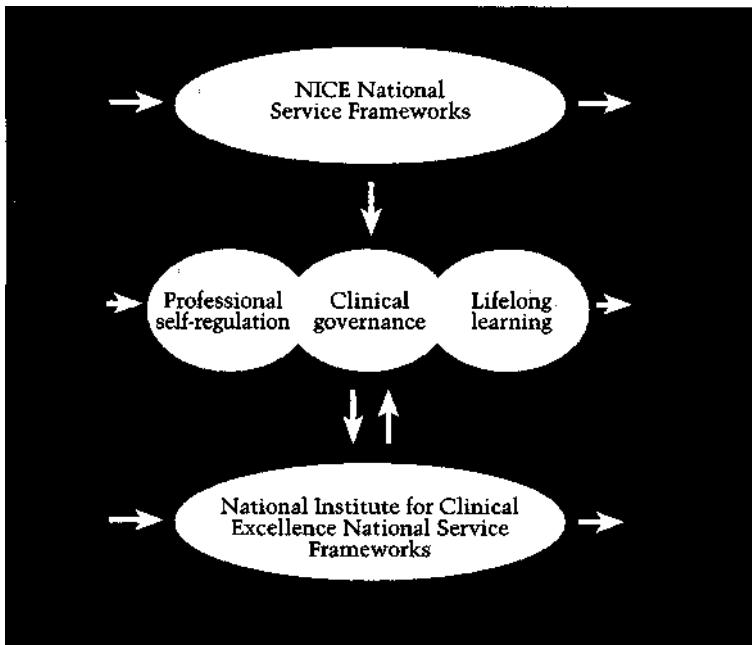
- clear national standards for services and treatments, through National Service Frameworks and a new National Institute for Clinical Excellence (NICE)
- local delivery of high quality healthcare, through clinical governance underpinned by modernised professional self-regulation and extended life-long learning
- effective monitoring of progress through a new Commission for Health Improvement (CHImp), a Framework for Assessing Performance in the NHS and a new National Survey of Patient and User Experience.

Setting standards

The NICE will promote clinical and cost-effectiveness through guidance and audit to support frontline staff. It will advise on best practice and appraise new approaches. Evidence-based National Service Frameworks will set out what patients can expect to receive from the health service in major care areas. Together these initiatives will set clear quality standards which all parts of the NHS will be expected to meet.

Because adequate feeding of nutritionally vulnerable patients is a clinical imperative on both effectiveness and quality grounds, we

Figure 1
Setting, delivering, and monitoring standards



recommend that nutritional care be incorporated into all relevant components of the new NHS effectiveness and quality agenda as a matter of urgency.

It follows from the above that there should be centrally agreed standards for nutritional care, including for example:

- nutritional quality and palatability of hospital meals
- preparation, distribution and serving of meals
- feeding practices
- nutritional screening, assessment and monitoring

RECIPE FOR A QUALITY SERVICE

- referral protocols
- nutritional support protocols
- nutrition information protocols (e.g. numbers screened, numbers requiring each level of support, food consumption/wastage, etc]
- audit protocols
- nutrition education and training of relevant staff
- organisation of nutritional care services within hospitals
- resources for the provision of food, help with feeding and nutritional support, including staffing levels and consumables
- performance assessment, performance management and clinical governance with regard to nutrition

We recommend that NICE builds on the solid base of existing studies in nutritional care and provide a core set of guidelines and standards. These should be incorporated into all relevant National Service Frameworks.

Delivering quality - Clinical governance

Setting core national standards, important though it is, will not be enough. We need consistent action locally to ensure that standards and guidance are applied. This will require some local ownership of standard-setting and audit. Clinical governance will be the process by which each part of the NHS will assure quality. In effect it will be the quality equivalent of financial responsibility.

"...the Government will require every NHS Trust to embrace the concept of 'clinical governance' so that quality is at the core, both of their responsibilities as organisations and of each of their staff as individual professionals."

From The New NHS: modern, dependable

Backed by a new statutory duty of quality, the clinical governance approach will introduce a framework of continuous improvement, monitoring healthcare quality at a local level. Clinical governance will require partnerships between health professionals, managers, other health staff, patients and carers. In effect, it will be everybody's business, engaging everyone in the drive for quality, focussing on what really matters.

"Clinical governance will help ensure that quality resumes its rightful place at the heart of the NHS."

From A First Class Service: quality in the new NHS

Clinical governance will be backed up by a comprehensive programme of lifelong learning by staff, rigorous self-regulation by professionals, and through a new system of external monitoring of care services. Each Trust must designate a senior clinician responsible for ensuring that systems for clinical governance are in place. Central to this will be monitoring and audit against agreed standards. The Chief Executive of each Trust will be accountable on behalf of their Board for assuring the quality of Trust services and will provide the Board with regular reports on quality.

NHS Trusts will need to have basic arrangements for clinical governance in place by early 1999 and to produce their first reports by Spring 2000.

The latest guidance, issued in March 1999,⁷⁵ sets out the generic principles and appropriate mechanisms to help Trusts, Health Authorities and PCGs to begin to put the clinical governance programme in place over a five year timeframe. It will be a long-term process, and this guidance is the first of many as the programme rolls out. One point the guidance emphasises is that the clinical governance framework must mesh closely with other systems of standards and guidelines affecting the quality of care in hospitals.

RECIPE FOR A QUALITY SERVICE

We believe that the wide spectrum of nutritional care, involving as it does a wide range of processes, skills and inputs, provides an ideal model for applying the multidisciplinary partnership approach to quality assurance embodied in the principles of clinical governance.

The scientific evidence points to very tangible clinical outcomes from coordinated quality-assured input by all players in the 'food chain', not just the clinical professionals,- patients, relatives and carers, must also be brought into the clinical governance process. Much good groundwork has already been done (see Appendix 2), and this offers an excellent basis upon which to build the clinical governance approach.

Assessing performance

Although NICE will produce clinical guidance against which performance can be assessed, it will not have a direct role in monitoring the uptake of its guidance and audit tools. This will be undertaken by a new Commission for Health Improvement (CHImp) through a range of initiatives including:

- a National Performance Assessment Framework
- review visits (including spot checks) of Trusts by the Commission
- the National Survey of Patient and User Experience

NHS Executive Regional Offices and Health Authorities will be responsible for ensuring that the recommendations from CHImp review visits are acted upon. Follow-up action plans for addressing identified deficiencies should be agreed between Trusts and Regional Offices.

The National Performance Assessment Framework

The new National Performance Assessment Framework, as outlined in an NHSE consultation document⁷⁶ will focus on six main dimensions:

- health improvement
- fair access to services
- effective delivery of appropriate healthcare
- efficiency
- patient and carer experience
- health outcomes of NHS care

Aspects of performance to be included in each dimension are as follows:

Dimension	Aspects of performance
<i>I Health improvement</i>	The overall health of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies
<i>II Fair access</i>	The fairness of the provision of services in relation to need in various respects: <ul style="list-style-type: none">- geographical- socio-economic- demographic (age, ethnicity, gender)- care groups (e.g. people with learning difficulties)

RECIPE FOR A QUALITY SERVICE

III Effective delivery of appropriate healthcare-	<p>The extent to which services are :</p> <ul style="list-style-type: none"> - clinically effective (interventions or care packages are evidence-based) - appropriate to need - timely - in line with agreed standards - provided according to best practice service organisation - delivered by appropriately trained and educated staff
IV Efficiency	<p>The extent to which the NHS provides efficient services, including:</p> <ul style="list-style-type: none"> - cost per unit of care/outcome - productivity of capital estate - labour productivity
V Patient/carer experience	<p>The patient/carer perceptions on the delivery of services including:</p> <ul style="list-style-type: none"> - responsiveness to individual needs and preferences - the skill, care and continuity of service provision - patient involvement, good information and choice - waiting times and accessibility - the physical environment; - the organisation and courtesy of administrative arrangement

**VI Health outcomes
of NHS care**

NHS success in using its resources to:

- reduce levels of risk factors
- reduce levels of disease, impairment and complications of treatment
- improve quality of life for patients and carers
- reduce premature deaths

(Taken from the green paper on the National Framework for Assessing Performance)

This framework will be an integral part of NHS accountability arrangements, ensuring that both quality and efficiency are central to the way the NHS is held to account. It will underpin the performance agreement between the Health Authority and Regional Office, the NHS contribution to the Health Improvement Programme, and the service agreement between a Primary Care Group and an NHS Trust. Routine performance monitoring of Trusts will be undertaken by the NHS Executive Regional Offices. Variations from expected good practice will increasingly be challenged locally by Health Authorities and Primary Care Groups, local media and the public.

Assessing performance in nutritional care

The Government are currently consulting on suitable sets of performance indicators to cover services pertaining to particular diseases or conditions (eg. coronary heart disease; mental health). However, in our view, the same framework lends itself to assessing broader aspects of NHS performance, such as nutritional care of hospital inpatients.

RECIPE FOR A QUALITY SERVICE

Thus, the six dimensions could assess the following components of nutritional care:

Dimension	Aspects of nutritional care
<i>Health improvement</i>	Mortality and morbidity among vulnerable groups of the population with high hospitalisation rates (e.g. older people). Nutritional care would be expected to have a marginal but significant impact
<i>Fair access</i>	<p>The fairness of provision of proper nutritional care (including help with choosing meals or feeding) to:</p> <ul style="list-style-type: none"> - inpatients with diverse cultural needs (e.g. with different dietary requirements, or who may not be able to speak English or read in any language when choosing from menus) - different care groups (e.g. frail elderly people, people with disabilities, adults with mental illness, children with learning difficulties)

Effective delivery of appropriate healthcare

The extent to which nutritional care is:

- evidence-based (e.g. accords with agreed guidelines)
- appropriate to need (e.g. validated screening/assessment protocols are properly applied on admission)
- timely (e.g. nutritional interventions are applied as early as possible during hospital stay)
- in line with agreed standards continuously monitored and regularly audited
- provided according to best practice (e.g. examples in line with agreed guidelines according to peer review)
- delivered by appropriately trained staff (e.g. guidelines on nurse training in nutritional assessment; volunteer training in help with feeding)

Efficiency

The extent to which nutritional care impacts on such indicators as:

- lengths of stay
- prescribing of nutritional supplements
- catering costs per head
- drug prescribing costs

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<i>Patient/carer experience</i>	<p>Patient/carer perceptions of quality of nutritional care including:</p> <ul style="list-style-type: none"> - choice, portion size and palatability of hospital food - cultural sensitivity of food provision - provision of fortified meals or nutritional supplements - timing of meal service (e.g. when patients are not absent from the ward, when doctors are not doing rounds) - courtesy of serving staff
<i>Health outcomes of NHS care</i>	<p>The effect of nutritional care services on such indicators as:</p> <ul style="list-style-type: none"> - nutritional risk monitoring - post-operative complication rates - wound healing - case fatality rates - re-admission rates - community healthcare needs on discharge - carer health needs

We recommend that a set of robust indicators concerning nutritional care of nutritionally at-risk or malnourished people in hospital to fit the National Performance Assessment Framework be developed and agreed. This would need to be consistent with similar frameworks being developed for related aspects of care, e.g. care of older people.

As a step in that direction, the Audit Commission should consider the use of an audit of nutritional care as a marker for assessing wider aspects of ward or hospital performance.

National Survey of Patient and User Experience

The Government is introducing a new national survey to be carried out annually at Health Authority level. This will not only explore patients' views of the medical and technical aspects of their care but also areas such as privacy, dignity, courtesy and the helpfulness of staff. The results will be fed into the quality performance management framework. Trusts will be required to demonstrate to the Regional Office that they have taken action to address issues raised by the Survey.

We believe that the new Survey offers a major opportunity to highlight quality issues concerning hospital food and feeding practices as well as other aspects of nutritional care, and the findings should be closely tied in with the clinical governance approach.

A national strategy for involving patients, users and carers more fully in the entire new NHS and social services quality assurance programme is planned for a launch in mid-1999. This is likely to be linked to the new Patients' Charter.

We recommend that patients', users' and carers' views of hospital food and help with feeding be incorporated into the proposed National Survey of Patients' and Users' Experience as a standing item from the outset, and that the findings are considered in tandem with the clinical governance programme.

Community Health Councils could also have an important role in bringing patients' and users' views to bear at national and local level.

RECIPE FOR A QUALITY SERVICE

Hospital nutrition in Health Improvement Programmes

In *The New NHS* White Paper each Health Authority is charged with leading the development of a local Health Improvement Programme in collaboration with other local partner agencies including Primary Care Groups, Trusts, local authorities, the voluntary sector and the public.

A key principle underlying such programmes is the reduction of inequalities, particularly inequality of access to services. One very practical way to contribute to this would be to help ensure that vulnerable inpatients have access to nutritious and palatable food and appropriate nutritional support, not only whilst in hospital but also post-discharge.

Healthcare commissioning

Primary Care Groups will shortly begin to take over from Health Authorities much of the commissioning of local health services including hospital services. They will be responsible for developing and agreeing long-term service agreements with Trusts.

We recommend that Health Authorities and/or Primary Care Groups include specific requirements concerning nutrition (e.g. nutritional assessment, provision of food and nutritional support, follow-up) for vulnerable inpatients in long-term service agreements.

Education and training of health professionals

Increased emphasis and effort must be placed on raising awareness of the importance of food and nutrition among health professionals, particularly doctors and nurses, who are still largely unconvinced as to the role of nutrition in health and illness in the developed world.

Nutrition must be a more prominent feature of student curricula and qualifying examinations.

Nutrition should be included as a core element of undergraduate and postgraduate medical education, as well as the training of nurses and other key health professionals. The contribution that food and feeding make to hospital care should be a key element of this.

Research

Whilst it is true that more evidence is needed on the extent of the problem, the precise organisational factors involved, and the effectiveness of different approaches to tackling it, there is nevertheless enough existing evidence to make a strong case for a fundamental change in the way food and nutrition are managed in UK hospitals by bringing them into clinical care. Studies from elsewhere in Europe, the US and Australia, suggest that undernutrition in hospital is not a problem unique to the UK (among the more developed nations) - but this is no cause for complacency.

The relative paucity of UK studies in some aspects of hospital food and nutrition points to the need for further research in this important but neglected area of healthcare. For example, the main gaps are:

- descriptive studies quantifying the extent of the problem in different types of hospital in the UK, e.g. acute general, long stay general, mental hospital. There is also a need to study the problem in nursing and residential homes
- studies to evaluate the routine use of validated nutritional screening and assessment tools
- studies to develop and validate food consumption or plate waste survey tools

RECIPE FOR A QUALITY SERVICE

- observational studies of the accessibility of food to patients of differing nutritional needs, e.g. those requiring help with feeding themselves; those who need food between main meals,- those who are away from the ward during mealtimes
- trials to provide evidence on outcomes, effectiveness and costs of different approaches to feeding different groups of vulnerable patients
- qualitative studies of perceptions of key stakeholders (including clinicians, managers, patients, relatives/carers) regarding various aspects of food and nutrition in hospital
- evaluation of nutritional care as a model for developing clinical governance

There is a particular need for systematic reviews of the evidence about the consequences of undernutrition, and also of trials assessing the effectiveness or cost-effectiveness of different methods of nutritional care.

Managing food and nutrition at Trust level

This section looks at management arrangements to deliver quality nutritional care within NHS Trusts.

Board-level commitment

Trust board members should take a keen interest in the quality of food provided and the way nutritional care is managed across the Trust.

For nutrition to have the status it deserves within the Trust management environment, Trust boards should be fully committed to the notion of food provision being a key component of clinical care and subject to the clinical governance programme.

Performance assessments should be regularly reported to the board before being forwarded to the NHSE Regional Office. Whilst chief executives would be directly accountable for lapses in quality of nutritional care, the board, through its chair, would have to take ultimate responsibility for the performance of the Trust in this respect. The Commission for Health Improvement will investigate Trusts where there is perceived to be a problem, and we would argue that this should include problems with food and nutritional care.

Coordination at senior level

The routine food service, the identification of patients at risk or already undernourished, the provision of appropriate nutritional support and monitoring of patients all require wide co-ordination and communication. Our review has found widespread support for the establishment in every Trust of a coordinating group of senior officers to oversee the whole spectrum of nutritional care, from catering contracts to parenteral nutrition. A local example of good practice is given in Appendix 3.

In practice, coordination of nutritional care within each Trust should be the responsibility of a named senior health professional (e.g. dietitian, nurse, clinician) reporting via the Medical or Nursing Director to the Trust senior management team. The named health professional should be supported by a senior multidisciplinary coordinating committee. Our suggested title for such a committee is the Nutritional Care Committee.

Members of such a committee could comprise:

- a senior clinician
- a senior nurse

RECIPE FOR A QUALITY SERVICE

- a senior hospital dietitian
- a senior hospital pharmacist
- the chief catering officer
- a speech and language therapist
- an appropriate business manager
- and others as appropriate to each hospital

The committee would normally be chaired by the named health professional responsible for coordinating nutritional care. The committee must be given sufficient power and authority to be able to influence policy. It should work closely with the therapeutics committee. It should ensure coordination of nutritional care across all care groups.

A dedicated Nutritional Care Services Directorate

One management model that we would recommend is that of a clinical support directorate with responsibilities extending across the whole spectrum of nutritional care, from routine food provision to specialist clinical nutrition.

The Nutritional Care Services Directorate would manage the following functions:

- input into drafting catering contracts
- input into monitoring catering contracts
- providing clinical dietetics, including nutritional assessments and drawing up of individual nutritional care plans

- training ward staff in nutritional screening, feeding skills and monitoring food consumption and nutritional status
- providing nutritional support advice and expertise
- supervising clinical nutritional interventions
- The Nutritional Care Director would be supported by the Nutritional Care Committee and would be answerable to the Medical or Nursing Director.

Food service

Hospital menus and meals should provide sufficient choice to offer healthy, balanced nutrition, and appropriate special diets, within available resources. Arrangements for food preparation, distribution and serving should deliver food of defined standards in terms of nutritional quality, balance, palatability and temperature with acceptable levels of wastage. The precise methods of food preparation (e.g. cook-serve, cook-chill or cook-freeze) will vary from hospital to hospital, depending on the hospital's size, physical layout, kitchen space, staffing levels, inpatient numbers, and other factors. The method of distribution and serving will depend on similar factors.

Full discussion of these issues is beyond the scope of the present report. Suffice it to say that each method of preparation and distribution has its advantages and disadvantages in terms of such issues as nutrient losses (notably vitamin C and folate when food is chilled or frozen, or held hot for long periods), menu flexibility, food wastage, quality control, food hygiene requirements, equipment requirements, energy consumption, staff skills in the kitchen, staff skills in the ward, and other factors. Methods that have found most adherents from the nutritional standpoint are those involving bulk distribution by trolley to the wards

RECIPE FOR A QUALITY SERVICE

where the food is plated by ward staff according to portion sizes preferred by each patient. These methods allow more choice and flexibility, and thus decrease food wastage.⁷⁷ (See local examples of good practice in Appendix 3).

Consideration should be given to adopting bulk-distribution, ward-based plating systems or ward-level food preparation/storage areas.

Catering contracts and service agreements

Contracting-out also creates difficulties in making food service part of the clinical delivery. However, experience at a number of hospitals suggests that contractors are able to be sufficiently flexible if the requirements are specifically written into their contract/service agreement and they are paid enough to cover the costs. **Contracts should include special therapeutic meals and provision of snacks and/or meals at ward or near-ward level.**

Adequate contract monitoring is crucial, and the costs for this should also be built into the contract. One suggestion is that the contractor pays for the audit but the hospital runs it. This way the money can be ring-fenced and hospital management costs can be kept to a minimum.

There must be agreed guidelines for caterers and an agreed contract monitoring framework. A named senior health professional should be given responsibility for ensuring that the contract reflects nutritional standards (e.g. by adhering to agreed standards or guidelines). This officer should report to the Nutritional Care Committee.

Budgets

A fundamental aspect of the management of nutritional care services within each Trust is the way budgets are earmarked and devolved. If

nutritional care is to be fully accepted as a truly clinical function, the budgets that make up the whole spectrum of nutritional care, from catering to parenteral nutrition, must be managed within the clinical care directorate structure.

With the model of a Nutritional Care Services Directorate that we have proposed, all the component budgets, including catering and dietetics, would be brought together under that single unit of management.

However, an alternative model, still retaining clinical control, might be for the catering budget to be divided up between care groups, allowing for more appropriate specifications regarding food and feeding arrangements for each particular care group, including near-ward or ward-based food preparation and storage. It could also be compatible with a Nutritional Care Services Directorate, which would provide the full range of services on a service-level agreement basis.

No doubt there are other models, and it would be for each Trust to arrive at the most suitable for its configuration and pattern of care. However it is most important that the budgets are held in the clinical domain and are overseen by the Nutritional Care Committee.

Catering budgets should be ring-fenced, and not seen as an easy target for 'efficiency savings'. Routine meals should provide sufficient calories, nutrients and variety to supply the needs of the average hospital inpatient. A proportion of the budget should be earmarked for 'therapeutic nutritional support' which would cover the provision of special meals or snacks for malnourished and nutritionally at-risk patients, meals for patients requiring special therapeutic diets, snacks or meals at ward level, extra dietetic support, and extra help with feeding vulnerable patients. This budget should also be ring-fenced.

Budgets for catering, distribution, serving, feeding and nutritional support must be adequate to achieve the required standards. They must

RECIPE FOR A QUALITY SERVICE

be ring-fenced and held under the heading of clinical services rather than 'facilities' or 'hotel services'. The budget holder should be the named senior health professional responsible for nutritional care, supported by the Nutritional Care Committee.

Managing nutritional care at ward level

Nutritional screening

As with any clinical intervention, the first step in the nutritional care of patients is properly to assess need. The purpose is to determine what level of nutritional care or support is appropriate - e.g. routine hospital food, 'special' (fortified) hospital food, food plus nutritional supplements, special diets, help with oral feeding, tube feeding, parenteral nutrition. This involves assessing 'nutritional risk', i.e. risk of malnutrition.

The process is two staged. First a quick and simple screening exercise performed by nursing or medical staff on admission to pinpoint those patients who need a fuller assessment. Second the assessment performed by a dietitian to determine precise nutritional care requirements. There are validated evidence-based scoring systems for both of these stages.^{78 79} Proper training of nursing or medical staff is crucial if nutritional screening is to be worthwhile. So too is monitoring and audit of screening and assessment.

All too often, nutritional screening is simply a perfunctory 'box-ticking' exercise, if performed at all. It is important to ensure that it is clearly linked to appropriate intervention.

Patients who are malnourished or at risk of malnutrition should be identified as early as possible using a simple validated standard screening protocol that is quick and easy to administer by nursing staff

and is applied to all patients on admission. A named nurse should be made responsible for nutritional care on each ward or unit, and should ensure that all patients are screened as specified above.

Help with feeding

Delivering food to the patient is one thing - ensuring it is eaten is another. Many patients become malnourished in hospital because they are not given enough help with feeding themselves. For all patients the overall responsibility for ensuring appropriate and adequate feeding rests with the nursing staff.

However, the increasingly technical and complex nature of their work, together with shortages of staff, often means that nurses need extra help with this task. Support usually takes the form of non-nursing staff acting as nutritional care assistants, variously titled 'ward assistants', 'hostesses' or other such term. It is important that help with feeding individual patients in need of assistance is clearly written into job descriptions of such support staff and is seen as something more than merely placing food in front of patients. If not carried out by ward staff, systems should be put in place to make effective use of relatives and volunteers for this task.

Whichever system or structure is used, it must be underpinned by proper nutritional care training, audit and adherence to standards.

The nurse designated as responsible for nutritional care on each ward should ensure that patients are eating adequately, with or without help, or if necessary are referred to the dietitian for nutritional support. The nurse should report on this to the medical personnel managing each patient.

RECIPE FOR A QUALITY SERVICE

Ward or 'near-ward' kitchens

There is a widely felt need for at least some patients, with particular nutritional needs, to have specially prepared meals or between-meal snacks. This can be achieved with food preparation or storage areas at ward or near-ward level. This becomes cost-effective where there are wards with a high proportion of nutritionally vulnerable patients. This arrangement would allow those patients assessed to be in need of nutritional care in the form of 'extra' quality meals to be referred to the 'nutritional care cook'. Under the direction of the dietitian or nutritional support team, this specially trained cook would visit the patient, devise an appropriate meal, prepare it and deliver it straight to the bedside. The higher costs of such a small-scale, personalised service would be offset by lower food wastage, improved nutrient intake with less need for nutritional supplements, and improved clinical outcomes (e.g. shorter length of stay). The service (staff costs, ingredients, energy consumption, etc) could be funded out of the Nutritional Care budget. An example of this kind of approach is quoted in Appendix 3.

Ward staff should have ready access to snack foods between meals for patients who may need it. Nutritionally vulnerable patients (e.g. sick children, frail older people) should be placed in wards with 'kitchen areas', or near-ward kitchens, for preparing special meals or snacks.

Nutritional support

There is evidence that where clinical nutrition is managed by a multi-disciplinary approach such as a nutrition support team, there is enhanced cost-effectiveness and increased quality of care and outcomes.⁸⁰ A typical 'nutritional support team' would comprise a dietitian, an appropriate doctor, a nutrition nurse specialist, a pharmacist, and a speech and language therapist. A team approach to

specialist nutrition management raises awareness, coordination and cooperation.

Patients found to be malnourished or at risk of malnutrition on initial screening should be referred to a dietitian to have their nutritional status more rigorously assessed as a baseline. They should be provided with a clear 'nutritional care plan' specifically tailored to their needs as an integral component of their clinical management.

Adherence to the plan should be the responsibility of the ward nursing team, led by the nurse responsible for nutritional care, supported by the dietitian and, where appropriate, a multidisciplinary team of other key health professionals - the 'nutritional support team'.

Monitoring and audit

Simple monitoring/audit of nutritional status is crucial and should be mandatory. Patients should be weighed on both admission and discharge. Adherence to agreed standards with regard to feeding on the ward should be the subject of random audits as part of clinical governance.

Wastage should also be routinely monitored. Nurses should be trained to quickly assess food left on the plate. Surveys should be conducted to ascertain the reasons for food being left.

We believe that proper feeding and adequate nutrition should be used as markers to assess ward performance.

Information

Nutritional status assessments, nutritional care plans, and monitoring and audit results should be coded in a standard way on hospital databases. The information should be accessible by all relevant

RECIPE FOR A QUALITY SERVICE

authorised staff, including the patient's GP and social services care manager (if appropriate).

Post-discharge care

It is important that, on discharge, the nutritional status of all at-risk patients, together with any nutritional care plan, be properly communicated to the patient's carer, GP and, where appropriate, social services care manager to ensure proper follow-up care.

Communications to the carer, GP and/or social services care manager regarding post-discharge care should be audited as part of the quality framework for hospital nutritional care.

APPENDIX 1

BACKGROUND, AIMS AND METHODS FOR THIS REPORT

In September 1997 the Nuffield Trust hosted a seminar to consider the problem of malnutrition in hospital, to hear about current research and to propose new approaches. As well as an update of current evidence and practice, the meeting proposed an analysis of the policy issues surrounding the management of nutrition in hospitals.

Subsequently, one of the meeting participants, Professor Senga Bond, produced a comprehensive resource pack to guide practitioners, including guidelines for staff at ward level, examples of good practice, and a review of the evidence. A further report focusing on the therapeutic role and clinical management of nutrition in hospitals was taken forward by a working group, led by Dr Simon Allison under the auspices of BAPEN (the British Association for Parenteral and Enteral Nutrition). The BAPEN group's report is expected shortly. It will provide practical advice and examples and its recommendations will complement those of the present report.

Aims

- to review the benefits of and barriers to improving the quality of nutrition for vulnerable hospital inpatients at risk of malnutrition
- to consider how ward staff, clinicians, hospital Trust managers and healthcare commissioners could be more fully engaged in making improvements
- to identify the main central and local policy gaps in encouraging improvement
- to make recommendations as to how these gaps could best be filled in the context of the rapidly changing NHS

APPENDIX 1

Methods

Following the original Nuffield Trust seminar in September 1997, we conducted semi-structured interviews with key participants and corresponded with other experts and stakeholders. We reviewed more recently published scientific evidence, guidelines and policy documents; and held a project workshop hosted by the Nuffield Trust in April 1998 to consider the wider management and policy implications of the issue. A key theme of the workshop was the potential place of hospital nutrition in the emerging effectiveness and quality agenda of the 'new NHS'.

The seminar and workshop participants, interviewees and correspondents are listed below.

Nuffield Trust seminar participants, September 1997

Professor Senga Bond	<i>Professor of Nursing Research Centre for Health Services Research, University of Newcastle upon Tyne.</i>
Professor John Edwards	<i>The Worshipful Company of Cooks Centre for Culinary Research, Bournemouth University.</i>
Professor David Foskett	<i>School of Tourism, Hospitality and Leisure, Thames Valley University</i>
Professor Walter Holland	<i>Professor of Public Health Medicine London School of Economics.</i>

Professor Peter Jones	<i>School of Service Industries Bournemouth University</i>
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Peter Lumsden	<i>Adviser, NHS Finance Kensington, London</i>
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Project workshop participants, April 1998

Dr Simon Allison	<i>Consultant Physician Queen's Medical Centre, Nottingham.</i>
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Sylvia Banks	<i>Nursing Research and Development Practitioner, St James's University Hospital, Leeds.</i>
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Professor Senga Bond	<i>Professor of Nursing Research Centre for Health Services Research, University of Newcastle upon Tyne.</i>
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Amanda Bristow	<i>Formerly Research Fellow Department of Public Health Sciences, Guy's, King's St Thomas' School of Medicine.</i>
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David Browning	<i>Associate Director Audit Commission.</i>
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Professor John Edwards	<i>The Worshipful Company of Cooks Centre for Culinary Research, Bournemouth University.</i>
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APPENDIX 1

Jennifer Elliott	<i>Chair, Association of Community Health Councils for England and Wales.</i>
Professor Walter Holland	<i>Professor of Public Health Medicine London School of Economics.</i>
Tim Jones	<i>Policy Manager, NHS Confederation.</i>
Professor John Lennard-Jones	<i>Emeritus Professor of Gastroenterology Clinician and Adviser, Sussex.</i>
Dr Alan Maryon Davis	<i>Senior Lecturer Department of Public Health Sciences, Guy's, King's and St Thomas' School of Medicine.</i>
Jennifer Stiles	<i>Director The Relatives' Association.</i>
Margaret Thomas	<i>Dietetic Services Manager St James' University Hospital, Leeds</i>
Bob Wenlock	<i>Nutrition Unit, Department of Health.</i>
Richard Wilson	<i>Director of Nutrition and Dietetics, King's Healthcare NHS Trust, London.</i>

Interviewees and correspondents

Professor Tim Lang	<i>Department of Food Policy Thames Valley University.</i>
Peter Lumsden	<i>Adviser, NHS Finance Kensington, London</i>
Gill Oliver	<i>Director of Patient Services Clatterbridge Centre for Oncology, Wirral</i>
Maggie Page	<i>Dietetics Consultant Ipswich</i>
Karen Sorenson	<i>Director of Nutrition Guy's and St Thomas' NHS Trust London</i>
Amanda Stokes Roberts	<i>Director of Quality, St George's Hospital, London</i>
Natalie Tiddy	<i>Head of Quality Lambeth Southwark and Lewisham Health Authority, London</i>

APPENDIX 2

UK REPORTS AND STATEMENTS TO DATE

This section presents an overview of recent major reports and statements influencing policy and practice in the UK.

I CENTRAL GOVERNMENT AND ITS AGENCIES

The Nutrition Task Force (NTF)

The NTF was a multisectoral group set up by the Department of Health as part of a co-ordinated strategy aimed at achieving the Health of the Nation targets and promoting co-operation between all interested parties. Working groups looked at previously identified priority areas and, among many others, produced the following publications of relevance to hospital nutrition:

- *Nutrition Guidelines for Hospital Catering* (1995)
Provides nutrition guidelines on general standards and standards for specific patient groups, provides pointers to areas of particular concern or where there may be potential problems.
- *Nutrition and Health. A Management Handbook* (1994)
Aims to 'help NHS organisations improve their local nutrition-related performance' through background information, ideas for practical action, examples of good practice and sources of further information.
- *Nutrition: Core Curriculum for Nutrition in the Education of Health Professionals* (1994)
Reviews the content and need for education and training in nutrition for health professionals and provides guidance on developing the nutrition components of education and training programmes. In particular it sets out proposals for key nutritional elements to be incorporated into a core training of health professionals; nurses, doctors, dentists, pharmacists and other

professionals allied to medicine such as physiotherapists and speech and language therapists.

- *The Contribution of State Registered Dietitians.* London: Department of Health (1994)
Aims to raise awareness about the role of dietitians and encourage good practice.
- *Nutrition for Medical Students. Nutrition in the Undergraduate Medical Curriculum* (1996)
Concerned with learning resources, curriculum structure, nutrition teaching, skills and assessment and examinations.
- *Nutrition Guidelines: a checklist for audit* (1996)
Gives a checklist with which to measure a hospital's performance against the 1994 guidelines for catering.

Other work commissioned by the Department of Health

Eating Matters (1997)

This is a resource pack for use by ward staff, developed by the Centre for Health Services Research, University of Newcastle-Upon-Tyne. The aims of the pack are to assist hospital staff to meet patients' dietary needs while they are in hospital. It focuses particularly on the needs of older adults and provides evidence, examples and case studies.

The National Audit Office (NAO)

In 1994 the NAO report on NHS catering showed that 85% of patients nationally were satisfied with the service they received. However, the report also identified examples of poor management, low levels of satisfaction, wide variations in cost and some examples of poor catering practice. Various recommendations were made for action by the NHS Executive, Health Authorities and hospitals.

APPENDIX 2

The NHS Executive

Hospital Catering: delivering a quality service (1996) looks specifically at the issues of contract management, food hygiene and safety, nutrition, meal service and quality, cost control and gives examples of good practice and some statutory requirements relating to these areas, for example the provision of adequate servings of protein.

The Government's standing Committee on the Medical Aspects of Food Policy (COMA)

COMA is responsible for providing guidance on the nutritional requirements of the UK population. *The Nutrition of Elderly People* report⁸¹ (1992) made recommendations that the impact of acute and chronic illness on the requirements of elderly people needed comprehensive study.

'Health Professionals should be made aware of the impact of nutritional status on the development of and recovery from illness' and '...of the often inadequate food intake of elderly people in institutions'

'Assessment of nutritional status should be a routine aspect of history taking and clinical examination when an elderly person is admitted to hospital'

'Effective methods of ensuring adequate nutrition need to be developed and evaluated for elderly people in hospital or institutions'

The Patients Charter, 1995

This includes specific standards relating to food and catering services.

- a guide should be provided for each patient explaining the hospital's catering policies and catering services
- a choice should be provided of dishes including meals suitable for all dietary needs
- a choice of portion sizes should be available
- patients' meals should not be ordered more than two meals in advance
- the catering manager's name should be made available
- help should be readily available for patients where required to help them make use of the catering service

II MULTIDISCIPLINARY REPORTS

British Association for Parenteral and Enteral Nutrition

In 1992 the British Association for Parenteral and Enteral Nutrition (BAPEN) was formed. This was in response to recommendations made by the King's Fund report⁸² that a forum should be created which draws together and represents common interests of patients and health professionals. BAPEN aims to:

- set standards of clinical practice in nutritional support
- educate and train health care workers, patients and policy makers in the prevention of malnutrition during illness
- promote research.

APPENDIX 2

Since its formation BAPEN has produced a number of reports looking at *Organisation of Nutritional Support in Hospitals (1994)*; *Standards and Guidelines for Nutritional Support of Patients in Hospitals (1996)*; and *Hospital Food as Treatment (in press)*. It also runs multidisciplinary training courses for nutrition teams.

Organisation of Nutritional Support in Hospitals highlighted the shortfall in the organised provision of nutritional support for patients in hospital. It emphasised the financial cost of prolonged hospital stay attributable to preventable complications of malnutrition. It suggested that each hospital should create a multidisciplinary 'nutritional steering committee' and 'nutritional support team'. The committee would define audit standards for detecting malnutrition, for catering, feeding and nutritional support, and for referral to the support team.

Standards and Guidelines for Nutritional Support of Patients in Hospitals sets out sample protocols for detecting malnutrition, criteria for assessing nutrition support services, and standards for staff training, patients' rights, quality and audit.

III PROFESSIONAL STANDARDS AND GUIDELINES

Individual professional organisations have produced a variety of recommendations, standards and guidelines.

These include:

The Hospital Caterers' Association

Good Practice Guide; food service standards at ward level (1997)

Provides a practical guide looking at issues such as co-operation and communication, meal presentation and service, waste control, food hygiene and safety, training and ward kitchen design.

The British Dietetic Association

Dietetic Standards of Care for the Older Adult in Hospital (1993)

Dietetic standards targeted at care of the older adult.

Malnutrition in Hospital (1996)

This position paper outlines the extent of the problem and makes recommendations regarding the role of the dietitian in treating and preventing malnutrition.

Parenteral and Enteral Nutrition Group (PEN) - Dietetic Standards for Nutritional Support (1996)

Gives standards specific to nutritional support developed for use by dietitians.

National Professional Standards for Dietitians Practising in Health Care (1997)

Sets national standards of good practice.

The British Society of Gastroenterology

Guidelines on Artificial Nutrition Support (1996)

Specifies that gastroenterologists must be able to identify malnourished patients and those at nutritional risk, arrange appropriate nutritional intervention, supervise and monitor treatment in the hospital, and when indicated in the home.

The English National Board for Nursing, Midwifery and Health Visiting (ENB)

Nutrition for Life: issues for debate in the development of education programmes (1995)

APPENDIX 2

Developed for use by practitioners, managers and all those involved in the education of nurses, midwives and health visitors.

Royal College of Nursing

Nutrition Standards and the Older Adult (1992)

These standards with criteria look at the assessment of past and/or potential difficulties in eating, enabling the client to eat and drink, monitoring and evaluating nutritional status and care.

IV PATIENT REPRESENTATIVE GROUPS

Association of Community Health Councils for England and Wales

Hungry in Hospital! (1997)

Information collected from local Community Health Councils and members of the public. Gives accounts of individual experiences and makes recommendations. The first of these is:

'Accusations that patients are starving to death when they are in hospital must be taken seriously and the Department of Health must take steps to ensure that these accusations are investigated.'

The Patients' Association

Catering for Patients in Hospital (1993)

This report was produced in response to complaints from patients about hospital food and a survey carried out amongst members of the organisation. It draws attention to particular problems and makes suggestions for catering standards (quality, nutrition, monitoring of intake).

VI STATEMENTS

The UK Central Council for Nursing (UKCC)

Letter from the Registrar (1997)

This letter, issued in response to widespread discussion about the nurse's role following publication of the *Hungry in Hospital* report, made the following statement:-

'Nurses have an implicit responsibility for ensuring that patients are appropriately fed-

It follows from this that a named nurse should be identified as having lead responsibility for this at ward level.

APPENDIX 2

SUMMARY OF UK REPORTS AND STATEMENTS

Organisation Report/Action

BAPEN

Organisation of Nutrition Support in Hospitals 1994

- All patients in UK hospitals who are diagnosed as malnourished or at risk of developing malnutrition should have access to a nutrition support team (NST)
- All major UK hospitals or hospital groups should appoint a nutrition steering committee (NSC) to be responsible for setting standards for and delivery of catering services, dietary supplements and nutritional support
- All NSCs should appoint at least one nutrition support team to implement standards of nutritional support laid down by the NSC

BAPEN

Standards and Guidelines for Nutritional Support of patients in Hospitals 1996

- The purchasers of health care should insist on the adoption of standards for the organisation and provision of nutritional support
- The standards used should be based on those in this document adapted to suit local needs
- There is a management policy that all patients receive adequate and appropriate nutritional support as laid down by a quality assurance programme

- There is an inter-departmental multidisciplinary NSC
- There is a catering liaison group representing caterers, nurses, doctors, and dietitians
- There is a nutrition support team available to advise on all aspects of nutritional support
- Agreed and explicit arrangements are laid down for the organisation and funding of those patients continuing on artificial nutrition at home or elsewhere in the community
- There is a published policy for provision of artificial support
- There is a policy for the assessment of nutritional status of patients
- There are written guidelines to help identify those patients likely to benefit from referral to the nutrition support team
- There are policies and procedures regarding equipment
- There are protocols and procedures relating to enteral feeding
- There are protocols and procedures relating to parenteral feeding
- There are policies and procedures for the discharge of patients on nutritional support into the community

APPENDIX 2

- There is a continuing education programme on general nutrition and techniques of nutritional support for all those staff involved in the clinical care of patients
- Appropriate patients may expect to receive care from the nutrition support team and to have all aspects of nutrition management explained, discussed and agreed with them
- A clear and understandable explanation of the patient's nutrition management is provided to the patient, family, carers, ward staff and community health professionals
- The patient, family and carers are appropriately advised and trained
- The views of the patient, family, carers are considered
- Patients on artificial nutrition have direct and immediate access to professional advice
- Patients or their legally authorised representative have the right to accept or refuse nutritional support
- There is a monitoring and recording system which allows audit
- There is a system for assessing patient satisfaction with the service provided
- The standards demonstrate effective and measurable benefits to the patient

BDA

Malnutrition in Hospitals (1997)

- State-registered dietitians should be involved in training medical and nursing staff to identify patients at risk of malnutrition
- Dietitians should be actively involved in menu planning to ensure that a nutritionally adequate diet is provided in hospital and that patients requiring special or therapeutic diets are catered for
- Patients who require artificial nutritional support or a supplemented diet should have access to a dietitian
- Adequate resources should be available to ensure that high quality nutritional care, whether via the oral, enteral or parenteral route, can be delivered and monitored
- Dietitians should foster close links with the other health care professionals involved in the detection and management of malnutrition
- Dietitians should be involved with artificial nutritional support and keep abreast of current literature in this field

BDA

National Professional Standards for Dietitians Practising in Health Care (1998)

- Screening / appropriate referral
- Developing and implementing a plan of care
- Working co-operatively with others

APPENDIX 2

- Responsible for explicit quality of service
- Communicating, nutrition education resources, education and training

BDA (NAGE) *Standards of Care for the Older Adult in Hospital (1993)*

- The dietitian advises on nutritionally adequate food which is acceptable to the patients and appropriate to patients' needs
- The dietitian sets up a screening system with other professional staff whereby patients admitted to hospital are screened to identify those at risk nutritionally
- The dietitian advises on hospital policies that affect nutritional care of the older adult
- The dietitian assesses those patients identified as requiring nutritional intervention
- The dietitian manages the diet therapy for patients referred to the service
- The dietitian co-ordinates the provision of nutritional support
- The dietitian completes a written record for all patients seen in dietetic care
- Dietetic treatment is communicated to the care team
- The dietitian provides nutrition education to those

involved in the care of the older person

- The dietitian provides appropriate and accurate information to clients concerning nutrition and diet therapy

BDA (PEN) *Dietetic Standards for Nutritional Support (1996)*

- Dietitians are trained in current aspects of nutritional support in order that they remain up-to-date, competent and safe to practice
- Dietitians actively promote the identification and treatment of protein energy malnutrition in association with other health care professionals
- Managers of nutrition and dietetic services ensure that there are written policies and procedures on the provision of nutritional support both within the hospital and community
- Managers of nutrition and dietetic services ensure that resources are available for the provision of nutritional support both within the hospital and community
- Dietitians assess the nutritional status of all patients referred for nutritional support
- Dietitians assess the nutritional requirements of all patients referred for nutritional support and revise these as appropriate

APPENDIX 2

- Dietitians liaise with medical staff to determine the most appropriate route for nutritional support and promote the use of the enteral nutrition as and when possible
- Dietitians communicate with relevant professionals from other disciplines to ensure that suitable parenteral nutrition is provided
- Dietitians recommend an appropriate nutritional formulation and administration regimen taking into account the individual patient's clinical and nutritional requirements
- Dietitians monitor patients on nutritional support to enable the therapeutic plan to be modified as required
- Dietitians work co-operatively and communicate with other members of the nutrition support team or, if no recognised team is in place, with professionals from other disciplines involved in nutrition support
- Dietitians provide accurate, comprehensive and current written documentation for each patient
- Dietitians liaise with patients/carers and relevant professionals regarding the safe discharge of patients on nutritional support into the community

RCN

Nutrition Standards and the Older Adult (1993)

- The client has an initial assessment made of their food and fluid intake and eating and drinking patterns

- The ward/unit team works towards ensuring that the organisation of the ward and staff is responsive to and meets the individual requirements of the client in order to satisfy their eating and drinking needs
- The nutritional goals set for the client and the care received are continually evaluated and revised

ENB

Nutrition for Life: Issues for Debate in the Development of Education Programmes (1995)

- Every educational and health care institution should review its programmes in light of the Nutrition Task Force's work
- Nutrition themes should be integrated through both pre-registration and continuing pre-registration programmes
- Nutrition themes should reflect positively the needs of multi-cultural, racial and socio-economic groups
- Programme assessments should include measurement of students, behaviour and performance in nutritional practice
- Every student should be able to conduct a detailed nutrition assessment of a healthy person
- Education and health-care institutions should:- promote healthy nutrition practices, provide a wide range of contemporary literature in nutrition. Nutrition themes should be among the priorities in research and development portfolios

APPENDIX 2

Centre for
Health
Services
Research,
University of
Newcastle-
upon-Tyne

Eating Matters(1997)

- Acting on patients' complaints
- identifying training needs, providing training and assessing competence of professional and support staff
- Changing meals provision and ordering systems to make them more responsive
- offering special menus and enriched and attractive food for those with special needs
- asking patients for their opinions about the meals provided
- creating multi-disciplinary and cross-departmental dietary care groups
- employing special assistants and involving volunteers and families to assist at mealtimes
- stopping all other ward activities when meals are being eaten
- providing patients with better information about ordering food and the importance of eating and drinking
- introducing routine nutrition screening on admission and providing wards with the appropriate equipment to do so
- developing local protocols for the care of those 'at risk' of under-nutrition and including nutrition in 'pathways'

- conducting audits of dietary care and acting on the findings

UKCC

Responsibility for Feeding of Patients (1997)

Registrar's
letter

- Nurses have an implicit responsibility for ensuring that patients are appropriately fed. This is reflected in the UKCC's code of professional conduct:- "While registered nurses may of course delegate the task of feeding patients, for example to unregistered practitioners, the overall responsibility remains with the registered nurse."

British
Society of
Gastroenter-
ology

Guidelines on Artificial Support (1996)

- Nutrition screening of admissions (weight, height, brief diet nutrition history)
- Goals of nutrition support, prevention or management of nutritional depletion should be clearly defined
- All hospitals should have guidelines for artificial nutritional support (selection, management, amount, monitoring) and protocols for management of complications
- Nutritional support should be given by the enteral route where the intestine is accessible. Patients in whom the need for tube feeding will exceed 2-4 weeks should be considered for PEG

APPENDIX 2

- Where possible TPN should be administered by the peripheral route
- A nutrition support team provides safe and effective nutrition support and guidelines for nutrition management and monitoring
- Patients receiving home parenteral nutrition are best managed in regional/supra-regional centres

Department of Health *The Nutrition of Elderly People (1992)*

COMA

- Health professionals should be made aware of the impact of nutritional status on the development of and recovery from illness
- Health professionals should be aware of the often inadequate food intake of elderly people in institutions
- Assessment of nutritional status should be a routine aspect of history taking and clinical examination when an elderly person is admitted to hospital
- Effective methods of ensuring adequate nutrition need to be developed and evaluated for elderly people in hospital or institutions

King's Fund *A Positive Approach to Nutrition as Treatment (1992)*

- Improved awareness and understanding by doctors and nurses of under-nutrition and its consequences

- Every adult's height should be recorded once in general practice and hospital. Patients should be weighed regularly so that weight-for-height values can be assessed. A note about each patient's nutritional status should be mandatory in medical and nursing admission records
- Whenever malnutrition is detected, the cause should be established, a plan of treatment made and its effects monitored
- Every hospital should organise its nutritional services to link management, catering and all the clinical disciplines involved
- The quality of nutritional support in acute medical (including elderly) and surgical wards should be the responsibility of a nutrition team (senior clinician, clinical nurse specialist, dietitian, pharmacist)
- In paediatric departments and intensive therapy units the quality of nutritional support should be the responsibility of one or more members of their staff
- Records should be kept of the clinical indication for each course of nutritional treatment, its type, duration and clinical outcome, including any complication(s)
- A budget should be allocated to nutrition support teams based on this audit of their work load, outcomes and costs

APPENDIX 2

- Managers should take account of the potential cost of complications and increased hospital stay due to malnutrition when assessing the cost of nutritional support
- Enteral feeds at home should be prescribed by the GP and regulations should be amended so that necessary disposable equipment can also be prescribed in the community. The hospital nutrition team should offer the same service to the community health team as it does to ward staff in hospital
- The care of patients who give themselves IV infusions at home should be limited to hospitals which have a well organised nutrition team, although care should as far as possible be shared with the GP and community team. Identification of the source of funding should not inhibit the prompt provision of this treatment at home when needed
- Clinical nutrition should be recognised as a discipline by medical schools, royal colleges and professional organisations
- An academic forum for nutrition should be established in every medical school to foster education and research
- Dietitians, nutritionists and nurses should be involved in the teaching of medical undergraduates and postgraduates. Questions on nutrition should be asked in under- and postgraduate exams

- An organisation should be included which draws together and represents the common interests of patients, academic nutritionists, dietitians, nurses, pharmacists, doctors and the pharmaceutical industry. This body should set standards for nutritional care, promote professional training and research, provide authoritative advice and foster public awareness of nutritional treatment in illness

NHS

Executive

Hospital Catering: Delivering a Quality Service (1996)

- Contractors should provide meals which meet patients' dietetic and nutritional requirements
- Catering procedures should comply with the Nutrition Task Force's guidelines for hospital caterers
- Patients should be advised on their dietary needs and on suitable choices
- Chefs should be trained in nutrition to meet dietary needs
- Contractors should keep prescribed records to demonstrate that nutrition and dietetic requirements are monitored and met
- The Trust's dietetic manager should ensure that nutrition standards are satisfactory
- An annual independent audit should be conducted to show meal quality to be satisfactory and to meet patients' needs

APPENDIX 2

- Food waste should be identified and controlled
- A guide should be provided for each patient explaining the hospital's catering policies and catering services
- A choice of dishes should be provided, including meals suitable for all dietary needs
- A choice of portion sizes should be available
- Patients' meals should not be ordered more than two meals in advance
- The catering manager's name should be made available
- Help should be readily available for patients where required to help them make use of the catering service

Health of
the Nation
Nutrition
Task Force

Nutrition and Health a Management Handbook for the NHS (1994)

- Suggests approaches and offers examples - not definitive but intended as an aid to the consideration of possible local strategies and initiatives

Health of
the Nation
Nutrition
Task Force

Nutrition Guidelines for Hospital Catering (1995)

- Each main meal should provide a minimum of 18g protein
- Across the day the menu should be capable of providing a minimum of 1200-2500 Kcal (average: 1800-2200 Kcal)

- All menus should be planned to provide essential nutrients for the client group they are to serve
- Mealtimes, food availability and suitability should be planned to be appropriate to patients' needs
- All patient menus should be checked for nutritional adequacy at the planning stage by a dietitian
- There is a requirement for NHS catering to meet the nutritional requirements of patients
- Standard recipes should detail a standard approach to the cooking and serving of each dish
- Adequate numbers of ward staff should be available at mealtimes to ensure patients are fed
- Those patients needing assistance with eating and drinking must be helped whilst their meals are hot and appetising
- All patients should be weighed on admission
- All patients should have an initial assessment made of their food and fluid intake and eating and drinking patterns. Any significant changes should be noted and acted on
- A risk assessment programme should be incorporated as part of the normal admission process, in liaison with nursing, medical and dietetic staff
- Any relevant information should be incorporated into the plan of care for the patient
- Patients should be weighed weekly

APPENDIX 2

- An identified nurse should coordinate all aspects of patient nutritional intake in a particular area, eg. ward
- There must be a locally agreed policy on the collection of a patient's tray. This must include identification of responsibility for assessing the percentage or proportion of the meal eaten and any plate waste
- If more than one meal is missed the reason must be identified, any consequent problems addressed and action taken
- Implementation locally needs to take into account and reflect each hospital's own specific circumstances
- A guidance group should be set up to implement this guidance
- Support from senior managers at Trust level is essential to allow time to carry out the development work on the menus and support any necessary changes to current policy or procedures
- Consideration should be given at a senior level to the longer term remit and role of the implementation team in monitoring adherence to and progress towards implementing the recommendations
- A package of monitoring systems should be set up that is evident at all stages of the food chain
- There should be evidence of assessment of nutritional status on admission, or at pre-assessment clinics where appropriate

- The policy covering who has responsibility for collection and serving meals should allow for documentation of the hand-over of responsibility and assessment

South East *Service Standards. Nutritional Guidelines:*
Thames RHA *The food chain (1993)*

- All NHS guidelines on the quality of provisions purchased should be followed
- All health districts and Trusts should actively participate in the contracting process for the supply of provisions
- A named catering manager for each kitchen is responsible for provisions' purchase. A log book should be maintained for stores staff and kitchen staff to record occasions when ingredients required were not available
- The catering manager charged with responsibility for provisions' purchase should be adequately trained in purchasing, reporting and returning procedures
- Staff responsible for provisions stores should be dedicated to that role and be accountable to the catering manager
- Kitchens serving 500 beds or more should have ingredients kitchens to support the implementation of standard recipes for patient needs

APPENDIX 2

- Standard recipes should be introduced for the production of patients' food
- Batch cooking procedures should be introduced
- A thorough review of communications systems in kitchens should be undertaken with a view to improving the timeliness and accuracy of internal communications and communications with the rest of the hospital
- Each kitchen should have a log book to register communications. The log book should record the date, time of the message, who took the message and what action ensued. The book should be reviewed by the kitchen manager and the catering manager daily
- Each ward should have a durable notice informing them of meal times, last order times for ad hoc requests, when trolleys will be collected, contact number/name for ad hoc requests, contact number/name for complaints
- All kitchens should strive to ensure that food advertised is always provided
- Food production staff should be trained in the proper presentation of food and have pride in how food leaves the kitchen
- A review of the equipment required to present food properly should be undertaken

- A thorough review of crockery, cutlery, trays and service equipment presented to the patient should be undertaken
- Every district and Trust should undertake a thorough review of the working conditions and remuneration package offered to its kitchen staff
- The RHA should take an initiative to revitalise the training, development and career prospects of kitchen staff
- Ward staff should familiarise themselves with the food service systems available and participate in choosing the system which is best suited to their patient group
- Food distribution staff should be directly accountable to the catering manager
- Trolley routes and timings for food distribution should be carefully planned
- Food distribution staff should inform the nurse responsible when the food has arrived on the ward. A formal handover of responsibility should take place
- Regular audit of distribution routes and timing should be carried out
- All hospitals should make financial provision for the maintenance of equipment and have in place a functioning capital equipment programme

APPENDIX 2

- A minimum standard for ward provision should be set so that ward issues can be complementary to the patients' menu. All wards will be issued with a list of the provisions they are expected to hold
- The budget for ward issue provisions should be devolved to ward sisters/managers
- Assistance and contribution from the dietetic and catering departments in all districts and Trusts should be sought with regard to the development of programmes of in-service training for nursing staff
- Principals of Colleges of Nurse Education should review the nutritional content of nurse training curricula in light of the nursing role in the food chain. Curriculum content should be up to date, appropriate and relevant
- A named nurse on each ward should be given overall responsibility for the co-ordination of all aspects of patient feeding
- Nursing staff should work with dietetic and medical staff to develop a system of nutritional risk screening to be carried out as part of the routine admissions procedure. Patients who are already malnourished or at risk of becoming malnourished can be identified and appropriate action taken

- Each hospital should develop a system of communication that enables accurate delivery of food to the wards. In particular the communication of details of admissions, discharges and patient transfers needs to be addressed and some operational policy produced
- Blanket referral arrangements should be sought with all consultant staff enabling nursing staff and other members of the multidisciplinary team to initiate action required to optimise patients' nutrition
- The named nurse should be responsible for ensuring that ward staff offer patients a choice of food. That nurse should also ensure that ward staff collate the information and communicate it to the catering department
- All incidents of patients not receiving food they have chosen should be recorded and reported to the catering manager
- A log book should be kept at ward level to record any problems related to patients' food. This book, along with the kitchen book and the provisions book, should be reviewed regularly by the food service team
- Nursing staff should review the patients' day and ensure there is adequate free time before and after meals
- Where possible no clinical tests or procedures should be carried out at designated mealtimes. Nursing, medical and other staff must respect patient mealtimes

APPENDIX 2

- Some investment should be made in making the patients' environment a pleasant place to eat
- Nursing staff should participate in choosing the type of food service most appropriate for their patients
- Nurse managers and ward sisters/managers should effect good utilisation of nurse time so that skilled staff are available at the bedside at mealtimes, both to help dependent patients eat and observe the food intake of self-caring patients
- Nursing staff should work with other staff to optimise patient feeding
- Nursing and dietetic staff should provide a system for the accurate recording of food intake
- Ward staff and catering management in agreeing mealtimes should also agree when trolleys and service equipment are ready for return
- Catering management systems should be installed in all hospitals as a matter of urgency
- Catering management systems should be capable of integration with the hospital information system, so that there may be free flow of information between the two
- Catering management systems should be capable of dietetic management also. Nutritional management systems should be at the core of the software enabling nutritional accounting of patients' menus to take place

- The regional computer system should be commissioned to evaluate all catering systems software available in the UK and provide recommendations for purchase
- Systems should be installed which enable patients to choose their food as close to the time that food is to be served as possible
- All managers of hospital information systems should investigate patient meal provision and plan the integration of catering and dietetic services into the hospital information network
- Medical schools should introduce students to the hospital food chain during their clinical placement
- All new medical staff should be familiarised with a hospital's system of food service as a part of general induction on appointment
- Medical staff should strictly observe mealtimes and try to ensure that no ward rounds or procedures interfere with mealtimes
- Medical staff should carefully review all procedures involving patient starvation and keep such procedures to a minimum
- Senior medical staff should ensure that they are in a position to give an informed opinion when influencing the allocation of resources to food service
- Senior managers should take on the implementation of nutrition guidelines at each point in the food chain

APPENDIX 2

- In light of NHS reforms and contractual obligations to purchasers, senior management should strategically review the allocation and re-evaluate the importance of hospital food provision
- Expert catering, dietetic, nursing and medical advice should be available at a sufficiently high level within general management for effective hospital food service management to take place
- In the light of the influence on provider unit efficiency and costs, senior management should review the allocation of resources committed to food service
- Senior management should set up systems of quality control which involve all key members of the food chain, caterers, dietitians and nursing and medical staff

South East *Service Standards Nutritional Guidelines (1993)*
Thames RHA

- All patients' menus should be planned to provide the COMA recommended levels of nutrients and appropriate food energy for the patient group they are serving
- The patients' menu should provide a healthy choice which complies with national or local food policy guidelines
- The hospital menu should provide a minimum of 50g (and be capable of providing 90g) of protein per day

- Each main protein item on the menu should provide between 12-18g of protein
- The menu should be capable of providing a range of energy intakes - a minimum of 1200Kcal per day
- All patients' menus should be checked against the standards in this document for nutritional adequacy by a dietitian at the planning stage
- Menus should be planned using standard recipes of known nutritional composition
- Every effort should be made to offer all patients a choice of food
- All institutions should aim to have systems running which will enable patients to choose their food no further in advance than their next meal
- The menu planner should be aware of the cultural, ethnic, religious and social diversity of the population he/she is planning for

The Patients' Association *Catering for Patients in Hospital (1993)*

- Meals should be served at times that reflect the normal eating patterns of the majority of patients. Availability of meals should be adjusted to allow for patients' day treatments, post-operative hunger or lack of appetite and where admission to the ward is made outside ward mealtimes
- Patients should be able to order as near to the meal itself as possible

APPENDIX 2

- Menus should be based on a two-weekly cycle. There should be a choice of at least four main dishes, including vegetarian and salad dishes. Ethnic minorities should be catered for by providing authentic and traditional food, and all dishes should be described on the menu, listing ingredients
- The children's menu should reflect the foods they are used to at home
- Snacks should be available
- There should be adequate staffing so that patients who cannot feed themselves, or who need encouragement, have the full attention of a member of staff to be with them while food is still hot. The staff member should have responsibility to monitor and report on patients' intake of food and liquid
- There should be:-
 - attractive presentation of food
 - choice of portion sizes
 - hot and cold beverages available at all times
- All dishes should meet minimum requirements of COMA reports 1984 & 1991, with dietary reference values adjusted where appropriate to meet the needs of different patient groups
- Nurses should receive appropriate training in nutrition and be capable of evaluating whether patients are receiving adequate nutrition
- Nurses should collect trays from patients for monitoring of intake

- Patients should be weighed on entering hospital and regularly during their stay
- There should be a regular evaluation of food and catering services, looking at quality, content and presentation
- Food as presented to the patient should be tasted and evaluated by patient representatives and/or nurses
- Routine collection of information from patients or staff should be reported back to catering staff for consideration by a multidisciplinary team of caterers, dietitians, doctors, nurses, patient representatives
- Opportunities should be made for members of the catering department to have occasional direct contact with patients

ACHCEW *Hungry in Hospital? (1997)*

- Accusations that patients are starving to death must be investigated
- Roles and responsibilities at mealtimes must be defined
- Existing guidance with regard to hospital catering must be enforced
- The Patients' Charter for Wales should include the same standards as for England

APPENDIX 2

<p>Health of the Nation Nutrition Task Force</p>	<p><i>Core Curriculum for Nutrition in the Education of Health Professionals (1994)</i></p> <ul style="list-style-type: none"> • Identifies a minimum core of essential knowledge for the curriculum for all health professionals. Includes understanding the importance of providing appropriate and safe clinical nutritional support and knowing when and how to refer to a dietitian or another specialist in clinical nutrition • Inclusion of questions on nutrition in professional exams • Curriculum development in nutrition for all levels of education and training
<p>Health of the Nation Nutrition Task Force</p>	<p><i>Nutrition in the Undergraduate Medical Curriculum (1996)</i></p> <ul style="list-style-type: none"> • Learning resources: establish a national programme to:- <ul style="list-style-type: none"> - identify, register and distribute resources, develop new learning resources to meet the defined needs - establish a steering group to take responsibility for the activity - encourage a professional grouping to take collective ownership of the activity - set up a centralised resource to serve as a hub of this network, a dedicated co-ordinator to be responsible for the programme, financial support to cover the costs of setting up the infrastructure, ongoing staffing and administrative costs and costs of production associated with the development and supply of resource materials

- ensure ongoing evaluation and development of materials within the programme
- Human nutrition can be incorporated as a vertically integrated theme, to link basic sciences, clinical and public health aspects of health and disease in the core curriculum
- Human nutrition offers the potential of horizontal integration as a component of problem-based approaches
- There can be a value in single courses in nutrition to complement thematic learning
- Human nutrition is well suited to special study modules particularly for public health nutrition
- 'Starter lists' should be offered of learning objectives and special concepts in human nutrition
- All medical schools should be made aware of the nutrition core curriculum document and further copies should be sent to medical schools for consideration by the curriculum committee
- Each medical school should appoint a senior faculty member to the position of nutrition coordinator on the curriculum committee. This should be a permanent position which will be maintained when the original appointee leaves

APPENDIX 2

- Medical practitioners should have a basic level of competence in nutrition integrated with and applied to other clinical knowledge. Teaching of nutrition should draw widely on available skills across disciplines, including dietitians
- Nutrition should be promoted as a model subject for vertical and horizontal teaching throughout the course and the nutrition being taught should be relevant to what a doctor needs to know
- Nutritional topics and questions should be included in the student logbooks for the clinical course and in the assessment process
- It would be helpful to have an agreed procedure for clinical screening of the nutritional status of patients. This should be part of any routine examination, for example when clerking a patient on admission
- Continuing medical education should seek to make many groups of health professionals more nutrition literate, so they would be better able to contribute to the teaching and assessment of nutrition. It is encouraging that Nutrition Society meetings are now recognised for CME credits
- Undergraduate teaching should establish an appreciation of the breadth of nutrition and the appreciation that most health problems have a nutritional component
- Nutrition training should have clinical and personal relevance

- Postgraduate training in nutrition should be established at the same time as undergraduate training, so there is a continuum between the two
- Postgraduate training should be targeted to at least three specific groups of health professionals: GPs, hospital based health professionals and public health nutritionists
- The training should lead to an appreciation that nutrition training is an important part of all clinical training
- Nutrition should be recognised as a medical speciality and this recommendation should be formally supported and promoted by the Royal Colleges
- Implementation of these recommendations will lead to :
 - structured nutrition training by various educational and clinical departments
 - improved structure of nutrition services
 - a focus of nutrition in clinical practice

APPENDIX 3

LOCAL EXAMPLES OF GOOD PRACTICE

Developing a strategic approach to nutritional care management

Example 1 - St George's Hospital, London

Led by the Director of Quality, the hospital has established a multidisciplinary Nutrition Strategy Committee (NSC) with the following Terms of Reference:

1. To bring together managers and professionals involved in the provision of 'normal' food and nutritional support within the Trust.
2. To advise through the existing Medical Advisory Committee the Medical Director and Chief Executive on matters relevant to nutritional practice and policy.
3. To manage a Nutrition Support Team and coordinate nutritional support services throughout the Trust.
4. To produce guidelines for the universal nutrition assessment of hospital patients for appropriate nutritional management and referral to the Nutrition Support Team. To advise on the purchase of suitable products relevant to dietetic therapy and nutritional support.
5. To develop a strategy for improving the nutritional education of health professionals.
6. To agree clinical standards for structure, process and outcome in the provision of nutritional care which may be applied to audit and the contracting process.
7. To liaise with individual specialties through the existing Service Delivery Unit structure. Where necessary, to co-opt additional members by agreement with the Medical Advisory Committee.
8. To review expenditure on catering and nutritional support in order to improve cost-effectiveness and quality.

Membership of the committee comprises:

- Manager, Dietetic Services
- Pharmaceutical Manager
- Director of Nursing
- Estates Director
- Director of Quality
- Business Manager
- Faculty of Healthcare Sciences representative
- Health Promotion Hospital Coordinator
- Consultant Clinician

The Committee's main achievement to date has been to complete a comprehensive audit of the Trust's food services based on *Nutritional Guidelines for Hospital Catering* (DoH 1995) and to develop an Action Plan.

Contact: Amanda Stokes-Roberts, Director of Quality

Developing a strategic approach to nutritional care management

Example 2 - St James' University Hospital, Leeds

St James's and Seacroft Hospitals have taken a strategic approach to developing patient nutritional care which has involved a systematic review of the literature, Trust-wide audit work and the development and implementation of Principles and Guidelines for Practice. The project plan was initiated in early 1996 and has been led by a multi-professional steering group chaired by the Dietetic Services Manager

APPENDIX 3

and comprising representation from Medicine, Nursing, Dietetics, Operational Management, Speech and Language Therapy, Occupational Therapy, Catering, Hotel Services and Pharmacy.

Gaining commitment at all levels of the organisation has been achieved through wide consultation and collaboration at all stages of the project plan. The support of the Trust board and, in particular, the Chief Nurse has been central to the success of the project plan and has enabled the nutritional care theme to be firmly embedded into the organisational plans in the following ways:

- a Trust-wide audit formed part of the Leeds Health Authority Clinical Audit Contract in 1996/97
- nutritional care was clearly identified as a corporate objective for 1996/97
- nutritional care is identified as a nursing priority within the current Nursing and Midwifery Research and Practice Development Strategy.

Contact: Margaret Thomas, Dietetic Services Manager

Commitment from the organisation to the project plan has also been demonstrated through the agreement to fund a Dietitian for 18 months to support the implementation of the Nutritional Care Principles and Guidelines for Practice.

Educating hospital staff about food and nutrition

Leicestershire Nutrition and Dietetic Service

A team of 50 dietitians is providing a county-wide in-service nutrition education programme for a range of hospital-based health personnel -nurses, nursing auxiliaries, ward assistants, housekeepers, and the occasional doctor.

The input mainly comprises ward-based tutorials covering:

- Nutritional content of food
- Presentation of food
- Delivery of food
- Positioning of patient for eating/feeding
- Early recognition of malnourished or nutritionally at-risk patients
- Referral policy for nutritional support
- Communication
- Documentation
- Monitoring and audit

This is backed up with a wide range of locally produced materials, a newsletter, displays, etc.

The main problems are the rapid turnover of staff and a reluctance to release staff from the ward. Ward-based sessions aimed at the whole team have proved to be the best approach.

Contact: Alison Scott, Dietetic Manager

Setting up a ward-based food service

Example 1 - Clatterbridge Centre for Oncology, Wirral

This regional cancer treatment centre with 155 beds and lengths of stay often lasting six or seven weeks was subject to regular criticism about the quality of meals. The food service involved central preparation and plating, and wagon distribution of insulated trays of plates. Problems included spillage and cooling of meals, patients changing their minds about menu items and quantities, and confusion over who ordered

APPENDIX 3

which meal - all of which resulted in high levels of wastage.

To tackle this, a small team was set up, including the catering manager, dietitian and nursing service manager, and the decision was made to run a trial of a ward-based meal service on a single ward. The team fully engaged the ward manager, nursing staff and ward domestic staff in working through the practicalities of the trial service. Special equipment and facilities were provided, and ward staff, particularly the nurses, were trained in food handling and hygiene.

Results were 'very positive'. Patients were able to choose just what they wanted, and how much they wanted, there and then. The pre-heated ward trolley kept food hot. Spillage was eliminated. One difficulty was that 'popular' items ran out very quickly. Nurses too were happier with the new system and, because they had been involved all the way along, did not mind plating the meals. Furthermore, they could advise patients on particular foods to choose for best nutrition, and the new system made audit easier.

Among other benefits, this successful trial demonstrated that the hospital managers valued staff and understood the need to involve, from the outset, all the stakeholders, especially those who would be serving the food on the ward.

Contact: Gill Oliver, Director of Patient Services.

Setting up a ward-based food service

Example 2 - King's Healthcare, London

King's College Hospital is a large general teaching hospital in inner south London, with a largely deprived, culturally diverse local catchment population. The hospital has a centralised food preparation, tray-based system delivering meals to the wards in heated trolleys.

Recently the Trust has been developing and evaluating a ward-based service in a number of wards. This involves food being served on the plate on the ward, so that patients can choose what they want to eat, and how much, there and then. It also allows for a cafeteria-like atmosphere, making mealtimes more sociable. A further benefit is that the required near-ward kitchens can also be used for preparing snacks.

Contact: Richard Wilson, Director of Nutrition and Dietetics.

Evaluating a near-ward kitchen

Queen's Medical Centre, Nottingham

Three 30-bed medical wards containing a high proportion of nutritionally at-risk elderly patients can call on the resources of a near-ward kitchen. All patients are routinely screened by the nursing staff and a proportion referred for full assessment by the dietitian. Those judged to be likely to benefit from special 'nutritional care meals' and whose stay is likely to be longer than four days, are then referred to the 'diet cook' who visits the patient before each meal, discusses menu options, prepares the meal and delivers it to the bedside. This averages about ten patients during weekdays.

Routine monitoring and audit have shown that food wastage is reduced to about 10% compared to the 40-50% prevailing across the rest of the hospital, and the need for further nutritional support (eg. supplements) in those patients receiving special meals has been reduced.⁸¹

Contact: Joy Field, Nutrition Sister

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