



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of nutrition and hydration at Beaumont Hospital, Dublin

Monitoring programme for unannounced inspections undertaken
against the National Standards for Safer Better Healthcare

Date of on-site inspection: 10 August 2016

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent Authority established to drive high quality and safe care for people using our health and social care and support services in Ireland. HIQA's role is to develop standards, inspect and review health and social care and support services, and support informed decisions on how services are delivered. HIQA's ultimate aim is to safeguard people using services and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation** — Registering and inspecting designated centres.
- **Monitoring Children's Services** — Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality** — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Table of Contents

Introduction.....	6
Findings	8
Theme 1: Person-centred care and support	8
Theme 2: Effective care and support.....	13
Theme 3: Safe care and support.....	16
Theme 5: Leadership, governance and management	13
Theme 6: Workforce	23
Conclusion.....	25
References	26

Introduction

In 2015, the Health Information and Quality Authority (HIQA) began a monitoring programme to look at nutrition and hydration care of patients in Irish hospitals. HIQA used the *National Standards for Safer Better Healthcare* to review how public acute hospitals (other than paediatric and maternity services) were ensuring that patients' nutrition and hydration needs were being adequately assessed, managed and effectively evaluated.⁽¹⁾ A national report of the review of nutrition and hydration care in public acute hospitals was published in May 2016 which presented the findings of this monitoring programme.⁽²⁾ This report described areas of practice that worked well in hospitals and identified opportunities for improvement (the report is available on HIQA's website, www.hiqa.ie). In that report, the following four key areas for improvement were identified:

1. All hospitals should have a nutrition steering committee in place.
2. All patients admitted to hospital should be screened for the risk of malnutrition.
3. Hospitals must audit compliance with all aspects of patients' nutritional care and share the findings with all relevant staff groups involved in food service and patient care.
4. Hospitals should strive to improve patients' experience of hospital food and drink by engaging with patients about food variety and choice.

Following the publication of the national report, HIQA commenced a programme of unannounced inspections in public acute hospitals in Ireland (with the exception of paediatric and maternity services) to continue to monitor compliance with the *National Standards for Safer Better Healthcare* in relation to nutrition and hydration care for patients.⁽¹⁾ The inspection approach taken by HIQA is outlined in guidance available on HIQA's website, www.hiqa.ie – *Guide to the Health Information and Quality Authority's review of nutrition and hydration in public acute hospitals*.⁽³⁾

The aim of the unannounced inspections is to determine how hospitals assess, manage and evaluate how they meet individual patients' nutrition and hydration needs in the hospital as observed by the inspection team and experienced by patients on a particular day. It focuses on the patients' experience of the arrangements at mealtimes, screening patients for their risk of malnutrition, governance and audit of nutrition and hydration care and training staff on nutrition and hydration care.

Health Information and Quality Authority

The report of findings following inspections identifies areas of nutrition and hydration care for patients where practice worked well and also identifies opportunities for improvement. Each service provider is accountable for the implementation of quality improvement plans to assure themselves that the findings relating to areas for improvement are prioritized and implemented to comply with the *National Standards for Safer Better Healthcare*.⁽¹⁾

As part of the HIQA programme of monitoring nutrition and hydration care in public acute hospitals against the *National Standards for Safer Better Healthcare* an unannounced inspection was carried out at the Beaumont Hospital on 10 August by authorized persons from HIQA, Dolores Dempsey-Ryan, Aoife Lenihan, Siobhan Burke, Paul Dunbar and Conor Dennehy between 10:15hrs and 15.05hrs.⁽¹⁾

The hospital submitted a completed self-assessment questionnaire in August 2015 as requested by HIQA of all public acute hospitals (with the exception of maternity and paediatric services). References to this are included in this report where relevant.

Inspectors visited three wards during the midday meal to check first-hand that patients received a good quality meal service, had a choice of food and that they were provided with assistance with eating if required. Inspectors observed one meal, spoke with 15 patients, their relatives when present and 16 members of staff, including managers. During the inspection, inspectors used specifically developed observation, interview and record review tools to help assess the quality of care given to patients in acute hospitals with the focus on nutrition and hydration.

HIQA would like to acknowledge the cooperation of hospital management, staff and patients with this unannounced inspection.

Findings

Theme 1: Person-centred Care and Support

Healthcare that is person-centred respects the values and dignity of service users and is responsive to their rights, needs and preferences. The *National Standards for Safer Better Healthcare* ⁽¹⁾ state that in a person-centred service, providers listen to all their service users and support them to play a part in their own care and have a say in how the service is run. This includes supporting individuals from different ethnic, religious or cultural backgrounds.

During the on-site inspections, inspectors looked at the timing of meals and snacks, how hospital staff consulted with patients about meal choice and whether patients got fresh drinking water and a replacement meal if they missed a meal. Inspectors also looked at the assistance patients were given with meals, and whether patients had their meals interrupted for non-essential reasons.

Meal service and timing of meals

In-house staff provided catering services at the hospital. A cook-fresh food production system was in place and meals were centrally plated. A cook-freeze system was in use for texture-modified puréed meals.* The mealtimes reported in the hospital's self-assessment questionnaire were as follows:

- Breakfast: 7.30am-8.45am
- In between meal snack: 10.00am-11.00am
- Midday meal: 11.45am-1.00pm
- In between meal snack: 2.00pm-3.00pm
- Evening meal: 4.15pm-5.15pm

*A "cook-fresh" food service system is the standard method for preparing food in hospitals, which involves cooking, plating, and serving food hot.

A "cook-freeze" food service system involves freezing the food after it is cooked and then re-heating the food prior to serving. Centrally plating food involves placing food onto plates at one central location, such as the hospital kitchen.

Texture-modified diets may include soft diets, minced and moist diets, smooth pureed diets and liquidized diets due to swallowing difficulties.

- Evening snack: 6.45pm-10.45pm

National guidelines recommends that there should be four hours or more between the end of each main meal and the beginning of the next, and mealtimes should be spread out to cover most of the waking hours.⁽⁴⁾ Catering staff told inspectors that the main meals were served between the times stated in the completed self-assessment. Based on the meal times stated by catering staff in two of the wards inspected, the hospital was adhering to best practice guidelines with a four-hour interval between the three main meals of the day. However in the third ward visited, inspectors were told that there was an interval of less than four hours between the midday and evening meals. Inspectors spoke with patients and the majority were satisfied with the mealtimes. One patient commented that meals were served too early.

Hospital managers and nursing staff told inspectors that they observed the principles of protected mealtimes[†] by aiming to reduce non-essential interruptions to support patients' experience of mealtimes. Visitors were allowed to visit to assist their relative with their meals and inspectors observed this to be the case on the day of inspection. Inspectors also observed an ensuite bathroom being cleaned on one ward during the course of this mealtime, which, although carried out discreetly, was not wholly considerate of patients' needs.

Of the 15 patients who spoke with inspectors, nine patients experienced no interruptions to mealtimes, three said it rarely occurred, one patient said they were sometimes interrupted and two patients did not comment. One patient told inspectors that a member of nursing staff advised medical students that a meal was about to be served and to finish their conversation with that patient. This request was followed and the patient was able to have their meal without interruption.

Choice and variety of food

The hospital stated in its completed self-assessment questionnaire that menu options were outlined to patients by menu card. On the day of inspection, hospital management and ward staff confirmed that this was the system in use for patients to select their meal choice. Inspectors viewed the weekly menu cards which rotated

[†] Protected mealtimes are periods when patients are allowed to eat their meals without unnecessary interruptions, and when nursing staff and the ward team are able to provide safe nutritional care. Unnecessary interruptions can include routine medication rounds, ward rounds, non-urgent diagnostic tests and visitors. However, HIQA recognizes that there are a small number of areas in a hospital where policies on protected mealtimes may be contrary to the daily functioning of that unit.

on a four-weekly basis. Patients were provided with four or five options for their midday meals including meat, fish and vegetarian options. Patients had the option to order soup or fruit with their midday meal on the menu card. Patients could also choose their accompanying dishes, desserts and what drinks they would like for the midday meal. Inspectors noted that mashed potatoes were the only type of potatoes served on the four-weekly menus. For the evening meal, three or four choices were presented with options including a sandwich, salad and a hot meal. On the day of inspection, patients who spoke with inspectors confirmed that they got a choice of meals.

Texture-modified diets include meals that are suitable for patients with swallowing difficulties of varying severity. They should include options for patients who require soft, minced and moist, smooth puréed and liquidised diets.⁽⁴⁾ Hospital managers and ward staff told inspectors that choices were available for patients requiring texture-modified diets. Inspectors viewed the texture-modified meal menus and patients requiring texture-modified dishes had a choice of meals. Inspectors also observed texture-modified meals served to patients on both wards. The meals looked appetising and all food types were separated on the plate. Inspectors were satisfied that choice was available for patients who required a texture-modified diet.

Best practice guidelines suggest that high-calorie snacks should be offered between meals, mid-morning, mid-afternoon and late evening.⁽⁴⁾ This may be particularly relevant if there is a long period of time between the last meal of the day and breakfast the following morning. Hospital managers told inspectors that snacks were offered on all wards in the morning and evening and on some wards in the afternoon. On the day of inspection, catering and nursing staff told inspectors that two wards offered no snacks between the midday and evening meals, but offered snacks at 10am and in the evening. In the third ward, inspectors were informed that there was a snack round in the afternoon.

Inspectors asked patients if they were offered snacks. Of the patients inspectors spoke with, the majority said they were offered tea or coffee and biscuits as a snack in the morning and cake, sandwiches, cheese, and crackers for their evening snack. Patients on one ward told inspectors that they were also offered tea and biscuits in the afternoon. One patient expressed the view that the evening meal was served too early and they were only offered biscuits as a snack.

Overall, there were a range of choices of meals and snacks available to all patients including patient on texture-modified diets.

Missed meals

Catering and nursing staff told inspectors that the hospital had a system in place to cater for patients who missed a meal. For example, if a patient missed a meal during the meal service, a meal could be held back for up to 90 minutes. Alternatively, the kitchen could be contacted up to 7pm to obtain a replacement meal or a snack as required. Six patients who reported missing a meal told inspectors that they were facilitated with a replacement meal.

Catering for patients with ethnic, religious and cultural dietary needs

The *National Standards for Safer Better Healthcare* state that patients should experience healthcare that respects their diversity and protects their rights.⁽¹⁾ Dietary practices within and between different cultural groups can be quite varied. It is important not to assume what an individual's dietary practices are just because they belong to a particular faith or culture. This may vary depending on practices such as fasts, festivals, food restrictions and other requirements.

The hospital stated in its completed self-assessment questionnaire that there were menu options available for patients from different ethnic, religious, and cultural backgrounds. Hospital managers and catering staff told inspectors that they could provide Halal[‡] meals on request. Vegetarian meals were also available.

Assistance

The hospital stated in its completed self-assessment questionnaire that assistance from nurses, healthcare assistants and volunteers to support patients at mealtimes was mostly available.[‡] Hospital managers told inspectors that staff could be redeployed to specific wards from other areas of the hospital to ensure that there were sufficient staff numbers to assist patients. Nursing staff also told inspectors that staff breaks were scheduled after patients had eaten their meals to ensure staff were always available to offer assistance to patients with their meals. Hospital managers told inspectors that they were planning to introduce a system whereby

[‡] Halal food refers to meat prepared as prescribed by Islamic law.

[‡] The self assessment questionnaire offered the following four options to answer the question on the availability of support: always; mostly; sometimes; never.

volunteers, under the supervision of nursing staff, would provide companionship and some assistance to patients with their meals such as opening of food packaging.

The system in place to identify which patients required assistance included a section in the nursing assessment that detailed whether patients required partial or complete assistance with eating and drinking. This information was also communicated verbally between nursing staff during shift handovers, which were also attended by healthcare assistants. A red table mat system had been introduced on two of the wards inspected as a quality improvement initiative to highlight patients that needed assistance and inspectors observed these in use. Catering and nursing staff told inspectors that they also operated a 'hold back' system whereby a meal was held back until a nurse or healthcare assistant was available to assist patients with their meals.

Catering staff were informed verbally by nursing staff about which patients required assistance and also on a white board in the kitchen. This white board listed patients' names, their bed numbers, whether patients required assistance with eating and drinking and information on specific dietary needs for example texture-modified diets. It was the responsibility of nursing staff to update the kitchen white board.

Inspectors observed the midday meal and noted that patients were positioned comfortably prior to the meal with dining and feeding aids provided as required. Inspectors observed that nurses and healthcare assistants provided patients with assistance as required. One visitor was present during this mealtime and was seen to provide assistance to their relative.

Patients' experience of meal service – food quality

All patients have a right to safe, nutritious food and the provision of meals should be individualised and flexible.⁽⁴⁾ On the day of inspection, inspectors observed meals as they were being served and found that food was served in an appetising way (meals served on the day of inspection included turkey or chicken stew with mashed potatoes and vegetables).

Inspectors spoke with patients about their views on the quality of food provided in the hospital. Patients were generally satisfied with the meal service, for example, some patients used phrases such as; "always hot and on time" and "very well cooked". However, some patients gave mixed responses to the meal service. Two out of 15 patients expressed general dissatisfaction with the food offered as one patient said they do not like hospital food and the second patient would like other

options particularly for desserts. Another two patients told inspectors that they would like bigger portion sizes for their meals.

Hydration and availability of drinks

On the day of inspection, inspectors observed that drinking water was readily available to patients with jugs and plastic cups of water within easy reach of patients. Catering staff, nursing staff and hospital management told inspectors that water jugs were replaced with fresh water in the morning and refilled as required by members of the catering staff. Patients that spoke with inspectors confirmed this. In general, inspectors were satisfied that patients had access to sufficient hydration throughout the day.

What worked well?

- Patients were offered a choice of meals including those requiring texture-modified diets.
- A system was in place to provide patients with a replacement meal.
- A system was in place to identify patients who required assistance with meals.

Theme 2: Effective Care and Support

Effective care and support in healthcare means consistently delivering the best achievable outcomes for people using a service in line with best available evidence. In the context of effective care and support for patients, this means that nutrition and hydration care is evidence-based, planned, coordinated and delivered to meet individual patient's initial and ongoing needs. It means assessing patients' risk of malnutrition using a validated assessment tool, monitoring aspects of their nutrition and hydration care and referring patients who are at risk of malnutrition to a dietitian for further specialised input. National guidelines recommend that screening for risk of malnutrition should be carried out on every patient within 24 hours of admission to hospital.⁽⁴⁾

Inspectors reviewed patient healthcare records and spoke with healthcare professionals during the inspections about how they identified and monitored patients who were at risk of malnutrition and or dehydration.

Patient assessment and malnutrition screening

Inspectors reviewed the healthcare records of 15 patient on the day of inspection. This was a small sample size and did not involve a representative sample of the healthcare records of all patients at the hospital. The inspection team focused, in particular, on patients who were at risk of malnutrition, had been referred to a dietitian and or required a specific therapeutic diet. The inspection team found that the hospital had a structured nursing assessment for all admitted patients. All 15 patient healthcare records reviewed by inspectors included a nursing assessment of nutrition and hydration within 24 hours of admission. Thirteen of these assessments were fully completed with entries for all of the required fields in the documentation. Two records were partially complete, as they had not recorded certain items such as whether the patient required assistance with eating and drinking.

The hospital stated in its completed self-assessment that the Malnutrition Universal Screening Tool (MUST) was the screening tool being used in the hospital. This is the tool recommended in the national guidelines.⁽⁴⁾ All three of the wards visited by inspectors were screening patients for malnutrition used the MUST tool. It was practice to screen patients for their risk of malnutrition on admission to the hospital and to re-screen weekly thereafter. Of the 15 healthcare records reviewed, six had a fully completed MUST assessment within 24 hours of admission while eight had not. One patient record had a note stating that it was not possible to obtain a weight or height for the patient and was, as such, not possible to obtain a MUST score.

The MUST tool required the recording of patients' weight and height. Inspectors found that one of the wards visited did not have access to equipment to measure patients' height. Staff advised inspectors that they obtained patients' height by either estimating it or asking the patient to provide the measurement.

On one of the wards visited staff advised that it was not possible to obtain a weight or height for many of the patients for valid clinical reasons. Inspectors were informed by staff on this particular ward that they used a measurement of the mid-upper arm circumference (MUAC)[§] instead to estimate a patient's body mass index (BMI) and determine their risk of malnutrition based on this. However, a BMI estimate was recorded in the patient's record and not the MUAC measurement.

[§] The MUAC is a measurement of the circumference of the left upper arm, measured at the mid-point between the tip of the shoulder and the tip of the elbow. It is used to estimate the body-mass index of a person where a weight and height measurement is not available.

Eleven of the 15 healthcare records reviewed by inspectors showed that the patients had been admitted for more than one week. As such, according to hospital practice on screening for malnutrition, these patients should have been re-screened. Of the 11 records, four had no evidence of being re-screened for their risk of malnutrition.

Inspectors examined the food and fluid balance charts in the healthcare records. Of the 15 records reviewed, 10 had fluid balance charts. All of the 10 used quantitative measures, but two were not fully completed and up-to-date. Six records contained food charts. All six used semi-quantitative measures as recommended by the national guidelines.⁽⁴⁾ One of the food charts was not fully completed and up-to-date.

Overall, inspectors found that over half of the patients whose healthcare records were reviewed were not screened for their risk of malnutrition on admission and patients that should have been rescreened for their risk of malnutrition were not always rescreened.

Equipment for screening

During this inspection, inspectors observed some of the required equipment used to screen patients for the risk of malnutrition was in place. This included weighing scales, chair scales (for more frail and dependent patients), stadiometers[◇] and measuring tapes.

All three wards had access to a measuring tape and hoist scales. Two wards had access to a chair scales whereas the chair scales on the third ward was broken. Two of the three wards had access to stand-on scales. Two chair scales and one hoist observed by inspectors had been calibrated within the past 12 months. However of the three wards visited, only one had a stadiometer.

Patient referral for specialist assessment

As part of the on-site inspection, inspectors reviewed the systems in place to refer patients to dietetic or speech and language therapy services. Patients who had a MUST score of two or more were routinely referred to a dietitian and referrals were made via a computerized system.

[◇] A device for measuring a person's height.

Of the 15 healthcare records reviewed, inspectors viewed a documented assessment of the patient by a dietitian in eight of the healthcare records reviewed. Dietitian assessments were highlighted in the healthcare records with a purple sticker. Of these eight patients, three had been seen by the dietitian on the same day of referral; four were seen within 24 hours; and one patient was seen within two working days.

Six patient records contained assessments by a speech and language therapist for a swallowing assessment. Of the six, four were seen on the same day of referral and two were seen within 24 hours of the referral.

Overall, inspectors were satisfied that patients had good access to dietetic and speech and language therapy services.

The Dietetic Manager told inspectors that they used an information management system to record activity levels regarding the numbers of patients referred and seen by dietitians. This activity was analysed with regard to the effectiveness of their priority system for assessing patients for review by dietitians.

What worked well?

- There was timely access to dietetic and speech and language therapy services.

Opportunities for improvement?

- Patients should be screened for their risk of malnutrition screening within 24 hours of admission and re-screened weekly in line with national guidelines.
- Staff should have access to appropriate equipment to measure patients' height.

Theme 3: Safe Care and Support

Safe care and support recognises that the safety of patients and service users is of the highest importance and that everyone working within healthcare services has a role and responsibility in delivering a safe, high-quality service. Certain areas relating to nutrition and hydration care are associated with a possible increased risk of harm to patients. These include:

- identifying whether hospitals have systems in place to ensure that the right meal is served to the right patient
- ensuring patients are not experiencing prolonged fasting unnecessarily
- ensuring patient safety incidents relating to nutrition and hydration care are reported, recorded, investigated and monitored in line with best available evidence and best practice guidelines.

Communication of dietary needs

The hospital had a number of methods for communicating the dietary needs of patients. On admission, staff documented information regarding patients' nutrition and hydration needs in the nursing admission and assessment notes including any specific dietary requirements. The information recorded on admission was communicated to catering staff via a white board in the ward kitchen. Inspectors observed this white board and noted it contained various diet-related information including whether the patient required a texture-modified diet, high-calorie high-protein diet and other dietary requirements such as 'low salt'. Catering staff collected menu choices from patients via coloured menu cards. The different colours identified patients' special dietary requirements.

Catering staff who spoke with inspectors said that the system outlined above worked well and that it served to ensure patients got the correct meal. Nine out of 15 of the patients who spoke with inspectors said that they always received the correct meal. However, four patients said that did not always receive the correct meal (the remaining two patients did not comment on this). Two patients indicated that they did not receive the meal they ordered, but received a different meal. A third patient stated that they received a particular meal despite not selecting that meal on the menu card provided to the patient the previous day. A fourth patient was prescribed a fat free diet and told inspectors that they had not received it.

Patients safety incidents in relation to nutrition and hydration

Hospital staff and management reported that there had been no patient safety incidents or written complaints received from patients in relation to nutrition and hydration in the last 12 months.

Opportunities for improvement

- Patients did not always receive the correct meal in line with their dietary requirements.

Theme 5: Leadership, Governance and Management

The *National Standards for Safer Better Healthcare* describe a well-governed service as a service that is clear about what it does and how it does it.⁽¹⁾ The service also monitors its performance to ensure that the care, treatment and support that it provides are of a consistently high quality throughout the system.⁽¹⁾ Best practice guidelines state that hospital management must accept responsibility for overall nutritional care in hospitals. In addition, hospital managers, dietitians, physicians, nurses, catering managers and food-service staff must work together to achieve the best nutritional care. Hospital management must facilitate and give priority to such cooperation.⁽⁴⁾

Best practice guidelines recommend that hospitals form a nutrition steering committee to oversee nutrition and hydration care in acute hospitals.⁽⁴⁾ The role of this committee includes the following:

- help implement national guidelines
- set the standard of care in relation to nutrition for hospitalized patients
- review the food-service system, nutritional risk screening and audits.

The inspection team looked at key leadership, governance and management areas aligned to the *National Standards for Safer Better Healthcare* and sought information relating to the governance arrangements in place to oversee nutrition and hydration practices.

Nutrition Steering Committee

The hospital had a Nutritional Steering Committee, which was set up in January 2015 and was co-chaired by two senior executive leads — the Head of Clinical Services and Business Planning and the Director of Nursing. The Chairs of the Committee rotated every six months. It had agreed terms of reference that detailed the purpose, membership, reporting structures, meeting frequency and Committee's

responsibilities. The purpose of the Committee was to direct and support the implementation of a comprehensive programme of nutritional care to ensure that all patients of Beaumont Hospital received nutritional care, support appropriate to their needs, and that risks associated with poor nutrition were prevented.

Hospital managers told inspectors that the Nutrition Steering Committee reported into the Senior Management Team and they in turn reported into the Hospital's Board of Management. A number of sub-committees, which included the Nutrition Services Working Group, the Nutrition Screening Steering Group, the Parenteral Nutrition Committee and the Productive Meals Module Committee reported into the Nutrition Steering Committee.

The Nutrition Steering Committee had met six times between January 2015 and June 2016, and aimed to meet quarterly. Inspectors requested and reviewed copies of agendas and minutes for the last six meetings; all meetings had been minuted. Examples of quality improvement initiatives progressed by the Committee included the following:

- the implementation of the MUST screening tool on all wards
- a plan to introduce the red mat system to identify patients who required assistance with meals, already in place on four wards, to all wards
- plans to introduce a volunteer programme, under the supervision of nursing staff, aimed at providing companionship to patients at meal times and offering assistance with opening food packages
- a plan to audit the nutrient content of food.

Policies

Policies are written operational statements of intent which help staff make appropriate decisions and take actions, consistent with the aims of the service provider, and in the best interests of service users.⁽¹⁾

During the inspection, inspectors found that the hospital had a system in place for staff to access policies on the hospital's electronic information system. At the time of inspection, Beaumont Hospital had not approved hospital specific policies related to malnutrition screening, protected mealtimes or fasting, but had a nutrition and hydration policy in draft format which included information on the MUST screening tool, managing patient mealtimes, dysphagia and modified consistency diets.

Inspectors concluded on the day of inspection that the hospital needs to progress with the development, approval and implementation of nutrition and hydration policies to standardize nutrition care and meal service provision at the hospital.

Evaluation and audit of care

The term audit is used to describe a process of assessing practice against evidence-based standards of care. It can be used to confirm that current practice and systems meet expected levels of performance or to check the effect of changes in practice.

It is recommended that the nutrient content and portion size of food should be audited per dish annually, or more often if the menu changes.⁽⁴⁾ Hospital managers told inspectors that they planned on acquiring software to analyse the nutrient content of the hospital meals, but at the time of the inspection, an audit of the nutrient content and portion size of meal had not been conducted as recommended in the national guidelines.

Inspectors were provided with copies of completed audits, which included audits of compliance with screening patients for their risk of malnutrition using the MUST tool and observational audits of mealtime processes. Inspectors viewed a number of MUST screening audits from 2013 to 2016. In October 2015, a MUST screening audit was carried out on a ward that specialised in care of the older person using quality improvement methodology to implement the MUST screening tool. The audit results indicated that this ward had achieved 100% compliance with MUST screening. Inspectors viewed monthly MUST screening audits on this ward for 2016 and noted that in general this ward scored 100%. However, there was evidence that the MUST screening score was less than 100% on some of the monthly audits viewed. This highlights the importance of carrying out monthly audits to reflect practice and address areas of low performance.

In April 2016, a second ward aimed to reduce the incidence of acquired under-nutrition during in-patient stay using weekly audits of the completion of the MUST screening tool over an eight-week period. The results showed a gradual improvement in compliance with completing the MUST tool to 80%.

Inspectors also reviewed a report of an observational audit conducted in 2015 that looked at 650 meals served to patients. The results showed that the majority of patients who required assistance with meals received it, and patients' comments were positive about the food service. The report highlighted areas that required improvement in relation to timely assistance with meals, that patients were satisfied with the choice of meal options available and that of 650 meals observed, less than

4% (23) patients received an incorrect meal. The audit also identified the type of interruptions that occurred during mealtimes and these included medication rounds, taking blood samples during meals and nursing handover during breakfast.

During the inspection, inspectors were given examples of where quality improvement initiatives were planned and being implemented to address areas for improvement highlighted by audit findings. The hospital should build on this culture of audit to ensure that key areas identified in the audits for improvement are addressed, for example, ensuring all patients are screened for their risk of malnutrition, patients always receive the correct meal and are offered assistance in a timely manner.

Evaluation of patient satisfaction

Hospital managers told inspectors that the hospital had carried out an in-patient experience survey in 2015 and the catering department had carried out patient satisfaction surveys in 2014 and 2015.

Inspectors viewed the hospital's in-patient experience survey and noted that three of the eleven questions in the survey related to nutrition and hydration. These questions related to asking patients about their experience of help being provided in a timely manner, the quality of the food received and satisfaction with special dietary requirements. The results of the in-patient experience survey highlighted that the majority of patients reported that they had been given help with meals in a timely manner, but not all patients reported being asked about their personal dietary requirements or received meals that met their dietary requirements.

The catering department carried out patient satisfaction surveys in 2014 and 2015 and asked patients 25 questions that included the following:

- Are you on a special diet?
- Is the menu layout easy to follow?
- Is there a good choice for the following meals (breakfast, dinner and evening tea)?
- If you miss a meal is there a replacement meal?
- Can you get a drink or a snack if you request it?
- Did you get assistance with your meals?

Inspectors viewed the survey results and found that patients were satisfied with the meal choices offered and received a snack or drink if they requested it.

Quality improvement initiatives

Hospital managers and nursing staff told inspectors about a number of quality improvement initiatives that had been introduced on individual hospital wards using the 'plan, do, study, act' (PDSA) quality improvement methodology. For example a number of wards had implemented improvements to their ward routine, such as a red mat that was placed on the meal tray to identify which patients required assistance with meals.

One ward inspected introduced a communication white board in the ward kitchen to ensure that certain patients who were on specialized diets received the correct meal. Nursing and catering staff told inspectors that these white boards also recorded information regarding which patients required assistance with meals. This ward also implemented a system of coloured signage to be placed over the beds of patients who had undergone gastrointestinal surgery to ensure that they received the correct specialized diets as prescribed by the surgical team.

Hospital managers and nursing staff told inspectors that speech and language therapists and members of a multidisciplinary team carried out a project aimed at improving the patients' experience of texture-modified meals. Staff involved tasted texture-modified diet meals and checked the consistency was correct.

One ward implemented an admission check list — using quality improvement methodology — to ensure staff completed the MUST screening tool for each patient admitted to this ward. This admission sheet improved their compliance with completion of the MUST screening tool.

Overall, inspectors found that the wards visited during the inspection had introduced quality improvement initiatives which can be shared with other wards in the hospital.

What worked well?

- The hospital had an established Nutrition Steering Committee that had implemented a number of improvements in the nutrition and hydration care of patients.
- The hospital had conducted a number of audits for nutrition and hydration care, including regular audits on screening patients for their risk of malnutrition and patients' experience of mealtimes.

Opportunities for improvement?

- The hospital needs to develop policies in relation to nutrition and hydration care to guide staff and standardize nutrition care and meal service provision at the hospital.
- The hospital needs to audit the nutrient content and portion sizes of hospital meals in line with national guidelines.

Theme 6: Workforce

It is important that the members of the workforce have the required skills and training to provide effective nutrition and hydration care to patients. Evidence suggests that there is a lack of sufficient education in nutrition among all healthcare staff due to the delay in transferring nutritional research into practice in hospitals.⁽⁴⁾

Best practice guidelines recommend that hospitals:

- include training on nutrition in staff induction
- have a continuing education programme on general nutrition for all staff involved in providing nutritional support to patients
- provide staff involved in the feeding of patients with updated nutritional knowledge every year
- a special focus should be given to the nutritional training of non-clinical staff and the definition of their area of responsibility in relation to nutrition and hydration⁽⁴⁾

Training

The hospital stated in its completed self-assessment questionnaire that specific training was provided to staff through lectures, workshops and poster presentations. The hospital also indicated that catering staff received training in the preparation of special and restrictive menus.

On the day of inspection, hospital managers told inspectors that new members of nursing and healthcare assistant staff had been provided with training on the MUST tool during their induction training. Inspectors were also informed that training on MUST had been given to clinical nurse managers and it was their responsibility to train ward staff. Clinical nurse managers confirmed this on the day of inspection. All

nursing staff and healthcare assistants confirmed that they had received training in the use of MUST and relevant training records were seen by inspectors.

Hospital management informed inspectors that training, delivered by dietitians and speech and language therapists, was provided to all levels of staff in the hospital. This training was delivered annually in a formal setting and covered topics such as food descriptors for modified foods and fluids and therapeutic diets. Staff spoken with during inspection confirmed that they attended this training with one healthcare assistant commenting positively on the learning gained from this training.

What worked well?

- Induction training on MUST was provided to all nurses and healthcare assistants.
- All levels of staff received formal training on annual basis from the hospital's dietitians and speech and language therapists.

Conclusion

The inspection team found, on the day of inspection, that Beaumont Hospital had implemented a number of quality improvement initiatives relating to nutrition and hydration. The hospital had an established Nutrition Steering Committee in place that played a key role in raising the importance of the provision of good nutrition and hydration care across the hospital, and had implemented a number of quality improvement initiatives.

The hospital routinely screened patients for the risk of malnutrition on admission on some of the wards and were planning to introduce the MUST tool throughout the hospital. However, when inspectors reviewed a small sample of patient healthcare records on the day of inspection they found that malnutrition screening was not always carried out within 24 hours of admission and that weekly re-screening was not always carried out. This should be a key area of focus for improvement by the hospital following this inspection.

HIQA recognizes that the number of patients inspectors spoke with during the inspection was a limited sample of the experience of all patients who receive care at the hospital. Inspectors observed that patients who required assistance were offered assistance in a prompt manner. All patients were offered a choice of meals including patients on texture-modified diets. While most patients were positive about the meals offered, other patients offered mixed views on the meals. A small number of patients reported that they had not always received what they had ordered.

Inspectors found that the hospital had conducted a number of audits in relation to aspects of nutrition and hydration care, including regular audits on screening patients for their risk of malnutrition and the patients' experience of mealtimes.

The hospital must now ensure that quality improvement efforts and arrangements in place for meeting patients' nutritional and hydration needs are maintained so that the nutrition and hydration care of patients continues to improve. To achieve this, the hospital's Nutrition Steering Committee must continue to encourage and support the screening of patients for risk of malnutrition and develop evidence-based policies on nutrition and hydration. They must also continue using a structured approach to conduct regular audits including auditing of the nutrient content and portion size of meals in line with national guidelines. A key feature of this process is the inclusion of patients' experience of nutritional and hydration care and use of their views to inform and direct current and future quality improvements in the area of nutrition and hydration care.

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