



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of nutrition and hydration at Midland Regional Hospital, Mullingar

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

Date of on-site inspection: 28 July 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.
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- **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.

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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.

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* ⁽¹⁾ an unannounced inspection was carried out at the Midland Regional Hospital, Mullingar on 28 July 2016 by authorized persons from HIQA, Aoife Lenihan, Dolores Dempsey-Ryan, Paul Dunbar and Conor Dennehy, between 09:30hrs and 14:30hrs.

The hospital submitted a completed self-assessment questionnaire in September 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 two 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 18 patients, their relatives when present and 12 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, 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 interruptions.

Meal service and timing of meals

Catering services at the hospital were provided by in-house staff. A cook-chill and centrally plated system was in use. A cook-freeze system was in use for texture-modified diets.^{*†} Multi-task attendants were observed serving meals from a food trolley on the ward and referring to a diet sheet to ensure that each patient was served the correct meal.

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

†A "cook-chill" food service system involves chilling the food after it is cooked and re-heating the food prior to serving. 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.

The mealtimes reported in the hospital's self-assessment questionnaire were as follows:

- Breakfast: 8.30am
- Snack: 10.30am
- Midday meal: 12.30pm
- Evening meal: 4.30pm
- Late evening snack: 8.30pm

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⁾ Inspectors spoke with 18 patients regarding the meal service. Fifteen of the 18 patients interviewed were satisfied with the mealtimes. While inspectors found that the hospital was adhering to best practice guidelines with a four-hour interval between the three main meals of the day, three patients told inspectors that meals were served too early. On the day of inspection, inspectors observed multi-task attendants interacted well with patients and bed tray tables were generally free from clutter and within the reach of patients.

Interruptions of patients' mealtimes by ward rounds and diagnostic procedures should be minimised and patients allowed to eat undisturbed.⁽⁴⁾ Hospital managers and nursing staff told inspectors that the hospital's Nutrition Steering Committee had plans to implement protected meal times[‡] as a quality improvement initiative to reduce interruptions to patients during mealtimes.

Inspectors spoke with 18 patients about interruptions during meals. Ten of the 18 patients experienced no interruptions; six patients said it rarely happened, two patients said it sometimes happened. However, during the inspection, inspectors saw a number of examples of patients' meals being interrupted by ward routines for example, medication rounds and the taking of blood samples from patients during mealtimes.

Choice and variety of food

The hospital stated in its completed self-assessment tool and inspectors found that menu options were outlined verbally to patients. Hospital managers told inspectors

[‡] 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.

that they also used picture menus to communicate information about menu choices to patients with communication difficulties.

The Catering Manager told inspectors that there were two distinct weekly meal plans, which were rotated once every two weeks. Inspectors viewed the weekly menu plan on offer to patients, and noted that there were a variety of options available to patients for their midday meal for example, bacon, minced beef, chicken, salmon or a vegetarian option. There was one main meal option for the evening meal that varied each day and patients could choose this or scrambled eggs, a salad or sandwiches. Patients could choose between ice-cream and jelly, rice pudding or custard for dessert. Inspectors spoke with 18 patients who reported that they were offered three or four choices for their meals.

Patients on therapeutic diets could order from the standard menu with some restrictions for example, patients requiring a diabetic diet received sugar free desserts. Nursing staff told inspectors that catering staff accommodated patients' individual requirements, for example a patient who required a specific diet following surgery had a special menu tailored to their needs.

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 pureed and liquidised diets.⁽⁴⁾ Texture-modified meals were prepared in-house and presented on a dividing plate with separate sections for each food item. Inspectors viewed the texture-modified menus and noted that patients on a soft diet or a minced moist diet had an adequate number of choices. However, patients requiring a smooth pureed or liquidised texture-modified diet were offered one main meal option or custard and inspectors were of the view that there were limited choices for these patients.

Best practice guidelines suggest that high-calorie snacks should be offered between meals, mid-morning, mid-afternoon and late evening.⁽⁴⁾ Hospital managers, nursing staff and multi-task attendants told inspectors that snacks were offered to patients at 11am and between 8.30pm and 9pm. These included soup at 11am and sandwiches, biscuits and cake in the evening. The majority of patients that inspectors spoke with confirmed this. Hospital managers and nursing staff told inspectors that high calorie high protein snacks were available and prescribed for specific patients following assessment by the dietitian.

Missed meals

Hospital managers and multi-task attendants told inspectors that the hospital had a system in place to cater for patients who missed a meal. This included keeping an extra meal on the ward for a short period during mealtimes. In addition multi-task attendants could request a replacement meal from the kitchen or staff canteen. On the day of inspection, two patients who had missed a meal confirmed that they had been offered 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 that there were menu options for patients from different ethnic, religious, and cultural backgrounds. Hospital managers, nursing staff and multi-task attendants confirmed this to be the case on the day of the inspection. Hospital managers told inspectors that they sourced Halal[‡] food from an external company that supplied Halal meals. Vegetarian meals were also available on the daily menu.

Assistance

The hospital stated in its completed self-assessment that assistance from nurses and healthcare assistants to support patients at mealtimes was always available.[§] Hospital managers and nursing staff told inspectors that information regarding which patients required assistance with meals was documented on the nursing assessment and communicated to nurses and healthcare assistants during the nursing handover. Hospital managers and nursing staff told inspectors that the Nutrition Steering Committee had recently proposed a quality improvement initiative to put a system in

[‡] 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.

place to easily identify patients who require assistance with meals such as serving meals on a red tray or using a red serviette placed on their meal tray to identify patients that require help.

Inspectors observed that patients were positioned comfortably prior to the midday meal and those patients who required help with positioning were offered assistance. Patients were provided with dining and feeding aids as required. Inspectors observed that patients who required assistance were assisted by nursing and healthcare staff in a timely way. For example, inspectors observed patients being offered assistance with opening desserts, adding butter or seasoning to their meal and with eating their meal. Inspectors observed one visitor providing assistance to their relative during the midday meal.

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 had been served in an appetising way. Inspectors spoke with patients about their views on the quality of food provided in the hospital. Patients spoke positively about how the food tasted. For example, some patients described the food as; 'always fresh and hot', 'portion size good' and 'variety good'. However, one patient told inspectors that they would like more 'soft food' and a second patient said they would like healthier food options.

Hydration and availability of drinks

On the day of inspection, inspectors observed that drinking water was readily available to patients with jugs and glasses of water within easy reach of patients. Hospital managers and multi-task attendants told inspectors that multi-task attendants replenished water jugs in the morning, afternoon and evening. Patients confirmed this to be the case on the day of inspection.

What worked well?

- Patients expressed satisfaction with the quality of the meals served.

- Patients were offered a range of snacks.
- Patients' water jugs were replenished with cool, fresh water frequently throughout the day.

Opportunities for improvement

- Patients should be able to eat their meals without unnecessary interruptions.
- The meal choices available to patients that required pureed and liquidised texture-modified 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 10 patients 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 10 patient healthcare records reviewed by inspectors had a nursing assessment of nutrition and hydration completed within 24 hours of admission. Inspectors found

where patients required a specific therapeutic diet; this was noted in the nursing assessment.

The hospital stated in its completed self-assessment that the Malnutrition Screening Tool (MST) was implemented in four wards. Hospital managers told inspectors that all wards were screening patients for their risk of malnutrition and that they were considering implementing the Malnutrition Universal Screening Tool (MUST) which is the recommended screening tool according to the national guidelines to replace the MST.⁽⁴⁾

On the day of inspection, inspectors found that it was practice to screen patients on admission and re-screen weekly. Inspectors found that the MST formed part of the hospital's Pressure Ulcer Assessment Tool and was not assessed independently. This meant that the MST score was not recorded as an individual score, but formed part of the pressure ulcer assessment score.

Of the 10 healthcare records reviewed, five patients had been screened for their risk of malnutrition using the MST. One patient's record had no screening carried out on admission and the remaining four records had a partially completed MST score documented.

Of the 10 healthcare records reviewed by inspectors, nine patients had been admitted for more than one week. As such, each of these should have been re-screened for their risk of malnutrition in line with national guidelines. However, inspectors found that four out of these nine patients had been re-screened for their risk of malnutrition.

Inspectors found that of the 10 healthcare records reviewed, seven patients were weighed on admission, one did not have their weight documented as the patient was transferred to the Intensive Care Unit. There were no documented reasons given for not recording the weight of the other two patients.

Inspectors were given a sample copy of the hospital's 'intake and output record' that was used to record patients' fluid intake and output. They were also given a copy of a 'food and fluid record chart' from the hospital's Department of Nutrition and Dietetics. Of the 10 healthcare records reviewed, two indicated that a food chart was required. Inspectors found that one of the two food charts used semi-quantitative measures as per the national guidelines and the other was not fully complete and up-to-date.⁽⁴⁾ Seven patient healthcare records contained an intake and output record to record fluid intake and output, all of which used quantitative measures. However, of the seven, three were not fully completed and up-to-date, as they had not calculated the patients' total daily fluid balance.

Equipment for screening

Inspectors observed the equipment available for staff to weigh patients. Both of the wards inspected had a chair scales and a standing scales. One standing scales was new so had not required calibration at the time of inspection. The other standing scales and both of the chair scales observed by inspectors had not been calibrated within the past 12 months as required.

Patient referral for specialist assessment

As part of the on-site inspection programme, inspectors reviewed the systems in place to refer patients, who required specialist nutritional assessment, to a dietitian. Hospital managers and nursing staff told inspectors that patients with an MST score between three and five were referred to the dietitian by the medical team. Patients with a MST score of two were commenced on a high calorie high protein diet.

Dietitian assessments were highlighted in the records with a purple sticker and of the 10 healthcare records reviewed, five contained a documented assessment of the patient by a dietitian. As none of the records contained a date of referral to the dietetic services it was not possible for inspectors to determine the length of time a patient had to wait to be assessed by a dietitian.

Hospital managers and ward staff reported that patients were generally seen by the dietitian within forty-eight hours of referral but that some patients who were deemed low priority for assessment by a dietitian could, on occasion, be discharged home without being seen. These patients were either seen by a dietitian in the hospital's outpatients department or referred to dietetic services in the community.

Opportunities for improvement

- Screening and rescreening patients for their risk of malnutrition in line with national guidelines.
- Accurate and complete recording of food and fluid charts.
- Weighing equipment needs to be calibrated within the required timeframes.

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 a patient's nutrition and hydration needs in the nursing admission and assessment documentation including any specific dietary requirements. Nursing staff told inspectors that information regarding patients' specific diets was communicated to catering staff via a white board in the ward kitchen. Patients' dietary needs were also communicated at nursing handover.

Inspectors observed information on texture-modified diets displayed on laminated information sheets over patients' beds to ensure that patients received the correct texture modified diet and minimise the risk of patients getting the wrong meal. Staff reported that the systems in place to communicate dietary needs worked well and that patients always got the correct meal. All 18 patients who spoke with inspectors confirmed that they received the correct meal at mealtimes.

However, during the inspection, inspectors viewed the lunch order sheet and noted that patients' meal choices were recorded on a diet sheet with reference to the patients' bed number but the space to record patients' names had not been completed.

Patients safety incidents in relation to nutrition and hydration

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

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 stated in its completed self-assessment questionnaire that it had a Nutrition Steering Committee that had met twice in 2014. However, at the time of submitting the self-assessment tool, no meetings of the Committee had taken place during early 2015 due to the retirement of the Dietitian Manager. Following the submission of the self-assessment questionnaire, the Nutrition Steering Committee reconvened in October 2015 with an Assistant Director of Nursing as Chair. In the

weeks prior to inspection, the hospital had recently appointed a new Dietitian Manager who now chairs the Committee.

The Nutrition Steering Committee has agreed terms of reference that detailed the purpose, membership, reporting structures, meeting frequency and values of the Committee. The purpose of the Committee was to address the requirements of national guidelines and to provide a forum for raising the profile of nutrition within the hospital. The terms of reference stated that the Nutrition Steering Committee was to meet quarterly. Inspectors reviewed the minutes of meetings and noted that seven meetings had taken place since October 2015. There was representation on the Committee from all disciplines of staff as recommended in the national guidelines with the exception of an occupational therapist and pharmacy staff.⁽⁴⁾

The Nutrition Steering Committee's terms of reference also provided for the setting up of nutrition working groups to focus on particular areas related to nutrition and hydration that required improvement. On the day of the inspection, hospital managers told inspectors that four working groups would be set up to progress on quality improvement initiatives. However, at the time of the inspection these working groups had not yet met.

The Nutrition Steering Committee had conducted a self-assessment on nutrition and hydration practices within the hospital in December 2015. This outlined areas requiring improvement, the action required, who was responsible for each action and the timeframe for completion. Inspectors were given a progress report from May 2016 and while there was evidence that some progress had been made in relation to some actions outlined within the action plan, many actions were still awaiting implementation.

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, Midland Regional Hospital Mullingar had a policy on nutrition screening and policies on the use of oral nutritional supplements, the commencement of nasal gastric feeding or total parenteral nutrition during out of hours. Hospital managers told inspectors that the hospital was in the process of developing a number of

additional nutrition and hydration policies and that a Policies, Procedures and Guidelines Group was established in December 2015 to assist in this process.

Mullingar Regional Hospital needs to develop a comprehensive suite of policies as a priority in relation to nutrition and hydration care to guide staff and standardise 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 although a software package to analyse the nutrient content of food was in place, the hospital had yet to carry out such an audit on patient food. An audit on portion size had also not been undertaken.

The hospital gave inspectors copies of two audits carried out in 2014 and 2016 in relation to compliance with screening patients for their risk of malnutrition. The first audit in August 2014 showed that out of 30 patients, 60% had an MST score completed and 80% were weighed (it was unclear from the data whether the patient was weighed on admission). Of 23 patients who should have been rescreened, ten were rescreened.

The most recent audit carried out on two wards in January 2016 looked at 12 patients and found that screening had not been completed for 11 patients. This audit also looked at the recording of patients' weights and found that seven out of 12 patients had been weighed. The need for hoist weighing equipment and staff education on malnutrition screening was highlighted in this audit report.

The hospital had completed an audit in October 2014 entitled 'facilitating food and nutrition care and safe eating, drinking and swallowing' in relation to patients' mealtime experience. The tool detailed 27 questions for staff to complete in relation to patients' mealtime experience, for example if patients got assistance with meals, whether patients got the correct meal and whether patients' specific diet requirements were recorded. However, inspectors found that although a detailed audit tool had been developed, the data had not been analysed and presented in a report with recommendations for practice improvement and this audit had not been repeated to date.

Overall, the hospital could further develop the system of audit for nutrition and hydration care for patients. In particular, this includes auditing compliance with screening patients for their risk of malnutrition on a more regular basis to identify areas requiring further attention. This also includes conducting audits in other areas of nutrition and hydration care as identified by the Nutrition Steering Committee and auditing the nutrient content and portion sizes of hospital meals to provide assurance to the hospital that nutrition and hydration practices reflect national guidelines and hospital policy.

Evaluation of patient satisfaction

Hospital managers told inspectors that the hospital had recently carried out a patient satisfaction survey that focused on environment, menu choice and meal services. Inspectors were provided with a copy of this survey from May 2016. The survey included four specific questions relating to meal service within the hospital.

The results of the survey showed that patients were happy with the meal choices and portion sizes offered and more than half of the patients surveyed agreed with changing the main meal of the day from midday to the evening time (58% agreed with changing the mealtime and 42% disagreed). Inspectors found that the results of the patient survey had been discussed at the most recent Nutrition Steering Committee meeting and one of the Nutrition Working Groups had been assigned to respond and address these findings.

The hospital's Nutrition Steering Committee should continue engaging with patients and consider further methods, in particular when introducing changes to the current menu and food service, to ensure that the patients' experience of the food and meal services informs the hospital's Nutrition Steering Committee quality improvement programme.

Quality improvement initiatives

Inspectors found that the Nutrition Steering Committee had a clear action plan that focused on quality improvement issues identified by the hospital during the completion of the self-assessment tool. Inspectors noted and hospital managers confirmed that a greater emphasis was placed on this action plan following the recent appointment of the Dietitian Manager and the introduction of the four Nutrition Working Groups.

What worked well?

- The hospital had a Nutrition Steering Committee in place.

Opportunities for improvement

- A structured programme of audit for nutrition and hydration care, including regular audits on screening patients for their risk of malnutrition and audit of the nutrient content and portion sizes of meals could provide the Committee with assurance that nutrition and hydration care practices reflect national guidelines and hospital policy.
- The hospital needs to develop a comprehensive suite of policies and procedures in relation to nutrition and hydration care to guide staff and standardise nutrition care and meal service provision at the hospital.
- The hospital should ensure that quality improvement projects as outlined in the quality improvement plan targeted at improving the nutrition and hydration care of patients at Midland Regional Hospital, Mullingar are implemented.

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 that specific training was provided to staff through lectures and workshops. The hospital also indicated that catering staff received training in the preparation of special and restrictive menus.

On the day of inspection, hospital managers and nursing staff told inspectors that training on the MST had been given to clinical nurse managers and it was their responsibility to train nursing staff and healthcare assistants working on their wards on an informal basis. Nursing staff confirmed this on the day of inspection and told inspectors that they were provided with training on an informal basis on screening patients for their risk of malnutrition at induction and in the last number of weeks. Nursing staff also told inspectors that they had training on how to thicken fluids. Inspectors viewed training records and found evidence that nurses and healthcare assistance attended training on malnutrition screening.

Hospital managers told inspectors that multi-task attendants were provided with some training on nutrition and hydration practices relevant to their role and inspectors confirmed this from viewing training records.

Opportunities for improvement

- Structured and specific training on nutrition and hydration in line with national guidelines needs to be provided to all staff involved in patient care.

Conclusion

Overall, inspectors found that the Midland Regional Hospital, Mullingar had recently re-established the hospital's Nutrition Steering Committee who had devised a plan for quality improvement in relation to nutrition and hydration practices at the hospital. However, the hospital now needs to implement a number of improvements in relation to nutrition and hydration care. In particular, the development and implementation of a comprehensive suite of policies and procedures in relation to nutrition and hydration care to guide staff and standardise practice. Although the hospital was screening patients for their risk of malnutrition, a recent audit in January 2016 showed that compliance with this was poor and needed improvement.

HIQA recognises 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. Patients who spoke with inspectors were satisfied and complementary about the food and drinks they received. Patients also reported that they were satisfied with the choice offered. However, inspectors found that the choice and variety of texture-modified diets was limited.

Inspectors reviewed a small sample of patient healthcare records and found that although these patients were screened for their risk of malnutrition, only half (five out of ten) had their screening scores completed accurately and not all patients were rescreened for their risk of malnutrition in line with national guidelines.

Inspectors found that the hospital had recently audited compliance with screening patients for their risk of malnutrition and some aspects of patients' experience of food services. However, the hospital did not have a structured approach to conduct regular audits of nutrition and hydration practice to improve the quality of service delivered.

Hospital management must now progress with the implementation of quality improvement projects targeted at improving the nutrition and hydration care of patients at Midland Regional Hospital, Mullingar. Improvements should include the development of evidence-based policies, a structured approach to conducting regular audits which includes the auditing of the nutrient content and portion size of meals in line with national guidelines. A key feature of this improvement process is the evaluation of patients' experience of nutritional and hydration care and using patients' views to inform and direct change or to reinforce good practices where they exist.

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