



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# **Report of the unannounced inspection of nutrition and hydration at Tallaght Hospital, Dublin**

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

Date of on-site inspection: 18 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.



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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.<sup>(1)</sup> 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.<sup>(2)</sup> 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](http://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.<sup>(1)</sup> The inspection approach taken by HIQA is outlined in guidance available on HIQA's website, [www.hiqa.ie](http://www.hiqa.ie) – *Guide to the Health Information and Quality Authority's review of nutrition and hydration in public acute hospitals*.<sup>(3)</sup>

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

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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*.<sup>(1)</sup>

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 Tallaght Hospital on 18 August 2016 by authorized persons from HIQA, Dolores Dempsey-Ryan, Aoife Lenihan, Paul Dunbar and Conor Dennehy, between 10:10hrs and 16:00hrs.<sup>(1)</sup>

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 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 13 patients, their relatives when present and 10 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* <sup>(1)</sup> 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 reasons.

### Meal service and timing of meals

In-house staff provided catering services at the hospital. Cook-fresh and cook-chill food production systems were in use and meals were centrally plated.\* The mealtimes reported in the hospital's self-assessment questionnaire were as follows:

- Breakfast: 7.30am-8.30am
- In between meal snack: 10.45am-11.45am
- Midday meal: 12.10pm-1.00pm
- In between meal snack: 3.00pm-3.30pm
- Evening meal: 5.10pm-5.45pm
- Evening snack: 8.45pm-9.15pm

National guidelines recommend 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.<sup>(4)</sup> Catering staff and hospital

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\* 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-chill" food service system involves chilling the food after it is cooked and re-heating the food prior to serving. Centrally plating food involves placing food onto plates at one central location, such as the hospital kitchen.



management told inspectors that the main meals were served between the times stated in the completed self-assessment questionnaire. Inspectors found that the hospital was adhering to best practice guidelines with a four hour interval between the three main meals of the day.

Inspectors spoke with 13 patients regarding the spacing and timing of mealtimes and eight patients told inspectors that they found the mealtimes were too early. The remaining five patients said that meals were served at suitable times. Hospital management informed inspectors that they were looking at the timing of meals following patients' feedback from the 'Zero Harm starts with Good Nutrition and Hydration 2016 Campaign' where a number of patients highlighted that evening meals were too early and not all wards had an afternoon tea round.

The hospital had not implemented a protected mealtime's policy<sup>†</sup>, but nursing staff informed inspectors that interruptions from medical or nursing staff rarely occurred during mealtimes. Inspectors spoke with 13 patients and while some patients said they experienced no interruptions to their mealtimes, other patients said they did have their meals interrupted. During the course of the meal observed, nursing staff were carrying out medication rounds on one ward inspected. Cleaning staff were also observed to be carrying out their duties in the wards and patients' rooms during the course of the midday meal. This was not wholly considerate of patients' needs.

## **Choice and variety of food**

The hospital stated in its completed self-assessment questionnaire that menu options were outlined to patients by menu cards. On the day of inspection, catering staff told inspectors that they verbally communicated the menu choices to patients the day before the meal was served, for example, the menu for Wednesday's meals were outlined to patients on Tuesday afternoon.

Inspectors viewed the daily menu cards which rotated on a weekly basis. Patients on a normal diet were provided with four or five options for their midday meals. Inspectors noted that while the vegetables served with the main meal varied from day to day, creamed potatoes were served every day. Patients could choose from a

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<sup>†</sup> 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.

variety of desserts. For the evening meal, four or five choices were presented with options including a sandwich, salad and a hot meal.

Inspectors also reviewed menus for patients requiring a specific therapeutic diet, for example a renal or gluten free diet, and noted that such patients were also provided with three to five choice of meals. A healthy choice menu was also available. On the day of inspection, patients who spoke with inspectors confirmed that they got a choice of meals.

Texture-modified diets<sup>‡</sup> include meals that are suitable for patients with swallowing difficulties of varying severity. Menus should include choices for patients who require texture-modified diets.<sup>(4)</sup> Hospital managers told inspectors that texture-modified meals were prepared onsite and moulded in the shape of the original food items; for example, pureed carrots were in the shape of carrots. Inspectors observed texture-modified meals served to patients, which were presented in moulds and looked appetising.

Catering and nursing staff told inspectors that choices were available for patients on a texture soft diet, but were limited for patients on other texture-modified diets. Inspectors viewed the texture-modified meal menus and noted that patients on a texture-modified soft diet were offered three choices for lunch and four choices for their evening meal. However, patients on a minced, moist, and smooth puréed diet only had one option for the midday and evening meals.

Overall, inspectors found that there was a range of choices available to patients on standard and therapeutic menus. However, the choice for some patients requiring texture-modified diets was limited.

Best practice guidelines suggest that high-calorie snacks should be offered between meals, mid-morning, mid-afternoon and late evening.<sup>(4)</sup> 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, nursing and catering staff told inspectors that a snack consisting of tea and biscuits was offered to patients on all wards between meals and in the evening. Soup was also offered to patients between the morning and midday meals.

Patients who had been assessed by a dietitian as requiring high protein, high calorie snacks were given additional snacks. In addition, the hospital's MUST screening tool directed staff to give patients who were at medium or high risk of malnutrition

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<sup>‡</sup> Texture-modified diets may include soft diets, minced and moist diets, smooth pureed diets and liquidized diets due to swallowing difficulties.

nourishing snacks. Nursing staff told inspectors that these could be ordered from catering staff, for example rice pudding, cheese and crackers and or muffins. Inspectors observed a snack round before the midday meal and noted that such snacks were present on the snack trolley.

Inspectors asked patients if they were offered snacks. Of the patients inspectors spoke with, the majority said they were offered tea and biscuits as a snack between meals in addition to soup, which was served before the midday meal. However, two patients were unsure if they were offered any afternoon snack and a third patient said that they were not offered any snacks throughout the day. Inspectors found that one ward served afternoon snacks while the other ward did not.

Overall, inspectors found that snacks were offered to patients. However, unless patients were identified as being at risk of malnutrition, the snacks offered to patients were limited to tea and biscuits or soup in the morning.

## **Missed meals**

Hospital managers told inspectors that if a patient missed a meal they could obtain a hot replacement meal from kitchen until 7pm. However, a number of ward staff were unaware of this and told inspectors that if patients missed their meal they could be offered sandwiches or toast. Other staff said that a replacement meal could only be obtained from the kitchen until 2:30pm. Of the 13 patients spoken with by inspectors, nine patients reported missing a meal during their hospital stay. All nine indicated that they were facilitated with a replacement meal with five of these patients stating that received either a sandwich or tea and toast.

Overall, while the hospital that they had a system in place where a hot replacement meal could be obtained from the kitchen when a patient missed a meal, not all ward staff were aware of this system.

## **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.<sup>(1)</sup> 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 <sup>¥</sup> meals on request. Vegetarian meals were also available in the hospital.

## **Assistance**

The hospital stated in its completed self-assessment questionnaire that assistance from staff to support patients at mealtimes was sometimes available.<sup>§</sup> Hospital managers and nursing staff told inspectors that nurses and healthcare assistants provided assistance to patients. Hospital managers told inspectors that there were adequate numbers of staff to provide assistance to patients and that daily checks were made on the levels of staff available to provide assistance. Nursing staff who spoke with inspectors said that staff breaks were organised outside of meal times to ensure staff were available to provide assistance to patients with meals.

Nursing staff on both wards visited told inspectors that delays in providing assistance could occur due to a shortage of staff. Hospital managers and nursing staff told inspectors that information regarding which patients required assistance with meals was communicated at nursing handover, through nursing assessment documentation and care plans.

None of the 13 patients who spoke with inspectors indicated that they required assistance with their meals. 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 two patients who required assistance during the midday meal and noted that assistance was provided in a discreet and sensitive manner. Nursing staff and healthcare assistants were also seen to offer assistance throughout the mealtime.

## **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.<sup>(4)</sup> On the day of inspection, inspectors observed meals as

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<sup>¥</sup> Halal food refers to meat prepared as prescribed by Islamic law.

<sup>§</sup> The self assessment questionnaire offered the following four options to answer the question on the availability of support: always; mostly; sometimes; never.

they were being served (meals served on the day of inspection included bacon and cabbage and chicken and mushroom pie). While some meals were observed to be presented in an appetising manner, it was observed that other meals appeared overheated and dry. For example, one meal of salmon served with potatoes and vegetables appeared dry, and there was scorch marks on the plate. In addition, a dish of rice pudding observed appeared congealed.

Inspectors spoke with 13 patients about their views on the quality of food provided in the hospital. Of the 13 patients interviewed, eight patients were satisfied and five patients were dissatisfied with the quality of the food offered. While some patients described the food as 'warm and nutritious' and 'hot', other patients told inspectors that the food was 'stuck to the plate' and described some meals served as 'dry'. These findings were consistent with some of the findings from the hospital's Food Service Survey 2015. Overall, inspectors found that patients offered mixed views on the quality of food served.

## **Hydration and availability of drinks**

On the day of inspection, inspectors observed that drinking water was readily available to patients with jugs of water within easy reach of patients. Hospital managers, catering and nursing staff told inspectors that water jugs were replenished with fresh water in the morning and refilled throughout the day if required by catering staff. The patients that spoke with inspectors confirmed this to be the case. In general, inspectors were satisfied that patients had access to sufficient hydration throughout the day.

## **What worked well?**

- Water jugs were replenished with fresh water during the day.

## **Opportunities for improvement**

- The hospital needs to review and improve the patients' experience of the food served and the timing of meals.
- Some staff were unaware that patients could be provided with a hot replacement meal.
- Reduce unnecessary interruptions to mealtimes across the hospital wards.

- All patients should be given a choice of meal including those that require a texture-modified diet.

## **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.<sup>(4)</sup>

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 that where a patient required a specific therapeutic diet, it was noted in the nursing assessment.

The hospital stated in its completed self-assessment questionnaire that a number of malnutrition screening tools were in use throughout the hospital. However, on the day of inspection nursing staff advised that the Malnutrition Universal Screening Tool (MUST) was the only tool being used for screening. The MUST is the recommended screening tool according to the national guidelines.<sup>(4)</sup> Malnutrition screening was not carried out on every ward in the hospital. However, both of the wards visited by inspectors on the day of inspection were screening all patients for their risk of malnutrition. It was hospital practice to screen all patients within 24-hours of admission and re-screen those patients who were identified as being at risk of malnutrition weekly. The MUST tool was a separate document included in patients' healthcare records. Staff advised inspectors that they inputted each patient's weight

and height measurements with other details into an online calculator which calculated the MUST score which was then recorded in the patient's healthcare records.

Of the 10 healthcare records reviewed, five patients had been screened for their risk of malnutrition. Four records had no evidence of malnutrition screening. One record did not contain a screening record as the patient had not been admitted for more than 24-hours at the time of inspection. These findings concur with the hospital's MUST screening audits.

Of the 10 healthcare records reviewed by inspectors, six patients had been admitted for more than one week. As such, each of these patients should have been re-screened for their risk of malnutrition in line with national guidelines. However, inspectors found that only one of these six patients had been re-screened for their risk of malnutrition. Staff informed inspectors that patients were not routinely re-screened if their initial screening showed no risk of malnutrition.

Inspectors found that of the 10 healthcare records reviewed, nine patients were weighed on admission. One patient did not have their weight documented, as they had not been admitted for more than 24-hours at the time of inspection.

Inspectors were given a sample copy of the documents used to record patients' fluid intake and output and food intake. Of the 10 healthcare records reviewed, four indicated that a food chart was required. Inspectors found that all of these food charts were present in the relevant patients' healthcare records. They all used semi-quantitative measures as per the national guidelines and were fully complete and up-to-date.<sup>(4)</sup> This concurs with the hospital's nutritional two monthly audit findings where the results were 100% for both wards inspected.

Four patient healthcare records contained a fluid intake and output chart. All four of these charts used quantitative measures as recommended. However, none of the records were fully complete, as they had not documented the total fluid balance at the end of the day.

## **Equipment for screening**

During this inspection, inspectors observed some of the required equipment used to screen patients for the risk of malnutrition. This included weighing scales, chair scales (for more frail and dependent patients), stadiometers<sup>◇</sup> and measuring tapes.

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<sup>◇</sup> A device for measuring a person's height.



Both of the wards inspected had a functioning chair scales which had been calibrated within the past year. One ward had a hoist scales which was calibrated appropriately while staff on the other ward advised that they had access to a hoist scales if required. One ward had access to a stadiometer whilst the other ward did not. Height was estimated on this ward by measuring the length of the patient's forearm (ulna length) and they had access to a measuring tape to measure this.

## **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. Staff also used their clinical judgment to refer patients to dietetic services. For example, patients on special diets or who had surgery. Speech and language therapy referrals were made if staff had concerns about a patient's ability to swallow and they required a swallowing assessment. Staff made referrals via a computerised system.

Dietitian assessments were highlighted in the records with a purple sticker and of the 10 healthcare records reviewed; seven contained a documented assessment of the patient by a dietitian. Inspectors referred to the computer system to identify when each of these patients were referred for assessment. Two patients were seen on the same day as being referred; two patients were seen within a day; two patients were seen within two days; and one patient was seen after six days.

Hospital managers and ward staff reported that patients were seen promptly by the dietitian. The hospital used a priority rating system to prioritise referrals and aimed to see high priority referrals (i.e. those who require Parenteral Nutrition Support and or Enteral Tube Feeding) within 24 hours of referral. Patients who were deemed low priority for assessment by a dietitian could, on occasion, be discharged home without being seen. These patients were referred to their general practitioner (GP) for follow up care with community services.

Five patient records had a documented assessment by the speech and language therapy department which were marked with red stickers. Of the five, one was seen on the same day as assessment; one was seen within a day and another was seen within two days. Inspectors could not obtain referral dates for the remaining two records. Hospital managers and nursing staff told inspectors that patients referred to the speech and language therapist were seen in a timely manner, and where a patient's experienced swallowing difficulties; they were reviewed immediately following referral.

## **What worked well?**

- Nursing assessments of nutrition and hydration were carried out for all patients on admission.
- All food charts observed by inspectors used semi-quantitative measures, were fully completed and up-to-date.
- All patient records reviewed by inspectors had a documented weight within 24-hours of admission.
- There was good access to dietetic and speech and language services.

## **Opportunities for improvement**

- The hospital should introduce malnutrition screening for all patients including rescreening patients for their risk of malnutrition during their hospital stay in line with national guidelines.
- Fluid intake records should be complete and up to date.
- All wards should have access to equipment to measure patients' heights.

## **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 displayed various diet-related information including whether the patient required a texture-modified diet or high-calorie high-protein diet. Catering staff advised that nursing staff or dietetic staff updated this board as required. Colour-coded menu cards were given to patients in the morning so they could choose what they wanted to eat for the following day. These cards were conveyed to the kitchen and were placed on patients' trays upon serving. However, of the 13 patients who spoke to inspectors, three patients advised that they did not always receive the correct meal.

In one of the wards visited by inspectors, it was observed that there was dietary information posted on the entry to the rooms. The information consisted of a whiteboard, which listed the bed numbers and the dietary requirements alongside the bed numbers. Information observed on this board by inspectors included 'fasting' or 'sips of water'.

During the midday meal service, inspectors observed one instance of a patient not receiving a meal because the catering staff were under the impression the patient was fasting as the patient was listed as fasting on the whiteboard, but the patient advised staff that they were no longer fasting. Another patient had a meal served on the bed tray table and it was left there for about ten minutes. The inspector informed a member of the nursing staff and they removed the tray, as the patient was too unwell to eat. A third patient was observed being offered the wrong meal as they had moved to a different bed, but this was corrected immediately.

Overall, inspectors found that there needs to be a more reliable system of communication of patients' dietary needs at a ward level that is not so reliant on nursing and catering staff vigilance, particularly when a patient's needs change or if a patient has moved to a different bed.

## **Patients safety incidents in relation to nutrition and hydration**

Hospital managers and nursing staff reported that no patient safety incidents had been reported or written complaints received from patients in relation to nutrition and hydration in the last 12 months. However, on the day of inspection, inspectors noted that there was evidence in a patient's healthcare records that a patient who

required a minced moist diet had experienced a choking incident from receiving a meal that was not suitable. The patient required assessment by a speech and language therapist as a result, and although they did not experience ongoing harm from this incident, inspectors were not satisfied that this incident was reported appropriately via the hospital's incident management system to ensure that this error was not repeated. The incident had also not been relayed to the ward manager. Concerns in relation to this particular issue were raised with hospital management during the course of the inspection by inspectors.

## **Opportunities for improvement**

- There needs to be more effective communication of patients' dietary needs, particularly when patients' dietary needs change, to ensure patients received the correct meals.
- The hospital should ensure that healthcare staff are aware of what constitutes a patient safety incident and report such incidents including near misses, such as the delivery of an unsuitable meal to patients requiring modified consistency food or special therapeutic meals.

## **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.<sup>(1)</sup> 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.<sup>(1)</sup> 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.<sup>(4)</sup>

Best practice guidelines recommend that hospitals form a nutrition steering committee to oversee nutrition and hydration care in acute hospitals.<sup>(4)</sup> 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 2014 and chaired by the Director of Quality, Safety and Risk. It had agreed terms of reference that detailed the purpose, membership, reporting structures, meeting frequency and functions of the Committee. The purpose of the Committee was to oversee the implementation of the recommendations of the national guidelines<sup>(4)</sup> for preventing under-nutrition in Tallaght Hospital.

Hospital managers told inspectors that the Nutrition Steering Committee reported into the Quality, Safety and Risk Management Executive Committee and that membership of the Nutrition Steering Committee was in keeping with the national guidelines. A number of working groups, which included the Feeding Eating Drinking Swallowing (FEDS) Group, and the Mealtimes Process Review Group reported into the Nutrition Steering Committee.

The Committee had met six times between July 2014 and July 2016 and aimed to meet quarterly. Inspectors requested and reviewed copies of agendas and minutes for the last six meetings. There was a record of discussion and agreed outcomes. The discussions focused on nutrition and hydration policies, MUST screening, development of an electronic meal ordering system, the Zero Harm starts with Good Nutrition and Hydration campaign and the results of audits.

Inspectors viewed the Nutrition Steering Committee's programme of work and noted that key leads and sub-groups were assigned to work on a number of projects such as MUST screening, protected mealtimes, meal-ordering systems and policies. However, while a 'traffic light' system was used to note the status of each project, there were no clear defining timelines set for each group to achieve the Committee's objectives.

## **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.<sup>(1)</sup>

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. The hospital had a food, nutrition and hydration care policy, which included MUST screening and a number of guidelines on fasting patients before surgery and radiological interventions. Hospital managers told inspectors that they planned to develop a MUST screening policy to support the implementation of MUST screening for all patients within 24 hours of admission to 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.<sup>(4)</sup> Hospital managers told inspectors that they were progressing with implementing an electronic meal ordering system — moving to ordering meals on the same day of service — and following completion of this process, they planned to audit the nutrient content and portion size of food.

Inspectors were provided with copies of completed audits in relation to nutrition and hydration and these audits included the Nursing Instrument for Quality Assurance (NIQA) audits, mealtime process audits, and audits of artificial nutritional support (parenteral nutrition and enteral feeding).

Tallaght Hospital had developed a Nursing Instrument for Quality Assurance (NIQA) and this instrument was used to collect and analyze data on each ward every two months. Inspectors viewed the 2016 results relevant to the wards inspected and found that data was collected for a number of quality indicators. Quality indicators used included compliance with recording of patients' weights on admission, MUST assessment and rescreening and documented evidence of referrals to dietitians. Inspectors viewed the results, and noted that they varied from month to month with some of the results highlighting areas for improvement, and other monthly results showed performance on nutritional management as 95-100%. The hospital had completed a three-day audit of MUST screening of patients within 24-hours of admission in July 2016 on both wards inspected. Inspectors viewed the results of these audits and noted that while one ward performed well for screening of those patients identified as having a problem with eating and drinking, the other ward had areas for improvement identified.

While both wards visited during the inspection performed well with regard to recording patients' weights on admission, MUST assessment and rescreening required some improvement.

## **Evaluation of patient satisfaction**

The Catering Department carried out Food Service Surveys in 2015 and 2016. Patients were asked eleven questions and some of these questions related to the variety of the menu offered, correct meal and taste of food to dietary requirements provided. Inspectors viewed the results and noted that with regard to variety and correct meals offered the results varied from audit to audit across both wards. Patients' feedback on the meal service varied and reflected some of what the inspectors found on the day of inspection.

## **Quality improvement initiatives**

Hospital managers told inspectors about a campaign called 'Zero Harm starts with Good Nutrition and Hydration', which took place over three days in the hospital in May 2016. This campaign had been introduced to highlight the essential role that good nutrition and hydration played in the medical care of patients. Posters were designed with information leaflets for patients and staff to communicate the message that 'Zero Harm starts with Good Nutrition and Hydration'. A multidisciplinary team visited hospital wards over a three-day period to talk to patients and staff about the purpose of the campaign. Hospital managers told inspectors that seven quality improvement themes emerged from the campaign and they planned to address these themes through the various working groups that reported into the Nutritional Screening Committee.

Inspectors viewed the results and noted that areas for improvement identified through the seven themes included timing of meals, food and menu comments, availability of water and ice, fasting, meal assistance and mealtimes, weights and MUST screening. Patients' feedback included comments about the evening meal being served too early, and ensuring staff were available to offer assistance with meals. Some patients reported positively on the food, while others requested improvement with the presentation of food, menu choices and review of the meal ordering system to same day meal ordering. Hospital managers told inspectors that they were progressing with the development and implementation of an electronic meal ordering system where patients could order meals on the same day that were served.

Hospitals managers told inspectors that a mealtime process audit had been carried out on one ward to measure the level of support available to patients during the main mealtime service. The hospital subsequently implemented protected mealtimes as a quality improvement initiative on this ward and patient's assistance and support with meals increased from 55% to 85%. The findings of this mealtime audit highlighted the need to review the systems in place on the ward during mealtime service to ensure that staff were available to provide mealtime support to patients. Hospital managers told inspectors that they planned to implement protected mealtimes as a quality improvement initiative on medical and surgical wards.

Inspectors observed that one of the wards visited had introduced a white board as a quality improvement initiative to display, and communicate information on the results of various quality audits. Information displayed was clearly presented in an easy to understand format and contained details for patients and their families about mealtimes and the patients' advocacy service.

### **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 of nutrition and hydration care, including regular audits on screening patients for their risk of malnutrition and patients' experience of mealtimes.
- The hospital had developed a number of policies in relation to nutrition and hydration care to guide staff and standardize nutrition care.

### **Opportunities for improvement**

- The auditing of the nutrient content and portion sizes of the hospital's meals to meet 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.<sup>(4)</sup>



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.<sup>(4)</sup>

## **Training**

The hospital stated in its completed self-assessment questionnaire that specific training was provided to staff through lectures, workshops and from dietitians and speech and language therapists. 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 by dietitians. They reported that clinical facilitators provided training on MUST and nutrition care plans to staff on the wards. Nursing staff confirmed this on the day of inspection and inspectors viewed relevant training records.

Inspectors spoke with catering staff who reported that they had not received any specific training on nutrition and hydration, but had been provided with training on food hygiene.

## **What worked well?**

- Training on MUST was provided to all nurses.

## **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

The inspection team found, on the day of inspection, that Tallaght 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.

Inspectors found, on the day of inspection that the hospital was screening patients for their risk of malnutrition on admission to some wards, but not all wards. Inspectors reviewed a small sample of patient healthcare records on two wards visited, and found that while some patients were screened for their risk of malnutrition, weekly re-screening of all patients had not always been carried out. Screening all patients for their risk of malnutrition and rescreening patients while in hospital should be a key area of focus for improvement by the hospital following this inspection.

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. However, the hospital had not audited the nutrient content and portion sizes of hospital meals as recommended in the national guidelines.

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, but patients on texture-modified diets were offered a limited choice of meals. While some patients were positive about the meals offered, other patients offered negative views on the quality of meals. A small number of patients reported that they had not always received what they had ordered. In addition, inspectors found one incident where a patient on a texture-modified diet received a meal of the wrong consistency. Hospital managers should ensure that effective communication systems are in place so that patients receive the correct meals, this is particularly important for patients that require texture modified diets or special therapeutic diets.

The hospital's Nutrition Steering Committee must continue to implement quality improvement initiatives to improve nutrition and hydration practices, and support the screening of all patients for risk of malnutrition. The hospital had conducted regular audits in relation to nutrition and hydration, but needs to include auditing the nutrient content and portion sizes of meals in line with national guidelines. A key focus for quality improvement is to improve the patients' experience of the food served and mealtimes.

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