



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of nutrition and hydration at South Infirmary Victoria University Hospital, Cork.

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

Date of on-site inspection: 15 November 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

About the health information and quality authority	3
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	18
Theme 6: Workforce	22
Conclusion.....	23
References	25

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:

- All hospitals should have a nutrition steering committee in place.
- All patients admitted to hospital should be screened for the risk of malnutrition.
- 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.
- 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 South Infirmery Victoria University Hospital on 15 November 2016 by authorized persons from HIQA, Dolores Dempsey-Ryan, Siobhan Bourke and Noelle Neville between 10.10hrs and 15.30hrs.⁽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 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 12 patients, their relatives when present and 13 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-fresh and centrally plated food service system was in use.* The mealtimes reported in the hospital's self-assessment questionnaire were as follows:

- Breakfast: 8.00am-9.00am
- In between meal snack: 10.30am-11.30am
- Midday meal: 12.30pm-1.30pm
- In between meal snack: 2.00pm-2.30pm
- Evening meal: 4.30pm-5.30pm
- Late-evening snack and or drink: 7.00pm-10.00pm

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 found that the hospital was not adhering to best practice guidelines with a four hour interval between the three main meals of the day.

* A "cook-fresh" food service system is the standard method for preparing food in hospitals, which involves cooking, plating, and serving food hot. Centrally plating food involves placing food onto plates at one central location, such as the hospital kitchen.

Health Information and Quality Authority

Inspectors spoke with 12 patients regarding the spacing and timing of mealtimes and eight patients told inspectors that they were satisfied with the mealtimes. However, four patients said that meals were served too early.

Hospital managers told inspectors that they had a draft protected mealtime policy in place and had implemented protected meal times[†] on some wards. On the day of inspection, inspectors visited one ward, which had implemented the principles of protected mealtimes. Nursing staff and healthcare assistants told inspectors that non-essential interruptions, such as medication rounds, were changed to a later time to facilitate protected mealtimes. However, inspectors observed nurses doing a medication round and cleaning staff cleaning patients' rooms during the midday mealtime. On the second ward visited where protected mealtimes had not been implemented, inspectors observed non-essential interruptions, such as visitors visiting and a medication round occurring during the mealtime. These findings were consistent with the findings from a recent mealtime audit carried out by the hospital in November 2016.

Of the 12 patients who spoke with inspectors, nine patients experienced no interruptions to mealtimes. However, two patients said that their meals had sometimes been interrupted and one patient said it rarely happened.

Choice and variety of food

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

Inspectors viewed the weekly menus on offer to patients on standard and therapeutic diets, and noted that there were two choices on the menu each day for the midday and evening meal. This was confirmed by the twelve patients who spoke with inspectors on the day of inspection. Hospital managers and catering staff told

[†] 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.

Health Information and Quality Authority

inspectors that if patients expressed dissatisfaction with these options, they were then offered an alternative such as fish, chicken or a vegetarian option.

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⁾ Inspectors viewed the texture-modified menus and noted that patients had only one meal option for the midday and evening meal. However, catering staff told inspectors that if patients did not like the main option, for example, fish, they were offered an alternative such as a beef dish. On the day of the inspection, inspectors observed soft and minced moist meals, and noted that they were presented in an appetising way.

Overall, inspectors found that while patients on normal or therapeutic diets had two choices for their midday and evening meal, there was only one option for patients requiring texture-modified diets. The hospital should ensure that all patients including those on texture-modified diets are offered a choice for all meals.

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 and ward staff told inspectors that there were three daily snack rounds, which included a mid-morning snack, a 5.30pm snack of scones or cakes following the evening meal and a snack at 8pm.

Inspectors viewed a snack menu for patients on a standard, therapeutic, or texture-modified diet. Ward staff told inspectors that information regarding which patients required high protein high calorie snacks was recorded on a daily diet sheet and by use of a coloured card displayed over the patients' bed to identify patients on high protein high calorie snacks. Inspectors observed this practice on the day of inspection. All patients who spoke with inspectors said that they had been offered a variety of snacks which included a drink of tea, coffee or milk with biscuits, yoghurt, buns or cakes. Overall, there was a wide variety of snacks available to all patients including patients on texture-modified diets.

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

Missed meals

Hospital managers and catering staff told inspectors that the hospital had a system in place to cater for patients who missed a meal. Ward staff told inspectors that a meal would be kept aside in the ward kitchen for a patient for a short period. Alternatively, staff could contact the kitchen or the hospital canteen up to 5pm to obtain a replacement meal. Patients were also offered other options such as a salad, tea, toast, sandwich or a snack. One patient who reported missing a meal told inspectors that they had been 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, catering and nursing staff told inspectors that they could provide a choice of Halal[§] and Kosher^{**} meals if requested. Vegetarian meals were also available.

Assistance

The hospital stated in its completed self-assessment questionnaire that assistance from nurses and healthcare assistants to support patients at mealtimes was always available.^{††} Hospital managers and ward staff told inspectors that they had a

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

^{**} Kosher foods are those that conform to the regulations of kashrut (Jewish dietary law).

^{††} The self-assessment questionnaire offered the following four options to answer the question on the availability of support: always; mostly; sometimes; never.

Health Information and Quality Authority

number of systems in place to identify patients who required assistance with meals, which included the following:

- identified through the patient's nursing assessment on admission and recorded in the nursing assessment documentation
- verbally communicated during nursing and healthcare assistant handover
- red tray system to identify patients who required assistance
- red jug to identify patients who were at risk of dehydration
- modified cutlery to assist patients with eating and drinking.

Hospital managers and nursing staff 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. Visitors were also able to visit the ward during meal times to assist their relatives with 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 that nurses and healthcare assistants provided patients with assistance as required. Patients who required assistance with their meals were easily identified as they had their meals served on a red tray. Overall, inspectors were satisfied that the hospital had a number of systems in place to identify patients who required assistance with meals.

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. Inspectors noted that desserts were served separately to the main meal. This practice can support patients (for example patients with dementia) who may choose to eat only the less nutritious sweet foods in place of their meal. Inspectors spoke with patients about their views on the quality of food provided in the hospital. The majority of patients were satisfied with the meal service, for example, some patients used phrases such as; "good food" and "hot food". However, one patient said they did not like hospital food and another patient said the tea was cold.

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

Health Information and Quality Authority

patients. Hospital managers, catering and nursing staff told inspectors that water jugs were replaced with chilled water three times a day. Patients who spoke with inspectors confirmed this. Patients were also served a variety of drinks, which included tea, coffee or milk during the snacks rounds throughout the day. In general, inspectors were satisfied that patients had access to sufficient hydration throughout the day.

What worked well?

- Patients were offered a variety of snacks between meals.
- 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.
- Patients in general spoke positively about the quality of the food.
- Water jugs were replenished with fresh water three times during the day.

Opportunities for improvement

- Patients on texture-modified diets should be offered a choice of meals.
- Reduction of unnecessary interruptions to mealtimes across hospital wards.

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 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 the 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. Nine of the 10 patients' healthcare records reviewed by inspectors included a completed nursing assessment of nutrition and hydration within 24-hours of admission and one was partially completed.

The hospital stated in its completed self-assessment questionnaire that it used the Malnutrition Universal Screening Tool (MUST)⁽⁴⁾ to screen patients for their risk of malnutrition. However, screening was limited to patients assessed as being at risk of pressure ulcer development using the Braden Scale as part of the skin bundle for pressure ulcer prevention.^{**} Hospital managers and nursing staff told inspectors that it was hospital policy to complete the Braden score on all patients on admission, and use the MUST tool to screen patients with a Braden score of less than 18 for their risk of malnutrition. This meant that not all patients were being screened for their risk of malnutrition within 24-hours of admission. Hospital managers told inspectors that they had set up a working sub-group and planned to introduce MUST screening on a phased basis to screen all patients for the risk of malnutrition using the MUST tool.

Both wards visited by inspectors were screening patients for their risk of malnutrition using the MUST tool which formed part of the skin bundle for pressure ulcer prevention. Of the 10 healthcare records reviewed by inspectors, three belonged to patients who had a fully completed MUST assessment as their Braden score was less than 18, the remaining seven healthcare records belonged to patients with Braden scores greater than 18.

^{**} Braden Scale for Predicting Pressure Ulcer Risk is a tool that was developed to help health professionals assess a patient's risk of developing a pressure ulcer. The tool includes an assessment of nutritional status looking at normal patterns of daily nutrition.

Health Information and Quality Authority

Of the 10 healthcare records reviewed by inspectors, all patients had their weight recorded on admission. Six healthcare records belonged to patients who had been admitted for more than one week and all these patients were reweighed. Three of these six patients were rescreened using the MUST tool for their risk of malnutrition as their Braden score was less than 18. One of the six patients who had been reweighed had lost weight during their hospital stay and also had a Braden score of less than 18 following reassessment. This patient was subsequently screened for their risk of malnutrition using the MUST screening tool and referred to a dietitian.

Five of the ten healthcare records reviewed contained fluid intake and output charts which used quantitative measures as recommended by national guidelines. Four out of these five charts were complete and up-to-date and one was incomplete. Two healthcare records contained food charts and both used semi-quantitative measures as recommended by the national guidelines and were complete and up-to-date.

Overall, inspectors found that the hospital was screening some patients for their risk of malnutrition as part of their skin bundle for pressure ulcer prevention. The hospital needs to proceed with the implementation of MUST screening for all patients for their risk of malnutrition in line with national guidelines.

Equipment for screening

During the inspection, inspectors observed 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. Such weighing equipment was easily accessible on both wards visited. However, not all equipment observed by inspectors indicated that they had been calibrated within the last 12 months.

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. Patients with a MUST score of two or more were routinely referred to a dietitian.

Of the 10 healthcare records reviewed, five belonged to patients who required dietetic referral. Four of the five patients were referred to a dietitian because of their

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

Health Information and Quality Authority

low Braden score and one patient, who had a normal Braden score on admission, was referred to the dietitian for clinical reasons. All five patients had been seen on the same day of referral.

Four patient healthcare records contained swallowing assessments by a speech and language therapist. All four patients were seen on the same day of referral.

The Speech and Language Department had audited their referral assessment times in March 2016. Inspectors viewed the audit results and noted that 90% of patients were seen within one working day of receipt of a referral and all other patients were seen within two working days of receipt of referral.

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

What worked well?

- Staff had access to appropriate equipment to measure patients' weight.
- There was timely access to dietetic and speech and language therapy services.

Opportunities for improvement

- Screening all patients admitted to the hospital for their risk of malnutrition using a validated screening tool as outlined in the national guidelines.
- The calibration of weighing equipment on a yearly basis or as per manufacturer's instructions.

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:

Health Information and Quality Authority

- 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

Hospital managers and staff outlined the communication systems in place to communicate patients' dietary needs between staff to ensure that patients received the correct meals. On admission, information about patients' nutrition and hydration status, including their dietary needs was documented in the nursing assessment documentation. The skin bundle for pressure ulcer prevention also included a section regarding patients' nutrition and hydration status.

A daily diet sheet listed patients' names, their bed numbers, whether patients required a red tray to highlight that they 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 daily diet sheet for catering staff. Hospital managers told inspectors that a standardized meal order sheet was used on all wards to collate patient meal orders and this was sent to the kitchen. Each meal that was sent to the ward was labelled with the patients' bed number and coloured stickers were used to highlight therapeutic meals.

Inspectors saw colour coded signs displayed over patient beds to aid identification of a patient on a therapeutic diet to ward staff. Inspectors also saw colour coded cards on the meal trolleys which were used as a reference for staff to ensure that patients received the correct meal. All patients who spoke with inspectors stated that they had always received the correct meal. On the day of the inspection, inspectors observed patients who required a specific diet receiving the correct meal.

Patients safety incidents in relation to nutrition and hydration

There was a system in the hospital for reporting patient safety incidents related to nutrition and hydration care. Hospital managers and nursing staff reported that there had been one patient safety incident reported in relation to nutrition and hydration care in the last 12 months. This incident did not result in harm to the patient involved.

Hospital managers told inspectors that there were no complaints received in relation to nutrition and hydration in the last 12 months and that the hospital had a system in place to manage complaints in the event of any arising.

What worked well?

- There were systems in place to ensure patients received the correct 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.⁽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 they had a Nutrition Steering Committee in place. Hospital managers told inspectors that the Nutritional Steering Committee was established in 2009 and its members included

Health Information and Quality Authority

dietitians, speech and language therapists and catering staff. In 2015, the Committee increased its membership to include nursing staff, a risk manager, and a patient liaison officer. Hospital managers told inspectors that the Nutrition Steering Committee had access to advice from medical and pharmacy staff if required.

The Nutritional Steering Committee had agreed terms of reference that detailed the membership, functions and responsibilities of its members, meetings and record keeping. The functions and responsibilities of this Committee were to work as a multidisciplinary team to provide optimal nutritional and hydration care to acute patients in South Infirmity Victoria University Hospital.

The Nutrition Steering Committee had met seven times in 2016, and aimed to meet every two months. Inspectors requested and reviewed copies of agendas and minutes for the last six meetings; all meetings had been minuted. Inspectors noted that each action plan had a lead person assigned to implement quality improvement initiatives, audit nutrition and hydration practice, and develop relevant policies. These plans had detailed notes on progress to date.

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 ward staff had access to hard copies of hospital policies on the ward. The hospital had some policies relating to nutrition and hydration care in place, including nutrition and oral hydration policy. The Malnutrition Universal Screening Tool (MUST) for screening patients for their risk of malnutrition formed part of the guidelines for pressure ulcer prevention. Hospital managers told inspectors that they had policies on fasting and protected mealtimes in draft format.

The hospital needs to progress with the approval and implementation of a comprehensive suite 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 had completed an audit of the nutrient content and portion size of meals on the standard menus in May 2016 and high protein high calorie menus in June 2016 and inspectors viewed copies of these audits. The results of these audits highlighted that standard menus and high protein, high calorie menus were not in line with national guidelines.⁽⁴⁾ Hospital managers told inspectors that meals were subsequently fortified to ensure that they met nutritional requirements.

Inspectors were provided with copies of other completed audits in relation to nutrition and hydration care. These included:

- Compliance of texture-modified diets with national descriptors,⁽⁵⁾
- Referrals to speech and language therapists,
- Mealtime audit,
- Observational audit of interruptions of patients' meal times,
- Meal ordering system and identification of patients on therapeutic diets,
- Oral nutritional supplements,
- Vending machine food and drink products.

Inspectors viewed a 2015 audit result of the meal ordering system and identification of patients on therapeutic diets. The audit result highlighted that over 50% of wards in the hospital had neither a standardized meal ordering system in place or system to place a discreet coloured card over patients' beds to identify patients on therapeutic diets. This meant that errors could occur whereby a patient might receive the wrong meal. Hospital managers told inspectors that following this audit, a standardized meal ordering system was introduced across the hospital, and all wards had implemented coloured cards which were displayed in frames over patients' beds to identify patients on therapeutic diets. This was confirmed by ward staff on the day of inspection.

Overall, inspectors found that the hospital had carried out a number of nutrition and hydration audits including auditing the nutrient content and portion size of food in line with national guidelines. However, the hospital had not audited compliance with

Health Information and Quality Authority

their MUST screening tool as part of the skin bundle for pressure ulcer prevention. The programme of audit of nutrition and hydration care should be further developed to include audit of compliance with screening patients for the risk of malnutrition. The hospital needs to maintain a structured approach to auditing, to ensure that regular auditing of nutrition and hydration practices are prioritized by the Nutrition and Steering Committee.

Evaluation of patient satisfaction

Hospital managers told inspectors that they had carried out regular patient experience surveys. Inspectors viewed three patient experience surveys results, from the period of March to September 2016, on one of the wards visited. The questions in the survey related to information given to patients and their expectations of care. Thirteen to 16 patients participated in these surveys. The survey results varied from 70% to 87% and patients' overall comments about their experience of care were positive.

Inspectors viewed the results of a 2016 patient experience survey of the meal service. Patients were asked to rate their experience of the quality of the food, variety of choices offered on the menu, the temperature of the food and drinks and their experience of the service. Twenty-one patients participated in the survey and rated their experience of the meal service as either good or very good. A similar patient experience survey carried out in 2015 rated the overall quality of the food as either very good or exceptional.

Quality improvement initiatives

The hospital told inspectors about a number of recent quality improvements initiatives implemented in relation to nutrition and hydration which included the following:

- Standardizing the meal ordering system across the hospital to ensure that all patients received the meal that they had ordered.
- Introducing discreet coloured cards over patients' beds to identify patients on specific therapeutic diets or snacks.
- Introducing a red tray system to identify patients who required assistance.
- Introducing a red jug to identify patients who were at risk of dehydration.

Health Information and Quality Authority

- Record on daily diet sheet the names of patients who require a red tray.
- Introducing the MUST screening tool to identify some patients at risk of malnutrition.

What worked well?

- The hospital had an established Nutrition Steering Committee that had implemented a number of quality improvement initiatives to support nutrition and hydration care of patients.
- The hospital had conducted a number of audits of nutrition and hydration care, including auditing the nutrient content and portion size of menus.
- The hospital conducted surveys of patient experiences of meals to improve nutrition and hydration care.

Opportunities for improvement

- The hospital needs to progress with the development of a number of policies in relation to nutrition and hydration care to guide staff and standardize nutrition care.
- The hospital should audit compliance with the use of the MUST tool to screen patients for the risk of malnutrition.

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

Health Information and Quality Authority

- 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 medical, nursing, healthcare assistants and catering staff through lectures and workshops.

On the day of inspection, hospital managers and ward staff told inspectors that dietitians and speech and language therapists delivered regular training to ward staff including training on texture-modified diets, thickened fluids and dysphagia. Catering staff received training in relation to nutrition and hydration during their induction programme. Inspectors viewed training records for 2016 on MUST and on texture- modified diets on the day of inspection.

Nursing staff were provided with training in relation to pressure ulcer prevention which included training on the use of the MUST tool. Hospital managers told inspectors that they planned to provide the Health Service Executive online training for nursing staff on the MUST screening tool.

Inspectors viewed a nutrition and hydration information folder which was developed by the dietitians for staff on the wards.

Opportunities for improvement

- The hospital should develop a standardized training programme for staff, relevant to their role, on issues relating to nutrition and hydration that is in line with relevant national guidelines.

Conclusion

The inspection team found, on the day of inspection, that South Infirmity Victoria University Hospital had implemented a number of quality improvement initiatives relating to nutrition and hydration. The hospital had a 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.

The hospital had selected the MUST tool as part of the skin bundle pressure ulcer prevention tool to screen some patients for their risk of malnutrition. However, inspectors found that the hospital was not screening all patients for their risk of malnutrition in line with national guidelines. The hospital should proceed with the implementation of screening and rescreening for all patients in the hospital in line with the national guidelines. ⁽⁴⁾

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. The majority of patients who spoke with inspectors were satisfied with the quality of food and drinks that they received while in hospital. There were a number of menu choices available for patients on standard and therapeutic diets. However, patients on texture-modified diets had limited choice. Inspectors observed that patients who required assistance were offered assistance in a prompt manner.

Inspectors found that the Nutrition Steering Committee had carried out a number of audits on aspects of nutrition and hydration care including audit of the nutrient content and portion size of meals. They had also carried out patient experience surveys. However, inspectors found that the hospital had not audited compliance with their MUST screening tool used to screen patients for their risk of malnutrition. This should be a key area of focus for improvement by the hospital following this inspection. In addition, the hospital needs to develop and implement a number of policies relevant to nutrition and hydration.

The hospital must now ensure that quality improvement efforts and arrangements in place for meeting patients' nutritional and hydration needs continue to improve. To achieve this, the hospital's Nutrition Steering Committee must encourage and support improvements in screening all patients for their risk of malnutrition, and continue to implement a structured system to audit nutrition and hydration care. A key feature of this 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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