

Report of the unannounced inspection of nutrition and hydration at St Columcille's Hospital, Dublin

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

Date of on-site inspection: 5 July 2016

About the Health Information and Quality Authority

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

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

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation** — Registering and inspecting designated centres.
- **Monitoring Children's Services** — Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality** — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **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.¹ A national report of the review of nutrition and hydration care in public acute hospitals was published in May 2016 which presented the findings of this monitoring programme.² This report described areas of practice that worked well in hospitals and identified opportunities for improvement (the report is available on HIQA's website, www.hiqa.ie). In that report the following four key areas for improvement were identified:

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

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

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

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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 St Columcille's Hospital, Loughlinstown, Dublin on 5 July 2016 by authorized persons from HIQA, Dolores Dempsey-Ryan, Aoife Lenihan and Conor Dennehy between 11:00hrs 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 one ward 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 10 patients and their relatives when present and 12 members of staff, including managers. During the inspection, inspectors used specifically developed observation, interview and record review tools to help assess the quality of care given to patients in acute hospitals with the focus on nutrition and hydration.

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

Findings

Theme 1: Person-centred Care and Support

Healthcare that is person centred respects the values and dignity of service users and is responsive to their rights, needs and preferences. The *National Standards for Safer Better Healthcare* 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.¹ This includes supporting individuals from different ethnic, religious or cultural backgrounds.

During the on-site inspection, 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, if needed, 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 using a cook-fresh system for standard menus and a cook-chill system for texture-modified diets.^{* †} Food was plated on the ward and this practice was observed on the day of inspection.

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

- Breakfast: 8.00am
- Soup: 10.30am
- Midday meal: 12.00pm
- Evening meal: 5.00pm
- Evening snack: 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

* A "cook-chill" food service system involves chilling the food after it is cooked and re-heating the food prior to serving. A "cook-fresh" food service system is the standard method for preparing food in hospitals, which involves cooking, plating, and serving food hot.

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

waking hours.⁴ 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 ten patients regarding the spacing and timing of meals and nine patients told inspectors that they were satisfied with the mealtimes. However, one patient told inspectors that mealtimes were too early and they would like dinner an hour later. Inspectors observed that catering staff engaged well with patients, for example, staff addressed patients by name.

Hospital managers and staff told inspectors that the hospital had introduced a protected meal times[‡] policy. They reported that there had been some challenges in implementing this policy as some patients were scheduled for tests or procedures during the midday meal time. Managers told inspectors that this issue was being addressed through the hospital's Nutrition Steering and Food Forum Committee with proposals to change the time of the midday meal from 12pm to 12.30pm to facilitate less interruptions during the midday meal.

On inspection, inspectors observed that bed tray tables were free from clutter and within the reach of patients. The ward environment was conducive to eating, and inspectors observed no evidence of non-essential interruptions during the midday meal. The ten patients whom inspectors spoke with said that they had not experienced interruptions during their mealtimes.

Choice and variety of food

The hospital stated in its completed self assessment tool that menu options were verbally outlined to patients and picture menus were also used.

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. This was confirmed by patients. However, three patients told inspectors that it was sometimes difficult to remember what they ordered the day before. Catering staff told inspectors that they also used laminated coloured picture menus, which inspectors viewed, to outline menu choices to patients with communication difficulties.

[‡] 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.

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Catering staff told inspectors that there were three distinct weekly meal plans, which were rotated once every three weeks. Inspectors viewed the weekly menus on offer to patients, and noted that there was one meal recorded on the menu each day for the midday meal and one for the evening meal.

On the day of inspection, hospital managers, catering and nursing staff told inspectors that patients are offered a number of choices for their midday meal. Catering staff stated that patients were offered the main dish of the day (for example, turkey bake on the day of inspection), and if patients expressed dissatisfaction with this option, they were then offered either steamed or fried fish, chicken, scrambled egg or a vegetarian option. The alternative option to the main dish of the day did not change and was consistently steamed or fried fish or chicken. There were three choices for the evening meal for example, bacon and tomatoes, salad or sandwiches.

Patients told inspectors that they were offered a fish or a meat dish for the midday meal and a choice for the evening meal. All patients who spoke with inspectors reported that they were satisfied with the menu choices provided. Catering staff told inspectors that patients on therapeutic diets could choose from the standard menu, which was then tailored for their specific requirements.

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 for smooth pureed and mince moist diets and noted that patients had only one meal choice for the midday meal and for the evening meal. However, on the day of inspection, catering staff told inspectors that they verbally offered scrambled egg or shepherd's pie as an alternative if they did not like the main option.

Catering staff told inspectors that texture-modified meals such as smooth pureed meals were prepared freshly in-house and were presented in moulds in the shape of the original food items; for example, pureed carrots were in the shape of carrots. On the day of the inspection, inspectors observed that pureed meals had been presented in an appetising way on a dividing plate with separate sections for meat and vegetables.

Overall, there was a lack of variety in the menu choice for all patients in that the alternative option to the main dish of day did not vary.

Best practice guidelines suggest that high-calorie snacks should be offered between meals, mid-morning, mid-afternoon and late evening.⁴ Catering staff told inspectors

that patients were offered soup mid-morning. The hospital had introduced nourishing afternoon snacks, with a focus on nutrient content, for specific patients following assessment and recommendations by dietitians and speech and language therapists. Inspectors viewed a snack sheet, which outlined the particular snack ordered for a given patient. Catering staff reported that patients who were not on the nourishing snack list could ask for a snack, but they were not routinely offered to all patients. However, snacks were available to all patients from 7.30pm and included such items as sandwiches cheese and crackers, biscuits, fruit, tea and coffee.

On the day of inspection, ten patients told inspectors that they had been offered a variety of snacks between meals. Five patients reported that they had received soup between 10.30am and 11am. All ten patients told inspectors that they were offered an evening snack between 7.30pm and 9pm. Six of the ten patients reported being offered tea, biscuits or sandwiches.

Missed meals

Catering staff and hospital managers told inspectors that the hospital had a system in place to cater for patients who missed a meal. It was practice to keep some meals in the ward kitchen with a symbol 'FR' (fresh cooked) on it to denote that one of these meals could be reheated for a patient if required. In addition, catering staff could contact the kitchen for a replacement meal up to 6pm. After this time, patients were offered snacks such as sandwiches, scones, rice pudding or yogurts.

On the day of inspection, eight out of ten patients told inspectors they had not missed a meal during their hospital stay. Two patients who had missed a meal told inspectors that a meal had been put aside for them.

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's completed self-assessment stated that there were options for patients from different ethnic, religious, and cultural backgrounds. On the day of inspection,

staff and hospital managers confirmed that ethnic, religious, and cultural food could be provided if required. Halal[¥] food was available as it was regularly prepared for staff in the hospital. Vegetarian meals were also available on the daily menu.

Assistance

The hospital stated in its completed self-assessment that assistance from nurses and healthcare assistants to support patients at mealtimes was mostly available.[§] Hospital management also reported that they ensured that staff were deployed as appropriate to assist patients with meals on a daily basis. Staff and hospital managers told inspectors that information regarding which patients required assistance was communicated during nursing handover and through the use of a red tray system. This system meant that patients who required assistance had their meal served on a red tray to indicate to staff that they required assistance with eating and drinking. Catering staff told inspectors that they updated a communication white board in the ward kitchen with information about which patients required assistance each afternoon.

Nursing and catering staff told inspectors that the red tray system worked well. Inspectors observed that patients were positioned comfortably prior to the meal, and were provided with dining and feeding aids where needed. Inspectors observed that a number of patients required assistance on the day of the inspection and those that required assistance were easily identified by the use of the red tray, and were observed being assisted by nurses and healthcare assistants in a timely manner. Where appropriate, inspectors observed that patients were encouraged to eat independently, and were provided with enough time to eat their meal without being rushed.

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 catering staff plating patients' midday meals from a heated trolley on the ward corridor before serving to patients. Texture-modified dishes had been already plated on

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

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

dividing plates in the main kitchen. Inspectors observed meals as they were being served and observed that food was served in an appetising way.

Inspectors spoke with patients about their views on the quality of food provided in the hospital. All patients spoke positively about how the food tasted. For example, some patients described the food as 'tasty food', 'good choice'. All patients expressed satisfaction with the temperature of the food and reported their hot meals were hot on arrival.

Hydration and availability of drinks

On the day of inspection, inspectors observed that drinking water was readily available to patients with jugs and glasses of water within easy reach of patients. Catering and nursing staff told inspectors that water jugs were replaced with fresh water in the morning and evening and refilled as required.

Inspectors observed and a number of patients reported that they were offered drinks of milk as a snack. Patients told inspectors that they were offered soup, tea, coffee or milk each day between 10.30am and 11.00am and tea or milk were also offered as part of the main meal service. In addition, catering staff reported that it was practice to use specific coloured mugs to encourage patients with specific medical conditions to drink more fluid (patients with dementia).

What worked well?

- Patients were offered nourishing snacks between meals.
- There was a system in place to communicate which patient required assistance and this worked well.
- Patients spoke positively about the quality and taste of the food.
- Water jugs were replenished with fresh water twice during the day.

Opportunities for improvement

- The variety of meal choices available to patients including patients that required 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.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

The hospital had a structured nursing assessment record for all admitted patients that contained an assessment of activities of daily living including eating and drinking and a section for the level of assistance each patient required with meals, for example if a patient needed food to be cut up for them. There was a structured eating and drinking care plan for patients if required, and documents to record food and fluid intake used semi-quantitative and quantitative measures as recommended in the national guidelines.

The hospital had implemented the Malnutrition Universal Screening Tool (MUST) to screen and identify patients at risk of malnutrition on admission. The hospital policy on nutrition and hydration stated that all patients admitted to the hospital should be screened for their risk of malnutrition using the MUST screening tool within 48 hours of admission. Screening for the risk of malnutrition should be carried out on every patient within 24 hours of admission to hospital.⁴ When asked by inspectors why patients were screened within 48 hours of admission — rather than 24 hours as set out in national guidelines — hospital managers and nursing staff told inspectors that all patients were screened on admission and the 48-hour period referred to assessment by a dietitian where indicated when a patient was identified as being at a risk of malnutrition. The hospital policy also required patients to be rescreened weekly with the rescreening MUST score recorded.

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Inspectors reviewed the healthcare records of five 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.

In the five patient healthcare records reviewed by inspectors, four patients were screened for their risk of malnutrition using the MUST tool. However, one patient who had most of the screening tool completed with regard to height, weight and body mass index, did not have an overall MUST score calculated. Nursing staff told inspectors that patients were routinely rescreened at the weekend. Of the five healthcare records reviewed, three patients who had been in the hospital for more than one week had been rescreened.

Inspectors found that the nursing assessment section for eating, drinking and assistance in all five healthcare records reviewed had been completed with specific dietary requirements recorded. Two healthcare records contained fluid balance charts which were neither fully completed nor up-to-date. Nurses were required to record the food intake of two patients. Both of the food intake charts viewed used semi-quantitative measures of food intake and were fully complete and up-to-date.

Equipment for screening

During this inspection, inspectors observed that some of the required equipment used to screen patients for the risk of malnutrition was in place. These included hoist scales, chair scales (for more frail and dependent patients), stadiometers[◇] and measuring tapes. Such weighing equipment was easily accessible on the ward and had been calibrated as required within the previous 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. Nursing staff told inspectors that patients who were screened as being at high risk of malnutrition were referred and seen by the dietitian in a timely manner.

Following review of five patient healthcare records, inspectors found that two patients had been referred to the dietitian. One patient had been seen by the

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

dietitian within 48 hours of admission and a second patient, who had been identified during rescreening as being at risk of malnutrition, had also been reviewed by the dietitian within 48 hours of referral.

What worked well?

- The hospital routinely screened patients for the risk of malnutrition on admission to hospital.
- Patients had access to assessment by a dietitian when required.
- Staff had access to the required equipment to measure patients' weight and height.

Opportunities for improvement

- Fluid intake records should be complete and up to date.

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, patients are not experiencing prolonged fasting unnecessarily and systems are in place to ensure that 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

Nursing and catering staff told inspectors that they had a number of systems in place to communicate patients' dietary needs between staff to ensure that patients received the correct meals. These included the following:

- nursing assessment documentation
- nursing handover
- coloured symbols displayed discretely over patients' bed
- communication white boards in the ward kitchen

- instructions from the speech and language therapist displayed over patients' beds with information on texture-modified diets requirements.

On the day of inspection, inspectors found that patients' specific dietary requirements were documented in their healthcare records. Inspectors viewed dietary information displayed on a communication white board in the ward kitchen. This was also updated by the speech and language therapist regarding patients who required texture-modified diets. Inspectors observed patients receiving specific diets, for example, a therapeutic diet as identified on the communication board.

Hospital staff told inspectors, that information on texture-modified diets displayed on a laminated sheet over their bed ensured that specific patients received the correct - diet and minimised the risk of patients getting the wrong meal. Inspectors observed patients receiving textured modified diets in accordance with the instructions displayed. All ten patients who spoke with inspectors stated that they had always received the correct meal.

However, inspectors observed that it was practice to use bed numbers and not patients' names on the communication white board in the ward kitchen to identify which patient required a specific meal. This depended on staff vigilance if a patient moved beds and could increase the risk of patients receiving an incorrect meal should patients move bed or a new patient be admitted.

Patients safety incidents in relation to nutrition and hydration

Hospital staff and managers told inspectors that there had been no patient safety incidents or written complaints received from patients in relation to nutrition and hydration in the last 12 months. However, inspectors noted that in the minutes of the Nutrition Steering and Food Forum Committee (2015) that there had been reference to a 'few incidents' where patients had received the wrong consistency of thickened fluids. The hospital sought to address this matter through the development and display of a poster, which inspectors viewed, and this outlined information describing the consistency of an oral supplement used by the hospital against the national descriptors for thickening fluids.

The minutes of the Nutrition Steering and Food Forum Committee highlighted that the hospital was planning to provide training to staff on how to thicken fluids. Inspectors viewed training records of staff attendance at these training days. On the day of the inspection, inspectors also observed laminated sheets beside relevant patients' beds detailing how these patients' drinks were to be thickened with the prescribed thickener.

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. 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 and that hospital managers, dietitians, physicians, nurses, catering managers and food-service staff must work together to achieve the best nutritional care, and hospital management must 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.¹

Nutrition Steering Committee

The hospital had a Nutritional Steering and Food Forum Committee that was set up in 2010. The Committee was chaired by the Catering Manager from this time until January 2016 when the Deputy Hospital Manager became the Chair of the Committee. The Nutrition Steering and Food Forum Committee had agreed terms of reference that detailed the functions of the Committee and a list of membership. It also outlined the responsibilities of members.

Hospital managers told inspectors that the Nutrition Steering and Food Forum Committee reported into the Clinical Governance Committee. Inspectors requested copies of agendas and minutes for the last six meetings. The Committee had met six times between September 2015 and April 2016, meetings were well attended, and there was a record of discussion and agreed outcomes. There was representation on the Committee from all disciplines of staff as recommended in the national guidelines with the exception of medical staff. Hospital managers acknowledged this

and told inspectors that the Committee had formally requested that a member of the medical staff join the Committee.

Members of the Committee told inspectors that this Committee was a forum to bring managers from different departments together to resolve any issues and implement improvements. The inspection team found examples of this from the minutes of the meetings such as the implementation of red trays to highlight which patients required assistance. The inspection team found from reviewing documentation, interviewing management and talking with ward staff that the objectives of the Committee were clear and there was evidence of progress on a number of quality improvements of the nutrition and hydration care of patients.

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 viewed the hospital's policies relevant to nutrition and hydration and found that the hospital had a system in place for staff to access policies on the hospital's electronic information system and in hard copy in policy folders on the ward visited.

The hospital had a number of policies including nutrition and hydration policy with sections on screening patients for the risk of malnutrition and protected mealtimes. The hospital also had a draft policy for fasting patients who require anaesthesia or intravenous sedation.

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 Inspectors were given copies of the results of previous audits including a report from 2013 on the analysis of the nutritional composition of the standard and modified consistency menus for the patients. The findings of the analysis concluded that the energy and protein content of the normal and modified consistency diets were less than recommended by the national guidelines.⁴ The report made recommendations as to how the hospital could ensure that the energy and protein content of food could meet the requirements in the national guidelines, for example, fortifying food and providing

patients with nutritious snacks. Hospital managers told inspectors that the hospital had recently implemented a nutritional snack menu, which was devised to provide additional calories for patients as required.

Inspectors were provided with a copy of an audit report in relation to screening patients for their risk of malnutrition using the MUST tool. This audit was completed in June 2016 on all hospital wards. The results varied from 71% to 86% of patients being screened for their risk of malnutrition across all wards. Rescreening of patients as per hospital policy varied from 25% to 75%.

Other ward-based audits included audits carried out by the speech and language therapy department. These audits included reviewing texture-modified diets, whether patient support was provided as required and whether the addition of honey to breakfast and lunch benefited patients on texture-modified diets.

Overall, inspectors found that there was a culture of audit and evaluation of nutrition and hydration care by the Nutrition Steering and Food Forum Committee. The Committee reviewed results of audits and findings had been communicated to ward staff. More regular and repeated audits could provide the Committee with further assurance that nutrition and hydration care practices reflect national guidelines and hospital policy.

Evaluation of patient satisfaction

The hospital had carried out a patient satisfaction survey in relation to catering and meal services, commissioned by the Nutrition Steering and Food Forum Committee. Following this a report was published in May 2016 and a copy given to inspectors during the inspection. In this survey, eighteen patients had been asked seventeen questions by household staff.

The results indicated that most patients were satisfied with the menu and choice of food. In general patients agreed with the statement that they were 'made comfortable' and had a chance to 'freshen up' before meals. They were also satisfied, in general, with the meal times, the ward atmosphere, friendliness of serving staff, assistance given and receiving the meal they ordered. Patients all confirmed that they could get a snack or drink when they wanted and were offered a replacement meal if they missed a meal. Twelve out of 15 patients were satisfied with the portion sizes.

Patients rated the taste, temperature, layout and cleanliness of trays as 'excellent' or 'good', two out of seven patients rated the temperature as 'acceptable' and one

patient (out of 10) rated the appearance of the food as poor. The only area for improvement highlighted in the report was that a number of patients (5 out of 18) found the menu was hard to understand. Inspectors found evidence in the minutes of the Nutrition Steering Committee and Food Forum that menus had been simplified as a result.

Quality improvement initiatives

The hospital told inspectors about a number of recent quality improvements initiatives implemented in relation to nutrition and hydration including protected mealtimes, picture menus, the red tray system, symbols on laminated signs over the patients' beds to indicate dietary needs (snacks), and the recently introduced snack menu, including snacks for patients on texture-modified diets. They also reported that they had introduced soup for patients in the afternoon on one ward. However, following analysis of food wastage following this trial, this was not introduced as part of the hospital meal service.

What worked well?

- The hospital had a long established Nutrition Steering Committee that functioned well and had driven a number of improvements in the nutrition and hydration care of patients.

Opportunities for improvement

- A structured programme of audit for nutrition and hydration care, including regular audits on screening and rescreening patients for their risk of malnutrition, could provide the Committee with assurance that nutrition and hydration care practices reflect national guidelines and hospital policy.

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

Training

On the day of inspection, hospital management and nursing staff told inspectors that training had been provided to nurses on the wards in relation to the use of the MUST screening tool. Inspectors reviewed copies of attendance records at this training and found that the training was well attended.

Hospital managers told inspectors that catering and household staff had been provided with training on food safety and on texture-modified diets. All healthcare staff received training on texture-modified diets and dysphagia care.

Opportunities for improvement

- The hospital should develop a standardised 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 St. Columcille's Hospital had implemented a number of quality improvement initiatives relating to nutrition and hydration. They found that there was a long established Nutrition Steering and Food Forum Committee that had played a key role in raising the importance of the provision of good nutrition and hydration care across the hospital and had implemented a number of quality improvement initiatives.

The hospital routinely screened patients for the risk of malnutrition on admission to hospital. Inspectors reviewed a small sample of patient healthcare records on the day of inspection and found that these patients had been screened for their risk of malnutrition as per hospital policy. 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. Inspectors observed that patients who required assistance were offered assistance in a prompt manner. All patients who spoke with inspectors were satisfied and complementary about the taste of food and drinks they received. Patients reported that they were satisfied with the choice offered, however inspectors noted that from reviewing the menus that the variety of choice was limited.

Inspectors found that the hospital had developed a number of policies relevant to nutrition and hydration, and there was evidence that the hospital had audited aspects of nutrition and hydration care practices in the hospital. A structured programme of audit for nutrition and hydration care, including regular audits on screening and rescreening patients for their risk of malnutrition could provide the Committee with further and regular assurance that nutrition and hydration care practices reflect national guidelines and hospital policy.

The Hospital must now ensure that quality improvement efforts and arrangements in place for meeting patients' nutritional and hydration needs are maintained so that the nutrition and hydration care of patients continues to improve. To achieve this, the hospital's Nutrition Steering and Food Forum Committee must continue to encourage and support the screening of patients for risk of malnutrition and further develop the programme of audit and training for nutrition and hydration care. A key feature of this process is the inclusion of patients' experience of nutritional and hydration care and use of their views to inform and direct current and future quality improvements in the area of nutrition and hydration care.

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