



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of nutrition and hydration at St. James's Hospital, Dublin 8.

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

Date of on-site inspection: 26 October 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. James's Hospital on 26 October 2016 by authorized persons from HIQA, Dolores Dempsey-Ryan, Aoife Lenihan, Siobhan Bourke, Noreen Flannelly-Kinsella and Noelle Neville between 10.00hrs and 16.15hrs.⁽¹⁾

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

Inspectors visited three wards during the midday meal to check first-hand that patients received a good quality meal service, had a choice of food and that they were provided with assistance with eating if required. Inspectors observed one meal, spoke with 17 patients, their relatives when present and 17 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, if needed, and whether patients had their meals interrupted for non-essential reasons.

Meal service and timing of meals

Catering services at the hospital were provided by in-house staff. A cook-chill and buffet service system was in place.* The mealtimes reported in the hospital's self-assessment questionnaire 2015 were as follows:

- Breakfast: 8.00am-10.00am
- In between meal snack: 11.00am-11.30am
- Midday meal: 12.00pm-1.30pm
- Evening meal: 4.45pm-6.30pm
- Late-evening snack/drink: 8.00pm-9.00pm

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⁾ Based on the meal times stated above, the hospital was not adhering to best practice guidelines with a four-hour interval between the three main meals of the day on all wards. Hospital managers and ward staff told

A "cook-chill" food service system involves chilling the food after it is cooked and re-heating the food prior to serving. Buffet style at the patient's bedside involves serving meals onto plates from mobile buffet trolleys at the patient's bedside.

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inspectors that the Catering Department had conducted surveys in relation to patients' experience of mealtimes and brought about a number of changes on some wards in response to this feedback. These included:

- The timing of breakfast had been changed to a later time (8.45am or 9.15am) on some wards.
- The main meal of the day was changed from midday to the evening time on some wards.

Hospital managers told inspectors that as a result of changing the timing of the main meal to the evening on some wards, patients reported sleeping better, patients who were fasting for procedures had better access to a hot meal and there was less food wastage.

During the inspection, inspectors spoke with 17 patients regarding the spacing and timing of mealtimes and 11 patients told inspectors that they were satisfied with the mealtimes. However, six patients said that the midday meal was served too early.

Hospital managers told inspectors that they had a protected mealtime policy and had implemented protected mealtimes[†] on one third of the wards of the hospital. On the day of inspection, inspectors visited one ward, which had implemented protected mealtimes and ward staff reported that non-essential interruptions such as medication rounds were changed to an earlier time to facilitate mealtimes.

Inspectors observed no interruption to the midday meal on this ward. However, inspectors observed nurses carrying out medication rounds and medical staff talking with patients while patients were eating their midday meal on the two other wards visited.

Of the 17 patients who spoke with inspectors, ten patients experienced no interruptions to mealtimes and seven patients said that their meals had sometimes been interrupted. This finding concurs with the inspector's findings on the day of inspection, and with the findings from the catering service patients' experience surveys conducted in 2016.

[†] 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.

Choice and variety of food

The hospital stated in its completed self-assessment questionnaire and management and catering staff confirmed on the day of the inspection that menu options were outlined verbally to patients using menu cards. Inspectors viewed the weekly menu and noted that patients were provided with 10 to 12 options every day for the midday and evening meals. All patients who spoke with inspectors confirmed this.

Picture menus were used in designated areas to meet specific patients' requirements. The hospital had also developed a booklet called 'mealtimes and me' which was used to improve communication between staff, carers and families about patients' individual food preferences where there was difficulty in obtaining this information from the patient.

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 weekly menus for patients on all types of texture-modified diets, and noted that these patients had a number of choices of meals. Inspectors observed a number of texture-modified meals on the day of the inspection (soft and minced moist meals) which looked appetising and had food items such as vegetables and meat served separately on the plate.

National 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 between the last meal of the day and breakfast the following morning. Catering and nursing staff told inspectors that patients were offered hot drinks at 11am and 3pm and tea, biscuits or sandwiches at 8pm. Nursing and catering staff told inspectors that high calorie, high protein snacks were ordered for patients who required these snacks following an assessment by the dietitian. This information was recorded on a white board in the ward kitchen to ensure that the patients received appropriate snacks.

All 17 patients who spoke with inspectors said that they were offered snacks, which included tea, coffee, biscuits or sandwiches. Two patients with diabetes told inspectors that the dietitian ordered extra snacks for them, and another two patients on high calorie, high protein diets said they were provided with snacks such as yogurt, cheese and crackers.

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

Overall, inspectors were satisfied that patients were offered a wide choice of meals including those patients on texture-modified diets. However, inspectors found that the same vegetable side dishes were offered every day with the main meal of the day, for example mashed potatoes were served with the main meal every day. This finding was consistent with comments from patients in the hospital's catering service patient experience surveys.

Missed meals

Hospital managers, catering and nursing staff told inspectors that the hospital had a system in place to cater for patients who missed a meal whereby catering staff put aside a number of meals in the ward fridge, which could be heated up for a patient if required. Patients were also offered a choice of sandwiches, soup or a salad as an alternative to the hot meal during the day, and after 7pm when no hot meal was available.

Of the 17 patients who spoke with inspectors, nine patients told inspectors that they had missed a meal during their hospital stay. Eight of these patients stated that they received a replacement meal.

Catering for patients with ethnic, religious and cultural dietary needs

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

The hospital stated in its completed self-assessment questionnaire that there were menu options available for patients from different ethnic, religious, and cultural backgrounds. Hospital managers and catering staff told inspectors that they could provide a choice of Halal[§] and Kosher^{**} meals as requested. These meals were sourced externally. Vegetarian meals were also available.

§ 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).

Assistance

The hospital stated in its completed self-assessment questionnaire that assistance from nurses and healthcare assistants to support patients at mealtimes was mostly available.^{††} Hospital managers told inspectors that staffing levels had improved since the completion of the self-assessment questionnaire in 2015 and more healthcare assistants were available to assist patients with mealtimes. 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, but that delays in providing assistance could sometimes occur due to a shortage of staff.

Ward staff told inspectors that information regarding which patients required assistance with meals was communicated during shift handovers. On one of the wards visited, information on the assistance required by patients was communicated on a specifically designed handover sheet, which inspectors viewed.

On another ward visited, nursing staff told inspectors that as part of the protected mealtime initiative, information was recorded on a sign over the patient's bed regarding patients who required assistance with meals. Inspectors observed this on the day of inspection. Visitors are also able to visit the ward during meal times, outside visiting hours, to assist their relatives as part of the protected mealtime initiative.

Hospital managers and nursing staff told inspectors that some wards were piloting the use of coloured symbols on magnetic white boards at the patient's bedside to communicate information regarding which patients required assistance with meals. Inspectors noted that the use of these magnetic communication boards had been discussed at the Nutrition Steering Committee meetings.

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 in a timely manner and there was evidence of good social interaction between nursing, catering staff and patients.

On one of the specialist wards visited, inspectors observed a separate dining room where patients could eat their meals in a communal area instead of at their bedside.

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

Staff told inspectors that this was a quality improvement initiative identified to improve patients' experience at meal times for this particular group of patients.

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, in general, 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; "well cooked food" and "plenty of choice". However, two patients said although there were plenty of choices, the choices were the same every day.

Hydration and availability of drinks

On the day of inspection, inspectors observed that drinking water was readily available to patients with jugs and plastic cups of water within easy reach of patients. Catering staff, nursing staff and hospital management told inspectors that water jugs were replaced with fresh water twice a day and refilled as required by members of staff. Patients who spoke with inspectors confirmed this. Catering and nursing staff told inspectors that patients were offered tea, coffee or milk as part of the drinks and snack rounds at 11am, 3pm and with their evening snack. Inspectors were satisfied on the day of inspection that patients had access to sufficient hydration throughout the day.

What worked well?

- Patients, in general, spoke positively about the quality of the food.

Opportunities for improvement

- The hospital should review the timing of meals and the variety of accompanying dishes on the menu in line with feedback given by patients to inspectors and in the patients' experience surveys.

- The hospital should reduce unnecessary interruptions to patients' mealtimes in general ward areas.

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 15 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. Fourteen of the 15 patients' healthcare records reviewed by inspectors included a nursing assessment of nutrition and hydration within 24-hours of admission. The remaining healthcare record was partially completed.

The hospital had a policy on screening patients for their risk of malnutrition which formed part of the nutrition policy. All three wards visited by inspectors were screening patients for their risk of malnutrition using the Malnutrition Screening Tool (MST) tool. Hospital managers told inspectors that all wards in the hospital were screening patients.

Nursing staff told inspectors that it was the hospital's policy to routinely screen all patients on admission and those who scored two or more for their risk of malnutrition were referred to a dietitian. Patients who were not at risk of

malnutrition on admission were re-weighed weekly and re-screened if they had lost weight.

Of the 15 healthcare records reviewed by inspectors, 12 had a fully completed MST assessment within 24-hours of admission. Of the remaining three healthcare records, two patients did not have their MST completed for valid clinical reasons and there was no reason as to why the third patient did not have their MST completed.

Of the 15 healthcare records reviewed by inspectors, all patients had their weight recorded on admission. Eleven healthcare records belonged to patients who were in hospital for greater than one week and all of these patients were either re-weighed or were under the care of the dietitian.

Inspectors examined fluid intake and output and food charts in the healthcare records. Of the 15 healthcare records reviewed, eight contained fluid intake and output charts which had quantitative measures documented as recommended by national guidelines and were fully completed and up-to-date. Three healthcare records contained food charts and all three used semi-quantitative measures as recommended by the national guidelines and were fully completed and up-to-date.

Overall, inspectors found that the hospital had implemented screening patients for their risk of malnutrition and food and fluid records were up to date and completed as per national guidelines.

Equipment for screening

During this inspection, inspectors observed that the wards visited had access to weighing scales, chair scales (for more frail and dependent patients), stadiometers[◇] and measuring tapes. Such weighing equipment was easily accessible 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. Patients with a MST score of two or more were routinely referred to a dietitian and electronic referrals were accepted from both nursing and medical staff.

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

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In 12 of the 15 patient healthcare records reviewed, inspectors found a documented assessment of the patient by a dietitian. Eight of these 12 patients were seen by the dietitian on the same day of referral. Of the remaining four patients, one was seen within 24-hours of admission and one was seen within two working days. It was not possible to determine the referral date to the dietitian of two patients due to the temporary unavailability of the electronic patient referral system.

Nine patient healthcare records contained assessments by a speech and language therapist for a swallowing assessment. Of these nine, five had been seen on the same day of referral. Of the remaining four, three had been seen within 24-hours of admission and it was not possible to determine the referral date of one patient due to the temporary unavailability of the electronic patient referral system.

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

What worked well?

- The hospital was screening all patients for their risk of malnutrition.
- Food and fluid records were up to date and completed as per national guidelines.
- Staff had access to appropriate equipment to measure patients' weight.
- There was timely access to dietetic and speech and language therapy services.

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

Hospital managers, nursing and catering staff outlined the communication systems in place to communicate patients' dietary needs between staff to ensure that patients received the correct meals. These included documenting information regarding patients' nutrition and hydration needs in nursing assessment records on admission and on a daily diet sheet. This information was then transferred to a communication sheet for the main kitchen which was checked by catering staff before distributing meals to ensure patients always received the correct meal.

Hospital managers and nursing staff told inspectors that they were piloting on two wards different ways of improving communication between staff including the use of discreet symbols and magnetic white boards at the patient bedside. Hospital managers told inspectors that one ward had introduced a morning handover report between catering staff and nursing staff to improve communication about patients' dietary requirements.

Inspectors observed, on the wards visited, laminated signs over some patients' beds indicating the type of diet they required, for example, diabetic or texture-modified diet. All of the 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

A good patient safety reporting culture within a healthcare service means that patient safety incidents are being reported frequently. This allows for greater opportunities to learn and improve from patient safety incidents. ⁽⁵⁾ 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 fourteen patient safety incidents reported in relation to nutrition and hydration in the last 12 months. These incidents included patients not receiving the correct meal and patients experiencing prolonged fasting before surgery. None of these incidents resulted in harm to any of the patients involved.

Hospital managers told inspectors that formal complaints were managed in line with the hospital's complaints policy, but there was no system in the hospital for recording verbal complaints. Inspectors were told that if a verbal complaint was received, the issue was dealt with at local level.

Inspectors found that there was a good reporting culture in relation to nutrition and hydration incidents and hospital management told inspectors about a number of quality improvement initiatives that had been implemented following incidents and formal complaints in relation to nutrition and hydration. These included the implementation of protected mealtimes in wards, improved access to hot meals in the Emergency Department and the development of a fasting policy to ensure patients did not experience prolonged periods of fasting prior to surgery or procedures. Other quality improvement initiatives included the introduction of communication tools to improve communication between staff at ward level about patients' dietary requirements.

What worked well?

- The hospital had implemented a number of quality improvements in response to incidents and complaints in relation to nutrition and hydration.

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

At the time of the inspection, the hospital had a Nutritional and Hydration Steering Committee in place, which was established in 2012, and chaired by a medical consultant. It had agreed terms of reference that detailed the purpose, membership, meeting frequency and responsibilities of the group. The purpose of the Committee was to direct and support the implementation of a comprehensive programme of nutritional and hydration care in St. James's Hospital.

Hospital managers told inspectors that the Nutrition Steering Committee reported into the Hospital Executive and Hospital Board through the Hospital's Safety Framework.

The Nutrition Steering Committee had met seven times since January 2016 and aimed to meet at least quarterly. Inspectors requested and reviewed copies of agendas and minutes for the last six meetings. All relevant staff disciplines were

represented on the Committee. There was a record of discussion and action plans. Each action plan had a lead person assigned to each action. Actions included areas such as nutrition metrics, the use of a symbol to identify patients who required assistance at mealtimes, communication between teams, hospital policies, feedback from catering services patients' experience surveys and protected mealtime initiatives. Most areas of focus 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 the hospital had a system in place for staff to access policies on the hospital's electronic information system. The hospital had a number of policies including a nutrition policy, which included screening patients for their risk of malnutrition using the Malnutrition Screening Tool (MST), a hydration policy, protected mealtimes guidelines, and a fasting policy in draft format.

Inspectors concluded on the day of inspection that the hospital had developed a number of policies on nutrition and hydration. However, the hospital should prioritise the implementation of their fasting policy.

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 and texture-modified diets and inspectors viewed copies of these audits.

Inspectors were provided with copies of completed audits in relation to nutrition and hydration. The hospital had carried out an audit of preoperative fasting in response to patients' experience of fasting times for surgery in the hospital. This audit was carried out over a two-week period and 104 patients' fasting times were assessed. The findings of the audit concluded that patients fasted significantly longer if operated on in the afternoon compared to patients fasting for surgery in the

morning, and they fasted for longer than instructed. Recommendations from the audit included the development of a fasting policy and education to reduce preoperative fasting times.

Inspectors viewed the audit results of the hospital's 'nutrition metrics' which were carried out every three months. These metrics consisted of eight questions designed to audit nursing documentation with regard to weighing of patients on admission, completion of MST and identifying if a patient was at risk of malnutrition. The MST audit results for completion of MST assessment on admission varied across the three wards visited from January to July 2016. The results for completion of MST assessment on one ward were 20% to 80% and on the other two wards were 80% to 100%. Inspectors noted that ward staff and management addressed areas for improvement regarding individual metrics through actions plans.

Nutrition metrics also included questions on the implementation of 'altered nutrition care plans', completion of fluid balance charts and completion of a dietetic referral assessment. These audit results varied from 40% to 100% depending on each individual metric and on the individual ward.

An observational audit was carried out on two wards before and after the implementation of protected mealtimes to determine the number of patient mealtime interruptions and if assistance was provided to patients who required it. The results showed that following the implementation of protected mealtimes, interruptions to meals were reduced from 159 to 66 and assistance provided to patients increased from 87% to 93%.

An audit of patient preference for mealtimes on four wards over two days highlighted that the majority of patients (65%) were satisfied with mealtimes; however, if given a choice, the majority (89%) would usually eat later than the time scheduled by ward routine. Hospital managers told inspectors that the main meal of the day was subsequently changed from midday on some wards to the evening meal and patients' feedback was positive following this change.

Evaluation of patient satisfaction

Hospital managers told inspectors that the hospital carried out monthly catering service patient experience surveys. Inspectors viewed patients' experience survey results and noted that over 90% of patients rated the catering service as excellent or good and over 87% rated the food as excellent or good. However, a number of patients' comments highlighted that meals were served too early, and that more vegetable options and fresh fruit salad should be made available to patients.

Quality improvement initiatives

Hospital managers and nursing staff told inspectors about a number of quality improvement initiatives implemented in relation to nutrition and hydration which included the following:

- The introduction of protected mealtimes on a number of wards.
- The introduction of a dining room as an initiative to facilitate a communal dining experience and improve enjoyment at lunchtime for patients.
- The introduction of discreet symbols on a magnetic white board at the patient's bedside on two wards to communicate information about patients who required assistance with meals and their dietary requirements.
- The 'mealtimes and me' booklet to communicate with families and ensure patients' preferences were met where patients had difficulty communicating their needs and preferences.
- Implemented changes to mealtimes on some wards to allow patients eat their main meal in the evening time and have a light meal at midday.

What worked well?

- The hospital had an established Nutrition Steering Committee that had implemented a number of improvements to the nutrition and hydration care of patients.
- The hospital had conducted a number of audits relating to nutrition and hydration care including auditing the nutrient content and portion size of meals.

Theme 6: Workforce

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

Best practice guidelines recommend that hospitals:

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

Training

The hospital stated in its completed self-assessment questionnaire that specific training was provided to medical staff, nursing staff, care assistants, catering staff and volunteers involved in nutrition and hydration care through lectures, workshops, electronic learning and ward based learning.

On the day of inspection, hospital management and ward staff told inspectors that catering staff were provided with training during their induction programme on nutrition and hydration care and additional training twice during the year. Hospital managers told inspectors that training on nutrition and hydration documentation and assessment tools had been provided by the nursing practice development department to nursing staff. Speech and language therapists provided training in relation to texture-modified diets to nursing, catering staff and healthcare assistants. Medical staff were also provided with training on nutrition and hydration on induction.

Dietitians provided nursing staff with training on the use of MST tool and hospital managers told inspectors that 97% of nursing staff found this training useful. Training records were viewed by inspectors. In addition, nutrition metrics were used to identify which wards required training to improve compliance with metrics such as screening of patients for their risk of malnutrition. Nursing and catering staff told inspectors that they were provided with training on hydration and rehydration to

ensure that patients received fluids and their fluid intake and output requirements were monitored if indicated.

What worked well?

- Training on MST was provided to all nurses and healthcare assistants.
- Training was provided by the hospital's dietitians, speech and language therapists and by nurse practice development unit to all relevant hospital staff.

Conclusion

The inspection team found, on the day of inspection, that St James's Hospital had an established Nutrition Steering Committee in place that played a key role in raising the importance of the provision of good nutrition and hydration care across the hospital. The hospital had implemented a number of quality improvement initiatives relating to nutrition and hydration, which included screening patients for their risk of malnutrition on admission to all wards.

HIQA recognizes that the number of patients inspectors spoke with during the inspection was a limited sample of the experience of all patients who receive care at the hospital. Inspectors observed that patients who required assistance were offered assistance in a prompt manner. All patients were offered a choice of meals including patients on texture-modified diets. The majority of patients told inspectors that they were satisfied with the meal service and with the number of choices offered. However, a number of patients told inspectors that they sometimes experienced interruptions during their meals, some meals were served too early and there was no variety in the accompanying dishes served with meals. These findings were consistent with the findings from the catering service patient experience surveys.

Inspectors noted that the hospital had a good patient safety reporting culture for incidents relating to nutrition and hydration allowing greater opportunities to learn and improve practice. Inspectors found that the hospital had implemented quality improvement initiatives in response to nutrition and hydration incidents and complaints to improve communication and ensure patients received the correct meal and assistance. The hospital had also developed a number of policies on nutrition and hydration. Inspectors found that the hospital had conducted a number of audits including auditing the nutrient content and portion size of food, nursing documentation and compliance with the implementation of MST screening. They also carried out monthly catering service patients' experience surveys.

The hospital should 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. The hospital's Nutrition Steering Committee should continue to support the screening of patients for their risk of malnutrition and continue to conduct regular audits of nutrition and hydration care. A key feature of this process is for the hospital to continue the evaluation of patients' experience of nutritional and hydration care and using patients views to inform and direct current and future quality improvements in the area of nutrition and hydration.

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