



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of nutrition and hydration at Mercy University Hospital, Cork.

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

Date of on-site inspection: 25 January 2017

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 the Mercy University Hospital on 25 January 2017 by authorized persons from HIQA, Dolores Dempsey-Ryan, Siobhan Bourke, Noelle Neville and Barbara Foley, between 10:15hrs and 15:40hrs.⁽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 care.

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 reasons.

Meal service and timing of meals

Catering services at the hospital were provided by in-house staff. A cook-fresh food production system was in place and meals were centrally plated with the exception of meat, which was prepared through a cook-chill system.* The mealtimes reported in the hospital's self-assessment questionnaire were as follows:

- Breakfast: 8.15am- 9.15am
- In between meal snack: 11.00am- 11.15am
- Midday meal: 12.35pm- 2.00pm
- In between meal snack: 3.15pm- 3.30pm
- Evening meal: 5.00pm- 6.00pm
- Late-evening snack and or drink: 9.00pm- 9.15pm

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⁾ Catering and nursing staff told inspectors that breakfast was served from 8.15am to 9am, lunch was served from 12.35pm to 1.15pm and the evening

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

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meal was served from 5.00pm to 5.40pm. Inspectors found that the hospital was not adhering to best practice guidelines with a four hour interval between the end of each main meal and the beginning of the next. Inspectors spoke with 12 patients regarding the spacing and timing of mealtimes and 11 patients told inspectors that they were satisfied with the mealtimes. One patient said mealtimes were too early.

Hospital managers told inspectors that they had a draft protected mealtime policy in place and the hospital planned to implement protected mealtimes[†]. Ward staff told inspectors that medication rounds were changed to a later time to facilitate mealtimes, but meals were sometimes interrupted by, for example, patients going for tests. On the day of inspection, inspectors observed some interruptions at mealtimes such as, bed making and doctor's rounds.

Of the 12 patients who spoke with inspectors, seven patients experienced no interruptions during mealtimes. However, five patients said that their meals had been interrupted and two of the five patients stated that their meals were interrupted by doctor's rounds. These findings were consistent with the findings from the Patient Food Satisfaction surveys of 2015 and 2016 where patients highlighted that their meals had been interrupted. The hospital should now proceed with the introduction of the protected mealtime policy to reduce non-essential interruptions at mealtimes.

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 for the lunch and evening meals to patients on the day of the meal service. Healthcare assistants outlined the choices for breakfast the day before breakfast was served. Hospital managers told inspectors that picture menus were also available, to help patients with communication difficulties understand the menus.

Hospital managers, catering and nursing staff told inspectors that patients were offered five to six choices for their midday meal, which included the main dish of the day, and were offered three choices for the evening meal which included salad, omelette or sandwiches.

[†] 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.

Inspectors viewed the weekly menus plan that rotated on a three weekly cycle for standard and therapeutic diets. Patients were offered the main dish of the day and five other options for the midday meal and three options for their evening meals.

All patients interviewed on the day of inspection confirmed that they were offered a number of choices for their midday and evening meals. Hospital managers and ward staff told inspectors that if patients did not like the choices offered, they could order something else and one patient who was in hospital for a long period of time confirmed this.

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⁾ Hospital managers and ward staff told inspectors that meal options from the standard menus were available to patients on texture-modified diets, and these would be processed by the central kitchen to meet the correct consistency. Inspectors viewed the menus on offer to patients on texture-modified diets and noted that patients were offered the main dish of the day and three options for their midday meal and evening meal including a vegetarian option.

Overall, inspectors found that there was a range of choices available to patients on standard, therapeutic and texture-modified diets.

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 snack rounds, which included a mid-morning, afternoon and evening snack round. Information regarding which patient required high protein high calorie snacks was recorded on the ward's patient meal and snack list, which inspectors viewed. In addition, inspectors observed on one of the wards visited, a white board at the nurse's station, which had information discretely displayed, regarding which patients required a high protein high calorie snacks.

All 12 patients who spoke with inspectors said that they had received a variety of snacks for the mid-morning, afternoon and evening snack rounds. Snacks included biscuits, yogurts, fruit or sandwiches. These findings were consistent with the hospital's snack audit findings of 2016, which highlighted that patients were largely

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

positive about the variety of snacks, offered, but would like a greater variety of biscuits and herbal teas.

Missed meals

Hospital managers and ward staff told inspectors that the hospital had a system in place to cater for patients who missed a meal. Ward staff could contact the kitchen up to 6pm to obtain a chilled meal, which was regenerated for the patient in the ward kitchen. Alternatively, a hot meal was available from the staff canteen up to 7pm or patients could have a salad, sandwiches or tea and toast if required. Seven of the 12 patients who reported missing a meal told inspectors that they were facilitated with a replacement meal and four of these patients said they got a hot 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's completed self-assessment stated that there were options for patients from different ethnic, religious, and cultural backgrounds. On the day of inspection, ward staff confirmed that ethnic, religious, and cultural food options could be provided if required. Halal[¥] food was available. Vegetarian meals were also available on the daily menu.

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 told inspectors that while they had a nursing shortage,

[¥] 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.

they had enough healthcare assistants to assist patients with their meals and the clinical nurse manager on a ward would inform them if they required extra staff to assist patients with meals.

Hospital managers and nursing staff told inspectors that information regarding which patients required assistance with meals was communicated during nursing handover to nurses and healthcare assistants. In addition, a laminated sign detailing information on the type of assistance a patient required was displayed over some of the patients' beds following an assessment by the speech and language therapist. Information was also recorded on the nursing assessment documentation regarding patients who required assistance while in hospital.

On one of the wards visited by inspectors, ward staff told inspectors that they had a symbol discretely displayed on a sign over the patient's bed so that staff could identify which patient required assistance. However, inspectors did not observe this practice for patients who required assistance with meals on the day of the inspection. Nursing staff told inspectors that they also operated a 'hold back' system on this ward where some meals were held back until healthcare assistants were available to assist patients who required assistance with their meals. This practice was observed on this ward on the day of the inspection

Inspectors observed that patients were positioned comfortably prior to their meal, and were provided with dining and feeding aids where needed. Inspectors observed good social interaction between patients and ward staff and a number of patients were asked if they wanted butter, gravy or a glass of milk. One patient did not like the meal offered and was offered an alternative.

Patients were observed being assisted by nurses, student nurses and healthcare assistants in a timely manner. Assistance was offered with chopping up of food, opening of food packages and with feeding. Patients were also encouraged to self-feed and inspectors observed visitors assisting their relative with their meal.

Patients' experience of meal service – food quality

All patients have a right to safe, nutritious food and the provision of meals should be individualised and flexible.⁽⁴⁾

On the day of inspection, inspectors observed catering staff and healthcare assistants serving meals from a food trolley which were centrally plated and labelled with coloured stickers to highlight different therapeutic diets. Inspectors observed

meals as they were being served, and noted that the food was served in an appetising way.

Inspectors spoke with 12 patients about their views on the quality of food provided in the hospital. Ten patients who spoke with inspectors spoke positively about how the food tasted. For example, most patients described the food as “fresh” and “excellent”. However, one patient said it could be hotter and another patient wanted more choice.

Hydration and availability of drinks

On the day of inspection, inspectors observed that drinking water was readily available to patients with jugs and glasses of water within easy reach of patients. Hospital managers and ward staff told inspectors that water jugs were replaced with fresh water in the morning and in the evening and refilled as required. All patients confirmed this to be the case on the day of inspection.

Inspectors observed patients being offered soup, tea, coffee or milk with their midday meal.

What worked well?

- All patients including those on therapeutic and texture-modified diets were offered a choice of meals.
- A system was in place to provide patients with a replacement meal.
- 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

- 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. Each of the 10 patients' healthcare records reviewed by inspectors included a completed nursing assessment of nutrition and hydration within 24-hours of admission. However, inspectors found that only four of the 10 patients had been weighed on admission.

As part of the completed self- assessment, the hospital reported that they were screening patients on one ward using the Screening in Practice tool. On the day of inspection, hospital managers told inspectors that they were no longer using this tool and had changed to the MUST screening tool. The MUST is the tool recommended in the national guidelines.⁽⁴⁾ Hospital managers told inspectors that they were piloting the MUST screening tool on one ward since October 2016, and they planned to audit compliance with the MUST screening tool and introduce this tool to screen all patients for their risk of malnutrition across the hospital.

Inspectors visited two wards, one of which was screening patients for their risk of malnutrition. Inspectors reviewed five healthcare records on the ward that was piloting the MUST screening tool. Inspectors found that none of these patients had been screened for their risk of malnutrition.

Overall, inspectors concluded that the practice of screening and re-screening patients for their risk of malnutrition requires improvement and should be a key area of focus for the hospital following this inspection.

Of the 10 healthcare records reviewed, nine had fluid balance charts and all fluid balance charts used quantitative measures. Eight of the nine fluid balance charts were completed and up-to-date. Four of the healthcare records reviewed contained food charts. Three of the four food charts used semi-quantitative measures as recommended in national guidelines⁽⁴⁾ and were completed and up-to-date. The remaining food chart had been commenced on the day of inspection so it was too early to comment on its completion.

Equipment for screening

During this inspection, inspectors observed some of the required equipment used to screen patients for the risk of malnutrition. Inspectors observed that both wards had access to standing scales and stadiometers.[◇] However, while the standing scales on one of the wards visited had been calibrated, not all of the standing scales on the second ward visited were calibrated.

Access to chair scales and hoist scales was shared with other wards and was not observed by inspectors on the day of inspection.

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. As outlined in the hospital's policy, patients' requirement for dietetic referral is determined by the patients' clinical team. Referrals were recorded on a paper-based system and dietitians accepted referrals from medical staff.

Hospital managers and ward staff reported that patients were seen promptly by the dietitian. Six of the 10 healthcare records reviewed by inspectors belonged to patients who had a documented assessment by a dietitian. Of these six patients, three were seen by the dietitian on the same day of referral, two patients were seen by the dietitian within 24-hours of the referral and the remaining patient was seen within 48-hours of referral.

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

Hospital managers and staff told inspectors that patients referred to speech and language therapists were seen in a timely manner. Two of the 10 healthcare records reviewed belonged to patients who had a documented assessment by the speech and language therapy service and one of these patients was seen on the same day as referral. The remaining patient was seen within 24-hours. Overall, inspectors were satisfied that patients had good access to dietetic and speech and language services at the hospital.

What worked well?

- A nursing assessment of patients' nutrition and hydration needs was carried out within 24-hours of admission.
- There was timely access to dietitians and speech and language therapists for patients.
- Accurate and complete recording of food and fluid charts.

Opportunities for improvement

- Patients should be screened for their risk of malnutrition within 24-hours of admission and re-screened weekly in line with national guidelines.
- Weighing patients on admission and re-weighing as necessary.
- All equipment needs to be calibrated within the required timeframes.

Theme 3: Safe Care and Support

Safe care and support recognises that the safety of patients and service users is of the highest importance and that everyone working within healthcare services has a role and responsibility in delivering a safe, high-quality service. Certain areas relating to nutrition and hydration care are associated with a possible increased risk of harm to patients. These include:

- identifying whether hospitals have systems in place to ensure that the right meal is served to the right patient
- ensuring patients are not experiencing prolonged fasting unnecessarily

- ensuring patient safety incidents relating to nutrition and hydration care are reported, recorded, investigated and monitored in line with best available evidence and best practice guidelines.

Communication of dietary needs

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
- Instructions from the speech and language therapist displayed over patients' beds with information on texture-modified diet requirements
- Menu labels on the patients' trays which outlined the patients' meal ordered and bed number
- A special diet folder which provides patient specific information on special diets and special dietary requirements to all staff involved in patients' nutrition and hydration care
- Patient meal and snack list.

Catering staff and healthcare assistants told inspectors that patients' dietary needs were recorded on a daily diet sheet. This diet sheet listed all patients on the ward by name and bed number and staff checked the sheet before distributing meals to ensure that all patients received the correct meal. Ward staff told inspectors that therapeutic and texture-modified meals were labelled to ensure that the patient received the correct meal ordered and inspectors viewed texture-modified meals labelled on the day of inspection.

All 12 patients who spoke with inspectors stated that they always received the correct meal. On the day of inspection, patients who required a specific diet were seen by inspectors to receive the correct meal.

Patients safety incidents in relation to nutrition and hydration

Hospital staff and management reported that there were no high-risk incidents reported or written complaints received from patients in relation to nutrition and hydration care the last 12 months. There was one minor incident reported in the last 12 months where a patient on a texture-modified diet was offered the wrong meal, but this was addressed immediately and the patient was given the correct meal.

However, inspectors viewed the minutes of the Nutritional Care Committee for November 2016 and noted that six incidents relating to nutrition and hydration care were reported as being registered on the hospital's incident reporting system for 2016. These incidents included one incident relating to enteral nutrition and a second incident relating to a patient receiving a wrong diet post surgery. The Nutritional Care Committee subsequently implemented a number of quality improvement initiatives to ensure that patients received the correct meals which included the following:

- development of specific checklist of feeds and sip feeds and their allergen content called 'Free-From Status of Enteral Feeds and Sip Feed Supplements'
- development of a procedure for patient meal ordering and delivery
- requirement for nurses to sign off the ward meal ordering sheet with catering staff for the midday and evening meal and healthcare assistants for breakfast to ensure that the correct meal was ordered for each patient.

The hospital had a system for reporting patient safety incidents and a process for ensuring that incidents were reviewed through the hospital's governance structures.

What worked well?

- There were systems in place to ensure that 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 include the following:

- help implement national guidelines
- set the standard of care in relation to nutrition for hospitalized patients
- review the food-service system, nutritional risk screening and audits.

The inspection team looked at key leadership; governance and management areas aligned to the *National Standards for Safer Better Healthcare* and sought information relating to the governance arrangements in place to oversee nutrition and hydration practices.

Nutrition Steering Committee

The hospital had a Nutritional Care Committee, which was set up 2002. The Dietetic Manager chaired this Committee. It had agreed terms of reference that detailed the purpose, membership, objectives of the committee, meetings and record keeping. In 2016, the Nutritional Care Committee set up five key working groups and one of these working groups was responsible for nutrition screening. Hospital managers told inspectors that the Nutritional Care Committee reported into the Clinical Governance Committee.

The purpose of the Nutritional Care Committee at the Mercy University Hospital is to support the improvement of standards and patient experience in relation to oral nutrition and hydration care and service provision. Hospital managers told inspectors that there was representation on this Committee from all disciplines of staff as recommended in the national guidelines with the exception of a pharmacist. This Committee had developed a quality improvement plan for 2016 and had completed a comprehensive end of year report detailing the Committee's objectives and achievements to date for the Clinical Governance Committee.

Inspectors requested copies of agendas and minutes for the last six meetings of the Nutritional Care Committee. This Committee had met eight times between April 2016 and December 2016, meetings were well attended, and there was a record of discussion and agreed outcomes. Each action plan had a number of lead persons assigned to each action with a date of completion. Actions included areas such as screening patients for the risk of malnutrition, menus, policy development, audits, training, risk and incident reporting. Most areas of focus had detailed notes on progress to date, which included feedback from individual working groups including the Nutrition Screening Working Group.

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 and hard copies were also available to staff to reference on the ward.

The hospital had a policy on Oral Nutrition and Hydration and had drafted a policy on protected mealtimes. Hospital managers told inspectors that the hospital did not have a policy in place to screen patients for their risk of malnutrition and were reviewing the fasting guidelines.

Inspectors concluded that the hospital needs to continue to develop policies in relation to nutrition and hydration care including the development of a MUST screening policy to guide staff and standardize nutrition and hydration care and the 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 the hospital had completed audits of the nutrient content and portion size of meals every year since 2010. Inspectors were provided with a copy of the hospital's 'Nutritional Care Committee summary report 2010 and onwards' which also included the quality improvement plans required to improve the nutrient content of specific meals. These included a plan to fortify texture-modified meals and introduce food items, for example, oily fish, more green vegetables, liver and raisins to improve the nutrient content of specific meals.

Inspectors were given copies of the most recent analysis of the nutrient content and portion size of meals carried out in 2016. Seven hospital menus were analysed and these included the standard menu, texture-modified diet menus and high protein and high calorie diets. While the results showed that the weekly average protein content for the standard portion sized meals met national guidelines, the average fat content was above the national guidelines. In contrast, the analysis of texture-

modified meals showed that the meals met the national guidelines for fat content and were below the national guidelines for protein content. Recommendations were made following the analysis of the menus to meet compliance with national guidelines.

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

- conformance of the texture-modified consistency diets to the national descriptors ⁽⁵⁾
- safe delivery of therapeutic diet and observational study of mealtimes and interruptions
- special diet folder
- snack trolley service.

The audit on the safe delivery of therapeutic diets and an observational study of mealtimes and mealtime interruptions was carried out in June 2016. The aims of this audit was to assess whether the correct supporting documentation was in place for patients on texture-modified diets and if each patient received the correct texture diet, whether patients who required assistance with meals were provided with assistance in a timely manner and assess mealtime interruptions.

The audit findings showed that all patients on texture-modified diets during the audit received the correct meal. The speech and language therapist's signs were displayed over patients' beds for those patients who required it. Assistance was provided to all patients who required assistance with their meal in a timely manner with the exception of one patient who had to wait for a short period, but was later provided with assistance. The audit also showed that doctors, nurses, visitors and medication rounds interrupted mealtimes. Recommendations made following this audit included a plan to introduce protected mealtimes to reduce non-essential interruptions at mealtimes.

Overall, inspectors found that the hospital had carried out a number of nutrition and hydration care audits including auditing the nutrient content and portion size of food in line with national guidelines. However, the hospital had not audited compliance with their MUST screening tool. This should be a key area of focus for improvement by the hospital following this inspection.

Evaluation of patient satisfaction

Hospital managers told inspectors that the hospital had carried out patient food satisfaction surveys every year since 2010. Inspectors were provided with a copy of

the hospital's 'Nutritional Care Committee summary report 2010 and onwards'. The report indicated that patients overall were satisfied with the food and food service in the hospital and identified areas for improvement. Patients on texture-modified diets also completed these surveys although the report highlighted that feedback was reduced due to the limited number of patients who could participate in the surveys. Nevertheless, the surveys identified areas for improvement which included improving the taste and palatability of some texture-modified diets.

The inspection team were also provided with a copy of the most recent patient food satisfaction survey results for 2016. This report stated that ninety-seven per cent of patients were satisfied with the food and food service. However the survey also highlighted that the number of interruptions to patients' mealtimes in 2016 was similar to the findings of 2015 survey. Recommendations included introducing protected mealtimes to reduce non-essential interruptions to mealtimes and looking at the variety of cultural dishes offered to patients.

Quality improvement initiatives

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

- Quality improvement made in the area of nutritional composition of modified texture diets (minced-moist and pureed diets)
- Taste and palatability study of modified texture diets
- Picture menus to improve communication for patients with communication difficulties
- Catering cards were provided on patients' meal trays with a direct link to the catering supervisor to provide feedback on the meal service
- Snack trolley service
- Snack checklist for therapeutic diets
- Updating the special diet folders at ward level.

What worked well?

- The hospital had established a Nutritional Care Committee, which had implemented a number of quality improvement initiatives and had a clear defined quality improvement plan. This Committee developed an end of year report outlining annual objectives and achievements for the year.

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- The hospital had conducted a number of audits in nutrition and hydration care including analysis of nutrient content of menus.
- The hospital conducted an annual patient food satisfaction survey to improve patients' experience of nutrition and hydration care.

Opportunities for improvement

- The hospital needs to continue to develop policies in relation to nutrition and hydration care to guide staff and standardize nutrition care and meal service provision at the hospital.
- 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
- 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 nurses, healthcare assistants and catering staff involved in nutrition and hydration care through lectures, workshops and external study days.

On the day of inspection, hospital managers and ward staff told inspectors that nursing staff and healthcare assistants received training in relation to nutrition and hydration care from dietitians on the ward. Training was provided on upper gastrointestinal diets, ward diet folder and the MUST screening tool. Inspectors viewed MUST training records that showed that this training was well attended. Catering staff told inspectors that they received training from dietitians on texture-modified diets and therapeutic diets.

Speech and language therapists provided training to ward staff in relation to thickened fluids and dysphagia. Hospital managers told inspectors that medical staff were provided with information documents in relation to nutrition and hydration care during their induction. Inspectors viewed the training calendar in the hospital's end of year Nutritional Care Committee's summary report 2016 detailing the training provided to medical staff, healthcare assistants, catering and nursing staff in a training calendar.

What worked well?

- The hospital provided specific training to catering, nursing staff and healthcare assistants, which was outlined in a training calendar.

Conclusion

The inspection team found, on the day of inspection, that Mercy University Hospital had an established Nutritional Care 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 care, which included screening patients for their risk of malnutrition. The hospital was piloting the MUST screening tool on one ward. However, when inspectors reviewed a small sample of patient healthcare records on the day of inspection, they found that malnutrition screening was not carried out within 24-hours of admission and that weekly re-screening was not carried out. The practice of screening and re-screening all patients for their risk of malnutrition in line with national guidelines should be a key area of focus for improvement by the hospital following this inspection. ⁽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. All patients including those on therapeutic and texture-modified diets were offered a choice of meals. Inspectors observed that patients who required assistance were offered assistance in a prompt manner.

Inspectors found that the Nutritional Care Committee had carried out a number of audits on aspects of nutrition and hydration care including annual audits of the nutrient content and portion size of meals. 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 continue to develop and implement policies relevant to nutrition and hydration care. This includes prioritising the development of a policy for screening patients for the risk of malnutrition and implementation of the policy on protected mealtimes.

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 Nutritional Care Committee must implement the screening of all patients for their risk of malnutrition, and continue to implement a structured system to audit nutrition and hydration care. While the hospital carried out a patient food satisfaction survey annually, they need to use the patients' views to inform and direct change and to reinforce good practices where they exist.

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