



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of nutrition and hydration at University Hospital Kerry

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

Date of on-site inspection: 13 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* ¹ an unannounced inspection was carried out at the University Hospital Kerry on 13 July 2016 by authorized persons from HIQA, Aoife Lenihan, Dolores Dempsey-Ryan, Paul Dunbar and Conor Dennehy, between 09.30hrs and 14.30hrs.

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

Inspectors visited two wards during the midday meal to check first-hand that patients received a good quality meal service, had a choice of food and that they were provided with assistance with eating if required. Inspectors observed one meal, spoke with 13 patients, their relatives when present and 16 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.

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 interruptions.

Meal service and timing of meals

Catering services at the hospital were provided by in-house staff. A cook-chill food production and centrally plated system was in use*. The mealtimes reported in the hospital's completed self-assessment were as follows:

- Breakfast: 8.00am-8.45am
- Snack: 10.00am-10.30am
- Midday meal: 12.00pm-12.45pm
- Evening meal: 4.30pm-5.15pm
- Evening tea/coffee: 8.00pm-8.45pm

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.³ Inspectors found that the hospital was adhering to best practice guidelines with a four-hour interval between the three main meals of the day. Inspectors spoke with 13 patients and ten of these patients commented on the spacing and timing of mealtimes. Five patients were satisfied with mealtimes but five patients felt some meals were served too early. A number of patients commented that they would not eat at the same times in their home environment and acknowledged that it may not be possible to satisfy all requirements in this regard. In addition, one patient felt that the time between the midday meal and the evening meal was too long.

* 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.

Meal orders were taken by catering staff and meals and drinks were served by catering and housekeeping staff. Inspectors observed that, in general, catering and housekeeping staff engaged socially with patients and knew most of them by their first name. Inspectors observed that bed tray tables were generally free from clutter.

Inspectors observed a protected mealtime sign[†] outside the door of both wards inspected to discourage unnecessary interruptions at mealtimes. Nursing and catering staff told inspectors that the protected mealtimes policy was well respected by staff within the hospital and staff did not interrupt patients unnecessarily during mealtimes. Inspectors observed no evidence of non-essential interruptions from staff during the midday meal and the majority of patients told inspectors that their meals were not interrupted.

Choice and variety of food

The hospital stated in its completed self-assessment tool that menu options were verbally outlined to patients. Since the completion of this tool, the hospital had introduced a written menu card on two wards and hospital managers told inspectors there were plans to introduce menu cards to all wards. Hospital managers told inspectors that catering staff on wards that did not use menu cards verbally outlined the menu options to patients from the midday and evening meal order sheets, which detailed the dish of the day and alternatives available. Inspectors viewed the weekly menu cards which rotated on a three-weekly basis. Catering staff told inspectors that patients were informed about what was on the menu for the midday and evening meal after breakfast so they ordered on the same day the meals were served.

Patients had the option to order a regular or small portion and could also opt to have soup with their midday meal on the menu card. Details of the accompanying dishes were not described and the menu card stated that alternatives to the menu were available on request. However, there was only one option detailed on the menu card for the midday meal and the evening menu had the same five choices outlined every day without variation and included; a mixed grill, scrambled egg and tomato, a cold meat or fish salad or a sandwich (it was unclear what the option of sandwich was). This was confirmed by hospital managers and catering staff who told inspectors that if patients did not want the main meal described on the menu card they could

[†] Protected mealtimes are periods when patients and service users are allowed to eat their meals without unnecessary interruptions, and when nursing staff and the ward team are able to provide safe nutritional care. HIQA recognises that there are a small number of areas in the hospital where protected mealtimes policies may be contrary to the daily functioning of that unit.

request something else (for example a savoury omelette and fries, liver lyonnaise and or sandwiches in the evening).

On the day of inspection, nine out of ten patients that spoke with inspectors confirmed that they did get a choice of meals. Two patients told inspectors that they got one option for the midday meal but told inspectors they could ask for an alternative meal, seven patients confirmed that they got other choices for the midday meal apart from what was on the menu and one patient had not had an opportunity to order meals as they were admitted that day. One patient said that they felt that some staff offered more choices than others.

Hospital managers told inspectors that catering staff responded to patients' preferences and patients gave inspectors some examples of this, such as catering staff sourcing special food items on request such as a specific brand of herbal tea that the patient requested.

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 told inspectors that most of the standard menu meals were available to patients on texture modified diets and that these would be processed by the central kitchen on request. Inspectors viewed the texture modified meal menus and patients requiring texture modified dishes had a choice of meals. Inspectors also observed texture modified meals served to patients on both wards. The meals looked appetising and all foods were separated on the plate. Inspectors were satisfied that choice was available for patients on a texture modified diet.

The national guidelines recommend nourishing snacks and drinks be offered to patients between meals.⁴ This may be particularly relevant if there is a long time period between the last meal of the day and breakfast the following morning. Staff told inspectors that there were two main snack rounds during the day, one at 10am and an evening round at approximately 8pm. Staff relied on patients to ask for a snack if they wanted one at other times in the day. Patients mostly reported being offered a hot drink with biscuits as a snack. While other options were available (e.g. fruit, yogurts, milk, juice, yogurt drinks) these were not routinely offered as part of the snack round. Again, it was up to the patient to specifically request these items. In addition to the snack rounds, a shop trolley circulated throughout all the wards during the day selling soft drinks, fruit and confectionery.

Overall, while there were a range of choices available to patients and most patients had some choice, inspectors were not satisfied that there was a system to routinely

offer all patients the full choice of meals and snacks available. In addition there was a lack of variety for the evening meal as it did not differ day to day.

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. For example, if a patient missed their midday meal staff could phone the central kitchen to order a replacement meal, sometimes as late as 3pm. The same applied to the evening meal where catering staff could order a replacement meal up until 7pm. In addition to these arrangements, catering staff could order items from the hospital canteen if necessary. Five patients who reported missing a meal told inspectors that they were facilitated with a replacement meal.

Catering for patients with ethnic, religious and cultural dietary needs

The *National Standards for Safer Better Healthcare*¹ state that patients should experience healthcare, which 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 that there were menu options available for patients from different ethnic, religious, and cultural backgrounds. Hospital managers and catering staff told inspectors that they could provide Halal meals on request as these were also prepared for hospital staff on-site. Vegetarian meals were also available.

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 managers told inspectors that each ward did not have a full complement of healthcare assistant staff and patients relied mainly on nursing staff to provide assistance with eating and drinking. Clinical nurse managers and nursing staff told inspectors that assisting patients with meals was prioritized, for example, staff

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

breaks were scheduled after patients had eaten their meals. The system in place to identify which patients required assistance included a section in the nursing assessment and the eating and drinking care plan that detailed whether patients required some or full assistance with eating and drinking. This information was also communicated verbally between nursing staff during shift handovers.

Catering and housekeeping staff received a daily diet sheet but this did not make note of patients' assistance requirements and there was no system in place for staff who served meals to easily identify patients who needed assistance with eating and drinking during the meal service. As a result, there was no difference between how meals were served to those that required assistance.

Inspectors observed the midday meal and noted that patients were positioned comfortably prior to the meal and provided with dining and feeding aids as required. Inspectors observed two occasions where patients who needed assistance did not receive it in a timely manner. The inspector observed that one of the patients who required assistance had a meal placed on the tray table in front of them and pulled it onto their lap. As a result the inspector had to seek immediate assistance from nursing staff for this patient.

Patients' experience of meal service – food quality

All patients have a right to safe, nutritious food and the provision of meals should be individualised and flexible.⁴ On the day of inspection, inspectors observed meals as they were being served and found that food was served in an appetising way (the meal served on the day of inspection was bacon, mashed potatoes, cabbage and vegetables).

Inspectors spoke with patients about their views on the quality of food provided in the hospital. Most patients spoke positively about how the food tasted and the portion sizes. For example, some patients described the food as; 'couldn't praise it highly enough' and 'good choice all round'. However, two patients expressed general dissatisfaction with the food service. Both identified an issue with the temperature of the food and felt it was not sufficiently hot when served.

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, housekeeping and nursing staff told inspectors that water jugs were replaced with fresh water in the morning, refilled in the afternoon and as required by

healthcare assistants. In general, inspectors were satisfied that patients had access to sufficient hydration throughout the day.

What worked well?

- Most patients expressed satisfaction with the quality of the food and the meal service.
- Water was replenished twice during the day.

Opportunities for improvement

- Engage with patients to seek their views on the timing and spacing of meals.
- A full description of the choice of meals and snacks available should be communicated to all patients.
- The day to day variation of meal options offered to patients for the evening meal.
- The system in place for staff who served meals to patients to identify which patients who required assistance with meals.
- Ensure timely assistance for all patients who required assistance with meals.

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 spoke with healthcare professionals during the inspection about how they identified and monitored patients who were at risk of malnutrition and or dehydration. They also reviewed 11 patient healthcare records. 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 on patients who were at risk of malnutrition, patients who had been referred to a dietitian and or required a specific therapeutic diet.

Patient assessment and malnutrition screening

The inspection team found that the hospital had a structured nursing assessment for all admitted patients. All 11 patient healthcare records reviewed by inspectors had a complete nursing assessment of nutrition and hydration documented within 24 hours of admission. Inspectors found where patients required a specific therapeutic diet, this was recorded in the nursing assessment.

The hospital had a nutrition and hydration policy which included a section on malnutrition screening. The hospital policy required staff to screen patients for their risk of malnutrition on admission using the Malnutrition Screening Tool (MST). This was a different tool to the Malnutrition Universal Screening Tool (MUST) which was recommended by the Department of Health guidelines.⁴ However, there was no requirement in the nutrition and hydration policy to rescreen patients for their risk of malnutrition. This was not in keeping with national guidelines which recommend a review of the nutritional risk of the patient each week regardless of their admission nutritional risk score.

Inspectors found that 10 out of 11 patients whose healthcare records were reviewed had been screened for their risk of malnutrition as per hospital policy. One patient was not screened as staff could not weigh the patient for valid clinical reasons and the patient was unable to recall whether they had lost weight. This information was clearly documented in the patient's healthcare record.

Inspectors were given a sample copy of the hospital's 'intake and output record' which was used to record the patients' fluid intake and output. They were also given a copy of a 'food and fluid record chart' from the hospital's department of nutrition and dietetics. The inspection team reviewed 11 patient fluid intake and output records. Of the 11, eight had used quantitative measures while only two were fully complete and up-to-date. Those that were not complete and up-to-date did not have the daily fluid balances totalled.

Inspectors found that it was practice for nursing staff to document patients' food intake on the fluid intake and output records. Inspectors reviewed nine records where the patient's food intake was documented and found that eight out of nine records did not use semi-quantitative measures as recommended in the national

guidelines, had not been completed in full and were not up to date. One record out of the nine healthcare records reviewed had food intake documented on the 'food and fluid record chart' from the hospital's department of nutrition and dietetics and this was complete, up to date and used the correct semi quantitative measures.

Equipment for screening

During this inspection, inspectors looked for the required equipment used to screen patients for the risk of malnutrition. This included stand-on weighing scales and chair and hoist scales for more frail and dependent patients, and measuring tapes. The screening tool in use in the hospital did not require staff to measure the height of patients and as such, inspectors did not observe a stadiometers[◇] or a measuring tape.

One ward had access to a stand-on scales whereas the other ward inspected did not and both wards had access to a chair and hoist scales. The hoist scales observed by inspectors had been calibrated in the previous 12 months. However, there was insufficient evidence available to show that the either of the chair scales or the stand on scales had been calibrated within the required timeframe.

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 requiring a dietetic assessment were referred by the medical team, despite the fact that nurses identified patients who were high risk of malnutrition following nutritional screening (MST). Seven of the eleven patients whose healthcare records had been reviewed by inspectors had a dietetic assessment.

The Dietetic Manager told inspectors that the Department of Nutrition and Dietetics had a system of prioritising patients who needed to be seen by a dietitian. In spite of these challenges nursing staff and hospital managers told inspectors that patients had timely access to dietitians and it was rare that patients would be discharged without seeing a dietitian following referral. Hospital managers told inspectors that a business case had been submitted to senior management in relation to staffing resources to meet the demands on the dietetic service due to an increase in demand from expanding inpatient and outpatient services. Inspectors found that five of the seven patients had been seen by the dietitian within one to three days of admission. Two other patients were assessed by a dietitian a number of weeks following

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

admission but as the referral date was not documented it was unclear how long they had waited from the referral date. All patients who had an assessment by a dietitian had a specific nutritional care plan in their healthcare record.

What worked well?

- The hospital was screening patients for their risk of malnutrition on admission in all wards.

Opportunities for improvement

- Rescreening patients for their risk of malnutrition in line with national guidelines.
- Accurate and complete recording of food and fluid charts.
- The calibration of weighing equipment on a yearly basis or as per manufacturer's instructions.

Theme 3: Safe Care and Support

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

The hospital had several methods of identifying and communicating patients' dietary needs. On admission, patients' specific dietary requirements were documented in their healthcare records. Catering staff told inspectors that nursing staff documented information about patients' dietary needs on a daily diet sheet, for example if a patient required a specific diet. The diet sheet was given to catering and

housekeeping staff and listed all patients on the ward by name and bed number. While the diet sheet listed patients' specific dietary requirements, it did not record whether a patient required assistance with eating or drinking.

Catering and nursing staff who spoke with inspectors expressed the view that the systems to ensure that patients received the correct meal worked well. All of the patients who spoke with inspectors stated that they had always received the correct meal.

Patients safety incidents in relation to nutrition and hydration

Hospital staff and management reported that there had been no patient safety incidents received from patients in relation to nutrition and hydration in the last 12 months.

There had been two formal complaints in relation to the options available from vending machines in the Emergency Department. These had been discussed at the June 2016 Nutrition Steering Committee meeting and the decision made to communicate these to hospital management for their review and appropriate action.

What worked well?

- The hospital had systems in place to ensure patients received the correct meals.

Theme 5: Leadership, Governance and Management

The *National Standards for Safer Better Healthcare*¹ 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*¹ and sought information relating to the governance arrangements in place to oversee nutrition and hydration practices.

Nutrition Steering Committee

The hospital had a Nutritional Steering Committee, which was set up in February 2015 and was chaired by the hospital's Quality Manager. It had agreed terms of reference that detailed the aim, membership, reporting structures, meeting frequency and the responsibilities of members. The aim of the Committee was to direct and support the implementation of a comprehensive programme of nutritional care which was designed to ensure that all patients of University Hospital Kerry receive nutritional care and or nutrition support appropriate to their needs and preferences.

The Chair of the Committee told inspectors that the Nutrition Steering Committee reported into the Quality and Patient Safety Committee and that the progress of the Committee's work was formally communicated in the form of periodic written reports. The membership of the Committee was in keeping with the national guidelines. The Committee had agreed that as members of the Committee also sat on the Hospital's Drugs and Therapeutics Committee a pharmacy representative was not required.

Inspectors requested and reviewed copies of agendas and minutes for the last six meetings; all meetings had been minuted. The Committee aimed to meet six times per year and from reviewing the minutes of the Committee's meetings had met six times between September 2015 and June 2016. Attendance at meetings was in line with the Nutrition Steering Committee's terms of reference. There was a record of discussion, agreed outcomes and actions required as well as the plan of action for 2016. Examples of progress and work completed by the committee included developments on hospital policies for nutrition care, audits in relation to nutrition care and projects seeking feedback from patients on aspects of nutrition care and meal services.

The Committee submitted their work progress to senior management and also tracked and reviewed patient safety incidents and complaints in relation to nutrition at each meeting. The Chair of the Nutrition Steering Committee told inspectors that the hospital was planning to change the tool for screening patients for their risk of malnutrition from the Malnutrition Screening Tool (MST) to the Malnutrition Universal Screening Tool (MUST) in line with other hospitals in the South/South West Hospitals Group and as recommended by the national guidelines. The Chair of the Committee and hospital managers told inspectors that the timeframe for the implementation of the MUST tool was a long term plan and inspectors did not find detail of this in the minutes or planning documents of the Nutrition Steering Committee.

Overall the inspection team found that the objectives of the Committee were clear and the Committee's work plan and minutes of meeting reflected 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 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 computer network and nursing staff demonstrated that they could access them on the wards visited.

The hospital had a number of policies including a nutrition and hydration policy that included the process for screening patients for their risk of malnutrition. The hospital also had a policy on protected mealtimes and policies for fasting patients who were undergoing surgery.

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 was conducting a trial of software to audit the nutrient content and portion size of meals of the hospital menu, but had not yet conducted this analysis as recommended in the national guidelines.

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Inspectors were provided with copies of completed audits in relation to nutrition and hydration. A recent audit on screening patients for their risk of malnutrition and weighing patients on admission was conducted in June 2016. The results of the screening audit highlighted that five out of seven wards had screened 100% of patients and two wards had screened 90% of patients.

Inspectors were given the results of previous audits in relation to the recording of patients' weight on admission conducted in March 2015 (two wards), July 2015 (two wards), March 2016 (six wards) and June 2016 (seven wards). The results showed large variances between wards in the recording of patients' weight on admission. In the most recent audit, some wards were weighing all patients on admission or greater than 80% of patients (four out of seven) but three out of seven wards were either not recording weights or only recording weights in 10% of patients. The two wards that had been subject to all four weight audits showed improvement each time and had the highest compliance rating. The lowest compliance rating was on the wards that had only been subject to the two most recent audits. Findings indicated that consistent auditing of practice can lead to improvements in care.

A separate audit conducted in August 2015 looked at whether patients had lost weight while in hospital. The results showed that two out of 43 patients included in the audit had lost weight while in hospital.

The hospital had also audited compliance with the hospital's protected mealtimes policy each year in 2013, 2015 and 2016. The audit looked at whether patients were ready for their meal, whether patients were interrupted inappropriately during their meal and if so what interrupted their meal (for example ward rounds, doctors on the ward, nursing observations, medication rounds and visitors). The audit results from the 2016 audit showed that of 118 observations of patients mealtimes 20 out of 118 experienced inappropriate interruptions including; ward rounds (three cases out of 118), doctors on wards (one case), nursing observations (six cases), allied professionals attending patients (two cases), visitors (five cases), medication rounds (three cases) and other reasons that were not specified accounted for three interruptions. However, the number of interruptions had significantly decreased from the audit completed in 2013 when compared with the results from 2015 and 2016.

Overall, inspectors found an established culture of audit and evaluation of aspects of nutrition care which was supported and directed by the Nutrition Steering Committee. There was evidence that nutrition audits were planned and discussed at Nutrition Steering Committee meetings. The results of the audits on recording of patients' weight highlighted a continued need for tracking compliance with hospital nutrition policies to ensure that improvements are made and monitored on a regular

basis. The programme of audit of nutrition and hydration care could be further developed in the future to include audit of other nutrition and hydration practices and hospital policies related to nutrition, in particular auditing the nutrient content of hospital food to reflect national guidelines.

Evaluation of patient satisfaction

Hospital managers told inspectors that they had carried out patient satisfaction surveys on every ward on a monthly basis and the inspection team were provided with a copy of the results to date for 2016.

Patients were asked four questions in relation to nutrition and hospital food including; how they would rate the hospital food, was there healthy food on the hospital menu, did they get enough help from staff to eat their meals and would they like a menu card to choose from. Overall 77% patients rated the food as 'good' or 'very good'. The majority of patients agreed that there was always a healthy option available (74%) and of fourteen patients that required help with eating, eight answered that help was always available, three answered that help was sometimes available and three did not get help as required. Most patients answered yes to the question 'would you like a menu card to choose from' and hospital management told inspectors that a menu card was introduced as a result of this feedback.

Quality improvement initiatives

The hospital told inspectors about a number of recent quality improvements initiatives implemented in relation to nutrition and hydration. These included the introduction of a hospital volunteer programme, a shop trolley that sold snacks and fruit, the introduction of menu cards on some wards and providing a healthy option on the breakfast menu.

What worked well?

- The hospital had established a Nutrition Steering Committee which had implemented a number of quality improvement initiatives and had a clearly defined work plan.
- The hospital has an established culture of audit and evaluation of aspects of nutrition care which was supported and directed by the Nutrition Steering Committee. This could be developed and enhanced further.

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 that specific training was provided for medical, nursing, healthcare assistants and catering staff involved in nutrition and hydration care. Training was provided to staff through lectures and workshops. The hospital also indicated that catering staff received training in the preparation of special and restrictive menus.

On the day of inspection, hospital managers and nursing staff told inspectors that informal training had been provided to nurses on the wards in relation to the Malnutrition Screening Tool (MST). Nursing staff told inspectors that they had been provided with training on fluid thickening. Catering and nursing staff told inspectors that they had also received training on texture modified diets.

Inspectors requested copies of attendance records at nutrition and hydration training but these were not available as hospital managers told inspectors that training was provided in an informal way, including training on the use of the Malnutrition Screening Tool. They told inspectors that new staff were shown how to use the tool as part of their induction and nursing staff on the wards confirmed this with inspectors.

Opportunities for Improvement

- The hospital need a structured and specific training on nutrition and hydration in line with national guidelines needs to be provided to all staff involved in patient care.

Conclusion

The inspection team found, on the day of inspection, that University Hospital Kerry had implemented a number of quality improvement initiatives relating to nutrition and hydration. They found that the Nutrition Steering Committee had played a key role in raising the importance of the provision of good nutrition and hydration care across the hospital and had implemented key quality improvement initiatives.

The hospital had selected MST as the tool of choice to screen patients for their risk of malnutrition and had implemented screening on all wards. Inspectors reviewed a small sample of patient healthcare records and found that these patients were screened for their risk of malnutrition as per hospital policy. However, the hospital needs to review its policy on screening patients for their risk of malnutrition, as it was not in line with national guidelines in relation to rescreening patients.

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 not all patients who required assistance were offered assistance in a prompt manner. Most patients who spoke with inspectors were generally satisfied and complementary about the food and drinks they received. However, while the majority of patients highlighted that they were offered a choice of food at the midday meal, the written menu card did not outline the full range of choice available. The hospital should review its system of communicating menu and snack choices to patients to ensure that all patients have a choice of food and can obtain additional snacks if required.

Inspectors found that the hospital had developed a number of policies relevant to nutrition and hydration, and there was evidence of auditing of nutrition and hydration care practices in the hospital. A nutrition and hydration audit programme, which includes the requirement for auditing the nutrient content of meals provided in line with the national guidelines could provide assurance to hospital management and the Nutrition Steering Committee that the meals provide adequate nutrition for patients.

The Hospital must now ensure that quality improvement efforts and arrangements in place for meeting patients' nutritional and hydration needs continue to improve. To achieve this, the hospital's Nutrition Steering Committee must encourage and support improvements in screening patients for risk of malnutrition and expand the programme of audit 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 this.

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