National Nursing, Midwifery and Health Visiting Advisory Committee

Promoting Nutrition for Older Adult In-Patients in NHS Hospitals in Scotland

February 2002
National Nursing, Midwifery and Health Visiting Advisory Committee

PROMOTING NUTRITION FOR OLDER ADULT IN-PATIENTS IN NHS HOSPITALS IN SCOTLAND
Terms of Reference

To consider the implementation of nutritional standards for older adult in-patients in NHS hospitals in Scotland.
Executive Summary

Under-nutrition in older adult acute and long-stay hospital in-patients is known to complicate illness, delay recovery and prolong hospital stay. It is also implicated in a higher rate of mortality.

In preparing this report, care has been taken not to duplicate work that has already been undertaken in this area. To this end, the Working Group has tried to identify examples where the Nursing Home Core Standards for Nutrition have been implemented in NHS hospitals in Scotland and thus provide a practical guide to staff charged with taking the Standards forward. Whilst other reports offer examples of good practice covering a range of areas, there is no single piece of work which addresses the whole spectrum of nutritional care.

The report focuses on:

- pre-admission assessments and nutritional screening for patients 65 years and over;
- the importance of recognising symptoms of malnutrition;
- menu design;
- patient choice;
- the roles of healthcare professionals in maintaining nutritional standards; and
- training programmes.

Examples of practice developed by Trusts are included for reference.

Further work is indicated to develop an audit tool and to undertake a pilot study to evaluate the impact of volunteers and hostesses on nutrition care at ward level.
## CONTENTS

I. INTRODUCTION 1  

II. NURSING HOMES SCOTLAND: CORE STANDARDS 5  

III IMPLEMENTATION OF THE STANDARDS 6  

IV STAFFING 17  

V. EDUCATION AND TRAINING 22  

VI. MONITORING AND AUDIT 24  

VII. SUMMARY OF MAIN RECOMMENDATIONS 26  

References 29  

APPENDICES  

Appendix I: Membership of the Working Group 32
1. INTRODUCTION

Introduction

1. The National Nursing, Midwifery and Health Visiting Advisory Committee, (NNMHVAC), established a Working Group to consider how the nutritional needs of older people could be promoted in NHS hospitals using the Nursing Home Core Standards as a template for introduction or implementation. Although the Core Standards were primarily aimed at nursing homes, the final paragraph of NHS MEL (1999)54\(^1\) requested that NHS Boards and Trusts note that the standards should be applied to all NHS care facilities.

2. The Group chose to focus on older people as they represent a major group of patients within the NHS that has over time experienced problems with their nutritional intake and status while in hospital. The Group would, however, like to emphasise that the principles underlying the guidance in the report could be applied to many patient groups and that, while nutrition is a multidisciplinary issue, nurses have an essential role to play in promoting nutrition amongst vulnerable patient groups. The UKCC recently subscribed to this view when it corresponded with every hospital in the UK to remind managers that: 'Nurses have a clear responsibility for ensuring that the nutritional needs of patients are met'\(^2\).

The aim of this report is to support change and promote nutrition as a key element of patient care by providing professionals with practical guidance on how to implement the nutritional standards as set down in the Nursing Homes Scotland Core Standards for Nutritional Care.

Background

3. The importance of nutrition and its contribution to both survival and health is generally recognised. Despite this, however, the assessment of the nutritional status of older people is often neglected and as a consequence malnutrition may not be recognised or managed.

4. The terms malnutrition, under-nutrition and over-nutrition are often used interchangeably.

5. Malnutrition is an overarching term that includes:

- **under-nutrition** – inadequate food intake and/or the presence of metabolically active disease.
- **over-nutrition** – excessive food consumption
- specific nutrient deficiencies
- dietary imbalance due to inappropriate intake.\(^3\)
6. **Under-nutrition** is a term used to refer to depleted body mass (body weight) resultant from energy deficiency (calories), protein and trace-metal deficiencies. The presence of metabolically active disease can exacerbate any energy intake deficit. In older people, this type of nutritional deficiency can readily be mistaken for signs of ageing or symptoms of an underlying disease. Under-nutrition in hospital patients is of significant concern and can result in substantial morbidity and mortality\(^2\). For example, it is known to complicate illness, delay recovery and prolong hospital stay as well as reduce wound healing and increase risk of infection.

7. **Over-nutrition** is a term used to refer to excessive energy consumption of food and, like under-nutrition, can detrimentally impact on morbidity and mortality. Over-nutrition can also impact on other conditions such as diabetes and coronary heart disease. Whilst under-nutrition is the main focus of concern in older adults, the impact of over-nutrition should not be neglected.

8. Comprehensive reviews of the literature on nutrition and older people in hospital\(^2,4\) and the links between nutrition, ageing and health\(^5\) make it clear that malnutrition, in particular, under-nutrition, is a significant problem facing a considerable proportion of patients in both acute and long stay NHS facilities. Disturbing evidence\(^6\) points to deteriorating nutritional status following hospital admission beyond that which exceeds the pathophysiological impact. This is recognised in the recent Service Standards Report for the NHS Care of Older People\(^7\).

9. Recognition of malnutrition in clinical care is not new yet there are claims that "malnutrition remains largely unrecognised" and "all too common in hospitals"\(^8\) and suggests that the nutritional plight of older people is being ignored\(^9\). The publication of Hungry in Hospital\(^6\) has highlighted the "failure of NHS hospitals to attend the basic nutritional needs of mainly older patients"\(^10\). Despite heightened interest in the issue, the Director of the Relatives Association has asserted that "just because the problem of malnourishment in hospitals is being talked about doesn’t mean it is solved"\(^11\).

10. It is suggested that the clinical and economic consequences of undernutrition in hospital patients are considerable\(^12,13\). Increased susceptibility to pressure sores and prolonged healing times following hip fracture are among the clinical problems identified\(^5,13\) as potentially leading to prolonged hospital stay. It is suggested that the "economic consequences of undernutrition have been underestimated", and that treating malnutrition saves the average US hospital $1 million\(^12\). The King's Fund Centre estimate that savings of £226 million annually could be made in the UK by adopting a proactive feeding approach for undernourished patients thus improving recovery rates, decreasing complications, reducing length of stay and reducing costs per day of stay\(^14\).
Factors Affecting the Nutrition of Older People

11. Factors relating to under-nutrition in older people in hospital, and in other vulnerable groups, are many and varied. Age-related factors and impaired nutritional status following hospital admission are comprehensively covered in 'Eating Matters' and it is not the intention of the Group to duplicate that work.

Evidence of Malnutrition in Older People

12. A recent Scottish national audit project by Walker included a survey of the nutritional status of long-term care elderly in the NHS and non-NHS sectors. Mean values of Body Mass Index (BMI) of the population audited were compared with comparable values for a 'healthy' age-matched group. The prevalence of malnutrition identified from this survey was approximately 29% in the first year with some improvement and reduction to 21% in year three of the audit.

13. As well as depletion of endogenous fat and muscle reserves there is also poor functional ability but these take time, anything up to several months, before they are noticed and too often in the past they have been dismissed as signs of ageing or symptoms of an underlying disease.

The Problem of Nutrition

14. Nutrition in the Health Service has continually been highlighted as an area of concern. A number of organisational factors linked to undernutrition are highlighted in the British Association for Parenteral and Enteral Nutrition (BAPEN) Report 'Summary of Hospital Food as Treatment'. A lack of clarity as to who is responsible for the nutritional care of clients has been identified as one factor as have some of the rules and rituals which can occur in clinical practice. For example, a recent report suggests that nutritional provision by some Trusts may itself be inadequate to sustain nutrient balance. It has also been shown that provision of an adequate diet by the organisation may not necessarily equate to adequate intake.

Nutrition in Hospital

15. The BAPEN report advocates the concept of nutrition as an integral part of treatment and this approach is gaining support. In order to be effective, however, it is recommended that all staff become involved in the nutrition pathway from cooks, porters, catering assistants, nursing staff, hostesses, PAMs and doctors. It is also essential that there is an element of joint training which recognises the role of each individual in the nutrition pathway and the effect a break in the link would have on the patient. The role of management in supporting this approach is paramount for the promotion and development of the nutritional pathway.
Method of Working


17. In order to fulfil its remit, the Group was asked to:

- refer to existing literature, eg Health Advisory Service 2000;
- address each of the standards as outlined in the Nursing Homes Scotland Core Standards for Nutritional Care, NHS MEL(1999) 541, ie nutritional screening, dietary assessment, dietary intake, training and monitoring in view of content, delivery, choice and flexibility within an acute setting;
- identify in response to a request for information from Directors of Nursing Services innovative/transferable practice; and
- offer examples of how the standards have been implemented.

18. The composition and membership of the Group is shown at Appendix I.

Structure of Report

19. The report sets out to provide practical advice and examples of how the promotion of nutritional standards for older people in hospital has been addressed. To facilitate this approach and produce ‘user’ friendly guidance, the Group has:-

- outlined the problem of nutrition in older people, including a selective literature review;
- summarised the Nursing Home Core Standards for Nutrition;
- identified for each standard a practical working example of how the standard has been applied drawing on the range of professions involved, eg catering, nursing and dietetics; and
- made realistic recommendations which are believed to be sustainable and, where possible, lend themselves to the audit process.
II NURSING HOMES SCOTLAND: CORE STANDARDS

Introduction

20. The main core standards for nursing homes in Scotland were issued in 1997 under cover of a Management Executive Letter, NHS MEL (1997)34. These standards set out key criteria for the care of residents and the inspection and management of registered nursing homes in Scotland. In 1999, as part of the core standards, additional guidance was issued on standards of nutrition which set out a nutrition action plan and established hygiene standards for nursing homes. Although the guidance was primarily aimed at nursing homes, the final paragraph of the MEL requested that NHS Boards and Trusts note the application of the standards all NHS care facilities.

Purpose

21. The purpose of the standards was to improve the health and quality of life of those in care. In order to achieve this, key organisational objectives and management issues were set out that would allow for under-nutrition to be addressed within the context of a multi-disciplinary team.

Identification of Standards

22. The following standards were identified:

- Nutritional Screening;
- Dietary Assessment;
- Dietary Intake;
- Training; and
- Monitoring.

23. A statement containing the key aims for each standard was supported by structure and process criteria set out in the document. The nutrition action plan, a tool kit for organisations, promoted the ‘Health Promoting Health Service Framework’. The framework could be adopted for use at a number of levels within the organisation and the appendices provided useful material that staff might wish to develop for their own areas. The hygiene standards also provided valuable guidance on hazard analysis, cross-contamination risks, cleaning and pest control.

Action to be Taken

24. Nursing homes and NHS establishments are expected to develop and implement policies and protocols to accompany the standards and to involve all the relevant professionals.
III. IMPLEMENTATION OF THE STANDARDS

Introduction

25. The following sections set out each of the standards and identify the main points for consideration by health care staff.

Nutritional Screening: Core Standard Statement

On admission, and at regular intervals, every individual’s nutritional status should be assessed by suitably qualified staff in order to identify malnutrition or those at risk of becoming malnourished. Malnourished and ‘at risk’ individuals should be assessed regularly and appropriate action taken. Residents should also be screened for malnutrition if a change in their condition, both physically or mentally, indicates a change in eating or drinking patterns or habits.

26. The Group recommends that, for the over 65s, pre-admission assessments should include identification of nutritional risk, (ie the use of a nutritional screening tool and an appropriate locally devised action plan).

27. Nutritional Screening is a simple and rapid procedure that facilitates identification of nutritional risk in the older adult. Screening can be applied to a population to identify those at nutritional risk and is a subjective process. If used, the results of the screening process and subsequent screening at regular intervals during the episode of care will direct the action/care required.

28. Nutritional Assessment is the determination of nutritional status using appropriate objective markers such as dietary intake, biochemical data, anthropometry, (measurement of the human body), and clinical condition. Results of the assessment allow comparison with healthy individuals thereby permitting the experienced assessor to make an appropriate judgement on the patient’s nutritional status. In addition, the interpretation of sequential monitoring will permit appropriate judgements to be made on an individual basis.

29. Screening is the first step in nutritional assessment and acts as a trigger to identify any nutritionally ‘at risk’ patients and permit a nutritional plan of care to be developed. Screening should be carried out as soon as possible after admission to allow for early identification of ‘at risk’ patients and intervention strategies. If no immediate action is required screening should be repeated at regular intervals in case of deterioration. Not every patient requires a comprehensive nutritional assessment although every effort should be taken to record weight and monitor weight change over an appropriate time period. Consideration should also be given to the merits and practicalities of recording Body Mass Index (BMI). The screening process, however, is intended to identify those patients at risk of under-nutrition to allow effective use of labour-intensive nutritional assessment and appropriate and timely intervention.
30. Three central questions should be considered prior to incorporating nutritional screening of older adults into clinical practice:

- what screening tool should be used?
- who should perform the screening? and
- what are the implications of the screening procedure?

*What screening tool should be used?*

31. There are numerous subjective screening tools being used within the UK based on either a simple structured questionnaire or a scoring system.

32. As nutritional screening is a subjective process it relies on the professional skills and knowledge of the user to make a judgement. The British Dietetic Association suggests screening tools should be simple to use, acceptable to the patient and user, valid, reliable, sensitive and specific\(^\text{19}\). The tool should also be accompanied by an action plan, incorporating clinical guidelines, and be tested for its effectiveness in clinical practice. The screening procedure should be regularly reviewed and audited.

33. Consideration should be given to the benefits to patient care in relation to administration costs. Successful implementation of a screening tool may incur additional costs due to an increase in dietetic referrals and the provision of the required level of nutritional support. However, these costs would be offset by improvements in patient outcome.

34. Most screening systems have been developed to be used within specific specialist areas, eg care of older adults, mental health, day hospital patients, paediatrics, general medicine. In the absence of a generic screening system it is possible to use a method developed in a setting with a similar case-mix although some investigative work should be carried out to check for local variations.

35. Many screening tools currently used in the UK do not meet the defined requirements. Screening tools used by individuals who do not understand underlying clinical concepts may result in the nutritional 'risk' of a patient being incorrectly classified\(^\text{20}\).

36. A critical evaluation of these methods advocated that many of the current tools should be re-tested before becoming an integral part of nursing practice\(^\text{21}\).

37. Examples of screening tools are highlighted in Eating Matters\(^2\).
Examples of Good Practice:

[1] A Nutrition Screening Tool (NST) has been developed and tested within Ayrshire and Arran Primary Health Care Trust. The NST is designed to be completed by nursing staff and the results of the testing (in print) suggest that the tool will correctly identify patients already undernourished or at risk of becoming undernourished. The NST has been accepted for use by Ayrshire and Arran NHS Board and is part of the Trust Implementation Programme.

A training pack has been developed to support the screening tool. This pack includes a training module, copies of the tool for in-patient and day hospitals, guidelines for completion and a suggested care pathway.

The training pack is available from: The Registry, Ayrshire and Arran Primary Care Trust, 1a Hunters Avenue, Ayr, KA8 9DW.

[2] Hospital Trusts within Lothian have formed a group to highlight and promote nutritional care. This work will help to identify a generic nutritional screening tool that could be used in the acute setting. Criteria were set and a number of screening tools reviewed. Additionally, a literature search, survey of current screening practices within the UK and a sharing of experiences cumulated in the decision to recommend the Derby Nutritional Score (ref: Goudge DR, Williams A, Pinnington LL. Development, validity and reliability of the Derby Nutritional Score. J Human Nutrition and Dietetics 1998, 11 (5):441-421) to be piloted in designated areas within Lothian.

This exercise highlighted the difficulty in identifying a screening tool that met all the recommended criteria. The group concluded that screening tools which meet local requirements should be adopted and most importantly should always be accompanied by a locally agreed action plan.

[3] A Feeding and Nutrition Group has been established in the Care of the Elderly wards in West Lothian Healthcare NHS Trust. The aim of the Group is to enhance nutritional care of older adults through a co-ordinated interdisciplinary approach. Team members include representatives from catering, dietetics, speech and language, nursing staff, nurse managers and the nurse specialist in care of older adults.

Since its inception, the Group has implemented screening tools that identify swallowing problems and nutritional risk and implemented training programmes to improve compliance.

[4] The Renfrewshire and Inverclyde Primary Care Trust has developed good practice guidelines for the prevention, recognition and treatment of pressure damage. The guidelines contain 2 validated nutritional assessment tools – one for hospital use the other for the community.

[5] At Inverclyde Hospital, a validated nutrition screening tool was implemented on all wards in 1998. Dietetic staff worked closely with nursing staff to produce an easy to use format and provided on the ward training in its use. The tool aims to identify all age groups of adults at nutritional risk.

[6] In the Western Isles, a nutritional assessment tool and a standard that everyone should have an assessment within 24 hours of admission with regular re-assessment during their hospital stay is being taken forward.
Who should perform the screening?

38. The majority of screening tools have been developed for use by trained nursing staff who are in an ideal position to assess all patients admitted to hospital. Although nurses are often the first point of contact and thus have a crucial role to play, they should not have sole responsibility for the nutritional care of their patients but instead should be part of an inter-disciplinary approach. The nurse is pivotal in performing nutritional screening and determining the action required to move the patient through the appropriate care pathway.

What are the implications of the screening procedure?

39. Implementation of any nutritional screening tool will raise awareness and this, in conjunction with the results of the screening, may increase referrals for more in-depth assessment and support. This may put an increased burden on other departments in relation to staffing levels and financial constraints. Piloting of the selected screening tool should therefore take place prior to implementation to assess the impact on the necessary support services, eg catering, dietetics and the nutrition team. Any manpower issues should then be taken forward through the necessary channels, for example, Health Improvement Programmes and Trust Implementation Plans. Account should be taken of the fact that overall the initial increase in the cost may lead to a cost reduction in the long-term.

40. Implementation should be carefully planned to identify ward-based action plans that promote inter-disciplinary care and link with the other elements considered in this document.
Summary of Main Points on Nutritional Screening

- Implementation of nutritional screening is appropriate and necessary in many clinical areas.
- The screening procedure is the first step in nutritional assessment.
- Screening should be carried out as soon as possible after admission to allow for early intervention.
- If no immediate action is required, screening should be repeated at regular intervals in case of deterioration.
- A treatment pathway or action plan should accompany the screening procedure.
- The role of the nurse in performing nutritional screening and determining the action required to move the patient through the appropriate care pathway is pivotal.
- The ability to meet the defined requirements of nutrition screening should be taken into account when considering the choice of tool.
- In the absence of a generic tool it is possible to use a tool developed in a setting with a similar case-mix although some investigative work should be carried out to check for local variations.
- Consideration should be given to the benefits to patient care in relation to administration costs.
- The screening procedure should be linked to measurements of effective clinical practice.
- Implementation of nutrition screening should be accompanied by training programmes.
- Nutrition screening should be carefully planned to identify ward-based action plans, thus promoting inter-disciplinary care.
- The screening procedure should be regularly reviewed and audited.
- Wherever possible, patients and their relatives should be involved in these processes.
Dietary Assessment: Core Standard Statement

All residents’ diets and issues which affect eating and drinking should be addressed on admission and on an on-going appropriate-to-needs basis thereafter, but with (at least) six monthly formal reviews, in order to identify:

- Residents with poor food and fluid intake;
- Factors which may put residents at risk of inadequate or inappropriate dietary intake;
- Residents’ dietary preferences; and
- Residents on long-term diuretics who are particularly at risk of dehydration if oral intake is reduced.

41. Wherever possible, a patient’s dietary preferences should be met. This includes the provision of meals based on cultural, ethnic and religious grounds. If necessary, consideration should be given in association with the catering department to accessing foods from local caterers by invoking special contracts or contacting specialist suppliers depending on the volume required. Whilst staff should try to accommodate patients’ needs they must also ensure that these needs reflect the patients’ overall nutritional requirement.

42. The effect of alcohol on food consumption can easily be overlooked when assessing a patient’s nutritional state. Alcohol is, in small quantities, an appetite stimulant. A number of elderly people consume high quantities of alcohol which replaces energy from food and this can contribute to under-nutrition.

Dietary Intake: Core Standard Statement

Operational policies should reflect the current Department of Health Dietary Reference Values and individuals’ food and drink needs/preferences/requirements where menu planning and dietary provision are concerned.

Provision

43. It is recognised that frequent meals or snacks and assistance with eating can help to improve food intake. It is therefore useful, in addition to regular meals, if snacks and milky drinks are available. This approach raises a number of questions, not least, who determines the items to be held at ward level, who pays for them and any equipment necessary for their use and who is responsible for infection control. This has been successfully addressed at the Luton and Dunstable Hospital where snacks such as toast, biscuits, yoghurts and milky drinks are available for patients between and after meals. In the case of late admissions, ambient meals are served with bread and butter and a hot drink to those patients admitted after the evening meal.
44. Issues of hygiene can limit the use of equipment on wards but the Group would expect staff to liaise with infection control and the health and safety team to overcome any difficulties.

45. General guidance on equipment should be sought locally from Speech and Language Therapists, Occupational Therapists and Dietitians.

**Improving Distribution and Service**

46. Caterers should liaise with clinical colleagues on the most efficient method of food distribution for their particular location and should where possible (unless cook-chill or prepared within a cook-freeze system) keep time from production to consumption down to a minimum. The use of local guidelines which detail the maximum holding time of food in kitchens, in bain-marie’s and in trolleys is recommended.

47. The actual distribution system may be dictated by existing premises and systems. It is acknowledged, that many locations may not wish to change their type of food service in the short term as there may be a high capital cost involved in converting existing main and ward kitchens. It is essential that a multiprofessional team is involved in determining the strategic direction of nutritional services.

48. It is important that staff involved in the service of food at ward level receive appropriate training on portion control and meal presentation and that their knowledge of food handling is sufficient to ensure compliance with food hygiene standards.

49. The Group acknowledges that there may be some benefits derived from a chilled or frozen meal service where regeneration takes place locally as this can allow a certain amount of flexibility in meal times, compared with a conventional cook and serve system. Patients’ views should also be consulted.

50. Hospitals should be encouraged to introduce a meal ordering system where patients are able to order their meal choice as close to the meal service time as possible, as this may well reduce food wastage brought about by patients changing their mind, or the patient’s physical condition changing.

51. It is particularly important for hospitals operating a conventional “hotline” meals distribution system that the time from production to service is minimised for temperature control and quality purposes. All staff involved in the distribution of food to ward areas must be fully aware of their responsibilities with regard to timetables and be aware of what actions to take in the event of a delay.

52. If there is a plan to change or update a particular meals distribution system, caterers should ensure that discussions take place with ward staff, dietitians, portering and distribution staff to ensure that the best possible solution can be obtained for the patient. Patients’ views should also be taken into consideration.
Menu Design Analysis

53. **Patients who are able to order their meals should be given every opportunity to select their chosen menu items from a menu card that they can read and understand** (large print may be useful for some patients). **Food and health policies should be updated on a regular basis to ensure that they provide a suitable menu and up to date advice. The menu should cater for the needs of ethnic minorities** since most people, when they are unwell, seek comfort in the food that they are used to.

54. **Whilst the use of electronic readable menu cards certainly speeds up the processing of information, it can sometimes be difficult for older patients and patients with disabilities to complete this type of menu card. If this is the case, it is important that ward staff have the time to discuss with the patients their menu selection rather than selecting an item on their behalf.**

55. **The composition of the menu should provide a reasonable choice for the patient and ensure that patients who only require a light meal are able to be accommodated whilst still providing a traditional menu of at least two courses for lunch and supper.**

56. **Some older patients find it difficult to cope with three courses at meal times and a move towards small, more frequent meals may be beneficial. To this end it is worth considering reducing a three-course meal to a two-course meal and providing an additional snack or afternoon tea.**

57. **In addition to the food available through the menu, snacks (either provided by the catering department or at ward level) should be available to supplement the main menu where there is an identified need. This is particularly important where there is a large gap between the evening meal and breakfast.**

58. It is acknowledged that some Trusts do not allow the use of microwaves at ward level and this can restrict the snacks available. However, in locations where microwaves may be used, it is important that there are operational guidelines or a policy for staff to follow and that the staff are suitably trained in food handling.

59. **Relatives and friends will frequently try to provide additional food for the patient and possibly other surrounding patients which can pose a considerable risk. Relatives should therefore be encouraged to only provide pre-packed, date-stamped products (which have been handled and stored according to manufacturers recommendations) to reduce the risk of possible infection.**

60. **Local guidelines should be developed on the handling and storage of patients’ own food within hospital premises to ensure that brought-in food is handled correctly.**
61. Caterers should be able to provide consistency-modified diets to patients who require them (in line with the SIGN Guidelines) taking on board advice on the production of these meals from both their local dietitian and speech and language therapist. Some of these meals can look unappetising in their basic form, however, if they can be shaped and moulded then the product becomes much more attractive to the patient and therefore more likely to be consumed. Modification of consistency may necessitate fortification to retain nutritional value.

62. Where a menu operates for a diverse group of patients (for example, in the context of a general hospital) patients should be able to supplement the basic menu by means of snacks. The menu should be altered on a fairly regular basis to prevent menu fatigue within the long-term patient group.

63. Menu design should therefore take into account the needs of the patients and their length of stay. It should also try to ensure that all religious and cultural requirements can be met either directly from the main menu or by a special order arrangement.

64. If there is insufficient staffing at ward level to assist patients with feeding difficulties food can become cold and unappetising. This leads to increased ‘plate waste’, poor nutritional intake and increased use of food supplements. Some locations have been able to address this by utilising friends and relatives as volunteer feeders or by the use of two trolleys for the ward area with a time gap between the first and second trolley. This latter technique allows the ward staff to assist in feeding both the first and second sittings, with patients at both sittings receiving hot/fresh food.

65. In addition to the above, careful attention should be paid to social and environmental factors. The provision of food for older adult in-patients, particularly those in long term care, should be more than a function of everyday life. For example, studies have shown that sitting patients in a social situation within hospital can help them to increase their macro-nutrient intake. The establishment of an eating routine is also seen as important as a means of overcoming fluctuations in appetite and motivation, perhaps linked to major life events such as bereavement.

66. Menus should be reviewed on a regular basis. Ward staff, patients and the dietitian should advise on the suitability of the dishes on offer to ensure that the menu meets the majority of the patient’s requirements, both in terms of nutritional value and ease of consumption. A complete nutritional analysis of the menu should be undertaken so that the available choices meet national standards.
Examples of Good Practice:

[1] In Johnstone Hospital, Johnstone, the Clinical Nurse Manager led a project to look at the timing of patients meals, the appropriateness of the menu for older patients and the level of food wastage. As a result of the work, significant changes to the menu have been advocated including the introduction of a 'high tea style menu' from 4 pm.

[2] Tayside University Hospitals Trust undertook a survey of patients meals. A number of issues were identified including storage of food within ward areas to support the needs of patients with poor appetites and the development of a nutritional support role for health care assistants.

[3] The Primary Care and Acute Trusts in Ayrshire and Arran are working to develop a ‘Core Elderly Menu’ based on a three-week menu cycle that is suitable for older people. The menus have been analysed to ensure that they meet various national guidelines on nutrition including the Caroline Walker Trust and Nutrition Guidelines for Hospital Catering.

[4] Within the Argyll sector of the Lomond and Argyll Primary Care Trust the standard of dietary provision is being improved through menu redesign.

[5] At Borders Primary Care Trust a Nutrition Standards Group, which is led by dietitians and reports to the Director of Nursing, has proposed the introduction of a bedtime snack and the introduction of an ‘out of hours’ food box.

[6] At St. George's Hospital, Tooting, authentic frozen foods are provided, which include both Ugandan-style dishes and also ones more familiar to Afro-Caribbean people. The choice of an African meal has now been extended to first-generation Africans throughout the hospital.
Meeting Individual Patient Abilities and Needs

67. Ward staff should understand the importance of conducting a general assessment of patients on admission with a view to identifying any disability which could affect the patients ability to eat. An action plan/protocol should be produced for each individual patient’s needs.

68. A review or evaluation of the action plan should take place at regular intervals to see if the plans are working effectively and efficiently. In view of the fact that patients will have differing appetites, a choice of portion size, subject to the need for a proper nutritional balance, can assist in encouraging patients to eat.

Examples of Good Practice:

[1] Representatives from the Highland Acute and Primary Care Trust have devised a set of guidelines for the classification of textures for food and fluid for patients with dysphagia/chewing difficulties. The guidelines are to be adopted across all hospitals in Highland.

[2] A multidisciplinary group in Lomond and Argyll Primary Care Trust is implementing a training programme to improve practice with patients suffering from dysphagia.

[3] Dietitians and Speech and Language Therapists have developed a set of consistency classifications. These have been adopted by hospitals throughout Lothian and the impact of implementation is currently being monitored.

[4] Greater Glasgow NHS Board has produced a Food and Health Policy document which identifies the needs of the elderly and presents guidelines for those involved in their meal provision while in long-term care.
IV: STAFFING

Introduction

69. This chapter draws attention to the different types of staff who all have an important role to play in helping patients to determine and meet their nutritional requirements. It is, however, useful to give consideration to new approaches/roles in which the nutritional needs of patients can be addressed by collaborative working between nursing, dietetics and catering.

Nurses

70. Nurses in caring for patients holistically will have a central role to play with regard to patient nutrition. The named nurse will be responsible for ensuring assessment of nutritional status and the development and audit of the nutritional care plan.

Dietitian

71. Dietitians play a key role in the nutritional care of older adults and their remit within the multi-disciplinary team is crucial.

72. Identification of nutritional risk will highlight appropriate referral to the dietitian who will provide an in-depth assessment and management of nutritional care. The treatment offered is cognisant of the complex needs and care of older adults. The dietitian will also liaise with primary health care colleagues, social workers, home carers etc, to ensure nutritional care is continued in the community.

73. The dietitian provides education and training to all health professionals to ensure that staff have up to date information on food and nutrition issues. They will be involved in the development of health improvement programmes and nutritional policies, standards and procedures to support the care of elderly people. Dietitians also act as a resource for other health professionals and local communities.

74. The dietitian is an adviser in catering and food service, being involved in menu planning, development of food and health policies, monitoring of food service systems and the nutritional content of meals being offered.

75. Ongoing evaluation and audit of service delivery and therapies is an integral part of professional dietetic practice. This provides an opportunity to increase knowledge and provide effective, evidence based care.
### Dietetic Assistants/Generic Workers

76. Monitoring patient food intake is crucial to improving nutrition status and hence patient care. Such studies require time but not necessarily the skills of a dietitian. In 1998 the British Dietetic Association agreed a resolution that recognised this issue and agreed to develop the concept of the 'Dietetic Helper'. The results of initial work undertaken suggest that there is scope for two categories of assistant: a dietetic helper and a generic worker. Details of the core activities are detailed in the box below. It should, however, be noted that although the dietetic assistant can undertake all the tasks of a generic worker, the converse does not apply.

<table>
<thead>
<tr>
<th>Core Tasks for a Dietetic Helper</th>
<th>Core Tasks for a Generic Worker in Relation to Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The dietetic helper should be able to:</td>
<td>The generic worker should be able to:</td>
</tr>
<tr>
<td>Advise patients on menu options suitable for their dietary needs</td>
<td>Check that nutritional screening is taking place</td>
</tr>
<tr>
<td>Input diet history records for computer dietary analysis</td>
<td>Identify within protocols the need for the delivery of equipment for nutritional support</td>
</tr>
<tr>
<td>Add data to nutritional database</td>
<td>Collect data with reference to diet type and usage of supplements</td>
</tr>
<tr>
<td>Collect print out of relevant patient related data</td>
<td>Liaise with ward staff, catering department and patients with regard to food intake</td>
</tr>
<tr>
<td>Order special dietary products</td>
<td>Check and collate menu cards</td>
</tr>
<tr>
<td>Liaise with dietitians and diet cookery staff and other relevant professional staff</td>
<td>Assist patients to complete menu cards</td>
</tr>
<tr>
<td>Monitor quality standards and participate in audit and research</td>
<td>Prepare and administer nutritional supplements as directed by SRDs</td>
</tr>
<tr>
<td>Teach cooking skills within a nutrition education framework</td>
<td>Monitor and record supplements, food, fluid, snacks intake</td>
</tr>
<tr>
<td>Prepare information for diet preparation</td>
<td>Weigh and measure patients’ height and record appropriately</td>
</tr>
<tr>
<td>Maintain product information</td>
<td>Assist patients in eating and drinking</td>
</tr>
<tr>
<td>All the tasks identified above will be under the direct supervision of a state registered dietitian (SRD).</td>
<td>Identify and aid provision of feeding aids</td>
</tr>
<tr>
<td>Plus all the generic worker tasks</td>
<td>Identify patients’ food and drink preferences</td>
</tr>
<tr>
<td></td>
<td>Undertake ordering and stock control of dietary supplements</td>
</tr>
<tr>
<td></td>
<td>Check ward fridge temperatures</td>
</tr>
<tr>
<td></td>
<td>Check there is appropriate storage of food and supplements in ward and patient areas</td>
</tr>
</tbody>
</table>

Hostess or Health Care Assistants in Nutrition Support

77. The responsibilities of a ward hostess or health care assistant include the provision of support to the multidisciplinary ward team and to promote adequate nutrition intake for patients at risk of malnutrition.

78. Duties include:
   - Assisting patients with their choice of menu;
   - Liaison with the catering department;
   - Nutrition screening;
   - Monitoring of patient food charts;
   - Documentation of nutrition intake;
   - Participate in the care of patients unable to eat independently; and
   - Oral hygiene.

Examples of Good Practice:

[1] Ward Hostesses have been piloted within the Cardiothoracic ward at the Royal Infirmary of Edinburgh and it is anticipated that these posts will be incorporated in the new hospital.

[2] Within the Argyll sector of the Lomond and Argyll Primary Care Trust a helper has been employed with joint funding from nursing and domestic budgets. The helper assists with frail elderly patients to ensure adequate fluid intake and to positively promote nutritional supplements with nutritionally at risk patients. The benefits are obvious in that nutritional status has been improved and the risk of complications, due to malnutrition, have been reduced.

Nutrition Link Nurses

79. Link nurses can assist in the training of health care workers in the prevention of malnutrition during illness and promote the benefits of adequate nutrition whilst acting as the link with the dietitian and nutrition support team.

Example of Good Practice:

[1] In Lomond and Argyll Primary Care Trust nutrition link nurses have been introduced on wards to help progress standards for screening and other nutrition related issues. A training programme/network has also been developed to help support these nurses.
Nurse Nutrition Specialists

80. The role of the nurse nutrition specialist is to provide education to increase the awareness of the importance of nutrition to patient recovery. These specialists, in consultation with colleagues from other disciplines, provide appropriate artificial nutrition support for undernourished patients, develop procedures and guidelines for the provision of artificial feeding and liaise with the dietetic service on the provision of artificial nutrition support. They also initiate audits, advise members of the nutritional steering committee and act as a source of information on nutrition related issues.

Speech and Language Therapists/Occupational Therapists

81. Speech and Language Therapists have a key role to play in assessing patients with swallowing difficulties and in making recommendations for appropriately modified consistency diets and compensatory strategies to ensure patient safety. Occupational Therapists also have an important role in assessing patients’ level of disability as regards to feeding and recommending the appropriate specialised feeding aids to assist with this.

Volunteers

82. Volunteers can help patients who require assistance with feeding at mealtimes. They should be competent to carry out the task and have on-going assessment. Once the provision of a volunteer service has been established a designated person responsible for maintaining an adequate level of service provision should manage it. Volunteers can also provide much-needed assistance to nursing staff and can assist in the running of the ward at mealtimes. Volunteers should receive training in communication, hand hygiene, confidentiality, positioning of patients and patient dignity. In addition, they should know how to respond to a choking patient. A period of shadowing members of the ward staff, when they are feeding patients can be beneficial.

83. Whilst the use of volunteers and carers can be extremely useful in assisting ward staff with the service of food, it is crucial that these individuals are provided with sufficient training and indeed, are supervised. The use of a volunteer co-ordinator can greatly assist in providing additional support for the running of a ward or department, however, care has to be taken to ensure that there is always an adequate number of trained staff on duty to supervise volunteers.

84. There is a need to develop all staff involved in the service of food to patients to ensure that they understand their responsibilities and any risks involved in feeding a particular patient. They also require to feed back information to trained staff on patients who for any reason are not eating sufficient quantities of food or are experiencing swallowing difficulties.
Examples of Good Practice:

[1] Basildon and Thurock General Hospital carried out a ward hostess study in 1999. The main objective of the ward hostess was to “ensure patients requiring assistance with eating and drinking received identified help, record patients nutrition intake, ensure appropriate menu ordering and improve communication between wards and catering departments”. The implementation of the ward hostess programme at Basildon has shown a significant benefit to the nutritional wellbeing of patients. However, the responsibility for ensuring that the patients are fed still rests with the nurse in charge. Supplement drinks known as sip feed are regularly prescribed as a supplement to the patients oral dietary intake. Orsett Hospital found that “once assistance was given with feeding, sip feeding costs were reduced from £250 per month to £60 per month as verified by the pharmacy budget”27.

[2] An audit conducted in March 1998 looked at the potential need for a Ward Hostess for the patient meal service and recommended that “the patient meal service would improve following the permanent introduction of a ward hostess or designated person”28.

[3] The Royal Infirmary of Edinburgh commissioned a pilot study into food wastage at ward level and the resulting recommendations included the regular training of all staff involved in the meal service. The introduction of a ward hostess helped to reduce food wastage, increase patient satisfaction and facilitate additional nursing time 29. Food wastage was reduced as a result of patient choice at the point of delivery.
V: EDUCATION AND TRAINING

Core Standard Statement

All staff involved with the nutritional care of residents should have appropriate training in nutrition on induction with periodic updates and refreshers at least every two years thereafter.

85. Nurses and dietitians do not make the same clinical judgements when considering the factors influencing nutritional status and there is scope for improvement via training.

86. Training programmes should be implemented on the use of nutritional screening tools. In order to increase success and compliance with the training programmes they should also include information on the recording of dietary intake and nutritional concepts that influence nutritional status.

87. There is a requirement to train all staff involved in the nutrition pathway in order for the hospital to provide a high quality service. This training would include food production staff (diet cooks), distribution staff (porters), staff involved in plating of meals (hostess or ward staff) and appropriate nursing and domestic staff.

88. The literature often recommends improved education and training of staff involved in providing nutritional care as a means of achieving improved nutritional care. This tends to be assumed or asserted rather than evidenced, though Allison suggests that several studies have shown compliance with nutrition screening and quality of nutritional care to be related to in-service training and further enhanced by appropriately prepared link nurses.

89. Recommendations should be specific when describing the kind of educational programme required. For example, 'Health Professionals should have access to the necessary basic training that will enable them to assess and meet the nutritional demands of the elderly patient at risk of undernutrition.' It is accepted that, in isolation, no one type of educational input is likely to be successful. The implication is that education and training is best when adapted to fit the local context. To this end, the following recommendations for incorporation into local or national standards have been advocated:

- NHS Trusts should develop a local education and training strategy for enhancing nutritional care based on an audit of staff knowledge. Dietitians should play a key role in this process.
- Induction programmes and an annual update of at least two hours should be available for all staff involved in delivering any aspect of nutritional care.
- Pre-registration and undergraduate programmes should prepare nurses and PAMS for a leadership role in delivering high quality nutritional care.
• Short courses and regular updates on aspects of nutrition should be available to clinical staff.

• Credit rated specialist programmes should be available for the preparation of link or specialist nurses.

• Education and training should be adequately resourced in terms of staff time and funding.

Examples of Good Practice:

[1] Partnerships in Active Continuous Education (Queen Margaret University College) have developed a range of open and flexible learning programmes that meet the needs of individual learners with a background in healthcare. 'An introduction to Nutritional Screening – Aims, Issues and Actions' has been developed by a multidisciplinary team for those interested in finding out and understanding more about nutritional screening.

[2] Highland NHS Board will be revising their nutritional policy for older people. The policy already makes reference to general and specific nutrition guidelines and practical guidelines for catering staff.
VI: MONITORING AND AUDIT

Monitoring: Core Standard Statement

All homes should be monitored subject to on-going in-year inspection to ensure that adequate standards of nutritional care are being maintained.

90. Various systems are in place to monitor nutrition for older adults. These include:

* Royal College of Nursing: Nutrition Standards and the Older Adult
* The British Dietetic Association: Dietetic Standards of Care for the Older Adult in Hospital
* Health Services Accreditation: Service Standards for the NHS Care of Older People [Section 3.10 refers specifically to nutrition]
* Centre for Health Services Research, University of Newcastle: Eating Matters

91. In addition, the Nutrition Action Plan: A Tool Kit for Organisations Caring for People in Long-Term Care, issued as part of the Nursing Home Core Standards on Nutrition, provides a useful framework to move forward work on Standards.

Examples of Good Practice:

[1] Following the provision of the Scottish National Standards on Nutrition for the Frail Elderly in Nursing Homes, Borders NHS Board in conjunction with private Nursing Homes, developed a local version of the Standards for use within the NHS Board area. This was followed by a baseline audit of services for older people in January 2000. The audit revealed an overall compliance rate of at least 73% and recommended among other things that training be provided on the oral hygiene component of the Standards subsequent to a baseline audit of current practices.

[2] Cowglen Hospital, part of the South Glasgow University Hospitals NHS Trust has completed an audit on hydration titled ‘Nurse do I need a drink?’ The results of the audit, which revealed that patients in elderly care units do not receive enough fluids, have informed and revised practice within the hospital.
92. The Group concur with the recommendations of the Nuffield Trust\textsuperscript{35}, in particular, the importance of nutrition as a key element of clinical care and the clinical governance agenda. This is being pursued in Scotland by the Clinical Standards Board and the inclusion of nutrition within their generic standards. The Nursing Midwifery Practice Development Unit is looking at nutrition in the in-hospital population in relation to why and when nurses refer patients to dietitians as opposed to providing nutritional advice themselves. A similar project is also being undertaken for older people in in-patient facilities with Glasgow Caledonian University, the Queen’s Nursing Institute and the Foundation of Nursing Studies.
VII: THE STANDARDS IN NHS HOSPITALS: RECOMMENDATIONS FOR ACTION

1. In order to be effective it is recommended that all staff become involved in the nutrition pathway from cooks, porters, catering assistants, nursing staff, hostesses, PAMs and doctors (para 15).

2. The Group recommends that, for the over 65s, pre-admission assessments should include nutritional screening (para 26).

3. Issues of hygiene can limit the use of equipment on wards but the Group would expect staff to liaise with infection control and the health and safety team to overcome any difficulties (para 44).

4. The use of local guidelines which detail the maximum holding time of food is recommended (para 46).

5. It is important that staff involved in the service of food at ward level receive appropriate training on portion control and meal presentation and that their knowledge of food handling is sufficient to ensure compliance with food hygiene standards (para 48).

6. Hospitals should be encouraged to introduce a meal ordering system where patients are able to order their meal choice as close to the meal service time as possible, as this may well reduce food wastage brought about by patients changing their mind, or the patient’s physical condition changing (para 50).

7. All staff involved in the distribution of food to ward areas must be fully aware of their responsibilities with regard to timetables and be aware of what actions to take in the event of a delay (para 51).

8. If there is a plan to change or update a particular meals distribution system, caterers should ensure that discussions take place with ward staff, dietitians, portering and distribution staff to ensure that the best possible solution can be obtained for the patient (para 52).

9. Patients who are able to order their meals should be given every opportunity to select their chosen menu items from a menu card that they can read and understand (large print may be useful for some patients). Food and health policies should be updated on a regular basis to ensure that they provide a suitable menu and up to date advice. The menu should cater for the needs of ethnic minorities since most people, when they are unwell, seek comfort in the food that they are used to (para 53).

10. The composition of the menu should provide a reasonable choice for the patient and ensure that patients who only require a light meal are able to be accommodated whilst still providing a traditional menu of at least two courses for lunch and supper (para 55).
11. In addition to the food available through the menu, snacks (either provided by the catering department or at ward level) should be available to supplement the main menu where there is an identified need. This is particularly important where there is a large gap between supper and breakfast (para 57).

12. Local guidelines should be developed on the handling and storage of patients’ own food within hospital premises to ensure that brought-in food is handled correctly (para 60).

13. Where a menu operates for a diverse group of patients (for example, in the context of a general hospital) patients should be able to supplement the basic menu by means of snacks. The menu should be altered on a fairly regular basis to prevent menu fatigue within the long-term patient group (para 62).

14. Menu design should take into account the needs of the patients and their length of stay. It should also try to ensure that all religious and cultural requirements can be met either directly from the main menu or by a special order arrangement (para 63).

15. Menus should be reviewed on a regular basis. Ward staff, patients and the dietitian should advise on the suitability of the dishes on offer to ensure that the menu meets the majority of the patient’s requirements both in terms of nutritional value and ease of consumption. A complete nutritional analysis of the menu should be undertaken so that the available choices meet national standards (para 66).

16. Training programmes should be implemented on the use of nutritional screening tools. In order to increase the success of, and compliance with, the training programmes they should also include information on the recording of dietary intake and nutritional concepts that influence nutritional status (para 86).

17. NHS Trusts should develop a local education and training strategy for enhancing nutritional care based on an audit of staff knowledge (para 89).

18. Induction programmes and an annual update of at least two hours should be available for all staff involved in delivering any aspect of nutritional care (para 89).

19. Pre-registration and undergraduate programmes should prepare nurses and PAMS for a leadership role in delivering high quality nutritional care (para 89).

20. Short courses and regular updates on aspects of nutrition should be available to clinical staff (para 89).

21. Credit rated specialist programmes should be available for the preparation of link or specialist nurses (para 89).
22. Within each Trust there should be a designated individual with management responsibility for nutrition.

23. Clinical Standards Board Scotland to take forward the development of generic standards for nutrition and support clinical governance (para 92).

24. The Group recommends that future work be initiated on developing a comprehensive audit tool for nutrition, encompassing the whole spectrum of nutritional care for older patients.
References


MEMBERSHIP OF THE WORKING GROUP

Chairman:
Mrs C MacGillivray
Director of Nursing
Argyll & Clyde Acute Hospitals Trust

Members:
Mr I Aitken
Service Manager
Forth Valley Primary Care Trust

Miss E Campbell
Director of Nursing and Quality
West Lothian Healthcare Trust

Ms A Coleman
Senior Specialist Speech & Language Therapist
Lanarkshire Acute Hospitals Trust

Mr D Clarkson
Senior Nurse Manager
Whim Hall Nursing Home

Mrs L Davidson
Nutrition Nurse Specialist
South Glasgow University Hospitals Trust

Mr P Harrison
Service Manager
Elderly and Mental Health Services
West Lothian Healthcare Trust

Mr M Henry
Trust Operations Project Manager
Lothian Primary Care Trust

Mrs P Jenkins
Senior Charge Nurse
Tayside University Hospitals Trust

Mr I McIntosh
Head of Department of Adult Nursing
Napier University, Edinburgh

Mrs G McKee
Clinical Nurse Manager
Argyll & Clyde Acute Hospitals Trust

Mrs M Ogilvie
Senior Dietitian
West Lothian Healthcare Trust

Professor D Tolson
Professor of Gerenotoligical Nursing Health
Glasgow Caledonian University

Officers:
Mr R Samuel
Nursing Officer
Scottish Executive Health Department

Ms M Miller
Secretary
Scottish Executive Health Department