REPORT TO SCOTTISH EXECUTIVE HEALTH DEPARTMENT ON THE IMPLEMENTATION OF THE CLINICAL STANDARDS FOR FOOD, FLUID AND NUTRITIONAL CARE IN HOSPITALS
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CHAIRMAN’S FOREWORD

Good nutrition is fundamental to good health. The Health Service of all organisations should therefore ensure that patients in its care are well nourished. This is such a truism and the task so comparatively straightforward that we have paid insufficient attention to it, concentrating rather on the diagnosis and treatment of patients. This lack of attention to nutrition is not deliberate but has a real cost to patients and the Health Service. A significant number of patients are not as well nourished as they should be and their treatment is compromised by their nutritional status.

This report addresses the issues necessary to improve the nutritional status of patients in our hospitals. The problems lie not where popular opinion or the media would have us believe. The standard of food we provide in NHS hospitals is generally good and appreciated by patients. It is important to recognise this and the very positive foundation it offers for improving nutritional care. But nonetheless there are issues in our hospitals which must be addressed.

In “Our National Health” Scottish Executive Ministers recognised the need to improve the quality of nutritional care and the result is the NHS Quality Improvement Scotland (NHS QIS) Standards which were launched in September. The Standards herald a new approach to nutritional care and new thinking about its importance. They set out what needs to be done to achieve the highest possible standards of patient care within available resources.

For many, if not all, NHS hospitals that involves change in at least some aspects of how they provide nutritional care. This report highlights the key features that the NHS must address to ensure that those changes happen and the Standards are met. If we act on this report and achieve the NHS QIS Standards, then everyone concerned with patient care in hospitals will benefit. Patients will benefit because their nutritional needs will be identified as soon as they go into hospital and arrangements will be in place to ensure they are met. Staff will benefit because their patients will be healthier and their recovery faster. Hospital management will benefit from reductions in the average length of stay. If we implement the NHS QIS Standards and if we act on this report, Scotland will have given a lead to many other health systems. And in a small but significant way, the NHS shall have helped address another aspect of poverty and social exclusion, the impact of which is seen in under and malnourished patients.

There are many issues covered in this report and in the Standards, but the essence is that we must ensure that we measure and monitor the nutritional status of the patients we care for from admission onwards and that we ensure that these patients are properly fed. These simple challenges require a widespread understanding of the importance of the issue and commitment by management and professional staff to achieve the necessary changes which are set out in the rest of this report.

Alec Cumming
Chief Executive, Grampian University Hospitals NHS Trust
SUMMARY AND RECOMMENDATIONS

GENERAL

Malnutrition

All concerned with hospital management and patient care need to be aware of the benefits to patients and healthcare systems of immediate action to tackle under/malnutrition. Implementing the Standards for Food Fluid and Nutritional Care will help ensure this happens.

Obesity

Secondary care staff need to ensure that primary care teams are ready to provide appropriate weight reduction care by making them aware of this clinical problem before discharge from hospital.

In the non-acute hospital setting staff working with obese patients need to assist them to make appropriate meal and snack choices and may therefore require training in weight reduction as well as in general nutritional care

Leadership

It is for NHS Boards and Trusts to determine how the Standards for Food, Fluid and Nutritional Care will be implemented. But Boards and Trusts need to consider identifying an individual Director to assume responsibility for leading and co-ordinating activity to help move the new Standards, including the strategic plan, forward. They will also need to put in place appropriate support arrangements which might include identifying a project manager to support the lead Director and work with the Nutritional Care Group.

Attitude Changing

Food, fluid and nutritional care must be viewed as an essential clinical service and be given priority accordingly. Boards should aim to incorporate nutritional care into clinical and other planning mechanisms and ensure that it receives appropriate priority at every level. This requires a change in attitude and behaviour by many staff throughout the service.

Ministers and the Department need to work with NHS Chairs, Chief Executives and Boards to ensure that the leadership of the NHS at the highest level is convinced of the benefits of better nutritional care in hospitals. NHS QIS needs to maintain a dialogue with professions and staff groups over the implementation of the new Standards for Food, Fluid and Nutritional Care. Leaders of professions and staff groups need to ensure that nutritional care is a continuing subject for discussion with NHS Boards. NHS Chairs and Chief Executives need to promote the importance of nutritional care throughout their organisations.
Team working

Good healthcare is not delivered simply by individuals or even by individual professions, rather it depends on effective inter-disciplinary teams. NHS Boards therefore need to take action to strengthen inter-disciplinary nutritional care team working and leadership throughout hospitals.

Doctors

The Royal College of Physicians report Nutrition and Patients A Doctor’s Responsibility (2002) set out to influence clinical practice and encourage organisations responsible for health care professionals to increase their involvement in nutritional issues. The report makes 10 main recommendations covering nutritional screening and a number of other issues including education and training, audit, and clinical governance. Chief Executives, Medical Directors and hospital doctors generally need to consider the issues in the Royal College report and act on its recommendations.

Nurses

Nurses have a key role in identifying patients’ nutritional problems, in providing nutritional care and leading on nutritional care issues. They need to be convinced of the importance of nutritional care. Directors of Nursing should ensure that nutritional care is high on the agenda of all nurses and especially nurse managers.

Redesigning Services

NHS QIS needs to identify good practice and share its findings with the Health Service.

Hospitals need to examine their existing practices for example in relation to patients who require assistance with eating. It is crucial that they receive the help they need. Hospitals need to consider the mix of skills and abilities required to assist patients with eating and other aspects of nutritional care on the wards with a view to broadening the range of staff involved. This will not necessarily mean net additions to staff numbers. Adjusting skill mix and rotas may help meet nutritional care requirements.

Effective deployment of dietitians is essential to ensure that scarce professional skills are used to best advantage, for example through giving dietitians a larger role as advisers and consultants who might only be directly involved only in the more complex cases, identified through screening. This might also involve dietetic staff cascading knowledge and tasks to ward staff.

General Education and Training Issues

The Health Department needs to promote the PACE distance learning package on the Nutritional Care of the Hospitalised Patient. The Department also needs
to encourage NHS Education for Scotland to investigate the particular training needs of key staff groups beyond those met by the PACE package. The longer term aim should be to ensure that individual Boards do not have to develop original training material but can largely rely on standard training packages to meet all staff needs.

NHS Boards should act to increase the number of clinical placements available to student dietitians and encourage student training facilitators to support the development of training arrangements.

STANDARDS RELATED ISSUES

NHS Boards

Overall responsibility for nutritional care lies with the Directors of NHS Boards and Trusts. To ensure that nutritional care is being adequately addressed NHS Boards need to develop appropriate policies and a strategic plan.

Boards need to develop audit tools to monitor the implementation of the NHS QIS Standards. Nutritional Care Groups and lead Directors will wish to have regular reports on the implementation of the Standards.

Assessment

Effective assessment of a patient’s needs is fundamental to good nutritional care. Staff should be encouraged to see that assessing nutritional status is an important starting point for patient care. The availability of an assessment tool and equipment for measuring or estimating weight and height are also important.

NHS Boards need to be clear that although nurses are often the first point of contact for a patient and thus have a crucial role to play they do not have sole responsibility for the nutritional care of their patients. Nursing should be part of an inter-disciplinary team approach, involving catering staff, dietitians, speech & language therapists, occupational therapists, physiotherapists and others.

Benefits of Nutritional Care

While Boards will rightly aim to minimise increases in costs associated with improving nutritional care (for example, through changes in the mix of staff employed and their deployment) they need to be aware of the major benefits that improvements bring for patients. They also need to be aware of the potential for reduced costs through shorter length of stay.
Menu Planning

Menu planning teams need to be aware of the importance of a realistic assessment of the production capabilities of the catering department and the use of nutritionally analysed standard recipes.

Importance of Mealtimes

Boards need to ensure that all staff working on wards appreciate that routine clinical activity, such as investigations, ward rounds and procedures, is expected to cease at patient meal times. Boards may have to differentiate between what is possible in busy acute wards (the AMAU for example) and the generality of wards but at the very least the aim should be to minimise clinical activity at meal times.

Ordering & Cancelling Meals

Boards need to ensure that ward staff are encouraged to cancel meals for patients who have been discharged and that newly admitted patients are able to order meals. Serving a meal previously ordered by someone else to a newly admitted patient does not represent patient centred care.

Snacks

Boards need to ensure that the out-of-hours meals/snacks service is able to provide a sufficiently wide choice as to appeal to all patients. (For example, stroke patients should be able to get something to eat during the night.)

Legislation

The Nutritional Care Planning Group for each hospital needs to ensure that formal documented procedures are in place which cover all aspects of both the Food Safety legislation and the Health & Safety at Work requirements.

Patient Information & Communications

Catering departments need to identify individuals within the catering department as key contacts with wards.

The Planning Group needs to ensure that there is a formal procedure in place, designed to routinely audit the quality of patient food and fluids and establish whether patients' expectations are being met.

Boards need to have procedures in place to ensure that when patients are admitted their named nurse discusses arrangements with them.

Once an assessment has been made, the named nurse needs to ensure that information about their nutritional needs, including any food/fluid to avoid, is communicated to patients and their carers/relatives. This should include
practical advice about alternatives when significant changes to diet are advised.

**Education & Training**

The implementation of the principles outlined in the continuing education pack on the ‘Nutritional care of the hospitalised patient’ should be part of daily ward routine. Boards will need to ensure that there are practical and effective plans for the training of key staff involved.

Most of the work in effecting a change of approach, will be largely achieved by routine informal education on the wards.

Overall responsibility for the provision of local training initiatives for qualified staff should rest with the Directors of Nursing.

**National Arrangements**

The Department should establish a national forum for nutritional care issues. The Department should consult NHS Boards, health professions, specialist groups and other interested bodies, including NHS QIS, on the form this forum might take.
INTRODUCTION

Purpose

1. This document is a report commissioned by the Health Department from an inter-disciplinary group of NHS staff and representatives of patients’ groups (the “Departmental Food Group”). The membership of the group and its remit are shown at Annex A. The group was established in parallel with the NHS Quality Improvement Scotland (NHS QIS) Project Group which was developing the clinical standards for nutritional care in hospitals. One function of the Departmental Group was to tackle any issues which could not be fully addressed by the Standards. Membership of the two groups overlapped to encourage communications. During the course of its work the Departmental Group has also kept in touch with the Audit Scotland investigation of hospital catering (Catering for patients November 2003). This report draws from both the NHS QIS Clinical Standards on Food, Fluid and Nutritional Care Standards (September 2003) and the Audit Scotland report.

2. The purpose of this report is to reinforce the central importance of good nutritional care to the well-being of patients and the achievement of good clinical outcomes. We hope that the report will be welcomed as a practical means of raising the status of nutritional care within the NHS in Scotland in support of the new NHS QIS Standards. The quality of food prepared for patients in the NHS is generally good and this is borne out by patient surveys. This report aims at improving food, fluid and nutritional care overall and is not targeted at catering arrangements in particular.

Policy Background


4. The Diet Action Plan made a number of recommendations for the NHS. In particular, it suggested there should be better information on nutrition and diet for all groups of NHS staff. It also suggested that medical schools, the Royal Colleges, the National Board for Nursing Midwifery and Health Visiting and other bodies should ensure that appropriate emphasis was given to nutritional and dietary issues in education and training. For its part the CRAG report drew attention to the problems of under nutrition amongst older patients in long term care. To help ensure these issues were addressed, Our National Health invited the Clinical Standards Board for Scotland (CSBS now NHS QIS) to develop standards for the provision of food, fluid and nutritional care in hospitals.
5. In December 2001 CSBS established a project group, under the Chairmanship of Mrs Philippa Grant whose remit was to oversee the quality assurance process for the new Standard. After a period of development and public consultation the new Standards were published in September 2003.

6. There have also been other developments. Following the Regulation of Care (Scotland) Act 2001, Ministers set up the National Care Standards Committee to develop national standards. The National Care Standards, applicable to care homes and support services, were published in November 2001 and address, amongst other things, the issue of nutrition. As part of the regulatory process the Scottish Commission for the Regulation of Care (Care Commission) will use the standards to monitor the quality of care services and their compliance with the Act and Regulations.

7. In February 2002, the National Nursing, Midwifery and Health Visiting Advisory Committee issued a report on promoting nutrition for older adult in-patients in NHS hospitals in Scotland. The aim of the report was to support change and promote nutrition as a key element of patient care.

8. Most recently, the Scottish Executive Partnership Agreement published in May 2003 pledged the Executive to take action to promote good health and tackle issues associated with poor diet. The agreement is intended to ensure that adequate nutritional standards are in place for food served in care homes, hospitals, day centres and prisons.

**Meaning of Nutritional Care**

9. The term “nutritional care” may not be familiar to everyone. The term is used to describe a co-ordinated approach to the identification of the nutritional needs of individual patients and the delivery of food and fluid which meets these needs. This involves a range of different health professionals working together in the interests of the patient. Central to this approach is the realisation that the patient is an individual with needs and preferences. The nutritional care process involves determining the patient’s preferences and cultural needs and identifying and providing his or her physical requirements. Nutritional care involves following a patient’s progress through an illness and responding to changing nutritional requirements. It involves the monitoring and reassessment of nutritional status at regular intervals, referral for specialist care when appropriate and good communication with services in the community. Good nutritional care will require training and access to explanatory information for staff, carers and patients.

**Importance of Nutritional Care**

10. People who are ill, particularly in hospital, are more at risk of malnutrition, which in turn may delay their recovery, increasing their length of stay and the risk of complications. (Indeed many people who are admitted to hospital are already malnourished.) Illness may produce profound changes in an individual’s nutritional requirements, and may alter the appetite and the ability to eat and to communicate needs.
11. The provision of good quality food, fluid and nutritional care is therefore an integral part of the therapeutic care provided in hospital. In many respects, nutrition is the bedrock on which most other treatments rest. Meeting patients’ nutritional requirements will help them to get better more quickly and to keep healthy. The clinical importance of nutritional care, however, can be overlooked. This report aims to ensure this is no longer happens in the NHS in Scotland.

12. But nutritional care also plays an important social or psychological part in patient care. For example, within continuing care and particularly for elderly patients, mealtimes are a major social activity which patients enjoy. It is vital that this is recognised by all hospital staff and that patients are offered age appropriate food, a relaxing environment, and enough time and support to enjoy their meal.

PROBLEMS ASSOCIATED WITH NUTRITION

Malnutrition

13. Malnutrition is associated with a poorer clinical outcome in surgical and medical hospital patients. Moreover, once in hospital, patients frequently lose weight. This is especially true for those who are malnourished on admission. Malnutrition has a high patient cost as well as being associated with significantly higher healthcare costs. The Kings Fund Report (1992) indicated that the NHS could save more than £266m (1992 prices) annually if appropriate nutritional support was given to malnourished patients.

14. A large proportion of NHS patients are under-nourished with the proportion ranging from 13%-40% depending on the definition applied. Within Scottish elderly long-term care establishments the prevalence of under nutrition has been found to be 21%. This is high compared with national nutritional surveys where under-nutrition accounts for approximately 5% of the general adult population in the UK.

15. Reasons for the relatively high prevalence of under-nutrition in hospital are complex but not solely related to the disease process. Frequently dietary intake simply does not meet nutrition and metabolic needs. Often, malnourished patients are not identified on wards and so poor nutritional states remain untreated. Much of the problem relates to inadequate hospital management arrangements. Also staff may not regard nutrition as important. This lack of regard may reflect lack of training and awareness of nutritional issues. Other factors include problems with the social and physical environment and the quality, quantity, nutritional content and temperature of food. Yet hospital studies have clearly demonstrated that appropriate support can improve nutritional status and clinical outcome.

16. All concerned with hospital management and patient care need to be aware of the benefits to patients and their hospitals of immediate action to tackle under/malnutrition. Implementing the Standards for Food Fluid and Nutritional Care will help ensure this happens.
Obesity

17. The NHS QIS Standards do not specifically refer to obesity, although the nutritional assessment, screening and care plans required by the Standards will address obesity as well as malnutrition. However, obesity is an increasing problem in Scotland and it seems appropriate to offer some advice about it here. Obesity is associated with other long-term risks to health (e.g., diabetes and heart disease). The problems associated with obesity tend to occur over a long period of time and in many instances the acute hospital setting is not the place to start weight reduction regimens. However, over-nutrition does require to be highlighted in the acute setting and action should be taken when clinically appropriate but this is mostly once the patient has been discharged home. Secondary care staff need to ensure that primary care teams are ready to provide appropriate weight reduction care by making them aware of this clinical problem before discharge from hospital.

18. In the non-acute hospital setting weight reduction regimens are appropriate, as are healthy eating options and this requires to be taken into consideration when devising menus. Staff working with these patients need to identify those at risk and assist them to make appropriate meal and snack choices and may therefore require training in weight reduction as well as in general nutritional care.

IMPROVING NUTRITIONAL CARE IN THE NHS

Assisted Feeding and Nutritional Assessment

19. Two simple changes in behaviour are required to bring about a major improvement in nutritional care in the NHS. The first is that ward staff take responsibility for assessing the nutritional status of patients on admission, particularly with a view to identifying those who are under-nourished or malnourished. The second is that all patients who need assistance should be given the time and support they need to eat their meals and snacks.

Leadership

20. Nutritional leadership at Board, hospital management and ward levels is not as prominent or as influential as it might be. This may be because there is a general presumption that it is the design and delivery of clinical services that matters, Boards need to consider identifying an individual Director to assume responsibility for leading and co-ordinating activity to help move the new Standards, including the strategic plan, forward. They will also wish to consider appropriate support arrangements including identifying a project manager to support the lead Director and work with the Board’s Nutritional Care Group.

Priorities and Attitudes

21. There is often insufficient priority and commitment given to food, fluid and nutritional care from Board to ward level in Scottish hospitals, especially given its
importance in influencing clinical outcomes, length of stay and patient satisfaction. Food, fluid and nutritional care must now be viewed as an essential clinical service and be given priority accordingly. Boards should aim to incorporate nutritional care into planning mechanisms and ensure that it receives appropriate priority at every level. This will depend on a change in attitude and behaviour by many staff throughout the service. To assist this to occur Boards may wish to adopt a structure which reflects the importance of nutritional care (for example, a Nutritional Care Group at Board level with operational support to implement the nutritional care strategic plan and the NHS QIS Standards).

Cultural Change

22. Improving nutritional care in Scottish hospitals depends on a fundamental change in attitude and behaviour by Chief Executives, Medical and Nursing Directors and other senior managers and professional staff. The risk is that key opinion formers and decision takers regard the provision of food and fluid to patients as a non-clinical support service and a source of possible savings to support higher priority clinical services. Practical improvements in nutritional care depend on recognition by leaders throughout the NHS that nutritional care is an essential part of clinical care not an optional add-on. Evidence for the importance of nutritional care abounds and some influential voices have already begun to press for change. There are also some signs, for example from the recent NHS QIS peer review of older people in acute care, that the required changes are beginning to take place. But there is a need for a much bigger practical impact on attitudes and behaviour. We hope that consideration of this report and of the NHS QIS Standards which preceded it will prompt more widespread reconsideration of the importance of nutritional care.

Nutritional Care Concerns Everyone

23. Many different staff groups and professions contribute to the provision of nutritional care. Dietitians, for example, have a key role to play in supporting Boards’ nutritional care groups and in contributing to the education and training of other professions in aspects of nutritional care. But all professions need to see nutritional care as an important aspect of therapeutic care. Indeed all hospital staff need to see nutritional care as central to hospital care and at least as important as other (perhaps more technically demanding) parts of their jobs or professions.

Strong inter-disciplinary teams are vital…

24. Good healthcare is not delivered by individuals or even by individual professions, rather it depends on inter-disciplinary teams where staff work closely together to meet the particular needs of individual patients. This is particularly the case for nutritional care which involves a wide range of professions and specialist groups working together at different levels, stages and places throughout hospitals and Boards. **NHS Boards should therefore consider the measures they should take to strengthen inter-disciplinary nutritional care team working and leadership throughout hospitals. Dieticians have clinical expertise in nutrition and should work corporately as part of the team. They need to be supported**
in providing clinical leadership in key aspects of nutritional care and in the education and training of other key professions.

...Including Doctors ...

25. According to the Royal College of Physicians 2002 report (Nutrition and Health a Doctor’s responsibility) “doctors do not regard nutrition as important” and their “knowledge of nutrition and its clinical relevance remains poor.” The report suggests that doctors fail to recognise and treat nutritional imbalance partly because of its non specific nature. The report’s foreword says that it is a wake-up call to the medical profession to take clinical nutrition seriously. While doctors should play a key role in the detection and management of nutritional problems the report makes clear that it is also the doctor’s responsibility to “understand and appreciate the crucial role of other disciplines … in the nutritional care of patients.” The report emphasises the importance of screening for malnutrition and acting on the results. It also stresses the need for doctors to collaborate with colleagues in other disciplines when a care plan is made to address over or under nutrition. Chief Executives, Medical Directors and doctors generally should be aware of the issues in the Royal College report and its recommendations.

...and Nurses

26. Nurses have a key role in identifying nutritional problems, in providing nutritional care and leading on nutritional care issues. They need to be convinced of the importance of nutritional care. Directors of Nursing should ensure that nutritional care is high on the agenda of all nurses and especially nurse managers. Many nurses are convinced and nurses have often been at the forefront of improvements in nutritional care. But nurses also have many calls on their time and, for example, in busy AMAUs, where patients spend only a short time before being moved on, may not believe that initial nutritional assessment is their concern. Such thinking, where it exists, should be openly explored and addressed in order to bring about change.

Change is Required at all Levels

27. Changing attitudes and behaviour towards nutritional care is a major challenge for the NHS. Because lack of awareness and understanding of the key importance of nutritional care is widespread, this will take time. Change has to be tackled at a number of levels. Ministers and the Department have to work with NHS Chairs, Chief Executives and Boards to ensure that the leadership of the NHS at the highest level is convinced of the benefits of raising the standard of nutritional care in hospitals. NHS QIS has to maintain a dialogue with professions and staff groups over the implementation of the new Standards for Food, Fluid and Nutritional Care. Leaders of professions and staff groups need to ensure that nutritional care is a continuing subject for discussion with NHS Boards. NHS Chairs and Chief Executives must aim to promote the importance of nutritional care throughout their organisations.
Effective Use of staff

28. Staff need to take as much pride in the part they play in providing nutritional care as they do in any other aspect of their jobs. All staff need to be accorded full recognition for the important part they play in good nutritional care. They can justifiably be proud of what they do. Mutual respect and trust are central to establishing good communications between different departments and different professions and this in turn is the basis for ensuring good patient care and effective use of resources.

29. Greater emphasis on nutritional care has implications for a number of professions and staff groups. In particular, it has implications for dietitians and ward staff. The early evidence from implementing the Standard across Scotland suggests that NHS Boards are relying heavily on dietitians for their expertise and insight. The NHS may find that there is an increased demand for dietetic skills which cannot easily be met through increasing the number of dietitians employed. The way dietitians, associated professionals and other staff are deployed and supported will have to be considered to optimise skill mix and ensure that scarce professional skills are used to best advantage. This might involve giving dietitians a larger role as advisers and consultants who would only be directly involved in the more complex cases, identified through screening. This might also involve dietetic staff cascading knowledge and tasks to ward staff.

30. Nutritional care should be tailored to individual needs but hospitals may have to consider strategies for particular groups. For example, frail elderly patients whose initial assessment indicates that they are under-nourished or at risk but who can swallow must be assessed for the need for generic prescribed nutritional supplements plus or minus meal supplements. In those circumstances, dietetic referral would only be needed for others and those who do not improve on this regime.

31. Nurses rightly see nutritional care as one of their responsibilities. There are, however, a large number of pressures on the time of nursing staff some of which call for specialised techniques or require particular professional skills which only they can provide. The new NHS QIS Standards may increase the calls on the time of nursing staff, for example through requiring more nutritional assessment and screening. A proportion of patients, for example those with a disability, existing or acquired, will always require assistance to help them eat. It is crucial that they receive this help, be it with equipment or personal care. This is a fundamental part of nutritional care but one which evidence suggests is all too often overlooked. Hospitals need to ensure that the appropriate equipment is available on the ward or following assessment by an occupational therapist. Hospitals also need to consider the mix of skills and abilities required to assist patients with eating and other aspects of nutritional care on wards with a view to broadening the range of staff involved. Ward hostesses, housekeepers, dietetic assistants and other new staff groups may have a role to play. This will not necessarily mean net additions to staff. Hospitals should look carefully at adjusting skill mix and rotas to meet their nutritional care requirements.
32. Hospitals should also consider the working patterns of ward staff to ensure that there are sufficient numbers available to cover meal times. This may involve employing staff specifically to work at and around meal times. It may also mean re-deploying staff between adjoining wards as the number and mix of dependent patients alter. This should not happen where there is a risk of spreading infection. Nor should it be at the expense of damaging established relationships with patients.

**Education and Training**

34. Education and training will form an important part of improving nutritional care and responding to the NHS QIS Standards. General awareness raising and education in basic issues can form an important part of changing attitudes and behaviour. Training also has a part to play in strengthening inter-disciplinary teams particularly through leadership development, teambuilding and improved communications. Additional, on-the-job, skills training (for example, in assessment and screening, serving food and assisting patients to eat) will be an important part of meeting the NHS QIS Standards.

35. The Health Department and NHS Education for Scotland with guidance from Boards should ensure that standard training packages in nutritional care are available to meet the needs of all staff and professional groups. The Department should encourage the promotion of the Partnerships In Active Continuous Education (PACE) distance learning package on the Nutritional Care of the Hospitalised Patient, adapted if required, as a means of improving nutritional care.

36. There is evidence to suggest that greater involvement in student learning has a positive impact on qualified staff, through more effective evidence based practice, and also benefits patient care. It also has benefits for the recruitment and retention of dietitians. **Two immediate actions are required to help improve the supply of State Registered Dietitians. The first is to increase the number of clinical placements available to student dietitians within the NHS. The second is to appoint student training facilitators to support the development of training arrangements.**

**Resource Implications**

37. This is not a report about cutting costs of food or catering. It is concerned with improving the quality of nutritional care. Nor is it a report recommending that more resources must go into nutritional care, although that seems likely, at least in some hospitals. What is certain is that in the interests of patients the way we provide nutritional care in the NHS has to change. The new Standards inevitably involve striving to ensure that a level of performance is achieved. That may mean change and additional expenditure. It may mean re-designing service provision. That is for NHS Boards to determine.

38. But better nutritional care as well as improving the quality of our service can lower NHS costs by reducing length of stay. In addition, conventional techniques to
reduce food waste can produce savings which can be re-deployed to improve nutritional care. More accurate costing/charging of meals for staff and visitors can also provide increased revenue for nutritional care of patients. **Hospitals should examine their existing practices to ensure they offer value for money** (for example, addressing skill mix and the availability of staff to physically assist patients to eat may reduce waste without increasing costs as well as providing better patient care).

**Re-design/Good Practice**

39. If re-design of some services and activities is necessary to implement the Standards effectively, then identifying and sharing best practice throughout Scotland will be the key to success. There is evidence of good nutritional care practice. **NHS QIS should aim to identify good practice and share its findings with the Health Service.**

**FOOD FLUID & NUTRITIONAL CARE STANDARDS**

**Development of the Standards**

40. The Standards set by NHS QIS were drawn up by a project group, which included health service staff from relevant disciplines and members of the public. The Standards draw on clinical evidence and also the experience of the members of the project group who both provide and use the service. They are developed in line with policies and procedures originally agreed by the Clinical Standards Board for Scotland, now part of NHS QIS. The Standards are ‘an agreed level of performance and should be achievable, desirable and observable.’ There was a period of public consultation on the draft Standards, during which they were circulated widely. The responses to consultation and the two pilot peer review visits, which took place in this period, informed the process of revising the Standards for final release in September 2003. In due course, NHS QIS will conduct peer reviews of hospitals to assess performance against the standards. The findings will be published as local reports together with a national overview and made widely available to the public.

41. From this description of the process it should be clear that these standards are not being imposed on the NHS. The Standards were developed by NHS staff and patients and intended for NHS staff and patients. The Standards are rooted in the reality of current NHS practice but are at the centre of a process intended to improve the general level of service throughout the NHS. The Standards will ask challenging questions of some hospitals and some NHS Boards but questions which they should be able to address in best interests of patient care.
Generic Clinical Governance Standards

42. NHS Quality Improvement Scotland has also developed generic clinical governance standards of care that underpin all clinical services provided by NHSScotland. The decision to integrate the healthcare risk management standards developed by CNORIS and the NHS QIS generic clinical governance standards were set out in HDL(2003)29. Draft Healthcare Governance Standards are currently out for consultation – January-April 2004. The significance of food, fluid and nutritional care as a clinical issue, as a cultural issue and its position at the interface between the patient and various systems in a hospital makes nutritional care central to clinical governance.

43. The *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* should be read in conjunction with the generic clinical governance standards which provide a broader context. Some issues covered in those standards are emphasised in the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* where their importance merited a special mention, e.g. education for staff, and patient information.

Coverage of the Standards

44. The *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* apply to:

- all patients; and
- all hospitals.

The Standards cover the following areas:

- Policy and Strategy;
- Assessment, Screening & Care Planning;
- Planning & Delivery of Food & Fluid;
- Provision of Food & Fluid to Patients;
- Patient Information & Communication; and
- Education & Training for Staff.

45. The provision of nutritional care will vary. At one end of the scale is the routine provision of regular meals, relying on the services of catering staff and the support of ward staff and at the other are situations where patients rely entirely on clinicians and specialist nurses for the management of complex nutritional care through techniques such as intravenous and enteral tube feeding. Staff will have different responsibilities and training requirements according to the situations in which they are working.
IMPLEMENTING THE STANDARDS

Standard 1: Policy and Strategy

Rationale for Nutritional Care Strategies and Policies for Hospitals

46. The Diet Action Plan for Scotland in 1996 set out a programme to improve the health of people in Scotland. The main thrust was to encourage a healthier diet (low in fat and sugar, moderate in protein and high in complex carbohydrates). However, people that are ill and in hospital have particular needs, frequently at odds with general recommendations. The Diet Action Plan bound the NHS to implement the Nutritional Guidelines for Hospital Catering setting standards for catering and nutritional care at ward level. More recently the significance of nutrition in health and disease has been highlighted by a number of reports commenting on the lack of priority accorded nutritional care and the adverse impact on patients and resources. In 1999 the Scottish Executive released core standards of nutritional care for nursing homes (NHS MEL(1999)54) which were also expected to apply in all NHS facilities. The Scottish Health Plan reiterated the need for hospitals to improve nutritional care. To ensure that nutritional care is being adequately addressed NHS Boards need to develop appropriate policies and a strategic plan.

Planning Background

47. NHS Boards Nutritional Care Policies and Strategic Plans should help bring about a co-ordinated approach to nutritional care throughout their areas. To develop such plans it is crucial that Boards take account of the following:

1. Nutritional care audits/reviews for baseline information and development possibilities.

2. The age, length of stay, clinical grouping and ethnic mix of their in-patient populations. This is required to develop menus appropriate to patient groups.

3. Their catering systems and their implications for management and delivery of nutritional care.

4. Good practice in their or other Boards which can be drawn on or shared more widely.

5. The importance of patient choice and involvement in menu construction, meal selection, improving quality and other issues.

Organisational Structure

48. Individual organisations have their own local protocols and systems of food preparation and delivery. Different systems have different merits and the standards imply that those planning food, fluid and nutritional care will review the strengths and limitations of their own systems and plan accordingly. NHS Boards may need more
than one planning group to oversee the implementation of local protocols, particularly where the geography is complex and sites separated.

**Project Management**

49. Boards will have to consider how best to develop and implement their policies and strategic plans. This will include consideration of the type and mix of staff required and the leadership arrangements. Especially where professional/clinical staff are concerned Boards will have consider the need for backfill arrangements. It may be that especially at first Boards will wish to consider the employment of a project manager to work closely with the lead Director on these issues.

**Re-design**

50. By implication Standards require organisations to improve. Otherwise there would be little point in them. Much can be achieved by changing practice, by re-design by fostering a positive attitude to nutrition and by ensuring that the impact of any decision, action or change is assessed for its impact on the nutritional status of patients – for example, the decision to hold a ward round at the same time as meal time.

*Examples of good practice*

**Audit**

51. The Standards require that monitoring and audit are built into the practice of nutritional care. There is a deficiency of nutritional care standards and audit at all levels throughout NHS Scotland. **Boards should aim to develop audit tools to monitor the implementation of the NHS QIS Standards.** We expect that Nutritional Care Groups and lead Directors will wish to have regular reports on the implementation of the Standards.

**Accountability**

52. Boards should establish clear lines of accountability and reporting for nutritional care, including the clinical governance committee and operational management teams, to ensure that all issues relating to nutrition are addressed. This is critical given the diversity of personnel and departments involved in nutritional care all of whom have to work together to achieve the Standards (eg, transportation of meals at a time to meet patient needs).

**Operational Support**

53. The Standards call for the establishment of a high level nutritional care group tasked with overseeing the implementation of the Board’s strategic plan. Boards will wish to consider underpinning organisational arrangements for example multi-disciplinary operational groups tasked with specific aspects of the Standards. The composition of these groups will be dependent on local issues. The nutritional
care group will need to meet regularly to enable adequate monitoring and to support and advise on operational issues.

Clinical Nutritional Support Teams

54. The NHS QIS Standards require that Boards ensure that patients receiving complex nutritional support techniques such as parenteral feeding or complex tube feeding (such as percutaneous endoscopic gastrostomies) should have access to a clinical nutritional support team. The core membership of the team should include a doctor, a specialist nutrition nurse, a pharmacist and a dietitian. In many cases other doctors and health professionals such as radiologists may also be involved.

55. Larger hospitals and units particularly those with intensive care units will probably require a clinical nutritional support team on site. In smaller hospitals where complex techniques are used infrequently it is more important the Boards ensure links with established support teams so that patients can be referred when required. Patients requiring home parenteral nutrition (the most complicated nutritional support technique in common use) should be managed as part of the Scottish Home Parenteral Nutrition Clinical Network. (Clinical Co-ordinator, Mrs Janet Baxter, Ninewells Hospital, Dundee.)

56. Good practice requires Boards to establish or maintain clinical nutritional support teams. It will be essential to ensure that they provide support not only within the acute hospital setting but also within primary care where an increasing number of patients are managed at home on complex nutritional support including total parenteral nutrition and tube feeding via a gastrostomy. There is often no medical clinician with expertise in this field in primary care and a lack of clear processes to manage complex problems or access to relevant expertise to help address/resolve emergency problems that arise.

Standard 2: Assessment, Screening and Care Planning

Introduction

57. In a study published in the British Medical Journal in 1994 by McWhirter and Pennington it was revealed that 40% of the adult hospital admissions in the area of study had some degree of under-nutrition, and in half of these it was severe. Only 5% of these patients, however, were referred to a dietitian, and only 23% had been weighed. This was seen as a failure by staff to identify patients at risk. It is important that hospital managers and staff at all levels recognise their responsibility and accountability for nutritional care of patients.

Assessment

58. Assessing patients' nutritional status using appropriate objective markers such as dietary intake, height, weight and clinical condition is essential to ensuring they receive the food fluid and nutritional care which meets their needs. Reports by the Caroline Walker Trust and the British Association of Parenteral and Enteral Nutrition
(BAPEN) highlight the need to assess patients for under-nutrition. Fundamental to any system of nutritional care is a proper system of risk management which involves initial screening on admission followed by monitoring during hospital stay. Without initial assessment and nutritional screening, effective management and appropriate care is impossible. The use of a nutritional screening tool is a means of identifying patients at risk of malnutrition.

**Initial Assessment**

59. Initial assessment is usually undertaken on the first day of admission by nursing and medical staff. It can also be undertaken in out-patient clinics for example during pre-operative assessment. Assessment will identify patients’ nutritional preferences and needs while nutritional screening ascertains who is at risk of under-nutrition. The assessment will be documented in both the nursing and medical records.

60. **What is important, as well as the availability of an assessment tool or the capacity to accurately measure a patient's weight or height, or employ suitable surrogates, is appreciation by staff that assessing nutritional status is an important starting point for patient care and their readiness to act accordingly.**

**Screening**

61. In the course of undertaking a comprehensive assessment nutritional screening will be undertaken and has now to be carried out within one day of admission to hospital. Regular reassessments during the patient’s stay is essential to monitor change. Screening for under nutrition relies on the professional skills of the user to make a judgement on the nutritional status of patients. Most screening tools have been developed for use by trained nursing staff, who are in an ideal position to assess all patients admitted to hospital. [A screening tool should be simple to use, acceptable to the patient and user, valid, reliable, sensitive and specific. At present in NHS Scotland various screening tools are in use. Some are more reliable than others in identifying patients at risk. The elements within the Malnutrition Universal Screening Tool (MUST) developed by the Malnutrition Advisory Group, part of the British Association for Parenteral and Enteral Nutrition (BAPEN), have been identified as those elements which all screening tools should have.] When screening identifies patients at risk, an action plan should be drawn up to address the risk.

62. **Although nurses are often the first point of contact, and thus have a crucial role to play, they do not have sole responsibility for the nutritional care of their patients but instead must be part of an inter-disciplinary team approach.** The nurse is, however, pivotal in performing nutritional screening and determining the action required to move the patient through the appropriate care pathway.

63. More screening and increased awareness 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. **While hospitals**
should aim to minimise such increases in costs and resources (for example, through changes in the mix of staff employed and their deployment) they should also be aware of the offsetting benefits for patient care and potential for reduced costs through shorter length of stay.

**Care Planning**

64. As a result of assessment and screening a multi-disciplinary care plan should be developed, reviewed and refined. It should include documentation of the outcomes of assessment, screening, the need for repeat screenings, and actions taken. Care plans should demonstrate patient involvement in the decision-making process and outline appropriate action, progress and goal achievement. On discharge a care plan will be developed with the patient and, where appropriate, carer/relative, and will include the patient’s nutritional status, special dietary requirements, and the arrangements made for any follow-up required on nutritional issues including obesity (see paragraphs 17 & 18). This will be part of the normal discharge process.

**Equipment for Assessment & Screening**

65. The standards have a bearing on the provision of equipment for weighing and measuring. A stock take of equipment would be an appropriate preliminary measure for reasons set out in the Standards. The equipment in use should reflect the needs of the patient group concerned. (For example, in acute receiving areas hoists or bed scales should be available.)

**Link Nurses and other staff**

66. Nutritional care is the responsibility of all staff and Boards may wish to consider a range of staff initiatives to improve care. For example, Boards may find it helpful to identify link nurses as the lead person on a ward for nutrition and to promote awareness of the importance of nutrition in patient care. Link nurses can bring expert knowledge and act as a resource for the ward staff and for inter-disciplinary developments. A number of hospitals also use ward hostesses, housekeepers, dietetic assistants and volunteers in a range of duties to help ensure that patients receive the nutritional care they require.

**Standards 3 and 4: Planning and Delivery of Food and Fluid & Provision of Food and Fluid to Patients**

**Introduction**

67. Successful planning and provision of food and fluid for patients is dependent on good communications and it is essential that a multi-disciplinary planning group exists, in order to ensure that the service is based on patients’ nutritional and social needs. The key aspects of a successful planning and delivery process are considered below.
Menu Content

68. The planning group should draw on views from a range of staff (including Catering, Nursing, Dietetics and Medical) and patients. The patient viewpoint must be included to ensure that the “customers’” needs and expectations are understood. **In planning the menu, an important assessment is the actual production capabilities of the catering department and the use of nutritionally analysed standard recipes.** To encourage patients to eat, the food offered should provide variety and portion sizes should be appropriate.

Physical Environment/Facilities

69. We expect that patients will be afforded a suitable environment for eating. Some patients are likely to eat more in attractive dining areas with social interaction. Consideration should also be given to the condition of the facilities and equipment available to ensure that the ward offers a good environment for dining. Some patients will not be able to eat or drink without assistance as a result for example of arthritis, fractures or stroke. Lack of or ill-fitting dentures, poor vision and hearing all affect eating. Positioning patients where they are able to reach and eat food is also important.

70. Encouraging patients to eat is not just a matter of the physical environment. **Routine clinical activity such as investigations, ward rounds and procedures should be expected to cease at meal times.** Boards may have to differentiate between what is possible in busy acute wards (the AMAU for example) and the generality of wards but at the very least the aim should be to minimise clinical activity at meal times.

Time of Meal Provision

71. Meal times in hospitals are relatively inflexible and can bear little resemblance to patients’ usual meal times. It is essential that the needs of the various patient groups are considered when setting meal times. The social preferences of patients should be reflected in the time and content of meals, particularly the main meal. Attention should be given to the time gap between meals, with particular emphasis on ensuring there is not too great a gap between evening meal and the next day’s breakfast. It is important that there is adequate time allowed during the meal service period for patients to eat and drink. This may mean changing the times for the return of meal trolleys.

Meal Selection Process

72. The Planning Group must develop protocols and procedures which ensure that the patients have the opportunity to select their own meal from the menu. This selection should be made no more than 2 meals in advance. Whilst it is recognised that menus have to be changed from time to time for various reasons, wards should be told of any changes immediately to ensure that patients can be made aware. It is important to ensure that patients receive the dish they order. The catering department must also have in place procedures which allow for wards to advise of
meal cancellations due to discharges and more importantly to permit newly admitted patients to order meals. Serving a previously ordered meal to a newly admitted patient must be avoided.

73. Menu cards used for the patients should be clear, attractive and professionally designed with consideration given to sufficient dietary coding being included, without confusion to the patient. Menus should also be available for patients from ethnic minorities. Arrangements should be made for patients who are unable to read.

**Food Production Method, Delivery, Distribution & Service**

74. When the opportunity for investment arises, consideration should be given to the best method of food production (ie, traditional cook-serve, cook-chill, cook-freeze, meal assembly or a combination of methods) in the light of the pattern of patient demand.

75. It is also important to assess the most appropriate style of food delivery and service. The trolley/delivery systems can most often be dictated by the production method being used but it is essential to take account of the needs of the patient group/s. It may be that more than one style is required (eg, bulk, individually trayed/plated, hostess). Equally important is the general layout of the hospital. Are the meals being delivered within a single building or to a number of buildings or outlying sites from a central production facility? These are key considerations for service style and central to ensuring that good quality food is served to patients.

**Out-of-Hours Meals, Snacks & Beverages**

76. An important element of planning the catering provision for patients is consideration to the availability of snacks and beverages outwith the normal meal times. These must be available especially for patients who have missed a meal. The out-of-hours meals/snacks service must be able to provide a choice that all patients would want to and can eat. (For example, stroke patients should be able to get something to eat during the night.) This is particularly important for busy acute medical and rehabilitation wards which will struggle to stop all clinical activity at normal meal times. In such circumstances there should be a range of meals/snacks available to patients outwith normal meal times.

**Procurement of Produce**

77. In general, the majority of food supplies are secured via National Contracts. Product specification is high and the quality of product should be consistently high on receipt. Catering Managers should work closely with Supplies Managers to ensure that the full benefits of the contract arrangements are obtained. In addition, there should be a formal routine quality control check on receipt to ensure that quality complies with specification and the order placed.
Safe Working Practices and Procedures

78. All food and fluids must be prepared and served using planned safe working practices. **The Planning Group should ensure that formal documented procedures are in place which covers all aspects of legislation in respect of both the Food Safety legislation and the Health & Safety at Work requirements.** This can be achieved by having an effective HACCP (Hazard Analysis Critical Control Points) system in place. Such a system should cover food safety at both catering department and ward level. Catering and Nursing staff should work closely with the Control of Infection Team, with food safety procedures included in the Infection Control Manual.

Formal Communications Procedures

79. Good communication between wards and the catering department is essential for the provision of a quality patient meal service. It is vital that all staff involved in the catering service, from production through to the service, work together as a team. Poor communications can lead to a drop in quality and increase levels of waste. The benefits of good communications can be:

- Reduced waste meals
- Patients receiving the meal they order
- Problems being dealt with quickly
- Improved quality
- Help for future planning

80. **Catering departments should consider identifying individuals within the catering department as key contacts with wards.**

Staffing Issues

81. Skilled and well motivated staff are fundamental to a good catering service. In particular catering departments need cooks and chefs with the appropriate nutritional training. Ideally departments should aim for a multi-skilled production workforce with all cooks having the necessary dietary knowledge to eliminate the traditional problems in relation to staff cover. Where menus have been updated to meet current requirements of the new Standards, diets previously coded separately are now incuded in the main menu and no longer termed special diets. For example, provided the Healthy Eating choice has been developed and nutritionally analysed it can meet the requirements of a wide range of patients. This choice is generally lower in fat and sugar /or higher in fibre and is also suitable for patients on weight reduction, low fat, lipid lowering, high fibre and diabetic diets. This change of approach to menus lends itself to multi skilled cooks providing most of the production rather than depending on a staff mix including a small number of diet cooks providing specialised meals only. Moreover all NHSScotland cooks should have the ability to prepare modified consistency stage diets and also energy dense menu choices for the elderly.
Scheduled Monitoring and Review

82. Whilst in hospital, patients are encouraged to eat and drink in order to aid their recovery. Therefore, we must ensure that patients’ views are sought about their needs and whether or not they are being met. The Planning Group should ensure that there is a formal procedure in place, designed to frequently audit the routine quality of patient food and fluids and to establish whether or not the patients’ expectations are being met. (For example at Ninewells the Local Health Council is invited to sample meals on the wards and the local media is kept informed.)

83. There is a need for patient representation in the audit process and for regular satisfaction surveys. Survey and audit data provides a valuable aid in the general review of nutritional care and menu planning.

Standard 5: Patient Information and Communication

84. Patients’ views and preferences should be sought and acted upon to ensure that the food and nutritional care provided reflects their needs and preferences and fosters their well being whilst in hospital. Effective communication with patients who may be vulnerable and anxious can be supported by involving carers/relatives. Patients, carers, relatives and patient groups should also be involved in general planning and development of patient information and communication issues to ensure the views of patients and carers/relatives are fully integrated.

Patient Information

85. For planned admission to hospital, an information leaflet should be sent to patients in advance of their stay. Leaflets should be tailored to the hospital or ward to which the patient will be admitted. A sample menu could be sent to patients in advance. When patients are admitted their named nurse should discuss arrangements with them.

86. For admissions which are not pre-planned, an information leaflet and menu should be given to patients as part of admission procedures and the named nurse should ensure an explanation is provided if required. To encourage understanding, leaflets should be written in plain English and available in different forms and languages if required. The use of symbols/pictures should be maximised and access to interpreters should be arranged as appropriate.

87. The named nurse should ensure that their nutritional needs, including any food/fluid to avoid, are communicated to patients and their carers/relatives once an assessment is made. This should include practical advice about alternatives when significant changes to diet are advised.
Patient Feedback

88. One way of improving feedback might be to send a questionnaire to a sample of patients following discharge from hospital. Expert advice should be sought and questionnaires piloted before any widespread use. The views of patients in hospital for long stays should be regularly sought and acted upon. Partnership working with patient groups, Local Health Councils and voluntary organisations should give patients and carers the opportunity to express their views to a third party. All information and views collected at ward level, including themes from complaints and comments, will be of interest to the nutritional care group for assessing trends and preparing plans.

Standard 6: Education and Training for Staff

89. All staff involved in patient care should fully appreciate the importance of nutritional care and its role in improving patient outcomes, and have the necessary skills and understanding to carry out their role in the delivery of nutritional care. This requires a level of training and education. Boards should ensure that education on nutritional care is an element of induction training for all staff, with regular updates as part of continuing professional development.

90. The implementation of the principles outlined in the continuing education pack on the ‘Nutritional care of the hospitalised patient’ should be part of daily ward routine. This pack, produced by Queen Margaret University College, Edinburgh (the Partnerships In Active Continuous Education (PACE) packs) as part of the CRAG audit has been distributed to every Board in NHS Scotland with support from the Chief Nursing Officer. Staff who have not had access to this training pack should be targeted. The pack may require revision and perhaps extension to include the MUST screening tool.

91. Whilst the nutritional care elements of pre-registration education might be strengthened, in-house provision for the further education and training of qualified staff should probably be the primary and most immediate method of effecting change. To this end, Boards should approach NHS Education for Scotland and the Centre for Change and Innovation at the Scottish Executive for examples of good practice.

92. Education and training budgets always have to be carefully managed and it will be important to ensure that the training required to implement the NHS QIS Standards is properly targeted and delivered efficiently and effectively. This means taking full advantage of programmes of initial professional (pre-registration) education and nationally developed training packages. It may mean identifying nutritional care competences for different staff groups and developing competency-based training accordingly.

93. The operational nutritional care groups will also have to assess the priorities for training, which should be broader than simply safety, hygiene or other issues determined by legislation. Induction programmes for new staff, subsequent updates,
and programmes for existing staff who may not have attended earlier induction sessions, should include information on the catering system and procedures for food provision. This information could be imparted to all clinical disciplines. Most education around nutritional care, however, and most of the work in effecting a change of approach, will be largely achieved by routine informal education on the wards.

94. Whilst issues around food, fluid and nutritional care should be the concern of all who come into contact with patients and those who manage related services, the main focus for improving standards in this area must lie with nursing staff. They are the staff who are mostly responsible for the assessment, care and monitoring of patients in relation to nutrition. **Overall responsibility for the provision of local training initiatives for qualified staff should rest with the Directors of Nursing.**

**CONCLUSION**

95. Because of its inter-disciplinary nature nutritional care cuts across conventional management and accountability arrangements. Hospitals need to put organisational arrangements in place that will foster effective governance of nutritional care. The same is true at national level. The Department needs to consider the best means of ensuring that all the professions and specialist groups with an interest in nutritional care are brought together in a forum which can discuss issues and generate advice on good practice and other matters. **The Department should consult with NHS Boards, health professions, specialist groups and other interested bodies including NHS QIS about the need for a forum and the form it might take.**

96. This short report has aimed to give greater prominence to nutritional care issues to highlight their importance and to offer high level advice on improving the delivery of nutritional care and implementing the NHS QIS Standards. Nutritional care may have been somewhat neglected until recently but this is changing. This report was able to build on the analysis and conclusions of a number of documents especially the NHS QIS Clinical Standards for Food Fluid and Nutritional Care (September 2003) and the Audit Scotland report on Catering for patients (November 2003). Nutritional care will continue to be a significant issue for the NHS and further work remains to be done. This includes a national nutritional and catering specification which is currently being prepared.
Remit of Departmental Steering Group

The Departmental Steering Group was set up in response to Ministerial and public concern about nutritional care standards in NHS facilities in Scotland. It also addresses the pledges in “Our National Health”, published in December 2000, relating to food quality in the NHS. Ministerial concern has its origins in the report of the National Nutritional Audit of the Elderly in Long Term Care, published by CRAG in September 2000, which estimated that over 20% of elderly patients in long-term care were undernourished.

Ministers have asked that an action plan be prepared setting out the steps needed to improve nutritional care in hospitals. The action plan should be relevant to all patients, but is likely to have the biggest beneficial effect on long-stay patients. The majority of long-stay patients in Scottish hospitals are elderly. The departmental steering group is tasked with producing the action plan, calling in further expertise as may be necessary to do so.

Against that background, the remit of the Departmental Steering Group is:

To review current practice across NHSScotland in providing nutritional care to hospital patients, including arrangements for purchasing, preparing, distributing and serving food and drink in hospitals of all types.

To identify good practice in nutritional care, to recommend how this might be disseminated, and to consider how patients’ perceptions of the quality of their nutritional care might be enhanced bearing in mind the diversity of patients’ needs and backgrounds.

To examine progress by NHS Trusts in implementing the relevant recommendations of ‘Eating for Health – A Diet Action Plan for Scotland’ and of the National Nutrition Audit of the Elderly in Long-term Care.

To develop a nutritional specification for NHSScotland

To act as a sounding board and to help set the context for the development of nutritional care standards.

To develop guidance to support successful implementation of the nutritional care standards.

To make any recommendations for changes which the group believes to be necessary in the light of its work, to estimate the likely costs of implementing these recommendations, and to discuss ways in which cost impacts might be contained.
A distinct part of the action plan is the development of standards for nutritional care. This is a task that falls to the Clinical Standards Board for Scotland (now NHS Quality Improvement Scotland) but with the advice and support of the steering group as required. An NHS QIS sub-group has been set up to take this work forward.
DEPARTMENTAL STEERING GROUP MEMBERS

Mr Alec Cumming (Chairman from January 2003), Chief Executive, Grampian University Hospitals NHS Trust

Mr George Buchanan (Chairman until December 2002), formerly Chief Executive, Renfrewshire & Inverclyde Primary Care NHS Trust

Mr Billy Cunningham, Catering Services Manager, Ayrshire and Arran Acute Hospitals NHS Trust

Mrs Isabella Dickie, Hotel Services Manager, Ayrshire & Arran Primary Care NHS Trust – SPF Representative.

Ms Philippa Grant, Board Member of NHS QIS and Chairman of NHS QIS Food, Fluid and Nutritional Care Project Group

Mrs Alison Greer, Contracts Manager, Scottish Healthcare Supplies

Miss Morag MacKellar, Head of Nutrition and Dietetics, Forth Valley Primary Care NHS Trust

Mr Brian Main, Site Services Manager, Tayside University Hospitals NHS Trust

Dr Alastair McKinlay, Consultant Gastroenterologist, Aberdeen Royal Infirmary

Mrs Ina Miller, Inverclyde Community Care Forum

Mrs Ann Paterson, Head of Nursing, Elderly Services, Renfrewshire and Inverclyde Primary Care NHS Trust

Dr Jan Potter, Consultant Geriatrician, South Glasgow University Hospitals Trust

Mr Jim Rotheram, Facilities Manager, Fife Primary Care NHS Trust

Mr John Taylor, Scottish Association of Health Councils

Mr Chalmers Thomson, Head of Management Accounting, Ayrshire and Arran Acute Hospitals NHS Trust

Mrs Jacqueline Walker, Dietician, Tayside Primary Care NHS Trust

Ms Sunita Wallia, Community Dietician, Greater Glasgow Primary Care NHS Trust