Improving nutritional care

Participant information pack
Developed in collaboration by the RCN, NPSA and BAPEN
Improving nutritional care

Introduction

Food and water are essential elements of care – as vital to a patient as medication and treatment. Nutrition Now, launched by the RCN in 2007, aims to raise the standards of nutrition and hydration in hospitals and community settings.

Nutrition Now gives nurses the practical tools, support and evidence they need to make nutrition a priority in their areas of work.

Nutrition Now goals

1. Nutrition to be treated as a greater priority by nurses, other members of the multidisciplinary team, management and government
2. Patients’ experiences of nutrition and hydration to be enhanced
3. All ward environments and care home settings to implement the principles of Protected Mealtimes effectively
4. All inpatients and people in care home settings to have a nutritional screening completed and actioned within 48 hours of admission
5. Each country to have its own standards for nutrition and hydration
6. Initiate change in attitudes and behaviours towards nutrition and hydration.

To achieve the goals of the campaign, a series of activities and learning resources have been developed. This workshop forms one of those activities and specifically aims to achieve two of the goals of the campaign:

- All ward environments and care home settings to implement the principles of Protected Mealtimes effectively
- All inpatients and people in care home settings to have a nutritional screening completed and actioned within 48 hours of admission.

A website has been developed providing a variety of learning resources for nurses and there are case studies to help nurses enhance nutritional care. Please visit the website at www.rcn.org.uk/nutritionnow

Supported by an unrestricted educational grant from Abbott Nutrition.
About this workshop

More than ever before, health and social care organisations are being asked to look at services through the eyes of the patient. There is no doubt that front line staff have the biggest impact on the patient-client experience, and have good ideas about small changes that can make a big difference.

This workshop is about having some time to think about how you could enhance the experience of your patients and clients in relation to food.

It has been developed in partnership with the National Patient Safety Agency (NPSA), British Association for Parenteral Enteral Nutrition (BAPEN), Abbott Nutrition and is supported by the Patients Association and Age Concern.

This information pack is your personal copy of the programme materials. You are free to take notes or personalise this guide. You will deliberately find very little theory in these pages, it is a practical guide to help you to apply what you learn. If you need any more information on any topic, please ask your facilitator.
What you will learn

This workshop is about the impact that you and your team’s work has on patients, service users and clients, and their families, carers and members of the public in relation to food*. It takes a lot of people working together as a team, as well as individuals doing their own job well, to provide excellent nutritional care and service.

The workshop will help you to:

• Have further knowledge about the ‘Malnutrition Universal Screening Tool’ (‘MUST’)
• Further understand about patient safety issues
• Appreciate what you bring to the team, and what others contribute
• Discuss responsibilities that we all share in nutritional care
• Get other people on board with your ideas
• Find things that you can change and work with others to make those changes – remember small changes make big differences
• Feel good about your work.

The workshop also provides a number of practical tools that you can use back at work. It gives you time out to think about and discuss things about your place of work.

At the end of the workshop, you will be asked to provide details of any changes you will make back at work. Your organisation’s co-ordinator of this workshop will contact you in a few months time to find out what changes have occurred, so that your experiences can be shared.

* For the sake of simplicity, we will use the word ‘patient’ throughout this guide to mean patients, clients, service users, residents and their families, friends and members of the public.
Programme outline

10am – 4pm

Section 1: Setting the scene
Programme overview
Instructions

Section 2: Patient safety issues
What are the risks?
Protected Mealtimes

Section 3: Observations of care and improving service delivery
Using observations of care

Section 4: Working in teams

Section 5: Improving nutritional outcomes
Using the ‘MUST’ tool
Achieving improvements in malnutrition (AIM)

Section 6: Action planning

Section 7: Feedback and evaluation
Section 1: Setting the scene

Thinking about food and nutrition in health and social care

• What do you do well in your organisation in relation to food and nutrition?
• What are the issues and challenges for you?
• What would you like to see changed to enhance patient experience of food and nutrition?

In groups, identify three things that you think your organisation does well in relation to food and nutrition and three areas where you think nutritional care could be enhanced.

What we do well:

What are the challenges?

Areas that we could improve:
Section 2: Patient safety issues

Providing safe quality care is the responsibility of all members of the health and social care team. In England and Wales, the National Patient Safety Agency (NPSA) has been raising awareness of the patient safety issues related to nutritional care. They are currently the only organisation in the world which has focused on nutrition and safety.

The work of the NPSA in this area has been shared with health care professionals across the UK.

In this session the key themes will be identified. We will then have the opportunity to consider how Protected Mealtimes can help to improve nutritional care.

In 1859 Florence Nightingale wrote in her Notes on Nursing:

“Incomparably the most important office of the nurse, after she has taken care of the patient’s air, is to take care to observe the effect of his food. Thousands of patients are annually starved in the midst of plenty, from the want of attention to the ways which alone make it possible for them to eat.”

Of course, times have changed considerably, and nobody in the UK faces starvation on the scale of the 1800s. With today’s higher standard of living, poor nutrition should be avoidable.

Sadly, in 2006 the Healthcare Commission of England and Wales reported:

“Of those patients who needed help to eat their meals, fewer (58%) said they always received it, down from 62% in 2005. The rise in the proportion of patients saying they did not get enough help from staff to eat their meals is concerning, increasing from 18% in 2005 to 20% in 2006.”

Evidence suggests that 40 percent of all patients admitted to hospital are undernourished. This percentage increases once patients have been in hospital for one week, and often malnutrition goes both unrecognised and untreated.

The NPSA have identified the following themes where food and nutrition provides a threat to safe patient care:

- Dehydration
- Choking
- Nil by mouth – prolonged periods of time
- Nil by mouth – patients being fed
- Inappropriate diet and fluids
- Incorrect artificial nutrition
- Transfer of care
- Lack of assessment
- Lack of equipment.
The Protected Mealtimes Initiative (PMI) was a national initiative that formed part of the Better Hospital Food Programme. The purpose of the PMI was to allow patients to eat their meals without unnecessary interruption and to focus on providing assistance to those patients unable to eat independently.

The key principles of the PMI are therefore that any activity is focused on the meal and the patient:

- Making sure that the patient is ready to eat
- Making sure that the environment encourages eating
- Providing assistance
- Observation/monitoring
- Making sure that the patient is eating.

The PMI has been supported in the Chief Medical Officer’s report on the state of public health: A Fresh Look: Realigning Food Procurement in the Public Sector. The PMI aims to prevent some of the risks associated with food and nutrition which include the following:

- Prolonged hospital stays
- Delayed recovery
- Increased infection rates.
  (Sungurtekin et al, 2004)

These result in:

- Increased mortality (estimated to be eight times higher)
- Increased dependency upon discharge.
  (Sullivan et al, 2001)

More information can be found at: www.npsa.nhs.uk/nutrition
Nutrition patient safety quiz

This quiz has been developed by the National Patient Safety Agency

1. What degree of harm do nutritional incidences cause?
   a) No harm
   b) Low
   c) Moderate
   d) Severe
   e) Death
   f) All of the above

2. Have there been any reported deaths relating to nutrition?
   a) Yes
   b) No

3. What is the most frequently reported nutrition patient safety issue?
   a) Dehydration
   b) Nil by Mouth – prolonged periods of time
   c) Choking

4. Can Protected Mealtimes improve patient safety?
   a) Yes
   b) No
   If yes, why?

5. Is not weighing patients a safety issue?
   a) Yes
   b) No
   If yes, why?
6. What percentage of patients in hospital require artificial nutrition?
   a) 10 – 20%
   b) 30 – 40%
   c) 50 – 60%

7. Approximately what percentage of patients in hospital require textured modified diets?
   a) 2%
   b) 10%
   c) 20%

8. Name two patient groups at risk of dysphagia

9. Identify three reasons why patients become dehydrated in hospital

10. What is the percentage of patients admitted to hospital malnourished in the UK?
    a) 5%
    b) 20%
    c) 40%
Section 3: Observations of care and improving service delivery

This part of the workshop will introduce a simple quality improvement tool. You will have the opportunity to try this tool out and develop action plans.

Florence Nightingale wrote in Notes on Nursing in 1859 about observations of care:

“The most important practical lesson that can be given to nurses is to teach them what to observe; how to observe; what symptoms indicate improvement; what the reverse; which are of importance; which are of none; which are evidence of neglect; and of what kind of neglect.”

Observing closely how care or practice is delivered, and then learning from what you observe, has always been at the heart of good practice. It is a method that has proved invaluable for improving quality and, as such, it needs to be adopted as an integral part of the working day for all who are involved in care and delivery service.

This is a technique developed and refined through the RCN Clinical Leadership Programme. It involves two participants (one a member of the team being observed and the other a non-member) spending a period of time as observers in the service area. The focus for the observation will be mealtimes.

Participants take notes during the observation, and then feed back their observations to the team. Action plans are developed on the basis of the observations and discussion following the feedback.

Using observation of care/practice helps clinical leaders to take a step back and explain what happens in their clinical area, observe what is really happening, and feed back to staff with positive comments and areas for improvement. Staff members are actively involved in developing collaborative action plans to improve patient and client services.

Observation of care/practice can be included in quality strategies or annual objective setting. It also links naturally with patient story techniques outlined in the next part of this section. Observations also provide the clinical leader with time to see their team deliver care/practice and be able to assist team members with areas for development.
Improving nutritional care

Observation of care record sheet

<table>
<thead>
<tr>
<th>Clinical area:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of observation:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Time:</td>
</tr>
<tr>
<td>Name of outside observer:</td>
</tr>
<tr>
<td>Name of inside observer:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of what is observed</th>
<th>Questions for clarification</th>
</tr>
</thead>
</table>
Following your experience of observing mealtimes in your care setting, identify all of the areas that you observed being done really well in relation to food and nutrition, and three areas where you think nutritional care could be enhanced.

<table>
<thead>
<tr>
<th>What we do well:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Areas that we could improve:</th>
</tr>
</thead>
</table>
Section 4: Working in teams

“The best outcomes for patients and clients are achieved when professionals work together, learn together, engage in outcomes together.”
(Borrill, Carletta, Carter, Dawson, Garrod, Rees, Richards, Shapiro and West; 2002)

Effective teams use the talents of each individual who makes up the team. Being part of a team means that each member must understand what it means to be a team member, and be willing to contribute in a meaningful way.

Working in groups of 4–6, discuss the meaning of who makes up the nutritional care team.

The nutritional care team is made up by:

Do all of the people and roles that you have identified have the same goal around quality nutritional care?
Section 5: Improving nutritional outcomes

Nutritional screening and the ‘MUST’ tool

Malnutrition and its impact on clinical outcome may be underestimated in hospitalised patients, as many screening procedures require measurements of weight and height that cannot often be recorded in emergency patients. If nutritional screening is not completed, patient safety may be at risk.

‘Malnutrition Universal Screening Tool’ (‘MUST’) is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan.

The ‘MUST’ has been developed by BAPEN to screen all adults, (even if weight and/or height cannot be measured) to enable more complete information on malnutrition prevalence and its impact on clinical outcome.

The tool is being used both in hospitals and in the community. It is easy to use and can be used by all care workers.

A diagrammatic overview of the ‘MUST’ tool is shown on the next two pages. There are also some examples of case studies which you might like to work through after the workshop.

For more information about the ‘MUST’ tool and nutrition visit www.bapen.org.uk

Achieving Improvements in Malnutrition (AIM)

Background

There are three main stages to achieving improvements in malnutrition:

- diagnosis – using a nutritional screening tool such as the ‘Malnutrition Universal Screening Tool’ (‘MUST’)¹
- setting goals – to help motivate patients/clients to comply with their treatment²
- treatment and review.

The AIM programme has been developed by Abbott Nutrition. The focus of AIM is two-fold: firstly, to encourage the setting of nutritional goals for all malnourished patients as part of routine clinical practice, and secondly to improve patient and carer understanding of why they have been given a particular nutritional care plan and the benefits to them of complying with their nutrition treatment.

The setting of nutritional goals has been recommended by NICE³. These goals should be regularly reviewed and updated.

During this session we will explore the need for nutritional goals and their practical application in clinical practice.

You will be asked to think about how you manage and review nutritional care plans in your organisation and the opportunities for setting goals for your patients/clients.
References

1. www.bapen.org.uk
2. Data on file, Abbott Laboratories Ltd. 2008
'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:
- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 'MUST' Steps

**Step 1**
Measure height and weight to get a BMI score using chart provided. If unable to obtain height and weight, use the alternative procedures shown in this guide.

**Step 2**
Note percentage unplanned weight loss and score using tables provided.

**Step 3**
Establish acute disease effect and score.

**Step 4**
Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

**Step 5**
Use management guidelines and/or local policy to develop care plan.

Please refer to The ‘MUST’ Explanatory Booklet for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See The ‘MUST’ Report for supporting evidence. Please note that ‘MUST’ has not been designed to detect deficiencies or excessive intakes of vitamins and minerals and is of use only in adults.
Step 1
BMI score

- Score 0: BMI >20 (>30 Obese)
- Score 1: BMI 18.5 - 20
- Score 2: BMI <18.5

Step 2
Weight loss score

- Score 0: Unplanned weight loss <5%
- Score 1: Unplanned weight loss 5 - 10%
- Score 2: Unplanned weight loss >10%

Step 3
Acute disease effect score

- If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days, Score 2.

Step 4
Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition:
- Score 0: Low Risk
- Score 1: Medium Risk
- Score 2 or more: High Risk

Step 5
Management guidelines

0 Low Risk
Routine clinical care
- Repeat screening Hospital – weekly
- Care Homes – monthly
- Community – annually for special groups e.g. those >75 yrs

1 Medium Risk
Observe
- Document dietary intake for 3 days if subject in hospital or care home
- If improved or adequate intake – little clinical concern; if no improvement – clinical concern - follow local policy
- Repeat screening Hospital – weekly
- Care Home – at least monthly
- Community – at least every 2-3 months

2 or more
High Risk
Treat*
- Refer to dietitian, Nutritional Support Team or implement local policy
- Improve and increase overall nutritional intake
- Monitor and review care plan
- Hospital – weekly
- Care Home – monthly
- Community – monthly
* Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

All risk categories:
- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Record malnutrition risk category.
- Record need for special diets and follow local policy.

Obesity:
- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

Re-assess subjects identified at risk as they move through care settings
See The ‘MUST’ Explanatory Booklet for further details and The ‘MUST’ Report for supporting evidence.
Screening is a ‘MUST’: case studies

Case study 1

Mrs P is a frail 82 year-old lady admitted to hospital for assessment of her respiratory problems. She has always been a smoker but her daughter has recently persuaded her to stop. Her current weight is 44 kg and her daughter says she is about 5 feet 2 inches tall. When she attended clinic a couple of months ago she weighed 48 kg.

Her appetite is poor and recently she has only been able to manage small amounts of food and drinks due to her breathing difficulties. She lives at home on her own and manages with the help and support of her daughter who lives nearby.

What would be your dietary/care plan for Mrs P?

<table>
<thead>
<tr>
<th>What is her BMI Score on admission?</th>
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<tbody>
<tr>
<td>What percentage weight has she lost?</td>
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<tr>
<td>What is her percentage weight loss score?</td>
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<tr>
<td>What is her overall ‘MUST’ score/risk category?</td>
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</tbody>
</table>

What is her BMI Score on admission?

What percentage weight has she lost?

What is her percentage weight loss score?

What is her overall ‘MUST’ score/risk category?
Case study 2

Mr X is a 25 year-old man. He has always been keen on motorbikes and travels everywhere on his Harley Davidson. He is also a fitness fanatic and trains regularly at the gym. He weighs 80 kg and is 5 feet 11 inches tall. He describes himself as a ‘lean machine’ rather like his bike!

Yesterday he was travelling to a meeting at Silverstone when he was involved in a serious accident on the M1. He was rushed into hospital and admitted to intensive care with multiple injuries.

<table>
<thead>
<tr>
<th>What is his BMI Score on admission?</th>
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</thead>
<tbody>
<tr>
<td>What is his overall ‘MUST’ score/risk category?</td>
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</table>

Why is this fit young man at risk of malnutrition?

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Group work

STEP 1: BMI

Weight (kg)
- Ask partner to recall current weight
- Weigh partner using scales provided
- Note weights and comment on similarities and differences
- Use your own details to complete the boxes for Subject two.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Recalled</th>
<th>Measured</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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</table>

Height (m)
- Ask partner how tall he/she is.
- Measure partner's height using stadiometer provided.
- Note heights and comment on similarities and differences.
- Use your own details to complete the boxes for Subject two.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Recalled</th>
<th>Measured</th>
<th>Comments</th>
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<tr>
<td>1</td>
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</tbody>
</table>
BMI/BMI Score

Despite obtaining height and weight in different ways, you should find that most subjects will fall within the same BMI ‘band’ and therefore have the same BMI Score.

- Calculate BMI for yourself and your partner using recalled values and measured values and complete table below.

<table>
<thead>
<tr>
<th>Subject one</th>
<th>Subject two</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI (kg/m²)</td>
<td>BMI Score</td>
</tr>
<tr>
<td>Recalled weight and height</td>
<td></td>
</tr>
<tr>
<td>Measured weight and height</td>
<td></td>
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</tbody>
</table>

### STEP 2: Recent weight loss

- Assume each of you has lost 5 kg over the past 3–6 months. Calculate the percentage weight loss using the ‘MUST’ weight loss tables provided and calculate the score (i.e. previous weight = current weight + 5 kg).

<table>
<thead>
<tr>
<th>Subject</th>
<th>Current weight (kg)</th>
<th>Previous weight (kg)</th>
<th>Percentage weight loss</th>
<th>Weight loss score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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- Consider the clinical significance of the percentage weight lost.
STEP 3: Acute disease effect

- Clinical conditions that are likely to or have resulted in no or virtually no food intake for more than five days.
- Most likely to occur in patients admitted to acute hospitals.
- Which clinical conditions might apply?

STEP 4: Overall risk score

- Add together scores from Steps 1, 2 & 3 to obtain overall malnutrition risk score.

<table>
<thead>
<tr>
<th>Score</th>
<th>Subject one</th>
<th>Subject two</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute disease effect</td>
<td></td>
<td></td>
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<tr>
<td>Overall score</td>
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</tbody>
</table>

Other factors/subjective criteria for consideration

If you cannot obtain values/scores for steps one and two look at your client and form a clinical impression using the following criteria:

- Is he/she thin, acceptable weight or overweight?
- Have clothes/jewellery become loose fitting?
- Is there a recent history of reduced food intake or swallowing problems?

These factors will help you categorise your clients risk of malnutrition but will NOT enable you to assign a score.
Section 6: Action planning

The model that we are going to use for action planning is known as the Breakthrough Triangle. This was developed by Leeds University as part of the Leadership at the Point of Care Programme.

The first step in action planning is to get a clear picture in your mind of what you want the future to look like. Working in pairs, ask the following questions:

- What do you want from the change?
- How will you know when the change is complete?
- What else will improve when the change is made?
- What do you already have that will help you make the change?
- Is there something similar that you have done successfully?
- What are the next steps?

Once you have a clear idea of the future, it is important that you imagine yourself in that future. Imagine that the change has already happened, and you are reflecting on what made it a success. This reflection will lead you to the most important actions to take. Here is an example:

**Desired future – every patient in our service gets information about the food service in the organisation.**

```
Get leaflets printed
Talk to consultants
Talk to Nutritional Steering Group
Interest other members of the MDT in working on the leaflets – write a draft
See what is available on other wards
```

**Current situation – No information provided**
Your action plan

Use the triangle below to make your plan.

<table>
<thead>
<tr>
<th>In week one, I will:</th>
<th>In week two, I will:</th>
<th>In week three, I will:</th>
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<table>
<thead>
<tr>
<th>In week four, I will:</th>
<th>In week five, I will:</th>
<th>In week six, I will:</th>
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<td>•</td>
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</tbody>
</table>
Further resources and references

10 Key Characteristics of Good Nutritional Care – Supporting a multi-disciplinary approach to nutritional care and valuing the contribution of all staff groups working in partnerships with patients and users
www.npsa.nhs.uk/patientsafety/improvingpatientsafety/cleaning-and-nutrition/#10key

BAPEN (2007) Nutrition Screening Survey in the UK in 2007: Nutrition Screening Survey and Audit of Adults on Admission to Hospitals, Care Homes and Mental Health Units
http://www.bapen.org.uk

CG32 NICE Nutrition Support in Adults: Quick Reference Guide
http://www.nice.org.uk/guidance/index.jsp?action=download&o=29978

Council of Europe Resolution 10 key characteristics of good nutritional care
http://www.bda.uk.com/resources/071012CoEHospitalNutrition.pdf

Department of Health (2001) Essence of Care – patient focused benchmarks for Clinical Governance


High food wastage and low nutritional intakes in hospital patients, Clinical Nutrition, Volume 19, Issue 6, Pages 445–449 A. BARTON

Hospital Caterers Association (2006) Good Practice Guide Healthcare Food and Beverages Service Standards: A guide to ward level services


‘MUST’ materials are available to download free in PDF format from the BAPEN website. Printed copies are also available to purchase from the BAPEN office. bapen@sovereignconference.co.uk http://www.bapen.org.uk/must_tool.html

Protected Mealtimes Implementation Toolkit

Protected Mealtimes Review – findings report

Royal College of Nursing Nutrition Now Campaign
http://www.rcn.org.uk/newsevents/campaigns/nutritionnow


**Origins of the campaign**

“It is a national scandal that six out of ten older people are at risk of becoming malnourished, or their situation getting worse, in hospital.”

_Hungry to be heard_

“We receive calls and letters on nutrition and assistance with feeding over and over again...what is needed is not another Government catering stunt...but a radical re-assessment of nursing priorities.” — Patients’ Association

**The campaign aims to:**

Improve standards of nutrition and hydration in hospitals and the community by:

- providing practical resources
- working in collaboration with a variety of stakeholders.

This workshop aims to:

- increase awareness of the importance of food and nutrition
- promote greater understanding of patient safety issues
- give health care professionals the time to think about the nutritional care they provide
- share the outcomes from the Nutrition Now focus sites
- review nutritional screening and the AIM project
- provide an opportunity to develop an action plan on nutritional care.

**Outline for the day**

- Thinking about our experiences of food and nutrition in health and social care
- Patient safety issues
- Observing in practice
- Nutritional screening
- Action planning.

**Key issues for nurses**

- Time
- Staffing levels
- Patient throughput
- Food budgets
- Monitoring of food quality.

**Other activities and resources**

- The RCN Principles for Hydration and Nutrition
- The Hydration Best Practice Toolkit
- Council of Europe fact sheets
- Perioperative fasting resource – downloadable versions
- http://www.rcn.org.uk/develop
- ment/practice/perioperative_fasting
- All of the above and other information is available on the Nutrition Now website at www.rcn.org.uk/nutritionnow
**Nutrition and Patient Safety**

Presentation developed by Caroline Lecko  
Nutrition Lead  
National Patient Safety Agency

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**The National Patient Safety Agency**

- Established in 2001  
- Part of the NHS  
- Organised as three divisions with distinct functions:  
  - National Reporting and Learning Service (NRLS)  
  - National Clinical Assessment Service (NCAS)  
  - National Research Ethics Service (NRES)  
- Three National Confidential Enquiries

---

**The National Reporting and Learning Service (NRLS)**

The key objective is to improve patient safety by  
- Promoting a culture of reporting  
- Collecting and analysing information  
- Learning from things that go wrong  
- Providing feedback and guidance to healthcare organisations

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**Food for thought...**

- Up to 40% of all patients admitted to hospital are undernourished  
- This percentage increases once patients have been in hospital for one week  
- Malnutrition often goes unrecognised and untreated  
- Leading to prolonged hospital stays, worse outcomes and increased healthcare costs

---

**Nutrition: the patient safety issues**

- Choking  
- Dehydration  
- Nil by mouth  
- Inappropriate diet  
- Artificial nutrition  
- Lack of assessment  
- Lack of assistance  
- Missed meals  
- Catering services

---

**Nutrition: patient safety issues**

- Analysis of nutrition related patient safety incident between 1st January 2008 and 31st December 2008  
- Using free text word searches  
- All incidents reported as death and severe harm - 597  
- A sample of 300 incidents reported as moderate, low or no harm - from a pool of 38,437 incidents  
- Following analysis approx 20% of the incidents were identified as nutrition related patient safety incidents
Themes and trends
Reported deaths and severe harm

Themes and trends
Reported moderate, low and no harm

Protected mealtimes
How can they help?

What are protected mealtimes?
“A period of time when patients are allowed to eat their meals without unnecessary interruptions and when nursing staff and the ward team are able to provide safe nutritional care”

Protected mealtimes: Improving patient safety
Activity is focussed on the meal and the patient...
Protected mealtimes: Improving patient safety

- Making sure that the patient is ready to eat
  - Positioning patients
  - Providing appropriate equipment
- Providing assistance
  - Ensuring adequate diet and fluid intake
  - Reducing the risk of malnutrition and dehydration

Protected mealtimes: Improving patient safety

- Observation/monitoring
  - Appropriate diet and fluids
  - Monitoring for swallowing problems
  - Ensuring adequate diet and fluid intake
  - Reducing the risk of malnutrition and dehydration
  - Patients that are NBM remain NBM

NPSA Protected Mealtime Review

- Uptake of the protected mealtimes initiative remains variable between hospitals and between wards within hospitals across England and Wales
- There are inconsistencies around which mealtime services are protected
- There are inconsistencies in the type of clinical area that have introduced protected mealtimes

Protected Mealtimes Review

Barriers
- Ward rounds
- Diagnostic tests
- Visitors
- Other healthcare professionals

Critical success factors
- Trust policy related to protected mealtimes
- Promotion of the initiative
- Communication
- Leadership at all levels of the organisation

Protected Mealtimes Review

Recommendations
- All NHS staff are encouraged to report patients’ missed meals to the NPSA via their Local Risk Management System
- All NHS staff are encouraged to implement protected mealtimes to ensure their patients get the nutritional care they need
- Healthcare inspectors should include the implementation of protected mealtimes as part of their healthcare standards

Protected mealtimes resources

- Full report available
- Implementation resources available
  [http://www.npsa.nhs.uk/npsa/display?contentId=5830](http://www.npsa.nhs.uk/npsa/display?contentId=5830)
**Observations of care**

“The most important practical lesson that can be given to nurses is to teach them what to observe – how to observe – what symptoms indicate improvement – what the reverse which are of importance – which are none – which are the evidence of neglect – and what kind of neglect” (Nightingale 1866)

**Observation of care**

Information is that which an individual perceives as significant.

Sanger 1985

**Principles of observation of care**

- Open process
- All those involved have full access at all times to information collected
- Constructive feedback
- Collaborative action planning

**Undertaking observations**

- Observations last for 15-20 minutes
- If you see any unsafe care/practice, you will need to intervene
- You record everything you observe; your written record is available to staff if they wish to read it

**Benefits of observation of care**

To service users:
- possible areas of improvement are highlighted
- new ways of working are identified

To teams/organisations:
- good practice is identified and acknowledged
- experience of receiving feedback, action planning, problem solving and developing strategies to improve practice
- systems redesigned to meet needs of patients

**Findings from Borrill and West (2002)**

Teams that are effective in delivering high quality care have:
- a high degree of clarity over their team’s objectives
- a high level of participation in the team
- a high emphasis on quality
- a high support for innovation
Malnutrition in the UK: the importance of nutritional screening

Adapted presentation originally prepared by: Christine Russell RD
Chair
BAPEN’s Nutrition Screening Week

BAPEN

- Multi-disciplinary charity dedicated to raising awareness and standards of nutritional care
- Founded in 1992 - “A Positive Approach to Nutrition as Treatment” King’s Fund Centre Report
- Increasing focus on nutritional care and status of all consumers of health & social care
- Established the British Artificial Nutrition Survey (BANS) in 1996
- Published many reports regarding prevalence malnutrition
  - “Malnutrition Universal Screening Tool” (MUST) 2003
  - Health Economic Report 2005
  - Nutrition Screening week surveys (2008, 2009)
  - Combating Malnutrition: Recommendations for Action (2009)
  - Nutritional Screening in Sheltered Housing (2009)

King’s Fund Centre Report (1992)

“only when the assessment of every patient’s nutritional status has become routine will the full benefits of nutrition treatment be realised”

Defining malnutrition

No universally accepted definition but the following has been suggested:

“A state of nutrition in which a deficiency or excess (or imbalance) of energy, protein and other nutrients causes measurable adverse effects on tissue/body structure and function and on clinical outcome”

Elia M. 2003

Causes of malnutrition

Multifactorial!

- **Clinical** - associated with disease leading to problems such as nausea and vomiting, pain, malabsorption, infections, difficulty eating and swallowing, confusion, medication...
- **Important changes to the body with ageing**
- **Lifestyle** – accessibility shops, finances, cultural, living conditions, bereavement, depression, cooking ability and knowledge

Effects of under-nutrition on organ function

- **Psychology** – anorexia
- **Immunity** – increased risk of infection
- **Renal function** – loss of kidney ability to excrete Na & H2O
- **Hypothermia**
- **Impaired gut integrity and immunity**
- **Decreased Cardiac output**
- **Impaired wound healing**
- **Loss of strength**
Prevalence of malnutrition on admission to care (BAPEN NSW07)

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Overall</th>
<th>28% (22% high risk, 6% medium risk)</th>
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<tbody>
<tr>
<td></td>
<td>Acute hospitals</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>Community hospitals</td>
<td>29%</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Overall</td>
<td>30% (20% high risk, 10% medium risk)</td>
</tr>
<tr>
<td></td>
<td>Nursing homes</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Residential homes</td>
<td>22%</td>
</tr>
<tr>
<td>Mental Health Units</td>
<td>Overall</td>
<td>19% (12% high risk, 7% medium risk)</td>
</tr>
<tr>
<td></td>
<td>Acute units</td>
<td>31%</td>
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<tr>
<td></td>
<td>Long stay/rehab.</td>
<td>21%</td>
</tr>
</tbody>
</table>

Prevalence in other care settings

- ≥10 –20% in outpatients – high in patients with COPD
- 12 –14% in sheltered housing
- ~25% in patients receiving care at home

Consequences of malnutrition

- Increased risk of admission into hospital
- Increased complications and dependency
- Increased length of stay in hospital
- Increased cost of care
- Increased mortality
- More likely to be discharged into care home
- Increased risk of being re-admitted post discharge from hospital

Groups at risk

- Individuals with acute or chronic conditions
- Those recently discharged from hospital
- Older people

Malnutrition can be exacerbated by:

- Poverty
- Social isolation
- Substance misuse
- Religious / cultural beliefs / practices if not adequately considered when in care

The Malnutrition Carousel

- 28% of patients admitted to hospital are malnourished
- More GP visits
- More hospital admissions
- Longer stay
- More support post-discharge
- More likely to be discharged to Care Homes
- Up to 70% of patients discharged from hospital weigh less than on admission

Why screen for malnutrition?

- Malnutrition is not always visible, is more common than you think and costs health and social care ≥£13b/year
- At any one time, more than 3 million adults in UK are at risk
- 93% live in the community & 2% are in hospital where ~1 in 3 are at risk on admission
- Older people and those with chronic conditions are particularly at risk
- Help people stay independent and well in their own home as long as possible & reduce the need for admission into hospital

Supported by Abbott Nutrition

Improving nutritional care
Why screen for malnutrition?

- Effective management of malnutrition reduces the burden on health & care resources
- Regular screening is the only way that malnourished individuals can be identified and appropriate action taken
- Recommended / required by various bodies e.g. NICE, NHSQIS, Council of Europe, Care Quality Commission, Nutrition Action Plan

Who to screen & when? NICE recommendations

- In Hospital – on admission
- In Care – on admission & monitor as appropriate
- In the Community – on registering with a GP & at Annual Check for 75 years +

And whenever there is clinical concern

What is clinical concern?

Unintentional weight loss, fragile skin, poor wound healing, apathy, wasted muscles, poor appetite, impaired swallowing, altered bowel habit, loose fitting clothes or prolonged intercurrent illness. (NICE 2006)

Definitions

Nutritional screening

Rapid, simple general procedure done at first contact with subject to detect risk of malnutrition, done by nurses, doctors or other HCWs

Nutritional assessment

Detailed, more specific in depth evaluation of subject’s nutritional status, done by those with nutritional expertise (Elia M. 2003)

How to screen?

- Establish screening policy
- Use a validated tool
- One that is quick and easy to use
- Establish care plans
- Identify resources available / needed
- Educate and train staff
- Audit practice

‘Malnutrition Universal Screening Tool’ (‘MUST’)

A simple 5 step validated tool for use by all care workers in all care settings:

- Step 1 – height and weight to obtain BMI
- Step 2 – recent unintentional weight loss
- Step 3 – effect of acute disease
- Step 4 – overall score / category of risk
- Step 5 – management guidelines
Malnutrition Universal Screening Tool (‘MUST’)  

Screening as part of the patient’s journey

Where is he/she now?
- BMI an indication of current nutritional status
- Recent weight loss

Where has he/she come from? i.e past history
- Recent weight loss

Where is he/she going? i.e likely clinical course
- Acute disease effect

Step 1: BMI

- Obtain weight and height
- Calculate BMI or use BMI chart provided to get score
- Use recalled height and weight or recommended alternative methods of measurement if actual values cannot be obtained
BMI Score

<table>
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<tr>
<th>BMI</th>
<th>Score</th>
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<tr>
<td>&gt;20 kg/m²</td>
<td>0</td>
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<tr>
<td>18.5–20 kg/m²</td>
<td>1</td>
</tr>
<tr>
<td>&lt;18.5 kg/m²</td>
<td>2</td>
</tr>
<tr>
<td>&gt;30 kg/m² (obese)</td>
<td>0</td>
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Unintentional weight loss over 3–6 months

- <5% body weight: normal intra-individual variation
- 5–10% body weight: of concern
  - decrease in voluntary physical activity
  - increase in fatigue
  - less energetic
- >10% body weight: of significance
  - changes in muscle function
  - disturbances in thermoregulation
  - poor response or outcome to surgery and chemotherapy

Step 2: Weight loss score

- Indicates acute or recent-onset malnutrition

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<th>Score</th>
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<tr>
<td>&lt;5% body weight:</td>
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<tr>
<td>5–10% body weight:</td>
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<tr>
<td>&gt;10% body weight:</td>
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Step 3: Acute disease effect

- Patients who are acutely ill AND have had or are likely to have no nutritional intake for more than 5 days
  - Most likely to apply to patients in hospital
  - Add 2 to score

Step 4: Overall risk of malnutrition

- Total of scores from Steps 1, 2 and 3
- Document score
  - 0 = Low risk
  - 1 = Medium risk
  - 2 or more = High risk

“The old ones are the best

“It is not for the sake of piling up miscellaneous information or curious facts but for the sake of saving life and increasing health and comfort”

F Nightingale 1859
Achieving improvements in malnutrition

Goal setting

There are three main steps to achieving improvements in malnutrition

Diagnosis

- A screening tool such as the "Malnutrition Universal Screening Tool" (MUST) should be used

Setting goals in nutrition

- Helps motivate patients to comply with their treatment
- Treatment and review
- A Cochrane review suggests nutritional advice and nutritional drinks used for 3 months can improve outcomes

Patients often stop taking their nutritional drinks or complying with other nutritional therapies which can be due to:
- Lack of goals
- Not understanding the benefits
- Limited choice of product flavours

In summary

We should screen because:

- Malnutrition in UK is common and costs ≥£13 billion
- Screening identifies those at risk, enabling early intervention.
- Screening is simple and quick to do and recommended / required by various bodies
- Working together helps overcome barriers

The importance of achieving improvements in malnutrition

The facts

- Malnutrition is under recognised and under treated in the UK
- It is estimated that more than three million adults in the UK are either malnourished or at risk of malnutrition
- The vast majority (93%) of malnourished patients live in the community
- People with chronic diseases and the elderly are at greater risk of malnutrition
- The cost of disease-related malnutrition in the UK was more than £13 billion in 2007
- NICE has indicated an estimated net cost savings of over £28K per 100,000 population if Clinical Guideline 32 Nutrition Support in Adults was implemented effectively

The care plan

- Set aims and objectives
- Agree management and referral policy for those at risk
- Treat underlying conditions
- Improve nutritional intake
- Monitor and review
- Reassess subjects at nutritional risk as they move through care settings

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Limited choice of product flavours

Malnutrition is underrecognised and under treated in the UK

Lack of goals

1. Helps motivate patients to comply with their treatment

It is estimated that more than three million adults in the UK are

NICE has indicated an estimated net cost savings of over £28K per

A Cochrane review suggests nutritional advice and nutritional

1. The vast majority (93%) of malnourished patients live

Not understanding the benefits

People with chronic diseases and the elderly are at greater risk of

The importance of achieving all round nutritional care

Goal setting is an important part of round nutritional care

Setting goals

• Setting of goals is recommended by NICE guidelines for all patients receiving nutritional support
• Goals should be set on an individual patient basis, based on a healthcare professional’s assessment
• Short term and long term goals should be set where appropriate, be agreed in discussion with the patient/carer and help them achieve their objectives
• Clear treatment goals should be documented in each patient’s nutritional care plan
• Reviewing patients progress throughout their treatment is also an essential step

Patient’s objectives and goals

Example patient objectives might be:

• “I want my old clothes to fit me and be able to wear my wedding ring”
• “I want to get to my grand-daughter’s wedding”
• “I want to go to Wales for the weekend”

Example goals might be:

• weight gain of 0.5 kg per fortnight for a frail elderly patient who is underweight until target weight is reached
• weight maintenance for a postsurgical patient with a poor appetite until back to eating all meals and snacks
• Two nutritional drinks per day for up to three months or until target weight is reached.

References:

6. Clinical Guideline 32. Nutrition Support in Adults. NICE 2006. The Achieving Improvements in Malnutrition (AIM) programme has been developed by Abbott Nutrition. For more information, please contact your local Abbott Nutrition representative.

Why do we need action plans?

• A vision without a task is but a dream
• A task without a vision is drudgery
• A vision and a task are the hope of the world.

Inscription, Sussex Churchyard

Just before you go… remember

Almost everything you do will seem insignificant, but it is very important that you do it.
You must be the change you wish to see in the world.

Gandhi
10 Key Characteristics of good nutritional care in hospitals

- All patients are screened on admission to identify the patients who are malnourished or at risk of becoming malnourished. All patients are re-screened weekly.
- All patients have a nutritional care plan which identifies their nutritional care needs and how they are to be met.
- The hospital includes specific guidance on food services and nutritional care in its Clinical Governance arrangements.
- Patients are involved in the planning and monitoring arrangements for food service provision.
- The ward implements Protected Mealtimes to provide an environment conducive to patients enjoying and being able to eat their food.
- All staff have the skills and competencies needed to ensure that patient’s nutritional needs are met. All staff should receive regular training on nutritional care and management.
- Hospital facilities are designed to be flexible and patient centred with the aim of providing and delivering an excellent experience of food service and nutritional care 24 hours a day, every day.
- The hospital has a policy for food service and nutritional care which is patient centred and performance managed in line with home country governance frameworks.
- Food service and nutritional care is delivered to the patient safely.
- The hospital supports a multi-disciplinary approach to nutritional care and values the contribution of all staff groups working in partnership with patients and users.
Recommendations - Government of the member states should:

- Implement national recommendations in food and nutritional care in hospitals
- Promote implementation both in public and private sectors
- Ensure widest possible dissemination of recommendations

The Five Broad Areas of the Resolution:

1. Nutritional assessment and treatment in hospitals
2. Nutritional care providers
3. Food services practices
4. Hospital food
5. Health economics

There are over 100 recommendations within the resolution and they have been summarised by the Council of Europe Alliance into the 10 Key Characteristics.

Non-Government

The Stakeholders within the Alliance are:

- British Dietetic Association
- Hospital Caterers Association
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Speech & Language Therapy
- National Association of Care Catering
- British Medical Association
- British Association for Parenteral and Enteral Nutrition
- Intercollegiate Group on Nutrition Education
- Nutrition Society

Government

The Stakeholders within the Alliance are:

- National Patient Safety Agency
- Department of Health
- Scottish Executive - QIS
- Welsh Assembly Government
- Department of Health and Public Service - Northern Ireland