

# Food, Fluid and Nutritional Care

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Standards

October 2014



Evidence

Healthcare Improvement Scotland is committed to equality and diversity. We have assessed these standards for likely impact on the nine equality protected characteristics as stated in the Equality Act 2010 and defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. A copy of the impact assessment is available upon request from the Healthcare Improvement Scotland Equality and Diversity Officer.

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## 1 Introduction

### About Healthcare Improvement Scotland

**We believe that every person in Scotland should receive the best healthcare possible every time they come into contact with their health service.**

We have a key role in supporting healthcare providers to make sure that their services meet these expectations and continually improve the healthcare the people of Scotland receive.

We are part of NHSScotland and have four principle functions:

- providing sound evidence for improved healthcare, through the Scottish Medicines Consortium (SMC), the Scottish Health Technologies Group (SHTG), and the Scottish Intercollegiate Guidelines Network (SIGN)
- supporting the delivery of a safer health service and the reliable spread of best practice in quality improvement
- ensuring the effective participation of the public in the design and delivery of healthcare, principally through the Scottish Health Council, and
- scrutinising and quality assuring the provision of healthcare.

Our work programme supports the healthcare priorities of the Scottish Government, in particular those of NHSScotland's Healthcare Quality Strategy and the 2020 Vision.

For more information about our role, direction and priorities, please visit:

[www.healthcareimprovementscotland.org/drivingimprovement.aspx](http://www.healthcareimprovementscotland.org/drivingimprovement.aspx)

### Background

Food, fluid and nutrition are fundamental to health and wellbeing, and therefore to quality and safety in healthcare. *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* were first published by NHS Quality Improvement Scotland in October 2002 and revised in September 2003<sup>1</sup>. The need for the standards was identified following publication of audit data on malnutrition in hospitals<sup>2</sup>. The standards were designed to drive improvements in the recognition of malnutrition, in hospital catering, and in the promotion of a strategic and co-ordinated approach to food, fluid and nutritional care in NHS boards. A series of peer review visits to NHS boards followed and local reports were last published in 2010<sup>3</sup>.

The standards have continued to be implemented and reviewed against as part of the inspection programme Care of Older People in Acute Hospitals, which was announced in June 2011 and began in February 2012. In its first 6 months, this programme identified some positive developments in nutritional care as well as areas for improvement. Patients did not always have a nutritional care plan developed, implemented or evaluated, were not consistently screened for malnutrition, and were not always provided with adapted equipment and utensils when needed<sup>4</sup>. Despite investment and evidence of improvement, concern remains about quality in this area. In November 2013, a review of the inspection programme ('the Whittle review') published its conclusions, which affirmed the continuing importance of hydration and

nutritional care to the inspection programme and noted the need for updated standards<sup>5</sup>.

Over the same period, numerous strands of policy have emphasised the importance of hydration and nutritional care in settings other than acute hospitals, and in patient groups in addition to older people. For example, *Modernising Nursing in the Community* noted that community nurses are 'perfectly placed to protect, safeguard and manage risk, keeping people safe in the places they receive health care' and therefore have a key role to play in prevention and recognition of malnutrition, as well as promotion of healthy behaviours<sup>6</sup>.

In 2013, the Chief Nursing Officer, Patients Public & Health Professions Directorate of the Scottish Government commissioned Healthcare Improvement Scotland to produce an update of the 2003 *Food, Fluid and Nutritional Care in Hospitals*<sup>1</sup> standards with a remit of ensuring the standards were up to date, reflecting related guidance such as *Food in Hospitals; National Catering and Nutrition Specification for Food and Fluid Provision in Hospitals in Scotland* (2008)<sup>7</sup>, and extending the scope to include community as well as hospital care. The National Nutritional Care Advisory Board (NNCAB), co-chaired by Ros Moore, Chief Nursing Officer, and Alastair McKinlay, Consultant Gastroenterologist, NHS Grampian, agreed to provide specialist input and clinical assurance for the project (see Appendix 1 for NNCAB membership).

## **Purpose**

This document specifies a minimum set of 'standards' for food, fluid and nutritional care. A standard is a statement of an expected level of service which demonstrates delivery of safe, effective and person-centred healthcare, and promotes understanding, comparison and improvement of that care. Standards can be used for national consistency and for local improvement.

## **Scope**

The standards apply to the care of all patients, paediatric and adult, in both community healthcare and hospital care in Scotland, whether directly provided by an NHS board or secured on behalf of an NHS board. Although the standards apply specifically to healthcare settings, they have been developed in recognition of the integration agenda and the principles that apply to standards in both health and social care. National standards for social care are produced by the Scottish Government and regulated against by the Care Inspectorate.

The standards are equally applicable to all patients using NHS services in Scotland with regard to protected characteristics under the Equality Act 2010<sup>8</sup> as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

## *Community*

Within these standards, we use the term 'community' to mean services and care provided by the NHS in a patient's home or NHS setting (for example, community hospitals, day centres, or outreach services) and care delivered by district nurses,

health visitors, community psychiatric/mental health nurses, and school nurses. The remit of the standards does not include care provided by social care or independent private care staff, or care provision within a care home.

Standards 3 and 4 only apply to the care of patients in hospital.

### *Nutritional care*

The term 'nutritional care' embodies a co-ordinated approach to the delivery of food and fluid by different healthcare professionals, and recognises the patient as an individual with needs and preferences. As a process, nutritional care determines a person's preferences and cultural needs, defines their physical requirements, and then provides the person with what they need. It follows a person's progress through an illness, 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 between services and during periods of transition of care. Good nutritional care will involve training for staff, carers and patients, and access to information.

### *Complex nutritional care*

NNCAB are developing standards specifically for complex nutritional care. These standards will apply to patients receiving complex nutritional care, defined as delivery of nutrition and hydration through tubes and lines, including parenteral and enteral feeding.

### *Malnutrition*

Within these standards, 'malnutrition' means an imbalance between what an individual eats and what is required for health. Malnutrition, therefore, includes both undernutrition (inadequate energy intake) and overnutrition (excessive energy intake).

## **Format**

All our standards follow the same format. Each standard includes a statement of the expected level of care; an evidence-based rationale; and a list of criteria describing the structures, processes and outcomes that can be observed within organisations that meet the standard. Within these standards, all criteria are considered to be 'essential' or required in order to demonstrate that the standard has been met.

## **Implementation**

The quality of food, fluid and nutritional care in hospitals is scrutinised by Healthcare Improvement Scotland as part of the Care of Older People in Acute Hospitals inspection programme.

NNCAB are developing nutritional care measures based on the revision of the standards. Data relating to these measures will be collated and owned by NHS boards. NNCAB will review summary reports of these data and provide leadership to support their use to drive local and national improvement.

## 2 Summary of changes from the 2003 standards

The six topic areas covered by the 2003 standards and the standard statements have been broadly retained as these standards are widely implemented and, in the opinion of NNCAB, continue to reflect the key areas of quality for food, fluid and nutritional care. Therefore, the overall document should be familiar to professionals and members of the public who have been using and referring to the 2003 standards for over a decade.

Minor changes of wording may be found throughout the standards which are intended either to add emphasis to the 2003 wording, or to clarify its meaning and implementation in the context of present-day care. References have been updated.

The major change to the 2003 standards is the expansion in scope to cover community healthcare as well as hospital care. At present, the scope does not extend to social care; discussions are ongoing in Scotland as to how integrated health and social care standards should be produced. It is anticipated that integrated health and social care standards for food, fluid and nutritional care will be produced in the future and that this document will provide a basis for their development.

In addition to the above, the table below contains a summary of changes to the 2003 .

Section	Change from 2003 standards
1	<ul style="list-style-type: none"> <li>Standard statement updated to reflect <i>The Healthcare Quality Strategy for NHSScotland</i><sup>9</sup> and the expansion of scope beyond acute hospitals.</li> <li>Reference to <i>Oral Health and Nutrition Guidance for Professionals</i><sup>10</sup> added to rationale.</li> <li>Criterion 1.3 removed at this stage; to be replaced with new standard statement and criteria in the next edition of these standards (anticipated 2015).</li> </ul>
1.1	<ul style="list-style-type: none"> <li>'Health population needs assessment' replaced by 'current demographic data', reflecting current practice.</li> <li>Criterion (b) is a new addition.</li> <li>More examples of 'patient groups with particular needs' added.</li> <li>Minor rewording to reflect clinical governance and improvement activities within NHS boards.</li> </ul>
1.2	<ul style="list-style-type: none"> <li>Expanded list of items to be implemented.</li> <li>'Dentist' changed to 'senior member of the oral health team'.</li> <li>'Senior speech and language therapist' added.</li> </ul>

Section	Change from 2003 standards
2	<ul style="list-style-type: none"> <li>• Statement and criteria have updated wording to relate to community healthcare settings.</li> <li>• More detailed description of nutritional care assessment.</li> <li>• MUST specified as an appropriate validated screening tool.</li> <li>• More detailed description of expected timescales for access to specialist services for specified patient groups.</li> <li>• ‘Desirable’ Criterion 2.9 from the 2003 standards has been deleted as all criteria are now essential.</li> </ul>
2.6	<ul style="list-style-type: none"> <li>• More examples of ‘specialist services’ added.</li> </ul>
2.7	<ul style="list-style-type: none"> <li>• This new criterion has been added to incorporate relevant recommendations from <i>Starved of Care</i><sup>11</sup>.</li> </ul>
2.11	<ul style="list-style-type: none"> <li>• This new criterion has been added to address communication-related risks during periods of transition of care.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Reference to <i>Food in Hospitals</i> added.</li> <li>• Criteria combined and re-ordered for better logical flow: <ul style="list-style-type: none"> <li>- 3.6, 3.7 and 3.8 (2003) moved to Standard 4 (2014), and</li> <li>- 3.9 and 3.10 (2003) combined into 3.6 (2014).</li> </ul> </li> </ul>
4	<ul style="list-style-type: none"> <li>• Standard statement revised to apply to hospital settings only.</li> <li>• Criteria in this standard have been renumbered to reflect the chronological sequence of activity in providing food and fluids to patients and the incorporation of criteria from Standard 3.</li> <li>• Criterion 4.5 from the 2003 standards has been deleted. The same quality issues are covered in greater detail in criteria 3.2, 3.4, 5.3 and 5.5.</li> <li>• Reference to <i>Making Meals Matter</i><sup>12</sup> added.</li> </ul>
5	<ul style="list-style-type: none"> <li>• Rationale revised to reflect The Patient Rights (Scotland) Act 2011<sup>13</sup>.</li> <li>• Criteria added relating to format of communication (5.1) and information on community and social care organisations (5.2); subsequent criteria have been renumbered.</li> </ul>
6	<ul style="list-style-type: none"> <li>• Standard statement revised to clarify ‘appropriate education and training’ (2003 wording).</li> </ul>
6.1	<ul style="list-style-type: none"> <li>• Criterion 6.1 from the 2003 standards has been split into 6.1 and 6.2 for clarity; subsequent criteria have been renumbered.</li> </ul>
6.4	<ul style="list-style-type: none"> <li>• Additional components of nutritional care education specified to incorporate the findings and recommendations of <i>Starved of Care</i><sup>11</sup>.</li> </ul>



### 3 Standards for Food, Fluid and Nutritional Care

#### Standard 1 – Policy and strategy

##### Standard statement

Each NHS board has a policy, and a strategic and co-ordinated approach, to ensure that all patients receive safe, effective and person-centred nutritional care, irrespective of specialty and location (hospital or community).

##### Rationale

A strategic, co-ordinated and multidisciplinary approach is required as food, fluid and nutritional care are crucial for the wellbeing of patients<sup>1,11</sup>.

Good nutritional care improves disease outcomes and patients' quality of life<sup>14</sup>.

Malnutrition has significant financial implications for healthcare<sup>14</sup>.

Recent guidance demonstrates the important connections between oral health and nutrition, particularly for nutritionally vulnerable older people and children under 5 years old<sup>10</sup>.

##### Criteria

- 1.1 Each NHS board has a policy and a strategic implementation plan to improve the provision of food, fluid and nutritional care. These:
- (a) are patient-focused, follow the patient journey of care and ensure that a comprehensive and co-ordinated nutritional care service is provided
  - (b) include policies and pathways to ensure delivery of safe and effective care that meets individual nutritional care needs, including the care of nutritionally vulnerable groups such as children, people with swallowing difficulties, people with dementia and people receiving end of life care
  - (c) are based on current demographic data which are regularly reviewed, and consider local ethnic, religious and cultural patterns and the need for equality of access
  - (d) recognise patient groups with particular needs, for example children, those on therapeutic diets, such as gluten-free or texture-modified, and patients with learning disabilities or mental health conditions, including eating disorders
  - (e) are risk assessed and managed
  - (f) are discussed annually at NHS board level to evaluate progress and produce a plan for further action, based on:
    - reports from operational hydration and nutritional care groups
    - comments and feedback from patients and carers

- clinical incidents captured and reported through clinical governance and risk management
- any need for re-design, and
- any scrutiny and improvement activity

(g) are published in a format easily understood by, and accessible to, the public

(h) include a financial framework to underpin the implementation of the action plan, and

(i) ensure the inclusion of food, fluid and nutritional care in ongoing monitoring and improvement cycles.

**1.2** Each NHS board area has at least one strategic hydration and nutritional care group.

(a) The hydration and nutritional care group is responsible to the NHS board for overseeing the implementation of:

- Healthcare Improvement Scotland standards for food, fluid and nutritional care in all settings
- *Food in Hospitals: National Catering and Nutrition Specification for Food and Fluid Provision in Hospitals in Scotland*<sup>7</sup>.
- improvement requirements following inspections by Healthcare Improvement Scotland, and
- the NHS board's policy and strategic plan for food, fluid and nutritional care.

(b) The hydration and nutritional care group produces an annual written report, detailing progress made, action taken or required, and evidence of implementation of the NHS board's policy and strategic plan.

(c) The core membership of this group includes a senior manager reporting to the chief executive, a senior dietitian or dietetic manager, a lead doctor appointed by the medical director, a senior nurse appointed by the nursing director, a senior member of the oral health team, a senior speech and language therapist, a catering manager, patient representation and co-opted specialist expertise appropriate for the population.

## Standard 2 – Assessment, screening and care planning

### Standard statement

When a person is admitted to hospital, or to a community caseload, a nutritional care assessment is carried out. Screening for the risk of malnutrition is also carried out, both initially and on an ongoing basis. A person-centred care plan is developed, implemented and evaluated.

### Rationale

The majority of people who are malnourished or at risk of malnutrition are living in the community. Hospital admission presents an opportunity to identify malnutrition and initiate treatment, which can be continued in the community<sup>15</sup>.

The prevalence of malnutrition in patients admitted to hospital in Scotland has been estimated at 25%<sup>16</sup>. The proportion of Scottish adults who were overweight or obese in 2012 was 61.9%<sup>17</sup>.

The screening and assessment processes help identify malnutrition and factors that may prevent patients from eating and drinking appropriately to meet their nutritional requirements<sup>1</sup>.

Inspections of the care of older people in acute hospitals have identified that inaccurate measurement of height and weight is an issue in quality of care<sup>18,19</sup>. Inaccurate measurement of patient weight can have significant implications for patient safety, for example in the prescription of medicines and selection of equipment<sup>20, 21</sup>.

The Mental Welfare Commission for Scotland has recommended that NHS boards should have in place a multidisciplinary risk assessment process and clear guidance on decision-making on nutrition for people with swallowing difficulties<sup>11</sup>.

### Criteria

**2.1** A nutritional care assessment (see 2.2 and 2.3) is undertaken and recorded:

- (a) within 24 hours of admission to hospital, and
- (b) on the first visit after being assigned to a community nursing caseload.

**2.2** The nutritional care assessment should accurately identify and record:

- (a) measured height and weight, with the date and time that these measurements were taken (if estimates are used, this should be stated and a rationale provided)
- (b) food allergies or intolerances
- (c) eating and drinking likes and dislikes
- (d) Therapeutic or texture-modified diets requirements

- (e) cultural, ethnic or religious dietary requirements
  - (f) social and environmental mealtime requirements
  - (g) physical difficulties with eating and drinking, including swallowing difficulties
  - (h) the need for help and support with eating and drinking, for example prompting and encouragement, equipment or community meals, and
  - (i) oral health status.
- 2.3** The nutritional care assessment includes accurate screening for the risk of malnutrition using a validated tool that is appropriate for the patient population and includes criteria and scores that indicate actions to be taken, such as the Malnutrition Universal Screening Tool (MUST) for adults.
- 2.4** Repeat screenings are carried out in line with clinical need and at a frequency determined by the outcome of the initial subsequent screenings in line with the validated tool's guidance.
- 2.5** All assessments and screening activity should be recorded and documented in line with local organisational policy.
- 2.6** The assessment process identifies the need for referral to specialist services, for example dental and oral health, dietetic, occupational therapy, and speech and language therapy.
- 2.7** The NHS board has in place a multidisciplinary risk assessment process and clear guidance on decision-making on nutrition for people with swallowing difficulties.
- 2.8** Access to specialist services is ensured:
- (a) for hospital inpatients requiring urgent access to nutritional support: within clinically risk-assessed timescales which will not normally exceed 72 hours
  - (b) for hospital inpatients at high risk of undernutrition: nutritional support is provided immediately and specialist assessment takes place within 72 hours
  - (c) for outpatients and community patients: within agreed and clinically risk-assessed timescales which take into account the patient's individual need.
- 2.9** Where assessed as being required, a person-centred nutritional care plan is developed, followed and reviewed with the patient (and, where the patient is a child, with the parent or carer), and includes the:
- (a) outcomes of the initial nutritional care assessment
  - (b) outcomes of screening for the risk of malnutrition
  - (c) frequency and dates for repeat screenings, and
  - (d) actions taken as a consequence of repeat screenings.

- 2.10** The discharge plan is developed with the patient and, where appropriate, carer, and includes information about:
- (a) the patient's nutritional status
  - (b) special dietary requirements, and
  - (c) the arrangements made for any follow-up required on nutritional issues.
- 2.11** Information about the patient's eating, drinking and nutritional care requirements is effectively communicated and documented between wards or services during periods of transition of care.

## Standard 3 – Planning and delivery of food and fluid in hospital

### Standard statement

Formalised structures and processes are in place to plan the provision and delivery of food and fluid in hospitals, in line with *Food in Hospitals*<sup>7</sup>.

### Rationale

To plan menus effectively, multidisciplinary input is required, together with comprehensive knowledge of the hospital population<sup>1,7</sup>.

Effective multidisciplinary communication is vital for the efficient provision of food and fluid in hospital to ensure that patients' nutritional requirements are met, and to help minimise waste<sup>1,7</sup>.

The nutritional content of dishes needs to be analysed to ensure their nutritional adequacy<sup>1,7</sup>.

Meals need to be distributed to the wards and served without delay, to ensure nutritional content, temperature and quality are maintained<sup>1,7</sup>.

### Criteria

- 3.1** There is an operational group responsible for implementing a local protocol or protocols for the provision of food and fluid to patients. The core membership of this group includes a senior member of catering staff, a senior nurse, a doctor, a senior member of the oral health team, a senior dietitian, other allied health professionals including a speech and language therapist, and patient representation. The group will also have other representatives appropriate to population need (as identified in Criterion 1.1) and to the food delivery system.
- 3.2** The operational group is responsible for:
- (a) overseeing a local assessment of nutrition-related need
  - (b) producing a local 'food chain' protocol or protocols
  - (c) menu planning, including the use of standard recipes
  - (d) ensuring the food and fluid provided meets the requirements of the individual, is appetising, and is presented with consideration, taking into account comments and feedback from patients and carers
  - (e) ensuring the provision of food and fluid meets the requirements of *Food in Hospitals*<sup>7</sup> specifications
  - (f) setting main mealtimes appropriate for patient groups
  - (g) ensuring that when the evening meal and breakfast are more than 14 hours apart, a substantial snack (as defined in *Food in Hospitals*<sup>7</sup>) is available
  - (h) ensuring there is appropriate food and fluid available outwith main mealtimes
  - (i) ongoing monitoring and review of the food and fluid provided for patients

- (j) ensuring effective communication between wards and catering services, and
- (k) reporting to, and implementing issues devolved from, the strategic hydration and nutritional care group.

**3.3** All dishes and menus are analysed for nutritional content in line with *Food in Hospitals*<sup>7</sup>.

**3.4** Patient groups are consulted about new menus and dishes before they are introduced. The views of patients and parents in paediatric and maternity services are sought.

**3.5** There is a procedure:

- (a) for delivering the correct meals and dishes to the ward
- (b) for responding when an incorrect meal or dish is provided, and
- (c) to ensure that when a patient misses a meal, they are then provided with a meal that meets their needs.

**3.6** There are protocols, which are implemented and monitored, for the provision of:

- (a) all therapeutic diets, for example texture-modified diets, gluten-free diets, low potassium diets, oral nutritional supplements, high-energy and high-protein food and fluid, and
- (b) any requirement outwith the planned menu, such as nut allergy or vegan meals.

## Standard 4 – Provision of food and fluid to patients in hospital

### Standard statement

Food and fluid are provided in a way that is acceptable to all patients in hospital.

### Rationale

Efforts made to increase patients' enjoyment of meals can produce benefits in the amount of food consumed and, as a result, improve patients' nutritional status<sup>1</sup>.

The more pleasing a meal and its presentation, the more likely that the patient will enjoy the meal, consume it, and therefore receive the appropriate balance of nutrients it provides<sup>1</sup>.

Enabling patients to choose their meal close to the time it is served has been found to reduce food wastage<sup>1</sup>.

Each organisation is expected to make appropriate provision for food which meets the religious and cultural needs of all patients<sup>7</sup>.

Inflexible hospital routines, clinical procedures and ward rounds can disrupt mealtimes and therefore may reduce patients' nutritional intake<sup>12</sup>.

### Criteria

- 4.1** The nurse with responsibility for the ward or department is responsible for having in place documented systems and processes which ensure that:
- (a) individual patient requirements are identified and communicated at ward level
  - (b) correct meals and dishes are received on the ward
  - (c) meals are delivered to the correct patients at the correct temperature and texture
  - (d) there is adequate time for patients to eat and drink
  - (e) staff assist and support patients as required
  - (f) problems providing food and fluid are addressed as they arise and corrective action taken, and
  - (g) where required, the intake of food and fluid is accurately and timeously recorded, and the necessary action is taken and documented if this intake is inadequate.
- 4.2** Patients are given the opportunity to choose their own food and fluid. Choices are presented in a format suitable to the patient's identified communication needs (for example, pictorial menus). Where required, a person, who is aware of the patient's nutritional needs and preferences, helps them to choose.



- 4.3** Patients are given a choice for all food and fluid options provided, including therapeutic and texture-modified diets. There is a choice of portion size for all main courses.
- 4.4** Patients select their menu choice as close to the serving of the meal as possible, and no more than two meals in advance.
- 4.5** Unless clinically contraindicated, patients have access to fresh drinking water and fluids in line with local policy.
- 4.6** An adequate number of staff are available at mealtimes and snack times to provide food and fluid to patients and, where necessary, to provide prompting and assistance with eating and drinking.
- 4.7** All non-essential staff activity (clinical and non-clinical) is stopped during patient mealtimes and the principles of *Making Meals Matter*<sup>12</sup> are implemented.
- 4.8** Patients are encouraged and, if necessary, assisted to clean their hands before mealtimes.
- 4.9** Where clinically appropriate, patients are given the opportunity to choose whether to eat and drink at their bed or away from their bed (for example at side of bed or within a communal dining room).
- 4.10** Patients are provided with the equipment and utensils for eating and drinking that meet their individual needs.
- 4.11** Food and fluid are provided to patients at the correct temperature and texture. Where required, patients are given assistance with eating and drinking while the food and fluid is at the correct temperature.
- 4.12** Accompaniments and condiments are available and offered at each mealtime, subject to any dietary restrictions.

## Standard 5 – Patient information and communication

### Standard statement

Patients have the opportunity to discuss, and are given information about, their food, fluid and nutritional care. Patient views are sought and inform decisions made about the food, fluid and nutritional care provided.

### Rationale

Patients have the right to the information and support they need to make informed choices, and the right to give feedback or make complaints about the care received<sup>13</sup>.

Poor communication between staff and patients about food, fluid and nutritional care can result in patients' nutritional needs not being met<sup>1</sup>.

### Criteria

- 5.1 Information and communication about food, fluid and nutritional care are delivered in formats suitable to patients' identified communication needs.
- 5.2 NHS boards can signpost patients to community and social care organisations that may be able to assist patients with their food, fluid and nutritional care, for example community food initiatives, food co-ops, shopping services and meal services.
- 5.3 On, or before, admission to hospital, patients are provided with information on:
  - (a) how to order their meals
  - (b) mealtimes
  - (c) the content of meals and snack choices available
  - (d) facilities available for eating meals, and where meals are served
  - (e) the opportunities available for preparing and consuming food and fluid
  - (f) assistance with eating and drinking if required
  - (g) special equipment and utensils for eating and drinking if required
  - (h) the procedure for obtaining a meal if one is missed
  - (i) how to make a comment or complaint about the nutritional care, food and fluid provided, and
  - (j) how they will receive feedback following a comment or complaint.
- 5.4 All patients and, where appropriate, relatives and carers, are given quality-assured information about:
  - (a) the food and fluid that relatives and carers can and cannot provide for them, and
  - (b) the patient's individual nutritional needs, including any food or fluid to avoid.

- 5.5** Patients are encouraged to give their views on the food and fluid provided. These views are collected and trends are reported regularly to the relevant operational group.

## Standard 6 – Education and training for all staff

### Standard statement

Staff have the knowledge and skills required to meet patients' food, fluid and nutritional care needs, commensurate with their duties and responsibilities, and relevant to their professional discipline and area of practice.

### Rationale

Staff require training and information to ensure that the needs of patients are met<sup>14</sup>.

It is important that all staff involved in the provision of food, fluid and nutritional care recognise the critical nature of this task, and receive training in nutritional care<sup>14, 22</sup>.

### Criteria

- 6.1** All staff should be aware of the importance of food, fluid and nutritional care for patients' health and quality of life.
- 6.2** Staff who are in contact with patients at any point in the delivery of food, fluid and nutritional care are aware of:
  - (a) the local and national eating, drinking and nutrition policies and procedures relevant to their role
  - (b) meal and snack times
  - (c) procedures for ordering missed meals, and
  - (d) procedures for out-of-hours provision of food, fluid and nutritional care.
- 6.3** All staff in contact with patients and their food and fluid receive up-to-date training in health and safety issues and food hygiene, which is compliant with relevant legislation and commensurate with their duties.
- 6.4** A programme of nutritional care education is regularly reviewed and updated and ensures that staff with relevant responsibilities at any point in food, fluid and nutritional care provision are given guidance and training in:
  - (a) the correct use of screening tools and related measurements
  - (b) risk factors for dehydration and malnutrition
  - (c) recognising physical difficulties with eating and drinking
  - (d) providing assistance with eating and drinking, and
  - (e) care of patients with swallowing difficulties.

## 4 References

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**Appendix 1: National Nutritional Care Advisory Board membership**

<b>Name</b>	<b>Position</b>	<b>Organisation</b>
Janet Baxter	Improvement & Development Manager	NHS Tayside
David Bedwell	Assistant Director	NHS National Services Scotland
Claire Blackwood	Inspector	Healthcare Improvement Scotland
Michael Craig	Public Health Advisor (Nutrition and Healthy Weight)	NHS Health Scotland
Rosslyn Crocket	Executive Nurse Director	NHS Greater Glasgow and Clyde
Helen Davidson	Catering Strategy Dietitian, NHS Greater Glasgow and Clyde	British Dietetic Association
Jane Ewen	Nurse Consultant (Nutritional Care)	NHS Grampian
Joy Farquharson	Nutrition Champion (until April 2014)	The State Hospital
Janice Gillan	Head of Support Services, NHS Ayrshire & Arran	Hospital Caterers Association
Elaine Gordon	Practice Development Nurse	NHS Greater Glasgow and Clyde
Janie Gordon	Professional Head of Service Nutrition & Dietetics, NHS Fife	British Dietetic Association
Anne Hanley	Operations Manager	Healthcare Improvement Scotland
Fiona Mackenzie	Professional Advisor	Scottish Government
Ruth McKee	Consultant Colorectal Surgeon	NHS Greater Glasgow and Clyde
Alastair McKinlay	Consultant Gastroenterologist	NHS Grampian
Fiona McQueen	Nurse Director	NHS Ayrshire & Arran
Ros Moore	Chief Nursing Officer	Scottish Government
Sue Rawcliffe	National Development Officer	NHS Health Scotland
George Reid	Public Partner	
Mike Sabin	Associate Director, NMAHP	NHS Education for Scotland



<b>Name</b>	<b>Position</b>	<b>Organisation</b>
Marjory Thomson	Professional Adviser	Care Inspectorate
Joyce Thompson	Dietetic Consultant in Public Health Nutrition	NHS Tayside
Victoria Thompson	Professional Advisor	Scottish Government
Susan Watt	Learning & Development Co-ordinator	Royal College of Nursing

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and Scottish Medicines Consortium are part of our organisation.

