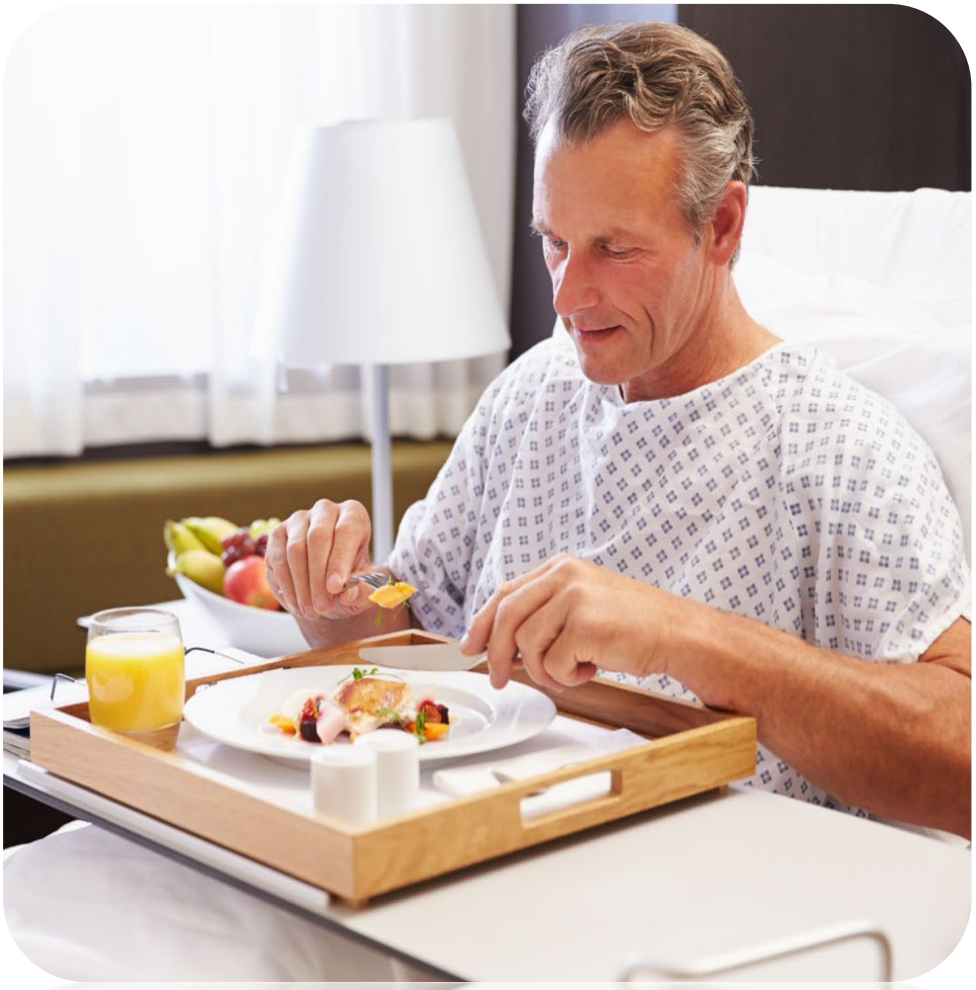
healthwatch Tower Hamlets

Executive Summary
Patient Leaders report on nutrition
Royal London Hospital



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Executive Summary

Project Background

The 'Nutrition Project' was initiated by Iain Macleod – a Patient Leader participating in the Healthwatch Tower Hamlets/Tower Hamlets CCG Patient Leaders programme. Patient Leaders are supported and trained to identify and develop a project with the aim of improving patient experience or outcomes.

Iain's initial interests in nutrition and hydration stemmed from visiting a neighbour at the Royal London Hospital surgical ward. Whilst visiting he observed another patient being served food, however this patient was asleep and no attempts were made to wake them up, later on a member of staff came and took away the untouched food tray. Iain felt that the staff should have made an effort to make sure that this patient had their meal, this is important as its recognised that good nutrition and hydration are important to overall patient recovery. As a result of this experience and by undertaking some desk based research into understanding nutrition and hydration concerns in hospitals (CQC Report- Dignity and Nutrition Inspection Programme, March 2013), Iain approached Healthwatch Tower Hamlets to see if this concern could be explored utlising Healthwatch's powers to request Enter and View visits.

Healthwatch Tower Hamlets supported Iain to draft a project proposal to Barts Health who agreed that this would be worthwhile initiative to pursue as part of their committment to exploring avenues that could improve patient nutrition and hydration. It is important to highlight that staff at Barts Health (Soft FM and Dieticians) feel that they have laid the foundation to improve patient's nutrition and hydration through recent initiatives (e.g. Malnutrition Universal Screening Tool (MUST) training, development of a Nutrition Action Team) however they feel that on a ward level the policies, initiatives and structures are sometimes not being implemented or adhered to. It was widely viewed that Healthwatch Tower Hamlets could provide an independent review of the current situation on a ward level and thereby help to identify concerns that they are already aware but did not have sufficient evidence to take action.

Key objectives

- to observe the food service at the point of delivery (breakfast, lunch and dinner) to identify what's working well and not so well, particularly any risks to inpatient nutrition and hydration.

- to speak to patients, family members and ward staff in order to develop a greater understanding of their perspective on the food, food service and support offered.
- to observe ward practices (by speaking to patients, family and staff) on fulfilling Barts Health and national expectations around hydration and nutrition standards (e.g. Malnutrition Universal Screening Tool (MUST), Red Tray Policy)
- Healthwatch Tower Hamlets to utilise its statutory powers to make recommendations and suggestions to Barts Health on how the food service and current practices (staffing, logistical) might be improved to minimise any risks to inpatient malnutrition and hydration.

Methodology

The Healthwatch Enter and View visit format (See Appendix 2 for **Enter and View Protocol**) was agreed as a useful method of undertaking the project as it provides a clear structure for undertaking the visits; reporting and utilising statutory powers to obtain a response. The following process was agreed with with Barts Health:

1. Healthwatch would visit four wards at the Royal London Hospital (suggestions were provided by dieticians with the final four chosen by Healthwatch Tower Hamlets).
2. The visits would take place throughout the course of the day from breakfast to dinner.
3. Wards would not be informed of the visits (unannounced), a member of staff from the dieticians team would introduce Healthwatch representatives to the ward manager on the day/time of the visit.

A total of 10 Healthwatch Tower Hamlets representative took part in the visits. The Healthwatch representative are lay members of the community (local residents/volunteers) that received training in undertaking Enter and View visits. Over the course of the four visits the representatives spoke to a total of 35 patients, the patients they spoke with were of a varied age range (20 plus to 70 plus) and from mixed background (White British, Bangladeshi, African).

Visit information and number of patient engaged

Ward / Meal Service	Date	Patients Engaged
10 E (Gastro) Whole day visit (Breakfast, Lunch, Dinner)	23rd February, 7-7pm	10 Patients

14E (Care of the Elderly)	25th February, 11.30	3 Patients
Lunch time visit	- 4pm	
9F (Renal)	1st March, 4.30- 7.30	10 Patients
Evening visit		
13D (General Surgery)	3rd March, 11.30- 4pm	12 Patients
Lunch time visit		

Key themes from visits

- A substantial number of patients did not eat (or entirely eat) the food that was offered at mealtimes. The common reasons ascertained from patient feedback and observation were:
  - they did not like the food being offered to them e.g. taste was bland, quality poor.
  - they did not get the food they had chosen the day before.
  - staff choose the meals for them (e.g. care of the elderly ward)
  - the description of food as read out by nurses did not match their expectations.
  - they felt the mealtimes were too early.
  - they could not physically eat the food as it was not appropriate (care of the elderly ward).
- Overall the Red Tray policy was not adhered to properly:
  - in many cases patients that were supposed to receive support with feeding did not receive support.
  - some red tray patient's food wastage was not recorded, Health Care Assistants (HCAs) threw away the food before it could recorded.
  - some red tray patients did not actually receive a red tray.
  - there was misallocation of red trays, patients that were not red tray were assigned red trays.
  - in one ward they ran out of red trays and as a result a red tray patient had to be given a normal tray.
  - There was also confusion amongst staff (particularly HCAs) about who the red tray patients were, in one instance a Healthwatch representative had to give the HCAs the correct information on who the red tray patients were.
- General perception was that mealtimes could be provided an hour later.
- Patients feel the menu needs to be rotated more frequently (weekly) to offer more varied choices.
- The majority of patients felt that there needs to be better food choices provided at breakfast service e.g. muffins, croissants.
- There was no evidence of menus being placed near patient's bedsides, generally menus were stacked in nurse's stations.

- Often the patients did not get the opportunity to see the menu with menu choices usually being read out to patients (observed across all wards visited).
- There was no evidence (backed by patient feedback) that patients were offered the opportunity to wash their hands prior to meal service.
- There was generally no offer of second helping to patients. Staff were generally quite quick in taking the food cart back to the kitchen.
- The dayrooms did not seem to be used during mealtimes as there was no patient at any of the dayrooms during meal service. On one of the wards dayroom were being used by staff for meetings/interview, and in one case a patient mentioned that a dayroom had become a staff room instead.
- There appeared to be substantial amount of patients that were given incorrect food, basically they were offered something that they did not order the day before- it was evident that one of the reason for this happening is the mistakes made by staff when transferring the information from the patient choice sheet to the sheet that goes to the kitchen.
- The meal service information sheet also had incorrect information on many occasions e.g. on some occasions the sheet did not state that patients were NBM, or specific dietary requirement as it did not state this some patients that were NBM were served food or food that they were not supposed to eat.
- It was widely observed that HCAs are not sufficiently supporting patients for preparation of eating their meals e.g. not moving the bed up or placing the tray in the appropriate position. It was also observed that HCAs made less attempts to position patients beds and tray if patient's family members were present- we observed few family members struggling to position the bedside tray and adjusting the bed setting to position the patient correctly.
- Nursing team are not communicating efficiently with HCAs and temporary staff in relation to patient needs, e.g. those that are Red patients, if patients are allergic, any specific dietary needs of patients. And Consultants not communicating with nursing team efficiently, especially in relaying information on patients that have come off NBM and or after surgery food advice and requirements.
- Overall HCAs seemed to lack the knowledge around the importance and significance of nutrition and hydration to overall patient recovery (concluded after discussion with HCAs).
- The majority of Nurses do not seem to be trained in MUST (observation)- nurses that were trained (Nutritional Link Nurses) seemed to struggled to provide relevant information on MUST and also fully understand the significance of MUST.

- There were substantial amount of patients that were struggling to eat their meal, they were generally deemed as not requiring support with feeding or monitoring- representative observed a number of patients struggling to eat their food and then eventually left most of the food on the plate.
- Across all wards there were generally no 'sandwiches' left after evening meals, so if a patient requested a sandwich out of hunger late evening there is usually no provision for them.
- There was general feeling that staff do not make sufficient effort to cater to patient needs if they request additional food or snacks.
- There was inconsistency of notices being being put behind patients bed (patient information) e.g. patients that are Nil by Mouth (NBM) did not have signs next to their beds to state that they are NBM, and this often resulted in nursing staff taking over meals for them. There was no notices to state that the patients had specific needs, e.g. dietary, allergies etc.
- There is a perception amongst patients that the menu does not seem to cater for the diverse community of the area it serves, e.g. there are a high population of Eastern Europeans that live in this catchment area, however there is not much options for them.
- There were also requests for more Halal options that cater for the younger generation and Muslim patients of different ethnic backgrounds- the current Halal food option is geared towards patients from Asian subcontinent and not Muslims of European and Middle Eastern background (They tend to eat less spicy food).
- Patients would like to have 'discount' for eating at the restaurant on the 5th floor, patient have mentioned that they can't eat the hospital food at least they an option to eat something else- this will be beneficial for their health.

Good Practice/ Positive Feedback

- On the whole protected mealtime seemed to be respected by doctors and consultants during our visits.
- Mealtimes did not seem to be rushed – all patients had sufficient time to finish their meals.
- In some wards the staff that were plating up the food from the food cart seemed to take pride in what they were doing e.g. they presented the food well on the plate.
- The breakfast service by the HCAs was very efficient (10E)- they understood patient needs e.g. what the patient likes, if the patient wants to be woken up for breakfast.
- Generally there was positive feedback on the care and treatment provided at the ward. There was particularly good feedback on the permanent staff.

General Recommendations

- To review the current catering contractor/supplier, the majority of patients do not hold the food quality in high regards (does not taste good, smells, bland, poor quality, not edible), this is the main contributory factor for patients not wanting to eat the food.
- To review the mealtimes- substantial majority of patients did not have breakfast as they either asleep or did not have appetite, lunch is too early and dinner is too early – all meals should be taken up by an hour
- Staffing/volunteer level needs to be increased during meal times so that patients can supported properly- during the visits some of the wards did not have sufficient staff to support patients during mealtimes e.g. Care of the Elderly Ward.
- Menus should always be available at patient bedside and pictures of the food option should be provided on the menu- the pictures will give patients an idea of what the food looks like; therefore, patients will be aware of what they have ordered and more likely to eat the food - this could potentially reduce food wastage.
- patients that are well enough should be encouraged to eat in the dayroom.
- Dedicated Ward hostess to deal with all catering requirement of the ward, including tea, coffee and snackS- this will ensure that there is no delay is patient requests (example UCL, Guys example).
- All staff should wear 'head covering' (hairnets) during meal services (HCA and Nurses).
- Patients should be offered discounts (or subsided) at the restaurant on the 5th floor (RLH), this will provide them opportunities to sometimes eat food they enjoy or want to eat.
- To be consistent in ensuring that patient information (e.g. if NBM, if deaf, allergies) is put behind patient bedside (notice), one of the patient said that she gets asked the same question by different staff and also get food offered on a daily basis, staff do not seem to know that she is allergic and has been NBM for a long while.
- There needs to be better communication on patient nutrition and hydration needs between consultants and ward staff after post-surgery or after coming off NBM. Staff complained that they were not told or given guidance post-surgery when NBM should be lifted and diet patient should be on post-surgery.
- More varied menu, weekly rota rather than fortnightly, this will take away the repetitive element when choosing food (avoiding repetition of food choices) – specifically wards that have longer term patients.
- There should be better and wider selection for breakfast e.g. toast, muffins, cakes, croissants. There needs to be a review of the breakfast service.

- To review the validity of the traditional three course meal offering.
- There needs to be better communication on patient nutrition and hydration needs .
- Wider selection of Halal items for second generation Muslims and Muslims of non-Asian background – the new generation of Muslims are more use to a western diet and the traditional rice and curry is not an expectation on their part- this view is slightly outdated.
- Nurses need to be proactively be trained on MUST by Nutritional Link Nurses- it seems train the trainer programme has not be implemented properly.
- HCAs need more specific training on Red Tray policy and need training on the importance of patient Hydration and Nutrition.
- There should always be 2-3 spare red trays kept in the food cart trolley, as highlighted representative observed that on one occasion there was not enough red trays for all red tray patients.
- To ensure that all patient information(red tray, NBM, allergies) on the food sheet is double checked properly before food service begins- this will ensure that mistakes that could potentially jeopardise patients health does not happen.
- Cold bottled water should be available on request
- Water should be provided in sealed bottles (excluding vulnerable and elderly patients).
- High energy drinks should be stored in a fridge and be served at accepted temperatures –some patients complained that the energy drinks were served too warm.
- Ward manager/senior nurse should always double check that all patients have received their food and also received the food they ordered- there needs to be better quality monitoring.
- Generally, staff should be supportive of patient's nutrition and hydration needs and do their best to cater for them.
- All patient's specific dietary needs should be catered for- If a patient is able to have only one variety of food due to allergies then this demands should be met on a daily basis.
- HCA should always correctly position patients beds and tray prior to meal service- this duty should not be neglected if family members are present.
- Better system for recording 'red tray' patient's food intake, the description used by staff seems very minimal
- Review the possibility of having NHS Food Packs in every ward.

Specific Recommendations

- There should be 2 x 250ml water bottles/jugs - Renal patients are limited to 500ml of fluids per day. Currently the water jugs are topped up twice a day to 750ml, this seemed like an oversight.

- Better monitoring of NBM patients, staff sometimes are not aware that patients are no longer NBM patients and do not order food for them. (General Surgery)
- The food menu needs to be more appropriate for elderly people- the current menu choices should be reviewed to evaluate if they are suitable for people on this ward. **(Care of the Elderly Ward)**
- Picture based menus should be used for selecting food preferences – this a must for ward like this. **(Care of the Elderly Ward)**
- More staff awareness and training around dementia and the environment needs to be more conducive to dementia patient needs. **(Care of the Elderly Ward)**
- Family members should be actively encouraged to come along to lunch and dinner to support with feeding, we observed that this can increase a patient's desire to eat more food as they are being supported by someone they know. **(Care of the Elderly Ward)**
- Substantial majority of the patients on this ward are vulnerable and do not have mental capacity therefore these patients should not be left on their own to eat, all (not just red tray patients) patients of this ward should receive more support and encouragement during mealtimes. **(Care of the Elderly Ward)**
- Staff should actively liaise with patient's family/carers to select food for them or acquire information on type of food they like to eat. The information on food preference could be on the bedside so there won't be any issues when selecting food for them. **(Care of the Elderly Ward)**
- The environment of the ward should be more conducive to dementia patient needs e.g. 'Forget me not' cards behind patients bed, environment and food products needs more colour contrasts (e.g. different colour toilet seats, food colours that are dementia friendly). We would recommend that the Trust Dementia nurses work more closely with this ward to make it more dementia friendly.

Recommendations for Discussion

- Representatives would like to recommend that Barts Health review the entire catering contract, there is widespread feeling that Barts Health are not getting value for money (per head, per patient) in relation to quality of food being provided.
- The traditional three course meal seems to be a outdated eating concept and therefore alternatives options should be looked at e.g. grazing / pick and mix menu.
- Representatives feel that catering staff should handle the entire food service and nursing staff should be completely taken out of the food service.
- Representatives would like to suggest that all wards should have a 'Ward Hostess' and their main duty would be to focus specifically on providing a

food service for patients. Deploying such a member of staff will also take away the over reliance on a busy nursing team and more importantly provide patients with a dedicated person to support with their nutritional and hydration needs.

- Representatives would like to recommend that all mobile patients should have the option to go a patient restaurant e.g. staff restaurant or public restaurant.
- Representatives would like to request that Healthwatch Tower Hamlets members are involved in the selection of a future catering supplier.

Acknowledgement

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