



GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

GET YOUR 10 A DAY AUDIT

February 2012

Contents	Page number
List of Tables	ii
List of Figures	iii-iv
Introduction	1
Background to audit	2-3
Aim	4
Objectives	4
Audit Methodology	5
Data Management	6
Results	7-27
Discussion	28-29
Conclusion	30
Limitations of This Audit	30
Recommendations	31
References	32-33
Glossary	34
Appendices	
Appendix 1 Pre MUST/ MUST screening tool	35-36
Appendix 2 “Get your 10 a day! The Nursing Care Standards for Patient Food in Hospital”	37
Appendix 3 Observational Audit Tool	38-40
Appendix 4 Case Note Audit Tool	41-42
Appendix 5 Steering Team membership	43

List of Tables

Table 1: Ward Environments to be audited across each Trust

Table 2: Total number of Case Note Audits by Trust

Table 3: Total Number of Observations recorded by Trust

List of Figures

Figure 1: Results of Case Note Audit by Age Group and by Ward Environment

Figure 2: Results of Case Note Audit by Age Group and by Gender

Figure 3: Results of Observational Audits by Age Group and by Ward Environment

Figure 4: Results of Observational Audit by Age Group and by Gender

Figure 5: Results of the percentage of participants who should have been routinely weighed within 24 hours of admission to hospital

Figure 6: Results of the percentage of participants who should have been routinely weighed within 24 hours of admission to hospital by Trust

Figure 7: Total percentage of participants who were weighed after 24 hours

Figure 8: Total percentage of participants who should have been routinely measured within 24 hours of admission to hospital

Figure 9: Total percentage of participants who should have been routinely measured within 24 hours of admission to hospital broken down by Trust

Figure 10: Total percentage of participants who after not being measured within 24 hours were measured after this time period

Figure 11: Total percentage of participants who had their Pre-MUST screening carried out within 24 hours of admission to hospital

Figure 12: Total percentage of participants who had their Pre-MUST screening carried out within 24 hours of admission to hospital by Trust

Figure 13: Total percentage of participants who after not having Pre-MUST screening carried out within 24 hours had it carried out after this time period

Figure 14: Total percentage of participants who have had their MUST Tool fully completed.

Figure 15: Total percentage of participants who have had their MUST Tool fully completed by Trust.

Figure 16: Total number of participants who have been in hospital for more than 7 days

Figure 17: Total number of participants identified as having a low nutritional risk who have been re-screened on a weekly basis broken down by Trust

Figure 18: Total number of participants identified as having a medium nutritional risk who have been re-screened on a weekly basis

Figure 19: Total number of participants identified as having a medium nutritional risk who have been re-screened on a weekly basis by Trust

Figure 20: Total percentage of participants who have a care plan which identifies their nutritional care needs

Figure 21: Total percentage of participants who have a care plan which identifies their nutritional care needs by Trust

Figure 22: Total number of participants identified as having a medium nutritional risk who had been referred on to a dietitian

Figure 23: Total number of participants identified as having a medium nutritional risk who had been referred on to a dietitian by Trust

Figure 24: Total number of participants identified as having a high nutritional risk who had been referred on to a dietitian

Figure 25: Total number of participants identified as having a high nutritional risk had been referred on to a dietitian by Trust

Figure 26: Total number of participants identified as having a medium nutritional risk who have had their food & fluid charts appropriately completed

Figure 27: Total number of participants identified as having a high nutritional risk who have had their food & fluid charts appropriately completed broken down by Trust

Figure 28: Total number of participants who are clearly identified as requiring assistance

Figure 29: Total number of participants who are clearly identified as requiring assistance by Trust

Figure 30: Total number of participants who were identified as needing full assistance eating and drinking as having received assistance

Figure 31: Total number of participants who were allowed to eat their meals without interruptions

Figure 32: Total number of participants who were allowed to eat their meals without interruptions broken down by Trust

Figure 33: Details of mealtime interruptions

Figure 34: Total number of mealtimes which interruptions occurred

INTRODUCTION

Good nutrition and the mealtime experience are of vital importance for individuals recovering from illness, or for those who are at risk of malnutrition¹. As far back as the 19th century, Florence Nightingale recognised that participants were starving. This was not because there was a lack of food, but because of the want of care and attention from healthcare staff to the ways which made it possible for them to actually consume the food.

Today we should be doing much better but malnutrition is still prevalent within our hospitals and community settings. Malnutrition is a debilitating and highly prevalent condition in the acute hospital setting, with studies reporting rates of approximately 40%². Malnutrition is associated with many adverse outcomes including depression of the immune system, impaired wound healing, longer lengths of hospital stay, higher treatment costs and increased mortality.

With all these outcomes comes a significant impact on resources. It has been reported that the cost of disease related malnutrition in the UK in 2007 was estimated to be more than £13 billion³. Surely at a time when there is such a strain on Health Service resources, we should be doing all within our abilities and resources to drive the cost down. In fact NICE have identified nutritional care as potentially the 4th largest cost saving within the NHS⁴.

This audit has considered the nutritional experiences of participants within the acute settings of each of the five Health and Social Care trusts. The management is compared to the Department of Health, Social Services & Public Safety (DHSSPS) standards set out in the 2007 document "Get your 10 a day!" Nursing Care Standards for patient food in hospitals⁵.

This audit has identified areas of good practice but there is more work required if we are to achieve the best possible outcomes for our participants in terms of their nutrition. Key recommendations have been identified and I would stress the need to acknowledge these and act on them as each and every one of us are responsible for the rate of malnutrition within the Northern Ireland population.

BACKGROUND TO AUDIT

The literal meaning of malnutrition is 'bad' nutrition and therefore the term can encompass wasting (under nutrition) and/or obesity (over nutrition). Despite this, the term malnutrition is more commonly used to refer to under nutrition rather than over nutrition. A suggested definition of malnutrition is as follows: a state of nutrition in which a deficiency, excess or imbalance of energy, protein, and other nutrients causes measurable adverse effects on tissue (shape, size, and composition), function and clinical outcome⁶.

Approximately 28% participants are said to be clinically malnourished on admission to hospital⁷ and concerns have been raised about nutritional support within healthcare organisations⁸. The report "*Hungry to be Heard*"⁹ argues that 4 in every 10 older participants arrive at hospital malnourished, participants aged 80 are five times more likely to be malnourished, the result being that

"...six out of 10 older people are at risk of becoming malnourished, or their situation getting worse, in hospital".

This percentage increases once participants have been in hospital for more than seven days, and often malnutrition goes both unrecognised and untreated. Additionally it has been reported that low levels of nutritional screening is historically undertaken by healthcare professionals¹⁰. The National Institute for Health and Clinical Excellence (NICE) has also reported that only 30% of people were screened on admission to hospital prior to issuing their guidance Nutritional Support for Adults¹¹. A recent survey by the British Association of Parenteral and Enteral Nutrition (BAPEN)¹² estimated that the cost of malnutrition to the UK NHS is around £7.3 billion a year, with over half this cost being spent on people aged 65 years of age and over. This survey also suggests that it is not just the older adult that is a risk of malnutrition, and, malnutrition continues to be under-recognised and under-treated¹³.

Nutrition is the subject of a Council of Europe resolution¹⁴, the focus of an Royal College of Nursing (RCN) campaign "*Nutrition Now*"¹⁵, and is supported within the DHSSPS "*Get your 10 a day! Nursing Care Standards for patient food in hospital*". These standards were developed collaboratively by the DHSSPS Directorate of Nursing & Midwifery and the Northern Ireland (NI) Office of the RCN as a response to the RCN's national *Nutrition Now* campaign^{5, 15}.

To assist nurses in the implementation and achievement of these standards the Regional Nutrition Standards Implementation Group was established in 2009. The group which was led by Ms. Rita Devlin, Practice Development Officer, RCN and Ms. Pauline Mulholland, Lead Dietitian, South Eastern Health & Social Care Trust on behalf of the Chief Nursing Officer DHSSPS included senior nurses and dietitians from each of the five Trusts across NI.

The regional group has taken forward the implementation of the standards via the development of the following to support nursing practice which include:

- Regionally agreed MUST Screening tool with pre-screening questions (Appendix 1)
- Regional evidence based guidelines for care planning
- Regional guiding principles to inform policy on nutrition for food service in hospital for adult inpatients
- Regional nutrition care bundle
- Audit tools and observations of practice templates

It is important to note that prior to the “*Get Your 10 a Day*” standards there had been a number of initiatives in recent years that were undertaken across NI which had aimed to address malnutrition in hospital patients. While short term improvements have been recorded these had not been sustained.

It is for this reason that the Regional Nutrition Standards Implementation Group choose to adopt the Institute for Healthcare Improvement ‘Care Bundle’ approach to implement the Get Your 10 a Day Standards to achieve sustained improvement of patient care. The care bundle approach links evidence, a measuring tool and a strategy for improving the clinical process to deliver evidence based practice.

Food and nutrition care bundles are interventions to minimise the risk of malnutrition in adult patients. Two aspects have been developed to date:

- Nutritional Screening
- Assistance with eating and drinking

Having agreed tools to support nursing practice to meet the standards regionally, in 2009/2010 a project involving nutrition students from Queen’s University Belfast and the University of Ulster was undertaken. The aim of this project was to evaluate the extent to which these standards had been implemented in all five Trusts and to support the further implementation in pilot wards in each Trust. A important finding from this work was that the pilot wards demonstrated an increase in nutritional screening, with the highest increase reported to be 94%. Results for compliance with assistance with eating again demonstrated an increase for all Trusts which ranged from 33% to 98%.

It is evident that here is a definite business case for promoting better nutrition within the hospital setting. The evidence available supports the view that malnourished participants are more likely to stay in hospital for longer, experience complications, and need more interventions and medications. Several guidelines advocate the use of systematic nutritional screening; however, it is far from universally adopted¹⁶. There is also a clear need across clinical, professional and economic domains to audit practice in relation to the identification and management of malnutrition in hospitals across Northern Ireland.

AIM

The aim of this audit is to examine current practice in line with specified DHSSPSNI standards, identify aspects of good practice and areas for improvement in the management of nutrition for people in hospital settings.

OBJECTIVES

The overall objective is to audit compliance with standards 1-7 as set out in "*Get your 10 a day! The Nursing Care Standards for Patient Food in Hospital*" (Appendix 1). Objectives are therefore to identify percentage of participants who received care in line with that expected for each standard as follows:

Test Standard 1: to determine the percentage of participants who had all aspects of nutritional screening carried out on admission i.e. Malnutrition Universal Screening Tool (MUST) tool fully completed

- Height and Weight measurements taken on admission to hospital
- Pre-MUST screening completed on admission to hospital
- MUST Screening completed on admission to hospital

Test Standard 2: to determine the percentage of participants who been re-screened on a weekly basis (MUST tool fully completed)

Test Standard 3: to determine the percentage of participants who:

- have a care plan which identifies their nutritional care needs and how they are to be met
- have been referred to a dietitian if required as per MUST tool

Test Standard 4: to determine the percentage of participants who have had their food & fluid charts appropriately completed

Test Standard 5: to determine the percentage of participants who require support eating and drinking that are clearly identified

Test Standard 6: to determine the percentage of participants who have been identified as needing assistance with eating and drinking who have

- received assistance with eating and drinking when it is required
- had input to identify their nutritional care and fluids needs as evidenced in their records

Test Standard 7: to determine the percentage of participants who had their mealtimes protected from interruptions thereby maintaining an environment conducive to people enjoying their meals and being able to safely consume their food and drinks safely

Audit Methodology

To conduct the audit two acute hospitals within each trust were selected and wards within each hospital identified for audit visits. To ensure consistency a settings template was designed (Table 1) and adhered to across the five HSC trusts. These settings included: Cardiology, Medical, Surgical and Care of the Elderly / Rehab settings. Additionally various mealtimes (i.e. breakfast, lunchtime, teatime) were targeted to ensure a true picture of mealtime experiences was obtained consistently across all mealtimes.

Table 1: Ward Environments to be audited across each Trust

	Breakfast	Lunch	Tea Time
Medical	1	2	2
Surgical	1	2	2
Care of Elderly / Stroke Rehab	1	2	2
Cardiology	1	2	2
Totals	4	8	8

Data Collection Method

Two main approaches were taken to capture the required information. Firstly a case note review was undertaken to capture information which should be recorded within participants records (for example, Pre- MUST/MUST scores, care plans). Secondly in order to capture the real-time patient experience observation audits were conducted.

Two questionnaires were designed as data collection tools specifically to capture the required information (Appendices 2 & 3); one for case note reviews and one for observational audits. These questionnaires were tested within the acute setting by experienced research staff.

Data was collected between Monday 4 July 2011 and Monday 10 October 2011.

Patient selection

Observational audit Participants that were observed during the observational audits were selected because they were identified as needing full assistance with eating and drinking. The way in which participants are identified as needing full assistance varied across the five HSC and included the Plate Model, a record in the participants' chart, patient is listed on white board, or red tray system, or as directed by the nurse in charge of the ward.

Case Note review audit For the completion of the case note reviews, the required number of patient charts were randomly selected by the auditor from all the patient charts available on each ward. All participants' charts were for patients who were still inpatients within that acute setting. No patient identifiable information was recorded in the conduct of the case note review. Participants were assigned Unique Identification numbers linked to HSC trust sites.

Data Management

Data was collected manually and then entered into Microsoft Excel 2010. Robustness of data entry was tested using double blind entry techniques. Data cleansing occurred with the help of an expert in this field.

Results

For ease of interpretation the findings will be presented primarily as results obtained for the case note/ observational audit. Data will then be presented as regional data, broken down into trust level data and finally data will be linked back to the standard being measured against.

Case Note Audit

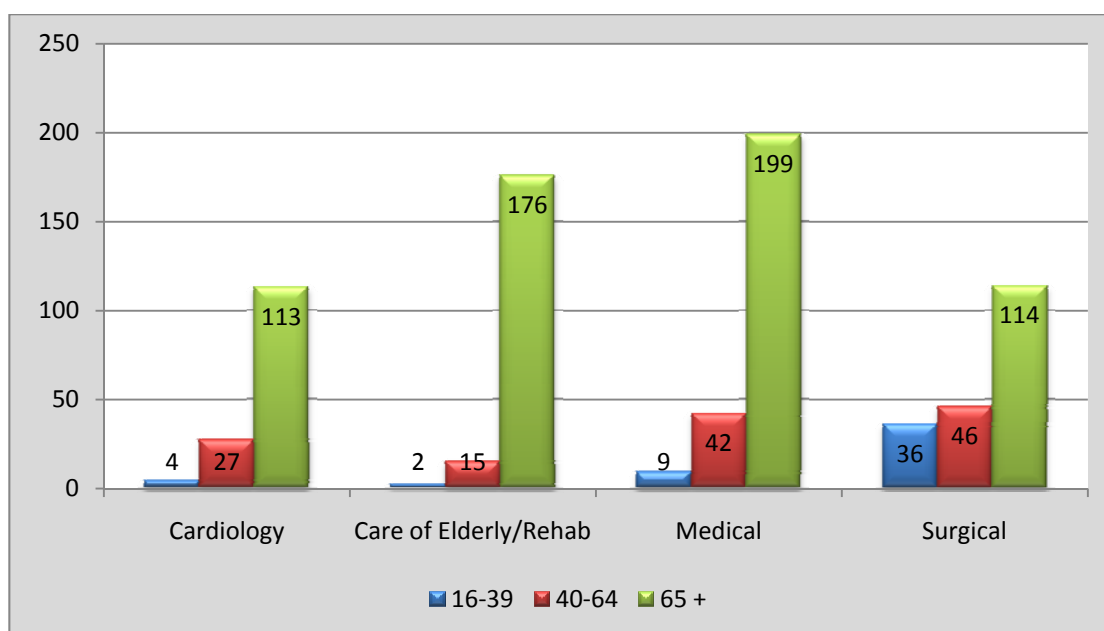
Case Note Audits were carried out across the five Health and Social Care Trusts which involved the observation of a total of 783 participants. These audits were carried out in Cardiology, Medical, Surgical and Care of the Elderly / Rehab settings.

Table 2: Total number of Case Note Audits by Trust

Trust	Total
Belfast Health & Social Care Trust (BHSCT)	165
Northern Health & Social Care Trust (NHSCT)	135
SEHSCT Health & Social Care Trust (SEHSCT)	152
SHSCT Health & Social Care Trust (SHSCT)	177
WHSCT Health & Social Care Trust (WHSCT)	154
Grand Total	783

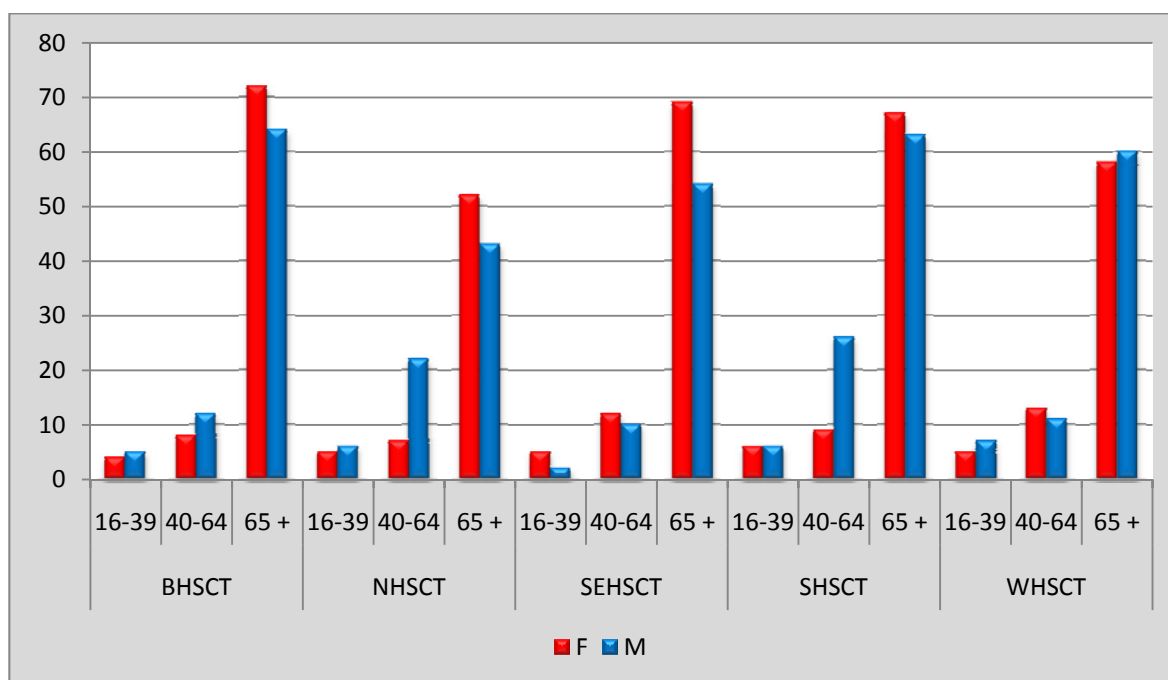
Overall it was found that 77% (602 out of 783) of case notes audited belonged to participants who were in the 65+ age band, 16% (130 out of 783) into the 40 – 64 age band and 7% (51 out of 783) into the 16 – 39 age band.

Figure 1: Results of Case Note Audit by Age Group and by Ward Environment



It was found that 50% of the sample was female participants (392 out of 783) and 50% of the sample was male participants (391 out of 783).

Figure 2: Results of Case Note Audit by Age Group and by Gender



Observational Audit

Observational audits were carried out across the five HSC trusts which involved the observation of a total of 185 participants. These audits were carried out in Cardiology, Medical, Surgical and Care of the Elderly / Rehab settings (Table 3).

Table 3: Total Number of Observations recorded by Trust

Trust	Total
Belfast Health & Social Care Trust (BHSCT)	40
Northern Health & Social Care Trust (NHSCT)	48
SEHSCT Health & Social Care Trust (SEHSCT)	32
SHSCT Health & Social Care Trust (SHSCT)	28
WHSCT Health & Social Care Trust (WHSCT)	37
Grand Total	185

Figure 3 shows the audit results by age group and by the ward environment. It is clear that the majority of participants who required assistance with eating were found in the Care of the elderly/Rehabilitation ward settings (43%; 80 out of 183). It is in keeping with the profile of patients in these settings that the majority of participants were over 65 years of age. Of interest are the findings that participants within surgical (22 out of 183) and cardiology settings (11 out of 183) were also identified as being in need of assistance with eating.

Figure 3: Results of Observational Audits by Age Group and by Ward Environment

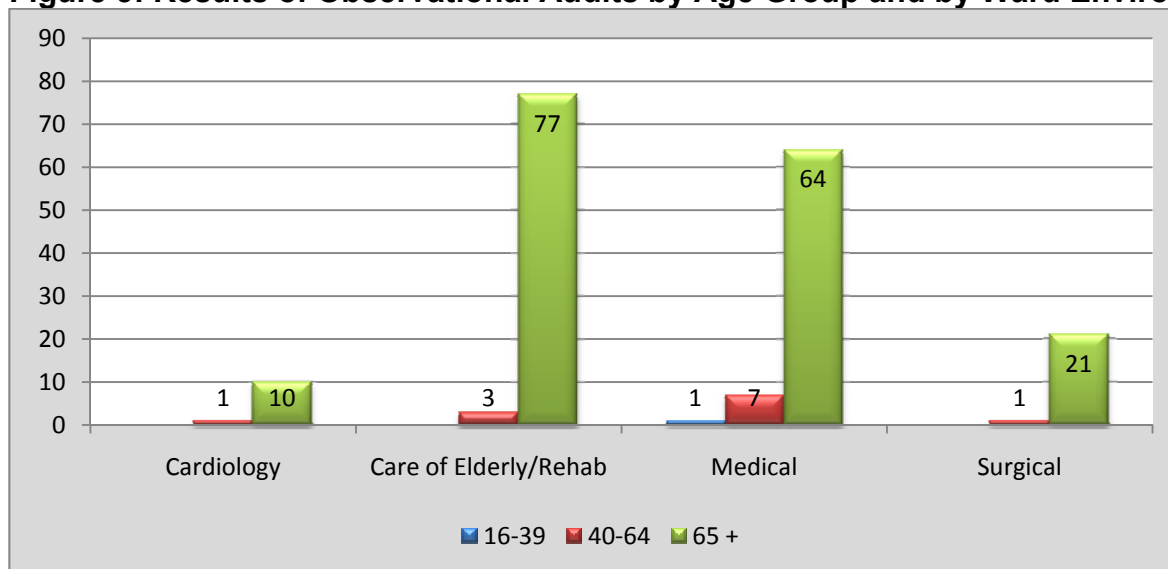
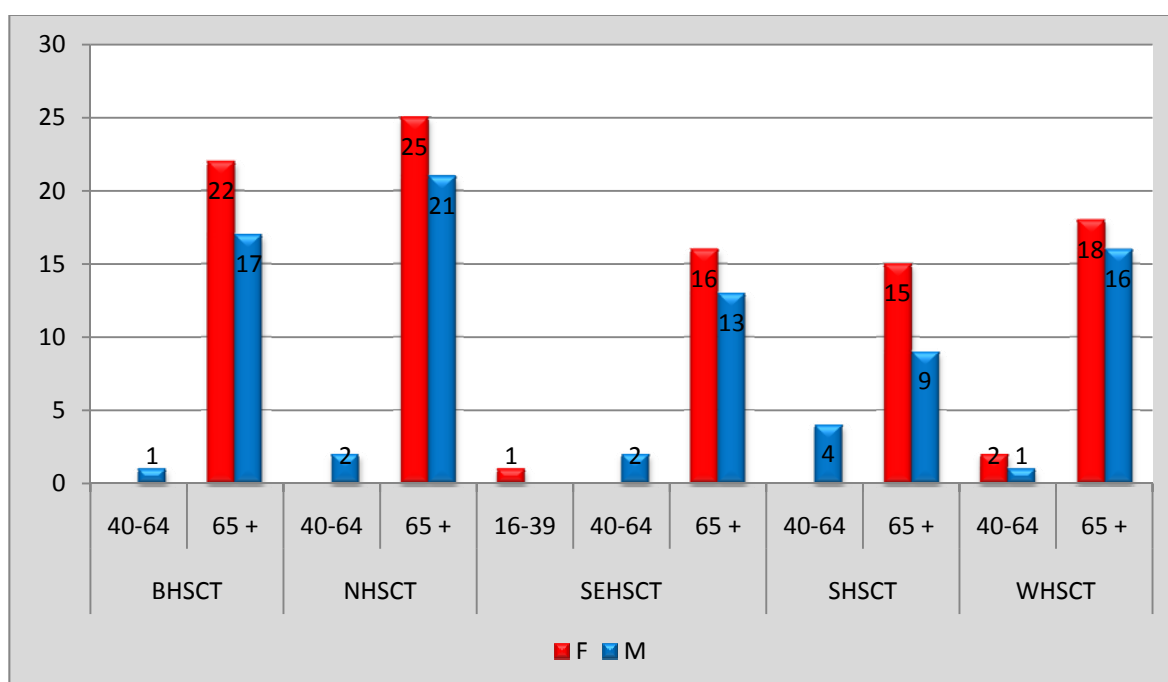


Figure 4 details that 93% (172 out of 185) of the case notes audited belonged to participants who were in the 65+ age band, with 6.5% (5 out of 185) reported to be in the 40 – 64 age band and 0.5% (1 out of 185) in the 16 – 39 age band.

In terms of gender it was found that 54% (100 out of 185) of the sample were female and 46% (85 out of 185) were male.

There was consistency across all the five HSC trusts in terms of age/gender profile; the majority of audit were conducted on women over the age of 65 years.

Figure 4: Results of Observational Audit by Age Group and by Gender



Test Standard 1: To determine the percentage of participants who had all aspects of nutrition screening carried out on admission i.e. Pre-MUST/ MUST Tool fully completed

From the audit the findings provided information on performance against standard 1 in various formats. Figure 5 shows that of the 783 patient notes audited, 16% (127 out of 783) of participants were not weighed within 24 hours of admission. Of the 84% who had their weight recorded a total of 52% (345 out of 656) of participants had their actual weight recorded. A further 23% (150 out of 656) had a “recalled” weight recorded and 25% (161 out of 656) had their weight recorded but it was not identified as either an actual or recalled weight.

Figure 5: Results of the percentage of participants who should have been routinely weighed within 24 hours of admission to hospital

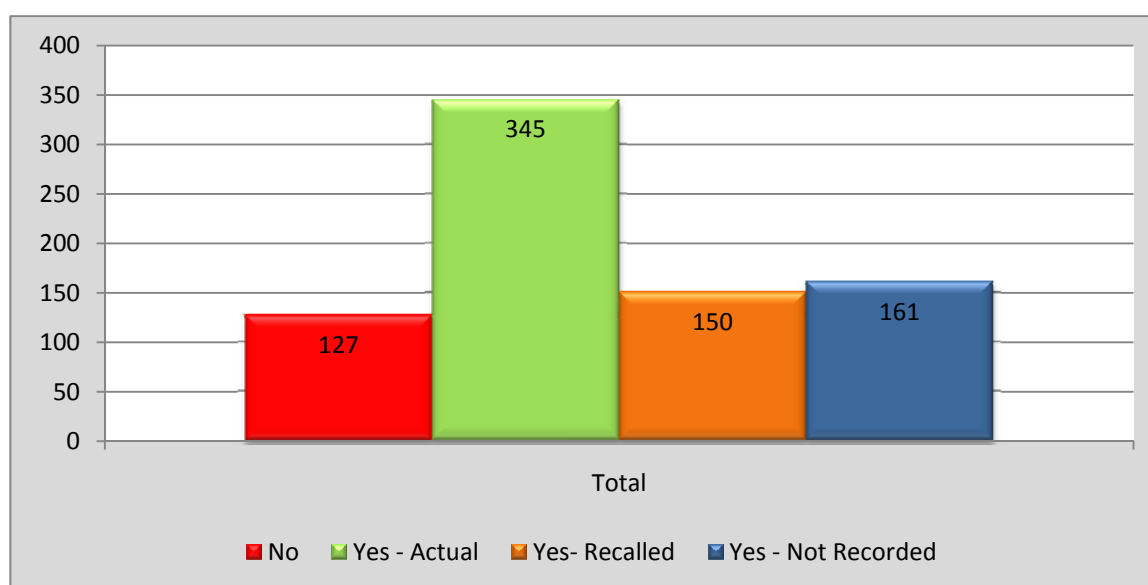


Figure 6 details that when the participants who were routinely weighed were considered across each Trust area it was found that a greater percentage of participants had their weights recorded at each Trust than did not have their weights recorded. This ranged from 91% (SEHSCT) to 72% (NHSCT).

Participants who did not have their weight recorded ranged across each Trust from 28% (NSHCT) to 9% (SEHSCT).

The participants who had their actual weight recorded (participant was weighed on a set of scales) varied across trusts and ranged from 62% (WHSCT) to 27% (BHSCT).

Figure 6: Results of the percentage of participants who should have been routinely weighed within 24 hours of admission to hospital by Trust

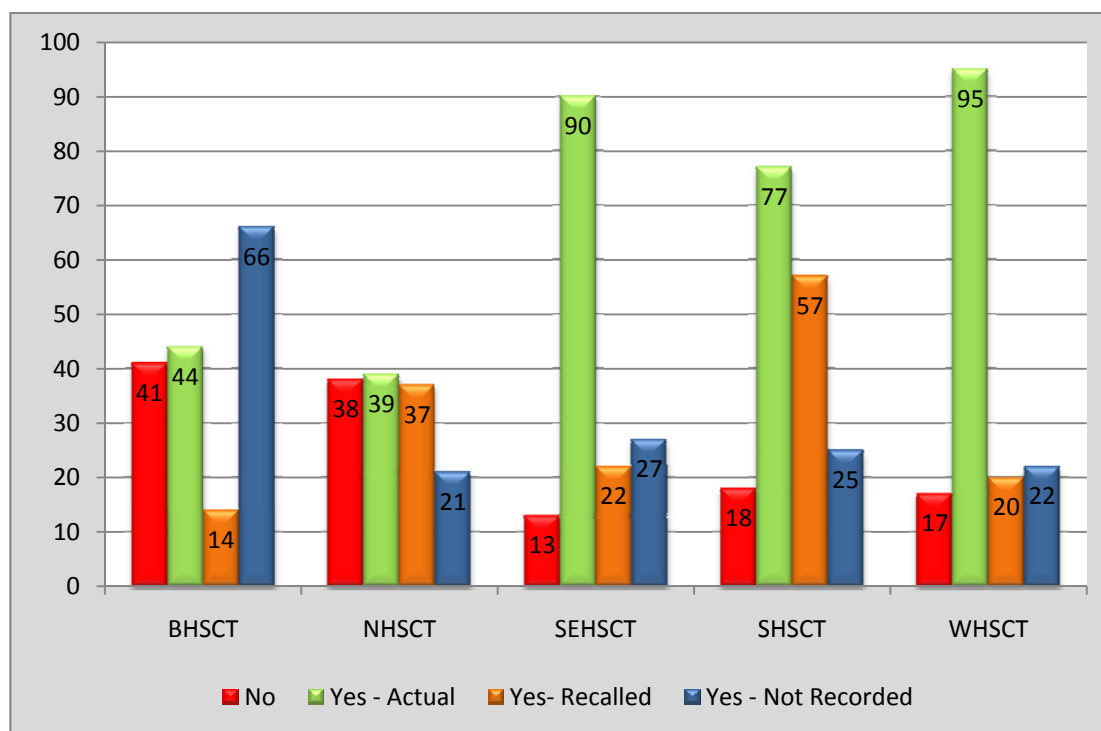


Figure 6 also informs us that the participants who had their weight recalled (participant verbally gave their weight to the nurse completing the PreMUST/MUST) varied across trusts and ranged from 32% (SHSCT) to 8% (BHSCT).

Finally on occasions it was found that a weight was recorded but it was not reported where the weight originated (i.e. actual or recall) and this ranged from 40% (BHSCT) to 14% (SHSCT/WHSCT).

Figure 7 shows that of the 118 participants who were not initially weighed within the expected 24 hour timeframe, 96% (113 out of 118) had still not been weighed at the time the audit was carried out.

Figure 7: Total percentage of participants who were weighed after 24 hours

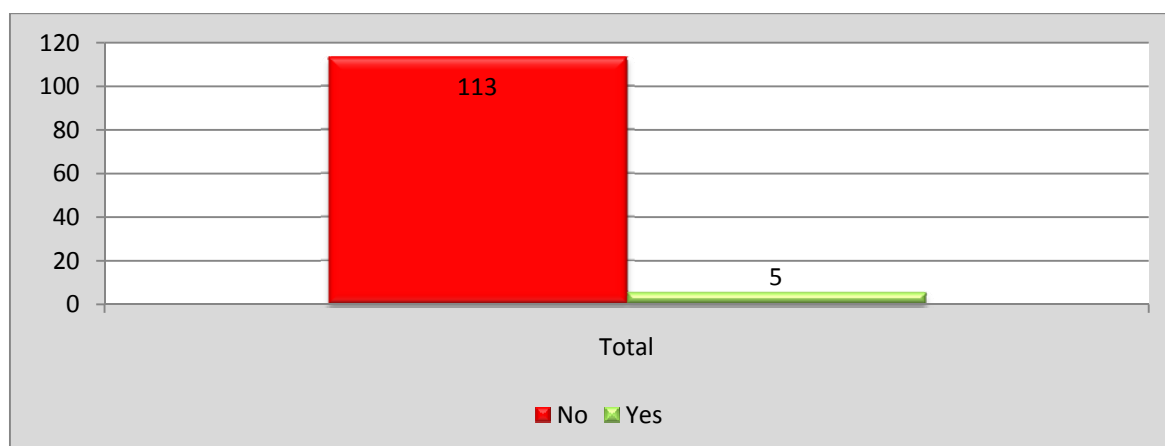


Figure 8 shows that of the 783 patient notes audited, 23% of participants were not measured within 24 hours of admission. Only 25% had their actual height measured. In addition 34% had a “recalled” measure recorded and 18% had their measure recorded but it was not indicated as either an actual or recalled measure of their height.

Figure 8: Total percentage of participants who should have been routinely measured within 24 hours of admission to hospital

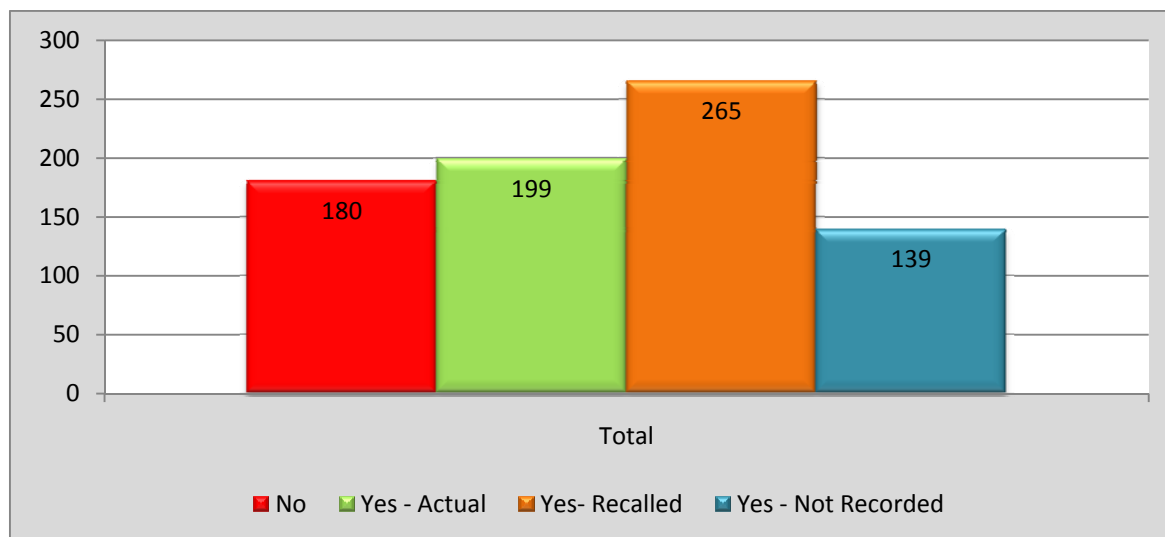
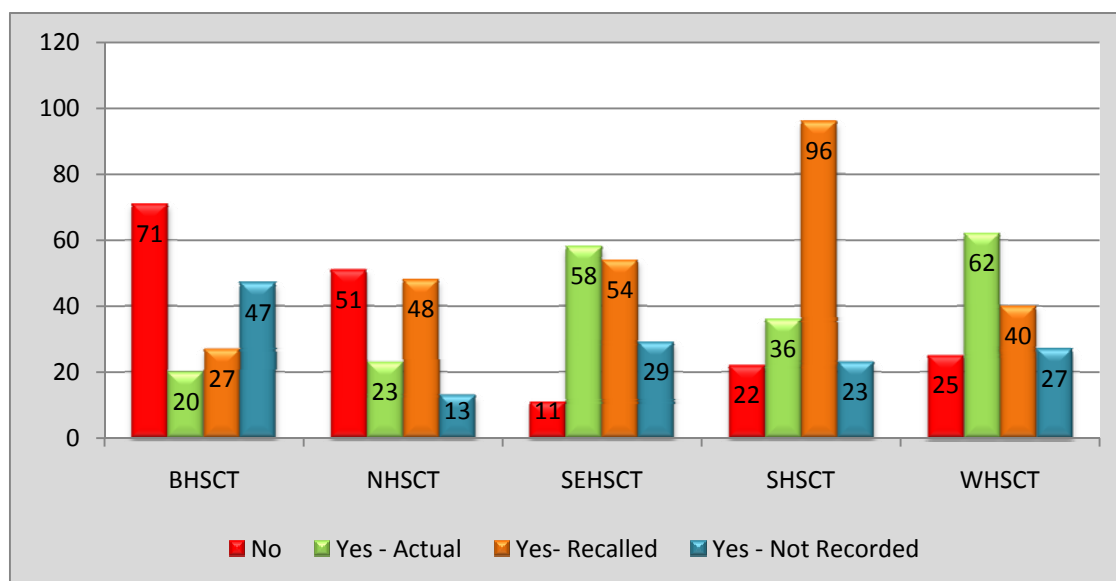


Figure 9 shows that of the participants who had their actual height measure recorded, results ranged from 40% (WHSCT) to 12% (BHSCT). For recalled heights, results ranged from 54% in (SHSCT) to 16% (BHSCT). For those participants whose height was recorded but it was not noted as actual or recalled weight, results ranged from 29% (BHSCT) to 9% (NHSCT).

For those participants who did not have their height measured, results ranged from 43% (BHSCT) to 7% (SEHSCT). Participants were measured in each Trust using an appropriate height measurement tool.

Figure 9: Total percentage of participants who should have been routinely measured within 24 hours of admission to hospital broken down by Trust



Of the 169 participants who did not have their initial height measure recorded and who had been admitted over 24 hours, 97% (164/169) had still not had their height measure recorded at the time the audit was carried out.

Figure 10: Total percentage of participants who after not being measured within 24 hours were measured after this time period

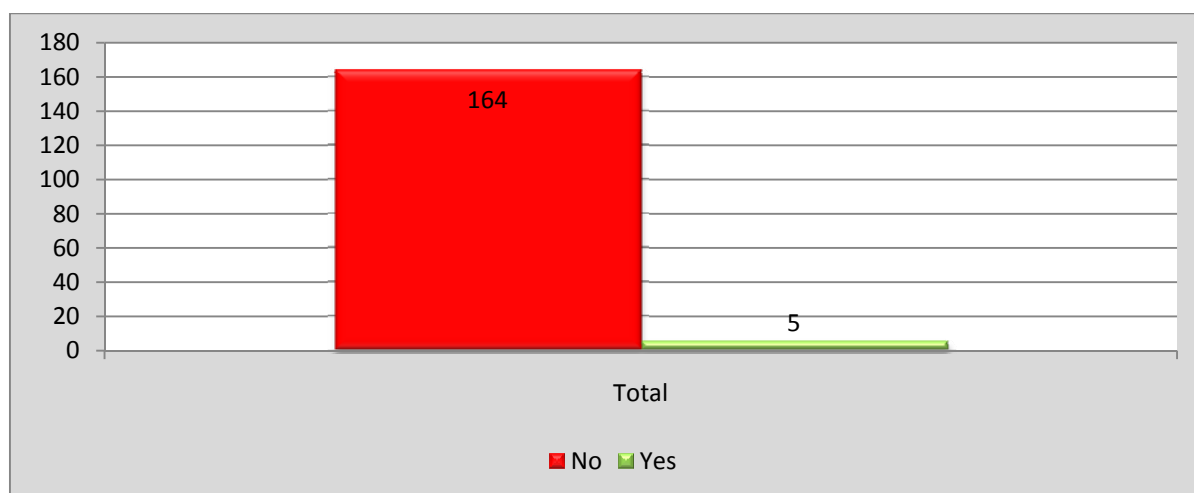


Figure 11: Total percentage of participants who had their Pre-MUST screening carried out within 24 hours of admission to hospital

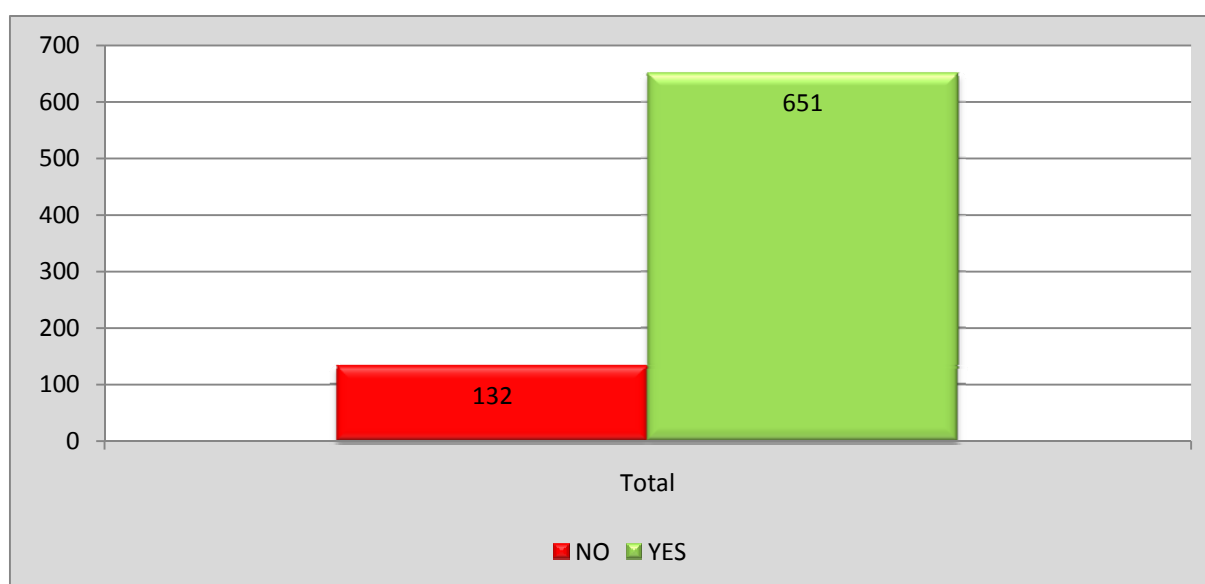
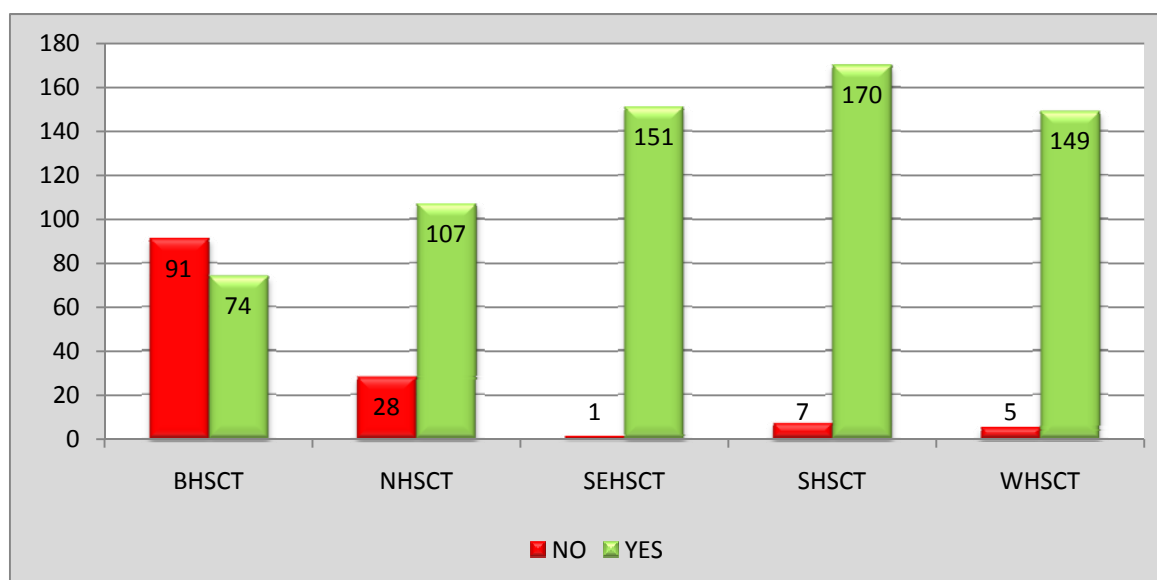


Figure 11 above shows that 83% (651 participants out of the 783 participants) audited had their Pre-MUST screening carried out within 24 hour of admission. This ranged across each trust from 45% (BHSCT) to 100% (SHSCT) as shown in Figure 12 below.

Figure 12: Total percentage of participants who had their Pre-MUST screening carried out within 24 hours of admission to hospital by Trust



Of the 128 participants whose Pre-MUST screening was not completed and who had been admitted over 24 hours, 98% (125 out of 128) had still not been screened using Pre-MUST at the time the audit was carried out (Figure 13)

Figure 13: Total percentage of participants who after not having Pre-MUST screening carried out within 24 hours had it carried out after this time period

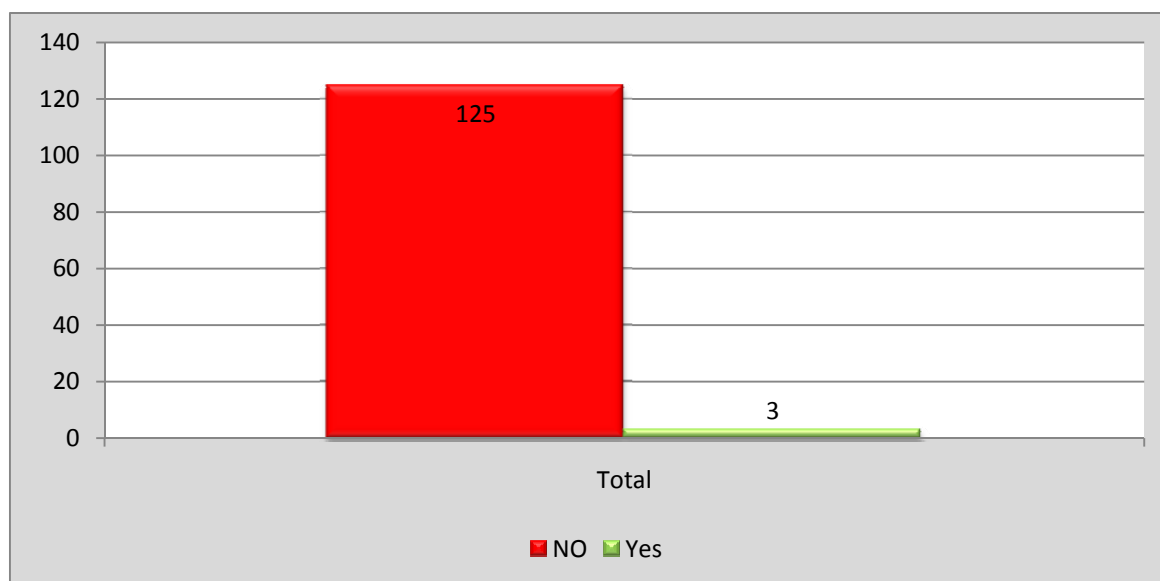


Figure 14 shows that of the 783 patient notes audited 31% of participants (n=247) were identified from their Pre- MUST screening as needing the full MUST completed. From this 247 participants, 85% (211 out of 247) had their MUST tool fully completed, while 15% (36 out of 247) did not have it completed.

Figure 14: Total percentage of participants who have had their MUST Tool fully completed

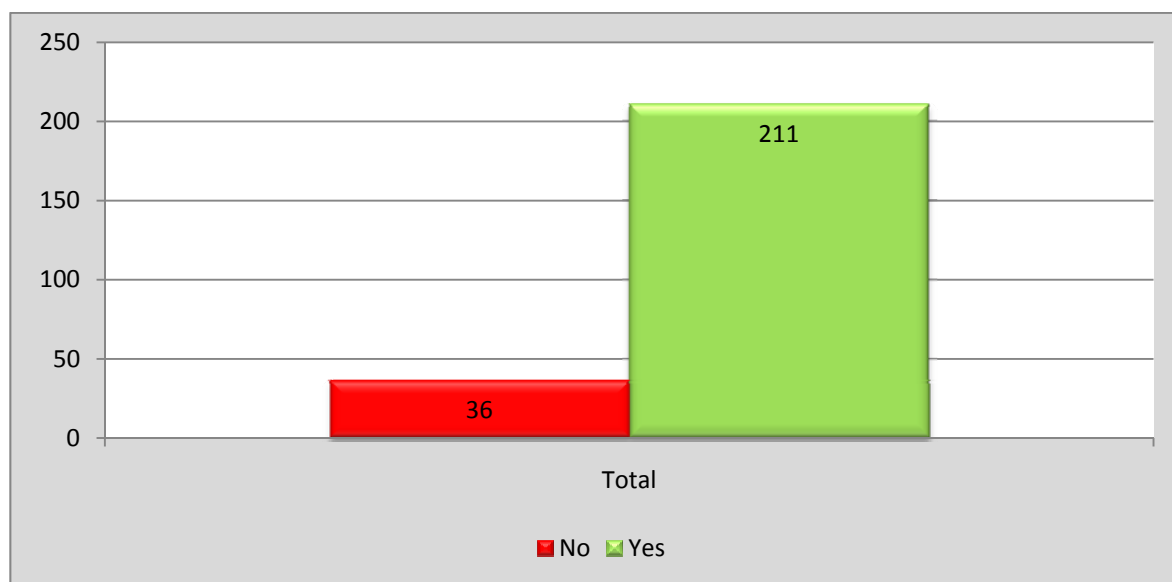
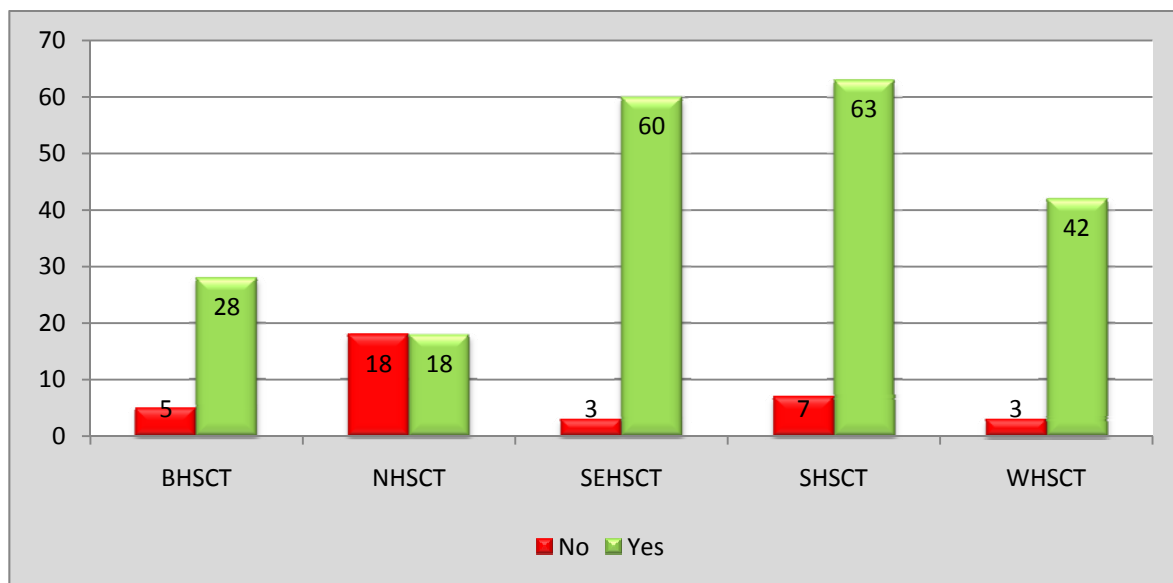


Figure 15 demonstrates that for participants who were identified as requiring completion of the MUST screening tool completion rates varied across the five HSC trusts with SEHSCT having a completion rate of 95% and NHSCT a rate of 50%. It is important to note that all five HSC trusts did not complete the MUST screening tool for all participants who required this.

Figure 15: Total percentage of participants who have had their MUST Tool fully completed by Trust



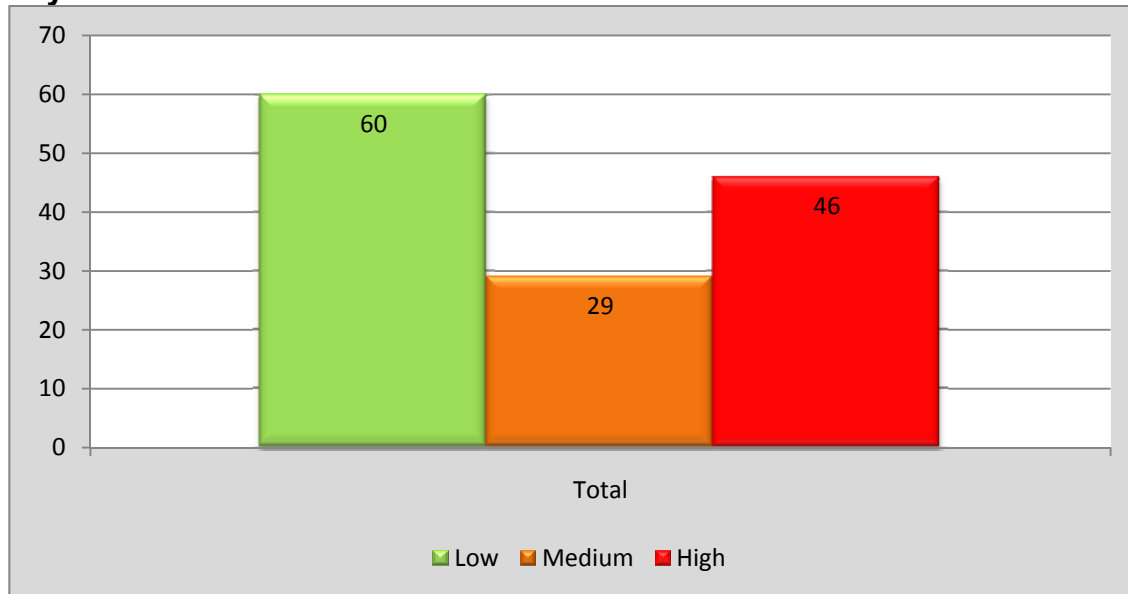
Test Standard 2: to determine the percentage of participants who been re-screened on a weekly basis (MUST tool fully completed)

When a patient is identified as being at risk of malnutrition using MUST there is a requirement to rescreen that person after 7 days (Appendix 1).

It was found that a total of 135 participants who had their MUST completed were identified as needing to be re-screened on a weekly basis i.e. participants had been identified as having a nutritional risk had been in hospital for more than 7 days.

Figure 16 details the participants in terms of the nutritional risk recorded: high (34%), medium (21%) or low risk (44%) of malnutrition.

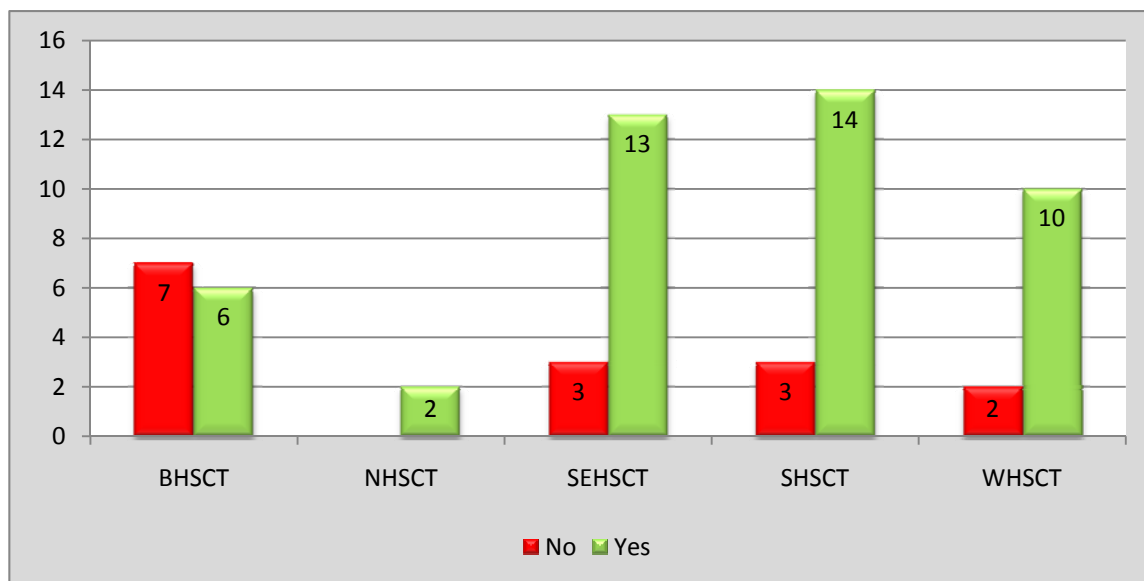
Figure 16: Total number of participants who have been in hospital for more than 7 days



Low risk of malnutrition Of the 60 participants identified as having a low nutritional risk, 75% (35 out of 60) were appropriately rescreened after 1 week and 25% (15 out of 60) participants were not screened accordingly.

Figure 17 shows that for the participants (n=60) identified as having a low nutritional risk rates of rescreening varied across the five HSC trusts. This ranged from 100% (NHSCT: 2 out of 2) to 18%, (SHSCT: 3 out of 13).

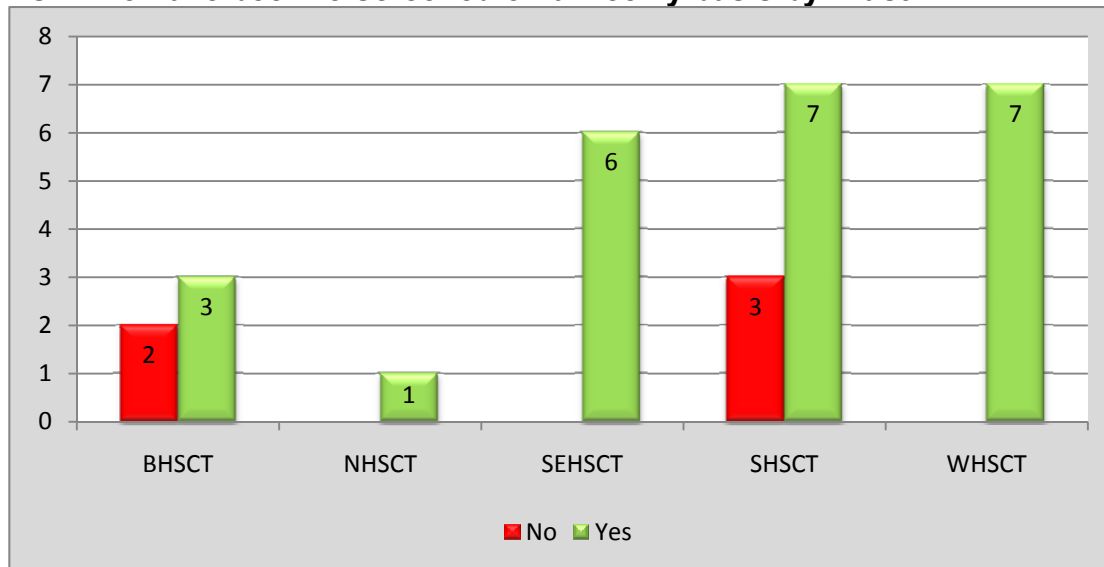
Figure 17: Total number of participants identified as having a low nutritional risk who have been re-screened on a weekly basis broken down by Trust



Medium risk of malnutrition Of the 29 participants identified as having a medium nutritional risk, 75% (24 out of 29) were rescreened after 1 week, while 17% (5 out of 29) participants were not.

Of the 29 participants identified as having a medium nutritional risk varied across the five HSC trusts as shown in Figure 18. This ranged from 100% for the WHSCT (7 out of 7 participants), the NHSCT 100% (1 out of 1 participant), SEHSCT (6 out of 6 participants) and BHSCT 66% (3 out of 5 participants).

Figure 18: Total number of participants identified as having a medium nutritional risk who have been re-screened on a weekly basis by Trust



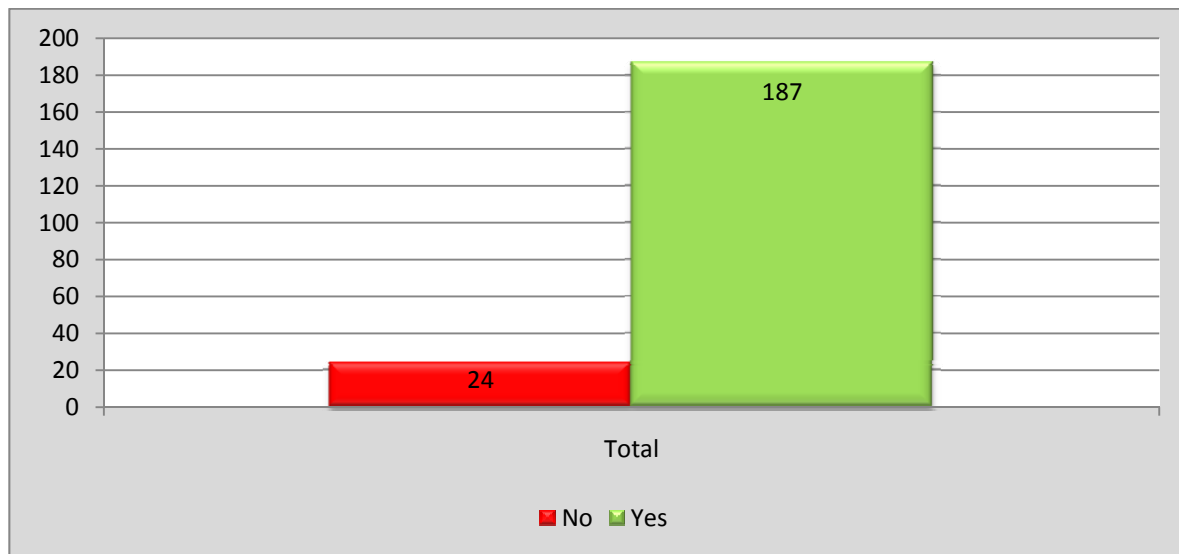
It is important to note that those participants who are identified at a high nutritional risk are not re-screened on a weekly basis as per the MUST Tool. These participants are referred directly to the dietitian.

Test Standard 3 to determine the percentage of participants who:

- **have a care plan which identifies their nutritional care needs and how they are to be met**
- **have been referred to a dietitian if required as per MUST too**

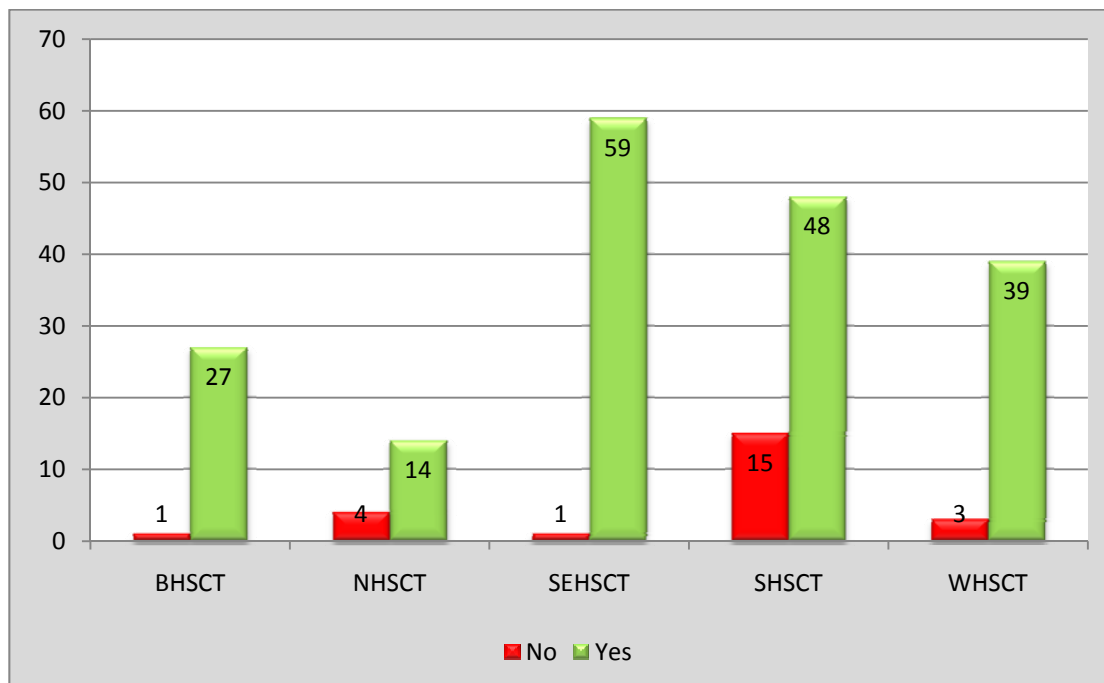
Figure 19 shows that of the 211 participants who had been identified as being at a nutritional risk, 89% (187 out of 211) had a documented care plan identifying their nutritional needs and how these were to be met. A total of 11% (24 out of 211) had no documented care plan identifying their nutritional needs and how these were to be met.

Figure 19: Total percentage of participants who have a care plan which identifies their nutritional care needs



The participants who had a documented care plan varied across the five HSC trusts. Figure 20 shows that this ranged from 98% (SHCST; 59 out of 60) to 76% (SHSCT; 48 out of 63) of participants having a documented care plan.

Figure 20: Total percentage of participants who have a care plan which identifies their nutritional care needs by Trust



It is important to note that participants deemed to be at a medium level of nutritional risk are only referred to dietetic staff if their risk status increases. It was found that only 9 participants initially deemed to be at medium risk had their status changed. Of these 9 participants 8 have been referred to dietetic staff. You will note from Figure 21 that one

participants risk status was reported to have reduced to a lower risk status. Of the remaining 8 participants, 88% (7 out of 8) were referred, while 12% (1 participant) was not.

Figure 21: Total number of participants identified as having a medium nutritional risk who had been referred on to a dietitian

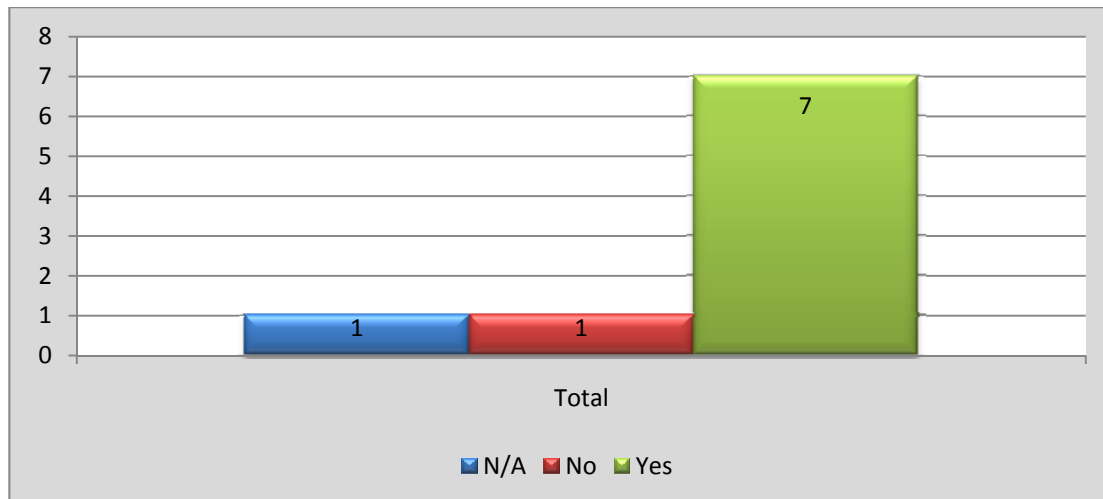


Figure 22 above shows that the rate of participants identified varied across the five HSC Trusts as detailed above. BHSCT had 100% of participants referred to the dietitian, SEHSCT Trust 67%, and SHSCT Trust 100%. Within the WHSCT the patient's risk status was recorded as having reduced to a lower risk status and therefore did not require referral onto a dietitian

Figure 22: Total number of participants identified as having a medium nutritional risk who had been referred on to a dietitian by Trust

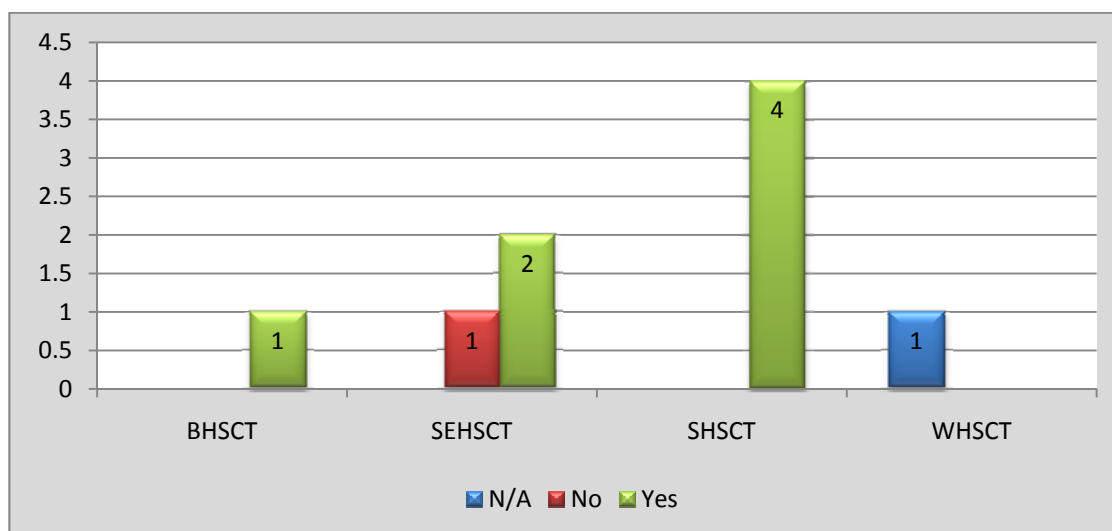


Figure 23 shows that a total of 65 participants were identified as being at high risk of malnutrition. For high risk participants 94% (61 out of 65) were referred onto dietetic staff.

Figure 23: Total number of participants identified as having a high nutritional risk who had been referred on to a dietitian

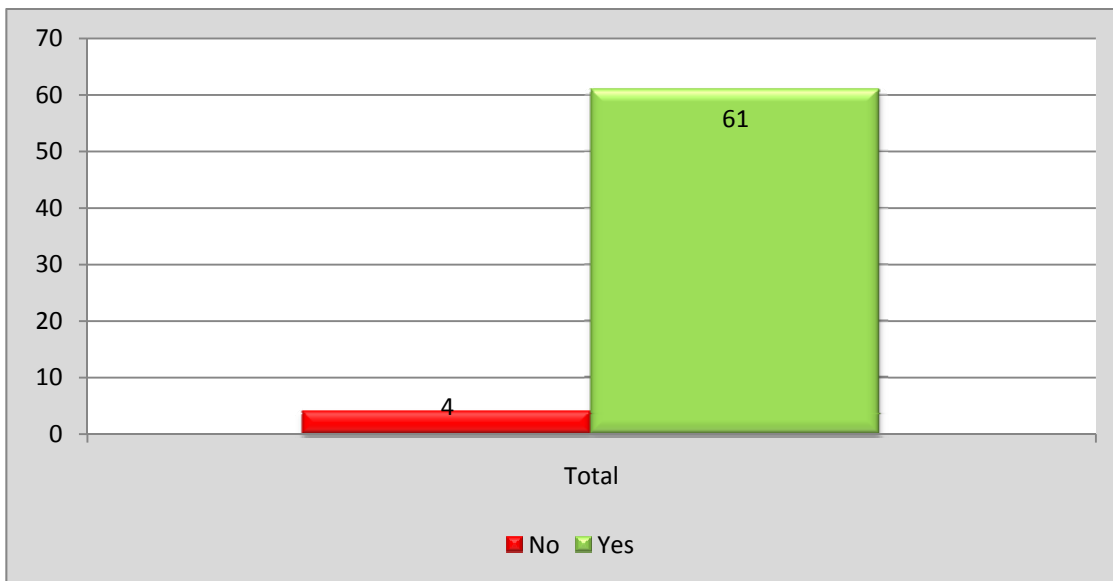
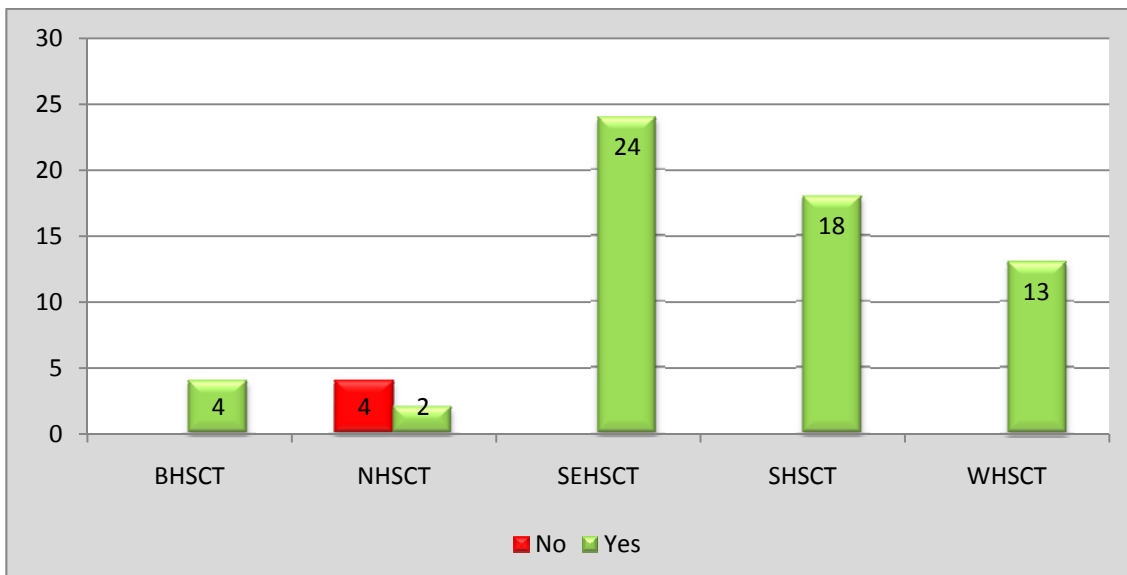


Figure 24 considers the findings for participants who had been identified as being at high risk of malnutrition and their referral to a dietitian. It was found that only 4 participants were identified that should have been referred but were not referred to a dietitian.

Figure 24: Total number of participants identified as having a high nutritional risk had been referred on to a dietitian by Trust

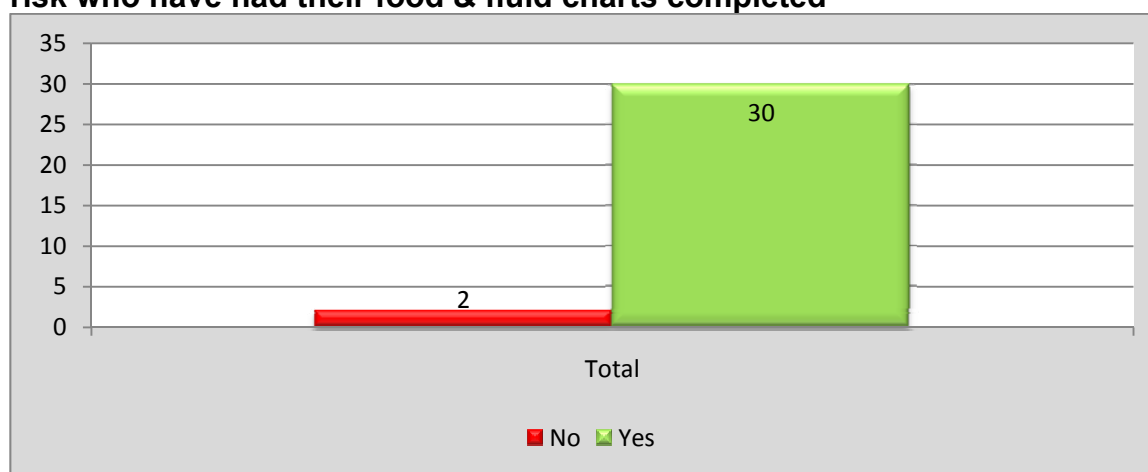


Test Standard 4: to determine the percentage of participants who have had their food & fluid charts appropriately completed

When people are identified as being at medium risk of malnutrition (Appendix 1) they should have a high protein/high energy diets ordered. Of the 37 participants identified as having medium risk of malnutrition a total of 87% (32 out of 37) had a high protein / high energy diet ordered as is recommended.

It is also recommended that a food and fluid chart should be completed. Of these 32 participants, Figure 25 shows that 94% (30 out of 32) were having their food intake monitored in food & fluid charts.

Figure 25: Total number of participants identified as having a medium nutritional risk who have had their food & fluid charts completed



Food intake monitoring varied across the five HSC trusts as shown in Figure 26 with BHSCT/WHSC/SEHSC having 100% of their participants food intake monitored.

Of the 56 participants identified as having a high risk of malnutrition, a total of 54 participants had a high protein / high energy diet recommended. Of these, the audit showed that 54 or 96% of participants had their food intake monitored in food chart.

Figure 26: Total number of participants identified as having a medium nutritional who have had their food & fluid charts completed broken down by Trust

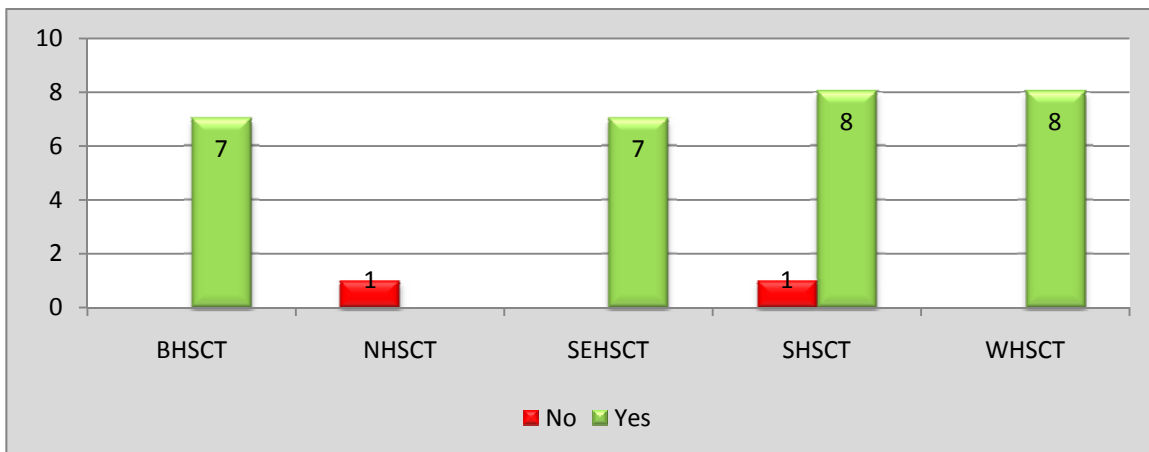
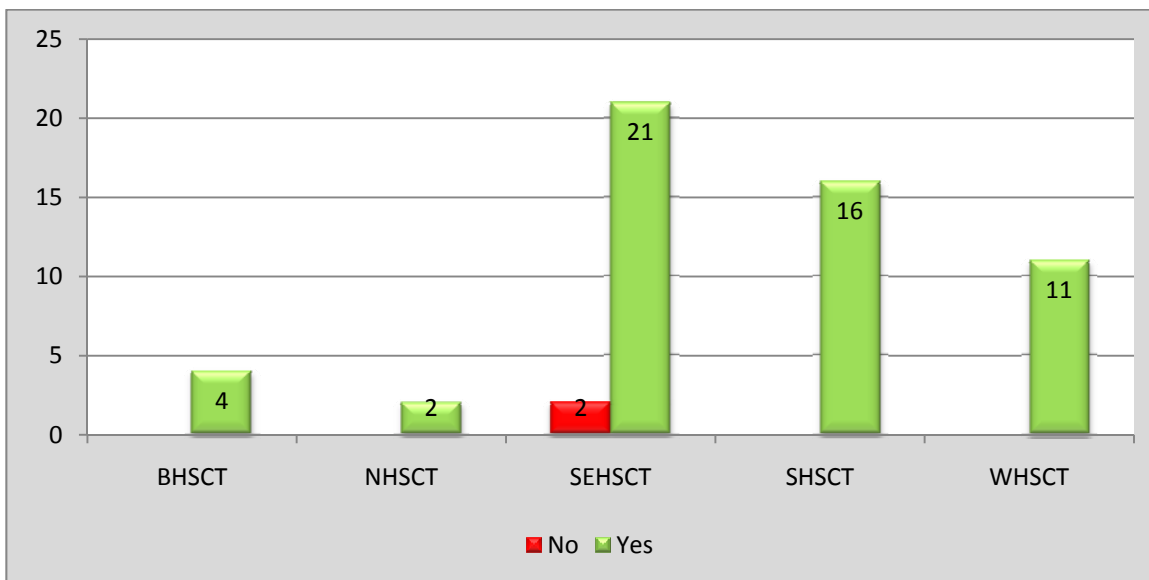


Figure 27 shows that of the five Trusts, four trusts were observed to have 100% of their participants who had been identified as having a high nutritional risk had their food charts completed appropriately.

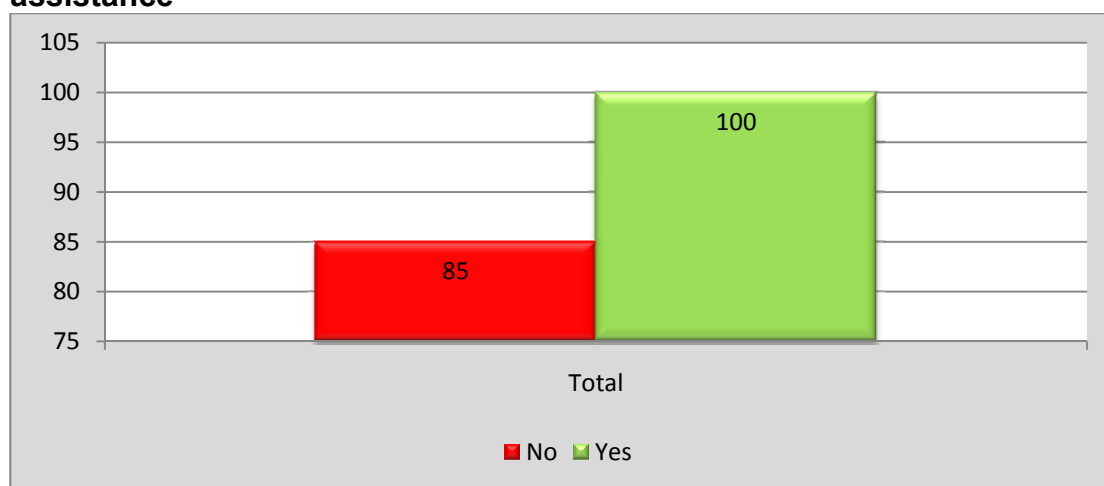
Figure 27: Total number of participants identified as having a high nutritional risk who have had their food & fluid charts appropriately completed broken down by Trust



Test Standard 5: to determine the percentage of participants who require support eating and drinking that are clearly identified

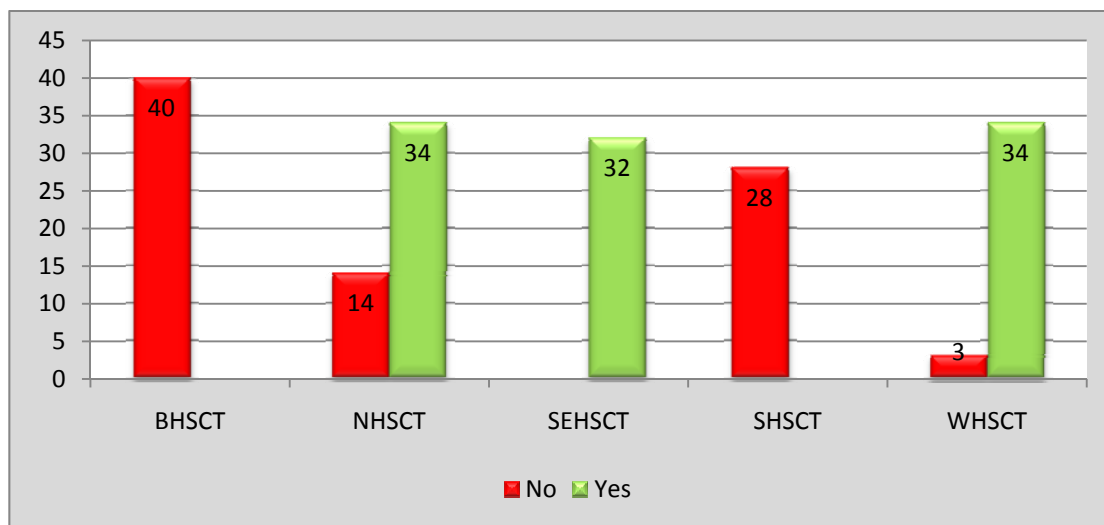
Of the total 185 participants observed , 54% (100 out of 185) of participants observed, had a system that identified them as requiring assistance with eating. These systems varied across the five HSC trusts. Systems used included the following: NHSCT use the Plate Model above each bed to identify participants who require assistance and this is broken down into participants who require full assistance, some assistance and no assistance with eating and drinking. The SEHSCT Trust use status boards to identify those who need assistance. The WHSCT Trust use red trays / Napkins to identify those who need assistance. The remaining 46% who were not clearly identified fell within the BHSCT and SHSCT. The nurse-in-charge of the wards verbally identified those participants who required support with eating and drinking.

Figure 28: Total number of participants who are clearly identified as requiring assistance



The 185 participants that were identified as requiring assistance varied across the Trusts as shown in Table above. NHSCT had 71% of participants clearly identified as requiring assistance, SEHSCT Trust 100% and WHSCT Trust 92%.

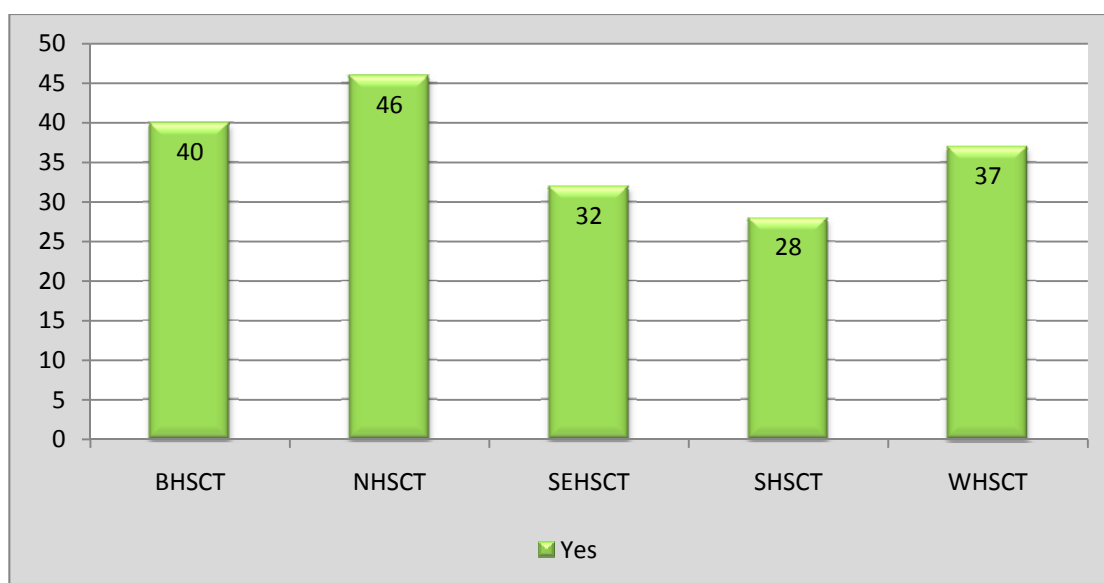
Figure 29: Total number of participants who are clearly identified as requiring assistance by Trust



Test Standard 6: to determine the percentage of participants who have been identified as needing assistance with eating and drinking who have received assistance with eating and drinking when it is required

Of the 185 participants identified as requiring full assistance with eating and drinking as Figure 33 shows, 2 participants were fasting and therefore did not require any assistance. Of the remaining 183, 100% of these participants received assistance with eating and drinking.

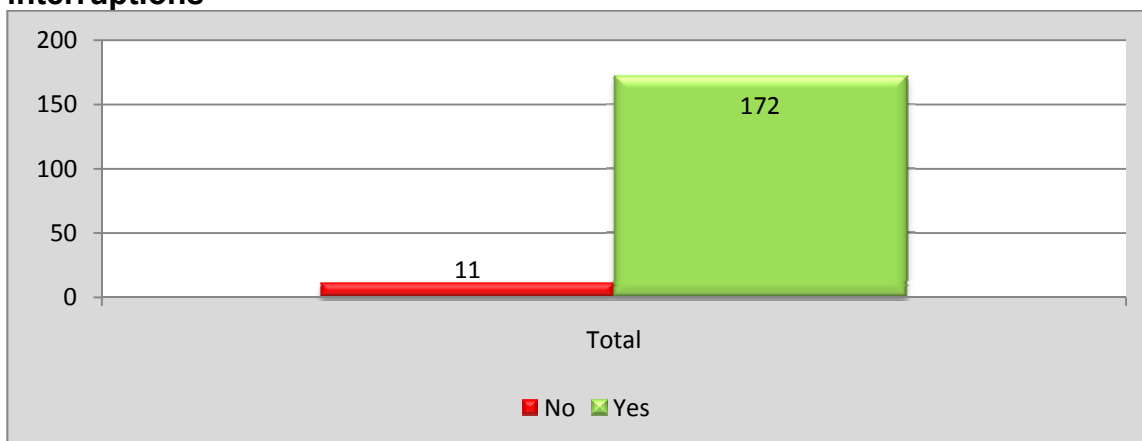
Figure 30: Total number of participants who were identified as needing full assistance eating and drinking as having received assistance



Test Standard 7: to determine the percentage of participants who had their mealtimes protected from interruptions thereby maintaining an environment conducive to people enjoying their meals and being able to safely consume their food and drinks safely

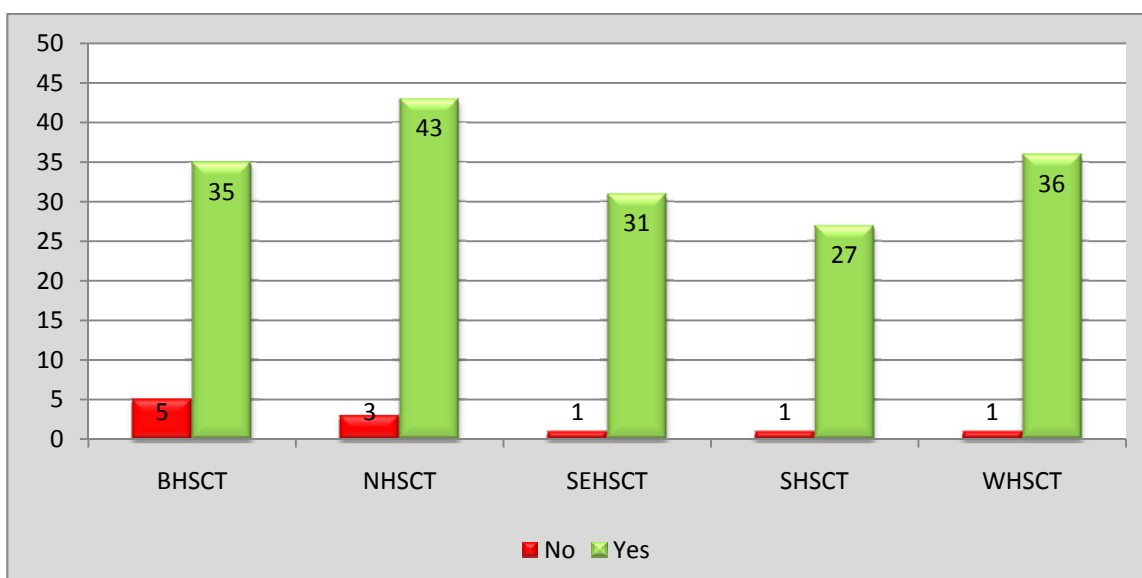
Of the 183 participants who received meals, 93% (172 out of 183) were allowed to eat without disruption. The remaining 7% (11 out of 172) were interrupted during the course of their meal.

Figure 31: Total number of participants who were allowed to eat their meals without interruptions



The number of participants who were allowed to eat their meals without interruption varied across the five HSC trusts. This ranged from 97% of participants in the WHSCT Trust to 88% in the BHSCT.

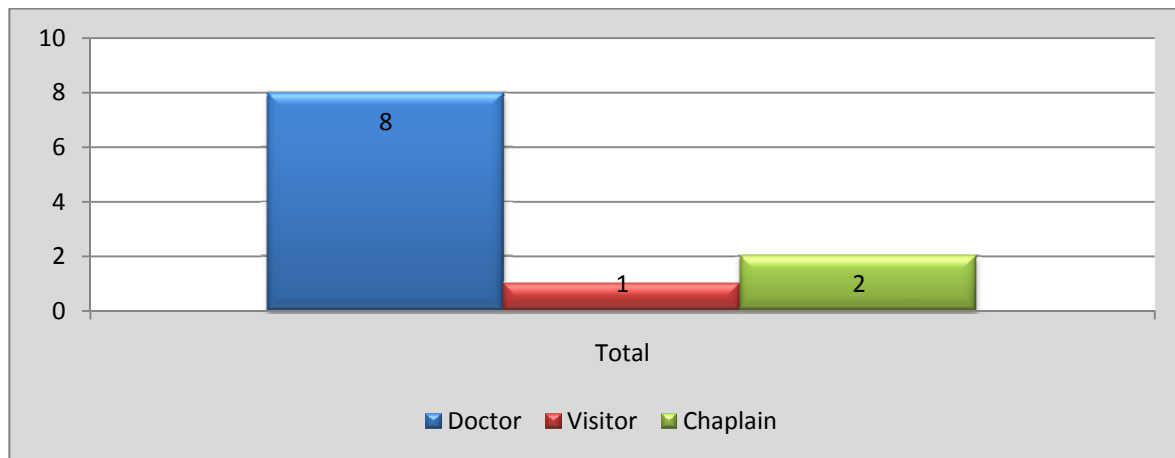
Figure 32: Total number of participants who were allowed to eat their meals without interruptions broken down by Trust



When the reason for the interruption was considered it was found that 73% of participants were interrupted by Doctors, 18% by Chaplains and 9% by visitors. The participants who

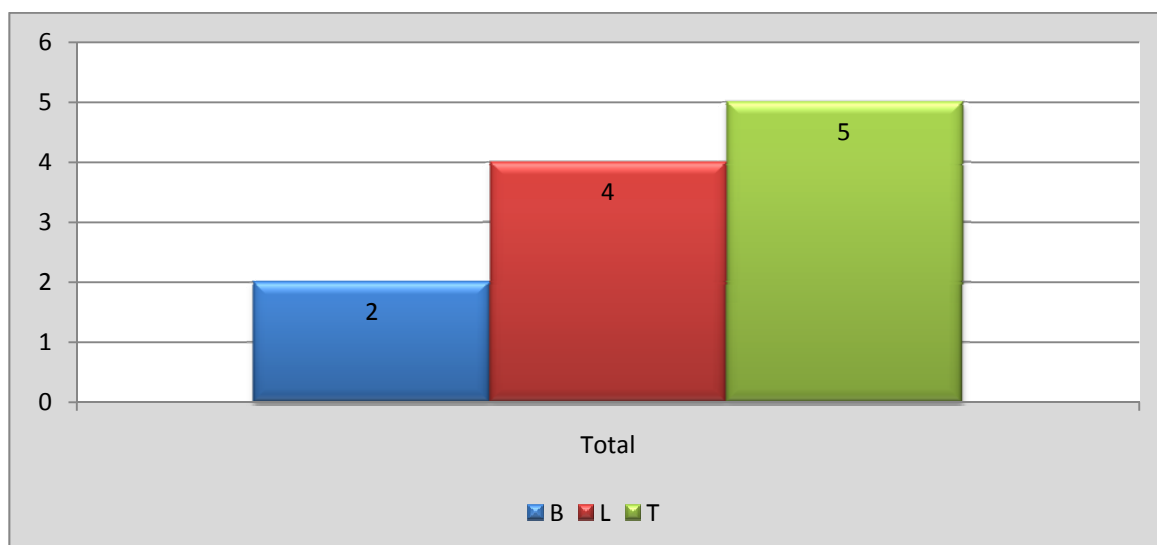
were disturbed by the Doctor had the following carried out, Medical Assessment / Examination, Blood Taken, Observation and Discussion.

Figure 33: Details of mealtime interruptions



The most common mealtime to be disturbed was the Tea Time meal, where interruptions were observed on 5 occasions (equating to 45%) compared to 4 occasions at for Lunchtime and 2 occasions for Breakfast.

Figure 34: Total number of mealtimes which interruptions occurred



Of all the 183 observations where the patient received food (2 patients were fasting), only 1 nurse in the SEHSCT was disturbed during assisting with a meal. When the reason for this considered it was observed that the nurse was being given urgent blood results for another patients under her care.

Discussion

The audit has demonstrated that, despite the implementation of the 10-a-day standards there were inconsistencies in the management of nutrition for people in hospital settings across Northern Ireland. It is clear that the participants who are inpatient within medical and care of the elderly/rehabilitation wards present with the highest need in terms of nutritional care. This group of people were found to be over 65 years of age and there was no difference in gender determined by this audit. A total of 738 case notes were audited and a further 185 observational audits were conducted on people who had been identified as requiring total assistance at mealtimes.

In terms of achievement against the DHSSPS *“Get your 10 a day! Nursing Care Standards for patient food in hospital”* for Standard 1 whilst 84% of patients had their weight recorded a total of 127 patients did not have their weight recorded. It is essential that all patients have their weight and height recorded if the HSC are to accurately identify those people who are at risk of malnutrition. There is also a need to determine consistency in terms of whether weight / height is an actual record or a recalled measure. Height and weight is used to calculate an individual BMI and is essential in determining their risk of malnutrition. If the basics are not accurate there is no accuracy in the screening result obtained.

When the findings are considered it is clear that there is a need for clarity regarding identification by the nurses of whether the patient weight has been obtained from actual weight or recalled weight. It was not known whether the participants weight was actual or recalled for 21% of participants- this could potentially lead to ambiguity for 161 people in the hospital settings across Northern Ireland. There is a real difference in accuracy in terms of actually weighing the patient and accepting the patient's weight as they have recalled it.

In terms of measurement of height overall there were greater numbers of people who did not have their heights measured than weights within the first 24 hours of admission. There were fewer heights that were actually measured than were recalled by the nurse. In comparison to the measurement of weight there were nearly double the participants who had their actual weight recorded that their height recorded.

It is important to note that when a patient did not have their weight/height recorded within 24 hours it was highly unlikely for them to be weighed or have their height measured at all.

In terms of nutritional screening using the PreMUST/MUST, whilst the majority of participants were screened (83% of participants) a significant number of 132 participants did not have this screening conducted. Again it is important to note that if this screening was not conducted within the first 24 hours it was highly unlikely that this was completed throughout the remaining of their hospital stay.

Of those who had their PreMUST screening completed 31% of participants required further screening using MUST. This figure is slightly lowered than the 40% predicted by Russel & Elia (2009)² but as the total population were not screened initially this would explain the lower than the expected figure. It is imperative that everyone is screened appropriately if we are to determine people at most risk of malnutrition.

It is important to note that 15% of participants who required that full MUST be completed did not actually have this completed. It is imperative that everyone who requires full MUST to be completed is screened appropriately if we are to determine people at most risk of malnutrition.

Of those participants who were screened using MUST the majority of participants (52%) were identified as having a low risk of malnutrition. Of note however is the fact that 30% of participants were identified as having a high risk of malnutrition.

In total 64% of those participant identified as being at risk of malnutrition had been in hospital for over 7 days. Of concern are the findings that 25% of low risk patients and 17% of participant with medium risk were not rescreened as directed following 7 days. If we are to manage people's nutritional needs it is imperative that risk screens are completed as directed by the experts within this field.

In addition to the need for appropriate screening, the DHSSPS "*Get your 10 a day! Nursing Care Standards for patient food in hospital*" clearly stated that people should have a care plan which identifies how their needs should be met. It is a positive finding that 89% of participants had a documented care plan. There is a need to ensure however that consideration is given to the 11% of participants who did not have this care plan in place. It is imperative that where care is required that all people have a care plan in place.

For people at a high risk of malnutrition to receive care from a dietitian a referral for that care should be made by the nurse. On four occasions this referral was not made. It is imperative that all people identified as having a risk of malnutrition are referred to the dietitian.

For those people who required food monitoring the audit demonstrated positive results and the majority of people did have their food and fluid intake monitored.

In terms of supporting people who required assistance with eating and drinking the audit results were positive. There was some potential to improve the way in which patients were identified as needing assistance but for those people who were identified as needing full assistance 100% of people received the assistance they required.

The DHSSPS "*Get your 10 a day! Nursing Care Standards for patient food in hospital*" clearly states that people should have their mealtimes protected from interruptions. The audit findings report that only 7% of people who needed total assistance experienced interruptions to their mealtime.

The most common person to interrupt this mealtime was the Doctor and a range of interventions were observed taking place. It was not possible to infer if this intervention was an appropriate or inappropriate intervention. The most common mealtime to be interrupted was the tea time meal which is often the most important mealtime in the hospital mealtime schedule.

Conclusion

To some extent, some of the findings from this audit of nutritional care echo those of earlier research¹⁷ which identified the key responsibilities of nurses for nutritional care: namely, assessment (screening), monitoring and referral for specialist assessment where appropriate, the promotion of good nutritional care by managing mealtimes, and enhancing the mealtime environment. Nutritional care has been defined as being:

“A co-ordinated approach to the delivery of food and fluid by different health professionals [that] views the patient as an individual with needs and preferences”¹⁸

Current practice related to the management of nutrition for people in hospital settings varies across Northern Ireland. Aspects of good practice and areas for improvement have been identified from the completed audit. Despite initiatives to improve their experience of eating in hospital, patients' nutritional needs could be better met of the standards inherent within the DHSSPS *“Get your 10 a day! Nursing Care Standards for patient food in hospital”*. Areas of improvement include the nutritional assessment, nutrition care plans and accuracy of monitoring (such as the recording of food intake or weight and height).

Limitations of this audit

Within the audit several assumptions have been made which must be noted to ensure appropriate interpretation of the results as follows:

1. PreMUST/MUST measures have been completed accurately
2. Actual weights and heights have been accurately measured and recorded
3. Recall weights / heights are often incorrect
4. BMI calculations are correct
5. Referrals to the dietitians have been made
6. Food charts are accurately completed
7. Participants have been correctly identified as needing assistance with eating and drinking

Recommendations

1. All participants should have their height and weight measurements carried out as soon as reasonably possible following contact with health & social care professionals.
2. To ensure accuracy, height and weight should be taken as an actual measurement as far as possible. Recalled weight should only be used if the participant's clinical condition does not allow actual weight to be obtained.
3. Staff should ensure that if a risk is identified in the Pre MUST screening then the full MUST should be completed. Adversely if NO risk is identified then the full MUST should not be completed.
4. Rescreening should be carried out on a weekly basis for those participants who are in hospital for more than 7 days.
5. A documented care plan should be completed for each patient that has an identified nutritional risk.
6. For people who are identified at high risk they must have a referral made to the dietitian.
7. Participants where possible, should have an input into their nutritional care plan. This input should be documented in their care plan.
8. While this audit focuses on the nurse's role, nutritional management of people in hospital is multidisciplinary in nature. Further audits should consider the role of all health and care staff within the hospital setting.
9. Further research should be conducted in other health and social care settings.
10. All trusts should have a method in place to identify if a patient requires assistance and this information should be up to date and accurate.
11. Staff should ensure that where a protected mealtime policy exists then this is enforced, where none is in existence then consideration should be given as to implementing a policy.
12. Whilst it is recognised that medical assessments are required throughout the day. Where possible assessments should be carried out outside mealtimes unless totally necessary.
13. Again it is recognised that doctors are busy. Ward rounds should not be carried out during mealtimes.
14. All unnecessary activity, whether medical or non-medical, should cease during meal times.

REFERENCES

1. Department of Health, Social Services & Public Safety (2011) *Promoting Good Nutrition - A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016*. Belfast: DHSSPS
2. Russell CA. & Elia M. (2009) *Nutrition Screening Survey in the UK in 2008*. Available from http://www.bapen.org.uk/pdfs/nsw/nsw_report2008-09.pdf
3. Elia M, Russell CA (eds.)(2009) *Combating malnutrition: Recommendations for Action. A Report from the Advisory Group on Malnutrition*, led by BAPEN. Redditch: BAPEN
4. National Institute of Clinical Excellence (2006) *Nutrition Support in Adults: oral nutrition support, enteral tube feeding and parenteral nutrition CG32*. London : NICE
5. Department of Health, Social Services & Public Safety (2007) *Get your 10 a Day, The Nursing Care Standards for Patient Food in Hospital* Available from www.dhsspsni.gov.uk/food_standards-10_a_day.pdf.
6. British Association for Parental and Enteral Nutrition (BAPEN)(2003) *Press Release: Backgrounder 2: Malnutrition and the Wider Context*. Available from www.bapen.org.uk/res_press_rel9.html
7. British Association for Parental and Enteral Nutrition (BAPEN) (2008) *Nutrition Screening Survey and Audit of Adults on Admission to Hospitals, Care Homes and Mental Health Units*. Available from www.bapen.org.uk
8. British Association for Parental and Enteral Nutrition (BAPEN) (2007) *Organisation of food and nutritional support in hospitals*. Available from www.bapen.org.uk
9. Age Concern (2006) *Hungry to be Heard. The scandal of malnourished older people in hospital*. London: Age Concern
10. Healthcare Commission (2007) *Inpatients Survey*. Available from www.healthcarecommission.org.uk
11. National Institute for Health and Clinical Excellence (2006) *Nutrition support in adults. Clinical guideline 16*. London : NICE
12. British Association for Parental and Enteral Nutrition (BAPEN)(2008) *The cost of disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults*. Available from www.bapen.org.uk/pdfs/health_econ_exec_sum.pdf
13. Department of Health (2007) *Improving Nutritional Care: A joint Action Plan from the Department of Health and Nutrition Summit stake holders*. London: Department of Health
14. Council of Europe Resolution ResAP(2003)3 on food and nutritional care in hospitals. Available from <https://wcd.coe.int/ViewDoc.jsp?id=85747>

15. Royal College of Nursing (RCN)(2006) *Nutrition Now Campaign*
www.rcn.org.uk/newsevents/campaigns/nutritionnow. London: RCN
16. Elia M, Zellipour L. & Stratton, RJ. (2005) To screen or not to screen for adult malnutrition? *Clinical Nutrition*, 24, (6), 867-884.
17. Harris G, Bond P (2002) Nutritional care for adults in hospital. *Nursing Times*, 98 (31): 32-33.
18. NHS Quality Improvement Scotland (2003) *Food, fluid and nutritional care*. Clinical Standards. Glasgow: NHS Quality Improvement Scotland.

Glossary

Actual Weight	This is the participant's weight taken on a set of scales
Recalled Weight	This is the participant's weight as reported by themselves or by a relative
Actual Height	This is the participant's height as measured by a measuring tape or other form of measuring tool eg using ulna measurement
Recalled Height	This is the participant's height as reported by themselves or by a relative
Routinely Measured	This refers to the participant's height, either actual or recalled
Pre MUST	This is screening tool used to determine if a full MUST Screening should be completed
MUST	This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
Care Plan	This is a written statement of an individual's assessed needs.
Low Nutritional Risk	This is an individual whose MUST Score is 0
Medium Nutritional Risk	This is an individual whose MUST Score is 1
High Nutritional Risk	This is an individual whose MUST Score is ≥ 2
Full Assistance	This is where a participant required a nurse or a family member to help them with all aspects of their meal



PreMUST/MUST DOCUMENTATION

<Addressograph>

Complete on admission: Date

Height.....m Actual ☐ or Recalled ☐

Weight.....kg Actual ☐ or Recalled ☐

BMI

PRE-MUST QUESTIONS:

Does the patient have :-

DATE			
1. A history of recent weight loss	Yes / No	Yes / No	Yes / No
2. Altered/decreased appetite for 7 days or more	Yes / No	Yes / No	Yes / No
3. A risk of under nutrition due to current illness e.g. difficulty eating/drinking	Yes / No	Yes / No	Yes / No
4 A need for assistance with feeding	Yes / No	Yes / No	Yes / No
5 A BMI less than 18.5 on admission	Yes / No	Yes / No	Yes / No
SIGNATURE			

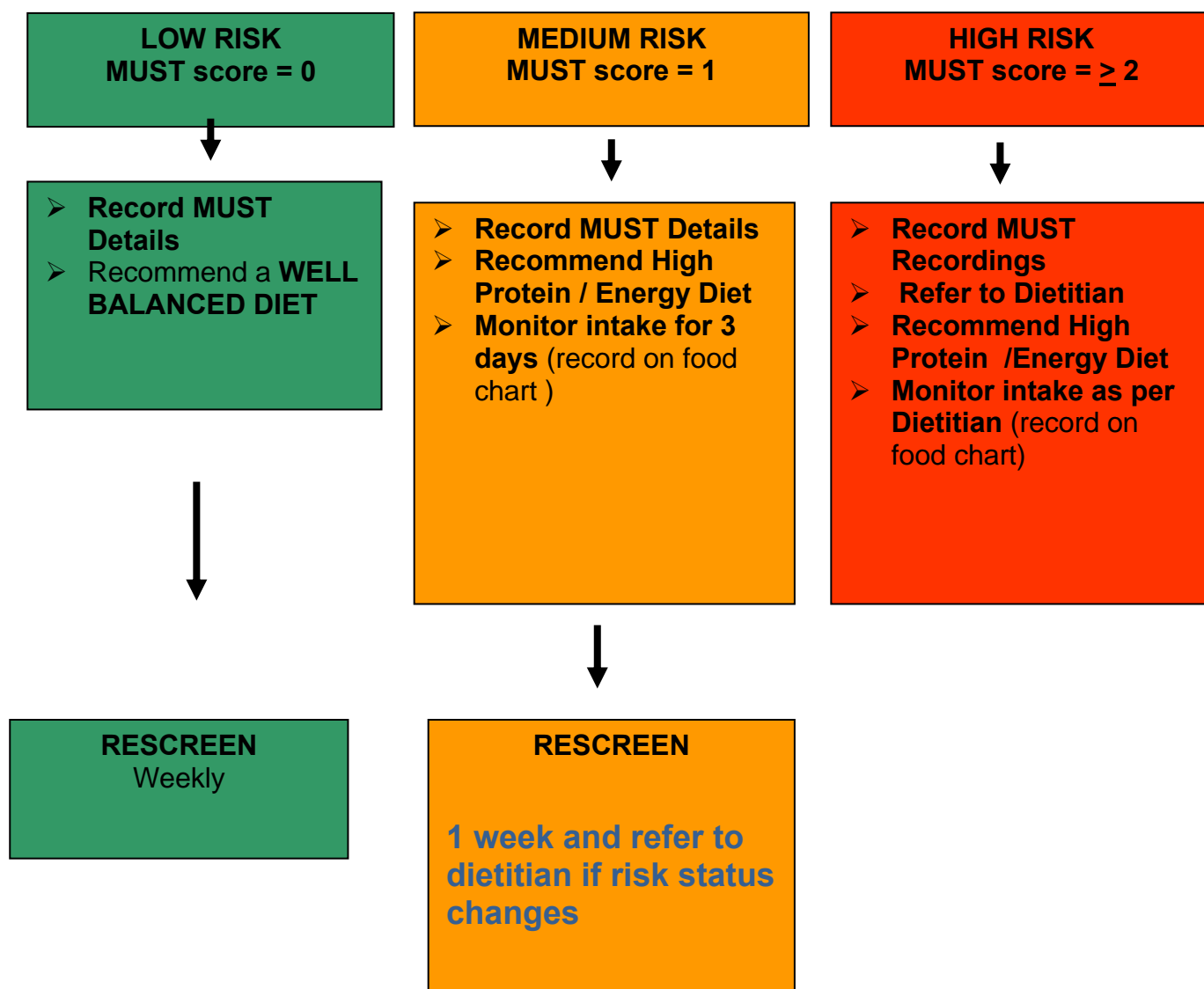
If answer is No to all of the above questions repeat screening weekly

If answer is yes to any of the above questions then complete 'MUST' below. Also repeat weekly

Date			
Weight (Kg) / MUAC (cm)			
Height (m) / Ulna length (cm)			
BMI			
	Score	Score	Score
STEP 1 BODY MASS INDEX-BMI			
• Over 20	0	0	0
• 18.5 to 20	1	1	1
• Less than 18.5	2	2	2
STEP 2 UNPLANNED WEIGHT LOSS IN LAST 3-6 MONTHS			
• Less than 5%	0	0	0
• Between 5-10%	1	1	1
• More than 10%	2	2	2
STEP 3 ACUTE DISEASE	2	2	2
• If patient is acutely ill AND there has been OR is likely to be no nutritional intake for more than 5 days			
TOTAL MUST SCORE: Low Risk =0 Medium Risk =1 High Risk ≥2			
SIGNATURE:			

Does the patient require assistance to maintain nutrition and hydration Yes / No

Malnutrition Universal Screening Tool (MUST) Flowchart



The Nursing Care Standards for Patient Food in Hospital

These are the standards as set out in “Get your 10 a day! The Nursing Care Standards for Patient Food in Hospital”.

Standard 1: All participants admitted to hospital are screened for risk of malnutrition.

Standard 2: Following screening by nurses, participants who are identified as malnourished or at risk of malnutrition are referred for and receive a nutritional assessment appropriate to their level of need.

Standard 3: Participants who require nutritional intervention will have a nursing care plan devised, implemented, evaluated and renewed to reflect the patient’s nutritional and physical care needs and which documents both the dietetic plan and the nursing care assessment.

Standard 4: Participants who require food and/or fluid intake to be monitored will have that activity carried out in a way that is informative, accurate and up-to-date.

Standard 5: Participants who require support with eating and drinking are clearly identified.

Standard 6: Participants who require support with eating and drinking receive assistance when it is required.

Standard 7: Participants will be served their food and allowed to eat their meals without disruption.

Standard 8: Participants receive their meals in a physical environment that is conducive to enjoying their food.

Standard 9: Participants are offered a replacement meal if they miss their meal for whatever reason and can access snacks at ward level.

Standard 10: The patient receives food presented in a way that is appealing and appetising.

Aspect 1:	Receiving a meal
------------------	-------------------------

Q.	Question	Pat. No: 1		Pat. No: 2		Pat. No: 3		Pat. No: 4		Pat. No: 5		Pat. No: 6	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Did patient receive a meal?												
2	If No is there a reason for the patient not receiving a meal i.e. fasting												

Aspect 2:	Assistance with eating
------------------	-------------------------------

Q.	Question	Pat. No: 1		Pat. No: 2		Pat. No: 3		Pat. No: 4		Pat. No: 5		Pat. No: 6	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Are people who need help to eat and drink readily identified e.g. plate completed above bed, red tray, status board												
2	Full assistance required												
	Some assistance required												
3	If the patient required assistance did they receive this?												
4	If NO please record what you observed e.g. could not reach food, not helped to sit upright etc												

Aspect 3:	Eat meals without disruption.
------------------	--------------------------------------

Q.	Question	Pat. No: 1		Pat. No: 2		Pat. No: 3		Pat. No: 4		Pat. No: 5		Pat. No: 6	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Was the patient allowed to eat their meals without disruption												
	If NO please indicate												
2	who disturbed them												
3	Why they were disturbed												
4	Was unnecessary activity on the observational area reduced during mealtimes												
5	If no please indicate what activity was being undertaken e.g. ward round, medication administration, other staff activity, other												
6	For the patient receiving assistance from the nurse, did the nurse get interrupted												
	If YES please indicate												
7	who disturbed them												
8	Why they were disturbed												

QUESTIONNAIRE 2: CASE NOTE / RECORD REVIEW FORM

Hospital Code		Ward	
----------------------	--	-------------	--

Case Note Number		Gender	M / F	Age Range	16 - 39	40 - 64	65 +
-------------------------	--	---------------	--------------	------------------	----------------	----------------	-------------

Section 1: All participants admitted to hospital are screened for malnutrition

Q	Weight	Yes	No	Actual	Recalled
1	Was the patient initially weighed within 24 hours of admission?				

Yes No

2	Was the patient initially weighed more than 24 hours after admission?			Actual	Recalled
		Record Time from Admission			

Yes No

3	Has the patient been in hospital for more than 7 days?				
---	--	--	--	--	--

Q	Height	Yes	No	Actual	Recalled
1	Was the patient's height recorded within 24 hours of admission?				

Yes No

2	Was the patient's height initially recorded more than 24 hours after admission?			Actual	Recalled
		Record Time from Admission			

Q	PRE-MUST / MUST Nutrition Screening	Yes	No		
1	Was the participants' pre-MUST nutrition screening completed within 24 hours of admission?				

Yes No

2	Was the participants' pre-MUST nutrition screening form completed more than 24 hours of admission?				
		Record Time from Admission			

3	Record the results of the MUST Screening form?			No to all Questions	Yes to one question

Yes No

4	Was the MUST tool fully completed for the patient?				
---	--	--	--	--	--

Section 2: MUST TOOL

Q	MUST TOOL	Yes	No	Notes
1	Was the patient deemed to be low risk?	<input type="checkbox"/>	<input type="checkbox"/>	
2	If “Yes” Is there evidence that a well-balanced diet has been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
3	Has the patient been in hospital for > 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	
3a	If “Yes” to Q3, is there evidence that the patient has been rescreened weekly	<input type="checkbox"/>	<input type="checkbox"/>	
4	Was the patient deemed to be medium risk?	<input type="checkbox"/>	<input type="checkbox"/>	
5a	If “Yes” to Q4, Is there evidence that a high protein / energy diet has been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
5b	Is there evidence that the participants' intake has or is being monitored for 3 days (food chart)	<input type="checkbox"/>	<input type="checkbox"/>	
6	Has the patient been in hospital for >7 days?	<input type="checkbox"/>	<input type="checkbox"/>	
7	If “Yes” to Q6, is there evidence that the patient has been rescreened after 1 week?	<input type="checkbox"/>	<input type="checkbox"/>	
8	Is there evidence that the participants' risk status has been changed?	<input type="checkbox"/>	<input type="checkbox"/>	
9	If “Yes” to Q8, is there evidence that the patient has been referred to the dietitian?	<input type="checkbox"/>	<input type="checkbox"/>	
10	Was the patient deemed to be high risk?	<input type="checkbox"/>	<input type="checkbox"/>	
11a	If “Yes” to Q10, Is there evidence that the patient has been referred to the dietitian?	<input type="checkbox"/>	<input type="checkbox"/>	
11b	Is there evidence that a high protein / energy diet has been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
12	Has the Dietitian recommended that patient's intake is monitored for 3 days?	<input type="checkbox"/>	<input type="checkbox"/>	
12a	If “Yes” to Q12, is there evidence that this has or is being monitored?	<input type="checkbox"/>	<input type="checkbox"/>	

Section 3: Recording and Record Keeping

		Yes	No	Notes
13	Where a nutritional risk (low, medium, high risk) is identified, is there a documented care plan?	<input type="checkbox"/>	<input type="checkbox"/>	
14	Is there evidence that the patient has had an input to their care plan	<input type="checkbox"/>	<input type="checkbox"/>	

Steering Team

Membership of the Get your 10 a Day Audit Steering Team

Name	Designation	Trust
Chairperson		
Dr Marina Lupari	Assistant Director Nursing – Research & Development	Northern HSC Trust
Members		
Mary Burke	Head of Medicine and Emergency Care	Southern HSC Trust
Rita Devlin	Senior Professional Development Officer	Royal College of Nursing
Anne Gormley	Lead Dietitian	Western HSC Trust
Bernadette Gribben	Senior Manager Nursing, Person-centred Care	Belfast HSC Trust
Lucy Hull	Nutrition and Dietetics Services Manager	Belfast HSC Trust
Ruth McDonald	Assistant Clinical & Social Care Governance Manager	Northern HSC Trust
Hilary Mathieson	Acting Dietetic Manager - Acute services	Southern HSC Trust
Ann Mills	Nursing Officer	DHSSPSNI
Pauline Mulholland	Lead Dietitian	South Eastern HSC Trust
Marian Murphy	Lead Nurse for Governance and Performance Nursing Directorate	Western HSC Trust
Elinor Welch	Lead for Person Centred Practice	South Eastern HSC Trust
Jonathan Wright	Project Facilitator	Northern HSC Trust

Further copies of this guideline can be obtained
by logging on to the GAIN Website.

www.gain-ni.org

GAIN Office
DHSSPS
Room C4.17
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Telephone: (028) 90520629