Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Nutrition and Hydration Policy for Adults in Hospital

This procedural document supersedes:
PAT/T 43 v.1 – Nutrition and Hydration Policy for Adults in Hospital.

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Executive Sponsor(s)	Karen Jessop – Chief Nurse
Author/reviewer: (this version)	Lizzie Shaw, Nutrition and Dietetics Manager
Date written/revised:	Januaury 2023
Approved by:	Nutrition Steering Committee and Policy Approval and Compliance Group (on behalf of the Patient Safety Review Group)
Date of approval:	March 2023
Date issued:	April 2024
Next review date:	January 2026
Target audience:	Trust wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	April 2023	• British Dietetic Association Digest added to Purpose • Section on mouthcare added • Section on Managing a nil by mouth patient added • Section on managing refeeding syndrome added • Governance Structure amended • Water jug appendix added • Therapeutic and cultural diet codes updated • Roles and responsibilities updated • Monitoring and compliance section ammended	Lizzie Shaw
Version 2	July 2019	• Updated and transferred to new style format. • Removal of reference to The Practical Guide to Nutrition Support for Adults PAT/T 35 v.2. (withdrawn) • Removal of reference to PAT/PA 16, Protected Mealtimes Policy (withdrawn) • Addition of Making Mealtimes Matter • Reference to nutritional screening in pregnancy and critical care • Additional information regarding discharge of patients at risk of malnutrition • Additional information regarding discharge of patients on Tube feeds. • Update of monitoring and compliance • Update of reference list • Update on fluid balance charts	Sophie Hempsall
Version 1 – PAT/T 43 v.1 (**Transferred**	June 2013	• Changed sections from 'Patient Administration' to 'Treatments/ Investigations' section. • Updated and transferred to new style	Vera Todorovic

from a Patient Administration policy to a Treatment policy)		format.	
Version 1 – PAT/PA 25 v.1 **(Originally a Patient Administration policy)**	May 2008	This is a new policy, please read in full.	Vera Todorovic

Contents

Page No.

1 INTRODUCTION

Providing patients with optimal nutritional care is an integral part of their treatment and provision of appropriate food and fluids to meet their needs is essential to maximise individual health outcomes.

Malnutrition has the potential to affect the whole hospital population and can adversely affect clinical outcomes for patients.

Hospitals have a duty to ensure that appropriate systems and processes are in place to both identify and manage patients at risk of malnutrition as well as ensuring that all patients have access to nutrition and hydration appropriate to their needs.

2 PURPOSE

The purpose of this policy is to highlight the processes involved in optimising the nutritional care of patients during their hospital stay.

2.1 Rationale for Optimising the Nutritional Care of Hospital Patients

Addressing poor nutritional care of patients is highlighted as a priority in several key national documents and the Trust is committed to ensuring that all the recommended standards and guidance are addressed. The following documents provide the framework within which the Trust is working to improve the nutritional care of its patients.

- NICE CG32 NICE Guidance on Nutrition Support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition (2006) Updated August 2017
- NICE QS24 NICE Quality standard 24: Quality standard for nutrition support in adults (2012)
- Care Quality Commission (CQC): Outcome 5 Nutrition, Regulation 14
- Essence of Care: Nutrition Benchmark (2010)
- 10 key characteristics of good nutritional care in hospitals. Council of Europe Resolution on Food and Nutritional Care in Hospitals (2007)
- Acute kidney injury: prevention, detection and management. NICE Guideline 148 (2019)
- Patient Led Assessment of the Care Environment PLACE (2019). Assessments relate to provision of safe and appropriate food and drink for patients and assistance

when required at mealtimes within an environment conducive to eating and drinking.

- A Toolkit to support the development of a hospital food and drink strategy (2016)
- Report of the independent view of NHS Hospital Food (2020)
- British Dietetic Association Digest (2017)

2.2 Prevalence of Malnutrition is Common in the Hospital Setting

According to NICE (CG 32, 2006) a person is defined as being malnourished if they have:

- A body mass index (BMI) of less than 18.5kg/m2
- Unintentional weight loss greater than 10% within the last 3 -6 months
- A BMI of less than 20kg/m2 and unintentional weight loss greater than 5% within the past 3 – 6 months

It has been estimated that at any one time more than 3 million people in the UK are at risk of malnutrition (undernutrition), yet it continues to be an under-recognised and under-treated problem. Furthermore, the public health expenditure on disease-related malnutrition in the UK in 2007 was calculated to be in excess of £13 billion per annum, about 80% of which was in England [1]. This is a heavy burden and cost to bear not only for individuals, but for health and social care services, and society as a whole.

It is estimated that 28-34% of patients coming into hospital are undernourished [3,4,5.]

One third (32%) of people aged 65 years or over are at risk of malnutrition on admission to hospital[5].

Data from studies in outpatient clinics suggests that 16-21%of patients are at risk of malnutrition (medium and high risk calculated from using the Malnutrition Universal Screening Tool 'MUST') with those at risk experiencing significantly more hospital admissions and significantly longer length of hospital stay [3,4,5] .

Malnutrition can arise at all ages from a wide range of acute and chronic diseases, as well as psychosocial factors (e.g. social isolation, bereavements.) The most vulnerable nutritionally at risk groups include those with chronic diseases, the elderly, those recently discharged from hospital, and those who are poor or socially isolated.[1,2]

With severe acute diseases, there is rapid loss of appetite, weight and body function. It may take weeks or months for full recovery, partly because of inadequate nutrition.

Weight loss usually begins before admission, deteriorates further in hospital, and may continue to deteriorate for a period after discharge from hospital.

Malnutrition can detrimentally affect virtually every system of the body. Randomised controlled studies and meta-analyses suggest that nutritional support of undernourished individuals can reduce mortality, complications after illness, length of hospital stay, readmission rates to hospital, decrease costs of care and improve well-being.[6]

2.3 Obesity

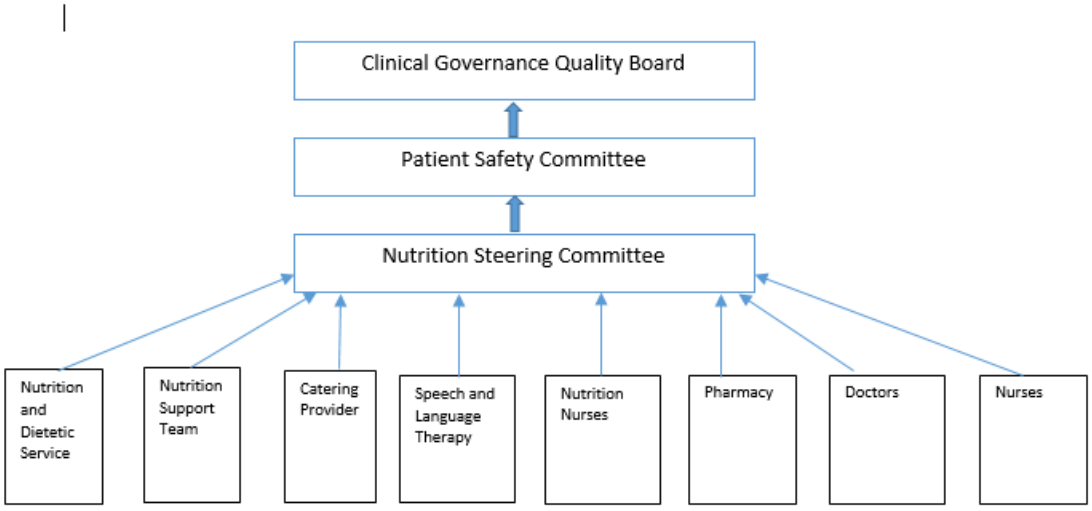
Obesity is a major clinical and public health issue and for patients in hospital this can adversely affect clinical outcomes. Identifying individuals who fall into this category and providing them with help and support at an appropriate time in their clinical care is an important role of the healthcare professional.

3 ROLES AND RESPONSIBILITIES IN THE PROVISION OF NUTRITION

Key responsibilities and duties of staff

Delivering excellent nutritional care to patients that are being cared for is a complex process and relies on good co-ordination. Standards of care need to be set, acted upon, audited and monitored and all staff within the Organisation have some responsibility to ensure that this happens.

Nutritional support therefore needs to be delivered via catering, ward nurses and the patient's medical team, supported by specialist advice and an authoritative, specialist-derived management structure which fosters excellence and responsiveness to external drivers.



Summary of local key responsibilities relating to the organisation of the Trust's nutritional services

Key groups	Role
Chief Executive and Trust executive team	Ensure that a robust strategic nutrition action plan is in place for the Trust, together with appropriate governance structures to ensure that standards of nutritional care are met and that risk management issues are addressed.
Nutrition steering committee	Develop strategic nutrition action plans for the Trust together with annual work plans and work streams and responsible for co ordinating the nutrition element of the inpatient quality accreditation tool.
Clinical governance committee	Ensure that the outputs and outcomes from the nutrition steering committee are discussed and appropriate action taken where needed.
Nutrition link nurses	Act as the champions and leads relating to the nutritional care of patients at ward level. Ensure that the operational action plans developed are in place at ward level and that staff are routinely trained and updated in the relevant processes.
Matrons	Ensure our patients receive safe and effective care at all times through audit and visibility and development of operational nutrition action plans.
Ward Manager	Ensure wards have a representative link nurse, ensure staff are released for nutrition related training, ensure compliance with nutrition related policies and initiatives such as Making Mealtime Matter.
Dietitians	Dietitians are the principal source of evidence-based information on food and nutrition and are important contributors and leaders of the nutritional care process. They provide nutritional advice and expertise for patients and staff in all units of the hospital, including catering and lead on the development of nutrition education and training programmes.
Nutrition Clinical Nurse Specialist	Manage and supportwards with patients receiving enteral and parenteral nutrition. Provide expertise in enteral feeding tube placement and management. Co-ordinate the nutrition link nurse programme and orivde education on enteral and parenteral nutrition across the Trust.

Catering	Supporting the governance of nutritional support provided by outside caterers.

Pharmacy	Input to nutritional care of patients via ward pharmacists, procurement and drug advisory services. Advise on parenteral nutrition composition and compatibilities and ensuring aseptic processes for preparation are adhered to. Advise on drug delivery via enteral tubes and on drug-nutrient interactions. Key role in monitoring and auditing compliance within these feeding systems.
Speech and Language Therapy	Responsible for the assessment and management of patients with oropharyngeal dysphagia and assist in the facilitation of communication for patients with communication impairment during mental capacity assessments to support feeding decisions.
Patients and Governors	Patients should be encouraged to take a positive approach to improving their nutrition and should be given information about what to expect and what to ask about when they come into hospital. Patients are represented by Governors through the Nutrition Steering Committee.

4 PROCEDURE

4.1 Nutritional Screening and Assessment

Nutritional screening is the first step in identifying patients who may be at nutritional risk or potentially at risk and benefit from appropriate nutritional intervention. It is a rapid, simple and general procedure used by nursing, or medical staff at first contact with the patient so that clear guidelines for action can be implemented.

The 'Malnutrition Universal Screening Tool' ('MUST') is incorporated into the assessments series on Nerve Centre

100% of inpatients over 18 years old should be screened within 24 hours of admission to the ward.

100% of inpatients over 18 years old should be screened following transfer between wards.

Children up to the age of 18 should be screened using the Paediatric Yorkhill Malnutrition Score (2008) and are not within the scope of this policy.

Patients are categorised as low (MUST 0), medium (MUST 1), high risk (MUST 2-3) or very high risk (MUST 4+). Nutritional care plan for individual patients based on their MUST score are shown on Nerve Centre when screening is completed.

In pregnancy, pre pregnancy BMI measurements of weight and height before pregnancy (or during early pregnancy) can be used to estimate pre pregnancy BMI. Mid upper arm circumference changes little during pregnancy and can be used to establish BMI. Weight change; gains < 1kg (<0.5kg in the obese) or >3kg per month during the 2nd and 3rd trimester generally require further evaluation[2.]

Patients admitted to the Department of Critical Care should have a nutritional assessment completed or an initial hospital admission MUST can be used as an initial screening.

Nutritional assessment is a more detailed, more specific, and in-depth evaluation of a patient's nutritional state carried out by the Dietitian. The assessment process allows more specific dietary care plans to be developed by the Dietitian for the individual patient. The management guidelines in the Trust's combined risk screening and assessment document indicate at what stage the Dietitian should be contacted for advice.

Patients who require a more detailed nutritional assessment will be referred to the Nutrition and Dietetic Service via the Nursing Metrics dashboard.

4.2 Provision of Food, Fluid and Nutrition to Patients

The therapeutic role of food within the healing process cannot be underestimated and food and the service of food and drink is an essential part of a patient's treatment.

Most patients coming into hospital are able to manage their normal diet and fluids during their hospital stay. Some patients however need additional nutritional support to help meet their nutritional requirements and this could be provided by

- Energy Dense menu choices, denoted by E on hospital menu
- Use of snacks and /or oral nutritional supplements (ONS)
- Enteral tube feeds e.g. via Nasogastric tube (NG), Nasojejunal tube (NJ) or percutaneous endoscopic gastrostomy (PEG) or other gastrostomy tube
- Parenteral nutrition e.g. via a Peripherally Inserted Central Catheter (PICC)

None is exclusive and more than one approach may be needed in order to meet the individual's nutritional needs.

Some patients will have problems swallowing and they must be referred to the appropriately trained professional e.g. Speech and Language Therapist. The correct textures for food and fluid can then be prescribed for that patient and appropriate arrangements made to ensure the patients nutritional requirements are met.

Wherever possible the aim is to re-establish the patient back onto their optimal oral diet.

4.3 Refeeding Syndrome

Increased nutrition following a prolonged period of starvation or malnourishment can result in refeeding syndrome. Refeeding syndrome is defined as medical complications that result from fluid and electrolyte shifts as a result of aggressive nutritional rehabilitation.
Calories may be from any source: oral diet, enteral nutrition (EN), PN, or intravenous (IV) dextrose (eg, 5% dextrose solution)[7].
The consequences of untreated re-feeding syndrome can be serious; causing haematologic abnormalities and result in death (8), however high-quality scientific evidence on the aetiology and management of refeeding syndrome is limited [7].

High risk of re-feeding problems if:
One or more of the following:

- BMI less than 16 kg/m2
- Unintentional weight loss >15% within last 3-6 months
- Little or no nutritional intake for more than 10 days
- Low levels of potassium, phosphate or magnesium prior to feeding

Two or more of the following:

- BMI less than 18.5 kg/m2
- Unintentional weight loss >10% within the last 3-6 months
- Little or no nutritional intake for more than 5 days
- A history of alcohol abuse or drugs including insulin, chemotherapy, antacid or diuretics

4.4 Making Mealtimes Matter

Nationally, the concept of Protected Mealtimes has been developed to improve patient's experience around mealtimes. The Organisation has translated the concept into Making Mealtimes Matter (Appendix 1), to focus the attention of all staff on the ward to the mealtime service, from preparing the patients through to completing food charts, including an emphasis on social dining where appropriate.

The privacy and dignity of patients at mealtimes should also be considered. There are patients who may feel uncomfortable eating and drinking in the presence of others (e.g. they have functional disabilities) and where this is the case this should be reflected in the patients care plan so that all staff involved at mealtimes are aware of the support required for that individual.

4.5 Hospital Menus

All patients admitted to hospital who are able to have an oral diet will be offered three meals and three snacks per day. Menu orders are taken at the bedside twice daily.

Patients requiring therapeutic, cultural diets, red tray or adaptive cutlery should be identified to the catering service via the appropriate 'special diet' form held on the ward. In addition they should be identified in the 'Nutritional Status' and 'Nutritional Information' section on Nerve Centre.

Cultural, religious and special diet menus available are:

Kosher
Halal
Vegan
Allergy Aware
Gluten Free
IDDSI compliant (level 6 Soft & Bite Sized, level 5 Minced & Moist, level 4 Pureed)
Renal Diet
Finger Food

The Standard Hospital Menu includes options coded as:
E – Energy dense
H– Healthier Eating
EC – Easy to Chew
V – Vegetarian
VG- Vegan

Any food allergies should be flagged on Nerve centre in the nutrition status section.

Where patients require assistance at meal and snack times red trays can be requested from catering in order to visibily identify those requiring assistance.

4.6 Food Charts

Food charts are used to assist in the monitoring of nutritional intake and form part of the Nutritional Care Plan for those identified as being at risk of malnutrition. Food and drinks offered and the amounts consumed should be recorded including oral nutritional supplements.

When used, a food chart must be reviewed after three days and the action plan completed.

4.7 Hydration and Fluid Charts

Hydration of the patient is as important as ensuring adequate food intake and the Trust is committed to ensuring that where appropriate patients are encouraged to take a range of fluids through the day and intake is documented in their care plans. If patients are unable to tolerate oral fluids the use of alternative routes e.g. enteral, IV for the provision of fluids should be discussed with the patient's clinical team.

Each ward area will have copies of the 'Volume in Vessels' poster and the information should be referred to when documenting oral fluid intake in care plans to ensure standardisation of recording.

A traffic light jug system is in place to promote hydration and provide a visual reminder to staff and patients on wards; red lid indicating first jug of the day, orange lid for the second jug and green lid for the third. (see appendix 2)

If a patient is on a fluid restriction a blue lidded jug should be used and the volume of water marked on the lid.

If a patient is receiving bowel prep a white lid should be used and clearly marked on the jug.

Where clinically indicated fluid balance charts should be accurately completed on nerve centre and reviewed by the ward team and necessary actions taken in order to reduce the likelihood of acute kidney injury and reviewed by the medical/surgical team daily.

Hydration is encouraged through the 'But First a Drink' initiative where health care professionals are to encourage patients to take a drink before beginning their intervention.

4.8 Mouthcare

Supporting patients with regular mouth care is a fundamental part of care that has frequently been identified as neglected and needing improvement. The Mouth Care Assessment Tool (IPOC 1788) is used to assess the mouth care needs of patients.

Good mouth care contributes to good oral health. Oral health is an important part of general health and wellbeing. It allows people to eat, speak and socialise without discomfort or embarrassment. Hospitalisation is associated with a deterioration of oral health in patients. This in turn has been linked to an increase in hospital-acquired infections (such as hospital-acquired pneumonia), poor nutritional uptake, longer hospital stays and increased care costs. Good oral health is also important for patient safety, dignity, and the ability to communicate is a key element of compassionate care.

4.9 Patients Nil by Mouth or Refusing Food

There is a high risk of malnutrition and hydration when a patient:

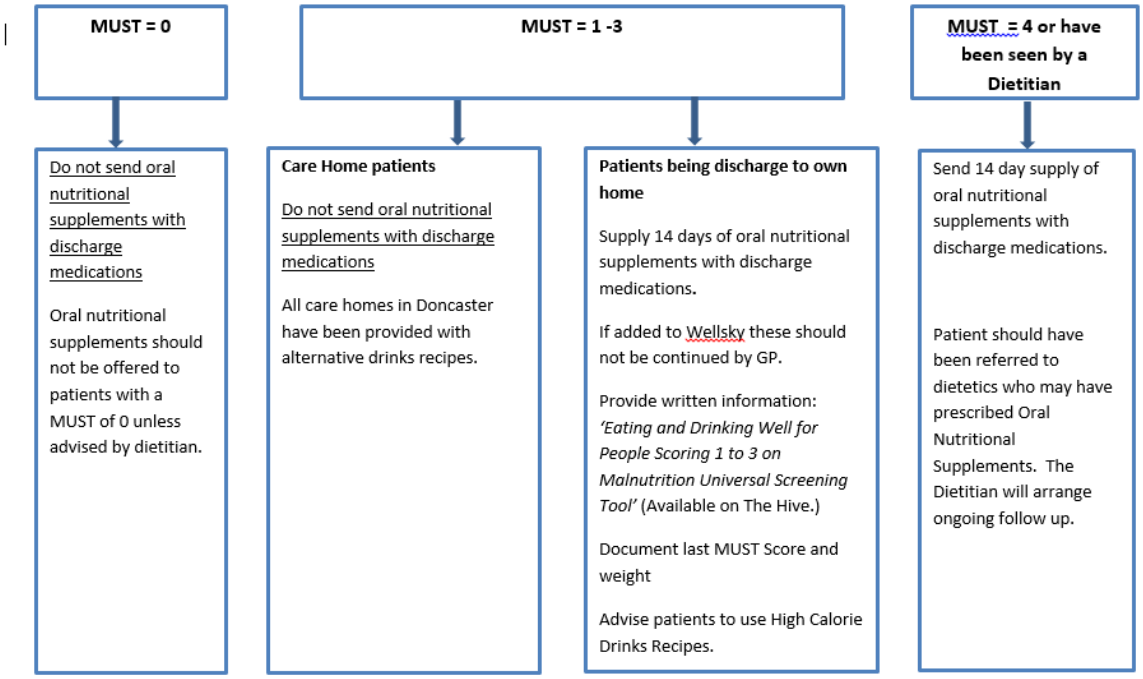
- continually refuses to eat or drink
- refuses to open their mouth
- is nil by mouth
- Is taking negligible amounts of food and drink

In these instances, a referral to Speech and Language Therapy and Dietetics should be considered. The appropriateness of clinically assisted nutrition and hydration (tube feeding), including the ethical issues involved, should be discussed by the multidisciplinary team as part

of the patient's daily clinical review with escalation to senior teams if there are delays or uncertainty. The nutritional status section on nerve centre should be updated to reflect discussions.

4.10 Discharge of Patients Requiring Continuing Nutritional Support

Discharging patients from DBTH on Oral Nutritional Supplements



Where a patient is to be discharged on an enteral tube feed a 14 day supply of feeds and equipment should be provided (See IPOC 1565). A copy of the Tube Feeding discharge checklist (WPR 46630) should be included in the medical notes. The dietitian should be informed 24 hours in advance of discharging a patient on an enteral tube feed in order to ensure training and support can be implemented to ensure a safe discharge.

5 ADDRESSING THE NUTRITIONAL NEEDS OF PATIENTS WHO LACK MENTAL CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

Where decisions are made regarding clinically assisted nutrition and hydration, outcomes of best interests discussions should be documented along with reasoning and communicated to community and primary care partners.

6 TRAINING/SUPPORT

Education and training programmes are in place for all staff relating to the nutritional care of patients. Matrons and ward managers are responsible for ensuring that their members of staff receive relevant education and training. This is monitored via the ward nutrition accreditation process.

The role specific training requirements of staff will be identified through a learning needs analysis.

Nutrition related learning
Food allergy and food hygiene awareness.
Insertion of Gastrostomy Tube and Low Profile Button Device
Nasal retention device insertion
Dysphagia training day
Foundation of cares
272 Aftercare of nasogastric and nasojejunal tubes
272 Acute kidney injury
000 Nutritional screening a 'MUST' for healthcare in hospital
Passing a fine bore feeding tube
Set up and Administration of Total Parental Nutrition* (TPN)

*Parenteral Nutrition is only to be delivered on wards who meet additional standards and training in accordance with the Parenteral Nutrition policy PAT/T 66 Parenteral Nutrition Policy

Training on nutrition including MUST screening is incorporated into the organisations preceptorship package for newly qualified nursing and allied health professional staff, the Person Centred Care (PCC) day and activity co-ordinator training.

An e-learning package on MUST is available and should be completed by all staff.

Menu Collectors employed by Sodexo, the organisations catering provider, receive yearly training on nutritional care including therapeutic and modified texture diets.

7 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Compliance with the procedural document is checked through Tendable. Results are discussed and action planned through the Nutrition Link nurse forum and Matron's meetings and overseen by The Nutrition Steering Committee.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Report to
Rolling Nutriton Action Plan agreed by the Nutrition Steering Committee to address the provision of nutrition and hydration across the Trust	Nutrition Steering Committee	Two yearly	Reviewed by Nutrition Steering Committee.
MUST assessements and action plans	Ward managers	Weekly and monthly	Collated within Tendable, shared with nutrition link nurses and overseen by Nutrition Steering Committee
Identification of nutritional status	Ward managers	Weekly	Collated within Tendable, shared with nutrition link nurses and overseen by Nutrition Steering Committee
Are patients assisted with nutrition and hydration when required	Ward managers	Weekly	Collated within Tendable, shared with nutrition link nurses and overseen by Nutrition Steering Committee
Monitoring of fluid balance and hydration status	Ward managers	Weekly	Collated within Tendable, shared with nutrition link nurses and overseen by Nutrition Steering Committee
Mini PLACE audits, including Making Mealtimes Matter compliance	Sodexo, Dietitians, Ward manager or Nutrition Link nurse	Yearly	Observational Audit Reviewed by Nutrition Link Nurse and Ward Manager and overseen by Nutrition Steering Committee

Education and training; The ward is able to demonstrate that ward staff are adequately and appropriately trained in the nutritional care and management of their patients.	Ward managers and Matrons	Annually	Recorded within OLM

8 DEFINITIONS

BAPEN	British Association for Parenteral and Enteral Nutrition
'MUST'	'Malnutrition Universal Screening Tool'
NJ	Naso jejunal
PEG	Percutaneous endoscopic gastrostomy
NG	Nasogastric
PICC	Peripherally inserted central catheter
PLACE	Patient Led Assessment of the Care Environment

9 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (see appendix 3)

10 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

CORP/EMP 4 Fair Treatment for All Policy
CORP/EMP 27 Equality Analysis Policy
PAT/PA 19 - Mental Capacity Act 2005 - Policy and Procedure, including Deprivation of Liberty Safeguards (DoLS)
PAT/PA 28 - Privacy and Dignity Policy
CORP/FAC 7 - Hospital Catering Policy – Provision of Feed to Patients, Staff and Visitors
PAT/T 66 - Parenteral Nutrition Policy
PAT/T 17 - Nasogastric Tube Management and Care Policy
PAT/T 69 - Nasal Retention Device Policy
PAT/T 16 - Percutaneous Endoscopic Gastrostomy (PEG)/Enteral Tube Care Policy
Individual Pathway of Care (IPOC) 1565 Tube Feeding Discharge Checklist for wards
Individual Pathway of Care (IPOC) 243 Combined Risk Screening and Assessment
Individual Pathway of Care (IPOC) 111 Adult Dietetic Referral
PAT/IC 5 Hand Hygiene

11 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016).

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu-general-data-protection-regulation-gdpr/

12 REFERENCES

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3. NICE QS24 NICE Quality standard 24: Quality standard for nutrition support in adults (2012)
4. BDA Digest (2017) https://www.bda.uk.com/uploads/assets/c24296fe-8b4d-4626-aeebb6cf2d92fccb/NutritionHydrationDigest.pdf
5. Care Quality Commission (CQC): Outcome 5 Nutrition, Regulation 14

6. Essence of Care: Nutrition Benchmark (2010)
7. 10 key characteristics of good nutritional care in hospitals. Council of Europe Resolution on Food and Nutritional Care in Hospitals (2007)
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9. Department of Health and Social Care. Report of the independent view of NHS Hospital Food (2020)
10. Department of Health. A Toolkit to support the development of a hospital food and drink strategy (2016)

APPENDIX 1 – MAKING MEALTIMES MATTER

Making Mealtimes *Matter*

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

- ✓ All available staff to focus on food and drink.
- ✓ Relatives and carers can help where appropriate.
- ✗ Avoid all non-essential activity and interruptions, unless providing urgent care.

Before mealtimes...

- ✓ Ring bell 10 to 15 mins before mealtimes.
- ✓ All clinical staff finish off tasks.
- ✓ Know which patients need assistance with feeding and allocate nurse/ healthcare assistant.
- ✓ Ensure patients have opportunity to visit the toilet.
- ✓ Sit patients up/in chair or take to the dining room.
- ✓ Clear patients tables and wipe clean.
- ✓ Offer hand wipes to patients as necessary.
- ✓ Vent the trolley for 5 mins.
- ✓ Staff to wash hands and wear PPE.

During mealtimes...

- ✓ Use red tray/red tray to identify patients who need help and/or who need their intakes monitoring.
- ✓ If patients require help, only to serve meals when a nurse is ready to assist.
- ✓ Ensure patients have:
  - Napkin
  - Appropriate drink
  - Correct cutlery
  - Condiments
  - Eating aids.
- ✓ Provide assistance if needed, eg. opening packets and cutting up food.
- ✓ Check patients are happy with choice of meal that everyone has a drink.

After mealtimes...

- ✓ Complete food and fluid balance charts.
- ✓ Ask patients "How was your meal?"
- ✓ Update Special Diet folder in preparation for the next meal.

Ward Mealtimes

Breakfast .....

Dinner: .....

Tea: .....

APPENDIX 2 – WATER JUG LIDS

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Red Amber Green
Water Jug Lids

A Trust-wide Quality Improvement
September 2019

Patients in hospital are at risk of dehydration. By using a simple, visual way of monitoring how much patients are drinking, we can work together to prevent dehydration, improving cognition, reducing falls and acute kidney injury (AKI).

Different colour jug lids show how much patients are drinking.

- Health Care Assistants should flag those patients who still have a red lid on their jug after the 2.30pm round to the nursing staff.
- Nursing staff should ensure there is a clinical review of the patient if still on a red lidded jug at 2.30pm.

Daily routine

7.30am
Ward Assistants will give every patient a 750ml jug of water with a **RED** lid.

12.00pm
Health Care Assistants will check every patient's water jug.

→ If jug is EMPTY, refill and change the lid to **AMBER** (update FB chart if applicable. Document in care plan).

2.30pm
Health Care Assistants will check every patient's water jug.

→ If jug is empty and lid is **AMBER**, refill and change the lid to **GREEN**.

→ If Jug is empty and lid is **RED**, change to **AMBER**. **If lid still RED, inform nursing staff** (update FB chart if applicable. Document in care plan).

Important

Patients on Fluid Restriction should have a blue lid. Please seek advice from the Speech and Language Therapist (SALT) for patients on thickened fluids.

APPENDIX 3 - EQUALITY IMPACT ASSESSMENT

Service/Function/Policy/Project/Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Nutrition and Hydration Policy for Adults in Hospital	Clinical Specialities	Lizzie Shaw	Existing	March 2023

1) Who is responsible for this policy? Name of Division/Directorate: Clinical Specialties

2) Describe the purpose of the service / function / policy / project/ strategy? The aim of the policy is to ensure that the provision of hydration and nutritional care for patients is a ward priority.

3) Are there any associated objectives? Legislation, targets national expectation, standards: To meet national guidance, NICS GG 32, QS 24 and CQC Outcome 5

4) What factors contribute or detract from achieving intended outcomes? none

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **March 2025**

Checked by: Lindsey Germain **Date:** 9/3/23