STRATEGY TO IMPROVE NUTRITIONAL CARE IN HOSPITALS

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EQIA	
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Consultation Record	Date
Nutritional Nurse Link Group	
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LPF	13 November 2008
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Consultant's Group	10 November 2008
AACAHP	04 November 2008
Hospital Nurse Management Group	04 November 2008
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CGCG	03 December 2008
Board	09 December 2008

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1. Introduction

The overall purpose of this strategy is to provide a framework for improving the food provision and nutritional status of patients in hospitals. To achieve this the strategy's aims are to ensure that:

1) Patients receive a high standard of nutritional care throughout their journey into and out of hospital.
2) Food and fluids are effectively and efficiently delivered to patients at all times during their patient journey.
3) All patients admitted to NHS Shetland are screened within 24 hours of admission using the MUST (Malnutrition Universal Screening Tool).

These aims will be achieved by working in a co-ordinated and strategic way to meet the NHS QIS standards as detailed in the Action Plan in Appendix 1 of the Nutritional Care Policy document.

2. Strategic Context

2.1 Demographics

NHS Shetland recognises that there are a number of patient groups with specific needs that need to be addressed in order to achieve this strategy. They are as follows:

- Children
- Frail elderly people
- Those who are clinically compromised or have physical disabilities which inhibit eating and drinking
- Adults, whose disability, mental illness or physical or mental infirmity causes them to be at risk
- Those with particular cultural or religious dietary requirements

2.2 Needs Assessment

The Shetland Population contains the following ethnic groups:

Group	Number of persons
All People	21,988
White Scottish	18,728
Other White British	2,660
White Irish	91
Other White	277
Indian	19
Pakistani	35

Bangladeshi	13
Other South Asian	11
Chinese	27
Caribbean	5
African	7
Black Scottish or Other Black	2
Any Mixed	63
Other Ethnic Group	50

Reference: The Shetland Census 2001

The Religious breakdown for Shetland is:

Religion	Number of persons
All People	21,988
No Religion	8,691
Church of Scotland	8,274
Roman Catholic	595
Other Christian	2,973
Buddhist	48
Hindu	4
Jewish	4
Muslim	56
Sikh	2
Another Religion	184
Not Answered	1,157

Ref: The Shetland Census 2001

A Black and Minority Ethnic Groups Health Needs Assessment took place for Shetland in 2003 and 2005. Little was mentioned in the report about nutritional care standards; however the following refers to specific dietary needs:

'Halal, kosher, vegan and vegetarian food are all available as clear options on printed hospital menus. The hospital keeps a frozen supply of halal and kosher meals: these foods are not available on the islands and are ordered from Aberdeen. For NHS staff who request these meals, the hospital has made arrangements for meals to be provided at the right times. Meals, separate fridges, and separate cooking equipment have been supplied for staff accommodation where necessary.'

There are many diverse ethnicities and religions within Shetland, some with very small populations. Different ethnic groups and religions have particular guidance about what they can and can't eat, or how their food is prepared, which means that any nutritional policy needs to be flexible enough to accommodate all needs.

2.3 Health Policy

Appendix 1 outlines the relevant policy documents that have informed this strategy. These are:

- QIS Clinical Standards for Food, Fluid and Nutritional Care in Hospitals (2003)
- Best Practice Statements
- Children Receiving Nasogastric and Gastrostomy Feeding (2003)
- Nutrition for Physically Frail Older People (2002)
- Nutritional Assessment and Referral in the Care of Adults in Hospital (2002)
- Towards a Healthier Scotland (1999)
- The Scottish Health Plan – Our National Health: A Plan for Action, A Plan for Change (2001)
- Eating for Health: Meeting the Challenge (2004)
- Resolution ResAP (2003) on Food and Nutritional Care in Hospitals (2003)3
- Diet Action Plan for Scotland (1996) (1996)
- Institutional Nutrition – NHS MEL (1999) 54
- The Regulation of Care (Scotland) Act 2001 (2001)
- The Nutrition of Elderly People and Nutritional Aspects of the Care in Long-term Care Settings (2000)

3. Goals of Nutritional Care in Hospitals

NHS Shetland is committed to fulfilling the Council of Europe Resolution Food and Nutritional Care in Hospitals[1] as supported by the British Association of Parenteral and Enteral Nutrition. This also encompasses

[1] Resolution ResAP (2003) Food and Nutritional Care in Hospitals (2003)3

the QIS standards on Goals of Nutritional Care in Hospitals. The Goals are outlined below:

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

4. NHS Shetland's Nutritional Care Framework

4.1 Nutritional Care Steering Group

The remit of the Nutritional Care Steering Group is as follows:

- To take the lead role in addressing issues relating to food, fluid and nutrition throughout the Board;

- To lead on the implementation of national standards and guidelines relating to food, fluid and nutrition throughout the Board, eg the NHSQIS Food, Fluid and Nutritional Care in Hospitals Standards; and

- To provide the overall strategic direction for nutritional care within the Board whilst also overseeing implementation throughout the organisation.

- To undertake the nutritional planning group function for the Board, and having responsibility for:

i) overseeing a local assessment of need
ii) producing a local 'food chain' protocol
iii) menu planning
iv) ensuring food and fluid provided meets the needs of the individual, the catering specification is appetising and presented with consideration
v) setting mealtimes and snacks
vi) ensuring there is appropriate food and fluid provided outwith main mealtimes
vii) ongoing monitoring and review of food and fluid provided for patients

Terms of Reference

The Group will operate according to the following terms of reference:

Chair

The group will be chaired by the Nurse Director who is an Executive member of the Board.

Membership

The Group will have the following core membership:

Nurse Director (Chair)
Medical Director
Assistant Director of Nursing (Hospitals)
Hotel Services Manager, Sodexo Healthcare
General Services Manager (Contract Monitoring Officer for Sodexo contract)
Oral Health Promotion Officer
Lay Representative
Pharmacy Manager
Clinical Governance Co-ordinator
Dietitian
Nutritional Champion
Speech and Language Therapist

Additional members will be co-opted for their expertise as the need arises.

Meetings

Meetings will be held monthly throughout the year. A schedule of proposed meeting dates being prepared at the beginning of each year ie April.

Agenda Items

Any member of the group can put forward agenda items by submitting these to the Chairman prior to the date of the next meeting.

4.2 Nutritional Link Nurses

Terms of Reference for the Nutrition Link Nurse Group (NLNG)

Each clinical area/ward has a Nutritional link nurse who meets with the Dietitian and Nutritional Champion monthly. Also included in the meeting is the General Services Manager and the Hotel Services Manager.

The NLNG is a forum to:

- Discuss Operational Issues and Concerns on all aspects of nutrition in hospitals
- Review Menus and dietetic issues relevant to in-patients
- Promote excellence in nutritional care through Nutrition Link Nurses

4.3 Nutritional Champion

The Nutritional Champion supports the improvement of nutritional care in hospital by providing a co-ordinating role, supporting and developing the nutritional infrastructure and ensuring a multi-disciplinary approach to improving nutritional care. The main responsibilities for this role are:

- To influence a wide range of staff to ensure delivery of the FFN agenda through assessment, good practice and monitoring of policy implementation, including the impact on patient care
- To participate in the Boards Nutritional Care Group
- To promote the FFN agenda and ensure that its principle aims are embedded in practice
- To fulfil a co-ordinating role and work collaboratively with colleagues in Clinical Governance, Audit and Risk Departments to ensure compliance with standards
- To produce regular reports on progress with the action plan
- To support and enable staff to implement the standards at a local level
- To assist in the delivery of educational programmes in relation to FFN across a range of clinical and non-clinical staff

4.4 Governance and Reporting

The Nutritional Care Steering Group will meet monthly. As a matter of routine it will update its action plan accordingly. Both the minutes of the meetings and the action plan will be received by the Clinical

Governance Co-ordinating Group who will monitor the activity and achievements ensuring satisfactory progress is being made. They will also be received by the Patient Focus Public Involvement Steering Group to ensure the public are involved in the planning and monitoring arrangements for food service provision.

The Nutritional Nurse Link Group will meet 6 weekly. The minutes of those meetings will be received by the Nutritional Care Steering Group who will monitor issues raised and provide support for finding appropriate solutions where needed to ensure high quality nutritional care is delivered to patients.

There is Lay Representation on the Nutritional Care Steering Group.

The organisational structure for Nutritional Care can be found in Appendix 2.

4.5 Annual Report to Board

The Chair of the Nutritional Care Steering Group will be responsible for producing an annual report for the Board in time for the July Board meeting to demonstrate progress in achieving the QIS FFN Standards.

5. Dietetic Service

5.1 About the Service

The Dietetic Service currently employs one Dietitian to cover the hospitals. They are responsible for the following:

- The organisation and delivery of NHS Shetland's Dietetics Service in hospital and community settings across the Shetland Islands and provide strategic direction for the service through policy development and service planning.
- To work as a specialist, autonomous clinician undertaking a varied and often complex clinical caseload, including nutritional assessment, treatment and ongoing reviews of patients.
- To act as a source of expert advice for matters pertaining to dietetics and nutrition for Shetland NHS Board and other statutory and voluntary organisations. To represent the service and promote dietetic and nutrition issues in all appropriate contexts.

NHS Shetland's Dietetics Service provides care to patients in hospitals; community and private homes throughout the islands and in 2006-07 received 1462 new referrals. In the absence of a Dietitian in Shetland, alternative arrangements will be made for accessing dietetic support and contact details made available.

5.2 About a Dietitian

Registered Dietitians are uniquely qualified to translate scientific information about nutrition and food into practical dietary advice. As well as providing impartial advice about nutrition and health, dietitians also advise about food related problems and treat disease and ill health.

5.3 About what a Dietitian Does

They are a key part of the healthcare team and also have an important training and advisory role. Here are examples of what a Dietitian does:

- Clinical advice to individuals on specific diets to help treat certain medical conditions.
- Information and support to enable people to reinforce or change their eating habits in order to promote good health.
- Support and training for health professionals and catering staff.
- Works closely with catering to develop menus, analyse menus and ensure food is appropriate for hospital patients.
- Policy development.
- Advice on good quality, up to date literature and information.
- Co-ordination of home enteral feeding across Shetland.
- Supporting dietary change in clients with disordered eating.

5.4 Where is it and when can it be accessed

Currently the Dietetics Service is based in Montfield Hospital. The Dietetic Service is available from Monday to Friday and can be accessed via primary or secondary care using the referral criteria detailed in the Board's Nutritional Care Policy.

6. Implementing the Strategy

6.1 Resources

In order to implement the Strategy the following resources are required:

Following the completion of an audit stock levels of crockery and cutlery were considerably below required levels. Wards had a vast array of different styles, sizes and patterns of crockery with no uniform design. Hardware (i.e. Toaster, kettle) was at required level.

In order to purchase new crockery and cutlery for the wards of a suitable design and style, cost would be approximately £3400.00 (depending on agreed style).

Annual replacement costs for hardware and crockery would be approximately £1500.00. This could be set up as an agreed fixed cost or charged as variable billing on an as needed basis (with controls in place to ensure efficiencies).

The Hardware and Crockery that is required to implement the policy and to be retained on each Ward/Day Unit is shown in Appendix 3.

When costs are known for the first year, each following year a new financial plan will be drawn up.

The cost of snacks is not yet known.

6.2 Patient and Public Involvement

As part of the Board's commitment to improving nutritional care in hospital, patients and public are encouraged to make comments regarding their mealtime experience through both formal and informal ways.

- The menu cards which are used by patients to select a meal of their choice have a section for comments.
- Ward staff have a feedback form which they complete making their own or patient's comment. This is collected by the Catering Manager and any specific comments are discussed at the Nutrition Link Nurse Meeting/Nutritional Care Steering Group as appropriate.
- As part of the monthly quality control of food, the quality control coordinator makes observations of meals supplied to wards for patients, checking quality and accuracy of meals ordered and informally meeting with patients to gain their feedback.
- On an annual basis a formal Patient Satisfaction Survey is completed and results fed back to the FFN Group and the NHS Shetland / Sodexo Partnering group.

Changes to patient feeding, for example new patient menus, are reviewed by the PFPI and NHS 100 groups. These groups also have the opportunity to meet the Catering team and make comments about the service provided. In addition any changes are reviewed at the Nutrition Link Nurse meeting where patients comments are considered.

6.3 Risk Assessment

The Strategy and Nutritional Care Policy have been risk assessed using the Risk Management Process approved by NHS Shetland. This process identified that failure to implement the strategy would result in a high risk to NHS Shetland. Approval of the Strategy and associated resources for implementation, training and monitoring, reduces the risk to medium (see Appendix 4).

6.4 Communication Plan

Communication of the Nutritional care Policy and Strategy will take place through information being provided via:

- Nutrition Link Nurse Meetings
- Local Partnership Forum
- All Heads of Departments
- Ambulance Service
- Induction at Ward/Department level

Posters to remind staff and visitors of the importance of managed mealtimes, will be developed and information on 'the food rules of religion' will be displayed at ward level.

6.5 Managed Meal Times

A Managed Mealtimes policy has been developed at NHS Shetland. This ensures that all non-essential activity is stopped during patient meal times and that wards foster a calm and relaxing environment for patients to enjoy the food they eat and support social interactions. For further information please refer to the Managed Mealtimes policy.

6.6 Equality Impact Assessment

The Equality Impact Assessment (EQIA) has been completed and is attached as Appendix 5.

Appendix 1

There are a number of policy documents, which have guided the development of this strategy:

1. **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals**. – NHS Quality Improvement Scotland (2003)
   http://www.nhshealthquality.org/nhsqis/files/Food, Fluid Nutrition.pdf

   This paper states that, " Each NHS Board needs to have a policy relating to food, fluid and nutritional care for patients in hospital, with a strategic and coordinated approach to ensure that all patients in hospital have their food and fluids delivered effectively and receive a high quality of nutritional care."
   These standards include sections on:
   - the strategic and coordinated approach required by NHS Boards to ensure both that food and fluid are delivered effectively in hospitals, and a high quality of nutritional care is provided;
   - assessment and screening, in relation to eating, drinking and nutrition, and the subsequent care planning that is required when a person is admitted to hospital;
   - the formalised mechanisms needed to actually plan and deliver food and fluid;
   - the subsequent provision of food and fluid directly to patients;
   - communication with patients about eating, drinking and nutrition; and
   - specific training and education requirements for staff.

   These standards will be used by NHS Quality Improvement Scotland to assess performance in the provision of food, fluid and nutritional care in NHS Boards throughout Scotland.

2. **Best Practice Statements**
   Best practice statements can be used in a variety of ways; they are intended to serve as a guide to good practice and promote a consistent and cohesive approach to care. Statements are intended to be realistic but challenging and can be used:
   - as a basis for developing and improving care
   - to stimulate learning amongst nursing teams
   - to promote effective interdisciplinary team working
   - to determine whether a quality service is being provided
   - to stimulate ideas and priorities for nursing research

   There are 4 Best Practice statements now, which are relevant to the development of this strategy:

   2.1 Children Receiving Nasogastric and Gastrostomy Feeding - Nursing & Midwifery Practice Development Unit (now part of NHS Quality Improvement Scotland), 2003
   http://www.nhshealthquality.org/nhsqis/files/GastrostomyNMPDU.pdf

   This best practice statement was developed by the Community Children's Nursing Network, sponsored and supported by the Nursing and Midwifery Practice Development Unit and a multi-disciplinary reference group. The aim of

the statement is to offer guidance to nurses, midwives and health visitors on best practice relating to the care of children in the community receiving nasogastric / gastrostomy feeding.

The Community Children's Nurse Network in consultation with their colleagues identified tube feeding of children being cared for in the community as a priority across Scotland. The statement refers to children from birth until transition to adult services, and therefore incorporates neonatal and community children's nursing services. The importance of communication and sharing of information between services is key to ensuring best practice for these children and this is reflected throughout the statement. Involving and informing parents/carers in all aspects of care is also highlighted. Children themselves are central to the statement and information provided to them should be appropriate to their age and level of understanding.

The statement is divided into 8 sections covering:

1. Assessment and Support of Child and Parents / Carers
2. Planning and Co-ordination of Care Prior to Discharge from Hospital
3. Equipment and Supplies
4. Care of the Gastrostomy Tube and Site
5. Oral Hygiene
6. Nasogastric / Gastrostomy Feeding at School
7. Holistic Development of the Child Receiving Nasogastric / Gastrostomy Feeding
8. Follow up Care for the Child Receiving Nasogastric / Gastrostomy Feeding

Each section contains a table corresponding to the what, why and how of best practice i.e. summarising the statement, the reason for the statement and how to achieve the statement or to demonstrate it is being achieved. Key issues and challenges are highlighted in each section.

2.2 **Nutrition for physically frail older people –** Nursing and Midwifery Practice Development Unit (2002)
http://www.nhshealthquality.org/nhsqis/files/BPSNutrition_frail_elderlyMay02.pdf

This statement was produced by the Nursing and Midwifery Practice Development Unit to offer guidance on meeting the nutritional needs of physically frail older people within continuing care facilities such as community hospitals, nursing homes/care homes. It was developed and demonstrated within a community hospital and has the potential to inform the care of dependent older people who are experiencing delayed hospital discharge or who reside within the community. It is for the use of nurses and care teams and provides information for older people and their families.

The statement covers:
Section 1:Assessment and Care Planning

Section 2: Promoting a Nutritious Diet
Section 3:The Environment of Care
Section 4:The Managerial Role of the Nurse
Section 5: Education and Training

2.3 **Nutritional Assessment and Referral in the Care of Adults in Hospital -** Nursing and Midwifery Practice Development Unit (2002)
http://www.nhshealthquality.org/nhsqis/files/BPSnutrition_assessment_May02.pdf

This statement was produced by the Nursing and Midwifery Practice Development Unit to offer guidance to nurses, midwives and health visitors on best practice relating to nutritional assessment and referral in the care of adults in hospital.

The statement is divided into five sections covering:

- admission to hospital
- nursing management of nutritional care
- screening and documentation
- criteria for nutritional referrals
- education and training

Each section contains a table corresponding to the what, why and how of best practice i.e. summarising the statement, the reason for the statement and how to achieve the statement or to demonstrate it is being achieved.

Several Scottish Executive/Government Papers highlight the importance of diet and nutrition both for health improvement and during hospital stay:

3. **Towards a Healthier Scotland** (The Scottish Office, 1999)
http://www.scotland.gov.uk/library/documents-w7/tahs-00.htm

This paper states that:
"Next to smoking, our diet is the single most significant cause of our poor health, contributing to a range of serious illnesses."

This Paper also states that the NHS itself must set an example by adopting policies to promote positive health and well-being in all settings and activities.

4. **The Scottish Health Plan - Our National Health: A Plan for Action, A Plan for Change.** (Scottish Executive, 2001)
http://www.scotland.gov.uk/Resource/Doc/158732/0043081.pdf

This paper made a number of recommendations aimed at improving the food and nutritional care patients receive. It also stated that:
"The improvement of service standards requires a recognition of the key role played by domestic and catering staff on promoting a safe and healthy environment for patients and staff……high quality, nutritious food is both desirable and necessary for

those in hospital or in other inpatient care. Fresh, nutritious food is essential to improving the health and functional ability of hospital patients."

5. **Eating for Health: Meeting the Challenge** (Scottish Executive 2004) http://www.scotland.gov.uk/Resource/Doc/47060/0012960.pdf

The key action within this paper for achieving the strategic Scottish Dietary targets is: "Promoting the preparation and provision of balanced meals by implementing and monitoring nutritional standards for the public sector for example within the NHS to ensure that the public sector is exemplary in its food provision."

The Scottish Centre for Healthy Working Lives

The Scottish Centre for Healthy Working Lives was set up to improve the health of working age people in Scotland by ensuring healthier and safer workplaces, promote healthier lifestyles and to develop the field of employability throughout Scotland. A key criterion of the Healthy Working Lives Award Scheme is that hospitals must provide health options to patients, visitors and staff.

Health Promoting Hospitals

Health promotion is considered a core quality dimension of hospital services as well as patient safety and clinical effectiveness. Against the rising incidence of chronic diseases, the provision of health promotion services is an important factor for sustained health, quality of life and efficiency. The European Network of Health Promoting Hospitals encourages an evidence based, all-inclusive approach to high quality nutrition.

6. **Resolution ResAP (2003)3 on food and nutritional care in hospitals** – Council of Europe Committee of Ministers https://wcd.coe.int/ViewDoc.jsp?id=85747

This resolution recommended that member states 'draw up and implement national recommendations on food and nutritional care in hospitals' based on the following principles:

- That access to a safe and healthy variety of food is a fundamental human right;
- Acknowledgement of the beneficial effects of proper food service and nutritional care in hospitals on the recovery of patients and their quality of life;
- Acknowledgement of the unacceptable number of undernourished hospital patients in Europe; and
- Acknowledgement that under-nutrition among hospital patients leads to extended hospital stays, prolonged rehabilitation, diminished quality of life and unnecessary costs to health care.

7. The **Diet Action Plan for Scotland (1996)** http://www.scotland.gov.uk/library/documents/diet-00.htm

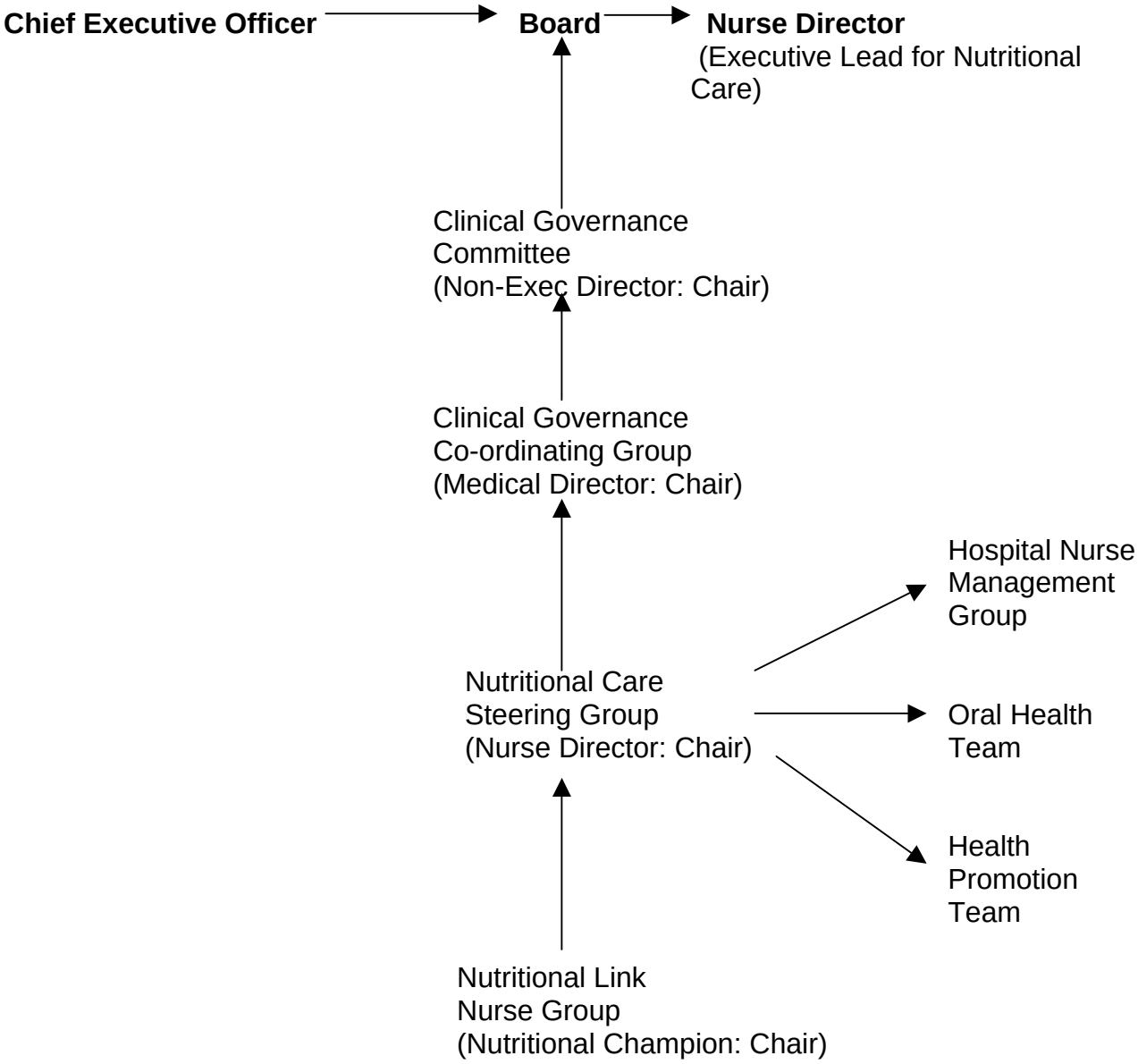
This document provided an action plan for the private and public sectors in Scotland to improve the health of the Scottish people and required the NHS to adopt The Nutritional Guidelines for Hospital Catering.

8. Institutional nutrition was also addressed in **NHS MEL (1999) 54** on core standards for nursing homes and expected their implementation in both NHS and private facilities.

9. The **Regulation of Care (Scotland) Act 2001** set up the **Care Standards Committee** to develop national standards for care homes which were published in 2001 and include recommendations to improve nutrition. (http://www.opsi.gov.uk/legislation/scotland/acts2001/asp_20010008_en_1)

10. The Clinical Resource and Audit Group (CRAG) of the Scottish Executive Health Department, which was subsequently integrated into NHS QIS, audited the nutritional status of elderly people in long stay care. **The Nutrition of Elderly People and Nutritional Aspects of the Care in Long-term Care Settings (2000)** found that 21% of older people in Scotland's long-term care establishments, including NHS and non-NHS sectors, were undernourished. Many did not receive their recommended daily allowance of energy and protein and were, unsurprisingly, losing weight. Inadequate intakes of micronutrients were also common and there was evidence that the situation was deteriorating over the 3-year course of the study.
http://www.crag.scot.nhs.uk/topics/nutrition/report.PDF

Appendix 2


Chief Executive Officer
Board
Nurse Director
(Executive Lead for Nutritional Care)
Clinical Governance Committee
(Non-Exec Director: Chair)
Clinical Governance Co-ordinating Group
(Medical Director: Chair)
Hospital Nurse Management Group
Nutritional Care Steering Group
(Nurse Director: Chair)
Oral Health Team
Health Promotion Team
Nutritional Link Nurse Group
(Nutritional Champion: Chair)

Appendix 3

Inventory of Stock Levels

Cups	30
Saucers	30
Side Plates	30
Dinner Plates	30 - Montfield Only
Soup/Dessert Bowls	30
Table Knives	40
Table Forks	40
Dessert Spoons	40
Tea Spoons	40
Kitchen Knives	3
Serving Spoons	6
Ladles	2
Fish/Egg Slice	1
Kettle	1
Toaster	1
Insulated Flask	1
Tea Pot	3
Small Jug	6
Large Jug	25
Chopping Board	1
Saucepan	2
Tumblers	30
Sugar Bowls	6
Tin Opener	1
Toast Rack	4
Ice Cream Scoop	2
Tongs	2
Table Trays	10
Cutlery Box	1
Condiments Set	30

Stock levels of dinner plates for Gilbert Bain Hospital are stored in kitchen and levels need to be maintained.

RISK ASSESSMENT FORM

IS THE RISK YOU HAVE IDENTIFIED A "SIGNIFICANT RISK"?
See definition and action to be taken on back page.

TO BE COMPLETED BY THE PERSON IDENTIFYING THE RISK

1. Describe the risk you have identified, include any specific groups which may be affected by the hazard, eg children, elderly people, visitors, staff, etc.
frail elderly patients at risk of malnutrition due to underlying medical condition e.g. Stroke, Dementia, Parkinsons Disease
It may be due to reduced function through ill health, cognitive function or physical inability e.g unable to independantly fee
feed or hydrate self

2. List any controls which are in place, eg equipment, signs, policies, procedures,etc.
Nutrition Policy and strategy for NHS Shetland
MUST (Malnutrition Universal Screening Screening Tool)
Red Tray Pathway
Discussed at Multidisciplinary meetings and AHP advice given on use of adaptations
Discussed at case Conferenc ces with patient, carers and families
Core careplan

3. List any actions you are going to take and any actions which you think should be taken to minimise the risk, eg contacting other services, changing procedures, etc.
Must screening to identify patients at risk
referral to dietician, occupational therapist, speech and language therapy, dental services as necessary
ensure equipment is available to aid independence and dignity, aprons, non-slip mats, cutlery etc.
Medication reviewed by Pharmacist and medical team
document risk in care plan and communicate the risk to multidisciplinary team and carers
use core care plan and ensure that it is updated annually
communicate with kitchen for meal replacement. Ensure stock of meal replacement drinks and puddings on the ward
audit use of MUST screening tool

Consider the risk you have described with no controls in place. What do you feel is the likelihood of an incident occurring and what impact would such an incident have? Using the descriptions overleaf to help you, circle the value on the Risk Matrix below, which you feel is most appropriate to this risk.

Impact / Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very High	Very High

Appendix 4

Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	x	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Name of person initiating this risk assessment	Laura Whittall	Designation	Ward Manager
Date assessment took place	4th June 2008	Area / Department	

Review date

FOR FURTHER INFORMATION OR ASSISTANCE PLEASE CONTACT:

Scott Miller
RISK AND INCIDENT C0-ORDINATOR
EXT 3365

NHSSCOTLAND Core Risk Assessment Matrices

Table 1 - Impact / Consequence Definitions

DESCRIPTOR	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience / clinical outcome, not directly related to delivery of clinical care.	Unsatisfactory patient experience / clinical outcome, directly related to care provision - readily resolvable.	Unsatisfactory patient experience / clinical outcome. Short term effects - expected recovery <1 week.	Unsatisfactory patient experience / clinical outcome. Long term effects - expected recovery >1 week.	Unsatisfactory patient experience / clinical outcome. Continued ongoing long term effects.
Objectives / Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project, project objectives or schedule.	Significant project over-run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient / visitor/ staff	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness. First Aid treatment required.	Agency reportable, eg Police (violent / aggressive acts). Significant injury requiring medical treatment and / or counselling.	Major injuries / long term incapacity or disability (loss of limb) requiring medical treatment and / or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint, peripheral to clinical care.	Below excess claim Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim. Complex justified complaint.
Service / Business Interruption	Interruption in a service, which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service, which has serious impact on delivery of patient care, resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to faciltiy leading to significant "knock on " effect.
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Inspection / Audit	Small number of recommendations, which focus on minor quality improvement issues.	Recommendations made, which can be addressed by low level management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage - short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media - long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media - adverse publicity <3 days. Public confidence in the organisation undermined. Use of services affected.	National / international media - adverse publicity >3 days. MSP / MP concern. Questions in Parliament. Court enforcement. Public inquiry / FAI.

Table 2 - Likelihood Definitions

DESCRIPTOR	Rare	Unlikely	Possible	Likely	Almost Certain
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Line Management Input

If you are not the person who initiated this risk assessment but are part of that person's line management structure, please add comments, controls or action plans related to this assessment below, giving your name and designation.

COMMENTS / CONTROLS / ACTION PLANS	
DATE	NAME AND DESIGNATION

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SENIOR MANAGER

Having added any comments, controls or action plans above, please now use the definitions above and the matrix below to give a Current Risk Value with any controls in place, circling the appropriate value.

Likelihood \ Impact	Negligible	Minor	Moderate	Major	Extreme
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Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

I WOULD LIKE TO REVIEW THIS RISK ON OR BY

NHSSCOTLAND Core Risk Assessment Matrices

Table 1 - Impact / Consequence Definitions

DESCRIPTOR	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience / clinical outcome, not directly related to delivery of clinical care.	Unsatisfactory patient experience / clinical outcome, directly related to care provision - readily resolvable.	Unsatisfactory patient experience / clinical outcome. Short term effects - expected recovery <1 week.	Unsatisfactory patient experience / clinical outcome. Long term effects - expected recovery >1 week.	Unsatisfactory patient experience / clinical outcome. Continued ongoing long term effects.
Objectives / Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project, project objectives or schedule.	Significant project over-run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient / visitor/ staff	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness. First Aid treatment required.	Agency reportable, eg Police (violent / aggressive acts). Significant injury requiring medical treatment and / or counselling.	Major injuries / long term incapacity or disability (loss of limb) requiring medical treatment and / or counselling.	Incident leading to death or major permanent incapacity.
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Risk Matrix

Impact / Likelihood	Negligible	Minor	Moderate	Major	Extreme
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Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	High	High
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NHS SCOTLAND
CORE RISK ASSESSMENT MATRICES
FOR REVIEW: OCTOBER 2008

This is a copy of the new matrices, which are being introduced into the NHS Shetland risk assessment process (and therefore the Risk Register) as current procedures are reviewed.

In use, the person assessing the risk will select the appropriate category, ie Patient Experience, Objectives / Project, etc. He / she will use the descriptors for that category and the appropriate likelihood definition to make an assessment of the significance of the risk, ie Low, Medium, High, V High.
Where a risk falls into more than one category (this is inevitable), a method of recording this will need to be developed. However, for simplicity we should use the highest impact level assessed to calculate the level of risk. eg If a risk impacts on Patient Safety – Minor, Staffing and Competence – Moderate and Financial – Major and the likelihood of an incident occurring is Possible, we should use the Major from the Financial category and the Possible likelihood to calculate the level of risk as High. See example below.

LIKELIHOOD — PATIENT EXPERIENCE — STAFFING AND COMPETENCE — FINANCIAL

	CONSEQUENCES / IMPACT				
LIKELIHOOD	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	**HIGH**	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

RISK LEVEL

Scott Miller
Risk and Incident Co-ordinator
October 2007

Appendix 5

1. Rapid Impact Checklist Shetland NHS Board – Nutritional Care Policy and Strategy

Which groups of the population do you think will be affected by this proposal? • minority ethnic people (incl. gypsy/travellers, refugees & asylum seekers) • women and men • people in religious/faith groups • disabled people • older people, children and young people • lesbian, gay, bisexual and transgender people • people of low income • people with mental health problems • homeless people • people involved in criminal justice system • staff	Other groups: Patients in hospital over the age of 16; in particular frail older people.
N.B. The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.	What positive and negative impacts do you think there may be? Which groups will be affected by these impacts?
What impact will the proposal have on lifestyles? For example, will the changes affect: • Diet and nutrition? • Exercise and physical activity? • Substance use: tobacco, alcohol or drugs? • Risk taking behaviour? • Education and learning, or skills?	The strategy and policy provide a formal structure for service delivery of food, fluid and nutritional care within NHS Shetland. This will lead to increased patient satisfaction and staff being fully aware of the importance of fluid, food and nutritional care and assisting with protecting mealtimes.
Will the proposal have any impact on the social environment? Things that might be affected include • Social status • Employment (paid or unpaid) • Social/family support • Stress • Income	
Will the proposal have any impact on • Discrimination? • Equality of opportunity? • Relations between groups?	The strategy and policy ensure that patients get the nutritional care they require, when they require it, taking into account religious or cultural preferences/requirements.
Will the proposal have an impact on the physical environment? For example, will there be impacts on: • Living conditions? • Working conditions? • Pollution or climate change? • Accidental injuries or public safety? • Transmission of infectious disease?	The system of protected mealtimes, which is being introduced, encourages a positive approach to food.
Will the proposal affect access to and experience of services? For example, • Health care • Transport • Social services • Housing services • Education	Experience of healthcare services should be more positive for those patients who might otherwise be nutritionally compromised.

Rapid Impact Checklist: Summary Sheet	
Positive Impacts (Note the groups affected) Patients in hospital receiving nutrition which is appropriate on a cultural, ethnic and religious basis.	Negative Impacts (Note the groups affected)
Additional Information and Evidence Required	
Recommendations	
From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not? No negative impacts have been identified. Therefore a full EQIA process has not been recommended.	

Manager's Signature: Nina Fraser **Date: 11th August 2008**