Nutrition Care

Summary This document describes the NSW Health framework for nutrition care and support to be implemented by Local Health Districts and other NSW public health organisations.

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Distributed to Public Health System, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes
Audience Administrative all staff; clinical; medical; allied health; nursing; dietitians

Secretary, NSW Health
This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
NUTRITION CARE POLICY

PURPOSE

Local Health Districts and other NSW public health organisations have a responsibility to provide nutrition care and support for all their inpatients and residents. This policy directive sets out the NSW Health framework for a strategic and coordinated approach to nutrition care and support from admission to transfer of care.

MANDATORY REQUIREMENTS

All NSW Local Health Districts and other NSW Health organisations which provide food and nutrition care services to patients must have in place nutrition care processes based on this policy directive.

The implementation of the Nutrition Care Policy in NSW Local Health Districts and other NSW public health organisations is to occur over a 24 month period as follows:

1. Implementation Standard: to be met within twelve months of release of the Policy
2. Compliance Standard: to be met within twenty four months of the release of the Policy

The requirements for meeting these standards are detailed in Attachment 1.

IMPLEMENTATION

Chief Executives are responsible for:

- Implementing the Nutrition Care Policy within their respective facilities
- Ensuring governance structures are in place at all sites within the Local Health District or Network
- Assigning responsibility, personnel and resources to meet the requirements of the policy
- Ensuring a staff/volunteer education and training program is in place
- Ensuring systems for nutrition risk screening and nutrition assessment using validated tools are in place
- Ensuring clinician work practices are consistent with the requirements of the Policy
- Ensuring a system to evaluate nutrition care is in place
- Reporting on the implementation and evaluation of the requirements of the Policy.

Nursing/Midwifery Unit Managers (or Nurse/Midwifery Manager where appropriate)

- Enabling and monitoring systems to ensure patients receive appropriate nutrition.

The Agency for Clinical Innovation is responsible for:

- Providing support to NSW Local Health Districts and other NSW public health organisations for the implementation of the Nutrition Care Policy.
Monitoring and evaluating implementation of the Nutrition Care Policy within NSW Local Health Districts and other NSW public health organisations in collaboration with the NSW Ministry of Health and Health Support Services.

Reporting on the implementation and evaluation of the Policy to the NSW Ministry of Health Nutrition and Food Committee. This includes recommendations for amendments to the Policy and other relevant documents such as nutrition standards and diet specifications.

**Health Support Services is responsible for:**

- Ensuring the standards set out in this policy and other related policies are incorporated into all Health Support Services’ activities including menu planning and design, food service and delivery in NSW Local Health Districts and other NSW public health organisations.

- Ensuring appropriate consultation and communication with NSW Local Health Districts and other NSW public health organisations.

**REVISION HISTORY**

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**ATTACHMENTS**

1. Nutrition Care Policy - Procedures.
Rescinded

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1 BACKGROUND

1.1 Food and nutrition in health

Good nutrition is important for everyone, but particularly for those who are ill or suffering from injury. The provision of adequate nutrition is an integral aspect of nutrition care and is associated with better patient outcomes. Hospital patients, who are already maintaining good nutritional status and those who are malnourished and gaining nutritional repletion, rely on the hospital to provide foods which are nourishing and acceptable to the patient in terms of their cultural and psychosocial needs. To achieve the best outcomes for the patient other issues such as patient access to foods and assistance with eating also need to be addressed.

Food is not only essential for physical health but also essential to an individual’s sense of self. Food has strong psychological connotations associated with nurturing. Frequently when a person is admitted to hospital, the only familiar thing and one of the few things the patient feels qualified to evaluate is the food. Familiar foods are important in stressful situations as they can represent comfort and security. Although hospital food services may be constrained by limitations, such as the system of food preparation and the statutory requirements of providing safe food to patients, they have a duty of care to meet the nutrition requirements and the cultural and psychosocial needs of each patient. All staff can contribute to making the hospital mealtime environment pleasant and can assist patients in accessing and enjoying their meals.

1.2 Hospital malnutrition – recognition and consequences

Hospital malnutrition is a world-wide phenomenon the causes of which are multifactorial. While many patients are malnourished on admission, the nutrition status of patients may worsen during the course of admission. This may result from impaired intake, impaired digestion and/or absorption, altered metabolic nutrient requirements and/or excessive nutrient losses.

Unless systematic efforts are made to identify and manage patients at risk, malnutrition may go undetected during the patient’s admission. If untreated, malnutrition can cause a wide range of adverse outcomes for the patient and the health system. These include:

For the individual:
- Delayed wound healing
- Increased risk of pressure areas
- Muscle wasting and weakness
- Increased prevalence of both adverse drug reactions and drug interactions
- Infection
- Dehydration
- Impaired mobility
- Diarrhoea, constipation
- Impaired metabolic profiles
- Apathy and depression.

For the health system:
- Increased lengths of stay
Nutrition Care

- Increased rates of readmission
- Increased costs
- Greater antibiotic use
- Increased complications
- Increased clinical intervention
- Increased staff time per patient.

1.3 Key definitions

The following terms apply in this document

**Malnutrition**
A state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), function or clinical outcome.\(^1\)

**Must**
Indicates a mandatory action

**Nutrition Care**
A coordinated multidisciplinary approach to the provision of nutrition that adapts to the consumer/patient’s individual needs and preferences throughout the healthcare journey. This encompasses all aspects of the nutrition continuum of care from nutrition assessment and intervention, including access to safe, acceptable and appropriate food services, nutrition supplements and/or enteral and parenteral nutrition.\(^2\)

**Nutrition Screening**
A process of identifying patients with characteristics commonly associated with nutrition problems who may require comprehensive nutrition assessment and may benefit from nutrition intervention.\(^3\)

**Nutrition Assessment**
A comprehensive approach to gathering pertinent data in order to define nutritional status and identify nutrition-related problems. The assessment often includes consumer/patient history, medical diagnosis and treatment plan, nutrition and medication histories, nutrition-related physical examination including anthropometry, nutritional biochemistry, psychological, social, and environmental aspects.

**Nutrition Support**
The provision of nutrients to make up the shortfall between the patient’s nutrient requirements and their nutrient consumption. Supplementary nutrition can be given in the form of additional snacks, enteral feeds or total parenteral nutrition (TPN).

**Should**
Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action

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1.4 Related NSW health policies and guidelines

PD2007_047 Foodborne Listeriosis - Control in Health Care Institutions

PD2010_049 Multipurpose Services - Policy and Operational Guidelines

PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals

PD2005_127 Records - Principles for Creation, Management, Storage and Disposal of Health Care Records

PD2007_061 Incident Management

GL2005_057 End-of-Life Care and Decision-Making – Guidelines

Agency for Clinical Innovation Nutrition Standards
- Nutrition standards for adult inpatients in NSW Hospitals
- Nutrition standards for paediatric inpatients in NSW Hospitals

Agency for Clinical Innovation Therapeutic Diet Specifications
- Therapeutic diet specifications for adult inpatients
- Therapeutic diet specification for paediatric inpatients

1.5 Other related documents

- NSW Food Authority, Guidelines for food service to vulnerable persons


2 POLICY AND GOVERNANCE

2.1 Governance

Governance structures should include consumer, clinical and corporate representation. Each Local Health District and Network should have a Food and Nutrition Committee that includes representatives from the following groups:

- Senior management
- Medical staff
- Nursing/midwifery staff
- Consumers and their carers
- Clinical dietetics
- Food services
• Other allied health staff (e.g. speech pathology, occupational therapy) as required
• other disciplines should be consulted as needed.

The role of local committees should include the following activities:
• Implementation of the nutrition care strategic plan
• Operational policy/procedure development, endorsement and review
• Effective communication of policies and procedures to staff
• Monitoring implementation of agreed standards
• Monitoring performance against agreed standards
• Evaluation of nutrition care which includes the consideration of feedback received from consumers and staff

A governance group at each health facility should be considered.

2.2 Policy Implementation in NSW Local Health Districts and other NSW public health organisations.

A strategic and coordinated approach is required by Local Health Districts and other NSW public health organisations to ensure a high standard of nutrition care is provided to patients. The implementation of this policy should be multidisciplinary in scope and address the following key elements:
• Implementation of the policy across the organisation
• Governance of nutrition care should include consumer, clinical and corporate representation
• Policy, procedures, service review and development should be informed by patients and staff views on nutrition care.

3 NUTRITION SCREENING

Nutrition screening is a key to early identification of patients with nutritional problems which may go unrecognised and therefore remain untreated during the patient’s hospital stay. Factors that may prevent a patient from eating and/or drinking adequately and safely while in hospital include, but are not limited to, physical difficulties, changes to sense of taste as a result of treatment or loss of appetite.

Nutrition screening is a rapid, simple and general procedure used by nursing, medical or other clinical staff to detect patients at risk of malnutrition.

NSW Local Health Districts and other NSW public health organisations must have in place a system for nutrition screening using a validated tool. The choice of tool and subsequent action pathway is dependent on the patient population and the staff resources available. Ideally the tool should be quick, simple, accurate and reliable. Nutrition screening should occur:
• on admission and then weekly during the patient’s episode of care
• at least monthly in slower stream facilities
• if the patient’s clinical condition changes.
All patients should have their weight and height documented on admission and weight should continue to be recorded at least weekly.

Patients whose score is ‘at risk’ on a validated screening tool or whose clinical condition is such that their treating team identifies them as at risk of malnutrition should be referred to a dietitian for a full nutrition assessment and nutrition support as appropriate.

4 NUTRITION ASSESSMENT

Nutrition assessment indicates the degree of an individual’s malnutrition and helps determine appropriate mitigation actions. Early detection of malnutrition and implementation of appropriate nutrition support reduces the risk of patients’ nutrition status deteriorating while in hospital.

Local Health Districts and Networks must have in place a system for nutrition assessment using a validated tool such as the Subjective Global Assessment (SGA) Tool, Mini Nutritional Assessment (MNA) and Patient Generated Subjective Global Assessment (PG-SGA). The nutrition assessment must be undertaken by a dietitian.

Patients requiring nutrition assessment should be seen by a dietitian within two working days of referral. If there is no dietitian available, a protocol that outlines the management of the patient until a nutrition assessment can be completed should be in place and communicated to staff.

Nutrition assessment should be discussed with the treating doctor and multidisciplinary team and documented in the patient’s medical record.

5 NUTRITION CARE PLANNING

Individuals identified as malnourished or at risk of becoming malnourished should have an appropriate nutrition care plan developed by a dietitian and documented. This nutrition care plan should contain clearly identified goals of treatment and may include social measures to ensure provision of meals, help with feeding, food and fluid intake records, modified menus, dietetic advice and oral nutrition supplements and/or artificial nutrition support. Patients and relatives should have input into the care plan.

Nutrition care plans should be:

- reviewed regularly and documented to reflect changes
- monitored to ensure goals are met with further action as necessary
- communicated appropriately to the patient and care givers.

Changes in a patient’s clinical condition that may impact on their nutrition should be monitored and appropriate action taken. Action may include re-screening, re-assessment and changes to care plans.

5.1 Transfer of care

Patients who require ongoing nutrition support on transfer of care should have a clear nutrition care plan documented. The plan should be communicated to the patient and/or carer as well as to any receiving facility. On transfer, the care plan for malnourished patients should include information about:

- nutrition status
- special dietary requirements
- provision/purchase and preparation of specialised nutrition support products and relevant equipment where required
• arrangements for follow-up.

Arrangements should be in place for continuing care, this could include but is not limited to, community care, private practitioners or an outpatient service such as a Home Enteral Nutrition (HEN) service.

If the patient has an ongoing need for specialised nutrition support items the patient should have access to, or be provided with, an adequate supply of these items while waiting for their own supply where required (eg enteral formula or equipment, thickened fluids, thickener).

6 PLANNING AND DELIVERY OF FOOD AND FLUIDS

Patients are more likely to eat a meal and receive the appropriate balance of nutrients it provides when the meal and presentation is pleasing and appetising. Meals should be delivered to the wards and served promptly to maintain the nutrition content, temperature and quality.

Effective multidisciplinary communication is vital for the efficient provision of food in hospital and to ensure that patients’ nutrition requirements are met while minimising waste.

6.1 Menus

The menu should provide the nutrition requirements of patients in accordance with the following:

• Nutrition standards for adult inpatients in NSW Hospitals
• Nutrition standards for paediatric inpatients in NSW Hospitals
• Therapeutic diet specifications for adult inpatients
• Therapeutic diet specifications for paediatric inpatients

Patients should be:

• provided on admission with information about meal services and the importance of nutrition in an easy-to-read format
• given the opportunity of selecting food and fluids from the menu
• assisted with menu selection, if required, by a qualified member of staff
• able to make their menu selections no more than one day ahead of the day of service. This has been shown to enhance meal consumption

Relatives/carers can provide assistance to patients who are unable to make their own menu selections, by either making menu choices on the patient’s behalf or informing staff of the patient’s food preferences.

6.2 Provision of food and fluids

Patients should be able to access a minimum of 1.5 litres of fluid per day unless contraindicated. Drinking water should be accessible to patients at all times as appropriate. Patients requiring thickened fluids whose fluid intake is insufficient to prevent risk of dehydration should be considered for additional hydration support.

All food provided by the hospital should comply with relevant legislative standards, including those pertaining to food safety. Systems should be in place to cater for high risk patient groups including those with dysphagia, allergies and those who are severely immunocompromised.
Where possible, patients’ nutrition requirements should be provided by food. Oral supplements should not substitute for, or be relied upon, to enhance the provision of food and fluid unless there are clear clinical indicators.

Patients who cannot consume adequate nutrition orally, including those patients on textured diets, should be considered for artificial nutrition support.

Patients who are designated as ‘Nil-By-Mouth’ for more than three days should be considered for artificial nutrition support.

The diet ordering and the meal delivery systems should be efficient, timely and safe.

The number of meal occasions (mealtimes) should be spread out to cover most of the hours spent awake. Food should be available for patients who are admitted out of normal hours, or who are not present at ward mealtimes.

Specific nutrition concerns related to end-of-life issues should be considered according to GL2005_057 End-of-Life Care and Decision-Making - Guidelines

7  THE MEALTIME ENVIRONMENT

Hospital routines, clinical procedures and ward rounds can disrupt mealtimes and significantly reduce patients’ nutrition intake. A relaxed and pleasant mealtime environment enhances patients’ enjoyment of their meals and can influence the amount of food and fluids they consume.

Clinical staff should focus on creating a mealtime environment conducive to eating, and providing feeding assistance where required during mealtimes. This includes:

- minimising interruptions to the patients’ meal times such as ward/medication rounds, teaching and diagnostic procedures to the patient’s meal time
- preparing patients for eating prior to the meal delivery. (e.g. positioning, toileting, hand washing and clearing of over-bed trolleys)
- providing patients who are able the opportunity to sit out of bed to eat their meals
- ensuring patients are able to access their food and open packaging.

8  PROVISION OF ASSISTANCE TO EAT AND DRINK

Many patients require some form of assistance with eating and drinking while in hospital. This ranges from assistance with opening packages to fully assisted feeding. If assistance with eating and drinking is not provided when required, patients’ nutritional status may be compromised.

Independence with eating and drinking should be promoted in a safe and supportive way.

Patients should be:

- treated with respect and dignity at all times when being prepared for and receiving food and fluids
- given adequate time (at least thirty minutes) to consume their meal before the tray is collected
- provided with appropriate modifications to their meal to assist them with accessing and/or eating the meal
• provided with equipment/utensils to meet their individual needs including adaptive aids, cutlery and drinking devices.

Carers, relatives and volunteers can be involved in assisting patients to eat if deemed safe by the clinical staff and if any necessary training has been provided.

Wards should be adequately staffed at mealtimes and the importance of providing timely and individualised assistance with eating and drinking should be recognised in work allocations.

A system for the development and assessment of new food products, packaging, dinnerware and cutlery for ease of accessibility and useability by patients should be in place. Such a system should include consultation with appropriate stakeholders (e.g., consumers)

9 STAFF EDUCATION AND TRAINING

Training and education programs enhance an understanding of the link between good nutrition care, preventing malnutrition and delivering better patient outcomes.

All staff involved in nutrition care should:
• understand their role and responsibilities, and receive appropriate education and training
• be aware of the role of food and nutrition in preventing malnutrition, maximising patients’ clinical outcomes and quality of life
• be appropriately qualified and have knowledge of key aspects of nutrition care
• be aware that nutrition status may be compromised in patients who are overweight or obese.

Education programs on nutrition care and malnutrition should be provided annually and additionally as required.

10 EVALUATION

NSW Local Health Districts and other NSW public health organisations must have a system to evaluate nutrition care. The system must include monitoring and reporting of the following:
• audit of weight and height documentation
• audit of nutrition screening and nutrition assessment
• patient food satisfaction surveys.
11 BIBLIOGRAPHY


North Sydney Central Coast Area Health Service, 2008, Nutritional Care Policy, Document No. PD 2008_002

Sydney South West Area Health Service, 2009, Food and Nutrition, Document No. PD2009_030

Sydney West Area Health Service, 2006, Food and Nutrition Policy, Document No. Poly10414

12 ACKNOWLEDGEMENTS

The Agency for Clinical Innovation (ACI) Nutrition in Hospitals Group
Northern Sydney Central Coast Area Health Service
Sydney South West Area Health Service
Sydney West Area Health Service
13 LIST OF ATTACHMENTS

1: Implementation checklist
Attachment 1: Staged Implementation Checklist

It is expected that NSW Local Health Districts (LHDs) and other NSW public health organisations will meet:

- the implementation standard within 12 months of the release of the policy
- the compliance standard within 24 months of the release of the policy

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LHDs and other NSW public health organisations have a Nutrition Care Policy implementation plan.

LHDs and other NSW public health organisations have a nutrition care governance structure that has clinical, consumer and corporate representation in place that is appropriate for each facility.

LHDs and other NSW public health organisations are responsible for assigning responsibility and personnel to implement the Nutrition Care Policy.

Equipment (such as scales, height measures and specialised feeding equipment) is available to support the implementation of the Nutrition Care Policy in clinical areas.

Patients have their weight and height measured and documented on admission and then weight measured weekly.

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<td>There is a system in place to ensure patients undergo a nutrition assessment using a validated nutrition assessment tool. This should occur within two working days of referral to a dietitian.</td>
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<td>There is a staff training and education program in place.</td>
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<td>There is a system in place to evaluate nutrition care which includes:</td>
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<td>• audit of weight and height documentation</td>
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<td>• nutrition screening and nutrition assessment compliance audits</td>
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<td>• patient food satisfaction surveys.</td>
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