Food in Hospitals: National Catering and Nutrition Specification for Food and Fluid Provision in Hospitals in Scotland

The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other regulators to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards. We provide independent assurance and protection for people who use services, their families and carers and the wider public. In addition, we play a significant role in supporting improvements in the quality of services for people in Scotland.

[1]T= Technical; G= General; E=Editorial

Paragraph No.	Page	Type[1]	Comment
		G	We signpost social care services to Food in Hospitals as good practice and so we welcome an opportunity to comment on Food in Hospital: National Catering and Nutrition Specification for Food and Fluid Provision in Hospitals in Scotland.
Introduction 1.1	13	G	We suggest that the important social aspect of eating be included in the first paragraph.
1.3 Policy Background	15	G	States 'In 2000 the Clinical Resource and Audit Group (CRAG) P 19P found 21% of older people in Scotland's long-term care establishments (including NHS hospitals) were undernourished. The food consumed by residents was significantly less than the dietary recommendations for many nutrients including energy.' We consider that the CRAG report also goes on to make an important point 'The reasons for this are unclear and were beyond the scope of the audit, but may relate to poor social and physical environments aspect on wards and staff practice falling short of standards in relation to meeting people dietary needs.'
1.3	16	G	Second paragraph states 'Most of those affected were at high risk. Nutritional status often declines

			further after admission to hospital because acute illness or injury can impair appetite, swallowing, and intestinal absorption' In our experience, there are other reasons for a decline in nutritional status which should be included, such as a lack of appropriate support to eat or drink or older people eating in their own room without social contact at meals.
1.3	16	T	The last paragraph states 'Two fundamental considerations that hospitals need to address in order to provide a service which is likely to meet the dietary and nutritional needs of its patients, is **maximise opportunities** for patients to eat and drink: the provision of substantial snacks, out-of-hours service provision, on-ward provisions and also **maximising the choice of suitable foods** and fluids available.' If this is fundamental then it should be included as a separate point in Menu planning standards Table 3 pages 31-33.
1.3	17	T	Paragraph 4 states 'These recommendations re-iterate the need for regular nutritional screening, multi-disciplinary working and education and training in the hospital setting. They also state that 'healthcare professionals should ensure adequate quantity and quality of food and fluid is available in an environment conducive to eating and there is appropriate support, e.g. modified eating aids, for people who can potentially chew and swallow but are unable to feed themselves' The revised Food in Hospitals does not discuss an 'environment conducive to eating'. This would be an important issue to address especially with specialist units where older people eat alone in their room and may not have been given the option to eat in the dining room.
1.3	17	E	States'Audit Scotland (ref 15) in November 2003 audited all NHS Boards in Scotland and showed similar findings. Recommendations included that the Departmental Implementation Group should develop or commission national catering and nutrition specifications for NHSScotland.' The specification was already under development by then and an initial draft completed. The need for a specification was included in the Food Fluid and Nutritional Care Standards published in 2003.

2.3.1	27	T	Fourth paragraph states ‘alongside nutritional screening’. Nutritional screening tends to be understood as screening for the risk of malnutrition. We would suggest changing nutritional screening to nutritional care assessment. It would make it consistent with the term used in the FFNC standards that are quoted on page 24.
2.3.2 First paragraph	28	T	States ‘Many of the nutrient standards that have been set in Table 2 are common to both 'nutritionally well' and 'nutritionally vulnerable' patients. A healthy balanced diet of service is inappropriate for the 'nutritionally vulnerable' patient.’ In our opinion, this sentence could be misinterpreted. A healthy balanced diet generally refers to the proportion of fat, sugar and energy. Nutritionally vulnerable patients still need food from each of the five food groups, perhaps more so to obtain the vitamin and minerals they need. We would suggest that this be incorporated.
Table 2	29	E	Non starch polysaccharides (g) listed as 184 for nutritional well column. This must be a typing error.
Table 2	30	T	Water –the references should be to reference 9 and not 7 The first column states ‘Water’. Technically speaking the 2000mls and 1600mls quoted is for drinking fluids. In our work, we use the European Food Safety Authority (Efsa) DRV for water 2010 “water intake as 2500 for men and 2000 for women. Water intake is predominantly through consumption of water and beverages (70-80%). It is normally assumed that the contribution of food to total water intake is 20-30%. This relationship is not fixed and depends on the type of beverage and on choice of foods (Efsa 6.1 See page). However, the average proportion is usually taken as drinking water and beverages 80% plus water contained in food 20% (ref Efsa) Food water content is usually below 40% in bakery products, between 40 and 70% in hot meals, more than 80% in fruit and vegetables and about 90% in both human and cows’ milk. Diets rich in vegetables and fruit provide significant amounts of the total water intake, while e.g. fast food products as a rule have

			low water contents (ref Przyrembel, 2006). The definition of a beverage is 85 to 90% water content. (ref EFSA section 6.1 para one)
Menu planning standards Table 3	32	T	States 'A **minimum of two courses** at the midday and evening meals To provide a menu that will enable the range of energy and nutrient requirements and dietary preferences of the patient population to be met.' Consideration should be given to adding further information such as that to meet patients preferences and dietary needs there may need to be flexibility by providing a third course. For example a menu set for soup and main course but a pudding would also be available for some patients.
Menu planning standards Table 3 Sixth box down	32	T	States 'A hot meal option at midday and at the evening meal. To increase patient choice and ensure the varying dietary needs and preferences of the patient population are met.' We would question if the provision of a hot meal would increase choice for all needs e.g. vegetarian, energy dense, healthy option?
Food –based standards Table 4 Breads, other cereals and potatoes	34	E	States 'Bread is a good source of energy; offering extra bread with every meal will allow those with higher energy requirements to increase energy intakes. Wholegrain breakfast cereals are a good source of fibre and can be useful in managing individuals with constipation (>3g/100g).' It is not clear what >3g/100g applies to. We assume it is 3 g fibre per 100g breakfast cereals. We would also add that wholemeal bread is also useful in managing constipation.
Food –based standards Table 4 Fruit and Vegetables	34	T	States 'The menu must provide the opportunity for patients to **choose at least five servings of fruit and vegetables** across a day including as wide a variety as possible' We commonly find in our regulation work that services are interpreting this as 5 fruit and vegetables on the menu. We would suggest that a statement be added that more than five fruit and vegetables on the menu will be required to allow for preferences and appetites.

			It would also be appropriate if it could be added that fruit and vegetables also contribute to helping avoid constipation.
Food –based standards Table 4 - Meat, fish and alternatives	34		States ‘The maximum intake of processed red meat must not exceed 90g/day.’ It is unclear if this an individual target. There is a need to have clarity between personal targets and menu planning targets.
4.1 Para 1	36	T	States ‘With awareness that 80 - 100% of patients in hospitals rely completely on food provided by the catering service for their nutritional needs it is important to remember, many of the problems that arise in the provision of nutritionally balanced food are potentially preventable with good planning’ In our opinion, it is not just ‘provision nutritionally balanced food’, it is provision of food that meets the dietary and nutritional needs of the hospital population (as in the hospital patient population assessment).
4.1 Para 5	36	T	States ‘In theory a standard hospital diet may be designed to meet nutritional requirements, however in practise it may not be eaten by individuals who are unwell or have a suppressed appetite,(ref 28, 31) as such individual nutritional needs will not be met. (ref 28, 32)’ In our opinion, this needs added to as it is also that patients preference and needs have not been fully recognised, for example the provision of soft easily chewed snacks (as in the hospital patient population assessment)
4.2.1	37	T	To assess the dietary needs of different patient populations, the following information should be included: (ref 4, 7, 30, 31, 32) □ age; □ gender; □ cultural, ethnic, social and religious diversity;

			□ physical and/mental health needs; □ food preferences; □ length of stay; □ nutritional risk We suggest that reasons be given for the inclusion of this information and an example of what this would mean for menu planning, such as that the older population may require more easily chewed food. This would tie in with the text on page 38 which states 'there are some groups of the population whose dietary requirements may need to be considered separately when planning a menu: □ children; □ people with swallowing difficulties - □ people with Dementia; □ people receiving end of life care
4.3.1 Second para	41	T	States 'Patients provided with food that they are familiar with and enjoy are more likely to consume it, ensuring that they receive the nutrition provided on the plate. Provision of greater choice is more likely to meet individual food preferences and individuals' dietary needs.' In our opinion, this is such an important point but it could get lost and therefor it should be in the Menu Planning Standards Table 3 pages 31-33.
4.31 Third para	41	E	States 'The inclusion, preparation and cooking of a variety of foods specified in the five food groups needs nutrient-dense foods. Additional dietary needs, for example the need for a texture modified diet (refer Section 5.6) should be under-pinned by this menu planning guidance to remain flexible if the diverse needs of the hospital population are to be met with 'ordinary food'. ref22 In our opinion, the above information does not make complete sense and may benefit from rewording

4.3.1 Third para	41	T	States 'Such patients' meals should still be based on starchy foods with wholegrain choices available, they should have moderate portions of meat, poultry, fish and alternatives and should aim for five portions of fruit and vegetables per day they should have full-fat foods and avoid low-fat versions and sugary foods can be eaten in moderation, but not at the expense of more nutrient-dense foods.' In our opinion, it should be added that these patients need to meet the DRV range of nutrients. We also think a comment should be added that the dietary intake should be person centered. It may be that for a specific patient pudding is the best way to increase this intake.
4.3 2 Last sentence	41	E	States 'The five food groups should underpin menu planning for all.' We consider that as this is such an important point, it should be stated earlier.
Menu planning guidance Table 5- Bread, rice, potatoes, pasta and other starchy cereals	42	T	States 'Provide *small sandwiches (*ref 9,10), crackers, oatcakes*, muffins*, tea breads, plain or fruit scones or pancakes as snacks appropriate for the patient group.' In our experience, scones and pancakes would not normally be categorised as fatty and sugary foods.
Menu planning guidance Table 6: Fruit and vegetables	43	T	States 'A hospital menu must offer the opportunity to choose **at least five servings** of fruit and vegetables (**minimum 400g uncooked**)(ref40) across a day including as wide a variety as possible (can include snacks).' In our opinion, more clarity is required between a person's target and a menu planning target. Although the guidance states **at least five a day,** we would suggest expanding the text to include some reference to personal tastes, appetites etc we consider that more opportunity and choice is more likely to allow an

			individual patient to meet their 5 a day.
Menu planning guidance Table 6: Fruit and vegetables Rational	43	E	States 'This food group is an important source of fibre, folate, potassium and vitamin C' To be consistent, fibre should also be included in Food –based standards Table 4 Fruit and Vegetables.
Menu planning guidance Table 6: Fruit and vegetables	43	T	States 'Provide an option for soft, easy to eat fruit or prepared fruit salad.' We would suggest adding - ensure veg and fruit intake can be offered pureed. This would be consistent with Table 8 Milk and Dairy which states textured modified dietary choices should be available. Additionally, we consider that prunes be added in relation to constipation problems.
Menu planning guidance Table 7: Meat, fish, eggs, beans and other non-dairy sources of protein Rational	44	E	States 'While pulses, nuts and seeds contribute to protein, non-haem iron, zinc and fibre intakes.' We would suggest adding beans to the above list.
Menu planning guidance Table 7: Meat, fish, eggs, beans and other non-dairy sources of	44	E	Fish - fresh, frozen, tinned and fish products such as fish cakes and fish fingers. Oily fish includes fresh tuna (not tined tuna), salmon, sardines, mackerel and herring Appendix 4. We suggest that canned tuna be added to the list in the first line.

protein Rational Food options			
Menu planning guidance Table 7: Meat, fish, eggs, beans and other non-dairy sources of protein	44	T	**'Always** include a protein alternative to meat for vegetarian meals such as kidney beans, chickpeas and texture-modified proteins. NB. Cheese can also be used. Meat alternatives for vegetarian dishes should offer a variety of foods from this group. Use eggs as a base for vegetarian meals **regularly** throughout the menu cycle' We would question if this is consistent with the page 45 foot note about vegetarian sources.
Table 7:	44	E	Reference duplicated
Menu planning guidance Table 8: Milk and dairy foods	45	E	Provide 'smooth' yoghurt for texture modified dietary choices as appropriate. We suggest that this is expanded to ensure yoghurt is just one of the options for textured modified diets choices. In our experience, we find that residents may not experience sufficient choice and variety, and that there may be an over-reliance on yoghurt.
Table 8 Foot of page	45	T	* Vegetarian sources of protein should be varied over the week. Over-use of cheese should be avoided. Vegetarians should be provided with a range of foods not only to provide protein but also other vitamins and minerals. Too heavy reliance on eggs and cheese results in a diet too high in energy and fat especially saturates. As in our comment above, this is not quite consistent with the Table 7 meat , fish , eggs menu planning

			guidance on page 44.
Table 9: Foods and/or drinks high in fat and/or sugar (and foods high in salt) standards	46	T	States ‘and butter should be available at all meals’. Given that there are salt guidelines, we suggest that there should be a comment on the salt content of butter.
Table 9: Rationale	46	T	This does not address that some fats provide essential fatty acids, and margarine and cooking oils may be the main source.
Table 9: Foods and/or drinks high in fat and/or sugar (and foods high in salt) standards Foods	46	E	We propose that this section is organized into: Fats Sugary foods Fatty and sugary foods Normally scones and pancakes would sit in this section but it is not included here.
Menu planning guidance Table 10: Water and beverages	47	T	Beverages can be served with breakfast but it is recommended they be served following the lunch and evening meal so not to 'fill-up' those patients with small appetites. (ref27) Given the hydration issues in hospitals and social services, we question this guidance and the strength of evidence behind the guidance. In our opinion, this could be interpreted as stating that patients should not be offered water with meals. In our experience, patients can need drinks with meals to help swallowing or promote fluid intake. Whether a patient gets a drink with a meal should be a patient centred decision. The reference 44 ‘Water for Health: Hydration Best Practice Toolkit for Hospitals and Healthcare' Has been superseded by Water for Health: Hydration best practice toolkit for hospitals and healthcare 2007 Royal College of Nursing

Menu structure	47	E	Menu structure will vary between hospitals, affected by the operational issues discussed above, We would question what is meant by operational issues.
4.4	48	E	Appropriate patient representation should be engaged in this process. The prevention of under nutrition begins with good menu planning. In our opinion, this is a very important point but it is probably lost. We feel that it could be highlighted more.
Table 11: Suggested menu structure	49	E	We would suggest including prunes with fruit
Table 12: A suggested range of snack items including energy and protein contents	54	E	It would be useful to include something about oral health and a reference to the NHS Health Scotland Oral Health and Nutrition Guidance for professionals 2012. We note that a range of snacks for pureed diets is not included.
4.7.1 Portion sizes Essential criteria	63	E	States ‘a choice of different portion sizes for patients can be achieved in a number of ways, but as a minimum the protein containing part of the meal should have two portion sizes available. Additional larger servings of carbohydrate and vegetable components can be available We note that this is not mentioned in the menu planning standards.
Table 17: Higher	69	T	States ‘Including a choice of high calorie breakfast cereals, e.g. frosties, sweetened’

energy diet menu planning guidance			We question if these should be categorised as high calorie breakfast cereals. Please see Composition of foods, McCance and Widdowson: Cornflakes 376kcal per 100g and 30 g portion =112Kcal Frostis 381kcal per 100g and 30 g portion = 114Kcal Muesli, Swiss style (added sugar0) 363 per 100g Muesli no added sugar 366 per 100g
Table 17: Higher energy diet menu planning guidance	70	E	Last item in table Offer small, energy and nutrient-dense easy to eat snacks as appropriate for patient group: □ cakes and biscuits; □ small sandwiches; □ crisps; □ full fat custard pot or yoghurt. In our opinion, this should match earlier advice and include snacks scones, pancakes.
5.3.1 Table 18: Criteria for healthier eating code (per portion**)**	72	E	We note that no energy has been entered for dessert.
532	75	T	Suitable healthy eating snacks for patients on diabetes medication, e.g. insulin, must

Table 19			be available for example; □ fresh and dried fruit; □ low-fat yoghurts; □ fruit bread, malt loaf, oatcakes, crumpets. It would be helpful to say why these snacks should be available. Similarly, earlier in the document it is recommended that additional starch and bread should be available at meals, but again it would be helpful to explain the reasoning behind both these statements. In our experience, we find that there is an on-going issue with social care nursing and care staff's carbohydrate awareness. As examples, an insulin dependent diabetic may require additional carbohydrates added to a 'healthy diet'or diabetics with poor appetites may require pudding with sugar in them.
5.6.2			States 'The National Patient Safety Agency (NPSA) along with the BDA, Royal College of Speech and Language Therapists (RCSLT), Hospital Caterers Association (HCA) and the National Nurses Nutrition Group (NNNG) produced National Descriptors for Adults (ref 6) to guide local implementation and interpretation of different food consistencies. In the reference no 6 is the British Dietetic Association and Royal College of Speech and Language Therapists. National Descriptors for Texture Modification in Adults (2002): http://members.bda.uk.com/Downloads/dysphagia.pdf We note that the above publication is no longer held on the BDA web site. We were advised that the most recent version dated 2011 was removed due to the national review of food textures. We initially found the publication on the NACC web site but it seems to have now been removed. NACC Dysphagia Diet Food Texture Descriptors April 2011 National Patient Safety Agency Download from: http://www.thenacc.co.uk/assets/downloads/170/Food%20Descriptors%20for%20Industry%Final%20-

			%20USE.pdf
7. Catering and Nutritional Guidance for Children **7.1 to 7.4 inclusive**	123	T	7.1 Paragraph three states 'Diets must be tailored to suit young children's nutritional and energy needs and also their stage of development. Guidance has been produced for early year's childcare settings (ref 77) We note that this reference is for guidance that has been superseded by Setting the Table nutritional guidance and food standards for early years childcare providers in Scotland (2015 Health Scotland). In our opinion, the whole of section 7 needs more emphasis for the under 5 years and to reflect the guidance available, especially for those under 1 year and the introduction of solids. We would suggest adding the following to the policy context: • Nutritional requirements for food and drinks in schools (Scotland) Regulations 2006 • Better Eating, Better Learning A New context for school food 2014
Audit and Monitoring for Children menus Table 34	139	T	Second box states 'Are menus appropriate to age group available?' We would suggest that this is split into the following: Are menus appropriate for those under 1 year including introduction of solids Are menus appropriate for those aged 1-5 years Are menus appropriate for school aged children
Appendix 1	142	T	Paragraph 4 States 'When menu planning for older adults, consideration to the provision of soft and easy chew meal options in line with the guidance provided for modified textures stage D and above' We suggest that this is also listed in the Menu planning standards Table 3 page 31-33

		G	We note that the last paragraph has the first mention of oral health in the document. In our opinion, this should be mentioned earlier.
Appendix 1 Last bullet point	143	T /E	States 'In terms of format of the menu card, consideration to the size of font used and perhaps the use of photographs.' We propose that, taking account of patients with dementia and short term memory problems, additional words should be added –'or visually seeing choices at the point of service.'
Appendix 2 Dietary reference values	153	E	The reference given is11, which is the DRV in Department of Health, Dietary Reference Values for Food Energy and Nutrients in the United Kingdom. Report of the panel on Dietary Reference Values of the Committee on Medical Aspects of Food Policy. Report on Health and Social Subjects. London: HMSO (1991). We suggest therefore that there is a need to add the SCANS references for salt and energy.
Appendix 3 Carbohydrate	155	T/E	States 'NMES10T are not directly related to the development of CVD, essential hypertension, diabetes mellitus or behavioural abnormalities (ref11) therefore reducing the amount of sugar on the menu for the general hospital population is not essential. (ref32) We would question if this is consistent with advice given early in this document.
Appendix 3 fluid	159	T	States 'For adults, fluid requirements are 30-35mls/kg/day.7 Fluid balance and the mechanisms controlling this can be affected by illness: increased fluid losses due to a raised body temperature, other significant fluid losses through vomiting and diarrhoea, wound exudates.35, 37 A better hydrated patient can use fewer medicines, e.g. laxatives.27 The body's correct fluid balance can also be compromised by certain illnesses and medication use causing thirst and excess salivation, increasing requirements.7, 27' We advise that the values for fluid requirements of 30-35 mls/kg/day have been superseded. The Care Inspectorate was involved with NHS colleagues in a recent review of Hydration good practice. From a review of the evidence the current key guidance is as follows:

			• 25-35 ml per kg body weight There is no guidance on when to apply 25 through to 35mls. • Caution should be exercised in very thin or obese individuals, as the relationship between body weight and fluid requirements is unlikely to be linear; using 25-35 /kg is likely to underestimate or over estimate. (BDA Pen 2011) • 1 ml per kcal intake for adults and 1.5 ml per kcal intake for children (national academy of science). The publications are not explicit however it is taken that these value are for Total Water Intake and not just drinking fluid. These figures are for the maintenance of hydration and not applicable for the correction of dehydration.
Appendix 5	162	T	We would question why there are no choice of vegetables at a lighter meal.
Appendix 5	163	T	We would question why there is no choice of carbohydrate/starch at a lighter meal.
		G	In our opinion, there was little information/reference around managing obesity within the document