Borders NHS Board

Meeting Date: 5 March 2020

Approved by:	Nicky Berry - Director of Nursing, Midwifery & Acute Services
Author:	Sarah Horan, Associate Director of Nursing & Head of Midwifery

FOOD, FLUID & NUTRITION UPDATE

Purpose of Report:

The purpose of this report is to assure the Board that the planned activity relating to Food, Fluid and Nutrition is being delivered with an improvement focus and that this is evident throughout NHS Borders in relation to the Healthcare Improvement Scotland (HIS) Complex Nutrition Care Standards.

Recommendations:

The Board is asked to **note** the report.

Approval Pathways:

This report has been approved by Nicky Berry, Director of Nursing, Midwifery & Acute Services

Executive Summary:

Following unannounced inspection by Healthcare Improvement Scotland in June 2017, the board were updated on the 17th January 2019 on the progress of the required action plan. The purpose of this paper is to further update the board on the progress and practice which has been embedded in relation to Food, Fluid & Nutrition across NHS Borders and highlight new developments and innovation.

Impact of item/issues on:

Strategic Context	To provide assurance of on-going focus to achieve the Complex Nutritional Care Standards outlined by Healthcare Improvement Scotland as this issue is critical to patient safety.
Patient Safety/Clinical Impact	This paper is aligned to Clinical Governance & Quality work plan to ensure Health Improvement Scotland standards are delivered within NHS Borders
Staffing/Workforce	There will be minor backfill requirements to release Ward Staff for training, this will be minimised and met from existing staff budgets.
Finance/Resources	Potential financial benefits due to a reduction in spend on avoidable harm. Promotes safe, effective affordable care.
Risk Implications	The key risk are;

	1. Patient Care, if patient's food, fluid and nutritional (FFN) needs are not met then their health and wellbeing will be compromised. 2. If patients FFN needs are not met there will be more likelihood of them remaining in Hospital for prolonged periods with all the attendant risks to them and others. 3. Reputational risk. The actions in our plan are designed to mitigate these risks.
Equality and Diversity	A rapid impact assessment process has identified the specific cultural and religious dietary requirements of some patients as an area requiring specific focus and education of staff to discover these and ensure the needs are raised with catering staff, all menus and needs are provided by our on-site catering staff.
Consultation	N/A.
Glossary	NHS – National Health Service HIS – Health Improvement Scotland FFN – Food, Fluid & Nutrition MUST – Malnutrition Universal Scoring System SOP – Standard Operating Procedure HCSW – Health Care Support Worker SAER – Significant Adverse Event Review PCCT – Person Centred Coaching Tool AUPR – Adult Unitary Patient Record IV – Intravenous Fluid FY1 – Foundation Year one BGH – Borders General Hospital MAU – Medical Assessment Unit DME – Department of Medicine for the Elderly

SITUATION

An unannounced inspection was carried out by Healthcare Improvement Scotland in June 2017. A robust action plan was implemented following this to address actions that were required. This was presented in a paper to the board on 17th January 2019 (Appendix 1). The purpose of this paper is to update the board on continuing progress against the Health Improvement Scotland Complex Nutritional Care Standards.

BACKGROUND

The Associate Director of Nursing for Acute is the Lead for Food Fluid and Nutrition across the Board area. Significant progress was made over the course of 2018/19 in relation to training all nursing both, registered and unregistered in undertaking Malnutrition Universal Scoring System (MUST). Over the course of this period 112 registered nurses and 90 health care support workers were trained as part of the clinical update programme and HCSW study day. This initial training carried out by Dietetic staff has been further strengthened by the appointment of 2 senior nurses to support the continuous improvement of nursing practise in relation to meeting the nutritional and hydration needs of patients within NHS Borders.

The Food Fluid and Nutrition Strategy group meet on a monthly basis and is chaired by Sarah Horan and co-chaired by Kim Smith, Practice Development Lead.

ASSESSMENT

Governance and Leadership for Nutritional Care - The FFN Strategy Group have reviewed and renewed Standard Operating Procedures (SOP's) for the Completion of Menu Cards (Appendix 2) & Protected Mealtimes (Appendix 3). The ability to report incidents and adverse events directly in relation to Food, Fluid and Nutrition by the inclusion of extra criteria on datix has facilitated the thematic review of incidents to commence and improvement plans to be initiated.

Adequate training for staff on aspects of Food Fluid and Nutrition - Following on from the direct educational input from the dietetic team a series of "Tool box talks" which are informal group discussions that focus on MUST training carried out by a Quality Improvement nurse and the lead nurse for excellence in care. To date 6 x Student nurses, 8 x HCSWs, 1 x APS (Band 4 in training), 11 x Staff Nurses, 1 x Charge Nurse, 2 x Senior Charge Nurses & 2 x Clinical Nurse Managers have been involved in these discussions. The introduction of a learn pro module on MUST which will supplement the face to face training will be also introduced late spring 2020.

Documentation Completion - A slight amendment has been made so that all MUST scores are calculated on 'actual' not 'estimated weight', this is direct learning from SAER outcomes and has been agreed by the FFN Strategy group. The MUST documentation is reviewed as part of the PCCT work (Appendix 4). As part of the new Adult Unitary Patient Record (AUPR) the must tool has been displayed in a more user friendly manner to support increased compliance. Purchase of innovative equipment 'weighing pat slide' in admission areas in the Borders General Hospital has supported the move to all patients being weighed on admission. Recent audits have shown 80% of all patients now weighed on admission. The Community Hospitals are in the process of purchasing the weighing pat slides.

Ongoing Improvements – A lead Nurse for Hydration was appointed in October 2019 to lead improvement work on Intravenous Fluid (IV) use and appropriate hydration of inpatients across NHS Borders aligned with the National Fluid programme. Version 8 of the fluid management chart is ready to be rolled out (Appendix 5). A Patient Fluid leaflet has been created which has been trialled and early quality indicators are positive. The leaflet requires further investigation and discussion at the Documentation Group. The draft leaflet has also been presented at FY1 teaching sessions and Surgical Medical Meetings allowing access to numerous staff to raise awareness and education around appropriate IV fluid use. Small group educators will complete face to face sessions with all trained nursing staff within BGH. Aim for blanket roll out early April 2020. New coloured jug lids for the water jugs have been introduced, this is a traffic light system to help staff keep patients hydrated, each morning patient will be given a full water jug with a red lid. Throughout the morning or once the jug has been emptied the jug will be refilled and replaced with an amber/yellow lid then with a green lid, this will show that each patient has achieved an adequate intake of fluid over 24 hours. A blue lid indicates when nursing staff are monitoring balance and intake is restricted. This will be tested in the Frailty Unit in MAU, Two Bays in DME and all the Community Hospitals.

Audits on compliance with MUST continue, this consists of random samples of 5 patient records/case notes which are reviewed each week (or approximately 20 patients per month by the Excellence in Care Lead & Clinical Improvement Facilitators to monitor documentation care planning. The Quality Improvement facilitator will focus on continuing tool box talks and 'spot' audits of patients with risk factors to facilitate focused improvement work.

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above.

NHS board Chair

Signature: John Raine

Full Name: John Raine

Date: 10/1/18

NHS board Chief Executive

Signature: Jane Davidson

Full Name: Jane Davidson

Date: 09/01/2018

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1	**Area for improvement 1: Screening and Initial Assessment** Must ensure that a nutritional care assessment is undertaken and recorded within 24 hours of admission to hospital for all patients. This includes accurately recording measured height and weight, with the date and time that these measurements were taken (if estimates are used, this should be stated and a rationale provided), eating and drinking likes and dislikes and oral health status, screening for the risk of malnutrition and re-screening as appropriate, all assessments and screening activity in line with local organisational policy, and the assessment process and indentifying the need for referral to specialist services, for example dental and oral health, dietetic, occupational therapy, and speech and language therapy (see page 12). *Actions:*				
1.1	NHS borders use MUST tool as Nutritional care tool, this will be expanded to include date, time and action or estimated weight.	30/09/17	Associate Director of Nursing & Midwifery	Complete	15/09/17
1.2	Deliver training on MUST assessment and the importance of completion of documentation within 24 hours of admission for RN's and HCSW's.	30/11/17	Associate Director of Nursing & Midwifery	Detailed training plan for NHS Borders, BGH trained in MUST 90% as at 10/01/18 (excluding night staff, who are being trained separately). Rollout to the Community	

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
				Hospitals is currently being planned.	
1.3	Prepare a plan for ongoing update training.	30/08/17	Associate Director of Nursing & Midwifery	Complete: • FFN training included in corporate induction from January 2018 • Update training commencing August 2019 as that will be a whole year since start of training.	13/12/17
1.4	Provide refresher training to FFN champions.	31/12/17	Operational Lead Training & Professional Development	First refresher training was on 13th December 2017 (13 attendees). Link nutritional nurses identified across NHS Borders. Additional training date of 5th February 2018 for the 7 who were unable to attend in December. Complete as above and merge with 1.3.	30/6/17
1.5	Deliver ongoing support and development for FFN	30/10/17	Operational Lead	Complete	

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	champions.		Training & Professional Development		03/11/2017
1.6	Adjust OPAH weekly quality review to focus on accuracy of MUST assessment, re-screening and actions taken from MUST assessment.	30/06/17	Head of Clinical Governance & Quality	Complete	Roll out of PCCT complete.
1.7	Audit of compliance with FFN standards – develop Person Centred Coaching Tool approach as audit mechanism for senior nurses to provide learning and ongoing training to their teams and test effectiveness.	Testing August - October 2017	Head of Clinical Governance & Quality	PCCT Rolled out across all areas in BGH and Community. PCCT coaching tool weekly update of compliance sent to CNM, ADON and GM's There will be a monthly quality audit commenced.	Compliance maintaining tool complete testing by 22/12/17 then rolled out.
2	**<u>Ares for improvement 2 and 3: Person Centred Care Planning</u>** Must ensure that where assessed as being required, a person centred nutritional care plan is developed, followed and reviewed with the patient or carer (see page 14). *Actions:*				
2.1 a	Develop effective & reliable use of person centred nutritional care plans: Provide ward-based education on fundamentals of care	31/01/18	Associate Director of Nursing & Midwifery	Training commenced on 01/10/17. Nutritional care planning has been	

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	planning.			covered in MUST training. PCCT will ensure quality of nutritional care planning. Testing of the new unitary patient records will be complete by the end of February 2018. A timeline for the roll-out of care plans will be agreed once the unitary patient records are embedded into practice. This has been discussed with HIS.	
2.1 b	Develop effective & reliable use of person centred nutritional care plans: Refine and test care planning documentation using improvement approach. Must ensure that people in hospital are involved in decisions about their care and treatment. Capacity for decision-making must be assessed in line with Adults with Incapacity (Scotland) Act 2000. When legislation is used, it must be fully and appropriately implemented. This includes consulting with any appointed power of attorney or guardian. These discussions including any discussions	31/01/18	Associate Director of Nursing & Midwifery	Training commenced on 01/10/17. Nutritional care planning has been covered in MUST training. PCCT will ensure quality of nutritional care planning.	

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	with the patient's health records (see page 14). *Actions:*				
2.2	Capacity training to be included in the Induction training for all new Doctors.	03/08/17	Associate Medical Directors (AMD's)	Complete	03/08/17
2.3	Annual training to be provided for all Consultants covering capacity for decision making.	31/08/17	Associate Medical Directors (AMD's)	AMD's working on plan for 2018.	31/08/17
2.4	Refine OPAH weekly quality review to facilitate specific feedback to medical staff.	31/08/17	Associate Medical Directors (AMD's)	Associate Medical Director for Clinical Governance & Quality is developing a change plan to address poor compliance with AWI and 4AT. Improvement plan commenced 10/11/17.	
2.5	Heads of Clinical Service and Associate Medical Directors to ensure compliance and improvement actions.	30/09/17	Medical Director	Complete	18/09/17
6	**Area for improvement 4 & 7: Food, Fluid and Nutrition** Must ensure that mealtimes consistently are managed in a way that ensures that patients are prepared for meals and that are principles of Making Meals Matter are implemented (see page 18).				

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	Must ensure that oral nutritional supplements are available and are accurately recorded for patients who require them and appropriate action taken in relation to intake as required (see page 18). *Actions:*				
6.1	Establish a consistent approach to mealtimes on wards: Develop role descriptor for mealtime coordinator.	30/10/17	Quality Improvement Facilitator for Clinical Effectiveness	Complete	08/11/17
6.2	Agree and implement a process for the provision of oral nutritional supplements and ensure accurate recording.	30/10/17	Catering Dietician and Associate Medical Director and Associate Nurse Director	Ward 4 testing new documentation and processes, with the intention to scale up and spread is ongoing until 14th February 2018. Scale up and spread anticipated thereafter.	
10	**Area for improvement 8: Skills and accountability** Must ensure that staff have the knowledge and skills required to meet patients' food, fluid and nutritional care needs, commensurate with their duties and responsibilities and relevant to their professional disciplines and area of practice (see page 19).				

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	Actions:				
10.1	Provide education as outlined above in actions 1.2, 1.3, 1.4, 1.5, 2.2 and 2.3.	Timescales as outlined above	Associate Director of Nursing and Midwifery/Operational Lead for Training and Development/ Associate Medical Director	As above timescales.	
10.2	Provide clarity of roles and responsibilities in nutritional care policy.	31/10/17	Associate Director of Nursing and Midwifery	Complete	23/11/17
11	**Area for improvement 9: Leadership and management** Must ensure there is governance and leadership for nutritional care in order to provide assurance to the NHS Borders' Board that the provision of food, fluid and nutrition meets the required national standards for safe and effective patient care. This must include (but not restricted to): a strategic hydration and nutritional care group which produces an annual report, policies and pathways to ensure delivery of safe and effective care that meets individual nutritional care needs, and evidence of appropriate risk assessments and management (see page 20).				

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	Actions:				
11.1	Develop Food, Fluid and Nutritional Care strategy.	31/12/17	Director of Nursing and Midwifery	Complete.	14/12/17
11.2	Refresh steering group for FFN to provide a strategic focus, including a review of membership.	30/09/17	Associate Director of Nursing and Midwifery	Complete	
11.3	Develop appropriate NHS Borders wide policies and pathways to ensure delivery, using learning from other NHS organisations.	30/11/17	Director of Nursing and Midwifery	Policies are complete. Pathways are in development and expected to be completed by September 2018.	
11.4	Ensure improved annual reporting to Board Clinical Governance Committee (CGC) in line with annual workplan.	31/03/18	Associate Director of Nursing and Midwifery	Complete	29/11/17
12	**Area for improvement 5, 6 & 10: Communication** Must ensure that fluid balance and food record charts are commenced and accurately completed for those patients who require them and appropriate action is taken in relation to patients intake or output as required (see page 18). Must ensure all artificial feeds and water are fully and accurately recorded in line with local protocol (see page 18).				

Ref.	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	Must ensure that all documentation is dated, timed and signed and space should be made available for this on the activities of daily living section of the Adult Unitary Record and each Rapid Risk Assessment (see page 21). *Actions:*				
12.1	Agree consistent process for recording fluid balance.	31/10/17	Associate Director of Nursing & Midwifery	Complete	18/09/17
12.2	Reinforce standards of good record keeping and audit compliance including testing a Person Centred Coaching approach.	31/10/17	Director of Nursing & Midwifery	Complete	18/09/17
12.3	Add space for date, time and signature to the activities of daily living section of the Adult Unitary Record and each Rapid Risk Assessment form as part of a full revision of the full Adult Unitary Record by the Short Life Working Group.	31/01/18	Associate Director of Nursing & Midwifery	Testing of the new unitary patient records will be complete by the end of February 2018. A timeline for the roll-out of care plans will be agreed once the unitary patient records are embedded into practice. This has been discussed with HIS.	

Title	*Standard Operating Procedure for The Completion of Menu Cards*
Document Type	*Standard Operating Procedure (SOP)*
Issue number	*1*
Approval/Issue date	*14 November 2019*
Review date	*14 November 2021*
Approved by	*Food Fluid and Nutrition Group*
Prepared by	*Caroline Wylie - Quality Improvement Facilitator – Patient Safety* *Garry Tucker – Clinical Risk Facilitator*
Developed by	*Patient Safety Team – Clinical Governance and Quality* *Food Fluid and Nutritional Care Steering Group*
Reviewed by	*Food Fluid and Nutritional Care Steering Group*
Equality & Diversity Impact Assessed	*N/A*

Introduction

NHS Borders recognises that food, fluid and nutrition are fundamental to health and wellbeing, and therefore to quality and safety in healthcare.

It is essential that patients receive meals that meet their individual' dietary requirements including their eating and drinking likes and dislikes; food allergies and therapeutic diet stipulations. Any cultural/ethnic/religious needs must also be taken into account.

To ensure that this happens, patient menus must be completed fully and accurately and checked before they are forwarded to the Catering Team for preparation of meals.

All multi-disciplinary staff are responsible for adhering to this Standard Operating Procedure (SOP) and ensuring safe nutritional care and adequate hydration.

Purpose/Intent

The purpose of this SOP is to provide instruction on how to complete patient menu cards in adult inpatient areas within Borders General Hospital (BGH) to reduce the risk of patients receiving inappropriate or unsafe meals.

This document is intended to be used in conjunction with the NHS Borders Food, Fluid and Nutritional Care Policy.

Procedure

- Patient's food, fluid and nutritional needs must be communicated to every member of the ward team every shift and when any changes arise. This should be included in the patient handovers and/or written safety brief as routine and documented where appropriate

  The staff handover/safety brief will include information on those patients who:
    - require therapeutic diets, texture modified diets or have particular food requirements e.g. high calorie/high energy, gluten free, oral nutritional supplements, restricted foods
    - have dyspahgia (swallowing problems)
    - are nil by mouth
    - have food allergies
    - require a Food Intake Chart
    - require adapted cutlery
    - require assistance with eating/drinking

- The person in charge of the ward will identify at least one appropriate Ward Meal Coordinator (for the day/shift). This person may be any discipline and any band but must not be a volunteer.

- The Ward Meal Coordinator will ensure that;

    - All staff on the ward are aware of the practice of completing menu cards and that they are encouraged to adhere to this procedure

- All patient menus are completed for the following day as the per the procedure outlined below:

- When the blank patient menu cards arrive from the kitchen in the morning, the Ward Meal Coordinator will assign at least one appropriate member of the ward team to assist in their completion

- The staff member will use the handover/safety brief to inform the needs of each patient, ensuring that the correct menu card is chosen and then completed accurately

- Staff must choose the correct menu card for each patient:
  - yellow dysphagia menu for modified textured diets that include texture C (pureed), texture E (mashed on ward prior to patient eating meal) and texture E (leave unmashed).'
  - white standard menu for all other diets including soft options, high calories/high energy, healthier choice, vegetarian options and those modified for therapeutic and allergy needs(e.g. gluten free, dairy free, nut free, low potassium, low residue).

- Each menu will need to have three meals (per card) marked with:
  - the name of the patient
  - the ward name/number
  - large portion / small portion
  - a diet label (where available)
  - other dietary requirements and/or allergies must be hand-written

- Wherever possible menu cards will be completed with the involvement of the patient, their relative or carer

- The completed menu cards are then collected and checked by the Ward Meal Coordinator, using the handover/safety brief, to confirm:
  - the correct number of menus have been competed to cover all patients
  - the menu card is fully completed
  - meal choices are suitable for the patient's dietary requirements and allergens and ensure a label or handwritten note has been added where necessary
  - patients requiring modified texture meals have ordered correct textured options on a yellow menu card

- The menu cards are placed on the appropriate meal trolley to be returned to the kitchen

- When the ward receives their meal trolley they must check that the number of meals ordered have arrived. The Catering Team must be contacted if there are any discrepancies

- Meals should be checked as they are removed from the trolley to ensure that the items delivered match the menu cards and are appropriate and safe for the patient to consume

- In the event of any menu card having been partially or incorrectly completed, this must be reported to the Senior Charge Nurse of the ward

- It is expected that the Senior Charge Nurse will report this via NHS Borders electronic adverse event recording system (Datix). The Senior Charge Nurse will be required to investigate how any errors occurred and discuss these with the Ward Meal Coordinator responsible on that day/shift.

Title	*Standard Operating Procedure for Protected Mealtimes*
Document Type	*Standard Operating Procedure (SOP)*
Issue number	*1*
Approval/Issue date	*14 November 2019*
Review date	*14 November 2021*
Approved by	*Food Fluid and Nutrition Group*
Prepared by	*Garry Tucker – Clinical Risk Facilitator* *Caroline Wylie – Quality Improvement Facilitator – Patient Safety*
Developed by	*Patient Safety Team – Clinical Governance and Quality* *Food Fluid and Nutritional Care Group*
Reviewed by	*Food Fluid and Nutritional Care Group*
Equality & Diversity Impact Assessed	*14/08/2019*

Introduction

Good nutritional care and adequate hydration are essential elements of a patient's treatment. Protected mealtimes are periods of time when all non-urgent activity stops, enabling the patient to eat without interruption and allowing staff to provide assistance. This ensures that maximum priority is given to good nutritional care.

The patient and their family or carers should be made aware of the mealtime process as soon after admission as is reasonably possible. They should be informed that visiting during mealtimes is only allowed if the intention is to assist or encourage the patient to eat and drink.

All multi-disciplinary staff are responsible for adhering to this Standard Operating Procedure (SOP) and ensuring good nutritional care and adequate hydration are provided to our patients.

Purpose/Intent

The purpose of this SOP is to demonstrate how protected mealtimes should be implemented within NHS Borders inpatient settings.

This document is intended to be used in conjunction with the NHS Borders Food, Fluid and Nutritional Care Policy.

Procedure

- The person in charge of the ward will organise staff mealtimes to maximise the number of people available to assist patients with eating & drinking

- The person in charge of the ward will identify an appropriate Ward Meal Coordinator of any discipline or band (but not a volunteer). This person will ensure that:
    - all staff on the ward are aware of the practice of protected mealtimes and that they are encouraged to adhere to this procedure

    - appropriate signage is displayed outside the ward to inform staff and visitors of the protected mealtime period

    - all non essential duties cease on the ward, e.g. ward rounds, drug rounds, GP visits, cleaning, documentation, therapy - unless clinically appropriate

    - staff directly involved with patients at mealtimes will avoid answering the telephones. Clinical areas may consider identifying a specific person to answer all calls

    - patients requiring assistance are identified by the ward team prior to the serving of meals and consideration is given to the order in which meals are served and who will assist each patient

- Before the serving of food, clinical staff should prepare themselves, the environment and their patients:

- all eating surfaces should be cleaned and cleared of items not conducive to mealtimes such as urine bottles, used dressings and tissues

- consideration should be given to where patients sit to support both the safety and the social aspects of mealtimes. If there are communal areas then patients are to be encouraged and assisted to sit at the table

- where appropriate, patients should be assisted to the toilet prior to meals being served

- patients should be assisted to sit in an appropriate eating position, i.e. upright at 90°

- patient's who wear dentures should be assisted to clean and fit them

- all patients should be given the opportunity to wash their hands or use hand wipes

- patients should be offered appropriate personal protective equipment, e.g. serviettes, aprons

- tables should be within reach and set with appropriate equipment, e.g. plate guards, adapted cutlery, cups

- staff should ensure their hands are washed and that they are wearing appropriate personal protective equipment, e.g. blue aprons. Any relatives, carers or volunteers should be encouraged to do the same.

- Meals should be checked as they are removed from the trolley to ensure that the items delivered match the menu cards and are appropriate and safe for the patient to consume

- Meals should be served and delegated staff members should proceed to help those patients who require prompting, supervision or assistance to eat or help with the removal of any packaging

- Hot food should ideally be served within 15 minutes of the arrival of the meal trolley onto the ward

- Interruptions during mealtimes should be minimised. Anyone entering the ward during this time should be made aware of the mealtime process and encouraged to return after the meal is completed

- When trays or plates are removed staff should check the proportion of food consumed and where appropriate this should be recorded on a Food Intake Chart or in the patient's healthcare records

- Staff should ensure all non catering items are removed from the tray before placing them back into the meal trolley, e.g. medicine pots, tissues, cotton wool balls

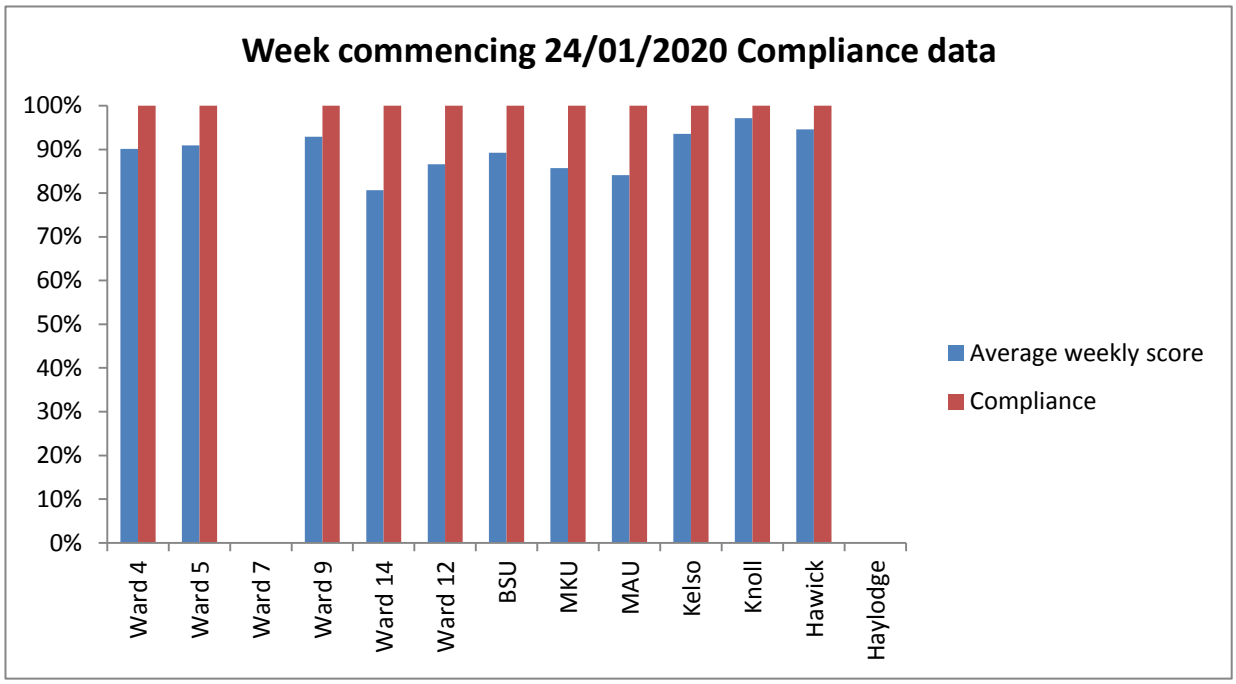
- Any packaged cold food items that are unopened, such as sandwiches or jelly, should be removed from the trays, labelled with the patient's details and placed in the ward food refrigerator

- If a relative or carer is assisting the patient to eat they should be encouraged to assist in the completion of any Food Intake Charts

- After meals are completed and trays or plates have been removed, patients should be assisted to remove any aprons or serviettes. Checks should be carried out to ensure that none of the patient's personal belongings, such as their dentures, have been wrapped up in an apron or serviette.

- Patients should be offered hand wipes and staff should ensure patient's hands, mouth and clothes are free of foodstuffs

- Staff should tidy and wipe tables and ensure all debris is removed


Week commencing 24/01/2020 Compliance data
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Ward 4
Ward 5
Ward 7
Ward 9
Ward 14
Ward 12
BSU
MKU
MAU
Kelso
Knoll
Hawick
Haylodge
Average weekly score
Compliance

Affix Patient Label
Name:
CHI:
Date of Birth:

Intake Output Chart

Date: **Patient weight**: _____

Previous Day's Intake: **Output:**

Reason for chart

Maintenance Goal Today: _____ **ml** (**See Overleaf**)

Time	Intake (ml)					Output (ml)				
	Oral	Oral Type	Enteral	IV	IV Type	Urine / Total	Stool / Stoma	Vomit / Aspirate	Drain / Fistulae	Blood
01:00										
02:00										
03:00										
04:00										
05:00										
06:00										
07:00										
08:00										
09:00										
10:00										
11:00										
12:00										
13:00										
14:00										
Subtotal										

Stop and Check			
Intake (Oral/Enteral + IV) less than **500ml**?	Yes	No	If Yes to any question or if any concern **inform nurse in charge**
Urine less than **300ml?**	Yes	No	
Other losses more than **500ml**?	Yes	No	

15:00										
16:00										
17:00										
18:00										
01:00-18:00 Total										
19:00										
20:00										
21:00										
22:00										
23:00										
00:00										
24 hr Totals										

Total Intake (ml)		**Total Output (ml)**	
		Fluid Balance (ml) (Total Intake minus Total Output)	

Use a volumetric pump to administer IV fluids

DAILY ADULT INTRAVENOUS/SUBCUTANEOUS FLUID PRESCRIPTION CHART

Prescribe fluids for a maximum of 24 hours on this chart – **N.B. NOT FOR PAEDIATRICS**

NHS Borders

Affix Patient Label Name: CHI: Date of Birth:	**Date**: **Patient Weight**: **Maintenance goal today** (including oral intake) 30ml/kg/24hrs (20-25ml/kg/24hrs in frail elderly) _____ Date of Latest U&Es/Hb_____**checked?** (circle): **Yes / No**

1. Assess patient	**Hypovolaemic (reassess regularly)**		**Euvolaemic (fasting >8hrs)**	**Hypervolaemic (overloaded)**	Special cases **ESCALATE**	
2. Why give fluid?	**Resuscitation**	**Replacement**	**Maintenance**	**Restriction** _____ ml	Cardiac dysfunction	
					Renal / Liver failure	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Fluid challenge 250 -500ml over 5-15mins & reassess	Estimate losses in past 24 hrs. Give replacement before maintenance.	30ml/kg/24hrs Subtract other intake **Today's IV needs**: **= _____ml**	Fluid restrict. Consider diuresis. Ensure patient receives fluid goal.	Obstetrics	
					Head Injury	
4. Which fluid?	PlasmaLyte148 (PL148) OR Blood on BTS chart	PL148 0.9%NaCl+KCL for upper GI loss	0.18%NaCl/ 4%Glucose +/- KCL * **If Na ≤132 use PL148**	ESCALATE & D/W Senior Clinician.	***Give 40mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating**	

Never give 0.18%NaCl/4%Glucose/KCL at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on intravenous insulin use 0.18%NaCl/4%Glucose/KCL

**Subcutaneous fluids– See Scottish Palliative Care Guidelines and S/C Fluids on Intranet.
Subcutaneous Fluids Administration Procedure

Weight (kg)	**Maintenance Requirement /24hr** (30ml/kg/24hrs)	**Rate** (ml/hr)
35-44	1200 ml	50
45-54	1500 ml	65
55-64	1800 ml	75
65-74	2100 ml	85
≥75	**2400 ml (max)**	**100 (max)**

PLEASE PRESCRIBE IN ml/hr FOR MAINTENANCE FLUIDS

Resuscitation / Replacement Fluid in this box Still hypotensive after 2000ml of resuscitation fluid? Escalate/CCOT/ITU

Fluid +/- Additions e.g. KCL / $MgSO_4$	**Vol** ml	**Rate** ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start Time	Given by / Checked by
			Stop	Review				
			Stop	Review				
			Stop	Review				
			Stop	Review				
			Stop	Review				
			Stop	Review				
			Stop	Review				

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids**

			Continue					
			Stop	Review				
			Continue					
			Stop	Review				
			Continue					
			Stop	Review				
			Continue					
			Stop	Review				

DO NOT USE IN PAEDIATRIC PATIENTS ≤ 16YEARS. (Paediatric charts available in ward 15 Ext 26015)