

Clinical Standards ~ *September 2003*

# Food, Fluid and Nutritional Care in Hospitals

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# 1. Introduction

This document introduces NHS Quality Improvement Scotland's *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals*. These standards were developed by the Project Group convened by NHS Quality Improvement Scotland and apply to specific elements of the service. They include sections on:

- the strategic and co-ordinated 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.

The 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.

The initial sections of this document provide background information on NHS Quality Improvement Scotland and the basic principles used to develop the standards (Sections 2 and 3 respectively).

The development of the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* is outlined in Section 4, and the membership of the Project Group undertaking this work is given in Section 5. The overarching principles guiding development of the standards are provided in Section 6.

Section 7 provides basic information about food, fluid and nutritional care, and the evidence underpinning the standards is presented in Section 8.

**Section 9 contains the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals*.**

Finally, Section 10 provides a glossary of terms used in the standards.

## 2. Background on NHS Quality Improvement Scotland

NHS Quality Improvement Scotland was established as a Special Health Board on 1 January 2003 as a result of bringing together the Clinical Resource and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS Quality Improvement Scotland is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

A part of this remit is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals and members of the public, NHS Quality Improvement Scotland sets standards for clinical services, assesses performance throughout NHSScotland against these standards, and publishes the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service. A wide range of diseases and services is at present being addressed, including infection control, vascular services and specialist palliative care.

### **Project Groups**

For each service in the work programme, NHS Quality Improvement Scotland appoints a project group comprising appropriate healthcare professionals and members of the public to:

- oversee the development of, and consultation on, the standards;
- recommend an external peer review process; and
- report on its findings to the NHS Quality Improvement Scotland Board.

As part of their rolling programme, individual project groups ensure that the standards are regularly evaluated and revised so that they remain relevant and up to date (reflecting new procedures and treatments). They also ensure that targets of achievement are raised as performance improves.

### **Development of Standards**

The way in which standards are developed is a key element of the quality assurance process. Groups working on behalf of NHS Quality Improvement Scotland are expected to:

- adopt an open and inclusive process involving a wide range of both members of the public and professional people through a variety of mechanisms;
- work within NHS Quality Improvement Scotland policies and procedures; and
- test standards through undertaking pilot reviews to ensure that they meet the principles of NHS Quality Improvement Scotland.

In addition to standards for specific services or conditions, generic clinical governance standards have been set which apply to all clinical services.

### **Review**

The framework for the NHS Quality Improvement Scotland review process is as follows:

- once the standards have been finalised, each relevant NHS Board/service is asked to undertake a self-assessment of its service against the standards;
- a review team visits the NHS Board/service on behalf of NHS Quality Improvement Scotland to follow up this self-assessment exercise with an external peer review of performance in relation to the standards; and
- NHS Quality Improvement Scotland reports the findings for the NHS Board/service, based on the self-assessment exercise and on the external peer review.

Peer review teams are multidisciplinary, including both healthcare professionals and members of the public. All teams are led by an experienced clinician and are supported by staff from NHS Quality Improvement Scotland.

All the processes being developed are subject to review and evaluation, and this will help NHS Quality Improvement Scotland improve its quality assurance system.



## Further Information

For further information about NHS Quality Improvement Scotland, or to obtain additional copies of these standards, please contact:

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Copies of all NHS Quality Improvement Scotland publications can also be downloaded from the website (**[www.nhshealthquality.org](http://www.nhshealthquality.org)**).

### 3. Background on Clinical Standards - Basic Principles

The standards set by NHS Quality Improvement Scotland are:


- focused on clinical issues and include non-clinical factors that impact on the quality of care;
- written in simple language;
- based on evidence (recognising that levels and types of evidence will vary);
- written to take into account other recognised standards and clinical guidelines;
- clear and measurable;
- achievable but stretching;
- developed by healthcare professionals and members of the public;
- consulted on widely;
- published on paper and electronically (on the Internet); and
- regularly reviewed and revised to make sure they remain relevant and up to date.

Some standards are common to all clinical services, others specific to particular conditions.

#### **Format of Standards and Definition of Terminology**

All standards set by NHS Quality Improvement Scotland follow the same format:

- each standard has a **title**, which summarises the area on which that standard focuses;
- this is followed by the **standard statement**, which explains the level of performance to be achieved;
- the **rationale** section provides the reasons why the standard is considered to be important; and
- the standard statement is expanded in the section headed **criteria**, which states exactly what must be achieved for the standard to be reached.



As already mentioned, NHS Quality Improvement Scotland aims to set standards that are **achievable but stretching**. This is reflected in the criteria. Most criteria are **essential**, in that it is expected that they will be met wherever a service is provided. Other criteria are **desirable**, in that they are being met in some parts of the service and demonstrate levels of quality which other providers of a similar service should strive to achieve. Each project group is responsible for determining which criteria are essential and which are desirable.

The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering of the criteria is not a reflection of priority. The distinction between 'essential' and 'desirable' is the only way in which criteria have been prioritised.

## **Generic Clinical Governance Standards**

As mentioned earlier in this document, generic clinical governance standards have been developed which apply to clinical services generally.

Copies of the generic clinical governance standards are available on request from NHS Quality Improvement Scotland or can be downloaded from the website ([www.nhshealthquality.org](http://www.nhshealthquality.org)).

## 4. Development of the Clinical Standards for Food, Fluid and Nutritional Care in Hospitals

### Background to the Project

The effective delivery of food and fluid and the provision of a high quality of nutritional care is crucial for the well-being of patients in all hospitals. The view of the public in Scotland is that there should be an improvement in the provision of food and nutritional care in hospitals.

In *Our National Health: A Plan for Action, A Plan for Change*, the Scottish Executive outlined its commitment to improve the quality of nutritional care provided in hospitals. Commitments were made on implementing recommendations from *Scotland's Health: A Challenge to Us All*, *Eating for Health - A Diet Action Plan for Scotland* and *The Nutrition of Elderly People and Nutritional Aspects of Their Care in Long-Term Care Settings*. This latter report, published by the Clinical Resource and Audit Group (CRAG) in 2000, revealed that 21% of older people in Scotland's long-term care establishments, including NHS and non-NHS sectors, are undernourished. This commitment was further endorsed in May 2003 when the Partnership Agreement, *A Partnership for a Better Scotland*, included the aim of ensuring adequate nutritional standards for food served in hospitals. Another key document informing the standards was the Scottish Executive's MEL 54, accompanying the *Nursing Homes in Scotland Core Standards* produced in 1999.

Although it was recognised that obesity is an increasing problem in Scotland, and has implications for health, the primary purpose of these standards was to address the risk of malnutrition in hospitals.

A commitment was made that standards would be developed on the provision of food, fluid and nutritional care in NHSScotland. At the same time, the Scottish Executive Health Department established a Departmental Steering Group on Food and Nutritional Care with the remit, drawn up in March 2002, to make recommendations on how to deliver these commitments.

In December 2001, a Food, Fluid and Nutritional Care Project Group was established, chaired by Philippa Grant (Board Member) whose remit was to oversee the Clinical Standards Board for Scotland (CSBS) quality assurance process for this project. The Project Group is multidisciplinary and includes both health service staff and members of the public. Membership of the Project Group can be found in Section 5.

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## Draft Standards

The first task of the Project Group was to develop, in line with the then CSBS policies and procedures, draft standards for the provision of food, fluid and nutritional care in a hospital setting. Members of the Project Group drew upon their own experience of both providing and using services. The draft standards built on work already done in this area by organisations which have now been integrated to form a new clinical effectiveness organisation, NHS Quality Improvement Scotland, in January 2003. The organisations and input were:

- **Clinical Resource and Audit Group (CRAG)**  
Produced the initial report, which established the baseline audit used as the foundation for these standards.
- **Clinical Standard Boards Scotland (CSBS)**  
Introduced policies and procedures for the development of standards.
- **Nursing and Midwifery Practice Development Unit (NMPDU)**  
Produced a best practice statement on nutrition.
- **Scottish Health Advisory Service (SHAS)**  
Produced quality indicators for older people.
- **Health Technology Board for Scotland (HTBS)**  
Involved in reviewing validated tools for screening for undernutrition based on the principles of simplicity of use, consistency of approach and building on good practice.

The food, fluid and nutritional care in hospitals project is therefore one of the first projects co-ordinated by the above organisations coming together as NHS Quality Improvement Scotland.

NHS Quality Improvement Scotland is committed to working in partnership with the public and to widening the opportunities for enabling patients, carers and the public to inform its work. As part of this commitment, the Project Group used a 'snapshot survey' to inform the development of the draft standards. This survey identified issues about hospital food that are important to patients. Groups contributing to the survey included Age Concern Scotland, the Profound and Multiple Impairment Service, the Family Council of the Royal Hospital for Sick Children, Edinburgh, and a number of ethnic minority groups in Glasgow.

## Consultation

The draft standards were published in October 2002 and the consultation period ran until February 2003. Several different methods of consultation were employed:

- The draft standards were circulated widely, to relevant professional groups, health service staff, Local Health Councils, voluntary organisations and individuals, and responses to the standards were invited both by post and electronically.
- Open meetings were organised to elicit responses, again from both lay and professional people working in the NHS.
- A further public consultation exercise was conducted with the aim of involving health service users, carers and members of the public. This exercise involved the development and distribution of a comments form to provide a plain language guide to the standards and a framework for feedback. The comments forms were distributed widely through Local Health Councils and voluntary organisation networks. Comments forms were also sent, along with a short questionnaire, to a sample of 500 members of the South Lanarkshire Citizens Panel. In addition, five Fife User Panels discussed the draft standards and submitted comments, and focus group discussions were held at the Glasgow Central Mosque Day Care Centre, Wing Hong Chinese Multicultural Day Centre in Glasgow, Jewish Representative Council in Giffnock and the Patients' Council at the Royal Edinburgh Hospital, Edinburgh. A meeting was also held with the Family Council of the Royal Hospital for Sick Children, Edinburgh.

The responses from all these sources informed the process of revising the draft standards.

## Pilot Peer Review Visits

NHS Quality Improvement Scotland reviews performance against standards. The process of assessing performance usually takes the form of each organisation, which is involved in supplying the service, undertaking a self-assessment. This is then validated by a peer review visit. After the consultation period, the self-assessment and peer review process for the standards for food, fluid and nutritional care in hospitals were piloted in Grampian University Hospitals NHS Trust and Tayside Primary Care NHS Trust. This exercise further informed the refining of the standards.

The Project Group is now using the experience of the pilot visits in developing an appropriate self-assessment and peer review process, reflecting the perspectives of the Trusts and the pilot review teams.

## 5. Membership of the Food, Fluid and Nutritional Care in Hospitals Project Group

The membership of the Food, Fluid and Nutritional Care in Hospitals Project Group, chaired by Mrs Philippa Grant, NHS Quality Improvement Scotland Board Member, is presented below:

<b>Name</b>	<b>Title</b>	<b>NHS Board Area/Organisation</b>
Mr Andrew Anderson	National Co-ordinator	Maggie's Centres
Mrs Alison Blakeley	Advisor for Older People's Services	Scottish Health Advisory Service (NHS Quality Improvement Scotland since January 2003)
Mrs Sheila Board	Lay Representative	Highland
Professor Christine Bond (until March 2003)	Consultant in Pharmaceutical Public Health	Grampian
Mrs Lynne Cameron	Section Manager, Food and Drinks Section	Scottish Healthcare Supplies Division
Mr Scott Carmichael	Head of Performance Management North Boards	Scottish Executive Health Department
Ms Joyce Cormie	Lay Representative	Fife
Ms Angela Cullen	Project Manager	Audit Scotland
Ms Lynne Douglas	Lead Therapist, Research, Development & Clinical Effectiveness	Lothian
Mr Sheem Gill	Multicultural Health Officer	Greater Glasgow
Mr Bert Hannah	Lay Representative	Fife
Ms Gill Harris	Project Nurse	Nursing & Midwifery Practice Development Unit (NHS Quality Improvement Scotland since January 2003)
Mr Sean Hunter	Catering Services Manager/ Chairman	Lothian/ East of Scotland Branch, Hospital Caterers Association
Mr Paul Lee	Area Manager (North)	Age Concern Scotland
Dr Alastair McKinlay	Consultant Gastroenterologist/ Scottish Regional Representative	Grampian/ British Association for Parenteral and Enteral Nutrition (Scotland)
Dr Brendan Martin	Consultant in Geriatric Medicine & Clinical Director of Medicine	Lanarkshire
Mr George Reid	Trustwide Catering Manager	Grampian

## 5. Membership of the Food, Fluid and Nutritional Care in Hospitals Project Group

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Mr John Simmons (from March 2003)	Portfolio Manager	Audit Scotland
Mr John Taylor	Chairman, Local Health Council (until April 2003)	Borders
Ms Marjory Thomson	Professional Adviser - Nutrition	Care Commission
Dr Sara Twaddle (until December 2002)	Health Portfolio Manager	Audit Scotland
Mrs Jacqueline Walker	Dietitians Clinical Network Project Facilitator	Tayside
Ms Sue Welsh (until March 2003)	Team Manager, Older People	Dumfries & Galloway Council Social Work Department

Support from NHS Quality Improvement Scotland was provided by Ms Frances Smith (Director of Nursing and Quality - Standards and Reviews), Mrs Anne Hanley (Review Team Manager), Dr Donald Morrison (Senior Project Officer), Mrs Rosemary Hector (Project Officer), and Mrs Wendy Forbes (Project Administrator).

## 6. Overarching Principles

As mentioned in Section 2, NHS Quality Improvement Scotland has developed generic clinical governance standards, which are standards of care that underpin all clinical services provided by NHSScotland. The significance of food, fluid and nutritional care as a clinical issue, as a cultural issue, and its position at the interface between the patient and various systems in a hospital makes provision of nutritional care central to clinical governance. The *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* should therefore be read in conjunction with the generic clinical governance standards, which provide a broader context.

Some issues covered in the generic clinical governance standards are emphasised in the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals*, where the Project Group considered their importance merited a special mention, eg education for staff, and patient information.

A number of key points should also be noted in order to interpret and apply the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals*, namely:

- Whilst a patient's nutritional status will be recorded in the medical notes, these standards primarily address the issue of malnutrition in hospitals. These standards were developed as a response to research, which indicates that patients risk malnutrition in the hospital setting. The Project Group also recognises that obesity is an increasing problem in Scotland and that it is associated with other long-term risks to health, eg diabetes, heart disease. The problems associated with obesity tend to occur over a long period of time, whilst malnutrition can be addressed more immediately. When obesity is identified, it is important that this is highlighted in the medical notes and the patient referred to community services for advice and help.
  
- In drawing up the standards, the Project Group took into account those who are vulnerable and susceptible to malnutrition:
  - children;
  - older people;
  - those with physical disabilities which inhibit eating and drinking;
  - those with learning disabilities;
  - the mentally ill; and
  - those with particular cultural or religious requirements.

All patients in these groups have a particular risk of malnutrition in hospital. The Project Group also recognised that some patients, for various reasons, enter hospital with a high risk of malnutrition. These standards are designed to ensure that this is recognised and that appropriate action is taken.

- These standards apply to all patients. The standards are set at a level, which is achievable but stretching, and apply, in context, to all patient groups. For example, children are not mentioned separately in these standards but it is assumed that whilst the screening process and the appropriate action taken to avoid malnutrition will differ from those employed for adults, the principles identified in these standards remain applicable.
- The Project Group also recognises work completed for patients with particular needs. For example, NHS Estates in England and Wales has produced *Better Hospital Food: Catering Services for Children and Young Adults*. The Project Group does not envisage a conflict between these guidelines for particular groups and the NHS Quality Improvement Scotland standards for food, fluid and nutritional care in hospitals, but rather welcomes the complementary nature of these more specific guidelines.
- The food, fluid and nutritional care standards apply in all hospitals. Nutritional care is particularly important in the long-stay setting, where mealtimes assume significance in the patient's daily routine and in the opportunities for social interaction, and where the food and fluid, and how it is served, is related to the quality of life. Nutritional care, however, is also very important in the acute setting, where the clinical significance of good nutrition can often be easily overlooked.
- The Project Group recognises that the provision of nutritional care is on a continuum. This extends from one end of the scale, where there is the routine provision of regular meals, relying on the services of catering staff, to the other end of the scale where patients may rely entirely on the work of clinicians and nurses for the delivery of complex nutritional techniques. Examples include intravenous and enteral tube feeding.

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- The *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* bring together the patient at all stages in the journey of care, with the processes of planning, preparing and delivering food and fluid; in this context referred to as the 'food chain'. Legislation already determines many standards in the preparation of food and fluid. These NHS Quality Improvement Scotland standards are written with the intention of honouring and supporting the laws that are designed to ensure food hygiene and safety.
  - Individual organisations have their own specifications, local protocols and systems of food preparation and delivery. Each service delivery system has different merits and the standards infer that those planning food, fluid and nutritional care will review the strengths and limitations of their own systems and plan accordingly. It may be necessary for NHS Boards to have more than one planning group to oversee the implementation of local protocols, particularly where the geography is complex and sites are separated. The Project Group recognises that redesign of some services may be necessary to implement some of the standards. Identifying and sharing best practice throughout Scotland will be the key to seeking cost-effective solutions.
  - The Project Group recognises that good nutritional care requires effort on the part of many staff groups including doctors, the catering staff, and dietitians. The Project Group acknowledges that much of the routine nutritional care of patients is the responsibility of nurses. Indeed, the current standards were developed from the Nursing and Midwifery Practice Development Unit best practice statements on nutrition. These standards may require some changes in training for all staff but also have the potential to present new opportunities, in particular for nurses, to develop an interest in nutrition. The use of educational packages for practical training, for example the distance learning package for nurses designed by Queen Margaret University College, Edinburgh (the *Partnership in Active Continuous Education* packs) will be useful in assisting training and heightening awareness of nutrition amongst this professional group.
  - In order to ascertain a patient's nutritional status, an assessment must be made when a patient is admitted to hospital. Screening, using a validated screening tool, will follow this. The Project Group recognises that good professional judgement will enable those making the initial assessment to decide whom to exclude from screening.

- When screening identifies compromised nutritional status the reasons for this must be explored. At this point, other services will become involved. The standards, therefore, refer to other services such as those of speech and language therapists, dentists, occupational therapists and psychiatrists, in addition to dietitians. These standards are designed to allow those making the initial assessment the scope to decide at what point to refer to a dietitian; it would not be expected that a dietitian is necessarily involved in administering the screening tool.
- The standards have a bearing on the provision of equipment for weighing and measuring. It is the NHS Board operational division's responsibility to ensure that scales and other equipment employed for surrogate measurements are supplied, serviced and properly standardised, so that meaningful comparisons over time can be made during the patient's journey.
- The Project Group acknowledges that there are many pressures, particularly in the acute setting, on space available to patients in hospitals. Nevertheless, the option for patients to move away from their beds to a different area for meals is important, and would be considered clinically appropriate in the extended care setting. Mealtimes, for patients of all ages in rehabilitation, those in step-down care, day hospitals and continuing care, assume a social and psychological significance, and a separation of eating and sleeping functions would be considered good practice.
- The Project Group recognises that training will be required for all those, including carers, who are involved in the serving of food and fluid, and in assisting patients with feeding.

## 7. An Introduction to Food, Fluid and Nutritional Care in Hospitals

“Proper nutrition and health are fundamental human rights.”  
(Gro Harlem Brundland, Director General, World Health Organisation).

Food is necessary for life and represents a basic human right, but it is also a source of great pleasure, with important social, cultural, and religious functions. What we eat and drink affects our health and wellbeing and reflects our culture and beliefs.

A person's nutritional needs vary over time, depending, for example, on whether the person is growing, or on the person's level of physical activity. Illness may produce profound changes in an individual's nutritional requirements, and may alter the appetite, and the ability to eat and to communicate needs. Patients who are ill, particularly in hospital, are more at risk of malnutrition, which in turn may delay their recovery and increase the risk of complications.

The provision of good quality food, fluid and nutritional care is an integral part of the therapeutic care provided in hospital. Meeting patients' nutritional requirements will help them get better and keep healthy. The clinical importance of nutritional care, however, is often overlooked.

The term 'nutritional care' may not be familiar to everyone, but embodies a co-ordinated approach to the delivery of food and fluid by different health professionals, and views the patient as an individual with needs and preferences. It is the process that determines a person's preferences and cultural needs, defines his or her physical requirements, and then provides the person with what is needed. It follows a person's progress through an illness, by responding to changing nutritional requirements. It involves the monitoring and reassessment of nutritional status at regular intervals, referral for specialist care when appropriate, and good communication with services in the community. Good nutritional care will involve training for staff, carers and patients, and access to information.

The standards presented in this document were developed to reflect these aspects of nutritional care and are designed to follow the patient journey.

## 8. Evidence Base for the Clinical Standards for Food, Fluid and Nutritional Care in Hospitals

The evidence base for the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* was principally drawn from the following source documents:

1. Ad Hoc Group on Nutrition Programmes in Hospitals. Food and Nutritional Care in Hospitals: How to Prevent Undernutrition. Strasbourg: Council of Europe (2002 - for Council of Europe Committee of Experts on Nutrition Food and Safety and Consumer Health). <http://book.coe.int/GB/CAT/LIV/HTM/L1994.htm> [publication and ordering details] url cited 24/07/03.
2. Allison S. Hospital Food as Treatment. A Report by a Working Party of BAPEN [British Association for Parenteral and Enteral Nutrition], Maidenhead: BAPEN (1999). [www.peng.org.uk/food-as-treat.html](http://www.peng.org.uk/food-as-treat.html) [summary of report] url cited 23/07/03.
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<http://bmj.com/cgi/content/full/308/6934/945> [full article] url cited 24/07/03.
  16. McWhirter J, Pennington C. Patients Go Hungry in British Hospitals: Malnutrition Is Common, Unrecognised, and Treatable in Hospital Patients [Letter]. *British Medical Journal* (1997); 314 (7082): 752.  
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## 9. Clinical Standards for Food, Fluid and Nutritional Care in Hospitals

**STANDARD 1 - Policy and Strategy**

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**STANDARD 2 - Assessment, Screening and Care Planning**

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**STANDARD 3 - Planning and Delivery of Food and Fluid**

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**STANDARD 4 - Provision of Food and Fluid to Patients**

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**STANDARD 5 - Patient Information and Communication**

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**STANDARD 6 - Education and Training for Staff**

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## STANDARD 1 ~ Policy and Strategy

Standard Statement	Rationale
<p>Each NHS Board has a policy, and a strategic and co-ordinated approach, to ensure that all patients in hospitals have food and fluid delivered effectively and receive a high quality of nutritional care.</p>	<p>A strategic and co-ordinated approach is required as nutritional care, food and fluid are crucial for the well-being of patients in all hospitals. Reference: (7)</p> <p>Good nutritional care improves disease outcomes and patients' quality of life. Reference: (20)</p> <p>Undernutrition has significant financial implications for NHSScotland. References: (13), (14)</p> <p>Complex nutritional support is delivered best by a multidisciplinary support team. References: (26), (28)</p>

## Criteria

### Essential

- 1.1 Each NHS Board has a policy on nutritional care and a strategic plan to improve the provision of nutritional care, food and fluid. These:
- i) are patient-focused, follow the patient journey of care and ensure that a comprehensive and co-ordinated nutritional care service is provided;
  - ii) are based on a health population needs assessment, which considers local ethnic, religious and cultural patterns and which recognises the need for equity of access;
  - iii) recognise patient groups with particular needs, eg children;
  - iv) are risk-assessed and managed;
  - v) are discussed annually at NHS Board level to evaluate progress and produce a plan for further action, based on:
    - reports from operational nutritional care group(s);
    - any need for re-design; and
    - the need for managing change of attitude and behaviour;
  - vi) include a financial framework to underpin the implementation of the action plan; and
  - vii) are published in a format easily understood by and accessible to the public.

- 1.2 Each NHS Board area has at least one operational nutritional care group responsible to the NHS Board for overseeing the implementation of:
- NHS Quality Improvement Scotland standards for food, fluid and nutritional care in hospitals; and
  - the NHS Board's strategic plan.

The nutritional care group produces an annual written report, detailing progress made and action taken/required.

The core membership of this group includes a senior manager reporting to the chief executive, a senior dietitian or dietetic manager, a lead doctor appointed by the medical director, a senior nurse appointed by the nursing director, a catering manager, a dentist, lay representation and co-opted specialist expertise appropriate for the population.

- 1.3 Where complex nutritional techniques are employed, the patient has access to the services of a clinical nutritional support team responsible for the clinical aspects of intravenous and enteral tube feeding. The core membership of this team includes a doctor, a dietitian, a specialist nutrition nurse and a pharmacist. Clinicians should be part of the Scottish Managed Clinical Network for Home Parenteral Nutrition.

## STANDARD 2 ~ Assessment, Screening and Care Planning

Standard Statement	Rationale
<p>When a person is admitted to hospital, an assessment is carried out. Screening for risk of undernutrition is undertaken, both on admission and on an ongoing basis. A care plan is developed, implemented and evaluated.</p>	<p>Undernutrition in hospital patients, and factors that prevent a patient eating and drinking adequately, are frequently not identified, and nutritional state decreases throughout hospital stay. References: (4), (15), (16), (27)</p> <p>Malnutrition is estimated to affect 15-40% of hospital admissions. Reference: (14)</p> <p>Patients' energy intake is below their nutritional needs and average requirements, which puts them at risk of undernutrition. Reference: (27)</p> <p>The screening and assessment processes help identify undernutrition and factors that may prevent patients from eating and drinking adequately. References: (7), (20)</p>

## Criteria

### Essential

- 2.1 When a person is admitted to hospital as an in-patient, the following are identified and recorded within **1 day** as part of the medical/nursing assessment:
- height and weight;
  - eating and drinking likes/dislikes;
  - food allergies and need for a therapeutic diet;
  - cultural/ethnic/religious requirements;
  - social/environmental mealtime requirements;
  - physical difficulties with eating and drinking; and
  - the need for equipment to help with eating and drinking.
- 2.2 The initial assessment includes screening for risk of undernutrition. This screening is carried out using a validated tool appropriate to the patient population, and which includes criteria and scores that indicate action to be taken.<sup>1</sup>
- 2.3 Repeat screenings are undertaken in accordance with clinical need and at a frequency determined by the outcome of the initial and subsequent screenings.
- 2.4 The outcome of screening is recorded in the medical notes.
- 2.5 The assessment process identifies the need for referral to specialist services, eg dietetic, dental.
- 2.6 Patients have access to specialist services:
- within agreed timescales; and
  - 7 days a week for urgent cases.

<sup>1</sup> The use of the Malnutrition Universal Screening Tool (MUST) for adults and the calculation of body mass index, in association with appropriate centile charts for children, would be appropriate.

**STANDARD 2 ~ Assessment, Screening and Care Planning  
(continued)**

Standard Statement	Rationale
<p>When a person is admitted to hospital, an assessment is carried out. Screening for risk of undernutrition is undertaken, both on admission and on an ongoing basis. A care plan is developed, implemented and evaluated.</p>	

## Criteria

### Essential

2.7 A multidisciplinary care plan is followed, reviewed and refined, and includes the:

- i) outcomes of the initial assessment;
- ii) outcomes of the screening for risk of undernutrition;
- iii) frequency/dates for repeat screenings; and
- iv) actions taken as a consequence of repeat screenings.

2.8 The discharge plan is developed with the patient and, where appropriate, carer, and includes information about:

- i) the patient's nutritional status;
- ii) special dietary requirements; and
- iii) the arrangements made for any follow-up required on nutritional issues.

### Desirable

2.9 Patients referred to the dietetic service are seen within **2 days**.

### STANDARD 3 ~ Planning and Delivery of Food and Fluid

Standard Statement	Rationale
<p>There are formalised structures and processes in place to plan the provision and delivery of food and fluid.</p>	<p>To plan menus effectively, multidisciplinary input is required, together with comprehensive knowledge of the hospital population. Reference: (7)</p> <p>Effective multidisciplinary communication is vital for the efficient provision of food in hospital, to ensure that patients' nutritional requirements are met, and to help minimise waste. Reference: (7)</p> <p>Dishes need to be analysed by a state-registered dietitian to ensure their nutritional adequacy. References: (7), (20)</p> <p>Meals need to be distributed to the wards and served without delay, to ensure the maintenance of nutritional content, temperature and quality. Reference: (7)</p> <p>Inflexible hospital routines, clinical procedures and ward rounds can disrupt mealtimes and thus reduce patients' nutritional intake Reference: (9)</p>

## Criteria

### Essential

- 3.1 There is a planning group responsible for the implementation of a local protocol or protocols for the provision of food and fluid for patients. The core membership of this group includes a senior member of catering staff, a senior nurse, a doctor, a senior dietitian and allied health professionals and patient representation. The group will also have others appropriate to patient groups (as identified in the population assessment) and to the food delivery system.
- 3.2 The planning group is responsible for:
- i) overseeing a local assessment of need;
  - ii) producing a local 'food chain' protocol/protocols;
  - iii) menu planning, including the use of standard recipes;
  - iv) ensuring the food and fluid provided meets the requirements of the individual, the catering specification is appetising, and is presented with consideration;
  - v) setting main mealtimes appropriate for patient groups;
  - vi) setting mealtimes such that if the evening meal and breakfast are more than 14 hours apart, a substantial snack is available;
  - vii) ensuring there is appropriate food and fluid available outwith main mealtimes;
  - viii) ongoing monitoring and review of the food and fluid provided for patients; and
  - ix) reporting to, and implementing issues devolved from, the Nutritional Care Group.
- 3.3 All dishes and menus are analysed for nutritional content by a state-registered dietitian at the planning stage.
- 3.4 Patient groups are consulted about new menus/dishes before they are introduced.
- 3.5 There is a procedure:
- for the delivery of the correct meals/dishes to the ward;
  - for responding when an incorrect meal/dish is provided; and
  - to ensure that when a patient misses a meal he/she is then provided with a meal that meets his/her needs.

**STANDARD 3 ~ Planning and Delivery of Food and Fluid (continued)**

Standard Statement	Rationale
<p>There are formalised structures and processes in place to plan the provision and delivery of food and fluid.</p>	

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## Criteria

### Essential

- 3.6 The nurse with responsibility for the ward is responsible for having in place a protocol which ensures that:
- correct meals/dishes are received on the ward;
  - meals are delivered to the correct patients at the correct temperature;
  - there is adequate time for patients to eat or drink;
  - staff assist and support patients as required; and
  - patients' intake of food and fluid is monitored, and the necessary action is taken if this intake is inadequate.
- 3.7 All non-essential staff activity (clinical and non-clinical) is stopped during patient mealtimes.
- 3.8 There is an adequate number of staff available at mealtimes to provide food and fluid to patients and, where necessary, to provide individual assistance with eating and drinking.
- 3.9 There is a protocol for the provision of all therapeutic diets, including oral nutritional supplements, and for high-energy and high-protein food and fluid.
- 3.10 There is a protocol for the provision of any requirement outwith the planned menu, eg vegan meals.

## STANDARD 4 ~ Provision of Food and Fluid to Patients

Standard Statement	Rationale
<p>Food and fluid are provided in a way that is acceptable to patients.</p>	<p>Efforts made to increase patients' enjoyment of meals can produce benefits in the amount of food consumed and, as a result, improve patients' nutritional status. References: (7), (27)</p> <p>The more pleasing a meal and its presentation, the more likely that the patient will enjoy the meal, consume it, and therefore receive the appropriate balance of nutrients it provides. Reference: (7)</p> <p>Enabling patients to choose their meal close to the time it is served has been found to reduce food wastage. Reference: (7)</p> <p>Each organisation will be expected to make appropriate provision for food which meets the religious and cultural needs of all service users. Reference: (19)</p>

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## Criteria

### Essential

- 4.1 Patients are given a choice for all food and fluid options provided, including therapeutic and texture-modified diets. There is a choice of portion size for all main courses.
- 4.2 Patients are given the opportunity to choose their own food and fluid. Where required, they are given help in doing so from a member of staff who is aware of their nutritional needs and preferences.
- 4.3 Patients select their menu choice as close to the serving of the meal as possible, and no more than two meals in advance.
- 4.4 Food and fluid are provided to patients at the correct temperature and texture. Where required, patients are given assistance with eating/drinking while the food/fluid is at the correct temperature.
- 4.5 Meals/dishes provided for patients are appetising. Consideration is given to presentation, including the colour balance of dishes and when different courses are provided.
- 4.6 Patients are provided with the equipment/utensils for eating/drinking that meet their individual needs.
- 4.7 Accompaniments/condiments are available for patient use.
- 4.8 Where clinically appropriate, patients have access to fresh drinking water at all times.

### Desirable

- 4.9 Where clinically appropriate, patients are given the opportunity to choose whether to eat/drink at or away from their bed.

### Standard 5 ~ Patient Information and Communication

Standard Statement	Rationale
<p>Patients have the opportunity to discuss, and are given information about, their nutritional care, food and fluid. Patient views are sought and inform decisions made about the nutritional care, food and fluid provided.</p>	<p>Information and communication helps patients to make informed choices. Reference: (5)</p> <p>Poor staff/patient communication about food and nutritional care can result in patients' nutritional needs not being met. Reference: (9)</p>

## Criteria

### Essential

- 5.1 On, or prior to, admission to hospital, patients are provided with information on:
- i) how to order their meals;
  - ii) mealtimes;
  - iii) the content of meals and choices available;
  - iv) facilities available for eating meals, and where meals are served;
  - v) the opportunities available for preparing/consuming food and fluid;
  - vi) assistance with eating and drinking if required;
  - vii) special equipment/utensils for eating and drinking if required;
  - viii) the procedure for obtaining a meal if one is missed; and
  - ix) how to make a comment or compliment about the nutritional care, food and fluid provided.
- 5.2 Patients and, where appropriate, carers, are given information about the:
- i) food and fluid that relatives and carers can provide for them; and
  - ii) patient's nutritional needs, including any food/fluid to avoid.
- 5.3 Patients are encouraged to give their views on the food and fluid provided. These views are collected and trends are reported regularly to the relevant planning group.

### Standard 6 ~ Education and Training for Staff

Standard Statement	Rationale
<p>Staff are given appropriate education and training about nutritional care, food and fluid.</p>	<p>Staff require appropriate training and information in order that the needs of patients are met. Reference: (5)</p> <p>It is important that all staff involved in the provision of food and nutritional care recognise the critical nature of this task, and receive appropriate training in nutrition. References: (7), (20)</p>



<b>Criteria</b>
<p><b>Essential</b></p> <p>6.1 All staff should be aware of the importance of nutritional care for the patients' health and quality of life. Staff in contact with patients at any point in the 'food chain' are aware of:</p> <ul style="list-style-type: none"><li>i) the local protocol/s or processes for ordering and delivering food/fluid;</li><li>ii) meal and snack times; and</li><li>iii) procedures for ordering missed meals.</li></ul> <p>6.2 All staff in contact with patients and their food and fluid receive training in health and safety issues and food hygiene commensurate with their duties.</p> <p>6.3 There is a programme of nutrition education for staff, commensurate with their duties, which ensures that all staff with a specific responsibility at any point in the 'food chain' are given appropriate guidance and training, eg in the preparation of texture-modified diets, in the use of the screening tool and appropriate alternative measures, and in the recognition of physical difficulties with eating and drinking.</p>

## 10. Glossary of Terms

accreditation	A process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation.
acute sector	Hospital-based health services which are provided on an in-patient or out-patient basis.
allied healthcare professionals (AHP)	Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as dietitians, physiotherapists, occupational therapists, etc. Abbreviated as AHP, and formerly known as professions allied to medicine (PAM).
assessment	The process of measuring patients' needs and/or the quality of an activity, service or organisation.
audit	Systematic review of the procedures used for diagnosis, care, treatment, and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.
BMI	See body mass index.
body mass index (BMI)	Expresses weight in proportion to height, and is calculated as weight (kg) divided by height (m <sup>2</sup> ).
catering specification	A document which states the catering, food and nutritional requirements that a catering establishment must meet or provide.
clinical governance	A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.
Clinical Resource and Audit Group (CRAG)	CRAG was the lead body within the Scottish Executive Health Department promoting clinical effectiveness in Scotland. The main committee, together with its subcommittees provided advice to the Health Department, acted as a national forum to support and facilitate the implementation of the clinical effectiveness agenda and funded a number of clinical effectiveness programmes and projects. On 1 January 2003 CRAG was merged with four other clinical effectiveness bodies to create NHS Quality Improvement Scotland. See NHS Quality Improvement Scotland.

Clinical Standards Board for Scotland (CSBS)	The Clinical Standards Board for Scotland was a statutory body, established as a Special Health Board in April 1999. Its role was to develop and run a system of quality control of clinical services designed to promote public confidence that the services provided by the NHS met nationally agreed standards, and to demonstrate that, within the resources available, the NHS was delivering the highest possible standards of care. On 1 January 2003, CSBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS). See NHS Quality Improvement Scotland.
complex nutritional support	When a patient requires special techniques for nutritional care. Examples include intravenous and enteral tube feeding.
CRAG	See Clinical Resource and Audit Group (CRAG).
criterion(s)/criteria(pl)	Provide the more detailed and practical information on how to achieve the standard, and relate to structure, process or outcome factors.
CSBS	See Clinical Standards Board for Scotland.
data source	The source of evidence to demonstrate whether a standard or criterion is being met.
desirable (criterion/criteria)	Good practice that is being achieved in some parts of the service and demonstrates levels of quality to which other providers of a similar service should strive.
dietitian	A person who is specially trained in the nutritional needs/care of patients. A dietitian will assess a person in order that the food/fluid given to the person is nutritionally balanced and meets their therapeutic needs.
discharge	A discharge marks the end of an episode of care. Types of discharge include in-patient discharge, day-case discharge, day-patient discharge, out-patient discharge and allied health professions discharge.
essential (criterion/criteria)	A criterion that should be met wherever a service is provided.
evaluation	The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.
evidence-based medicine	Evidence-based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.
food chain	The processes involved in obtaining, preparing, delivering and serving food.
generic standards	Standards that apply to most, if not all, clinical services.
guidelines	Statements which help in deciding how to treat particular conditions.
HDL	See Health Department Letter.

<b>Health Council</b>	Each NHS Board area has a Health Council, an organisation whose aim is to promote public consultation and participation in health-related matters. Sometimes referred to as a Local Health Council.
<b>Health Department Letter (HDL)</b>	Health Department Letter (HDL - formerly known as Management Executive Letter - MEL), formal communications from the Scottish Executive Health Department to NHSScotland.
<b>healthcare professional</b>	A person qualified in a health discipline.
<b>Health Technology Board (HTBS)</b>	The Health Technology Board for Scotland (HTBS) worked to improve Scotland's health by providing evidence-based advice to NHSScotland on the clinical and cost-effectiveness of new and existing health technologies (medicines, devices, clinical procedures and healthcare settings). On 1 January 2003, HTBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS). See NHS Quality Improvement Scotland.
<b>HTBS</b>	See Health Technology Board for Scotland.
<b>in-patient</b>	A person who is admitted to hospital for observation, examination or treatment that requires at least one overnight stay.
<b>intravenous and enteral tube feeding</b>	Two ways of ensuring that, if patients are unable to eat food normally because of their health, they still receive the nutrients they need. Intravenous nutrition (or parenteral nutrition) provides a complete blend of nutrients in liquid form which is fed straight into the vein. Enteral tube feeding is when a patient receives a nutritionally complete feed through a feeding tube straight into the stomach or small intestine.
<b>Island NHS Board</b>	There are 3 Island NHS Boards (Orkney, Shetland and the Western Isles). They have always had a combined strategic and operational role. See NHS Board.
<b>malnutrition</b>	A state of nutrition in which a deficiency, excess or imbalance of energy, protein or other nutrients, including minerals and vitamins, causes measurable adverse effects on body function and clinical outcome.
<b>Malnutrition Universal Screening Tool (MUST)</b>	Malnutrition Universal Screening Tool developed by the Malnutrition Advisory Group of the main organisation for professions involved in nutritional care, the British Association for Parenteral and Enteral Nutrition (BAPEN).
<b>MEL</b>	See Management Executive Letter.
<b>monitoring</b>	The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.

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**multidisciplinary** A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.

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**MUST** See Malnutrition Universal Screening Tool.

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**NHS Board** NHS Boards are responsible for strategic planning, performance management and governance of each of Scotland's 15 local health systems. Most Board areas contain one Acute and one Primary Care Trust, with operational and employment responsibilities, but since 2001 they have operated within a strategic framework drawn up by the NHS Board. By 2004 Trusts will have been abolished and replaced by operating divisions of the NHS Board (see also NHS Trust).

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**NHS QIS** See NHS Quality Improvement Scotland.

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**NHS Quality Improvement Scotland (NHS QIS)** NHS Quality Improvement Scotland is a statutory body, established as a Special Health Board in January 2003. Its role is to focus on improving the quality of patient care and the health of patients. It will have a particular emphasis on the quality of care and the patient journey for vulnerable groups. NHS Quality Improvement Scotland has been created by the merger of five organisations: Clinical Standards Board for Scotland (CSBS); Health Technology Board for Scotland (HTBS); Scottish Health Advisory Service (SHAS); Nursing and Midwifery Practice Development Unit (NMPDU); and the Clinical Resources and Audit Group (CRAG).  
Website: [www.nhshealthquality.org](http://www.nhshealthquality.org)

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**NHSScotland** The National Health Service in Scotland.

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<b>NHS Trust</b>	A Trust is an NHS organisation responsible for providing a group of healthcare services for the local population. An Acute Hospital Trust provides hospital services. A Primary Care Trust provides primary care/community health services. Mental health services (both hospital and community based) are usually provided by Primary Care Trusts. Since 2001, Trusts have operated within an overall framework drawn up by their NHS Board. Subject to legislation, Trusts will be dissolved by April 2004, becoming operating divisions of the NHS Board. The NHS Board will be the single employer for the local system. In two areas - Borders and Dumfries & Galloway - since April 2003 there have been no Trusts or operating divisions with the NHS Board fulfilling a dual strategic and operational role (like the three Island NHS Boards). The term 'Trust' is retained in NHS QIS publications during the period of Trust abolition. Where unification has occurred, the term 'Trust' should be taken to signify an operating division of the local NHS Board. See also NHS Board.
<b>NMPDU</b>	See Nursing and Midwifery Practice Development Unit.
<b>Nursing and Midwifery Practice Development Unit (NMPDU)</b>	The Nursing and Midwifery Practice and Development Unit was set up in December 1999 in response to the White Paper 'Designed to Care' (1997). The overall aim of the Unit is to ensure that practice/role development is taken forward across Scotland in a consistent and cohesive way, so that benefits gained from new practice in one area can be easily identified and shared within the profession. On 1 January 2003 NMPDU was merged with four other clinical effectiveness bodies to create NHS Quality Improvement Scotland. See NHS Quality Improvement Scotland.
<b>nurse</b>	A person who is specially trained to provide services that are essential to or helpful in the promotion, treatment, maintenance, and restoration of health and wellbeing.
<b>nutrient</b>	Nutrients give us the energy, vitamins, minerals and other substances we need to live, function, grow and heal.
<b>nutrition specification</b>	A document which states the food and nutritional requirements that a catering establishment must meet.
<b>obesity</b>	The process of excess fat accumulation with multiple pathological consequences (characterised for epidemiological classification and for some clinical purposes by BMI > 30 kg/m <sup>2</sup> ).
<b>patient</b>	A person who is receiving care or medical treatment. A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by him/her when necessary. Sometimes referred to as a user.

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patient journey	The pathway through the health services taken by the patient (the person who is receiving treatment), and as viewed by the patient.
peer review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS QIS approach, all members of a review team are equal.
pharmacist	A qualified professional who understands the nature and effect of medicines and how they are produced and used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. Pharmacists use their expertise for the well-being and safety of users and the public.
primary care	The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.
protocol	A policy or strategy which defines appropriate action in specific circumstances, such as handwashing or assessment. These may be national, or agreed locally to take into account local requirements.
qualitative information	Qualitative data can include personal evidence or statements, samples of documentation, and is presented in non-numerical form.
quality assurance (QA)	Improving performance and preventing problems through planned and systematic activities including documentation, training and review.
quantitative information	Quantitative information is data presented in numerical form.
rationale	Scientific/objective reason for taking specific action.
referral	The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.
satisfaction survey	Seeking the views of service users through responses to pre-prepared questions and carried out through interview or self completion questionnaires.
Scottish Executive Health Department (SEHD)	The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland. Website address is: <a href="http://www.show.scot.nhs.uk/sehd/">www.show.scot.nhs.uk/sehd/</a>

Scottish Health Advisory Service (SHAS)	The Scottish Health Advisory Service was an independent body, originally set up in 1970, and reporting to the First Minister. SHAS existed to help to improve the quality of health service care and the quality of life for people with a mental illness; people with a learning disability or physical disability; and frail older people. On 1 January 2003 SHAS was merged with four other clinical effectiveness bodies to create NHS Quality Improvement Scotland. See NHS Quality Improvement Scotland.
screening tool	Aid to assess a patient's status. A nutritional screening tool is an aid to assess a patient's nutritional status.
secondary care	Care provided in an acute sector setting. See acute sector.
self-assessment	Assessment of performance against standards by individual/clinical team/Trust providing the service to which the standards are related.
SHAS	See Scottish Health Advisory Service.
snack	A small quantity of food eaten between meals. A substantial snack makes a significant contribution to a person's overall nutritional requirement.
specialist	A person who after education, training and experience, has become an expert in their field.
standard recipe	A recipe where the quantities and ingredients are set and defined, and should not be deviated from. A standard recipe should give a consistent quality product.
standard statement	An overall statement of desired performance.
statutory	Required by law. Enacted by statute, depending on statute for its authority as a statutory provision.
symptom	A reported feeling or observable physical sign of a person's condition that indicates a physical or psychological abnormality.
textured modified diet	Food/fluid that has had its consistency altered to enable a person to chew and swallow it safely without choking.
therapeutic diet	Food/fluid which has had its nutrients modified to meet the nutritional needs of a person, and which forms part of their medical treatment to prevent symptoms or improve nutritional status.
therapy	A word often used to mean treatment.
Trust	See NHS Trust.
undernutrition	When a person's nutritional status is compromised and/or nutritional requirements are not being met.
unified Board	See NHS Board.

## Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
  - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
  - ~ reaching our own conclusions and communicating what we find
- **partnership**
  - ~ involving patients, carers and the public in all parts of our work
  - ~ working with and supporting NHS staff in improving quality
  - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
  - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
  - ~ promoting understanding of our work
  - ~ explaining the rationale for our recommendations and conclusions
  - ~ communicating in language and formats that are easily accessible
- **quality assurance**
  - ~ aiming to focus our work on areas where significant improvements can be made
  - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
  - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
  - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

This document can be viewed on the NHS Quality Improvement Scotland website. It is also available, on request, from NHS Quality Improvement Scotland in the following formats:

- Electronic
- Audio cassette
- Large print

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