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Hospital Catering

Aneurin Bevan Health Board

Although the catering arrangements in the Health Board demonstrate many aspects of recognised good practice, performance is patchy and the Board is not yet effectively learning from good practice and applying it to all sites.

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Summary

1. Hospital catering services are an essential part of patient care given that good quality, nutritious meals play a vital part in patients' rehabilitation and recovery. Effective catering services are dependent on sound planning and co-ordination of a range of processes involving menu planning, procurement, food production and distribution of meals to wards and patients. Good communication is required across the range of staff groups involved, including managers, catering staff, dieticians, nurses, support staff and porters.
2. The outcome should be a flexible, cost-effective catering service that provides a good choice of nutritious meals that can accommodate patients' specific dietary requirements. Patients' nutritional status needs to be properly assessed and monitored, and arrangements put in place to help patients eat and enjoy their meals in an environment conducive to eating.
3. The importance of hospital food in supporting patients' recovery has been recognised in a number of Assembly Government initiatives. The most recent of these takes the form of a Hospital Nutritional Care Pathway and the development of all-Wales charts to record food and fluid intake. There has also been an *Improving Nutritional Care* training programme for all ward managers. These approaches support the *Free to Lead, Free to Care* initiative which is designed to empower ward sisters to take greater control of events on their ward. Best practice in nutritional care is further embedded through specific healthcare standards and the *Fundamentals of Care* ward level audit tool.
4. Work by the Audit Commission in Wales in 2001-02 showed that whilst there were some encouraging examples of good practice in relation to hospital catering, these needed to be replicated more widely and practices strengthened in a number of areas. Since then, annual data on facilities performance collected by Welsh Health Estates has highlighted significant variations between hospitals in the daily costs of feeding a patient, and continued problems with food wastage – some 880,000 meals were left untouched in 2008-09. Welsh Health Estates data also suggested that the roll-out of recognised good practice, such as protected mealtimes and nutritional analysis of menus, is also variable.
5. The Wales Audit Office has therefore decided that it would be timely to undertake further audit work on hospital catering to review progress since the Audit Commission in Wales report was published in 2001-02, and to examine the extent to which practices set out in the Hospital Nutritional Care Pathway are being embedded.
6. Our review sought to determine whether hospitals in Wales were providing efficient catering services that met recognised good practice. Our audit work looked at the hospital catering 'food chain' from planning and procurement through to the delivery of food to the ward and the management of mealtimes.

7. Our work in the Aneurin Bevan Health Board (the Health Board) has included fieldwork at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH) sites, and visits to the following wards (Exhibit 1).

Exhibit 1: Wards visited

Hospital	Ward	Specialty
RGH	B6	Acute Stroke Unit
	C4E	Acute Medicine
	D3E/W+CCU	Cardiology
NHH	2-4	Stroke Unit
	3-4	Gastro-intestinal and Colorectal Surgery
	EAU	Emergency Admissions

Source: Wales Audit Office

8. Our audit findings have been informed by an analysis of financial data relating to patient and non-patient elements of the catering service, and also by a patient survey to capture their experience of hospital food. Further details of the audit approach are provided in Appendix 1.

9. In addition, this report also incorporates the findings of recent Internal Audit work on the nutritional care pathway which was undertaken in five hospitals and 10 wards (Exhibit 2).

Exhibit 2: Wards and hospitals visited as part of the Internal Audit review of the nutritional care pathway

Hospital	Ward	Specialty
County Hospital	Talygarn	Adult Mental Health
	Cedar	Stroke Unit
	Hafan Deg	Older Adult Mental Health
NHH	1/2 Gilwern	Trauma and Orthopaedics (T&O)
	Ward 2/4	Stroke Unit
RGH	D2E	Medical Admissions
	C5W	T&O
	B6N	Haematology
St Cadocs	Adferiad	Adult Mental Health
Ystrad Mynach	Bron Gartref	Rehabilitation

Source: Aneurin Bevan Internal Audit

10. Our overall conclusion is that although the catering arrangements in the Health Board demonstrate many aspects of recognised good practice, performance is patchy and the Health Board is not yet effectively learning from good practice and applying it to all sites.

11. We have come to this conclusion because:

- catering service planning is effective, apart from nutritional assessment of menus and Health Board scrutiny of service risks and performance;
- the Health Board procures food effectively and is good at controlling the cost of food production, but the way wards in NHH order meals is leading to unnecessarily high levels of food wastage;
- meals are received in good condition but the ward environment is not always well prepared for mealtimes, and in NHH, nurses are not always sufficiently involved with the meal service;
- the wards visited in RGH had effective practices to ensure catering and nutrition support patients' recovery but there are weaknesses in the arrangements of the other hospitals; and
- we found patient satisfaction is relatively high, however there are problems with the way patient and service providers' views are collected and shared.

12. In coming to these conclusions, we identified a number of key strengths within the catering service and the way the Health Board delivers its services. These include:

- comprehensive strategies and policies relating to catering and nutrition which are currently being updated to reflect the Health Board's new management arrangements;
- procurement arrangements are well controlled and support menu delivery;
- the Health Board is the first in Wales to establish its own sustainable development policy;
- introducing a daily food allowance (currently standing at £3.85 per patient day) agreed with the catering service to control cost and quality;
- the Royal Gwent non-patient catering service is operating at a £226,000 profit, the only one in Wales with this performance; and
- food consistently arrives at the hospital ward in a good state reflecting the investment in appropriate equipment following the original 2000 audit.

13. There are number of key areas which could be improved and these include:

- the Internal Audit review has found not all patients are nutritionally screened within 24 hours as required under the Health Board's policy and the all-Wales nutritional care pathway;
- the majority of meals on the menu have not been nutritionally assessed;
- clearer Health Board reporting and monitoring arrangements for catering risks and performance issues;
- introducing a clear non-patient meal subsidy policy to set the framework for delivering this service;

- the overall arrangements for food production are not as well developed and controlled in NHH as they are in the RGH, this is because the ward meal ordering process is not sufficiently robust;
- patients in NHH do not always receive the meal they chose or one suitable for their dietary needs and in some instances patients who are nil-by-mouth are given meals; and
- the arrangements for supporting ward managers under *Free to Lead, Free to Care* to improve nutritional management are not well developed in NHH.

14. The detailed report that follows this summary provides further information in each of the areas that auditors examined.

Recommendations

15. A number of recommendations have arisen from this review. These are listed below.

Strategic planning and management arrangements	
R1	Improve the Health Board scrutiny arrangements for monitoring catering service risks and performance.
R2	Develop a range of performance indicators that monitor the main service risks such as food wastage, protected mealtime compliance, food safety issues and financial performance.
R3	All menu items should be nutritionally assessed along with any changes before they are implemented.
Procurement production and cost control	
R4	Improve NHH's meal ordering processes to ensure the patient is clearly identified and ward orders reflect the true patient demand.
R5	In NHH, introduce portion size choice onto the existing menu selection form and change existing catering practice to meet this choice.
R6	Strengthen existing wastage monitoring arrangements to identify practices which increase wastage.
R7	Introduce a clear subsidy policy to set the framework for delivering non-patient catering services.
Delivery to the ward	
R8	In NHH, establish whether the bed state data can identify demand more accurately and minimise unnecessary wastage.
R9	Introduce basic nutrition into the training programme for ward-based catering staff to improve their awareness of its importance and the need to follow ward procedures.

Meeting patients' nutritional needs and supporting recovery	
R10	Introduce protected mealtimes on all appropriate wards and establish arrangements that monitor compliance.
R11	Establish whether the current domestic service shift arrangements are impacting on protected mealtimes by requiring waste bins to be emptied between 12.00 and 13.00.
R12	Establish monitoring arrangements that measure compliance with the nutritional care pathway and the effectiveness of the chart review process.
R13	In NHH, improve the communication process between the ward and the catering departments to ensure patients always receive the right meal for their dietary needs.
Gathering views from patients and sharing information	
R14	Introduce effective arrangements for sharing information between nursing, dietetic and catering staff on nutrition management.
R15	Involve patients fully in developing the catering service.
R16	Building on the model established in RGH, and as part of the process of empowering ward managers under *Free to Lead, Free to Care* arrangements, introduce effective ward manager and senior nurse forums across the Health Board and all its hospitals.

Strategic planning and management arrangements

16. Catering service planning is effective, apart from nutritional assessment of menus and Health Board scrutiny of service risks and performance. We have come to this conclusion because:
    - there are comprehensive catering and nutrition strategies in place that are currently being reviewed to reflect the Health Board's new management arrangements;
    - the Nutritional Steering Group provides an appropriate means of reviewing plans and service delivery;
    - although dieticians have been involved in menu design groups, the majority of items have still to be nutritionally assessed; and
    - there are clear lines of accountability to the Performance and Quality Steering Committee, however the reporting arrangements for catering and nutrition issues to the Health Board are less clear.
17. The following table summarises the findings supporting the conclusion.

Table 1: Strategic planning and management arrangements

Good practice	In place?	Further information
Service planning		
The Health Board has clear strategies and policies for catering and nutrition	✓	In 2006, the previous trust established a comprehensive Food Services Specification which was integrated with the Nutrition Strategy and the subsequent Nutrition, Catering and Food Hygiene Policy. The Food Services Specification was designed to 'define the standards that patients and staff can expect of the hospital catering service, and promote effective working relationships between caterers, dieticians and clinicians'. This specification identifies the working arrangements and standards patients can expect in hospital and is currently being updated to reflect the Health Board's new management arrangements and changing financial pressures.

Good practice	In place?	Further information
Service planning (continued)		
Menu design reflects the strategy and policy	✓/✗	Although dieticians have been involved in menu design groups, the Health Board has recognised that catering dietetic support needed to be strengthened and recently appointed a dietician within the catering team.
Dieticians and clinicians are fully involved in strategy and policy development and menu planning	✓/✗	The dietetic service provides outpatient, inpatient and community services. Currently, there is a substantial focus on the community provision and the catering department's dietician has now taken a stronger lead with strategy development. Menus have still to be fully nutritionally assessed and following nutritional assessment of the standard recipes, the protein content of some vegetarian dishes was found to be low. As a result those recipes were adapted to increase the protein content. Catering managers in NHH also reported that menus had been recently 'tweaked' to include cheaper items but the nutritional impact of these changes had not been assessed.
Strategy identifies the most efficient and cost-effective means of food production	✓/✗	In 2006, the catering department undertook a best value review, which identified a delivery model which was incorporated into the Clinical Futures Strategy. This included establishing a Central Production Unit, although this model was amended by the Board to provide conventional cooking methods for the new community hospitals. The recent delay in implementing the clinical futures programme has meant the model is currently based on maintaining the status quo, which is the conventional cooking method for the majority of hospitals.
Evidence of workforce planning to match catering staff to demand	✓	In both hospitals, catering managers are confident that the current catering staffing arrangements are flexible and reflect service needs. The Health Board is currently evaluating the current workforce model and options include introducing a housekeeper role. Feedback from ward managers and senior nurses in RGH identified that splitting the ward domestic and ward hostess role had delivered improved services.

Good practice	In place?	Further information
Management arrangements		
Executive accountability for catering and nutrition is clearly identified	✓	Under the previous trust arrangements, the performance director was responsible for the catering services and the nursing director for nutrition. A similar model is currently being considered for the new Health Board. Catering services are essential to successfully managing nutrition and there are clear advantages in having the complete pathway under a single executive director.
The Health Board receives sufficient information on performance and practice in relation to catering and nutrition	✓/✗	The Health Board has established a range of key performance indicators for catering services covering food hygiene, food and nutrition audits, patient satisfaction surveys and food quality audits, which are reported annually to the Quality and Patient Safety Committee through the Clinical Nutrition Steering Group. These performance indicators do not cover all service risks such as food wastage, protected mealtime compliance, environmental health inspection issues and financial performance. This, combined with the complex reporting arrangements and possible information filtering process, may prevent the Board being fully sighted of performance issues and catering service risks.
A multidisciplinary group is in place to oversee the delivery of the catering service	✓	There is a sufficiently well-represented clinical nutrition steering group in place which meets regularly to oversee delivery of the catering nutrition strategies and policies. This group is also responsible for ensuring patients are involved in advising on the development and evaluation of the nutrition and catering services. In practice, this has been done through involving the third sector with organisations such as Age UK.
Lead nurse identified to help implement strategy and embed good nutritional practices	✓	This role is now the responsibility of the newly appointed patient experience and patient safety associate director of nursing.
Job descriptions and salary ranges for catering staff are harmonised across the Health Board	✓	Health Board managers confirmed that the arrangements are sufficiently harmonised across the whole organisation and that there were no major outstanding issues in catering.

Good practice	In place?	Further information
Management arrangements (continued)		
Sickness absence is within acceptable levels and is well managed	✓	Managers confirmed that there are effective arrangements in place to manage and monitor sickness absence. Currently, catering service sickness levels are averaging about 6.5 per cent, which is above the Health Board's 4.99 per cent target although the levels are reducing.

Procurement, production and cost control

18. The Health Board procures food effectively and is good at controlling the cost of food production, but the way wards in NHH order meals is leading to unnecessarily high levels of food wastage. We have come to this conclusion because:
    - procurement arrangements are well-controlled and support menu delivery, ensuring food is obtained from safe and reliable sources on time;
    - the Health Board is the first in Wales to have established its own sustainable development policy and is currently working with other organisations to develop this policy;
    - the Health Board has introduced a daily food allowance to control costs and set quality standards, adopting this approach was a recommendation in the 2001 national report;
    - food production arrangements are generally well developed but rely on a time-consuming manual paper system rather than an integrated IT solution;
    - the RGH non-patient catering service is operating at a £226,000 profit, the only service in Wales with this performance;
    - although most of the key measures to assist with cost control are in place, arrangements could be strengthened by developing a subsidy policy;
    - food production arrangements are not as well developed and controlled in NHH as they are in the RGH because of the way meals are ordered at the ward level; and
    - wastage levels are not consistently monitored across the hospital sites.
19. The following table summarises the findings supporting the conclusion.

Table 2: Procurement, production and cost control

Expected practice	In place at RGH?	In place at NHH?	Further information
Procurement			
Food is procured from approved suppliers, in line with arrangements set out in the all-Wales NHS Procurement Strategy	✓	✓	The Health Board's procurement arrangements for catering are through the Procurement department using the All Wales and NHS Supply Chain contracts. The current arrangements are currently being migrated into the Oracle system, which will simplify and further control purchasing arrangements.
Sustainable procurement arrangements are in place	✓	✓	The Health Board is the first in Wales to establish its own sustainable development strategy instead of relying on the arrangements embedded in NHS contracts. In addition, the Health Board is currently working with Cardiff University and Caerphilly County Borough Council on a joint project supporting a local sustainability model.
Procurement arrangements support the delivery of planned menus	✓	✓	The current arrangements support delivery of the menu with appropriate delivery schedules to meet production demands.
Production			
The Health Board operates a computerised catering system to facilitate production planning and control	✓/✗	✓/✗	Both hospitals use a well-established, paper-based menu selection process which is then manually collated through the Menumark IT system to produce production schedules. This process is thorough but time-consuming and resource-dependent.
Patients order meals less than 24 hours in advance	✓	✓/✗	Meals are ordered up to a day in advance; this means that new patients on their first day may be given the meal selected by the previous bed occupant. To improve ordering efficiency at RGH, a pilot is underway on four wards to computerise the process using handheld devices. This will also allow patients to choose their meals at the start of the day rather than the night before.

Expected practice	In place RGH?	In place NHH?	Further information
Production (continued)			
Standard costed menus are in use to ensure consistency of quality and cost	✓	✓	Standard costed recipes are in place based on a daily allocation of £3.85 per patient day. Establishing a daily food allowance is good practice. Dieticians identified that when the menu changes, they are not always given the opportunity to assess its content prior to its implementation.
A production plan in place to guide kitchens' tasks	✓	✓/✗	Production plans are in place although the NHH plan is based on poor information. To overcome this, catering staff contact the ward nursing staff to confirm patient numbers and special diets. The attention given to providing reliable information at the ward level was found to be low and often led to overproduction and a patient's dietary needs not being met.
Portion controls in place and supported by training	✓	✗	The bulk delivery system in RGH is based on standard meal portions using standard trays, with patients choosing the meal size at the point of delivery. In NHH, the menu choice form does not allow the patient to choose the size of their meal. Consequently, when meals are plated in the kitchens through the Ganymede system, they are based on standard size portions. This is unusual as best practice for plated systems normally includes providing for a patient's preference to reduce wastage.
Quality of food is monitored at key stages in production	✓	✓	Effective quality control arrangements are in place throughout the production process, supported by the Health Board's quality assurance monitoring programme.

Expected practice	In place RGH?	In place NHH?	Further information
Food safety			
Robust arrangements in place to ensure food safety (eg, food temperature checks)	✓	✓	Arrangements are in place, which are regularly monitored. At NHH, the food temperature is not checked once it reaches the ward. Managers do not see this as a problem because transportation times are quick and the temperature is maintained in the trolley.
A Hazard Analysis Critical Control Points (HACCP) policy is in place	✓	✓/✗	All policies in place, although the January Environmental Health Officer (EHO) report for NHH identified minor non-compliance issues.
Catering facilities regularly inspected by local EHOs	✓	✓	The Health Board's facilities are regularly inspected by five local authorities. This, at times, has produced differing advice. There is scope for the catering department to work with these local authorities to standardise reporting arrangements.
Action taken in response to EHO recommendations	✓	✓	High-risk issues are addressed through the catering department's business manager's rolling action plan. There are no recent EHO reports identifying any concern with the Health Board's approach.
Cost control			
Computerised catering system in place to support service management and monitoring	✓/✗	✓/✗	There is no fully integrated system in place. The catering department has invested in the EPOS IT system for controlling its restaurant activities and Menumark for inpatient production management.

Expected practice	In place RGH?	In place NHH?	Further information
Cost control (continued)			
Cost of catering service known and monitored	✓	✓	The catering service does not operate on a budget allocation system. Instead patient catering is funded by the number of meals produced reconciled against the bed state using a patient day meal cost of £3.85. Service managers see this approach as acting as a key driver to deliver efficient quality services. There is evidence that this approach is working. The Health Board's inpatient and staff restaurant services are separately identified and cost-managed. The catering service's business manager has established a comprehensive cost analysis system, which allows expenditure to be well controlled, with robust modelling and an income strategy able to respond quickly to market changes. This approach to business management is good practice.
There are effective and flexible ordering systems in place between the wards and the catering department	✓	✗	The ordering arrangements are managed more efficiently in RGH because the process is managed by the ward-based catering staff and supported by good communication. In addition, the high level of nurse involvement and an effective meal requisitioning system for last-minute patient changes or needs meant most needs were being met. The NHH system often results in extra meals and sandwiches being ordered by nursing staff, because existing arrangements are seen as not working for getting meals outside standard mealtimes.

Expected practice	In place RGH?	In place NHH?	Further information
Cost control (continued)			
Ward wastage is monitored: • Unserved meals • Uneaten food	✓	✓/✗	Food wastage is monitored and current published data for unserved meals is 12 per cent for NHH and nine per cent for RGH. Our observation work suggests the level in RGH could be higher at 19 per cent, and at NHH 35 per cent. The method for assessing wastage is not the same at RGH and NHH. In NHH, unserved meals are counted as those left in the trolley undisturbed. Therefore, removing the cover but not serving the meal removes it from the count. The Health Board does not measure plate wastage (partly eaten meals).
There is an agreed approach to subsidy/contribution from non-patient services	✗	✗	There is no subsidy policy in place although the catering services are committed to not subsiding. In 2008-09, RGH was operating at profit, the only one in Wales that year.
A pricing policy for non-patient meals is in place	✓	✓	The Health Board has introduced an effective pricing policy based on a clearly documented backward pricing approach (what the market can bear offset against production cost). Prices have been standardised across all hospitals which is good practice. A dual pricing policy is in place for visitors and staff. To reduce friction that can occur at the till, the catering service displays a standard price which is reduced at the till when staff present their identity badge. This approach is good practice as it increases compliance, both with the pricing policy and security badge policy.
Dining room wastage is monitored	✓	✓	Dining room wastage levels are monitored and staff receive basic training in portion size management.

Service cost comparisons

20. The audit included a review of costs which were benchmarked against the other health board hospitals. Our analysis of the 2008-09 catering service financial performance (Exhibit 3) has shown that total costs for the service are one per cent above the average for Wales.

21. When these operating costs are adjusted for income, the net costs per patient day vary with RGH (£12.37) above the Welsh average (£11.08), and NHH (£9.23) below the average costs (Exhibit 4).

22. Although the RGH non-patient income is a significant contributor to this financial performance, the percentage cost split matches the Welsh average for RGH, with NHH showing lower staff costs and higher provision costs (Exhibit 5).

23. In overall terms, the expenditure on patients' services is just above the average for Wales, with a marked variation between the two sites (Exhibit 6).

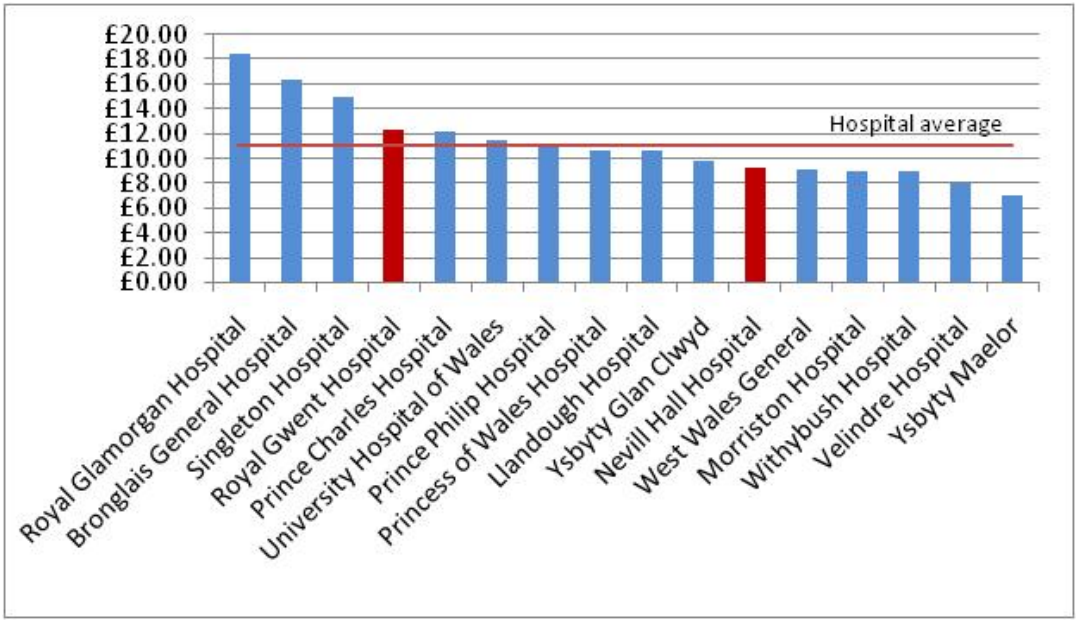
24. A more detailed analysis of both hospitals can be found in Appendix 2.

Exhibit 3: Service cost analysis

Analysis	Total cost per patient day (£)	Patient cost per patient day (£)	Non-patient service trading position (£)
RGH	12.37	13.33	226,000
NHH	9.23	9.04	-23,000
Combined service	11.33	11.91	202,000
Wales	11.08	10.04	

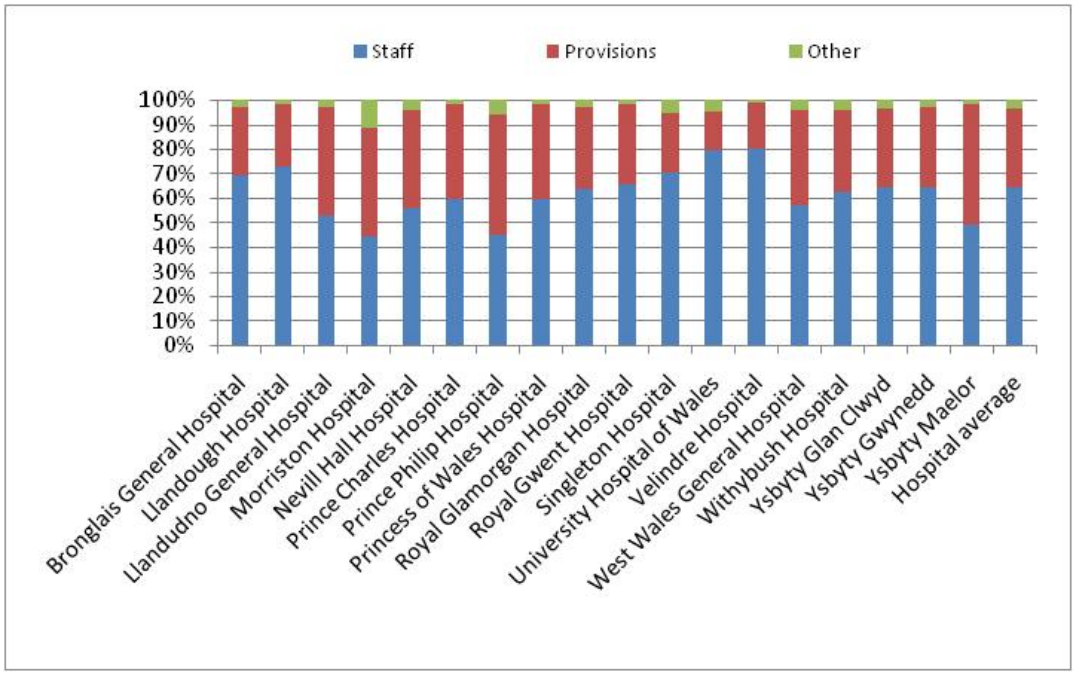
Source: Aneurin Bevan Health Board and the Wales Audit Office

Exhibit 4: Net cost of catering service per patient day



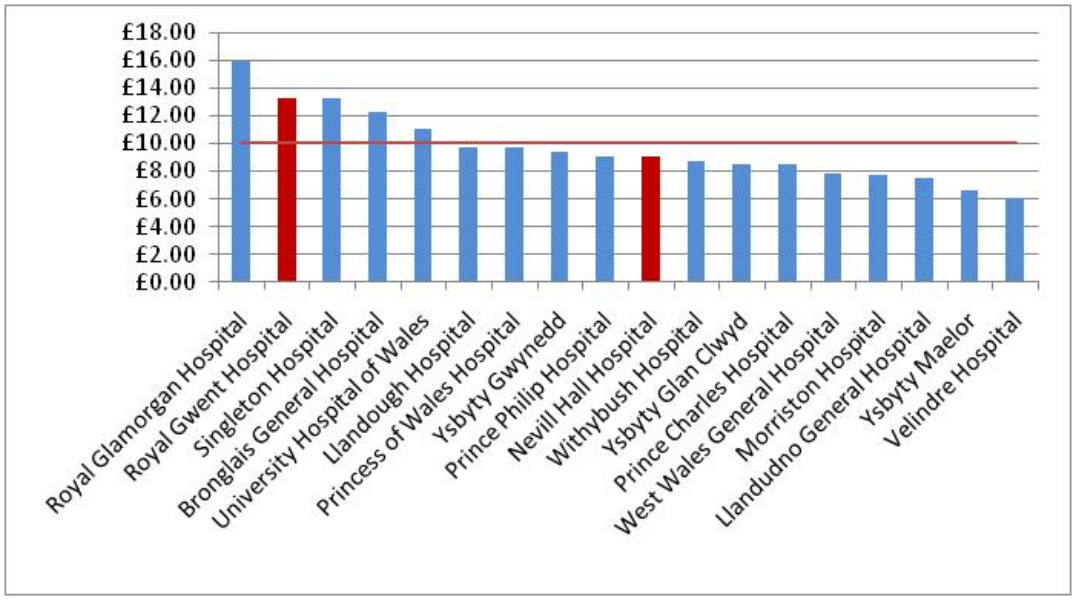
Source: Aneurin Bevan Health Board and the Wales Audit Office

Exhibit 5: Expenditure distribution



Source: Aneurin Bevan Health Board and the Wales Audit Office

Exhibit 6: Comparative costs of the patient service per patient day

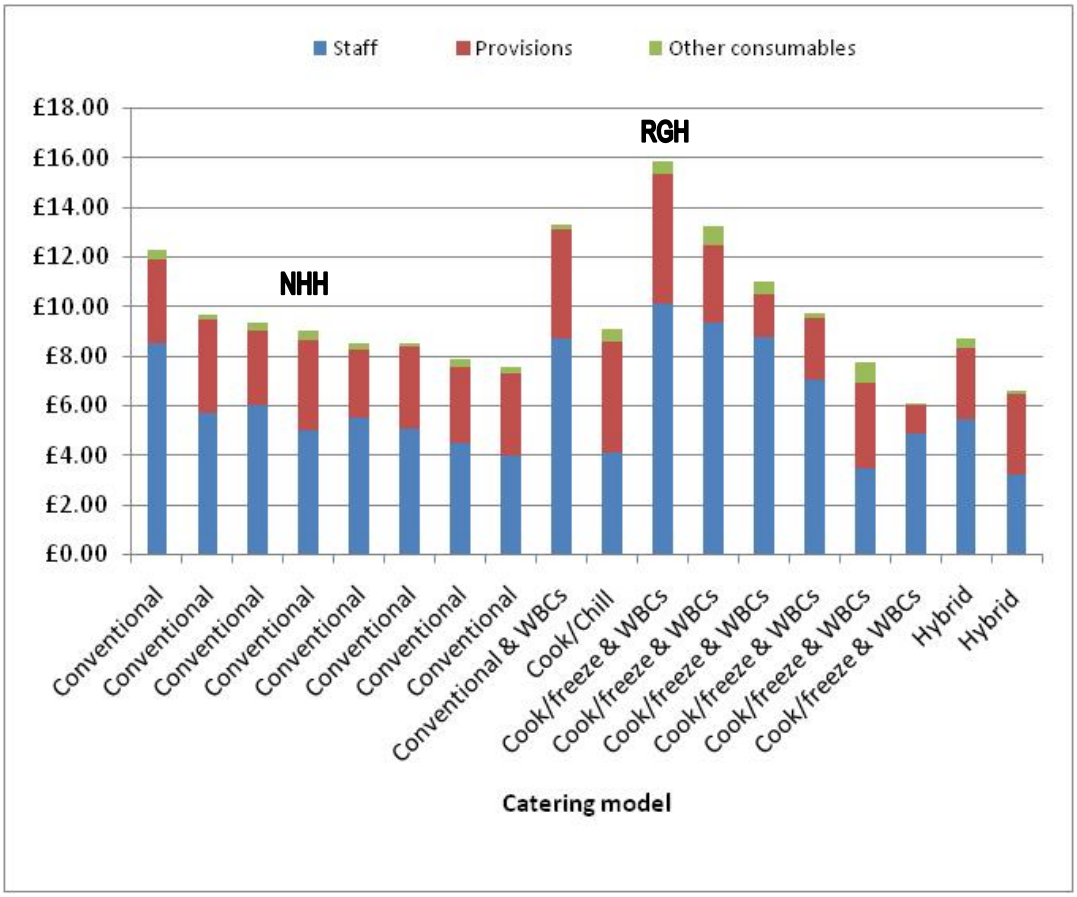


Source: Aneurin Bevan Health Board and the Wales Audit Office

25. Each type of cooking method and service delivery has its own strengths and weaknesses, and health boards need to make their own decisions as to what method is the most appropriate for their own organisation. The relative costs of these different approaches are summarised in Exhibit 7.

Exhibit 7: Total cost of patient catering per patient day 2008-09 by cooking and delivery method

WBC = ward-based catering staff



Source: Aneurin Bevan Health Board and the Wales Audit Office

Food wastage

26. Our review included an observational audit of food wastage from unserved meals and plate waste. The latter was measured by reversing the nutritional assessment documentation guidance contained in the All Wales Food Record Chart Guide. For example, a meal recorded as 75 per cent eaten for nutritional monitoring was recorded as 25 per cent plate wastage. In addition, we only applied this measurement if the plate waste included the higher cost main protein element rather than just vegetables. Although this method is not as robust as the food weight analysis tool, it does provide a sufficiently quick and sensitive way to identify problem areas.

27. The percentage of unserved meals was high and highest in the medical assessment wards because of patient flow. Efficient systems generate five per cent wastage. The overall levels were similar in both hospitals, around 17 per cent, which is above published figures suggesting there is scope to save around £172,000 across both sites. If systems and processes could reduce plate wastage down to levels of 10 per cent, an additional £138,000 could be saved (Exhibit 8).

28. The reasons for patients not eating their food can be complex, ranging from changes in their medical condition to just not liking the meal. Generally, the percentage of unserved meals was higher in RGH because bulk delivery systems generally have higher rates than plated systems. Plate wastage levels were higher in NHH because portion control management is less effective.

29. In NHH, there is significant scope to improve communication processes between the ward and catering department, and one catering supervisor has suggested more use could be made of bed state data. This would get over some of the difficulties by:

- allowing the meal chosen by a patient to follow the patient when they moved to a new ward;
- allow new patients to choose their own food, rather than be restricted to the choice of the previous bed occupant; and
- when a patient's status changes to nil by mouth for instance, provide an update to the catering team to let them know that the meal is no longer needed.

Exhibit 8: Meal wastage levels including predicted savings

Ward	Unserved meals	Plate waste	Total wastage	Possible efficiency savings unserved meals (5% target)	Possible efficiency savings plate wastage (10% target)
D3E/W+CCU	0%	4%	4%		
B6	15%	15%	30%		
C4E	34%	21%	55%		
3/4	11%	18%	29%		
2/4	5%	38%	43%		
EAU	27%	27%	54%		
			RGH	£129,000	£64,000
			NHH	£43,000	£74,000
Overall	**17%**	**21%**	**38%**	**£172,000**	**£138,000**

Source: Aneurin Bevan Health Board and the Wales Audit Office

Delivery to the ward

30. Meals are received in good condition but the ward environment is not always well prepared for mealtimes, and in NHH, nurses are not always sufficiently involved with the meal service. We have come to this conclusion because:

- food arrives at the ward in a good state reflecting the investment in appropriate equipment at NHH following the 2000 audit;
- the ward environment and patients are not always prepared to receive meals;
- food was generally well presented and remained in a good condition at the end of the mealtime;
- in RGH, nursing staff are an integral part of the meal service, generally this is not the case in NHH because the service is delivered by domestic staff;

- in RGH, the ward arrangements are robust and ensure a patient receives the right meal, this was not the case in NHH; and
- once the meal trolley arrives on the ward, patients receive their meal very quickly, minimising any loss of quality.

31. The following table summarises the findings supporting the conclusion.

Table 3: Delivery of food to the ward and patient

Expected practice	In place at RGH?	In place at NHH?	Further information
Food arrives at the ward at the right time	✓	✓	The meal service consistently started at the scheduled time. Ward managers confirmed there were no issues about meeting the schedule. In RGH and NHH, on occasions the trolley is delayed because of the high demands made on service lifts.
Food arrives at the ward in a good state (eg, right temperature)	✓	✓	The ward observation exercise found that the ward trolleys kept food at appropriate and recommended temperatures. Although the Health Board's policy requires food temperature to be monitored when it is received on the ward. This monitoring is not routinely undertaken in NHH.
Arrangements are in place to ensure that the patient receives the right meal	✓	✘	In RGH, patients use a standard menu choice form which is completed the previous evening. Ward hostesses in partnership with nursing staff ensure the forms are appropriately completed with the patient's identity and specific dietary requirements. In NHH, the same form is completed by the patient, although nurses often complete them. Consequently, the patient's name was not always completed on the menu choice form which included those requiring special diets. In RGH, the involvement of ward nursing staff in the service ensures patients receive the right meal. In NHH, unlike RGH, nursing staff are not actively involved in the service. Consequently, the service was not as effective. Meals and special diets are often only identified by the bed number and not the patient's name, and in some instances, not identified at all. Changes in the patient status are often not communicated to the ward hostess, and some patients who were nil by mouth had meals ordered for them, increasing wastage and the risk they would be given meals.

Expected practice	In place at RGH?	In place at NHH?	Further information
Dedicated staff (hostesses, housekeepers or ward-based caterers) are present to help serve the meals	✓	✓/✗	In RGH, there are dedicated ward-based hostess teams managed by a catering supervisor. This arrangement replaced generic domestic and catering staff. Ward managers were of the opinion that having separate, dedicated staff had markedly improved service delivery for both domestic and catering services. In NHH, there are no ward-based catering staff and the dedicated ward-based domestic staff served plated meals from the trolley.
Staff involved in serving food have been trained in food presentation	✓	✓	Ward-based catering staff are trained in basic food presentation.
Staff involved in serving food have been trained in food hygiene	✓/✗	✓	In RGH, catering staff are trained in food hygiene. Nursing staff who give the food to patients receive control of infection training. No work has been done to see if this complies with food hygiene requirements. In NHH, the domestic staff are given basic food hygiene training.
The patient environment is prepared to receive the meals	✓	✗	In RGH, the majority of wards have a de-clutter round between 10.00 and 11.00 to prepare the ward environment for lunch. Domestic staff emptied waste and clinical waste bins during the meal service because their shift finished at 13.00 and the meal service started between 12.00 and 12.30. In one ward, B6, the ward manager had arranged for domestic staff not to empty bins during the meal service. In NHH, only one ward was seen preparing the environment. This approach does not meet the Health Board's protected mealtime policy.
Patients have the opportunity to wash their hands before eating	✗	✗	Most patients are not given the opportunity to wash their hands before receiving their meal, although some do use the hand gel if prompted. Hand wipes are not provided with the meal, which further reduces the opportunity to clean hands.
Food is delivered to the patient quickly and efficiently	✓	✓	Most patients receive their meals within 20 minutes of the service arriving on the ward. This is good practice.

Food tasting results

32. Catering departments should be producing high quality meals for patients where quality should be maintained as they are presented to a patient. This means providing sufficient choice on the menu, serving attractive and tasty meals at appropriate temperatures. Monitoring the service in terms of the quality of dishes provided should take place continually to ensure that high standards are maintained and improved.

33. Our review included a food tasting panel involving auditors, catering, ward and dietetic staff. Using a simple 1-5 score, the panel assessed the food for:

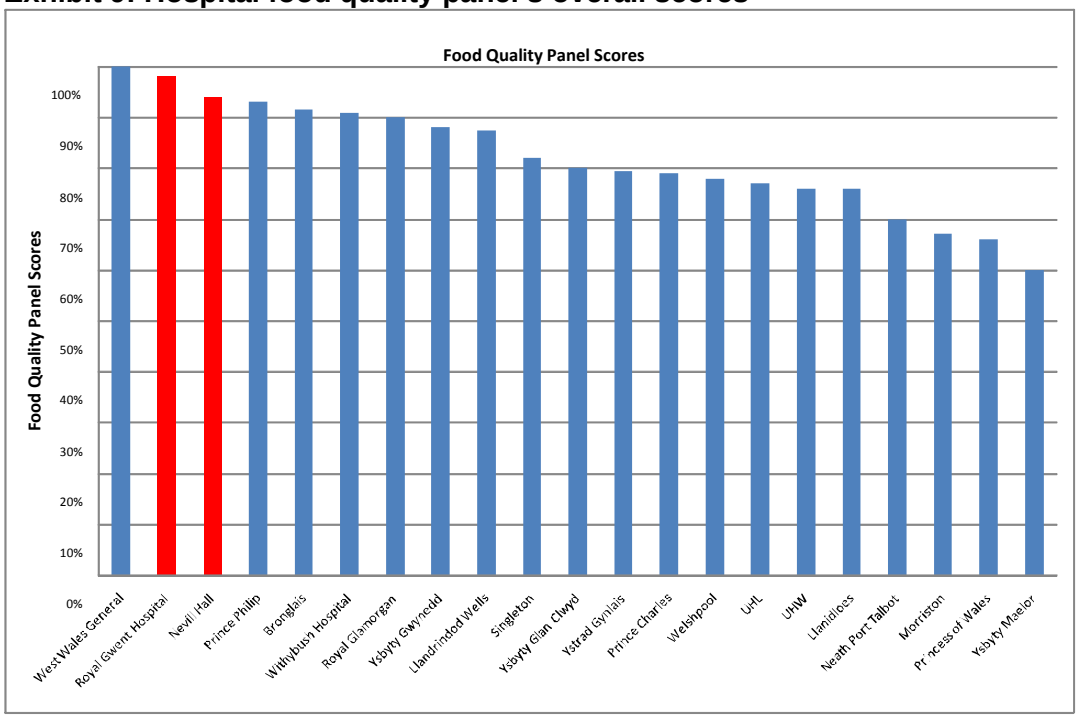
- temperature and appearance;
- smell, taste and texture;
- the correct item ordered by the patient from the menu; and
- the correct portion size requested by the patient.

34. Although such an approach will always have a degree of subjectivity to it, it was applied consistently at all the NHS organisations visited. This, therefore, provides an opportunity to draw some comparisons between different sites visited.

35. A maximum score of 100 per cent is possible if all the criteria tested received a '5 rating'.

36. This panel scored the food quality as 98 per cent in RGH and 94 per cent in NHH. This was amongst the highest ratings compared to other hospitals in Wales (Exhibit 9).

Exhibit 9: Hospital food quality panel's overall scores



Source: Wales Audit Office

Meeting patients' nutritional needs and supporting recovery

37. The wards visited in RGH had effective practices to ensure catering and nutrition support patients' recovery but there are weaknesses in the arrangements of the other hospitals. We have come to this conclusion because:

- a substantial number of wards have not introduced protected mealtimes;
- over the last year, ward managers in RGH have been supported to develop nutritional care management through *Free to Lead, Free to Care*, however, the same level of support has not been provided in NHH leading to less well-developed arrangements;
- the Internal Audit review of the nutritional care pathway found that not all patients are screened within 24 hours or regularly weighed as required in the Health Board's policy;
- although the red tray system has been widely adopted to identify patients requiring help to eat, many wards have opted to use a traffic light system which some ward managers see as better meeting the needs of patients;
- generally, the catering arrangements in RGH provide choice and respond effectively to meeting individual need, however, in NHH systems are not as well developed and patient needs are not always met;
- in NHH, the communication between the ward staff and the catering department was not always effective, increasing the risk that some meals do not meet a patient's dietary needs or that they are given food when they should not have it, for example, 'nil by mouth'; and
- patients' food and fluid intake is routinely recorded, although intake charts are not always signed off by registered nurses at the end of every shift as required under the all-Wales care pathway process.

38. The following table summarises the findings supporting the conclusion.

Table 4: Meeting patients' nutritional needs and supporting recovery

Expected practice	In place at RGH?	In place at NHH?	Further information
Patients are weighed and undergo nutritional screening within 24 hours of admission, supported by a validated nutritional screening tool	✓/✗	✗	The Health Board uses the MUST[1] tool which must be completed within 24 hours of admission. In RGH, our observation audit found all patients on the three wards had been assessed. However in NHH, in one ward, the MUST tool was not always used because some staff did not know how to use it. In addition, dieticians were generally concerned with the consistency of its use. During March and April, Internal Audit undertook a review of compliance with the nutritional pathway. This looked at a larger cohort of patients across the Health Board's hospitals. This audit found only: • 46 per cent of patients in the acute setting were screened within 24 hours; • 25 per cent in community hospitals; and • 15 per cent in a mental health setting. These findings suggest that there is still scope to improve nutritional assessment within the first 24 hours of admission. A more detailed review of Internal Audit's findings can be found in Appendix 4.
Where appropriate, patients are referred to a dietician, and/or to a speech and language therapist	✓	✓	All patients presenting as high risk for malnutrition were referred to a dietician. Ward managers reported good communication between nursing staff and dieticians particularly about patients requiring fortified diets.

[1] The Malnutrition Universal Screening Tool (MUST) has been designed by the Malnutrition Advisory Group (MAG) of the British Association for Parenteral and Enteral Nutrition (BAPEN) as an effective way of identifying adults (particularly the elderly) who are malnourished, at risk of malnutrition, or obese. The tool also includes guidelines for introducing an effective and suitable treatment plan.

Expected practice	In place at RGH?	In place at NHH?	Further information
A nutritional care plan is prepared and implemented, informed by patients' nutritional risk score	✓/✗	✓/✗	Generally, our review of care plans showed they conformed to the nutrition care pathway framework. The more detailed Internal Audit work found 60 per cent of patients with a MUST score of one or more had a care plan, which suggests compliance is still patchy. Weigh days have been introduced on some wards at weekends which had improved the weekly assessment regime. Although ward managers confirmed arrangements were improving, the Internal Audit review found only 35 per cent of patients had any documented evidence of being weighed weekly.
Protected mealtimes arrangements are in place	✓/✗	✗	The Health Board has a protected mealtime policy. During 2009, the Health Board reported only 25 per cent of wards in RGH and NHH had implemented the policy. The most recent Fundamentals of Care audit (February 2010) identified that seven general medicine or surgery wards in NHH and five wards in RGH still had to introduce protected mealtimes. Although the Health Board's policy states ward signage must include information about protected mealtimes, this information has been removed from the latest signs. Our ward observation audit of the three wards in RGH found protected mealtimes were actively applied. In NHH, protected mealtimes have not been consistently introduced. In one ward, a meal was removed from a patient because they were being taken to physiotherapy, which was then followed by a medical ward round further disrupting the mealtime.

Expected practice	In place at RGH?	In place at NHH?	Further information
Arrangements are in place to make sure that those serving meals are aware of patients' specific nutritional requirements	✓	✗	In RGH, nursing staff are actively involved in the service and are responsible for ensuring the patient receives the right meal. Meal presentation is the responsibility of the ward hostess. This active involvement of nursing staff is best practice. In NHH, nursing staff are not required to manage the delivery of meals to the patient, which is the responsibility of the ward domestic staff. This process relies on effective documentation and communication. Only one ward, 2/4, had reasonably robust systems in place and elsewhere patients were observed receiving the incorrect meal. On each occasion, nursing staff had to quickly intervene to prevent the patient eating the meal. Staff have confirmed some patients received a meal when they should not, and at times, patients had not been prevented from eating it, leading to cancelled operations and complications with their treatment.
Menu provides patients with a good choice of food	✓	✓	The three-week cycle menu has at least two main choices and a vegetarian choice.
Menu contains options for vegetarians	✓	✓	A vegetarian choice is always available.
Menu contains options for patients from specific religious/ethnic backgrounds	✓	✓	The Health Board has certified kosher and halal meals available on demand.
Arrangements are in place to identify patients who may need specific help eating their food	✓	✓/✗	In RGH, wards operate a red tray or traffic light system which identifies patients requiring help and active nutritional monitoring. In NHH, Ward 2/4 operated a traffic light system.
Patients are given assistance to eat if required	✓	✓/✗	In RGH, patients requiring help received it because the majority of ward staff including ward managers and qualified staff are involved with the meal service. In NHH, whilst in one ward there were five nursing auxiliaries helping patients with eating, only two were helping on another ward. On this ward, several patients struggled to feed themselves.

Expected practice	In place at RGH?	In place at NHH?	Further information
Patients are able to get snacks outside mealtimes	✓	✓/✗	The Health Board's patient menu is also the restaurant menu, which allows production flexibility and for additional meals to be obtained if necessary from the restaurant. The restaurant service operates between 07.00 and 04.00 in RGH and 07.00 to 18.30 in NHH. From 14.00, a selection of sandwiches was available on individual wards and nursing staff in RGH have access to ward kitchen facilities to provide cereals and bread. There is no access to similar facilities in NHH. Ward staff in NHH reported that they did not always have access to sandwiches. To overcome this, they were ordering more sandwiches than were required. This practice was common in EAU because of the emergency environment and the rapid flow of patients. Nursing staff anecdotal evidence suggested that on some occasions visitors were given patient food. Catering managers confirmed that their service was sufficiently flexible to provide snacks on demand and the issue appears to be poor communication.
Patients' food intake is regularly monitored using the All Wales Food Record Chart	✓	✗	Supporting the care pathway, the Health Board has produced a 'Nutrition Matters' file for wards, which contains all procedures and documents. In RGH, our ward observation audit found food charts were completed. In NHH, this was not always the case. The recent Internal Audit report found an inconsistent approach across hospitals, suggesting more work needs to be done to ensure compliance[2]. C4E was a pilot ward for NLIAH's Transforming Care at the Bedside process. Because nurses record a lot more of their interaction with patients, the management of nutrition had improved along with providing relatives with valuable information on what had been done to encourage the patient to eat.

[2] In complying with policies Internal Audit found registered nurses had signed other columns and not the RGN column and many signatures could not be identified as belonging to RGNs.

Expected practice	In place at RGH?	In place at NHH?	Further information
Food record chart is countersigned by a registered nurse at the end of each shift	✗	✗	Although the majority of ward managers were confident that registered nurses reviewed charts, they were not always countersigned to confirm this had been done. The Internal Audit review had found only 24 per cent of charts have been signed in RGH and six per cent in NHH, suggesting more needs to be done to ensure compliance.
Daily and weekly fluid input and output charts are in use	✓	✓	Fluid charts are in use although the Health Board has not started using the all-Wales chart. This is acceptable practice as the information is the same and existing stocks of the old charts are being used up.
Weekly fluid input and output charts are countersigned by a registered nurse once a day	✗	✗	Although the majority ward of managers were confident that registered nurses reviewed charts, they were not always countersigned to confirm this had been done.

Gathering views from patients and sharing information

39. We found patient satisfaction is relatively high, however, there are problems with the way patient and service providers' views are collected and shared. We have come to this conclusion because:

- patients' views of food and catering services were collected and analysed separately by the catering and nursing staff through separate fundamentals of care audits, catering department satisfaction surveys and individual ward surveys;
- the experience of ward managers and those of the catering service is not shared between different staff groups in any co-ordinated manner;
- the results of a recently published article on meeting the needs of patients' nutrition by one of the Health Board's senior nurses provides the basis for future discussions on improving the service;
- the patient survey undertaken as part of this audit has highlighted a range of views which need to be considered as part of the routine service planning and monitoring; and
- over the last year, the focus on developing the monthly ward manager fundamentals of care meetings in RGH has provided a good forum to improve nutrition management, a similar forum is not in place in NHH.

40. The following table summarises the findings supporting the conclusion.

Table 5: Gathering views from patients on catering services

Expected practice	In place?	Further information
There are regular activities to capture patients' views and experiences of catering services	✓	The catering service undertakes a patient questionnaire which at times involves recording the patient experience through bedside interviews.
Service users are represented on catering planning groups	✓/✗	Although the Health Board has a patient panel, there was no evidence that patients are taking an active role on planning groups. Instead this role is undertaken by organisations such as Age UK. This approach may not be inclusive and cover the full range of patient views.
Service users participate in quality reviews of the service	✓/✗	At the time of the audit, patients were not involved in audits. This role was provided by the CHC.
There are effective and co-ordinated arrangements in place to use patients' views and all staff group experiences to support service improvement	✗	There was little evidence to suggest that the views captured were shared more widely with nursing staff and dieticians.

Sharing nutrition management good practice

41. In RGH, ward managers met each month for a nursing practice day, which included the fundamentals of care experience with nutrient management. Ward managers reported that this meeting was empowering and allowed good practice to be shared and issues explored collectively.

42. This arrangement was not in place in NHH, the evidence suggests that this arrangement should be introduced quickly.

43. Senior nurses from across hospital sites had started meeting each other and arrangements were being developed to meet and share practice across the Health Board. It was planned to extend this arrangement to ward manager forums. These need to be introduced quickly and certainly within service groups.

44. Recently, one of the Health Board's senior nurses had an article based on observational nutritional practice published in the *British Journal of Nursing*[3]. This found a range of good and bad practice, the results of which provide a starting point for discussion.

[3] Mould. J (2009) Nurses 'must take control of the nutritional needs of patients' *British Journal of Nursing 2009 Vol 18 1056-1060*

Patient survey results

45. Our review included a patient questionnaire which was available to the general public. Exhibit 10 summarises some of the key findings from the survey and the full analysis can be found in Appendix 3. Issues that need to be explored further include:

- why patients do not recall the discussions they had about nutrition;
- the low number of patients weighed during their stay;
- choosing a portion size in NHH; and
- the management and delivery of snacks for patients.

46. Patients were invited to comment on the service they received, the majority of comments were about the good quality meals provided. There were some negative comments mainly centred on food not being hot enough. One patient did raise the issue that his religious beliefs could not be catered for over not drinking caffeine-based hot drinks. Several faiths have this belief as well as an individual's personal choice and it is not an unusual request.

Exhibit 10: Patient survey key findings

Question	RGH	NHH	Overall	Wales
Percentage of respondents who were weighed during their stay in hospital	66%	64%	65%	67%
Percentage of respondents whose height was measured during their stay in hospital	30%	34%	32%	32%
Percentage of respondents where a member of the hospital staff talked to them about their dietary needs	31%	39%	35%	41%
Percentage of respondents who were you able to choose the portion size	56%	27%	42%	65%
Percentage of respondents who thought the menu changed often enough	78%	54%	67%	67%
Percentage of respondents who missed a meal, given a replacement one	76%	76%	76%	80%
Percentage of respondents where snacks were available between mealtimes	35%	28%	31%	38%
Percentage of respondents who were satisfied with the food they received	82%	82%	82%	82%

Appendix 1

Audit approach

The audit sought to answer the overall question:

'Are hospitals in Wales providing efficient catering services that meet recognised good practice?'

The following sub-questions underpin the overall question:

- Are strategic planning arrangements relating to catering effective?
- Are procurement arrangements effective and is food sourced from safe suppliers?
- Is food production well controlled?
- Are there efficient arrangements to deliver the food to the ward, and to the patient?
- Do the arrangements at ward level help meet patients' nutritional needs and support their recovery?
- Are there effective arrangements in place to consult patients about the catering service they receive?

An audit module was developed around each of the sub-questions set out above.

Exhibit 11: Audit modules

Module	Audit tools
Module 1: Strategic planning arrangements	• Cost tree analysis • Patient experience survey • Management arrangements checklist • Interviews
Module 2: Procurement arrangements	• Cost tree analysis • Management arrangements checklist • Process walkthrough • Interviews
Module 3: Production control	• Cost tree analysis • Patient experience survey • Management arrangements checklist • Process walkthrough • Food quality survey • Interviews
Module 4: Ward delivery arrangements	• Patient experience survey • Ward observation tool • Food quality survey • Interviews

Module	Audit tools
Module 5: Supporting recovery	• Patient experience survey • Ward observation tool • Observational wastage tool • Food quality survey • Nutritional assessment tool • Interviews
Module 6: Patient engagement	• Patient experience survey • Interviews

Cost comparisons

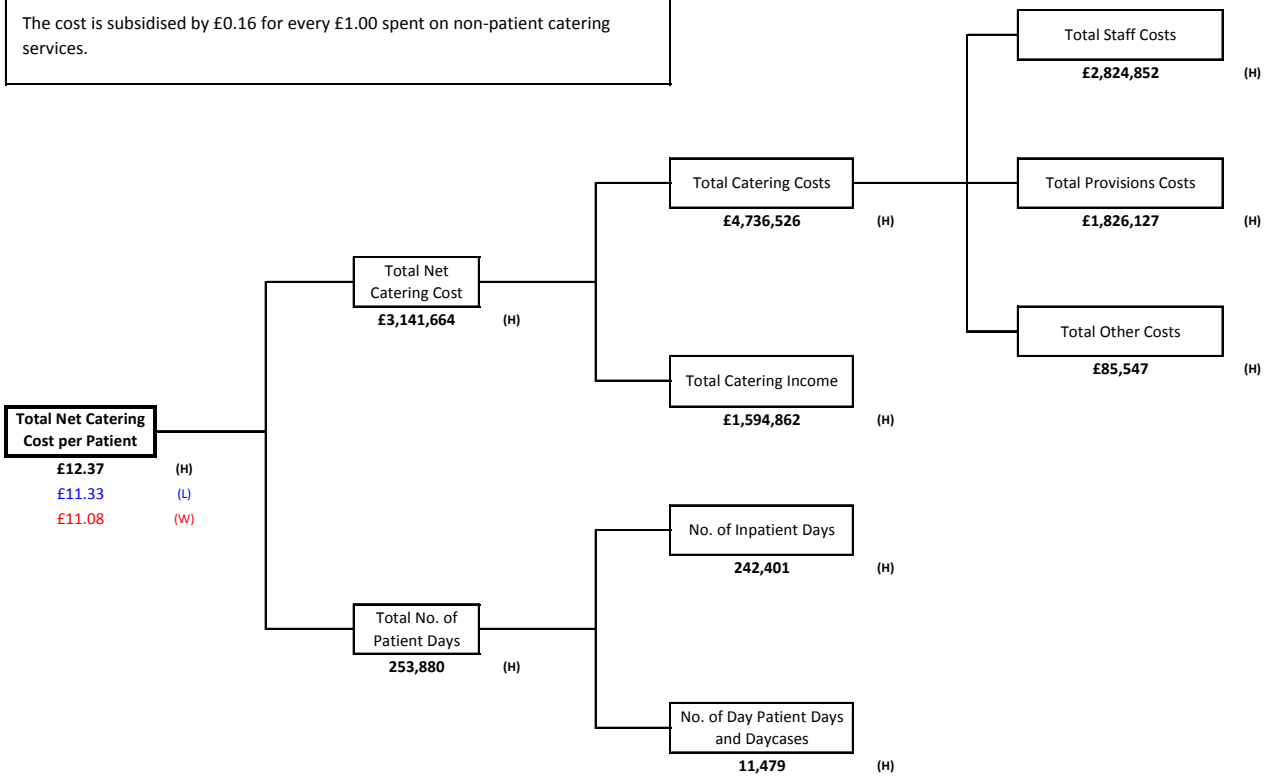
Total Catering Costs

Hospital: **Royal Gwent Hospital**
LHB/ Trust: **Aneurin Bevan Health Board**

Key Issues

The total net cost per patient day to the hospital is £12.37 compared to an LHB figure of £11.33 and a Welsh figure of £11.08

The cost is subsidised by £0.16 for every £1.00 spent on non-patient catering services.



Key
Hospital figures in bold;
LHB/Trust figures in blue;
Welsh figures in red.

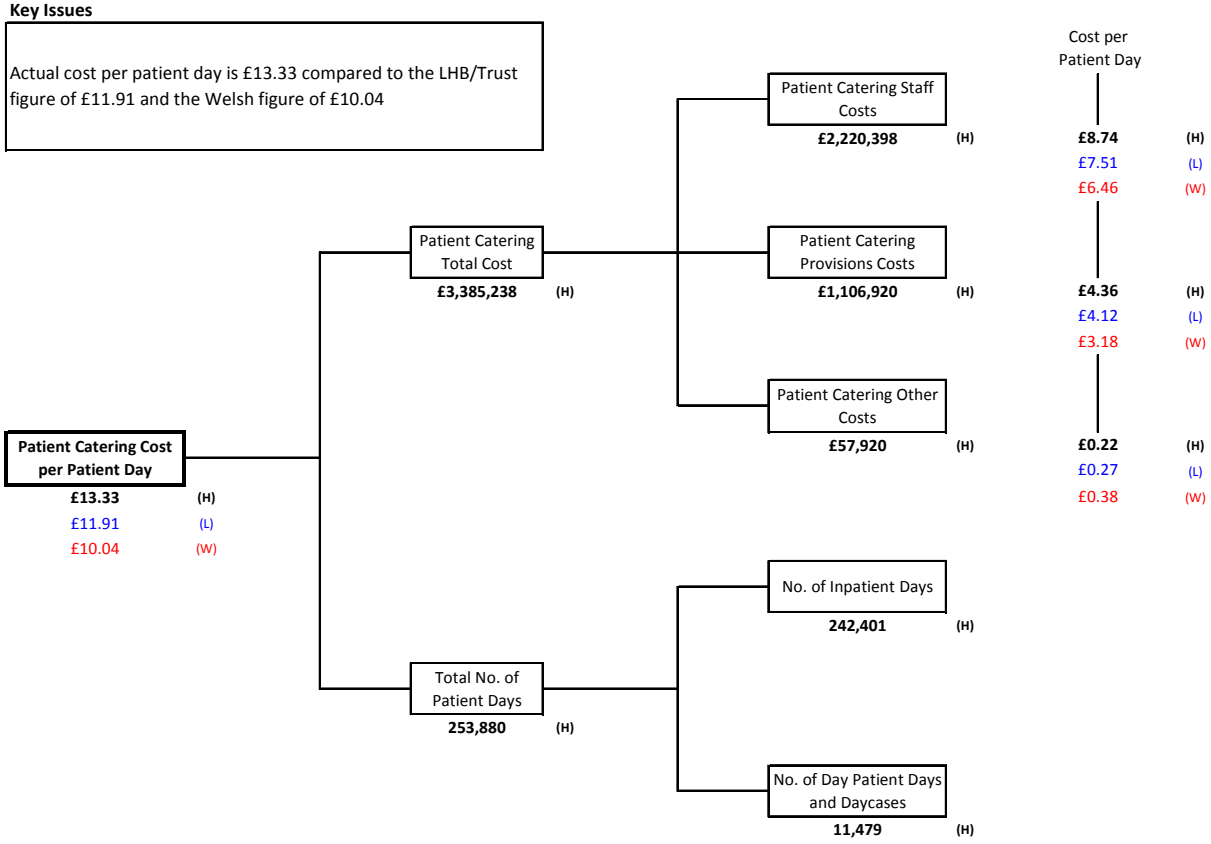
Notes
The LHB/Trust and Welsh figures are based on the hospitals that have particpated in the survey, not all hospitals in Wales have particpated

Patient Catering Costs

Hospital: **Royal Gwent Hospital**
LHB/ Trust: **Aneurin Bevan Health Board**

Key Issues

Actual cost per patient day is £13.33 compared to the LHB/Trust figure of £11.91 and the Welsh figure of £10.04



Prime cooking method: Conventional 0
Food regeneration: Not applicable
Service delivery: Bulk to wards
Washing up: Ward washing up

Key
Hospital figures in bold;
LHB/Trust figures in blue;
Welsh figures in red.

Notes
The LHB/Trust and Welsh figures are based on the hospitals that have particpated in the survey, not all hospitals in Wales have particpated

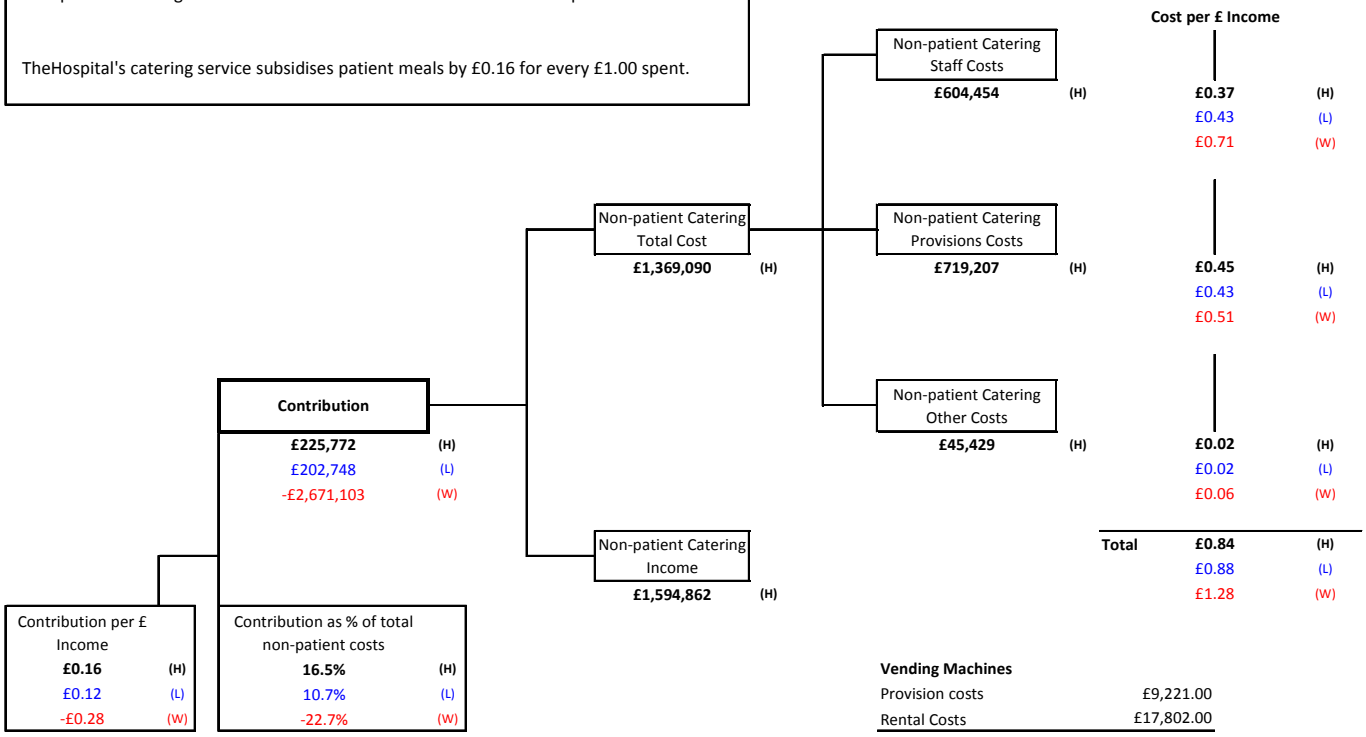
Non-Patient Activity Costs

Hospital: **Royal Gwent Hospital**
LHB/ Trust: **Aneurin Bevan Health Board**

Key Issues

Non-patient catering services does make a cost contribution to the hospital

TheHospital's catering service subsidises patient meals by £0.16 for every £1.00 spent.



Vending Machines	
Provision costs	£9,221.00
Rental Costs	£17,802.00
Total Costs	£27,023.00
Income	£21,343.00

Key

Hospital figures in bold;
LHB/Trust figures in blue;
Welsh figures in red.

Notes

The LHB/Trust and Welsh figures are based on the hospitals that have particpated in the survey, not all hospitals in Wales have particpated

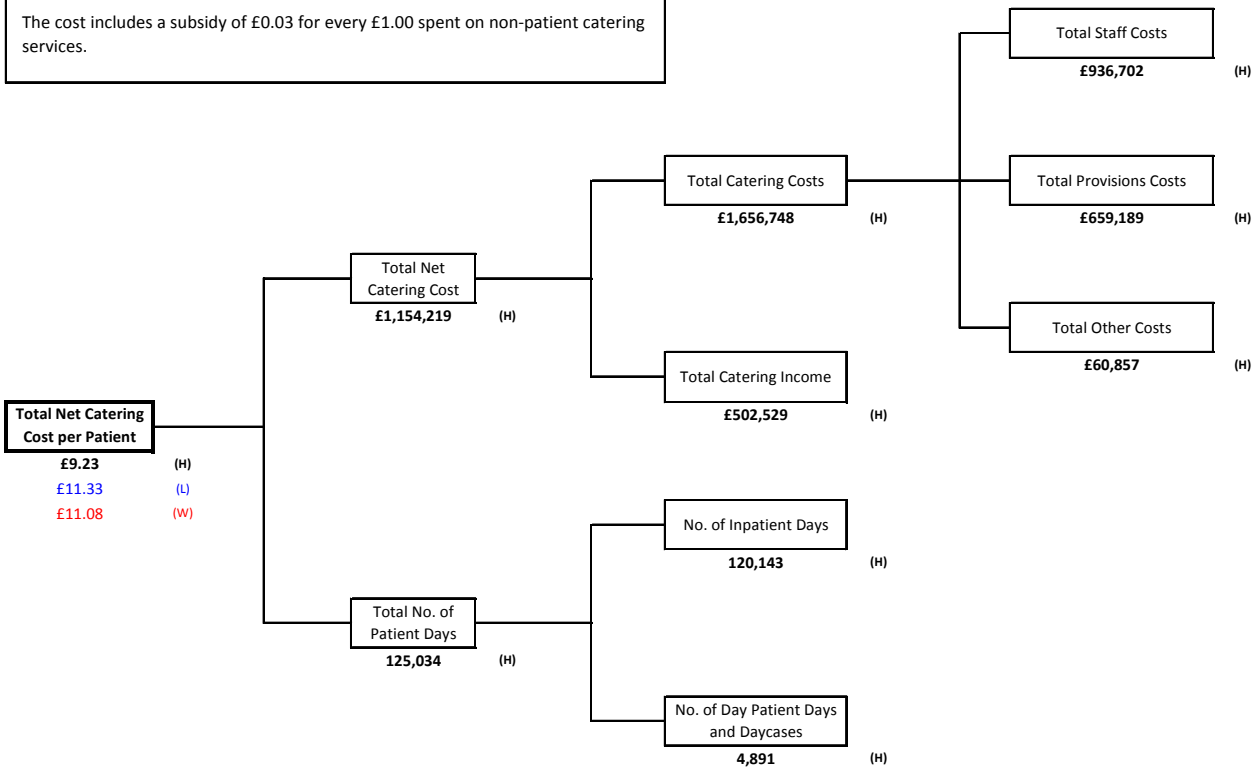
Total Catering Costs

Hospital: **Nevill Hall Hospital**
LHB/ Trust: **Aneurin Bevan Health Board**

Key Issues

The total net cost per patient day to the hospital is £9.23 compared to an LHB figure of £11.33 and a Welsh figure of £11.08

The cost includes a subsidy of £0.03 for every £1.00 spent on non-patient catering services.



Key
Hospital figures in bold;
LHB/Trust figures in blue;
Welsh figures in red.

Notes
The LHB/Trust and Welsh figures are based on the hospitals that have particpated in the survey, not all hospitals in Wales have particpated

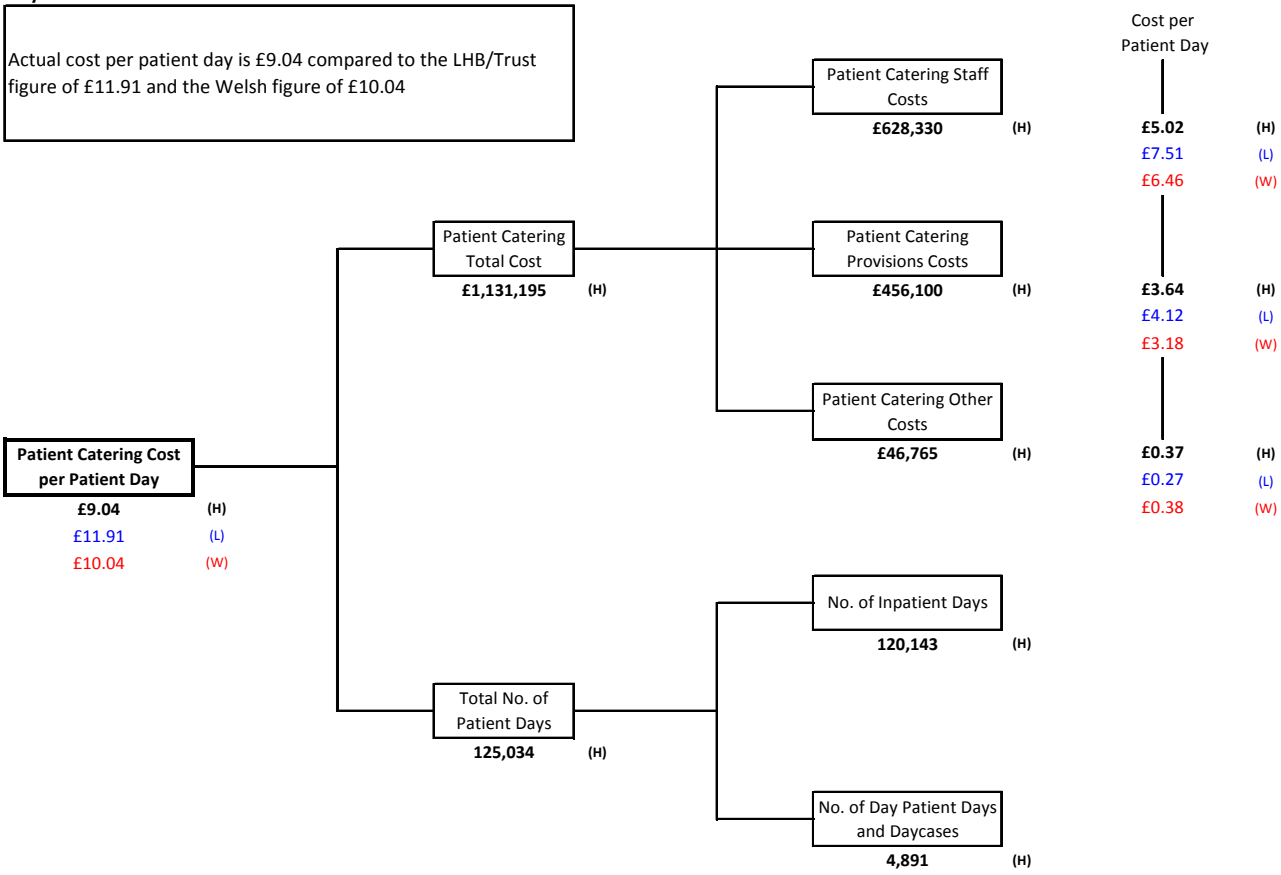
Domestic staff serve the food, their costs are not included in the analysis

Patient Catering Costs

Hospital: **Nevill Hall Hospital**
LHB/ Trust: **Aneurin Bevan Health Board**

Key Issues

Actual cost per patient day is £9.04 compared to the LHB/Trust figure of £11.91 and the Welsh figure of £10.04



Prime cooking method: Conventional 0
Food regeneration: Not applicable
Service delivery: Plated meals
Washing up: Central washing up

Key
Hospital figures in bold;
LHB/Trust figures in blue;
Welsh figures in red.

Notes
The LHB/Trust and Welsh figures are based on the hospitals that have particpated in the survey, not all hospitals in Wales have particpated

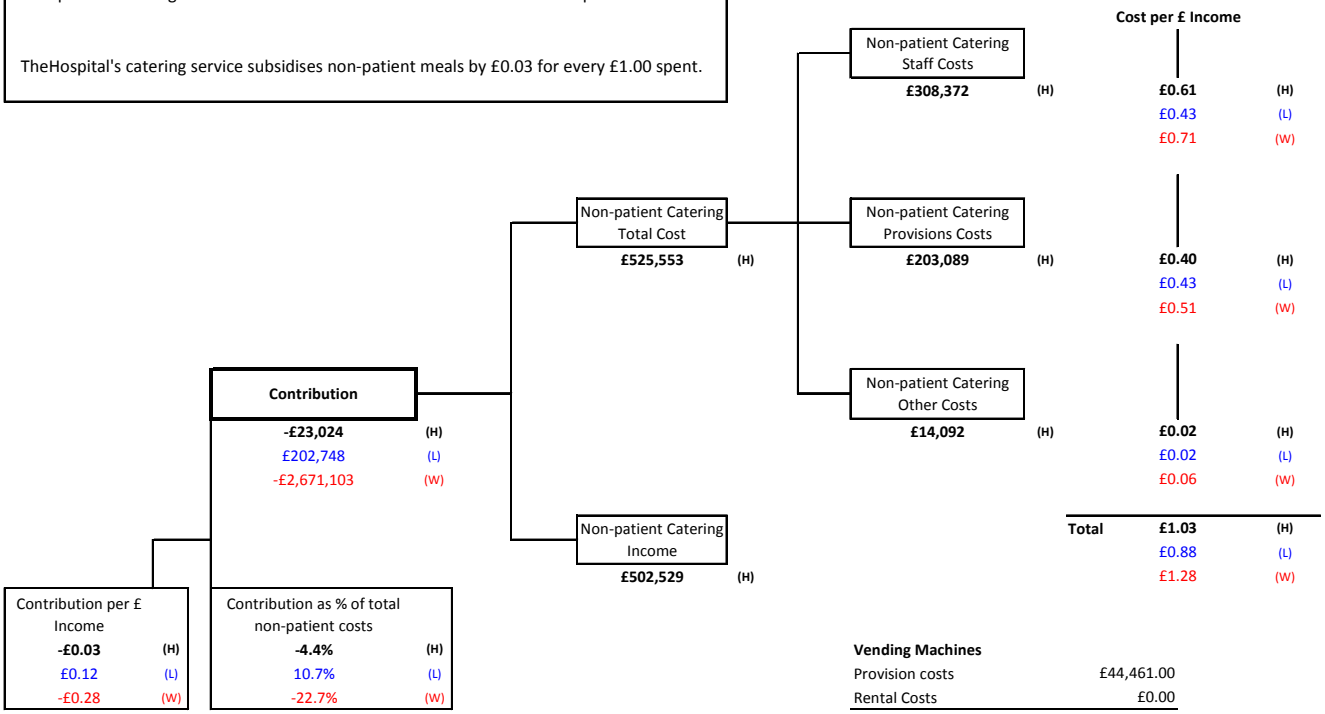
Non-Patient Activity Costs

Hospital: **Nevill Hall Hospital**
LHB/ Trust: **Aneurin Bevan Health Board**

Key Issues

Non-patient catering services does not make a cost contribution to the hospital

TheHospital's catering service subsidises non-patient meals by £0.03 for every £1.00 spent.



Vending Machines	
Provision costs	£44,461.00
Rental Costs	£0.00
Total Costs	£44,461.00
Income	£71,796.00

Key

Hospital figures in bold;
LHB/Trust figures in blue;
Welsh figures in red.

Notes

The LHB/Trust and Welsh figures are based on the hospitals that have particpated in the survey, not all hospitals in Wales have particpated

Domestic staff serve the food, their costs are not included in the analysis

Patient views

Number of returned surveys:

- RGH – 45
- NHH – 47
- Wales – 690

Results based on a combined response of ‘yes, most of the time’ and ‘yes, always’.

Question	RGH	NHH	Overall	Wales
Percentage of respondents who were weighed during their stay in hospital	66%	64%	65%	67%
Percentage of respondents whose height was measured during their stay in hospital	30%	34%	32%	32%
Percentage of respondents where a member of the hospital staff talked to them about their dietary needs	31%	39%	35%	41%
Percentage of respondents given food that was suitable for their dietary needs				
Percentage of respondents who could understand the menu	100%	98%	99%	96%
Percentage of respondents recognising the food options on the menu				
Percentage of respondents who had enough menu choice	86%	76%	81%	73%
Percentage of respondents who were able to choose the portion size	56%	27%	42%	65%
Percentage of respondents who thought the menu changed often enough	78%	54%	67%	67%
Percentage of respondents who had enough menu choice to suit their religious beliefs	97%	97%	97%	96%
Percentage of vegetarian or vegan respondents who had enough choice to meet their needs	97%	90%	94%	95%
Percentage of respondents who had a food allergy, where there was there enough choice to meet their needs				
How patients choose what meals to eat				
When patients choose what to eat				
Percentage of respondents given the chance to wash their hands before they ate food	79%	77%	78%	84%
Percentage of respondents who had a member of staff to help them get comfortable before the meal				
Where did patients eat most of their meals?				

Question	RGH	NHH	Overall	Wales
Percentage of respondents who thought the area where they ate their food was clean and tidy	96%	94%	95%	94%
Patients needing eating aids, who were provided with them				
Patients needing help when eating, who were given it				
If someone helped you to eat your food, who was it?				
If someone helped you to eat, was this soon enough after your meal arrived?				
Percentage of respondents who were happy with the time meals were served	94%	98%	96%	93%
Percentage of respondents whose meal was free from disturbance by nurses or doctors treating or assessing them	89%	84%	87%	88%
Percentage of respondents given enough time to finish their meal	100%	96%	98%	97%
Percentage of respondents who missed a meal, given a replacement one	76%	76%	76%	80%
Percentage of respondents getting the meal they ordered	84%	88%	86%	91%
Percentage of respondents who had fresh fruit available	66%	75%	72%	73%
Percentage of respondents where drinks were available between mealtimes	96%	96%	96%	90%
Percentage of respondents where snacks were available between mealtimes	35%	28%	31%	38%
Percentage of respondents where fresh water was available throughout the day	100%	98%	99%	97%
Percentage of respondents who had food served at the temperature they would have expected	77%	72%	74%	83%
Percentage of respondents given enough food to eat	82%	93%	88%	87%
Percentage of respondents who were happy with the taste of the food they were given	86%	82%	84%	83%
Percentage of respondents who were happy with the appearance of the food they were given	89%	84%	86%	84%
Percentage of respondents who were happy with the healthiness of the food they were given	91%	79%	85%	86%
Percentage of respondents who were satisfied with the food they received	82%	82%	82%	82%

Appendix 4

Internal Audit review findings

Inpatient area	Records reviewed
RGH	19
NHH	11
County	15
Ystrad Mynach	6
St Cadocs	4
Acute	30
Community	12
Mental Health	13

Inpatient area	Screened within 24 hours	Weighed within 24 hours	Care plan following MUST score	Record chart signed by a nurse
RGH	63%	53%	0%	24%
NHH	18%	64%	100%	6%
County	27%	73%	80%	
Ystrad Mynach	17%	83%	N/A	100%
St Cadocs	0%	50%	N/A	46%
Acute	47%	57%	40%	
Community	25%	58%	67%	
Mental Health	15%	85%	100%	

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