Rotherham Doncaster and South Humber NHS Foundation Trust

Nutrition and hydration policy

DOCUMENT CONTROL:

- **Version:** 9.3
- **Unique Reference number:** 398
- **Approved by:** director of corporate assurance
- **Date approved:**28 October 2026
- **Document Author:** chief allied health professional
- **Title of Accountable Director:** director of psychological professionals and therapies
- **Date issued:** 29 October 2026
- **Review by date:** 31 October 2029

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1. Document summary

1.1 What is this policy about?

This policy explains how we will help you to have enough food and drink while you receive care from the Trust.

Food and drink should be safe, suitable for you and something you can accept. We will listen to what matters to you. This includes your health needs, allergies, culture, religion, food choices and any help you need to eat or drink.

1.2 What will staff do?

- Ask what you like to eat and drink.
- Ask about allergies, intolerances and special diets.
- Check whether you need help, special equipment or a different food texture.
- Make sure food and drinks are within reach and offered in a way that is safe for you.
- Protect mealtimes from avoidable interruptions.
- Write down your needs and share important information when you move to another service.

Care must be person-centred, evidence-based and clearly documented. Where a person may lack capacity to make decisions about nutrition or hydration, colleagues must follow the Trust's Mental Capacity Act policy. Information about nutritional risks, support and care plans must be shared when the patient moves between services or care settings.

1.3 Checking your nutrition

Staff will usually check whether you are at risk of not getting enough nutrition. This check is called MUST.

The check should normally happen within 24 hours of admission or first contact.

- **Score 0:** staff will encourage a healthy, balanced diet.
- **Score 1 or more:** staff will make a nutrition care plan with you.

Your care plan may include extra snacks, nourishing drinks or adding energy and protein to food. A dietitian may be asked to help if needed.

1.4 Drinking enough

Drinking enough helps your body and brain work well. Staff will look for signs that you may be dehydrated.

You may be offered regular drinks, reminders or hands-on help. Drinks should be offered in a cup or other container that you can use safely.

Tell a member of staff if you feel thirsty, dizzy, weak, very tired or unable to drink enough.

1.5 Training

Relevant colleagues must complete MUST training at least every 3 years. Compliance is monitored through annual MUST and nutritional action planning audits, annual food-quality inspections, monthly patient feedback, incident reporting and local review.

2. Introduction and aim

People using NHS services must receive enough food and fluid to maintain life and good health and to reduce the risk of malnutrition and dehydration during care and treatment. Evidence shows that:

- many people receiving care in community settings are malnourished (Russell and Elia, 2011; Barker et al., 2011)
- malnutrition is linked to poorer health outcomes, slower recovery and higher healthcare costs (Stratton et al., 2003; Guest et al., 2011; Elia, 2015)
- dehydration is linked to higher rates of illness, disability and death in older people, and people admitted from care homes are often dehydrated (Hooper et al., 2014; Wolff et al., 2015)

The Care Quality Commission (CQC, 2015) requires services to assess people's nutritional needs and provide suitable food, prescribed supplements or parenteral nutrition. Services must also take account of each person's preferences and religious and cultural needs.

NHS England National Standards for Healthcare Food and Drink (NHS England, 2022) sets out eight standards that all NHS Organisations are required to meet. In older people living at home issues surrounding fluid supply need to be addressed in order to promote optimal hydration and avoid dehydration.

This policy does not cover the corporate functions of food and drink which are covered in RDaSH food and drink plan.

Of the NHS England (2022) National Standards for Healthcare Food and Drink, the following are covered in this policy:

- organisations must have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item
- organisations must consider the level of input from a named food service dietitian to ensure choices are appropriate

This policy incorporates recommendations in the British Dietetic Association Nutrition and Hydration Digest and NHS England 10 Key Characteristics of Good Nutrition and Hydration Care.

This policy explains the processes, requirements, roles and responsibilities for nutrition and hydration. It aims to make sure that every adult patient under the care of Rotherham, Doncaster and South Humber NHS Foundation Trust receives safe food and fluid in a form they accept and that meets their assessed needs. It also reinforces the importance of good nutrition and hydration for patients, visitors and colleagues.

2.1 Definitions

- **Nutritional care** means the food, fluid, support, procedures and environment used to help a person meet their nutritional needs. It is provided to all Trust patients in a way that suits the person and care setting.
- **Nutrition support** means action to maintain or improve nutritional intake where a need has been identified. It may include enriched food, snacks, nourishing drinks or supplements; feeding into the digestive system through a tube; nutrition given into a vein; and practical help to eat, drink or swallow safely.
- **Hydration** means replacing fluid lost through breathing, sweating and passing waste by taking in drinks and food. See British Dietetic Association fluid, water and drinks guidance.
- **Dehydration** is loss of body water, with or without salt, faster than the body can replace it (Thomas et al., 2008).
- **Fluid balance** is the balance between fluid taken in and fluid lost. A fluid balance chart may be used when a person is dehydrated, at risk of dehydration or needs monitoring for a clinical condition, following advice from the medical team.
- **Healthy balanced diet** means a diet based on the NHS Eatwell Guide.
- **Special diet** means a diet that cannot be chosen freely from the main menu because of an allergy, intolerance, medical need, religious or cultural requirement, or a vegetarian or vegan choice. The Eatwell Guide may need to be adapted to meet these needs.
- **Obesity** is excess body fat that may harm health. Patients with obesity must receive evidence-based care from admission to discharge in line with relevant NICE guidance.
- **Diabetes** is a lifelong condition in which blood glucose is too high. Patients with diabetes must receive evidence-based care from admission to discharge in line with relevant NICE guidance.
- **Malnutrition** is a lack, excess or imbalance of energy, protein or other nutrients that harms body tissues, body mass, function or clinical outcomes. A person may be at risk if their body mass index is below 20 kg/m², they have lost more than 5% of their weight unexpectedly in 3 to 6 months, or they are acutely ill and have had, or are likely to have, no nutritional intake for more than 5 days. Malnutrition can affect people who are underweight, overweight or obese. Use the malnutrition universal screening tool (MUST) on SystmOne or the Trust intranet to assess risk.
- **Refeeding syndrome** is a potentially fatal change in fluid and electrolyte levels when nutrition is restarted in a malnourished person. It can cause serious problems with phosphate, potassium, magnesium, sodium, fluid balance, glucose and thiamine.
- **Dysphagia** means difficulty eating, drinking or swallowing. It increases the risk of choking or aspiration and can affect nutrition and enjoyment of food. See the dysphagia management policy.
- **Aspiration** happens when food or fluid enters the airway and lungs instead of the oesophagus. This increases the risk of chest infection.
- **Polydipsia** means excessive or unusual thirst with excessive fluid intake. Psychogenic or primary polydipsia means a person chooses to drink excessive amounts of water.

2. Procedure

All patients and clients must receive food and drink that is safe, meets their assessed needs and is acceptable to them.

3.1 General principles

3.1.1 Personalised care

Colleagues must ask about and record each person's current food and drink needs and preferences. This includes cultural and religious needs, allergies, intolerances, sensitivities and any specialist diet. Suitable choices must then be planned and made available.

Nutritional care and treatment must be based on evidence and reflect the person's needs and preferences. Colleagues must support the person to make informed decisions and involve carers, parents or relatives where appropriate.

If a person may not be able to make a decision about nutrition, hydration, care or treatment, healthcare professionals must follow the Trust's Mental Capacity Act (2005) policy and its supporting code of practice.

3.1.2 Dietary needs

On admission to an inpatient unit, healthcare professionals must assess and record the person's dietary needs and preferences. This includes food choices, help or equipment needed for eating, and risks such as choking or aspiration. Refer to another healthcare professional when specialist assessment or support is needed.

Help patients choose food and drink that meets their nutritional needs, required texture and any other assessed need. Provide information in an accessible format so that the person can make their own choice wherever possible.

Offer food, fluids and medicines that meet the person's nutritional, and hydration needs and are suitable for their medical condition and ability to eat, drink and swallow safely.

Community colleagues should plan visits and interventions to avoid disrupting the person's mealtimes wherever possible.

Inpatient mealtimes should take place in a calm, suitable environment that supports eating and drinking.

Inpatients must be able to access food and drink at any time. They should not need to ask permission, although colleagues should support choices that are safe and suitable for the person's clinical needs. If the person may not have capacity to make this decision, follow the Mental Capacity Act (2005) policy.

Offer the support the person needs to eat and drink safely. This may include suitable aids, physical assistance, supervision or behaviour support where there is an identified choking risk.

Follow the Trust food safety policy whenever food or drink is provided. Serve food and drinks at a temperature that is safe and acceptable to the patient.

Standard menus must provide suitable choices for patients who are well nourished and for those who are nutritionally vulnerable. The daily energy target is 1,840 to 2,772 kcal. The protein target is 56 g for men who are nutritionally well and 45 g for women in the same age group. Patients who are nutritionally vulnerable need 79 g to 92 g of protein, and meals should aim towards the higher end of the energy range. A balanced meal, including an optional starter, main course and dessert, should provide about 500 kcal and 15 g of protein for a person who is nutritionally well, or 800 kcal and 27 g of protein for a person who is nutritionally vulnerable. The daily menu should include:

- 5 servings of fruit and vegetables
- 5 servings of potatoes, bread, rice, pasta and starchy carbohydrates
- 3 servings of dairy and alternatives
- 2 servings of beans, pulses, fish, eggs, meat and other proteins

Foods with a high fat or sugar content may be offered, but the emphasis will be different depending on individual needs.

A food service dietitian reviews the Trust's menus each year to make sure they meet the required standards.

3.2 Malnutrition screening

Record every malnutrition screening result and any nutrition support goals in the patient record. Share this information in writing when the person moves between services or care settings.

Review nutrition support at planned intervals. The review must consider why support is needed, how it is being provided, the risks and benefits, and whether the agreed goals are being met.

All inpatients and community patients must be screened for malnutrition. Screening is the first step in finding people who are, or may become, at nutritional risk and who may benefit from support.

Complete the malnutrition universal screening tool (MUST) template within 24 hours of admission to an inpatient ward or within 24 hours of first contact with a patient living at home. If it is not appropriate to complete every step, record the reason on the MUST template in SystmOne.

When Trust colleagues work in an acute hospital, acute hospital colleagues will follow their own MUST screening procedure. Trust colleagues must still complete the SystmOne MUST template and record "MUST considered and not completed".

3.2.1 Malnutrition screening in people with palliative care needs

Nutritional care for people receiving palliative care has three stages: early phase, late phase and the last few days of life. At every stage, care should focus on the person's comfort, enjoyment of food and drink, and quality of life.

For patients with palliative care needs the following guidance should be followed:

3.2.1.1 Early phase palliative care

- **Definition:** In early phase palliative care, the person has a terminal illness but is not expected to die soon. They may have years to live and may receive treatment to improve their quality of life.
- **Nutritional assessment:** Malnutrition screening and assessment are important. Early support may improve the person's response to treatment.
- **Community referrals and inpatient referrals:** Complete MUST screening and start the food-first nutritional action plan that matches the score. If the person continues to lose weight at review, refer them to the dietetic service.

3.2.1.2 Late phase palliative care

- **Definition:** In late phase palliative care, the person's condition is getting worse, and they may have pain, nausea or a reduced appetite.
- **Nutritional assessment:** Comfort and enjoyment are more important than the nutritional content of meals. Encourage the person to eat and drink what they enjoy. The aim is to support comfort, relieve symptoms and maintain quality of life, rather than achieve weight gain or reverse malnutrition.
- **Community and inpatient referrals:** Do not routinely complete MUST screening or start food-first treatment or oral nutritional supplements. Record "MUST considered and not completed" in the patient record. Use the late-stage palliative nutrition care or treatment plan when further guidance is needed.
- **Nutrition and hydration recording:** Use clinical judgement to decide whether recording food and fluid intake will benefit the person.

3.2.1.3 Last few days of life

- **Nutritional assessment:** In the last few days of life, care should focus on comfort and relief of symptoms.
- **Community and inpatient referrals:** Do not routinely complete MUST screening or start food-first treatment or oral nutritional supplements. Record "MUST considered and not completed" in the patient record. Offer mouth care and, if the person wishes and can manage safely, sips of fluid or small amounts of food.
- **Nutrition and hydration recording:** Use clinical judgement to decide whether recording food and fluid intake will benefit the person. Further guidance is available on the Trust intranet for dietetic service inpatients (staff access only) and dietetic service community (staff access only).

3.2.2 Equipment

All clinical teams or services are able to have access to the following:

- suitable weighing scales, such as standing, hoist or ramp scales, used in line with the manufacturer's instructions, calibrated and class III or above
- a tape measure for measuring mid-upper arm circumference
- a stadiometer for measuring height

If a patient cannot be weighed, use a proxy weight measure described in the full MUST guidance and record this in the SystmOne MUST template. Do not use a proxy height measure. Use a previous recorded height or a height recalled by the patient or someone who knows them.

3.3 Nutritional action planning

3.3.1 Screening results and action planning

If the patient's MUST score is 0, they do not need an individual nutritional action plan. Encourage a healthy, balanced diet and offer lower-calorie choices where appropriate.

If the patient's MUST score is 1 or above, create an individual nutritional action plan using the SystmOne MUST template and follow the principles below.

3.3.2 Food first approach

When a MUST score is 1 or above, create and use an individual nutritional care or treatment plan. Start with a food-first approach by using everyday foods and drinks to increase energy and protein. This may include adding milk powder, eggs, butter, cream or cheese to meals; offering energy-dense snacks such as cheese and crackers, rice pudding or yoghurt; and offering nourishing drinks such as milky drinks.

To reduce the risk of feeling full before meals, avoid offering large drinks immediately before eating. Do not offer low-energy alternatives, such as semi-skimmed milk, when the aim is to increase energy intake.

3.3.3 Oral nutritional supplements prescribing

Oral nutritional supplements are sterile drinks, semi-solid products or powders that provide energy, protein, vitamins and minerals. They are used when a person cannot meet their nutritional needs through food and drink alone.

Only discuss or prescribe oral nutritional supplements for an adult inpatient or community patient after a dietitian has assessed the person and recommended them. The dietitian will consider the relevant prescribing criteria, whether food-first and over-the-counter options have been tried, and the person's medical and social circumstances. The dietitian will provide the reason for the prescription when requested.

3.3.4 Nutrition via tube

The multidisciplinary team should consider tube feeding when a patient is malnourished, or at risk of malnutrition, cannot eat enough or cannot eat safely, and has a working digestive system that can be accessed safely.

Refer an inpatient who already has an enteral feeding tube to the dietetic service on admission. If a patient has a tube inserted while in an acute hospital, make a dietetic referral as part of discharge planning. Follow the enteral tube feeding adults policy.

3.3.5 Hydration

Good hydration is essential for health. Dehydration can reduce alertness and concentration and cause constipation. It is also linked to urinary tract infections, kidney stones and chronic kidney disease.

People are more likely to become dehydrated if they are older, have an acute or long-term illness, have cognitive impairment or reduced mobility, or need help to drink.

Even mild dehydration can affect thinking and increase tiredness. It can also cause low blood pressure, weakness and dizziness, which increase the risk of falls.

Drinks provide around 70% to 80% of our water needs. The remaining 20% to 30% comes from foods such as:

- soup
- stews
- some fruits and vegetables which contain a lot of water

Recommended adequate intake of water from drinks:	
Group	Intake
Adults including older people (men)	2000ml
Adults including older people (women)	1600ml
Those who are pregnant	1900ml

All drinks count towards fluid intake except alcoholic drinks above 4% alcohol by volume. Where it is safe, offer the person their preferred drink, at their preferred temperature and in the cup, mug or other drinking vessel they prefer.

The number of cups or glasses needed each day depends on the amount held by the person's preferred drinking vessel. Record this in the care plan so colleagues know how much to offer.

Support hydration by offering foods with a high fluid content, offering drinks with medicines and at routine points such as before therapy or during visits, and keeping drinks within easy reach.

Use clinical assessment to check whether a patient is drinking enough. This may include blood test results, fluid balance charts, urine colour and the person's report of thirst. People who depend on others for drinks, have dysphagia or are acutely unwell may need regular prompts, support or direct assistance.

Report any concern about dehydration to the clinician responsible for the patient. Further information is available in the British Dietetic Association guidance on fluid, water and drinks and hydration in older adults.

3.3.6 Plan of care

People who are malnourished or at risk of malnutrition must have a care or treatment plan that explains how their nutritional needs will be met. Record the plan, actions, outcomes and reviews in the electronic patient record so all colleagues understand the person's nutritional status and any support required.

Create and use a suitable care plan for anyone at risk of malnutrition or obesity, or who has specific dietary needs. Refer to another healthcare professional or service when specialist support is needed.

Create and use a suitable care plan for anyone who is dehydrated or at risk of dehydration. Refer to another healthcare professional or service when specialist support is needed.

Nutrition and hydration can affect the risk of falls and skin damage. Cross-reference the relevant care plans where these risks are linked.

A patient with swallowing difficulties who is known to speech and language therapy must have an eating and drinking care or treatment plan. The plan must explain how to manage the person's dysphagia. A speech and language therapist must review it if the person's condition or needs change.

A patient at risk of choking must have a care or treatment plan that explains how the agreed risk will be managed. Record the decision and the involvement of the multidisciplinary team, the patient and their family or carer, where appropriate.

Any colleague who cannot follow an eating and drinking care or treatment plan must tell their manager immediately.

On inpatient units, give orders for specialist foods, therapeutic diets or other dietary items to the food service assistant at least 24 hours in advance wherever possible.

3.3.7 Nutrition and fluid recording

Diet and fluid charts are required for the following inpatients:

- patients with a malnutrition universal screening tool (MUST) score of 1 or above
- patients with a gastrostomy tube who also have oral diet and fluids
- patients with a pressure ulcer or at high risk of developing a pressure ulcer
- patients refusing to eat or drink (please see malnutrition universal screening tool template for strategies to manage food refusal)
- if highlighted within an individual's personalised plan of care, for a cultural sensitivity, physical or mental health need or others as identified by the relevant clinician
- a copy of the personalised agreed plan of care should be offered to the patient or carer or family

Use clinical judgement to decide whether food and fluid recording will benefit a person in the last few days of life, as described in section 3.2.1.

A relevant clinician or the multidisciplinary team must monitor and review diet and fluid charts at least weekly. Record why the chart is needed and stop using it when it no longer supports a clinical purpose.

Diet and fluid charts can be completed via:

- performing an electronic care or treatment plan instruction (preferred)
- paper chart available on the malnutrition universal screening tool, step 5

Scan completed paper charts into SystmOne each day under letters and communications, using the title "SCANNED, food diary".

Record the type and amount of every food and drink offered, including snacks and nourishing drinks listed in the nutritional care or treatment plan.

Record clearly how much was eaten or drunk, for example half, three-quarters or all. Do not use unclear terms such as “small diet” or “good amount”. Do not leave the chart blank. If the patient refuses, still record what was offered and enter “nil” for the amount taken.
On the diet and fluid chart, include drinks that also provide energy or other nutrients, for example:

- orange juice
- Coca-Cola
- milkshakes
- ensure
- Fortisip

3.3.8 Review and referral

Repeat nutritional screening every week for inpatients. For people cared for at home, repeat screening as often as their condition and level of risk require.

After starting a nutritional action plan, repeat MUST screening. Refer the patient to the dietetic service if their score was already 1 or above and they have lost more weight. Also make an automatic referral when:

- if prescribed nutritional supplements on admission or not under a dietetic service in community
- grade 3 or 4 pressure ulcers

Inpatient services at Doncaster and Rotherham refer to Doncaster dietetic services. Inpatient services at North Lincolnshire to refer to Northern Lincolnshire and Goole NHS Foundation Trust.

Community services at Doncaster refer to Doncaster dietetic services. Community services at Rotherham refer to the Rotherham NHS Foundation Trust and North Lincolnshire refer to Northern Lincolnshire and Goole NHS Foundation Trust.

Review the care plan by checking the person’s medical condition and food and fluid intake. Update the plan whenever their needs or risks change.

Make dietetic referrals through the SystmOne MUST template. If the template is not available, use the referral form and guidance on the dietetic service intranet pages below.

Further information can be found on the trust intranet for dietetic service inpatients (staff access only) and dietetic service community (staff access only).

3.4 Other considerations

3.4.1 Risk of choking and aspiration

Seek specialist advice when a patient has an increased risk of choking, whether or not they have diagnosed dysphagia. Follow section 3.2 of the Trust dysphagia management policy.

3.4.2 Risk of re-feeding syndrome

A malnourished patient may develop refeeding syndrome when their food or nutrition intake increases. This can be life-threatening. The medical team and dietitian must manage and monitor the patient closely.

Patients at risk of refeeding syndrome should be managed in an acute hospital under medical supervision. They should not normally be admitted to a non-acute ward or managed in the community while this risk is present.

3.4.3 Mouth care

Regular mouth care is an essential part of care. Good oral health supports general health, wellbeing, eating, drinking, speaking and social contact.

Poor health and a stay in hospital can worsen oral health. Poor oral health is linked to hospital-acquired infections, including pneumonia, reduced nutritional intake, longer hospital stays and higher care costs.

Mouth care is a shared responsibility. Nursing and medical colleagues, speech and language therapists, dietitians, occupational therapists, pharmacists and other healthcare professionals must understand and support good oral care.

Provide mouth care to inpatients, and encourage it for community patients, at least twice a day using products and equipment suitable for the person. If the person is nil by mouth, provide or encourage mouth care at least four times a day where possible.

Further guidance and resources are available from Mouth Care Matters.

3.4.4 Dietary advice for wound care

Good nutrition and hydration support the healing of injuries, surgical wounds and pressure ulcers. Wounds are more likely to heal well when the person has enough energy, protein, vitamins, minerals and fluid, alongside any required treatment.

Encourage a varied, nutrient-rich diet with enough protein, vitamins and minerals. See the dietary advice for wound care leaflet for more information.

4. Responsibilities

4.1 Non-clinical support service assistants (domestic service colleagues)

- Check the patient diet board completed by clinical colleagues before ordering or serving meals.
- Ask clinical colleagues for advice about special diets and allergens.
- Support a positive mealtime experience by presenting food well and providing suitable cutlery and eating aids.
- Support protected mealtimes on all wards so patients can eat and drink without avoidable interruptions. Clinical activity should stop unless it is urgent or needed for safety.

4.2 Catering colleagues

- Provide high-quality food that meets national standards and patients' assessed nutritional needs.
- Provide clearly coded choices for cultural and special diets so patients and ward colleagues can make informed decisions.
- Keep allergen and ingredient information available through the catering intranet site, online ordering system and catering department.
- Review menus regularly with Facilities, ward colleagues, patients or their representatives, and dietitians.
- Use patient feedback to improve the service.

4.3 Occupational therapists

- Assess the person and provide interventions that manage risk, build skills, increase independence and improve the mealtime experience.
- Provide or recommend suitable equipment, positioning and techniques for eating and drinking.
- Support skills such as shopping, reading food labels, preparing food and cooking with fresh ingredients.
- Promote health and help patients make suitable food choices, including where nutrition affects conditions such as diabetes or obesity.

4.4 Speech and language therapists (SALT) or dysphagia trained practitioner

- When needed, complete a full assessment of the person's eating, drinking and swallowing and advise clinical colleagues.
- Work with dietitians when the person needs support from both services.

Please refer to the dysphagia management policy.

4.5 Dietitians

- Complete a full nutritional assessment after referral for a patient at risk of malnutrition.
- Advise colleagues, patients and carers and provide suitable dietary information.
- Advise on oral and enteral nutrition support and assess when another feeding route should be considered.
- Prescribe, or advise medical colleagues about, enteral feeds and oral nutritional supplements.
- Provide training and produce resources for colleagues and patients.
- Make sure hospital menus meet national nutritional standards and analyse new recipes or menu options, taking account of food safety requirements.

4.6 All clinical colleagues including clinical support colleagues

- Complete malnutrition screening using MUST and record it in the correct template.
- Provide personalised, evidence-based nutritional care through the appropriate care or treatment plan or contact the dietetic service if no suitable plan is available.

- Help patients choose suitable food and fluids and implement, review and update nutritional action plans, including at discharge.
- Record allergies and special dietary needs and tell catering colleagues. Contact the dietetic service if these needs create a nutritional risk.
- Arrange specialist assessment or treatment when identified in the care or treatment plan, including support from dietetics, speech and language therapy or occupational therapy.
- Complete recommended training and use professional development or supervision to maintain competence.
- Provide accessible information about menus and mealtime arrangements and protect inpatient mealtimes.
- Where the care or treatment plan allows, support carers to attend mealtimes to encourage or assist the patient and share information about eating and drinking needs.
- Liaise with catering colleagues about special diets, dysphagia recommendations and snacks.
- Check food brought in by visitors or carers and give advice in line with food safety procedures. Support this where it is safe and appropriate.
- Provide suitable alternative catering options, including self-catering where this has been assessed as appropriate, and make feedback routes available.

4.7 Matrons or service managers or clinical leads

- Make sure colleagues understand and follow this policy through induction, instruction, supervision and audit.
- Monitor compliance and act promptly when requirements are not met.
- Make sure clinical colleagues complete regular MUST and nutritional action planning training and can access relevant professional development or supervision.

4.8 Medical colleagues

Medical colleagues have a responsibility to work closely with clinical colleagues to:

- Work with clinical colleagues to follow and promote the correct MUST screening and nutritional action planning pathway for inpatients and community patients.
- Refer for specialist assessment or treatment when needed.

4.9 Care group directors

- Make sure policies and procedures are put into practice to meet patients' needs.
- Monitor compliance with this and related policies.
- Provide sufficient resources and make sure training requirements are met.

4.10 Nominated board director for food and drink

The nominated board director for food and drink must make sure effective nutritional care systems are in place, monitor those systems and report compliance with the healthcare food and drink standards to the Board.

5. Training

5.1 Malnutrition universal screening tool (MUST) training: Qualified nursing colleagues (band 5 and above) or another relevant colleague is identified by supervisor

- **How often should this be undertaken:** every 3 years as a minimum. Repeated training as and when felt required by clinical colleagues or management.
- **Length of training:** 1 to 2 hours.
- **Delivery method:** virtual training via Microsoft Teams or self-directed learning via the intranet or face to face.
- **Training delivered by whom:** dietitians or dietetic assistants.
- **Where are the records of attendance held:** electronic staff record (ESR) (learning and development team).

Doncaster dietetic service currently provides training for malnutrition. For all other clinical areas outlined in this policy, all qualified nursing colleagues (band 5 and above) or other relevant colleague identified by supervisor that are responsibility for implementing the contents of this policy, will need to be familiar with its contents.

As a trust policy, all colleagues need to be aware of the key points that the policy covers. Colleagues can be made aware through:

- 1-to-1 support and guidance from dietitians
- 1-to-1 meetings or supervision
- continuous professional development (CPD) sessions

6. Monitoring Arrangements

6.1 Audit of malnutrition universal screening tool (MUST) and nutritional action planning (NAP) pathway

- How and who by: clinical audit or local audit review system by ward manager or link champion.
- Reported to: quality and safety sub-clinical leadership executive (CLE) group.
- Frequency: annually.

6.2 Quality of Food

- How and who by: patient led assessment of the care environment (PLACE) inspections by head of facilities.
- Reported to: service managers or food and hydration forum.
- Frequency: annually.

6.3 Patient feedback

- How and who by: Care Opinion forms by Patient Experience team.
- Reported to: service managers or Organisational Learning team.
- Frequency: monthly.

6.4 Compliance with this policy

- How and who by: via audit, incident reporting form's, patient feedback by matrons or service managers or clinical leads.
- Reported to: care groups.
- Frequency: as they arise.

7. Related documents and associated references

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