



DELIVERING NUTRITIONAL CARE THROUGH FOOD AND BEVERAGE SERVICES

Executive Summary



FOOD COUNTS!

This document was produced by the Food Counts Specialist Group of The British Dietetic Association.

Members of the Working group:

Anne Donelan (Chair), Lauren Bowen, Allan Gimson (HCA), Shirley Hanazawa, Sadaf Saied, Christine Slee, Eileen Steinbock, Kate Williams

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This summary sets out the main points from each section of the full document which can be found on both the BDA website and on the Food Counts web pages (through the BDA website).

www.bda.uk.com

Section 1 Introduction

The aims of the document are to

- Produce a practical toolkit for dietitians that supports multidisciplinary working throughout the food provision chain
- Encourage co-operative and flexible working
- Promote excellence in food and beverage services
- Maintain a focus on the delivery of nutritional care
- Recommend standard methods and define terms.

A key principle is to promote the integration of the art and science of food.

Section 2 International and National Influences

This section highlights the main policy documents that set standards for foodservice in the four home countries of the UK, dietitians should be aware of these policy documents.

Europe

- Food and Nutritional Care in hospital: How to Prevent Undernutrition (Council of Europe 2003)

England

- The NHS Plan (DH 2000)
- Standards for Better Health. *Core standard 15* (DH 2006)

Northern Ireland

- Value for Money – audit of hospital food and beverage services (DH Social Services and Public Health 2001/2002)

Scotland

- Food Fluid and Nutritional Care Clinical Standards (Quality in Scotland September 2003)

Section 3 The dietitian's contribution to food and beverage services

The dietitian's role

The Health Professions Council (HPC) Standards of Proficiency Dietitians (HPC, 2003) provide expectations of the ways in which dietitians work in relation to the provision of food and beverage services.

- developing and maintaining good working relationships with staff at all levels
- leading the multidisciplinary team in developing policy
- being aware of standards and requirements, and working to meet or exceed them
- engaging in user consultation
- being aware of practical constraints
- using research evidence for service development
- applying negotiating and problem-solving skills.

Dietitians should achieve this through

- Dietetic partnerships among hospital dietitians and dietitians working for catering and food supply organisations
- Service planning and support including staff training and menu planning
- Service provision
 - Managing the eating environment
 - Providing patient information
 - Managing therapeutic diets
 - Monitoring and audit

Section 4 Food Consumption

- The prevention and management of malnutrition in hospital patients is a critical part of care, and foodservice is an essential element.
- Hospital food must meet the nutritional needs of all patients. It must also be appealing, and meet personal preferences.
- The environment must be conducive to eating.
- All staff need to support foodservice management and eating through protected mealtimes.
- The nutritional value of food left uneaten is nil so understanding and managing food waste is essential (see following table)

REASONS FOR UN-SERVED WASTE	REASONS FOR PLATE WASTE / REDUCED FOOD CONSUMPTION
<ul style="list-style-type: none"> • Over production in excess of the need to provide choice • Over ordering of meals (such as ordering a meal for a patient who is Nil By Mouth, just in case their dietary status changes) • Poor communication systems • Poor stock control • Poor portion control • Patient movements and discharges 	<ul style="list-style-type: none"> • Meal was not the patient's choice (often the case with a new admission) • No suitable 'special or personal diet choice' (p 36) • Meal ordering too far in advance • Patient's preference had changed • Patient may not have been feeling well due to medications, environment or pain • Patient unable to feed self and thus not fed (Burke, 1997) • Meal was unsuitable because it did not meet the patient's diet • Patient's diet was restrictive and he/she did not like the food provided • Portion size was too large • Patient was asleep, away from the bed, in an awkward position or interrupted • Unpleasant procedures/incidents taking place near to the patient
SUPPLEMENTS	
<p>Wastage of Supplements should be given equal weighting to food. Provision systems and audit must consider:</p> <ul style="list-style-type: none"> • Effect of giving supplements too close to mealtime(s). • Personal acceptability due to flavour, sweetness, texture, temperature. • Whether they are being given as prescribed especially if there is no clinical procedure in place (as with drug charts). • Systems to ensure good stock control; that track out of date items, and those that never reach the patient or are inappropriately stored in ward cupboards. 	

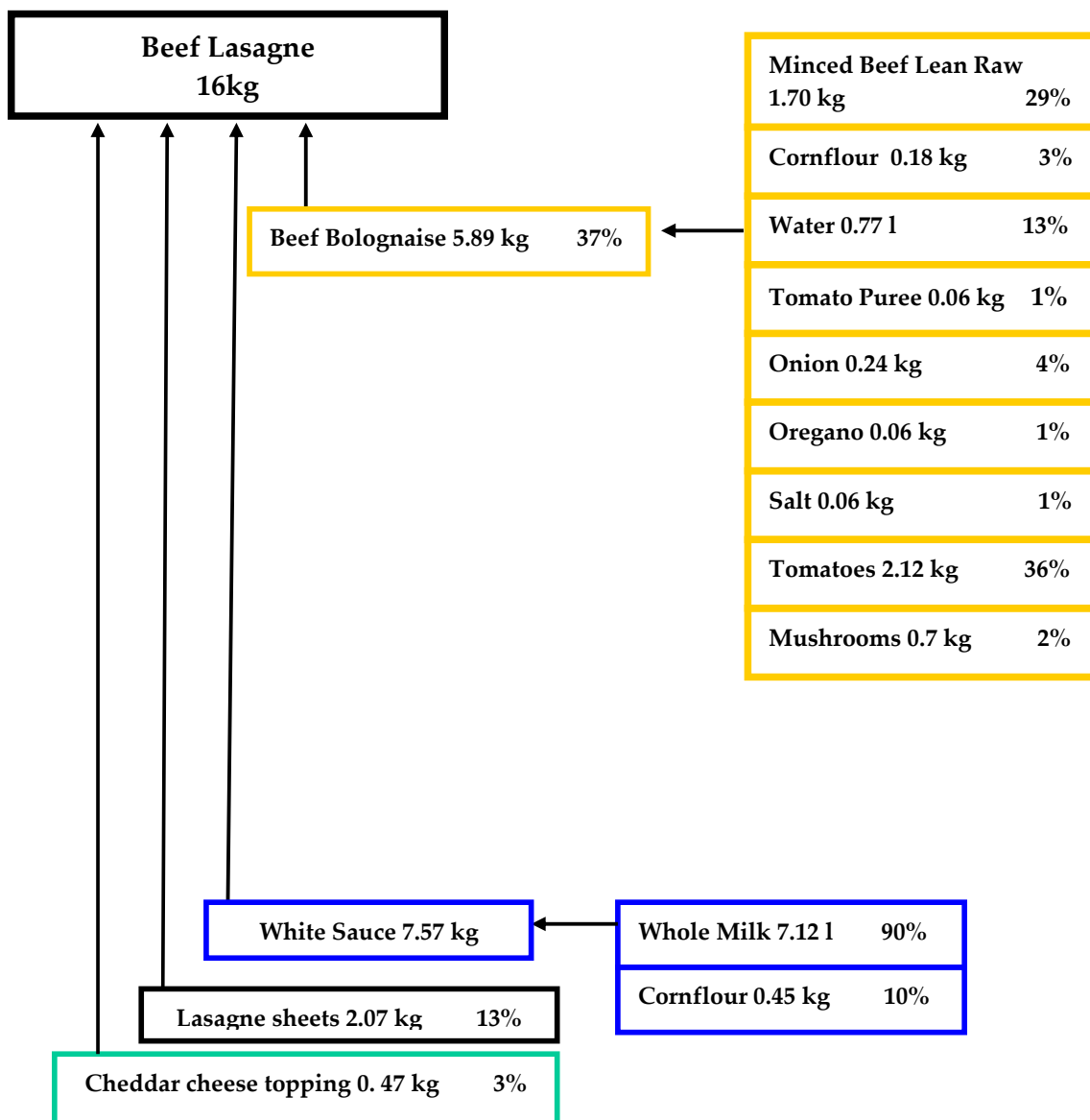
Section 5 Food Composition

The methodology recommended in this document improves consistency and transparency in providing professional dietetic opinion on the nutritional content of dishes and menus. This allows meaningful comparisons to be made, for example when distinguishing between tenders or tracking developments over time.

This section sets out in detail the method recommended for recipe analysis

This is a diagrammatic representation of the method of analysis

Fig III: Example: layered dishes such as “Beef Lasagne”



Makes approx. 70 x 227g portions

Nutrients	Nutrition per 100g	Nutrition per 227g portion
Energy	101kcal/428kJ	229kcal/971kJ
Protein	6g	14g
Carbohydrate	14g	32g
Sugars	3.5g	8g
Fat	20g	45g
Saturates	1g	2g
Fibre	0.3g	0.7g
Sodium	0.3g	0.7g

Section 6 Nutritional Content

This section sets out in detail the individual nutrients and fluid to be considered. It directs readers to sources of nutrition information and ways to present it. Key nutrients to consider are in the table below.

SIGNIFICANT NUTRIENTS FOR INGREDIENT, RECIPE AND MENU REVIEWS, AND THEIR VALUES (Non-italic- nutrients on label)

Nutrient	Usual units	Values given as	Useful conversion factors
Energy	kJ/kcal	Whole Number	kJ(p x17)+(c x17)+(f x 37) kcal(p x 4)+(c x 4)+(f x 9) kcal x4.2 =kJ
Protein	g	Whole number	
Carbohydrate	g	Whole Number	
Of which sugars	g	Whole Number	
Fats	g	Whole Number	
Saturates	g	Whole Number	
Monounsaturates	g	Whole Number	
Polyunsaturates	g	Whole Number	
Fibre (Englyst)	g	To one decimal place	
Sodium	mg	Whole number	mmol (x23)
Salt Equivalent	g	Whole Number	Na (g) x2.5
Calcium	mg	Whole number	mmol (x40)
Iron	mg	To one decimal place	mmol (x56)
Potassium	mg	Whole number	mmol (x39) (renal)
Phosphorous	mg	Whole number	mmol (x30) (renal)

Section 6 also includes information on other food constituents and hydration.

Section 7 Patient Menus

7.1 Menu Design

The menu planning team should include as a minimum a dietitian, a caterer, a nurse and a patient representative. The team should be clear as to what the menu must deliver nutritionally. The catering service specification sets the local standards. There are significant differences in hospitals in terms of patient populations served, food production, food service methods and site logistics.

Dietitians should consider

- Balance of Good Health
- Dietary composition of the menu
- Structure of the menu
- Structure of the patient day and meal timings
- Snacks
- Promoting public health, including 5-a-day
- Provision for sick people with increased requirements
- Identification of high risk patients
- Modification of food textures
- Diets for people with renal disease
- Diets for people with diabetes
- Food procurement and sustainability issues
- Allergy

The following descriptors can be used to identify particular needs

Therapeutic Diet	Modifications as a prescribed part of the treatment of a medical condition
Modified Consistency Diet	BDA & RCSLT descriptors
Test And Investigation Diets	Temporary, not necessarily nutritionally adequate
Special Diets	Religious and cultural
Personal Diet	Meeting personal preferences

Menus should reflect local population needs and healthcare organisations should develop their own guidance. Some needs are best met using 'a la carte' menus.

7.2 Menu Content

This section sets out in detail the ways in which menus should be planned to meet nutrition requirements for patients

7.3 Menu Planning

This section sets out in detail the broader issues that should be considered by the whole menu planning team

7.4 Analysing the menu capacity

This section sets out in detail the recommended minimum and maximum method for dietitians to assess the capacity of the menu to meet the needs of individual patients, with a variety of requirements.

Section 8 Dietary Coding

The toolkit recommends dietary coding should be kept to a minimum.

The two key diet codes that should be identified on patient menus are healthier eating and higher energy.

The toolkit provides guidance on these and other therapeutic codings that may be used as required.

CRITERIA FOR HEALTHIER EATING AND HIGH ENERGY CODES

DIET	AIM OF DIET	CRITERIA FOR CODING (PER DISH)	NOTES
HEALTHIER EATING	<ul style="list-style-type: none"> • To maintain good general nutrition and meet DRVs • To support public health messages on eating to protect and promote health • To support the clinical management of metabolic syndrome, diabetes mellitus, dyslipidaemia and cardiac risk, overweight and obesity, hypertension 	<p>Fat</p> <ul style="list-style-type: none"> • Entree should contain no more than 15g total fat, and no more than 5g saturated fat • Desserts should contain no more than 5g total fat, and no more than 2g saturated fat • Dishes containing oily fish. Menus should offer fish dishes prepared with minimal additional fat at least twice weekly, and oily fish at least once weekly (FSA, 2006 [online]) • Dishes containing partially hydrogenated oils (a major source of trans fatty acids) should be avoided where possible <p>Sugar</p> <ul style="list-style-type: none"> • Desserts should be based on reduced fat milk or fruit <p>Salt</p> <ul style="list-style-type: none"> • Main courses should contain no more than 1.5g Na, aiming for 1g by 2010 (FSA, 2006 [online]), Scientific Advisory Committee on Nutrition (SACN, 2003 [online]). <p>Fruits and Vegetables</p> <ul style="list-style-type: none"> • Menus should provide at least 5 servings of fruit and vegetables daily (FSA, 2006 [online]) and a variety of sources of dietary fibre. This should include raw fruit and salad daily. 	<ul style="list-style-type: none"> • Overall, total fat, salt and added sugar should be low • Where practical, fats should be unsaturated rather than saturated. • It is probably preferable to use carbohydrate sources of lower glycaemic index • Wholegrain cereal foods should be offered daily • 15g of added sugar <i>by recipe</i> is the realistic upper limit recommended by DMEG.

<p>HIGHER ENERGY / NUTRIENT DENSITY</p>	<ul style="list-style-type: none"> • To improve general nutrition and meet DRVs • To promote energy intake in those patients with small appetites • To provide a high intake of protein, vitamins, minerals and other essential nutrients • To provide a diet which can meet increased nutritional requirements in modest portions sizes and presentations which are appealing and easy to eat 	<ul style="list-style-type: none"> • Main courses at the main mid-day and evening meals should provide at least 500 calories. The balance should generally be about 300 calories provided by the main dish, and 200 cal by potatoes or other accompaniments. This should enable the menu to provide at least 70g protein per day. This supports meeting the recommendation made by BAPEN (1999) for people with increased nutritional needs (see pg 41) • Desserts should provide at least 300 calories, including accompaniments such as custard or other sauces. • Snacks of at least 150 cal should be provided twice daily • 600ml whole milk should be provided daily for those who like it • Five servings daily of fruit and vegetables should be provided in presentations which are easy to eat and nutrient dense • 2010 salt targets are common to everyone. Food should be primarily appetising to encourage patients' appetites. Recipes may need added interest to achieve suitable tastes. Some patients may need added salt and /or sauces for their personal tastes. 	<ul style="list-style-type: none"> • Energy density should be high, to promote adequate energy intake in small portion sizes. This may require the use of foods cooked with, or fortified with, fat and sugar. • Care should be taken to ensure dishes are appealing to people with small appetites • Patients who miss meals should be provided with a suitable alternative. • Appropriate foods should be available 24 hours per day • For people who have diabetes, and are unwell, it may be more important to have increased energy intake than limited added sugar.
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Section 9 Food Service Systems and Food Safety

Dietitians need to be aware of

- the different foodservice systems and their advantages and disadvantages
- the local foodservice systems
- food safety management including HACCP

Section 10 Contract Specifications

Dietitians should be involved in the foodservice specification, in particular to ensure

- Provision for the particular client group
- Meeting nutritional standards

Section 11 National Patient Safety Agency

Dietitians should be aware of the NPSA responsibility for

- Better Hospital Food
- Patient environment action teams (PEAT)
- Nutritional risk

Dietitians should also be aware of their responsibility to report incidences involving foodservice should be reported to NPSA. A missed meal is as important as missed medication.

ENDORSEMENT



On behalf of the Hospital Caterers Association, I would like to provide our support for the *Delivering Nutritional Care Through Food and Beverage Services: A Toolkit for Dietitians*. The HCA is working closely with the BDA on a number of initiatives, which aim to improve nutritional care and food service to our patients at ward level. The toolkit focuses on the importance of multi-disciplinary working and the 'catering liaison' dietetic role. In addition, it promotes the fundamental need for the dietitian to develop good team-working relationships with everyone involved in the nutritional care of patients, which includes caterers and nurses. If implemented effectively the toolkit has the potential to really make a difference to the nutritional status of our patients in hospital as we all know food is only nutritious if it is consumed.

Alison McCree
National Chairman
Hospital Caterers Association

Acknowledgment

Special thanks go to the Hospital Caterers Association for their invaluable expertise and support in the production of this document.