healthwatch Havering

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Enter & View

Queen's Hospital, Romford

Rom Valley Way
Romford RM7 0AG

In-patient meals

Second visit
4 & 5 October 2017

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is <u>your</u> local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

<u>Your</u> contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

***'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill***

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

In October 2016, following reports from patients and others alleging inadequate dietary arrangements (not necessarily at Queen's Hospital, Romford), Healthwatch Havering members visited Queen's Hospital to observe the serving of lunchtime food to patients in several wards [1] (referred to hereafter as "the first visit"). During this first visit, the members divided into three teams, and between them called at four wards – Bluebell A and B, Harvest A and Sunrise B. The members reported varied experiences:

> "The conduct of the mealtime at both the Bluebell and Harvest wards was satisfactory: food was served in adequate portions, seemingly in accordance with patients' orders and assistance with eating was available to those needing it. In Sunrise B ward, however, the story was very different: the food on offer was limited to "meatballs and potato", there were insufficient staff available to assist all patients with feeding, some patients' ability to move had been restricted for their own safety (but, by doing so, their ability to take food had been likewise restricted), and the food was indifferently served because the nursing and HCA staff were too stretched to attend properly to every patient."

Food served to patients at Queen's Hospital is procured on behalf of the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) by their contractor Sodexo Limited from Tillery Valley Foods, a specialist catering organisation based in South Wales. It is delivered to the hospital frozen and ready to be reheated. A range of foods is available through a variety of menus. Food for patients who do not have special dietary requirements is varied by rotation of menus over a two-week period;

[1] "Queen's Hospital, Romford: In-patient meals, October 2016" (Healthwatch Havering)

food for patients who have special dietary requirements is also available – should a patient require a specialised menu not generally catered for, a diet chef is available to discuss their specific needs with that patient.

The report of the first visit was shared with BHRUT (and other statutory bodies). BHRUT prepared an action plan in response to it, which was published alongside the report on the Healthwatch Havering website [2]. The most recent, updated version of the Action Log is set out in Appendix 1 to this report.

During the visit now reported on, Healthwatch members compared what they observed against the Action Log as well as the content and conclusions of the first visit. They also took account of the nutritional standards to which hospital food is expected to conform.

Appendix 2 sets out the formal response of BHRUT to this report, and includes a further Action Log arising from the current visit and report.

Nutritional standards

As reported after the first visit, NHS England (NHSE) has identified 10 key characteristics of good nutrition and hydration care [3]. These are:

1. Screen all patients and service-users to identify malnourishment or risk of malnourishment and ensure actions are progressed and monitored.
2. Together with each patient or service user, create a personal care/support plan enabling them to have choice and control over their own nutritional care and fluid needs.
3. Care providers should include specific guidance on food and beverage services and other nutritional & hydration care in their service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and drinks provision.

[2] http://www.healthwatchhavering.co.uk/sites/default/files/full_report_final_queens_mealtimes.pdf and http://www.healthwatchhavering.co.uk/sites/default/files/170424_response_to_healthwatch_-_april_2017.pdf

[3] NHS England (NHSE) website: https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics

5. Food and drinks should be provided alone or with assistance in an environment conducive to patients being able to consume their food (Protected Mealtimes).
6. All health care professionals and volunteers receive regular raining to ensure they have the skills, qualifications and competencies needed to meet the nutritional and fluid requirements of people using their services.
7. Facilities and services providing nutrition and hydration are designed to be flexible and centred on the needs of the people using them, 24 hours a day, every day.
8. All care providers to have a nutrition and hydration policy centred on the needs of users, and is performance-managed in line with local governance, national standards and regulatory frameworks.
9. Food, drinks and other nutritional care are delivered safely.
10. Care providers should take a multi-disciplinary approach to nutrition and hydrational care, valuing the contribution of all staff, people using the service, carers and volunteers working in partnership.

In addition, as reported in 2016, sources of advice and guidance on nutritional standards and guidance used by the hospital include the British Dietetic Association, the charity BAPEN's Malnutrition Universal Self-Screening Tool (MUST), Public Health England (Healthier and More Sustainable Catering: Nutrition principles) and Government Buying Standards for Food and Catering Services from the Department of the Environment, Food and Rural Affairs (DEFRA).

17 different main menus are available, rotating on a two-weekly cycle, and food meeting special dietary requirements such as kosher and halal or for people who are gluten-intolerant is also available.

The teams who carried out this visit saw nothing that would have led them to question the conformity of the meals that they saw being served with the required nutritional standards. In some cases, however, it was not entirely clear that patients' hydration was being fully addressed: not every patient who was seen appeared to have ready access to drinking water.

It is also vital that feeding and hydration, important though they are in themselves, are treated as part of the patient's wellbeing needs and overall recovery to good health and not just as another routine chore.

The 2017 visit

The dates of this visit were chosen to correspond to the anniversary of the first visit. It comprised two parts – on 4 October, an unannounced [4] visit was carried out by three teams of members, who visited between them four wards – Harvest A, Sahara A and B, and Sunrise B – to observe the ordering and subsequent serving of food to patients; and on 5 October a single team visited by prior arrangement to observe the collection of food from storage to its delivery to the ward to be prepared for serving to patients.

A perennial complaint about hospital feeding arrangements has been that, if a patient has ordered a meal but is discharged or moved elsewhere before the meal is served, the patient who is occupying the bed at the time of service receives the food ordered, although it may not be to their taste. At best, this means that the patient may have an unsatisfactory meal; at worst, the patient may not be fed, and the ordered meal will be wasted.

Partly to overcome that problem, each patient's food is now ordered through a computerised system called Saffron, using a process not unlike that used in many restaurants, where customers select from the menu and the server sends the order to the kitchen using a specialized mobile phone app. As will become evident from the reports of the visits, however, the process in practice works somewhat differently to the stated intent and not necessarily to the patient's advantage [5].

[4] BHRUT had been notified in advance that a visit would be carried out at some time between late September and late October but not of the exact date or time.

[5] One patient subsequently reported to Healthwatch that he had ordered a meal but was moved to a side ward before it could be served; at the mealtime, he did not get the food he had ordered (even though he was in the same ward, albeit in a different bed) but was given the meal ordered by the person who had previously occupied his new bed. This had no effect on the patient in

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The food is ordered by hostesses, who are employed by the contractor Sodexo rather than BHRUT employees. Hospital staff are not normally involved in food ordering and, on the rare occasions observed during the visits that they became involved, there appeared to be minimal interaction between the hospital staff, the hostesses and the patient.

4 October – visits to Harvest, Sahara and Sunrise wards

Healthwatch members arrived at the hospital at about 8.30am and divided into three teams, each visiting different wards.

Harvest A

On arrival, the team were met by the head nurse, who said that the new ordering system appeared to be working well.

The meal orders had already been taken in the main ward, but the team observed orders being taken in the side wards. All patients were shown the full menu on the tablet booking system by the hostesses, who were aware of restricted diets, and limited diets were explained to the patients. Plenty of time was given to the making of choices. Patients who did not like any of the available choices were offered alternatives such as sandwiches, and a choice of soft meal was also offered.

The team returned to the ward at lunchtime to observe the meals being plated and served. The meals were served on time. Only one person was doing this, but there were plenty of members of staff available to help with service to the patients, and to assist with feeding patients who required help. There were also family and visitors in the

question as he had no special dietary needs - but had he had any special needs, or did not like what was supplied, that could have been quite serious.

In another case, a patient who was living with dementia was served vegetarian food for eight successive days as no attempt appeared to have been made to ascertain her wishes by staff who seemed to have no awareness of how to deal with patients who have dementia.

ward at the time. The team felt that, if the plating were done by more than one person, delivery times would be improved but accepted that, as there is limited space for people to work near the food trolley, that might not be practicable. Hand sanitiser gel was available, and patients who were not confined to bed were able to take their meals at a table. Menus were on display at the central table in the ward. All patients who were asked said that they had received the meal they had previously ordered, and that they had enjoyed the food, which was appetising and hot.

Main meals were served along with a drink of the patient's choice, and the dessert course was served separately. Visitors were also happy with the meals that their relatives were eating.

Before leaving, the team spoke again to the head nurse, who told them he was pleased with the way the meal times were running. He felt that there was enough help at meal times, but that more volunteers would be welcome, and he had had a meeting the previous day with the Manager of the Volunteering Team for that purpose.

Sahara A and B

The team were greeted on arrival by the Ward sister.

These two wards are split evenly between stroke treatment and neurology patients, and separate Sodexo hostesses are dedicated to each side.

The hostess for Sahara A told the team that she had been with the company for 2 years whilst the hostess for Sahara B had only just completed 2 weeks' induction and this was her first day on the ward, to which she would be permanently attached. The team were told that her colleague from Sahara A would be available to give some support, but that hostess returned to her own ward following the team's arrival and did not return.

Copies of the menu (a two-week cycle) were available in all areas but,

as this was week 2 of the cycle, the team felt that it was confusing that both weeks' versions were available in some places. They were told that the week 1 versions should have been removed on Sunday evening (the visit was on a Wednesday).

The menus were comprehensive with a wide choice of hot and cold meals and desserts, and included some minority ethnic food choices. The team were later advised that patients who could not make an acceptable choice from the available menu would be offered a snack box or an item from the 24-hour menu (although the team did not observe this being offered).

The hostess explained that she had to serve breakfast to the single occupancy side wards prior to commencing taking lunch orders, with Health Care Assistants (HCAs) serving the large bays. She had, in fact, completed this task and taken some orders prior to the team's arrival.

Whilst she had a copy of the menu book with her, she was not observed showing it to any of the patients from whom she was taking orders. Against that, while other hostesses did hand menus to various patients, passing such an item around from person to person was a clear infection control risk.

The first patient she approached was identified as requiring a Halal diet and was offered only Halal choices from the menu, even though he might have wished to avail himself of a non-Halal, vegetarian meal.

The practice of offering only those (limited) choices which appeared to reflect any orientation on the above-bed notice board, was continued throughout the visit, including dessert and snack choices.

On the day of the visit, as is common in the stroke unit, many patients were "nil by mouth", which made the hostess' task much simpler to achieve in the time allotted.

The team did not observe the hostess washing or otherwise cleaning her hands during the visit. Indeed, the term "barrier nursing" seemed to be rather loosely interpreted by her, with little regard for airborne

infection or other forms of contamination.

On Sahara B, the newly-employed hostess was clearly having difficulty in achieving the task within the time constraints although the team considered that she was very patient and took more time to explain what was available, also consulting nursing staff where she was unable to take choices from particular patients.

The nursing staff were much quicker to encourage the patients with a very limited choice being offered and apparently scant regard to a patient's wishes. Their approach took the form of something like "There is roast chicken, you like roast chicken, don't you?" (Short pause) "Put roast chicken down for him".

The team asked the ward sister whether she had the opportunity of inspecting the meal choices to ensure that patients were not ordering inappropriate items, but she explained that time constraints meant that this did not always happen.

The hostesses tended to start at the top of the menu, and stop offering choices as soon as the patient indicated a meal was acceptable, never actually offering the full menu to patients.

The hostesses made no attempt to introduce themselves by name or to explain what they were doing; they simply walked up to each bed and asked what the patient wanted to eat that day.

Patients on these wards did not appear to be encouraged to peruse the menu before the hostess came around, and were thus denied an opportunity to make a more leisurely, informed decision on their meal choices.

The team felt nonetheless that the service appeared to have improved considerably since the 2016 visit.

The team returned to the ward at lunchtime to observe the meal service and were pleased to note that courses were generally served separately to ensure that hot desserts did not become cold. The

exception to this was those patients who required assistance with feeding, whose main courses were served last and whose desserts were served with the main course so that the meal trolley could be returned to the kitchen.

During this part of the visit, the team asked patients whether they had received the meals they had ordered and were assured that their requests had been complied with.

All meals were observed being served; they looked appetising and patients were happy with the quality of the food.

The team asked the hostess what happened in the event of their absence on leave or through sickness and were advised that sometimes a relief was provided but that, at other times, one hostess was required to cover both wards.

Although the Sahara A hostess had a relatively light workload (with 10 "nil by mouth" patients), she did not go to the assistance of her colleague on Sahara B even though she was clearly struggling through her first day.

The team felt that the more experienced hostess made assumptions about what individual patients might like, only offering limited choices, rather than offering from the whole menu.

The team felt that it might be better to ask whether an individual wanted a hot or cold meal initially, to reduce the number of choices to be explained.

Sunrise B

Introductions were made to the Sister on the ward and the team were then introduced to the hostess. She explained the procedure for ordering, with which she seemed thoroughly familiar, and knew how clearly to communicate with the patients. The team were much impressed by the rapport between her and most of the patients (some

were asleep; and in this instance, she would later go back to those patients, and if they were still asleep understood what they might like and would order for them, only approaching an HCA for further advice if she did not have a feel for what the patient would like).

Menus were available in each bay for Patients and Visitors alike to peruse.

With so many choices and many patients who were living with dementia, it was difficult for the hostess to read menus to them and obtain a response; the time taken on ordering was possibly longer than on other wards.

Two spare meals were ordered each day to account for any extra admissions.

Thirty plus one meals needed to be ordered on that day and the order placed with kitchen by 9.30am and drinks taken round for 10am. The team felt that this was much too tight a schedule to keep to as the dishwasher was out of action and had been so for at least a week. This meant cups and mugs needed to be collected and hand-washed prior to drinks being made. The team was told that the dishwasher had been reported as out of action twice during that week. The team considered that extra help should have been provided considering the type of patient in this ward.

The ordering procedure appeared much improved after the bedding in of the new system.

One patient complained about not receiving the meal she had ordered; the supervisor was advised and came up to sort this out.

Another patient claimed that she was being "force fed". The team reported to this to the Ward Sister as a safeguarding matter.

Once the orders had been taken the hostess took the team to the ward kitchen (this was when they were advised the dishwasher was not working) to show how the order was placed with the main kitchen:

however, the iPad battery ran out of charge and had to be recharged before the orders could be placed. This meant a delay, as no Wi-Fi connection was available in the kitchen.

The team were concerned about infection control as the hostess kept going into side rooms where infection control notices were clearly displayed, and the iPad should have been cleaned. The hostess was, however, observed to clean her hands frequently with both soap and water and hand gel.

Red Trays and Red Lidded Jugs were available, denoting patients who required help [6]. Some patients were sitting at the table with an HCA, who was giving them all her attention and interacting with the less able Patients. There was a good atmosphere in this ward, which must assist in the protected meal times.

5 October – meal collection and delivery

The team arrived at the hospital at 8am and were met by a representative of the contractors, Sodexo, who escorted them to the catering department where they were issued with protective clothing (hairnets and disposable coats). The cleanliness of the catering area was impressive but the corridor floors leading to it appeared to need scrubbing - there was evidence of a spillage of ink or something similar, as well as general grubbiness.

The team were introduced to the catering clerk whose task was to enter all meal orders on to the system prior to the staff picking and packing trollies for each ward. All staff in the main department were wearing protective clothing appropriate to their task and the area in which they were working.

The team were advised that the deadline for menus to be received was 10.30am – which they thought surprising as, during the previous day's

[6] The Red Tray and Lid system is used to denote patients who have a need for assisted feeding or drinking, to ensure that they receive help

visit, the team had been told that the deadline was earlier, 9.30am. This did help to explain confusion over deadlines observed during the visits the previous day, particularly the situation where a new hostess was clearly having difficulty getting around to all patients.

The team was told that all meals/dishes and sandwiches were brought in from the external suppliers in chilled containers and transferred into chillers in the catering area. There were separate storage facilities for ethnic meals. Many basic salads were made up within the department, prior to the addition of a source of protein in the form of, for example, cheese, ham or fish, to meet the demand. Unsurprisingly, demand tended to vary according to the weather/season.

Frozen meals were stored in a freezer - as listed in the 24-hour menu. These meals could be used in the event of a patient not being able to choose something appropriate from the main menu or where a late admission meant that it was not possible to provide a meal in the normal way. These meals were heated using microwave ovens.

Once the clerk had entered a ward's requirements onto the system, a picking list was printed, together with individual print outs which were sent to the ward indicating what each patient had ordered. All packing took place within a controlled area where the temperature was maintained at about 8ºC.

The food was taken to the wards on trolleys designed so that salads, cold desserts, snacks etc were carried on the top, away from the chilled area where all other meals are stored. One packer was assigned to each trolley and completed the packing according to the picking lists. Immediately a trolley was ready, a catering porter took it up to the ward pantry. The team accompanied a trolley to a ward, where they observed the ward hostess transfer all the food that did not require heating into the most appropriate storage space - e.g. a freezer for ice cream. The trolley was then positioned next to the ward oven and transferred by sliding units straight into the oven. Ovens were set to come on

automatically at 11.00am so that the food was ready for service at 12noon.

The delivery trolleys were then returned to the catering area where they were cleaned and disinfected ready for the next mealtime.

General observations

The team felt that, for some patients, the drinks containers and cutlery were inadequate. Everything possible ought to be done to ensure that those patients who can do so feed themselves and take drinks whenever they wish to; this did not appear always to be the case. Indeed, the team got a clear impression that patients were not encouraged to drink as often as they should to maintain proper hydration. While accepting that this may be a consequence of staff having too many other tasks to perform, the team felt that it required higher priority than appeared to be accorded to it. It would of course be self-defeating if a lack of attention to feeding and drinking resulted in a patient experiencing an extended, unnecessary stay in hospital or subsequent otherwise unnecessary readmission.

Aside from the specific issues about menus mentioned earlier in the report, patients did not appear to be aware that they could order from other menu selections – while the provision of food may not be a priority compared with clinical needs, well-fed and hydrated patients are more likely to have a satisfactory outcome overall, and this should not be overlooked.

Conclusions

Overall, the whole team felt that mealtime arrangements and meal quality had greatly improved since the first visit. Nonetheless, several issues emerged during the visit that require comment and attention.

The observations of the teams who carried out this visit suggest that the understanding of the service that hostesses should be providing is variable and inconsistent: whether that is due to inadequate training or for some other reason was not clear. It certainly seemed that some hostesses were not as attuned to the needs of patients as would have been desirable, with apparently scant understanding of, for example, infection control.

A lack of teamwork was evident: between Sodexo staff, between BHRUT staff and between Sodexo and BHRUT staff. This may be the result of inadequate or insufficient training rather than inherent difficulty – but whatever the cause, it requires attention and remedial action.

The team were disappointed to note that food was served in standard-sized portions only, with no allowance appearing to be made for people who had smaller appetites. While accepting that it is difficult to cater for every eventuality within the size of the service required at the hospital, the absence of any portion-differentiation means inevitably that more food waste will be generated than is strictly necessary. Some waste is inevitable of course, but it does seem perverse that people known to have small appetites do not have the opportunity to ask for smaller portions.

Also evident was an inflexible attitude to special diets – demonstrated by a lack of willingness to offer Muslims non-Halal but acceptable alternative foods, or by offering patients who have coeliac conditions non-special foods that are acceptable as part of a coeliac diet.

Confusion was evident over the deadline for ordering – some staff thought that orders needed to be registered by 9.30am, but others said the deadline was 10.30am. Again, this may be result of inadequate training; but if an artificially early deadline is observed, then patients may not receive the attention and, more importantly, the food choices they are entitled to.

Indeed, there did not seem to be any reason why those patients who had the capacity to do so to could not look at the menu and select their choice of meal in advance and simply place an order, rather than expect the

hostess to reel off several meal options and give the patient no time to make an informed choice.

That said, strange as it may seem, there is a possibility that there are too many food choices on offer. While it is admirable that a wide range of foods is available, it may be counter-productive to offer food choices that in practice no one wants. It is certainly wasteful if staff do not ensure that patients are aware of all the choices available before placing their orders.

During the visit, it was noted that a dish washer was out of order: the team were told that it had been reported as out of order some time previously, causing more work for the ward staff. The team mentioned this during a debriefing session immediately following the visit and it is understood that the dishwasher has subsequently been repaired. It should of course not be necessary for a visit by an external organisation to trigger a response to a repair request.

Recommendations

Although overall there have been improvements in the service since 2016, there remain areas where further improvement is required.

Training:

Although overall the hostesses appeared to give a good service, their understanding of infection control appeared much less than desirable. Given the importance of minimising the risk of hospital-generated infection, strict observance of infection control protocols is essential.

Co-operation between staff:

During the visit, the teams observed several instances where better co-operation between staff would have been better for patients.

Consistency:

While by no means under-estimating the difficulties of preparing,

delivery and serving food to several thousand patients in a relatively short space of time daily, the teams who carried out this visit were disappointed to note a lack of consistent approaches to the task. Much appeared to rest on the personal approaches of individual hostesses to their tasks and, although most patients seemed satisfied with the service they received, that was possibly because they were not aware of other options available to them but not actually offered. There were also concerns that risks arose from a lack of understanding of infection control.

These issues can be addressed by greater co-operation between hostesses and ward staff, and by better training for hostesses.

Food ordering and menus:

It was noticeable that few, if any, of the patients seen had the opportunity to consider the full range of food available. Subject to the requirements of maintaining infection control, all patients who can make an informed choice of meal should have ready access to the menu and simply give an order to the hostess when she arrives to take it. Only in the most exceptional of circumstances should hostesses need to read aloud the choices from their Saffron devices. This would also save time and enable the hostess to carry out their tasks more efficiently.

Nutrition and hydration:

The visiting teams saw nothing that led them to question the nutritional value of the food on offer. In some instances, the availability of smaller-sized potions might have been more economic and less wasteful and should be considered.

Doubts were raised, however, about whether all patients were able to maintain an appropriate level of hydration: in some cases, a ready supply of water to drink was not obviously available.

Accordingly, the following steps are recommended:

1. That BHRUT and Sodexo review the training given to hostesses to ensure that they are fully aware of the importance not just of hygienic food handling but of general infection control, and have the same general approach to their tasks in order to minimise the risk that staff approach the job differently, with different outcomes for patients
2. That greater co-operation between all levels of front-line staff, both BHRUT and Sodexo be encouraged, for the benefit of patients
3. That the procedure for taking orders be reviewed, that ordering deadlines be clarified and adhered to and that those patients capable of informed choice be given menus from which to select in advance of ordering their food
4. That the range of foods on offer be reviewed to ensure that:
   (a) special dietary requirements are addressed as flexibly as practicable and
   (b) patients are not caused unnecessary confusion by being offered an overwhelming range of food choice
5. That greater priority be accorded to ensuring that drinking water is within reaching distance of ALL patients, that both BHRUT and Sodexo staff take every opportunity to encourage patients to maintain their hydration and that nursing staff be alert to the possibility that individuals are failing to maintain an adequate level of hydration.

The formal response of BHRUT and Sodexo to these recommendations is set out in Appendix 2 following.

Healthwatch Havering thanks all service users, staff and other contributors who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 4 and 5 October 2017 and is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users and/or staff.

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APPENDIX 1

Barking, Havering and Redbridge University Hospitals NHS Trust

ENTER AND VIEW – MEALTIMES 6TH OCTOBER 2016

ACTION LOG FOR MATTERS ARISING FROM HEALTHWATCH ENTER AND VIEW INSPECTIONS

Item No.	Ward	Issue	Target closure date	Action	Status
1	Bluebell A & B	We are also including a list of the various menu options on the main menu that is currently accessible on the wards so that patients and relatives are made aware of what is available	August 2017	Next printing date for menu's to be confirmed {The responsible Manager] has explained on the main menus it states 'A wide of menus for special diets are available'	
2	Bluebell A & B	Dessert being served at the same time as the main course	September 2017	Course by course meal service has been in place for some time and this is monitored by the Sodexo catering manager. Housekeepers have been retrained in the correct procedure which is for all courses to be served separately. At times course by course is effected by other priorities on the ward and this will be highlighted to the senior sisters and charge nurses.	
3	Bluebell A & B	Patients not being given choice and last patients being served left over food	May 2017	Sodexo have full implemented the use of Saffron electronic food ordering via tablet on all wards. Ordering is done at the start of the day and meals ordered are delivered at mealtimes. Sodexo hosts have all been trained in the use of Saffron and are aware they need to ensure all patients are given a choice. We have made menus more visible by placing menus in a menu holder on the table in the centre of the bays or in side rooms on the bedside table.	

Item No.	Ward	Issue	Target closure date	Action	Status
4	Harvest A	Meals service late and experimental meal ordering system observed	May 2017	Saffron electronic food ordering system fully implemented and working effectively, daily ward submission of menus are monitored and where delayed are identified these are actioned immediately. Meal service being late is not a regular occurrence there are occasional problems due to Wi-Fi connection. Where this occurs IT and the ward manager are notified. Ward managers are also notified on the occasions where meal may be delayed	
5	Sunrise B	Dessert being served at the same time as the main course	September	Course by course meal service has been in place for some time and this is monitored by the Sodexo catering manager. Housekeepers have been retrained in the correct procedure which is for all courses to be served separately. At times course by course is effected by other priorities on the ward and this will be highlighted to the senior sisters and charge nurses.	
6	Sunrise B	Patient comment that the food was unappetising	September 2017	Regular food tasting is carried out at ward level with a varied range of people attending. Patient Experience team have arranged for food testing sessions to be attended by volunteers and patient partners in order to gather feedback.	
7	Sunrise B	Patients relative comment that his mother was not given an opportunity to choose her meal therefore resulting in her being given food she did not like	May 2017	Sodexo have full implemented the use of Saffron electronic food ordering via tablet on all wards. Ordering is done at the start of the day and meals ordered are delivered at mealtimes. Sodexo hosts have all been trained in the use of Saffron and are aware they need to ensure all patients are given a choice. We have made menus more visible by placing menus in a menu holder on the table in the centre of the bays or in side rooms on the bedside table.	

Item No.	Ward	Issue	Target closure date	Action	Status
8	Harvest A & Sunrise B	Meeting to be scheduled with Harvest A & Sunrise B Ward Managers and Sodexo to discuss the most recent Healthwatch report and their findings.	August 2017	Meeting held on 10 August 2017. Regular meetings to be held between ward managers and Sodexo.	

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APPENDIX 2

FORMAL RESPONSE TO ENTER AND VIEW VISIT

1 INTRODUCTION

Healthwatch Havering is the local consumer champion for both health and social care. Their aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally. Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

2 HEALTHWATCH REPORT DATE

Following an initial visit to observe mealtimes in October 2016, Healthwatch authorised representatives undertook a follow up visit to several wards at Queen's Hospital to enable Healthwatch members to assess the delivery and presentation of the midday meal, the help available to those patients who need assistance with feeding and how patients with varying needs coped with their meals.

3 BACKGROUND

The visit that is being responded to in this report took place on the 4th and 5th of October 2017 was to follow up to a mealtime service visit which took place in October 2016.

The visit in October 2016 was in response to reports from patients and others alleging inadequate dietary arrangements. During this visit, the members divided into three teams, and between them called at four wards – Bluebell A and B, Harvest A and Sunrise B.

On the 4th October, an unannounced 4 visit was carried out by three teams of members, who visited four wards – Harvest A, Sahara A and B, and Sunrise B – to observe the ordering and subsequent serving of food to patients. 5th October a single team visited by prior arrangement to observe the collection of food from storage to its delivery to the ward to be prepared for serving to patients.

4 BHRUT RESPONSE TO HEALTHWATCH HAVERING REPORT

Over all, Healthwatch feedback was that the service had improved since their visit in 2016. However, there were some concerns noted and recommendations made.

- **Recommendation 1**: That BHRUT and Sodexo review the training given to hostesses to ensure that they are fully aware of the importance not just of hygienic food handling but of general infection control, and have the same general approach to their tasks in order to minimise the risk that staff approach the job differently, with different outcomes for patients

  Response: A complete review of induction training for new hosts is currently underway, the new Patient Dining training pack being introduced in January 2018. This will be rolled out throughout the year covering a new topic.

- **Recommendation 2**: That greater co-operation between all levels of front-line staff, both BHRUT and Sodexo be encouraged, for the benefit of patients

  Response: Part of the nutrition advisory group with the trust which meets quarterly and will request that this item be part of the agenda. Hostesses to be invited to ward huddles and team meetings. Pe team attending meal time testing sessions monthly and provide feedback to Sodexo and ward.

- **Recommendation 3**: That the procedure for taking orders be reviewed, that ordering deadlines be clarified and adhered to and that those patients capable of informed choice be given menus from which to select in advance of ordering their food

  Response: Staff reminded that ordering deadline is 1015 hrs. Menus are placed on each bedside locker. Additional option menus are placed in menu holders in the central ward area. Sodexo supervisors to check that menus are available daily. Mealtime testing proforma to be drawn up by Sodexo and Patient Experience team to log and audit if patients are given menus in advance.

- **Recommendation 4**: That the range of foods on offer be reviewed to ensure that:
  (a) Special dietary requirements are addressed as flexibly as practicable and
  (b) Patients are not caused unnecessary confusion by being offered an overwhelming range of food choice.

Response: There are currently 17 menus available these take in to account dietary and religious needs as well as some cultural preferences based on the population. Meetings with the Trust and Sodexo are held monthly to review menu options.

- **Recommendation 5**: That greater priority be accorded to ensuring that drinking water is within reaching distance of all patients, that both BHRUT and Sodexo staff take every opportunity to encourage patients to maintain their hydration and that nursing staff be alert to the possibility that individuals are failing to maintain an adequate level of hydration.

  Response: Water jugs are topped up by domestic staff through the morning and by hosts through the afternoon.

  Ward staff should also be monitoring and filling jugs if needed. Reminders to be added and documented as part of morning huddle. Management checks to be carried out on a regular basis.

The trust and our mealtime service provider Sodexo have completed a detailed action plan which is attached to this report which details each recommendation and the actions that the trust is taking to address the concerns raised.

5 CONCLUSION

We would like to take the opportunity to thank Healthwatch Havering for undertaking this Enter and View visit and for the feedback provided in the report. We are aware of some of the issues identified and are managing these as part of the on-going aim to improve patient experience in relation to meal times.

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ACTION LOG FOR MATTERS ARISING FROM HEALTHWATCH ENTER AND VIEW INSPECTIONS

Item No.	Ward	Issue	Target closure date	Action	Status
1	Sahara B / Sodexo	Hostess did not wash or gel her hands throughout the visit	29th December 2017	Further training to be carried out with immediate effect with the hostess, and supervisor to support this new starter on a daily basis for the next two weeks with effect from 11 December when hostess is back on shift.	
2	Sahara B / Sodexo	Hostess did not introduce herself or explain what she was doing	29th December 2017	Further training to be carried out with the hostess and supervisor to observe over a two week period. Refresher training on be carried out, this will be monitored by Sodexo Supervisor. Ward Manager to log report any observed incidents to Sodexo supervisor. Breaches are managed through Sodexo disciplinary policy.	
3	Sodexo	Corridor leading to Catering dept. Floors had signs of spillage and general grubbiness	11th December 2017	The corridor has been cleaned. These areas are scrubbed over weekend periods and mopped daily. Daily checks to be carried out by Patient Dining team and additional scrubbing can be requested by the ward manager or Sodexo supervisor mid-week as required. Sodexo run monthly audits to ensure cleanliness of areas	
4	Sunrise B	Dishwasher out of action for at least one week.	11th December 2017	This was reported and dishwasher has been repaired. Correct process for reporting faults to be followed. All staff to be reminded of the procedure. Information being cascaded via Host Huddles.	

Item No.	Ward	Issue	Target closure date	Action	Status
5	Trust wide & Sodexo	BHRUT and Sodexo review the training given to hostesses to ensure that they are fully aware of the importance not just of hygienic food handling.	January 2018	A complete review of induction training for new hosts is currently underway, the new Patient Dining training pack being introduced in January 2018. which will be rolled out throughout the year covering a new topic.	
7	Trust wide & Sodexo	BHRUT and Sodexo review the training given to hostesses regarding general infection control	May 2018	Sodexo infection control passports being trained out to hostesses. All hostesses expected to be trained on booklet by end of May 2018	
8	Trust wide & Sodexo	Standardise approach to hostess and mealtime assistant tasks in order to minimise the risk that staff approach the job differently, with different outcomes for patients	May 2018	Hostess dining training will include this as part of the programme. Ward Managers to ensure that meal times are being delivered consistently on their area. Ward managers Introduce mealtime brief at morning huddles for ward staff and invite hostesses to attend.	
7	Trust wide & Sodexo	That greater co-operation between all levels of frontline staff, both BHRUT and Sodexo be encouraged, for the benefit of patients	March 2018	Karen Burroughs is part of the Nutrition Advisory Group with the Trust which meets quarterly and will request that this item be part of the agenda. Hostesses to be invited to ward huddles and team meetings. PE team attending meal time testing sessions monthly and provide feedback to Sodexo and ward.	

Item No.	Ward	Issue	Target closure date	Action	Status
8	Trust wide & Sodexo	Review procedure for taking orders to ensure that ordering deadlines be clarified and adhered to and that those patients capable of informed choice be given menus to select meals from in advance of ordering their food	February 2018	Staff reminded that ordering deadline is 1015 hrs. Menu's are placed on each bedside locker. Additional option menus are placed in menu holders in the central ward area. Supervisors to check that menus are available daily. Mealtime testing proforma to be drawn up by Sodexo and PE team to log and audit if patients are given menus in advance .	
9	Trust wide & Sodexo	That the range of foods on offer be reviewed to ensure that: (a) special dietary requirements are addressed as flexibly as practicable and (b) patients are not caused unnecessary confusion by being offered an overwhelming range of food choice	11th December 2017	There are currently 17 menus available these take in to account dietary and religious needs as well as some cultural preferences based on the population. Meetings with the Trust and Sodexo are held monthly to review menu options.	
10	Trust wide & Sodexo	That greater priority is accorded to ensuring that drinking water is within reaching distance of ALL patients, that both BHRUT and Sodexo staff take every opportunity to encourage patients to maintain their hydration and that nursing staff be alert to the possibility that individuals are failing to maintain an adequate level of hydration.	29th December 2017	Water jugs are topped up by domestic staff through the morning and by hosts through the afternoon. Ward staff should also be monitoring and filling jugs if needed. Reminders to be added and documented as part of morning huddle. Management checks to be carried out on a regular basis.	

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Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

healthwatch Havering

Healthwatch Havering is the operating name of
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