Protected Mealtimes Review
Findings and Recommendations Report
Executive Summary

The Protected Mealtimes Initiative (PMI) was a national initiative that formed part of the Better Hospital Food Programme. The purpose of the PMI was to allow patients to eat their meals without unnecessary interruption and to focus on providing assistance to those patients unable to eat independently.

The aim of the National Patient Safety Agency's (NPSA) review of the PMI was to establish the uptake of the initiative across Acute Trusts England and Wales and to identify the barriers and critical success factors to implementation.

The review was conducted by working with frontline staff such as nurses, dietitians and hospital caterers. In conjunction a questionnaire was circulated to nurses via the Chief Nursing Officers Bulletin and to the Executive Nurses group in Wales.

Results

Key findings of the review are:

• Uptake of the PMI remains variable between hospitals and between wards within hospitals across England and Wales

• There are inconsistencies around which meal time services are protected

• There are inconsistencies in the type of clinical area that have introduced Protected Mealtimes

There were consistent responses from the questionnaire and workshops about the barriers to implementation. The top four barriers identified are:

• Ward rounds
• Diagnostic tests
• Visitors
• Other healthcare professionals

Two key factors were identified as impacting on implementation are:

• Lack of “Board to Ward” level leadership
• Lack of education and training of all staff groups

The critical success factors identified are:

• Trust Policy related to Protected Mealtimes
• Promotion of the initiative

• Communication

• Leadership at all levels of the organisation

In terms of critical success factors all four workshops identified similar themes:

• Trust policy

• Promotion

• Communication

• Leadership

Recommendations

• The NPSA will share this report with the Royal Colleges and other relevant professional organisations

• All NHS staff are encouraged to report patients missed meals to the NPSA via their Local Risk Management System

• All NHS staff are encouraged to implement Protected Mealtimes to improve the safety of their patients at mealtimes

• Healthcare inspectors should include the implementation of Protected Mealtimes as part of their healthcare standards
Protected Mealtimes Review

1.0 Background

The Protected Mealtimes Initiative (PMI) was a national initiative which formed part of the Better Hospital Food Programme. It was supported by both NHS Estates and the Royal College of Nursing (RCN). The purpose of the PMI was to allow patients to eat their meals without unnecessary interruption, and to enable nursing staff to provide assistance to those patients unable to eat independently.

NHS Estates commissioned a Protected Mealtimes video/CDROM which was launched by Lord Warner in January 2004; a copy was sent to all Directors of Nursing in Acute and Primary Care Trusts. In addition, a checklist for the implementation of the PMI was developed by the Hospital Caterers’ Association and a co-badged RCN presentation was available on the Better Hospital Food website to provide further guidance and support for Trusts.

The Hospital Caterers’ Association launched a National Protected Mealtimes Day in March 2004. Trusts were asked to commit to implementing the initiative on one ward for one day - over 300 Trusts participated. NHS Estates also funded a series of Protected Mealtimes roadshows in which over 40 presentations were delivered to nearly 1500 delegates across the UK.

The PMI has been supported in the Chief Medical Officer’s report on the state of public health: A Fresh Look: Realigning Food Procurement in the Public Sector. The report discusses the initiatives of the Better Hospital Food Programme and identifies that many have been met with a mixed response. It is noted within the report that the PMI has been successful and that mealtimes should be protected in all hospitals, for both patients and staff, to provide support and time for those requiring assistance in eating.

To date there has not been a formal evaluation of this initiative in terms of the extent of implementation and of patient perspectives.

1.1 Review of current position

Reports seem to indicate that there are clear benefits associated with the PMI. For example, at Hull Royal Infirmary, a limited research study was undertaken on four wards which showed that 74% of the 26 patients monitored gained weight. Two wards where Protected Mealtimes were not implemented were used as a control group - 56% of patients in these wards lost weight.

Other evidence suggests that patient complaints and food wastage can also be reduced using this initiative. North Devon Healthcare Trust reported that during a pilot of Protected Mealtimes on four wards, complaints relating to hospital food fell dramatically. In June 2004 the Department for Environment, Food and Rural Affairs (Defra) reported on a Public Sector Sustainable Food Procurement
Initiative, Managing Food Wastage at Eastbourne District Hospital. Within this report, the PMI was identified as a crucial element in reducing food wastage. The catering manager at Nottingham City Hospital commented that “the introduction of Protected Mealtimes had helped to halve the amount of wasted food across the hospital”.

Early feedback received from the National Nutrition Nurses Group suggests that the main barriers in supporting this initiative include: “nurses’ perception of how important nutrition and meal times are in comparison to the other demands”, and “medical and allied health professional's attitudes to how important their role/treatment is in comparison to nutrition”. This was also the view of members of the Hospital Caterers Association who also felt that the success of Protected Mealtimes was dependent on leadership at ward level.

An early review of the NPSA’s National Reporting and Learning System (NRLS) did not identify a failure to implement Protected Mealtimes as a patient safety issue. However, patient safety incidents have been identified that suggest that a lack of monitoring and awareness of patient’s nutritional requirements does result in harm - for example, patients receiving inappropriate meals after they have been assessed and found to require textured modified meals due to dysphagia.

1.2 The need for the review

The 2006 Patient Environment Action Team (PEAT) results, which included the question: “Has the hospital/trust introduced Protected Mealtimes or a similar policy to provide such an environment on at least 60% of its wards”, demonstrated that 1001 of 1212 Trusts who completed reports (82.59%) have such a policy. This does not, however, provide information as to whether the policy has been implemented. Anecdotal evidence gathered by the NPSA Nutrition Lead whilst visiting trusts would suggest that this is often the case. Indeed, the Healthcare Commission’s Inpatient Survey 2005 clearly highlights that there is still cause for concern relating to patients receiving assistance at mealtimes. The study involved 80,000 patients who had stayed in hospital overnight. Of those a fifth (16,000) said that they needed assistance with eating, and of this number 40% (6,400) said that they never, or only sometimes, received help.

Analysis of the NRLS has identified specific patient safety themes occurring at mealtimes. Examples of these include patients receiving inappropriate diets i.e. normal diet instead of textured modified diets. There are also examples of patients receiving meals when they should be Nil by Mouth.

The profile of the review was increased with the launch of Age Concern’s ‘Hungry to be Heard’ campaign which received considerable media attention. One of the recommendations of the campaign was the implementation of Protected Mealtimes.
2.0 The Protected Mealtimes review process

The review of Protected Mealtimes consisted of two elements. A questionnaire was developed and distributed via the CNO bulletin in England and the Nurse Executives group in Wales, with the aim of establishing the uptake of Protected Mealtimes across England and Wales. The questionnaire also provided an opportunity for trusts to identify common meal services and clinical areas where Protected Mealtimes had been implemented, and to identify barriers and critical success factors to implementation. The second element involved engaging with frontline staff to gain an understanding of what Protected Mealtimes mean to them, and again to identify the barriers and critical success factors to implementation.

2.1 Questionnaire results

60 completed questionnaires were received – 53 from England and seven from Wales. The responses demonstrated that there were inconsistencies in the implementation of Protected Mealtimes, with one trust having applied the initiative on 1 ward whilst another had applied it on 730 wards. The responses were consistent across both England and Wales, and identified similar themes and trends across all care settings. (See Appendix 2 for details of questionnaire responses).

38 responses were from acute trusts, two from primary care, one from a mental health trust and 13 identified themselves as ‘other’. The majority of the ‘other’ responses were from trusts comprising a multi-range of organisations – mental health, community and acute. Six respondents failed to complete this part of the questionnaire.

Trusts were asked if Protected Mealtimes had been implemented on all wards. Responses to this question were consistent with anecdotal evidence, with a third of respondents having implemented Protected Mealtimes on all wards.

The majority of trusts have not implemented Protected Mealtimes for all patient meal services. It is a positive sign, however, that the lunch time meal service was the most frequently protected as this is often the time when most activity can occur.

Trusts were asked to identify if a Protected Mealtimes policy had been agreed at trust board level. Just over half (35) had a policy that had been agreed at board level. As Protected Mealtimes had reportedly been challenging to implement in some cases, trusts were also asked if they had previously implemented Protected Mealtimes but now ceased to operate them. Only 3 indicated that this had been the case.

Anecdotal evidence had suggested that the implementation of Protected Mealtimes was easier in certain clinical areas. The results of the questionnaire confirmed that the PMI had been implemented more readily in non-acute surgical/
trauma wards. However, of the 60 returned questionnaires just under half had been able to implement Protected Mealtimes into these clinical environments. A larger percentage had introduced the initiative into acute medical environments, both general and elderly, and rehabilitation clinical areas. Of the respondents' trusts had applied the initiative across all clinical areas. It is noted that paediatric, maternity and gynecological areas had the lowest levels of uptake. The responses indicate that Protected Mealtimes can be implemented in all clinical areas but that each area will have different challenges to implementation.

Trusts were asked to identify the barriers they had encountered when implementing Protected Mealtimes. Responses to this question suggest that external activities and individuals impact on ward-based teams’ ability to successfully implement this initiative; there appear to be specific issues relating to medical staff and diagnostic tests. However, respondents also identified that other healthcare workers - including porters, physiotherapists, Occupational Therapists and Infection Control Teams – as well as visitors, pose potential barriers.

Finally, respondents were given the opportunity to identify how their trust addressed these barriers and to share their successes in introducing Protected Mealtimes:

From an Assistant Director of Nursing:

“Discussions were held with Consultants, issues ongoing largely as a result of restrictions around Consultant job plans. Demand for diagnostic testing means that systems cannot be mainstreamed to “times of day” but this is geared around priority cases where possible. Following discussions with AHP’s [Allied Health Professionals] i.e. Physiotherapists, Speech Therapists, any AHP interventions were organised to take place outside protected meal times.”

From a Patient Experience Project Manager: talking about ways of sharing information

“Patient information leaflet; Visitors Charter; Review of ward visiting times; re-enforcement with Medics; patient comments; info in Doctor’s change over induction; implementation toolkit with best practice etc for the ward managers, Trust Talk articles; Staff news articles.”

From a Nutrition Nurse Specialist:

“We have provided education, support and reconfiguration of some the services provided, we have had to accept that if some patients have medical/surgical needs during these times that may compromise their health, this will of course take priority.”

From a Catering Manager:

“Persistence/keep going at it. Take time. Don’t try and do it all at once.”
From a Head of Nursing Facilities:

“We have successfully implemented the initiative in West Wing hospital which is a small hospital with four wards caring for rehabilitation patients with medical conditions, post-orthopedic surgery and stroke and longer stay rehab needs. The initiative has been driven in the main by a dietician with nursing support with the implementation. Clinicians and therapists are engaged and with, in the main, support from relatives and carers. Literature and posters are available to ensure new patients are informed of the initiative. An acute surgical ward has been very successful in implementing the initiative and anecdotal feedback appears to be that their success was due to forward planning prior to implementation.”

From a Ward Manager:

“Personally I consider sister/change nurses as key to ensuring this happens. Have developed a pack for wards to use when implementing which consists of Guidelines, Door sign, Article, Patient Visitors, Information leaflet.”

From Trust Head of Catering:

“After initial problems, most ward areas realised importance of PMT to help patients eat in a quiet uninterrupted environment and this resulted in improved appetite and reduction in plate waste.”

2.2 Regional Events

Between October and December 2006 the NPSA hosted four regional events, three in England and one in Wales. Delegates attending these events were recruited from stakeholder organisations, the Royal College of Nursing, Hospital Caterer’s Association, British Dietetic Association and the National Nutritional Nurses Group. The Royal College of Physicians were also invited to attend these meetings, but were unfortunately unable to nominate a representative.

The regional events were extremely successful with 100 frontline staff attending. The three events held in England were also attended by Age Concern England in response to their ‘Hungry to be Heard’ campaign in which Protected Mealtimes are identified as best practice.

The delegates were asked to define Protected Mealtimes. The following definitions are representative across the four workshops:

• “Protected uninterrupted time to focus on providing an environment conducive to eating”

• “An uninterrupted mealtime with no clinical interventions and all staff focused on patients’ nutritional needs”

• “Reduce level of non clinical activity to ensure that patients have a relaxed and leisurely mealtime in order to maximize well-being”
• “Protect the patient to ensure he/she has opportunity and time and assistance to eat their meal”

• “Opportunity for patients to enjoy their meals at their best and aid recovery”

• “A period of uninterrupted time for patients to eat and digest their meal allowing supporting staff the time to assist the patients with their meal”

The delegates were also asked to identify the barriers to implementation. In general the responses were in line with the questionnaire. However, the following additional themes were common throughout all four events:

• Education of nursing and medical staff

• Low priority of nutrition in clinical care

• Meeting targets – A&E times

• Lack of ownership from board to ward level

There was concern amongst all of the staff groups represented at the workshops at the inconsistent level of education provided at both trust and pre-/post-registration level. This concern related to all healthcare workers. It was felt that this failure to provide local and professional education contributed to the low priority of nutrition in clinical care.

There was also much discussion around the impact of government targets on ward based team’s ability to protect mealtimes. The most frequently mentioned targets included the A&E four hour targets and the reduction of length of stay. However, it was generally agreed that there should be flexibility around the implementation of Protected Mealtimes and that often the principles were applied too rigidly.

A frequent theme from the workshops related to leadership. It was felt that for the PMI to work there needed to be leadership across the whole organisation – from board to ward. Delegates often felt that without this high level support it was not possible to implement Protected Mealtimes.

The critical success factors again showed some correlation with the responses from the questionnaire but there was a strong view that the following also impacted on the successful implementation:

• promotion

• communication

• leadership

• trust policy
Delegates again felt that to be able to implement Protected Mealtimes there needed to be a trust standard supported at Board level within the organisation. Some delegates felt that there should be a national requirement for trusts to implement Protected Mealtimes and that this should be part of the Annual Health Check conducted by the relevant regulatory authorities in England and Wales.

Frontline staff who had successfully implemented the PMI into their clinical areas felt that prior to launching the initiative it was essential to promote the principles and the implementation plan to the whole hospital community. Many had developed resource information such as toolkits for implementation, visitor information and posters. There were some examples of creative ideas shared, such as the use of patient meal tray covers explaining Protected Mealtimes.

Communication was identified as a fundamental key to success. Where Protected Mealtimes appeared to be working, effort had been made to communicate with key personnel. This appeared to be essential in the engagement and support of medical staff and allied healthcare professionals.

Again, leadership was identified as critical. However, within the context of implementation it was generally identified as essential in the clinical area rather than within higher levels of the organisation. The focus of this leadership was on nursing staff.

### 3.0 The patient perspective

Although the PMI was launched in 2004, to date there is very little evidence of evaluation of the patient perspective of Protected Mealtimes. Some delegates at the regional workshops indicated that there had been a reduction in food related complaints and that patient satisfaction had improved at a local level.

The NPSA facilitated two patient participation meeting in early 2007 to gain patient views of nutritional care in hospitals. These meetings were attended by 30 members of the public who had been hospital inpatients in the last two years. The attendees were asked if they had been aware of Protected Mealtimes during their admission and overwhelmingly they had not.

A few thought that mealtimes were quiet simply because nurses used the time to catch up on paperwork. Several suggested that the concept of Protected Mealtimes was introduced in theory, but not carried out in practice, because staff did not care what patients were doing (‘whether eating or sleeping’) when they needed to undertake some checks. One man described this clearly:

“It was always “do you mind if I take your weight please?” and I said “Can I finish this meal?” “Oh, it won’t take a minute”. And after ten minutes somebody else comes along, “I forgot to take your blood pressure“ and by that time, the food has already gone back.”

This is perhaps representative of the conflicting demands often placed on frontline staff but also demonstrates the low priority nutrition is given within the
clincial environment.

4.0 Discussion

The review of Protected Mealtimes has identified that there are inconsistencies across the NHS in England and Wales in relation to the implementation of this initiative.

Frontline staff have identified key barriers to implementation along with creative and successful methods of overcoming these barriers. Consideration should be given to who is best placed to assist frontline staff in addressing barriers and to ensure that Protected Mealtimes are implemented across the NHS in England and Wales.

The NPSA has a fundamental role in working collaboratively with all key stakeholders on the development of resources and tools but is not in a position to drive forward this agenda alone, as the principles of Protected Mealtimes are multifaceted, involving aspects of the patient environment and safe nutritional care.

In March 2007, Ivan Lewis, Minister for Care Services, convened a Ministerial Nutrition Summit, to which the NPSA’s Nutrition Lead was invited. During this initial meeting there was much discussion and support for Protected Mealtimes. The outcome of this initial meeting was that an action plan will be developed in consultation with summit attendees, with the group meeting again on 17 July.

The NPSA’s role within this initiative should be to focus on the elements of patient safety related to nutritional care and to assist in gathering the evidence base that establishes Protected Mealtimes as instrumental in improving patient outcomes.

There needs to be greater collaboration between healthcare professional organisations and the focus of promotion now needs to include medical colleagues, allied healthcare professions and the public alongside nurses, dietitians and caterers. The NPSA’s role will be to work collaboratively with professional organisations, Royal Colleges and frontline staff.

Opportunity already exists for this work to be taken forward by the Council of Europe Alliance. This Alliance was established in 2006 to take forward the Council of Europe Recommendations on Nutritional Care in Hospital (2003) and the membership currently includes a majority of key stakeholder organisations. The NPSA should support the Alliance in taking this agenda forward.

There is also opportunity to share good practice examples to aid frontline staff to implement Protected Mealtimes. Consideration needs to be given to how this learning can be shared and utilised.
5.0 Conclusions

Following this review the NPSA is collaborating with the Royal College of Nursing’s ‘Nutrition Now’ campaign to promote Protected Mealtimes. The NPSA is also working in collaboration with the Council of Europe Alliance to promote Protected Mealtimes through the 10 Key Characteristics of good nutritional care in hospitals. This collaborative approach to promoting Protected Mealtimes has facilitated shared learning from this review.

The NPSA will be monitoring the uptake of Protected Mealtimes via the Patient Environment Action Teams (PEAT) results and will lead on a future work to identify the links to patient safety and patient outcomes with Protected Mealtimes.

6.0 Recommendations for the NHS and regulators

The following recommendations came out of the responses to the questionnaire and the regional events:

- The NPSA will share this findings and recommendations report with the Royal Colleges and other relevant professional organisations.
- NHS staff are encouraged to report patients missing meals to the NPSA via the NRLS
- All NHS staff are encouraged to implement Protected Mealtimes to improve the safety of their patients at mealtimes
- Healthcare inspectors should include the implementation of Protected Mealtimes as part of their healthcare standards
Acknowledgements

Many thanks to the RCN, HCA, NNNG and BDA for their ongoing support and commitment to the Protected Mealtimes initiative, and for nominating delegates to attend the regional events. I am also very grateful to the staff involved in the regional events, who shared their experiences in order to enhance learning about the complexities of implementing this initiative.

The NPSA would also like acknowledge the support of both the Department of Health and the Welsh Assembly Government.
Appendix 1

Protected Mealtimes questionnaire

To be completed by the Director of Nursing (or delegated to a colleague such as an associate director, modern matron or nutrition nurse specialist).

NHS Estates, in partnership with the Royal College of Nursing, introduced the Protected Mealtimes Initiative (PMI) in 2004 as part of the Better Hospital Food programme.

The initiative encourages hospitals to stop all non-urgent clinical activity on wards during mealtimes. During this time patients can eat their meals without interruptions and nursing staff are available to offer help to those who need it.

In the Chief Medical Officer’s 2004 Annual Report, it was recognised that the initiative had been successful and should be introduced in all hospitals.

The National Patient Safety Agency (NPSA) is proposing to undertake a review of the PMI to identify what barriers there are to uptake of Protected Mealtimes and to develop solutions to help NHS trusts implement it.

To assist with this review, it would be helpful if you could answer a few questions about Protected Mealtimes in your trust.

This questionnaire forms part of a larger project that will also involve the NPSA holding four regional events for frontline staff to share their experiences of the PMI. A report on the findings of this project will be made available.

Please return your completed questionnaire by 6 November 2006, either as an attachment to caroline.lecko@npsa.nhs.uk or by post to:

Caroline Lecko, Nutrition Lead
National Patient Safety Agency
4 - 8 Maple Street
London
W1T 5HD

If you have any questions, Caroline can also be contacted by phone:

Direct line: 020 7927 9568
Mobile: 07788 744479
1 How many beds and wards are there in your trust (if this information is not readily available, leave blank)?

<table>
<thead>
<tr>
<th>Type of NHS trust (acute/general, primary care, mental health)</th>
<th>Number of beds</th>
<th>Number of wards</th>
<th>Number of sites within the trust</th>
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</thead>
<tbody>
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</table>

2 Does your trust currently protect mealtimes on any of its wards?

Yes ☐
No ☐

3 How many of your trust’s wards protect mealtimes and does this represent all wards on site?


4 Which mealtimes are protected (tick as many as appropriate)?

- Breakfast ☑
  - Yes ☑
  - No ☐
- Lunch ☑
  - Yes ☑
  - No ☐
- Evening meal ☑
  - Yes ☑
  - No ☐

5 Is the Protected Mealtimes policy agreed by the trust’s board?

Yes ☐
No ☐

6 If there is more than one site in your trust, does the Protected Mealtimes policy apply to all sites and, if not, how many sites does it apply to?


7 Has your trust previously introduced a Protected Mealtimes policy but now ceased to implement it?

Yes ☐
No ☐
8 **Which areas in your trust operate Protected Mealtimes (tick as many as appropriate)?**

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<thead>
<tr>
<th>Area</th>
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<td>Stroke unit</td>
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<td>Paediatrics</td>
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<td>Other (please specify):</td>
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9 **What barriers to implementing Protected Mealtimes has your trust encountered (tick as many as appropriate)?**

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<td>Ward round times</td>
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<td>Nursing staff</td>
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<td>Other health workers</td>
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<td>Visitors</td>
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<td>Other (please specify):</td>
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10 **How has your trust addressed these barriers?**

11 **Please share your successes in introducing Protected Mealtimes, or any comments on your experiences**
12 Are you happy for us to contact you to discuss your experiences further?

Yes ☐

No ☐

If yes, please include contact details:

Thank you for taking the time to complete this questionnaire
Appendix 2

Table 1 – Type of Trust

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<th>Type of Trust</th>
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Table 2 – Does your trust currently Protected Mealtimes on any of its ward?

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Table 3 – Which mealtimes are protected?

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Table 4 – Is the Protected Mealtimes policy agreed by the Trust Board?

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Table 5 – Has your trust previously introduced Protected Mealtimes but now ceased to implement it?

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Table 6 – Which areas in your trust operate Protected Mealtimes?

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<th>Percentage</th>
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Table 7 – What barriers to implementation has your trust encountered?

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<td>Visitors</td>
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<td>Unreliable meal delivery times</td>
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<td>Other</td>
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Endnotes


