2. Standards

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The following Standards represent best practice and are based on the evidence and rationale found in sections 1 and 2 of the Adults Standards, along with alignment to National Safety and Quality Health Service (NSQHS) Standards.[8] There may be flexibility in how individual health services implement and achieve the Standards.

The terms 'recommended' and 'suggested' are used to identify the evidence justification for each of the Standards.

- If a Standard is **'recommended'**, there is strong evidence supporting its implementation.
- If a Standard is **'suggested'**, there is emerging evidence or expert opinion supporting its implementation.

2.1 Continuous quality improvement

Governance It is recommended that:
A nutrition steering committee is appointed, to meet six times annually, to monitor and progress food and nutrition quality and safety.
There is allocated EFT for a food service dietitian (ongoing or intermittently) with governance and reporting responsibilities within food services.
Quality assurance **It is recommended that:**
Feedback-driven quality assurance activities are undertaken, with documented evidence of outcomes and actions for communication, review and audit purposes.
There are quarterly (at a minimum) internal tray-line and/or point-of-service quality audits (presentation, accuracy, temperature, portion weight, taste and texture compliance).
There are six-monthly (at a minimum) internal food consumption and waste audits.
There are quarterly (at a minimum) point-of-service patient/family satisfaction surveys.
There are quarterly (at a minimum) patient/family feedback sessions, representing the health service population and including taste testing for existing and/or new dishes.
Services undertake responsive community consultation, including with local culturally diverse community groups.
Quality audit tools be used as part of a Continuous Quality Improvement (CQI) cycle, with documented evidence of changes for communication, review and audit purposes. (Refer to Appendix 9 of these Paediatric Standards for advice on quality audit tools).
Patient and family feedback mechanisms **To ensure alignment with NSQHS Standards, it is recommended that:**
There are clear internal processes for managing food service–related feedback and complaints, which may result in menu changes, with documented evidence of actions taken, for communication, review and audit purposes.
Patient/family representation reflects the health service population, with relevant cultural representation given the opportunity to provide input/feedback throughout the CQI cycle.
Equitable access to providing feedback be available via interpreters (language or relay for people who are blind, deaf or hard-of-hearing) to allow patient/family involvement.
Timely communication of action/inaction taken in response to patient/family feedback be given to participants.

Menu planning and review It is recommended that:
• Menu planning is led by a food service dietitian and food service manager, in collaboration with other key stakeholders including patient/family representation, to ensure the needs of the health service population are met.
• There are annual (at a minimum) full menu reviews for hospitals.
• Menu and recipe creation activities have documented evidence of the impact of the specific food service and menu ordering systems to do with taste, presentation and texture.
• Consideration is given to using electronic and/or flexible menu ordering systems to enable orders of preferred foods and fluids as close as possible to delivery times.
• Menus are designed to meet the nutritional requirements of most of the health service population, with documented evidence of demographic, clinical, cultural, religious, psychosocial, average length of stay and patient/family preference considerations.
• All menu items have documented standardised recipes and/or product specifications with serve sizes that have been endorsed by a food service dietitian and are followed by chefs/cooks and food service staff.
• All recipe or product changes or substitutions are approved by a food service dietitian.
• Meal presentation is included in documented recipes and product sheets, incorporating decanting, garnishing and any piping/layering/moulding requirements for texture modified meals.
• Seasonal menus with genuine changes to dishes, fruit and snacks based on seasonal produce and patient/family feedback are routinely considered.
• Menu items have commonly accepted and understood names and/or a description that accurately reflects the contents of the dish for ease of patient/family recognition.
• Pictorial and translated menus are available where there is an identified need in the health service population assessment.

2.2 Menu choice

It is recommended that:
• A variety of meal choices are provided, as depicted in the Minimum menu choice tables for paediatric patients.

2.3 Meal environment

It is suggested that:
• Distractions during mealtimes be avoided where possible (e.g. medical ward rounds/activities).
• Children are given appropriate supervision when eating.
• Smaller, developmentally appropriate child-friendly cutlery and crockery is available as a means of encouraging safe, independent eating.
• Packaging is easy to open.

2.4 Staffing

It is recommended that:
• Staff are allocated to all patients who need help with eating. Staff include nurses, personal care assistants, allied health assistants and trained volunteers.
• Regular training for food safety in alignment with FSANZ, the International Dysphagia Diet Standardisation Initiative (IDDSI) framework[41] and the National Allergy Strategy is undertaken and documented for all staff involved in producing and delivering meals.
• Regular training on providing assistance with eating, including risk management of dysphagia and food allergies, is undertaken and documented for all staff undertaking this support service.
• Meal ordering assistance is provided to patients who need extra help.
• Regular consumer engagement training is provided to all food service staff (chefs, kitchen staff and food delivery staff including personal services and care assistants) who interact with patients.
It is suggested that:
• Regular nutrition training (basic principles) be provided to all staff involved in patient meal delivery – for example, chefs/cooks, food service assistants, menu monitors, tray-line staff, delivery people (this could include personal services or care assistants) and nurses. (Note: this is different from malnutrition screening training required for nursing staff).

2.5 Sustainability and food procurement

It is suggested that:
• Food waste management plans integrate with the Victorian Government's *Sustainability in Healthcare – Environmental sustainability strategy 2018–19 to 2022–23*.
• Health services minimise the number of packets on a meal tray – for example, decanting cereals into a bowl and juice into a glass from bulk sources. There would be exceptions to this to ensure food safety, and management of allergies and specific diets (e.g. Kosher).
• Health services ensure that, where possible, foods are seasonal and sourced from local or Victorian producers.
• Health services consider developing an organisational local food procurement policy.

Refer to Appendix 4 for further information on sustainable food waste reduction strategies.

Section 2 of the Nutrition and quality food standards for paediatric patients in Victorian public hospitals.
Please refer to the separate Appendices and References sections.

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

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