Dear Sir/Madam

Thank you for your Freedom of Information request concerning cost of providing food to patients.

The Trust can provide the following information:

Note: data does not include the costs of TPN and nutritional supplements

1. For the most recent three financial years (10/11), (11/12) and (12/13) please state what the cost of providing food to patients was at your trust per patient per day?

   - 10/11 = £12.67
   - 11/12 = £12.73
   - 12/13 = £12.85

2. If you have a figure please state what percentage of food in the most recent financial year (12/13) was returned untouched by patients?

(Please note, only 13/14 to date available)

Month	Wastage
April	2.9%
May	3.6%
June	4.1%
July	4.2%
August	3.9%
September	3.2%
October	3.6%
November	3.6%
December	4.1%
January	4.3%

3. If you have an outside caterer that is responsible for supplying food to the Trust, please state the name of the company and how much it was paid by the Trust in (12/13)? Also state what level of involvement these outside caterers have? For example do they just provide the hospital with ready meals that are then distributed by Trust staff or are the caterers responsible for providing and serving the food?

   Medirest - **£2,959,250** (12/13). Medirest provide total catering management. Patient Steamplicity meals are manufactured by Medirest and the service provided by Medirest.

4. In the **2013 calendar year** please state how many complaints you logged from patients, or their relatives or friends, or hospital staff where either the primary concern or a secondary concern related to the provision and/or quality of the patient food?

   57

5. In relation to Q.4, which month saw you have the most complaints about food and how many complaints were logged?

   March/13

6. For the month identified by Q.5 (if more than one month has the same number of complaints then take the most recent month) please provide me with redacted copies of the complaints so to not breach S.40 of the Freedom of Information Act, but include the name of the hospital involved. If the original correspondence has been destroyed then please provide me with a detailed (two sentence) summary explaining the specific nature of the complaint, including the name of the hospital.

   See below- document

7. In the last financial year (12/13) has the Trust paid compensation to a patient or their family following a complaint about the provision/quality of hospital food? If so how much was paid and why was it paid? Have any complaints about hospital food been referred to the NHSLA.

   £0

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk , in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

Yours sincerely

James Cook
Information Governance Administrator

Mike Dunne
Information Governance Manager/Deputy Calidcott Guardian

Description
A prescribed parenteral nutrition bag was punctured whilst two nurses one (sterile) attempted to insert the spike of giving set into the(unsterile) bag of fluid.
Baby was weighed in community by community Midwife, baby had lost 12.5% of body weight (400g).
- no macaroni-cheese meals available on wards - no vegetarian pasta dish as replacement available - pasta-chicken-broccoli dish offered as replacement to patient, which was refused. I was informed that this was the only pasta dish left in the hospital, which then went cold. - apparently Medirest team had been briefed the day before that macaroni cheese was not an option, but the food was nevertheless ordered. - are some people who take the orders still using the old menus?
On the Neonatal unit I was informed by the staff nurse that there were NO bottles of preterm infant formula at all left on the unit and some preterm infants on SCBU were due to be fed. I was asked what alternative feed could be given. This caused great concern because we need to be very careful about what these vulnerable babies are fed. This situation should not have arisen as the feed had been ordered and should have been delivered the previous day according to the receptionist (Denise).
During a discharge planning meeting I had asked "staff Nurse" looking after "patient A" to ensure Dad is correctly trained with testing the NGT PH strip before dad is able to be discharged administering any form or medication and milk feeds. I had requested for the signed competency forms to be sent over to the CCNT in order to store in "patients A's" file. Myself and "staff Nurse B" (CCNT) had noticed that the forms were then sent blank with no proof of competency. I.e. no date or signatures.
Twilight visit to patient home as allocated for the administation of his medication and turning off of the peg feed. on arrival l noted that the peg feed is already turn off by patient carer and the remaining feed driping on patient floor, After drawing up patient medication l noted that the connector to use to adminster the medication via the peg tube was not instiu probably been cut off by patient carer or pull off at some point hence his medication was not given
patient said she found 3 hair in her food and one in the fruit salad.she showed to the catering staff.

fish and chips, chicken tikka and roast chicken not available on menu. Patients not informed yesturday when placing order for lunch today, so today patients who ordered one of these options were given a substittue. They were not asked what substitute they would like they were just given what was available in the fridge. 5 patients on cardiology, 1 patient on Gramham observed to be given a different meal that they did not order, and given no option to choose alternative. This incident will have affected all wards and all patients wo ordered one of these 3 meals.
Whist assisting with meals pt requested hot drink. Unfortunately the hot water supply (dedicated emmersion tap) has been broken since weekend. Reported to works Sun. This has impacted on the hot drinks availability for pts as not so easy for staff to make pts drinks in between set times, epecially at nights as less staff thus may be a risk. Catering staff having to use adjacent ward during day.
Patients food was served late by fifty minutes
On doing the rounds in the home this lunchtime it has been brought to my attention that there is not enough puree meals for our patients. On speaking to the Catering Assistant and the Catering/Domestic Supervisor they have been trying to get in touch with the Catering Supervisors but have had no response.
I am an OT and had a session booked with my patient. My aim of the session was to encourage the patient to independently feed herself. When I approached the patient I checked her chart to see what kinds of food she could eat – the chart reported pureed food. I asked the nurse whether the patient was alright to have porridge for breakfast and she replied yes. I then assisted the patient to eat her bowl of porridge. A couple of hours later I was informed by the same nurse that the patient had a PEG tube in situ and she was wondering if the patient could eat anything for lunch, I advised her to ask the Speech and Language Therapist regarding her swallow. She checked with the Speech and Language Therapist who reported that the patient was nil by mouth and should not be taking any liquids orally, I therefore should not have given her anything to eat at breakfast however this message had not been relayed to the team and the information board above her bed had not been revised.
meal not delievered or served on time. Its 13.30 and no-one has cme to serve food. Our protectd mealtimes are 13.00 and 18.00

TPN manufacture expiratory date has been crossed off by pen and initiated and dated on 22/11/13 in two occation. Bags which has been changed on 23/11 and 24/11. The stickers where the change has been made are made in pharmacy department.There has not been communication about this between the departments.
During lunch when medirest was cooking the food, the fridge was opened and i saw jacket potatoe that was ordered for the patient left in a carton mixed with other drinks and items. The jacket potatoe was not wrapped or covered in a plate but it was left exposed and looked unhygienic.
Patient was discharged home from the Royal London Hospital on an enteral feed which was supposed to run overnight via a feeding pump, however pump was not at the patient's home when the district nurse visited
This gentleman was leaving the delivery suit, however, before reaching the door he collapsed onto the floor. I had my back to him at the time whilst administering care to his wife. His wife bought my attention to her husband and i pulled the emergancy bell. The midwifery team arrived as did the obstetric dr's and anaesthetic dr's. Our client stated that her spouse has diverticulitis and was suffering in pain from an acute episode of this condition. Client states acute episode direct result of client unable to access fresh food from 'Chatters' resurant yesterday as it was only open to staff when he felt able to go as he did not wish to leave his wife. Therefore, clients husband ate food which exasibated his condition.
Patient attended the dietetic clinic with her mother. Patient is fed via nasogastic tube. Mum has been advised by SLT to give small quantities of puree only with nasogastric feeding being given via NG tube. During the clinic appointment patient started to cry and mum identified that patient was hungry and wanted to feed her. She proceeded to fill a syringe with feed and wanted to give this orally. I advised her that this should be given by tube rather than orally and helped mum to attach the syringe and supported mum in feeding . The position of the NG tube was not checked before starting NG feeding. Although there were no signs the tube being in the wrong position on feeding this was a potential risk. This would also have also reinforced bad practice giving a message to mum that checking the position of the NG before feeding was not necessary.

The total parenteral nutrition (TPN) that arrived for the patients on ITU on the evening of 6th June had a pungent smell to it including the inside red bag covering the TPN bag. I contacted the out of hours pharmacy to try to find out why. The on call pharmacist put me in touch with one of the TPN pharmacists by telephone who assured me it was due to the cleaning process. I stated that I was unhappy with the explanation as in all the years I had worked on ITU the TPN had never smelled this way before. The two patients on the unit did not have their TPN overnight. I found the TPN pharmacists attitude dismissive and unhelpful and she continued to display the same attitude when we spoke this morning on ITU.
Patient approached me to complain about how the lady that served tea spoke to her. whiles patient was speaking to me, she was in tears. Patient said she was spoken to as if she were a child. According to the patient, she had asked for a glass of warm milk but was told by the domestic that she did not have any on the trolley and that patient will have to wait till she finishes serving everyone tea. Patient said that she asked the domestic what she was using to make the hot chocolate to which the domestic answered hot water.
Patient not referred to dietitian's via EPR for Parenteral nutrition. Pharmacy emailed me, however by the time I received this it was too late to make additions of vitamins. minerals and trace elements to the bag as they are being outsourced. Plain bag ordered and bag with additions ordered
lunch served late, no host on ward at 13.00. cooking did not start until 13.10, first meal served 14.30. 1 patient did not have meal.
lunch served late. Host arrived at 12.15, first meal served at 12.20, (20minutes late).
meals served late. host did not arrive until 12.15 and first meal served at 12.20, 20minutes late.
Was doing meal time observation on ward at lunch time yesterday and the meals were served 20minutes late. 1 patient did not get a meal and had to wait 40minutes for alternative to be provided.
meals served 25minutes late. First meal served at 12.35. Host only arrived at 12.15 to cook meals.
A patient was recommended to be on a puree diet by the speech and language therapist due to swallowing problems. A normal/ non-pureed meal was ordered for and given to the patient (salmon). A relative was in the patient's room at the time, and told the member of staff who brought the meal that it was unsuitable for him.

EBM was handed over to a student nurse by one of the staff to be given to a baby. The student found out that the bottle was labelled with another baby's name, but defrosted labell was in the actual baby's name who was asked to be fed. The matter was reported to me immediately.
Baby was prescribed TPN start up fluid yesterday 30/12/2013 but baby receiving TPN maintenance bag instead. Discussed with the Specialist Registrar, advised to changed the fluids to start bag as baby's Sodium is increasing.
On entering patient's room, physio and OT noticed a food tray on patient's table containing a sandwich with a bite missing, an empty cup of orange juice and empty yoghurt pot. Therapists discussed with nursing staff looking after patient as patient was nil by mouth due to swallowing difficulties resulting from stroke only a week ago and there was no indication that this had changed. Nursing staff was not aware patient was nil by mouth and reported 'patient is eating now because his blood sugars are stable'. On checking patient's notes there was no indication that patient had been changed from nil by mouth from SLT. Last entry stated patient was still nil by mouth and this had been handed over to the Acute team on patient's transfer to this ward.
A pateint with coeliac disease needed to follow a strict gluten-free diet. During our conversation she informed me that she was not offered gluten-free meals (even though gluten free options are available on the menu). When she requested a gluten-free option, the host asked her 'what is gluten?'. She reported that she had been given meals that clearly weren't gluten free, e.g. porridge.
The bedisde nurse went to put the patients' Total Parenteral Nutrition (TPN) bag up when she discovered a leak once the sections had had their seals 'broken' so they could be mixed.

The above patient was referred to me within the NICU clinic due to faltering growth as a result of a cardiac condition. The patient was not from Hackney but from Enfield. Mum had requested to have her medical follow up at Homerton as she did not wish to be under the care of the North Middlesex hospital. I advised mum to alternate breastfeeding with a high energy formula called Infatrini to help with weight gain. I continued to monitor the patient by phone over the next few weeks. GOSH advised an NGT for top ups as Semra had been unwell and wasn't feeding so well. It wasn't known if this would be required in the longer term and so I continued to monitor regularly by phone. I was also liaising with the SLT in Enfield who was going in to the family home to review the patient. I discussed with SLT about dietetic provision in Enfield and she informed me that there was a dietitian who could do a joint home visit and follow ups with her. This sounded ideal for the family. I wrote a letter to transfer the patient and called to speak to the dietician but they were not in. The administrator gave me the fax number and my transfer letter was sent . I called the following week to check the referral was received and the administrator told me it was. I didn't think anything more about it until Viv left me a message to say that she couldn't accept the patient.
The patient was given TPN dated for 1/12/2013. I came on my shift on the night of 30/11/2013 and toted this. I have also noted that a TPN dated for the 29/11/2013 was taken out of the fridge and was on the ward to be given on for the night. The TPN expiry date is on 6/12/2013
Patient with dysphagia at high risk of aspiration given biscuits by domestic staff when giving out tea, despite recommendations for 'soft/moist diet only' being clearly displayed on a pink sign above the patients bed.

Speech and language therapist received a referral to carry out a swallowing review of a client who was receiving respite care at Mary Seacole Nursing Home. Handover from referrer (speech and language therapist at Homerton University Hospital) advised that client should take fluids thickened to a syrup consistency. SLT visited client at Mary Seacole for initial session approximately 1 week after admission. Nursing staff reported that the client had not been given thickened fluids as they did not have any thickening powder available and this was not on her medication list. No steps had been made to procure thickening powder from another source or to contact doctor to ask for this to be added to client's medication list. SLT proceeded to do assessmnet and deemed that client in fact no longer required thickened fluids, however, the client was placed at risk by not having recommendations from referring therapist adhered to.
The patient was having feed via naso-gastric tube.I was called by student nurse that the pump was bleeping and feed looked cuddled. I checked the feed and discontinued it and put another one.
Patient's deforsted mother expressed breast milk (EBM) was written 'fortified' in red on the bottle. No fortifier was prescribed for this patient. Patient was reported to have vomitted three times on the day, one feed was omitted due to abdomen distension and an abdomen X-Ray was done.
Patients dinner was not been delivered
Patient was admitted with vomiting and yellow aspirate from NG tube, Patient has long term NG tube requirement. Patients notes stated the NG was inserted on the 1/6/13. Beginning of a night shift on the 2/6/13 unable to obtain acid pH, NG inserted at 36 by left nostril. x-ray was done to confirm position, Showed NG was passed too far
CCNT contacted requesting patient Naso-gastric tube competence on tuesday 16th april. Naso-gastric tube competence not completed by any staff nurse. looking in notes ng competence were due to start on friday 12th, this was handed over on the thursday 11th nursing handover sheet. on friday 12th handover sheet no mention of the competences,for staff to compelte over the weekend.

CXR requested for patient to check NG tube with clinical details of unable to obtain aspirate. Patient brought for xray. CXR performed, NGT tip sited at approx. 3rd rib, guide wire still in place. Rang Team on ECU to inform them and to see if they would like to come to department to remove/advance NGT. Team did not want to come to department, told to send patient back. Went back to patient and asked patient to open mouth, NGT seen coiled in mouth. Escorting staff nurse explained patient had been opening and closing mouth in apparent discomfort but wasn't able to communicate why. Rang Drs again and informed of NGT in patient's mouth and for action to be taken as soon as patient back on ward. Informed Dr of NGT policy and that it had not been followed. NGT in mouth and not noticed prior to xray, demonstrating lack of adherence to protocol. Unneccessary radiation dose and discomfort.
Advised from staff nurses on Graham ward that the store room did not have Fresubin Energy and there was none on the ward therefore the patient was given an alternative feed (500mls Fresubin Energy Fibre). The short suppy of feeds in the stock room was discussed with a memember of the store team on Tues 13th August. He sdvised that the main contact - distribution manager, is currently on annual leave and that the team is short staffed which is effecting the management of the stock room.
lunch arrived on the ward at 1230pm without the menus,the server had to go back to the kitchen to collect them consequently serving did not start until 13.15pm. The reason for the delay was because the menus were not filled out the previous evening,however the Kitchen did not inform the ward staff of this and it only became apparent when a member of the kitchen staff was seen filling out the menus on the ward at 12.00. I spoke to the kitchen supervisor at 12.10 she appoligised but the food was not delivered for twenty more minutes.
The patient was given a cup of tea and a cup of water by domestic staff both of which were not thickened according to the patients drinking guidelines (above his bedside, on the whiteboard and in the kitchen). The patient is likely to have aspirated the fluid he drank.
Daughter reports patient had hypoglycaemic episode this morning at 02.57, blood glucose was 1.6mmols/l. Daughter gave patient sugar and ensure which elevated patient's blood glucose level to 5.3mmols/L by 04.13. Patient's daughter reports pt refused the ambulance. On visiting patient this morning, her blood glucose was 21.5mmols/L post breakfast.

Member of staff made aware that mother was using Nanny nutrition as top up. Midwife was concerned that this milk powder is not covered by the EEC regulations on infant formula.
I was inserting a naso-gastric tube(NGT) into a patient who had just been intubated. I could not get any apsirate and on checking on the X-ray the NGT was found to be in the right lung
The parents of a child were contacted by Fresenius home care regarding their feed delivery. Mother was informed on monday 9th September that the feed delivery was delayed as they had not received the prescription. The mother was called again on Thursday advising her to collect a prescription from the GP. THis is not the first time that there have been problems with the feed delivery. The child's sister also recieves regular deliveries and there are no problems. I have previously requested that both prescriptions are requested at the same time.
patient brought back to ward at 18.00 to be NMB for 1.5 hrs post procedure. Volenteer on the ward giving out food gave the patient 3 bowls of soup NBM sign was displayed
Was prescribed Fresubin Jucy a week ago. Recorded as 3 (refused) but patient says he was never offered any.
I was contacted on Tuesday 1.10.13 from Edith Cavell ward to inform me there was no Fresubin Original Fibre for a patient. The ward had previously run out of Fresubin Original Fibre feed on Friday. I checked the store room - there was none. I called the distribution manager who said that he was expecting a delivery (none in main stores) that afternoon and that feed had also been ordered for Graham ward and RNRU. About an hour later the feed order for GSU and RNRU was brought from stores to the Dietitian office. I said for them still to deliver to the relevant wards and we would stock up on Edith Cavell from there. I checked and ther was only 1 patient on this feed (the patient above) apart from those on GSU. My colleague to feed to Edith Cavell but GSU would not let her take a whole box as they may have someone admitted over the weekend. I contacted the Distribution Manager and he said the delivery may come that day. In veiw of the fact that we had less than 24hours feed for all the patients I requested an order from AAH that afternoon. I did then get an email in the afternoon to say that a delivery had been received. Some further bags of Fresubin Original fibre were taken to the ward ahead of the AAH delivery.

Patient was Hoisted out on his chair for an hour and half by the physio around 1500hrs and they said if i can disconnect the feed as they could not find a plug for it. I told them that the machine has got enough battery for that long.Patient was later hoisted back in bed and feed restarted. IT was not until around nineteen hundred hours that we realised that the feed was running at 300mls an hour instead of 150ml originally started in the morning. Patient coughed out some feed from the trachae and the wife called for a nurse and the feed was stopped and the patient suctioned immediately. Observation was done. ON call informed to came and review the patient. As we were waiting for the on call, he vomitted a lot of the feed out from the mouth and nose . Xray was done.
The child was admitted to ward due to difficulty feeding. A nasogastric tube was inserted and milk give 170ml bolus' 3 hourly. The concerns are that milk is not appriate as an enteral feed for a 5 year old child. Although the child tolerated the bolus feeds 170mls is a large bolus to give a child commencing on NG feed.
Agency staff (capital) was assigned for baby . Baby had longline inserted am in morning and Plain TPN was started at that time. On ward round 9 am sodium was found to be low and TPN was prescribed with extra sodium which was meant to be started in evening. But prescribed TPN was not started on that evening and next morning sodium was still low and it was found on ward round that baby was still running with Plain TPN instead of Prescribed TPN(with extra Sodium). Prescribed TPN was in Fridge since last evening.
Baby readmitted on day 3 due to poor feeding, weight loss and jaundice.
The patient requires a soft diet and full support to eat their meals. The Speech Therapist noticed the patient had been placed at their bedside to eat a meal of normal consistency food independently, putting her at significantly increased risk of aspiration.
Patient was visited by his friend at 1845hrs.As he came in the room,he lifted the pateint off the bed.He was stopped by a colleague who was with him. He was also seen putting bottle in his mouth.?water.He was stopped immeadeately.Not sure whether patient has drank or not.
Documentation for baby shows he received Nutriprem 2 instead of EBM or Preaptamil (which he should be on) during day shift on 13/1/13.

Due to a prescription not being recieved the family were not able to recieve thier delivery of feed and supplies. The family had already picked up a prescription from the GP the previous week. Grandmother had enough milk to last till monday but only enough plastics to last till saturday.
Patient has milk allergy. not offered milk free menu options. host reported that did not know what was milk free on menu and patient has only be having tuna sandwich for lunch and dinner for several days.
The patient had a nasogastric tube in longer than the 30 days it is licensed to be in situ. The patient had it in for another 30 days on top of that.
Lunch and dinner ordered by phone from the kitchen. Lunch arrived but dinner was not delivered. Bedside nurse was taking another patient to CT in the evening and did not see that the dinner was missing until the end of the shift (1930).
A patient was discharged from Royal Free Hospital on enteral feed and referred to the community dietitians (received 13/09/13). On 19/09/13 a telephone call was recieved stating that the pateint had yet to receive any feed. I was told that a request had been sent from Royal free to the GP, the GP reported he had written a prescription and sent it to the patient. However the patient had not received it as of 19/09/13. The GP agreed to resend, but as this could only be done by post the pateint was left potentially without any feed for up to a week. Fortunately the patient is not reliant on the enteral feed as his sole source of nutrition, and continues to eat and drink in the meantime- although this is unlikely to be enough to meet his full nutritional requirements.
Whilst walking down yellow corridor from Tempolar towards 2012 ward I noticed 5 meals (Steamplicity) on the windowsill in direct sunlight. I have no idea who put them there or when. the bottom meal was cool but top (chicken and rice i think) wsa warm to touch. Instructions on pack say to store below 5 degrees c. I beleive it is the hottest day of the year.
A nasogastric tube was put in to a patient for gastric decompression by myself. No aspirate achieved.No food was administered. An Xray revealed that the ng tube was in the lungs.

Patient was prescribed TPN plain bag as it was the weekend. TPN was taken out of the fridge and during the checking process it was identified that the TPN was actually for the following day. The benefits Vs. risk of returning the TPN to the fridge was discussed. TPN had been out of the fridge for approx 35 mins at this stage. Decision made by myself not to return as nutritiion was now at room temperature and as it was a plain bag there was minimal risk to the patient.
Food ordered from kitchen for supper but was not delivered. Could not get an answer on the phone.
There was no supply of milk for our patients to use for breakfast.
Patient is on a gluten-free diet and has been asked to order/receive a baked potato with every main lunch-time meal. He told me that he either receives the potato, but no main meal or a main meal and no potato.
The child was due a feed delivery but this was delayed due to the child having diffuclty obtaining a prescription from the GP enableing them to dispense the feed. Mum was told on the 2.10.13 that she needed to pick up a prescription for the feed. as mum only had enough feed to last till the 3.10.13 she was very distressed as she reported that she would need to make an appointment to see the GP before she could get a prescription which could take several days
wife came out of patient side room and informed staff nurse and palative nurse that she fed patient and he bit the plastic spoon and was unable to find the plastic bits nurse and doctor enter the room where wife informed them that patient has dislodge the plastic bits himself
On Saturday August24 2013 - slt/dietetic slt assistant found an unthickened tea - almost finished by the above patient and a glass of water unthickened in front of this patient. This patient is recommended to have thickened drinks (on this date he was recommended to have syrup thickened fluids (2 scoops of Thick and easy per 200 ml glass). This patient is complying with recommendations re thickener on the ward.
Informed by a staff nurse that the EBM in one of the milk kitchen freezers appeared to be defrosted/defrosting. 22.04.2013 INFO. FROM DUPLICATE Informed by staff nurse that the EBM in one of the freezer appeared to be defrosted and partially defrosting.
Reveiwed child in clinic. Parent reported that they were running out of feed had enough to last till the next day (saturday) . The parents had been advised that due to problems obtaining the prescription from the GP they were unable to deliver the feed and the delivery date had been prosponed until the monday.

The male infant has been sent by the community midwife in A&E due poor feeding and jaundice. The Baby lost more than 10% of his birthweight. After his admission to A&E the baby was tranferred to Templar.
TPN that was due to be changed yesterday had been left running. same was presribed on the fluid presription chart for changing but was not changed. Informed by nurse who looked after the baby informed team that the TPN did not arrive.
Nurse was observed by parents who are learning how to tube feed their baby to use the "WHOOSH" test when there was difficulty obtaining a gastric aspirate from the NGT. The tube had been re-sited but there was still insufficient aspirate for pH testing.
uncleaned trolley with tea , biscuits, milk, orange juice brought to chronic pain clinic for patients's snacks from catering department/ canteen.
Baby readmitted for jaundice and weight loss. Delivered in UCLH on 8/8/13. Discharged from there on 10/8/13. Admitted to Homerton on 11/8/13.
Food ordered for teo patients at dinner dinner one order made at mid day the second made at 17:00. Neither Meals turned up. Rang to kitchen at 17:40 with no answer. Went to kitchen at 17:50, casher said no one was in the kitchen. Rang kitchen again at 18:00 no answer. Attemted to contact Medirest on radio system for out of hours but no response was told this is terminal clean not kitchen supervisor. a catering assistant working in another part of the hospital heard the call on the radio and went to help and delivered one meal at 18:40. medirest supervisor on call also heard radio and turned up on ITU she stated that no order had been received in the kitchen and areranged for food to be delivered.
Visited by community midwife. Baby had lost 20% of birth weight. Birth weight: 2970g Weight today: 2380g Baby also appeared jaundiced and very sleepy (according to parents).
Day 2, Baby readmitted with 10% birth weight loss, following exclusive breastfeeding.
The patient had a naso gastric tube inserted and goats milk was being fed down the tube instead of a nutritional age appropriate tube feed. The child was underweight and had an unsafe swallow (reason for NGT insertion on admission to HUH.
baby was re-admitted for weight lost, total amount of weight lost was 11 percent.

when we arrived on the ward for hand over at 20.00 the ward was in a mess, all the food trays were left with food. what happen to infection control both clean and dirty trays anf plates were together. to my knowledge the catering staff usually come to collect all dirty trays after the supper is served.
I set the feeding pump machine and connected it at 24 hours rate not knowing that i have put the volume up and the rate down on the feeding machine,then the machine kept on making noise and i was wondering why so i called mum and told her that the machine kept on making noise. we both tried to trouble shoot and then discovered that the volume on the machine was set wrongly.
We have a hot food trolley every Wednesday morning with a cooked breakfast for our patients. The trolley from yesterday has not yet been collected by medirest staff despite numerous calls from us yesterday afternoon/evening and again this morning.
Delay in delivery of supper food trolley.
Patient with impaired swallow assessed yesterday. I recommended that the patient requires syrup thickened fluids in order to minimise risk of aspiration. When I arrived to review the patient on 11/1 cup of clear thin fluids next to his bed.
Patients lunch in graham ward came to the ward at 12:30 and was served at 12:50 .where as the lunch much be serve at 12:00 oclock .when asked why they are late ,they said the person who was supposed to be in graham ward didn"t turn up .
On Sunday 10.11.2103 various issues relating to the lunchtime srevice resulted in a mealtime service that did not meet the protected mealtime standard. Issues noted but not exclusive: Ward • Meals heated and left on trolley until trolley full. Result meal slips lost, trays balance precariously, first meals cooked served lukewarm • Patient on soft diet served incorrect meal – patient alerted server to error • Patient wanted soup in beaker – by the time beaker found in ECU no soup left • Side Room 1 meal left in kitchen and was served lukewarm due to haphazard service • Mask box empty outside Room 1 so no mask to wear to serve meal Medirest • Beaker (from ECU) damp with water residue inside • Hostess angrily said she had asked patient what she wanted the previous day. The patient had said she was not hungry and hostess had made a decision for her and ordered food • Hostess seemed irritable and unsure and had little experience of working alongside vulnerable people

a carer and i were about to prepare feed for Child A on the (10/11/13), and we noticed that the fomular milk has expired on(3/9/2013). the carer informed me that other nursing staff have being feeding Child A with the expired milk Neocate since Child A's admission on the 8/11/13.
Food ordered (dinner only) from the kitchen for a patient No food delivered & had to go over to the kitchen to collect some food as no one answered the phone.
patient found a spider leg in her salad.
Readmission of baby from community for raised bilirubin. Not feeding well.Day 4. Baby of Neiman #2483782
Reported by telephone by a Trust Governor issues experienced by a new mother on Templar Ward this morning 2.10.2013. Patient does not want to be identified. Woman had given birth and was hungry first thing in the morning
Very unwell patient in Sr. 1 was served his meal on a beige tray. My impression was that he was too unwell to feed himself and should at least have had a blue tray. no water within his reach. Speech and Langauge Therapist had written feeding instructions on notice board with drymarker pen, but the writing was degraded and made me unsure if patient was allowed unthickened drinks.
The patint only got one prescription (50% bag of Kabiven 9) for over the weekend (Fri, Sat, Sun)instead of 3 different prescriptions to help build the patient up. Therefore the patient did not meet full nutritional requirements due to pharmacy capacity.
The patient had a baby on Friday night 30th august. she was in the birthing centre. Saturday lunch - she was served a kosher meal - but sadly the fish part of the meal was frozen and unedible and the hot part of the meal had blown open and due to kosher specifications she was unable to eat the meal as it had blown open
Lipid completed early at 09am It was meant to infuse the day before and to run at 5mls/kg/day.The lipid that infused the day before was meant to be infused today and run at 10mls/kg/day.Therefore the lipid was wasted and there was not enougth lipid in the syringe to last to the afternoon.
No nutrison feed in stock on ITU to administer to the above named patient. Went to the stock room and there was none in there. I rang all thw warsd to find some and there was none.
Patient reported that she was not asked by medirest staff what food she would like. As a result the patient missed her lunch.

No staff to prepare the evening meal. I called the kitchen and reported the issue thinking someone would come. No-one had appeared by 18.45 therfore nursing staff made the evening meal and gave to patients. This is the third delayed meal in the past few days. The hospital is paying this company and they are failing to deliever the meals on time. It takes the nursing staff at least half an hour to do this and prevents the nurses doing other duties whiuch they should be. Staff have been shouted at by patients wanting to know where the food is therefore is unacceptable.
Patient is on nasogastric tube feeding, the day's feeding regime feeding was commenced at 9am. The physiotherapists came to have a session with the patient. At 11:00 the physiotherapist was asking for the nurse looking after the patient. The physiotherapist then informed that the tape used to hold the tube on the patient's nose is coming off but he put another piece of tape to hold the tube. He said he was not sure if it was ok. AT this point the nurse immediately went to the patient bed side where the nurse found the feed commenced at 09:00 has finished at 11:00. Feed went in too quickly as it was meant to finish at 14:00. It was noted that the tubing was not attached to the pump.?? came out during physio session ?? was not connected.
The patint only got one prescription (50% bag of Kabiven 9) for over the weekend (Fri, Sat, Sun)instead of 3 different prescriptions to help build the patient up. Therefore the patient did not meet full nutritional requirements due to pharmacy capacity.
During todays supper we had several meals missing even for the patients that arrived around 2-3 pm. I did approach caterind supervisoraround 5.20 pm regarding new patients and those that could eat supper(as that pt did not eat earlier and not order). She said that the hostess will come and check for new patients and those that need food. I also spoke to hostess about pt needing meal. Unfortunatelly she did not go around and cooked meals for those that were discharged already , and none of new pt received food. I did speak to catering supervisor in catering about the problem and she ensured me that she will speak to the hostess. Also the hostess, when asked why she did not check for discharges,replied that she can only ask nurses.The nurses replied that they were not asked . The catering supervisor said that I also should mention this problem to the ward manager.

Staff nurse ordered pt lunch in morning and it was not brought to pt. At 1400, staff nurse called kitchen with no answer. Staff went to canteen to get pt a lunch.
Orthodox Jewish Patient who follows Kosher diet given Sheppards pie from steamplicity menu Patient was not at bedside when order was taken the previous day as they were at another Hospital for a proceedure Host has guessed the order when they could have simply put "not at bedside" so order could be taken before the meal service on the day
Baby was readmitted to unit with 11.1% weight loss, client exclusively breatfeeding. Came to A/E as baby very sleepy.
It had been reported on the 8/8/13 that the client was urnning out of enteral feed and a delivery had not been made. the child had not recevied a prescription from the GP. The GP and pharmacy were contacted by dietitian and a prescription was faxed. On 14/13/13, a call was recevied by from client's carer. She reported that no feed had been delivered and the client had no feed for that evening. A call was made to the surgery and receptionist(Stamford Hill Practice) discussed that a prescrption had been sent on 09/08/13. Call to Day Lewis pharmacy and spoke with a member of staff. He discussed that a presciption had not been received on the day reported.
The patint only got one prescription (50% bag of Kabiven 9) for over the weekend (Fri, Sat, Sun)instead of 3 different prescriptions to help build the patient up. Therefore the patient did not meet full nutritional reqs due to pharmacy capacity.
Patient was admitted from Theatre intubated. Noted not to have NG. Fine bore NG tube inserted prior to routine chest xray. Nil aspirate therefore xray checked. Noted to be in R lung. Tube removed Dr informed. Dr re-inserted NG tube - nil aspirate - xray confirmed in the L lung. NG tube removed and reinserted using larygoscope and maggils - nil aspirate - Re-xray confirmed that in the stomach.
On Friday 18th Oct at 4.25 the patient's daughter approached SLT and questioned why her mother's eating and drinking guidelines had not been updated given that she had been eating all consistencies of food for quite a few days now. The patient confirmed that she had been eating 'everything'. Her daughter felt that she was managing all consistencies of food with no overt signs of difficulty. SLT recommendations were up to date but these reports highlighted the fact that guidelines in place are not consistently followed.

The patient was visited by SLT on 6/11/13 at 12.30pm for a lunchtime swallowing review. On arrival the patient was eating bread and did not have a red tray, which goes against her eating and drinking recommendations. Due to memory impairments this patient has difficulty remembering what she can and can't eat safely and she often tends to order something outside her recommendations. Particular care needs to be taken with this patient who should have a red tray at lunchtime.
Patient on TPN, currently being changed at 10am which is a suboptimal time. Discussed with Dietician and planned made to order an extra bag to facilitate a 1600-1800 change. The TPN arrived but the prescription was not with the TPN. The prescription was found the next day in the pnuematic system in a pod.
TPN bag for Sunday 12/05/13 was given to patient on Friday 10/05/13. This oversight was not discovered until Sunday night when a staff nurse wanted to put up TPN bag and could not find it. It has taken 3 days for a datix to be put out because the nurse who discovered the incident was a Staff bank nurse and she did not manage to do an incident form because it was too late by the time she finished her shift. None of the nurses present the following day knew what had happened exactly and were not in a position to write the incident. I am writing the incident as the person who gave the wrong TPN bag and later realised that the incident datix had not yet been raised.
Patient was sent home without a feeding pump.Patient was discharged from Royal London Hospital (Ward 12F). Patient is on overnight feeding.
The nurse gave mum another baby's breast milk and this was fed to the baby. mum discovered this after her baby had taken a half of the feed.
patient remove his NG tube and another one was replased but nurse could not get aspirate after the replacement. Dr on duty was informed and xray was ordered by Dr. After xray it was noted tube was not in the right place.
The patient was due for TPN on 25/10/13. A Central line was not inserted until late on 25/10/13 so TPN not given. The staff was working on the 26/10/13 and was helping to hand over the patient to Edith Cavell ward for the TPN as no staff trained to give it on Lloyd ward. The staff checked with ITU to see if the TPN bag was stored in their fridge prior to transfer. It was confirmed that there was a bag for the 26th as well as one for the 25th that had not been given. The ITU nurse requested that an incident form be completed for the bag not given on the 25th.

lunch served 30 minutes late. host did not arrive until 13.15. could be heard across the ward talking. first meal served at 13.30 (30minutes late). asked host what the delay was in serving meals, as she is the host for wecv who also served late and she said it was her fault she was talking to much to other staff.
meals served over 40minutes late for lunch. medirest host did not arrive on ward until 12.35, so cooking did not start until 12.40.
Meals served at 13.15, 15minutes late.
lunch was served in ward at 12.15 .About 15 patients requested fish and chips.The kitchen staff did not inform any member of the ward that they did not have any fish and chips for lunch today.He preceeded giving the wrong meal to the patients. He did not ask patients what alternatives they wanted. He continued serving any meals he had without asking patients what they wanted. I reported the incident to a staff member of the kitchen , the kitchen supervisor then told the kitchen attendant to stop and he should go asked the patients what they would like .nurse in charge is aware about the incident .
Patient is having hourly feed of mother expressed breast milk (EBM). Out of 65 bottles of frozen breast milk stored in the unit's freezer, 39 bottles were expired. The expired breast milk were expressed between 27/12/12-6/1/13.
fresubin 200ml to run for 12hrs .according to the regimen by the dietician 40ml to run for 10ml per hr finished in 2hrs,sister informed and dietician notified and she visited the patient to check and change the date of the regime to commence tomorrow 17/1/2013. Patient is fine, Observation stable. Temperature 36.4 pulse 86, saturation 100% blood preasure 132/84 respiration 18bpm.
Specialing a tracheostomy patient who is on TPN feed. checked for TPN in Thomas Audley fridge and ITU frindge and it was not there. Sister in charge then discovered the TPN for today and tomorrow in cooler box that was delivered yesterday. The TPN has been left out at room temperature for 24hours.
Patient had an OGD, during the procedure his NG tube was dislodged. It was resited under direct guidance. Correct position was confirmed by aspirate and PH. Following handover to the night staff it was noted that the NG tube was coiled in the patients mouth, the measurement remained the same.

Baby was being fed at 180 mls/kg/day since admission to SCBU on 10/07/13 soon after birth. She was completing bottles and also taking some ngt feeds. During ward round on 11/07/13 we(myself and Dr) noted that the volume was excessive and acted accordingly. The baby had a full abdomen on examination but was otherwise well with no other sighs of feed intolerance.
meals served late for lunch on ACU. Host was on the ward by 12.10 but forst meal did not get served until 12.20 (20minutes late).
meals served late. host did not arrive to cook meals until 12.35. cooking did not start until 12.40, so meals served at least 40minutes late.
meals served late for dinner. host did not arrive until 17.15, meals not served until 17.30.
lunch served late. host did not arrive until 12.30 and only after I went to catering at 12.20 to ask where the host was. Host reported she was late as there were problems with the menus and they had to be redone. first meal served 12.40 (40minutes late).
meals served 35minutes late. host arrived at 12.15. one patient did not have a meal.
meals were served late. host did not arrive to cook meals until 13.10 and first meal served at 13.30.
meals served 20minutes late. meals served at 13.20.
The patient involved requires constant supervision at meals times to support her eating and drinking - to ensure she is able to feed safely and go at the right speed to ensure safe swallow. The patient is also currently refusing an NG tube and therefore oral intake needed to be encouraged and monitored. The patient requires a puree diet and syrup thickened fluids given half a cup at a time only. On 07/05/13 it was noted by the SLT that the patient did not have the correct tray colour at lunchtime (tray colour informs the level of supervison needed - the patient requires red = full supervision), however the patient was being adequately supervised. On the 8th May at lunchtime the patient again had the wrong tray colour(blue - indicating the patient requires time but not supervision), although a student nurse was standing by her it, the patient appeared distressed, had food on her hands and face and was crying and pushing the food away. The patient has also been observed on two occasions at least (07.05.13 and 09.05.13) to be given unthickened fluid by the domestic staff and left unsupervised.

The patient requires puree diet and syrup thick fluids. The speech therapist noticed the patient was drinking an unthickened cup of tea whilst waiting for their lunch. The patient had been ordered a lunch of normal consistency food.
Student brought patient back to ward after physio session, patient requested drink pointing to water fountain (patient aphasic). Student gave patient half a cup of water, drank with no problems. Later found out next morning patient for thickened fluids only due to dysphagia. Informed clinical supervisor of incident.
Patient requires supervision and encouragement while eating and drinking to ensure adequate nutrition and reduce risk of aspiration. Staff memeber was seen talking to a friend who had visited her(the staff member) rather than be in direct observation of the patient. When challanged she stated that the patient was independent and seemed not to be able to feedback the swallowing guidelines in place, repeating that the patient only needed supervision, however she was not able to demonstrate what form this might take as described in the recomendations
Patient due 1000ml PEG feed over 10 hours. Given as two 500ml bags. Feed started at 18:00 at incorrect rate of 500ml per hour. First bag completed at 19:00.
Ryle tube (from theatre) not in situ, so tried to insert a fine bore NG instead. First attempt(myself) and second attempt (Sister)but both were shown to be in the lung when X-rayed.
on Sunday 22.9.13 I helped staff serve lunch to patients. Several food items could not be provided. I went to the main kitchens where this information was confirmed. - no trifle - no all day breakfast - no roast beef on Sunday 29.9.13 there were no bread rolls available.
patient had an endoscopy this morning and was given food at lunch time as post endoscopy plan said to keep NBM until 12.20. Surgeon came later to said that patient should not have eaten because of oesophagitis