Instructions

1. There are two parts to the audit:
   a. Part 1: General observations of the unit and descriptors of the mealtime being audited
   b. Part 2: Specific challenges or barriers to food intake experienced by selected patients

2. Auditor will arrive approximately 10 minutes before the anticipated meal start time to complete Part 1.

3. Auditor will try not to interrupt or alter the usual mealtime in any way.

4. After selected patients have completed their meals, auditor will ask questions (as shown in Part 2). Multiple copies of the second page with Part 2 may be used for a single meal.

5. If any questions are not applicable to an individual patient, auditor will note ‘N/A’.
   *The item on meal selection is N/A if there are no selective menus; this is not asked of patients.*

6. Auditor will write clarifying patient comments, in the space provided, such as type of assistance needed.

7. Part 2: To obtain the score, auditor will count the total number of ‘No’ responses for each patient.

Part 1: General observations of unit mealtime activity

Date of audit: _____________________________ Name of auditor: _____________________________

Which meal?  ❑ Breakfast  ❑ Lunch  ❑ Supper

Time auditor arrived on unit (e.g., 12:00 p.m.): _____________________________

Type/Unit (e.g., medical, surgical or name): _____________________________

Number of beds filled: _____________________________

Time meal truck arrived on floor: _____________________________ Time tray distribution started: _____________________________

Time tray distribution completed: _____________________________ Time of truck removal: _____________________________

Comment on the unit readiness for the meal and any delays/challenges that might influence the patients’ perceptions of the meal.

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________
### Part 2: Questions to ask patients...

#### How was your meal?

On a scale of 1 to 10 (1 is low and 10 is high), how important is your food and fluid intake (in hospital) to your recovery?

On a scale of 1 to 10, how much importance did staff place on your food and fluid intake?

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-rating</strong></td>
<td><strong>Staff rating</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

1. Did the meal come at an appropriate time for you?  

2. Did you get the food that you ordered (if applicable)?  

3. **a)** Did you have all of the food/drink items you wanted during this meal?  
   **b)** If you requested other items, did you get them? **N/A if none requested**

4. Was your meal appetizing (presentation and aroma)?

5. Were hot foods served hot?

6. Did you need help being positioned comfortably prior to eating, AND if so, was help provided? **N/A if no help needed**

7. Did you have everything you needed in order to eat/drink comfortably (such as your glasses, dentures, etc.)?

8. **a)** Were you able to reach your meal tray?  
   **b)** Were you able to open your food packages, OR did you get help to open packages?

9. **a)** Are you able to eat your meal without help (from staff or family)?  
   **b)** If staff helped you, did you get help when you wanted it? **N/A if no help provided by staff**

10. Did you have enough time to eat your meal?

11. Were you visited by staff mid-meal to see if you needed anything?

12. *If tray is untouched, ask:* did staff offer you any other food to eat?  
    **N/A if some items eaten**

13. Are you suffering from constipation, AND if so, have you been offered anything to manage it?  
    **N/A if no constipation**

14. Were you offered help to use the washroom before mealtime?  
    **N/A if no help needed**

15. Are you experiencing any symptoms like pain or nausea, AND if so, have you been offered anything to manage them?  
    **N/A if no symptoms**

16. Were you able to eat your meal without interruptions (e.g., doctor, nurse, physical therapist visiting)?

17. Was your meal free from noise, cleaning or other disturbances?

**Total of NO responses – a higher score indicates more barriers to the meal**

Is there anything we could do to make your meals better?