NUTRITION AND HYDRATION

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Introduction

This organisation believes that the provision of a healthy, nutritious and balanced diet for its residents is of vital importance. The organisation also believes that, with respect to food provided within the service or brought into the service, there is a duty to ensure that all staff and residents should be kept as safe as possible from food poisoning, and food-related illness, by the adoption of high standards of food hygiene and food preparation. This following is intended to:

- *Ensure that residents benefit from receiving food that is high quality, well-presented and prepared, and nutritionally solid*
- *Ensure that those with special dietary needs are supported*
- *Protect staff and residents from food-related illnesses*
- *Follow the NICE quality standard [QS61]: Infection prevention and control (Published April 2014).*

This organisation believes that every resident has the right to a varied and nutritious diet that provides for all of their dietary needs, and which also offers health, choice and pleasure. To accomplish this, each resident will be asked for their individual food preferences as well as their cultural, religious or health needs, and residents or their family will always be involved when planning menus and meal alternatives with them or their family.

Procedure

In this organisation the following procedure applies:

- All food will be prepared, cooked, stored and presented in accordance with the high standards required by the *Food Safety Act 1990*, the Food Safety (General Food Hygiene) Regulations 1995, the Food Safety (Temperature Control) Regulations 1995, and the Food Hygiene Regulations 2006
- Food allergens can be life threatening. This organisation will work with the resident to ensure that all food allergens are recorded in the care plan and that staff are both aware of them and check to ensure they are not present in the preparation of meals for the resident. Catering staff will follow the Food Information Regulations 2014, which came into force on 15 August 2014, especially in relation to labelling and informing residents. Staff and residents are made aware of any allergic reactions and how to respond to them. The following table indicates the most common symptoms of an allergic reaction and the parts of the body affected:

Body part affected	Physical reaction
Eyes	Sore, red and/or itchy
Nose	Runny and/or blocked
Lips	Swelling
Throat	Coughing, dry, itchy and swollen
Chest	Coughing, wheezing and shortness of breath
Gut	Nausea and feeling bloated, diarrhoea and/or vomiting
Skin	Itchiness and/or a rash

- Any allergic reaction can be life threatening; medical assistance will be sought immediately, and all emergency procedures will be followed
- Each resident will be encouraged and supported to eat three full meals each day, at least one of which will be cooked; however, if the resident prefers smaller, more frequent snacks then this will be catered for in the service provided

- Religious, personal or cultural special needs will be recorded in the care plan and will be fully catered for as required by the resident
- Menus will be created by chef, together with staff, residents and their family, if appropriate, so that the required shopping can be purchased
- In discussion with residents, menus may be changed regularly to stimulate appetite and discussion
- Special therapeutic diets will be recorded in the care plan and provided when these are advised and discussed by healthcare or dietetic staff with the resident
- It is important not to rush the mealtimes, but instead to create a relaxed atmosphere in which residents are given plenty of time to eat and enjoy their food.
- Food will be presented in a manner that is attractive and appealing
- If a resident neither wants nor eats their meal then either an alternative or a meal replacement may be offered, if appropriate; these changes should be recorded in the care plan
- Staff will help all residents to be as independent in feeding themselves as possible and will work to ensure their dignity while they are doing so. Eating difficulties will be identified within each resident's care plan and a plan of assistance agreed, involving both the resident and their carers
- The service will make whatever reasonable arrangements are necessary for a resident to be able to feed themselves with dignity and ease, including the provision of special eating aids and special food preparation; assistance with feeding will be offered in a sensitive and dignified manner, such as by the provision of finger foods
- http://collections.europarchive.org/tna/20100927130941/http://food.gov.uk/healthiereating/eatwellplate/

The model has eight key principles, which are as follows:

1. Food should be enjoyed
2. A variety of different foods should be eaten
3. The right amount should be eaten to maintain a healthy weight
4. Plenty of foods rich in starch and fibre should be included in the diet
5. Foods that contain a lot of fat should be avoided, and sugary foods and drinks should not be consumed too often
6. Vitamins and minerals in food are critical
7. Alcohol consumption should be within sensible limits
8. Menus should take into account any ethnic or cultural dietary needs of residents and should be sensitive to religious and cultural beliefs surrounding food.

For providers, this is an area where motivation and encouragement of the resident is central to the service delivery, where it is identified that the resident is making unhealthy choices.

Nutritional Screening

- Nutritional screening happens for all residents, to identify those at risk of malnutrition and to identify obesity; it is undertaken by a staff member trained to understand the process, and who liaises closely with other healthcare professionals such as dieticians, speech and language therapists, or the healthy living nurse.
- The five-step Malnutrition Universal Screening Tool (MUST) is used.
- Records are kept in the resident's plan of care.
- In this home in addition to validated screening tools such as MUST, in consideration are also the following factors:
  - A person's physical abilities (i.e. dexterity, strength to hold utensils, cups, etc.)
  - Mental abilities such as if a person can realise the need for nutrition
  - Mental state, such as depression, suicidal tendencies, etc.

<table>
<tr><th>ADL 7c</th><th colspan="3">MUST: RECOMMENDED CARE PLAN</th></tr>
<tr><td>*ROUTINE CARE
(MUST SCORE = 0, low risk)</td><td colspan="3">➢ No intervention required
➢ Repeat assessment in 4 weeks (a month)</td></tr>
<tr><td rowspan="2">**OBSERVE
(MUST score = 1, medium risk)</td><td>COMMENCE ORAL FOOD INTAKE RECORD FOR 3 DAYS</td><td colspan="2">A IF ORAL FOOD INTAKE IS <u>MORE</u> THAN HALF OF MEALS
☑ encourage oral intake to ensure all meals are completed + snacks are offered between meals.
☑ no further intervention required
☑ discontinue oral food intake recording
☑ repeat assessment of risk in 4 weeks (in a month)</td></tr>
<tr><td>REVIEW ORAL FOOD INTAKE AFTER 3 DAYS</td><td colspan="2">B IF ORAL FOOD INTAKE IS <u>LESS</u> THAN HALF OF MEALS
☑ encourage oral intake to ensure all meals are completed
☑ continue with oral food intake recording
☑ commence high calorie and high protein diet, including food fortification.
☑ encourage small frequent meals, snacks (2 per day) and home-made nourishing drinks (2 per day)
☑ review oral intake in 4 weeks (in a month)
☑ if no improvement after 4 weeks – move to <u>high risk</u> section</td></tr>
<tr><td rowspan="3">***TREAT
(MUST score ≥ 2, high risk)</td><td rowspan="3">☑ COMMENCE ORAL FOOD INTAKE RECORD
☑ COMMENCE HIGH CALORIE AND HIGH PROTEIN DIET, INCLUDING FOOD FORTIFICATION
☑ ENCOURAGE SMALL FREQUENT MEALS, SNACKS (2 PER DAY) AND NOURISHING DRINKS (2 PER DAY)
☑ COMMENCE ‘BUILD UP’ (1 sachet made with 200 ml full cream), COMPLAN (1 sachet made with 200 ml full cream), NOURISHMENT, OR ALTERNATIVES ONCE OR TWICE PER DAY IN ADDITION TO THE ABOVE.</td><td>IMPROVEMENT</td><td>☑ weight stable, increased or increased after 4 weeks
☑ continue to monitor oral intake and weight on weekly basis
☑ continue to assess nutritional risk on a monthly basis
☑ continue with current eating plan until a lower risk score is achieved</td></tr>
<tr><td>NO IMPROVEMENT</td><td>☑ losing weight (by 5% or more) or no improvement in eating after 4 weeks
☑ reinforce dietary advice (on the left) and record any improvement or deterioration</td></tr>
<tr><td>FURTHER DETERIORATION</td><td>REQUEST REFERRAL TO A NUTRITIONIST
(Use East Sussex Downs & Weald PCT formal request letter)</td></tr>
</table>

Accurate assessment of a resident's weight

a) Recording accurate body weight is a fundamental part of our residents' assessment and is undertaken by trained staff using the appropriate equipment. There are 5 key points:

- Recording accurate body weight is a fundamental part of nutritional screening
- Measuring body weight is vital for accurate prescribing of some medication and monitoring of fluid gain(oedema)
- It is important when admitting residents for whom specialist equipment, such as profiling beds for pressure relief, may be needed that there is an accurate and ongoing record of their weight
- Weighing scales must be calibrated each year and as part of the health and safety audits
- Staff must be trained and monitored to show they are competent in using weighing equipment correctly

b) While anyone admitted to a health or care setting who is unwell could be considered to be at risk of malnutrition, certain other groups also pose a definite risk and should be identified early. These include:

- ⚠ people with existing acute and long-term conditions such as chronic obstructive pulmonary disease

- ⚠ people with long-term, progressive conditions such as dementia and cancer
- ⚠ people who have been discharged from hospital recently
- ⚠ older people in general

c) On admission as part of the initial nutritional and hydration assessment/screening the resident's consent is gained to measure and record their weight.
d) If the screening identifies weight loss or the risk of weight loss, then the resident's weight should be recorded weekly.
e) If there is no identified risk or other indication, then weight should be recorded monthly.
f) If the resident is under the care of a health professional for weight loss or obesity, then the health professional will identify the frequency for the need to weigh the resident.

Inaccurate weighing

It is important to use appropriate and accurate weighing equipment to ensure that correct weights are recorded. This will also decrease the risks of errors in diagnosis by the health professional, interventions and or treatment and medication prescription. In this home a chair-scales are used which are calibrated annually.

Weighing the resident

- ensure the scales are balanced, or display zero before weighing the resident
- ensure that no part of the weigh platform or load receptor is touching a fixed object, such as a wall
- ensure the resident's clothing is not touching any fixed part of the scales or surroundings
- when using chair scales, ensure the resident's feet are not touching the ground and that their arms are not brushing against an adjacent fixture
- when monitoring periodical weight change ensure the resident always wears clothing of similar weight

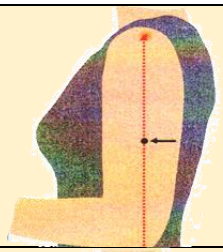
Alternatives for weighing residents

It is not always possible to obtain an accurate body weight for all residents on admission using the above equipment. The frailty of the resident may demand that in some circumstances alternative measures of recording a body weight must be considered. In such cases, staff should:

- ask the resident about their latest recorded weight
- check any previous care records
- ask their relatives for their last recorded weight
- undertake a visual assessment – does the person "look" thin? for example, are rings obviously loose on fingers
- work with dietitians and other health professionals following their advice

Care Staff are key in ensuring an accurate assessment of body weight, identifying potential risk and in the ongoing monitoring and identifying a need for the intervention by health professionals. Weight should not be considered as a one-off observation on admission but must be recognised as an important tool for ongoing assessment throughout the resident's stay and should be carried out by staff who have the appropriate knowledge, training and competencies. In this home we use MUAC:

ADL 7c	**MUAC (Mid Upper Arm Circumference)** ***(used when unable to take the weight of a person)***
	***a) ESTIMATING HEIGHT FROM ULNA LENGTH*** Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process), left side if possible

	***b) ESTIMATING BMI FROM MID UPPER ARM CIRCUMFERENCE (MUAC)*** The subject's left arm should be bent at the elbow at 90º angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.
	***c) MID-POINT ARM MEASURE*** Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug / close-fitting but not tight.
WEIGHT	***d) MUAC*** **If MUAC < 23.5 cm** — **BMI is likely to be < 20 kg / m²** **If MUAC > 32.0 cm** — **BMI is likely to be > 30 kg / m²**

ESTIMATING HEIGHT FROM ULNA LENGTH

ULNA LENGTH *(cm)*		32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
HEIGHT *(m)*	**Men (>65 years)**	1.87	1.86	1.84	1.82	1.8	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.6	1.6
	Women (>65 years)	1.84	1.83	1.81	1.79	1.7	1.7	1.7	1.7	1.7	1.7	1.6	1.6	1.6	1.6
ULNA LENGTH *(cm)*		25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
HEIGHT *(m)*	**Men (>65 years)**	1.65	1.63	1.62	1.60	1.5	1.5	1.5	1.5	1.5	1.5	1.4	1.4	1.4	1.4
	Women (>65 years)	1.61	1.60	1.58	1.56	1.5	1.5	1.5	1.5	1.4	1.4	1.4	1.4	1.4	1.4

Further Guidance

NICE guidelines [CG32]: Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition (Published February 2006). NICE Quality Statement [QS24] Nutrition Support in Adults:

Statement 1. People in care settings are screened for the risk of malnutrition using a validated screening tool.

Statement 2. People who are malnourished or at risk of malnutrition have a management care plan that aims to meet their nutritional requirements.

Statement 3. All people who are screened for the risk of malnutrition have their screening results and nutrition support goals (if applicable) documented and communicated in writing within and between settings.

Statement 4. People managing their own artificial nutrition support and / or their carers are trained to manage their nutrition delivery system and monitor their wellbeing.

Statement 5. People receiving nutrition support are offered a review of the indications, route, risks, benefits and goals of nutrition support at planned intervals.

https://www.nice.org.uk/guidance/QS24/chapter/List-of-quality-statements

Training Statement

All new staff should be asked to read this policy as part of their induction process. All staff undertake training in nutrition, the provision of a healthy balanced diet, food handling, in aiding residents with eating difficulties and the importance of accurate recording of the resident's weight.

Related Policies

Adult Safeguarding
Assessment of Needs
Care and Support Planning
Consent
Food Hygiene
Meeting Needs
Prevention of Pressure Ulcers

Appendix 1

PROJECT TACKLES WIDESPREAD DEHYDRATION IN CARE HOMES

A workshop, was delivered by the Leicester City Care Home Dietetic Team, covered the signs and symptoms of dehydration and malnutrition and explained ***how these conditions can be difficult to diagnose, in particular in older people with other health problems.*** Staff were given advice on how to avoid residents becoming dehydrated through building a regular intake of food and fluid into their care plans and they were also given examples of ways to monitor this.

Chris West, Director of Quality and Nursing at the CCG, said: *"**Residents who live in nursing homes are particularly at risk of developing dehydration because some of them already have complex health needs which can mask the symptoms.** Introducing this programme means we can increase the skillset of our nurses working in nursing homes to keep residents safe, well and supported"*.

Four Tips to Prevent Dehydration

1. **Understand the signs of dehydration:** All care home staff should understand the signs of dehydration so that prompt remedial action can be taken. Ensure your team know that any of the following signs should be reported immediately:
   - dry mouth and lips;
   - inelastic skin;
   - increased drowsiness;
   - dizziness;
   - low blood pressure;
   - constipation or dark,
   - concentrated urine.
2. **Place high risk residents on 'fluid watch':** Any resident identified as being dehydrated or at increased risk of dehydration should be placed on 'fluid watch', which means your team should be taking special measures to improve and monitor fluid intake. Staff should identify residents on fluid watch as being at high risk and for each individual, they should maintain a specific hydration care plan and a fluid balance chart.
3. **Promote morning hydration:** Overnight fluid loss and lack of intake whilst sleeping can mean that older people are at their highest level of dehydration in the morning. Aim to encourage 700-800ml of fluid intake by the end of breakfast and make the most of 'high contact' times when personal care is being carried out and fluid intake can be encouraged.
4. **Be creative with fluids:** Water, squash (though I'm not sure about squash as it is just sugar and makes people thirstier) and hot drinks will all be helpful in promoting hydration, but some residents may resist drinks due to a fear of incontinence or increased visits to the toilet. Consider other methods of improving fluid intake such as soup, ice lollies or ice cream, all of which can add to the volume of fluid consumed throughout the day.

Appendix 2

THICKENERS

Thickening agents such as Nutilis and Thick and Easy are commonly used by staff to modify the consistency of fluids provided to people with swallowing problems. However, reported incidents of choking, aspiration and other near misses suggest that staff often lack training about their use and they fail to understand the importance of providing the correct consistencies that are required.

Unsafe practice by your staff in the use of thickening agents can present life threatening risks to your service users. However, these can be avoided by ensuring that you provide appropriate training to all staff who use these products. Read on to find out the essential information every member of your team should know.

How to Prevent Choking by Using Fluid Thickeners Correctly

Fluid thickeners are most often prescribed for service users with swallowing difficulties caused by strokes, progressive neurological conditions or later stage dementia. They should only ever be used as

prescribed by the person's GP or Speech and Language Therapist. In every case, the person's care plan should provide explicit instructions in its use.

Five Key Steps for the Safe Use of Fluid Thickeners

1. **Follow Specialist Advice:** The Speech and Language Therapist treating the person in your care will have based their recommendation on their own assessment of the person's needs. Ensure that you always follow their instructions in order to reduce the risks to your service user.

2. **Recognise the 3 Standard Fluid Consistencies:** Be aware of the difference between the 3 standard consistencies that Speech and Language Therapists use to describe thickened fluids:

   Stage 1: Syrup consistency: fluids should be prepared so that it:
   - Can be drunk through a straw
   - Can be drunk from a cup
   - Leaves a thin coat on the back of a spoon.

   Stage 2: Custard consistency fluid: fluid should be prepared so that it:
   - Cannot be drunk through a straw
   - Can be drunk from a cup
   - Leaves a thick coat on the back of a spoon.

   Stage 3: Pudding / Puree consistency fluid: fluid should be prepared so that it:
   - Cannot be drunk through a straw
   - Cannot be drunk from a cup
   - Needs to be taken with a spoon.

3. **Measure Accurately:** Take care to measure the quantities of fluid and thickener accurately. If incorrect amounts are used, the fluid may not reach the required consistency and the risk of aspiration or choking is increased.
4. **Allow Time to Act:** Drinks should be allowed to stand for the recommended time stated on the instructions to make sure they reach the correct consistency before use. The effect of thickening powders is not instant and it can vary from product to product. Never just add more thickener if the consistency appears too thin.
5. **Dispose and Start Again if Unsure:** If the drink appears too thin, too thick or unusually lumpy, throw it away and start again rather than attempt to use it. It's always safer to start from scratch rather than experiment.

Appendix 3

HOW HOT SHOULD TEA / COFFEE BE? OR FOOD?

Health and Safety Adviser: from a health and safety point of view there is no temperature recorded or written that gives any guidance, so on this one common sense prevails. "The ability to judge **the temperature of drinks and food can become difficult for people with dementia**. ***A recommendation would be to ensure that food and drink are not too hot or too cold.*** **Make a reasonable judgement and be cautious.** ***If the cup feels too hot then the liquid within it will be. Equally if the cup is cold then the fluid within will be unpalatable. Always listen to the person for feedback when they are eating and drinking. If they indicate there is something wrong with the food or drink investigate why and respond accordingly".***

IF MUSIC BE THE FOOD OF LOVE…

5th February 2016 | Categories: Adult Social Care , Care Planning , Dementia , Food & Nutrition

Poor nutrition is commonly experienced by people with dementia. *So it was with interest this week to see a new initiative from the Imperial College Healthcare NHS Trust for the provision of specialist support to dementia patients to ensure that they are eating and drinking enough. The programme, Dementia Nutrition Support in Hospital Pathway (known as NoSH), has 3 levels and aims to provide a tailored response to individual needs.*

Pathways for nutrition support in patients with dementia

In NoSH, all patients admitted with dementia are placed on the first level of the programme: core support. This includes having their weights monitored, foods and fluid recorded and access to special snack boxes. For patients that require more support 'enhanced' and 'intensive' levels of the programme provide:

- **one to one support for dementia patients who struggle to eat and drink**
- **regular reviews**
- **development of eating and drinking goals for the patients in conjunction with the family and nursing team**
- **provision of 5 smaller meals, which can be easier for some people with dementia to manage than the traditional 3.**

Music and food intake: is there an association?

The provision in the programme was the use of music during meals. Can playing music really stimulate nutritional intakes?

Looking at scientific research, several studies have demonstrated the calming effect of music on service users with agitation and anxiety related to dementia. However, fewer studies have directly measured the effect of music on meal intake in long term care settings.

- *In a study of 27 nursing homes, it was reported that residents with dementia increased the percentage of the meal consumed by around 10% when relaxing music was played in the dining room with the evening meal over a 4 day period. However, the study was limited by short duration and estimation, rather than a weighed measure, of food intake.*
- *In another study involving 12 nursing home residents with Alzheimer's disease, researchers played familiar music during the midday meal every other week for 8 weeks, and meal intake was compared for music vs no music weeks. The authors reported an increase of 20% in calorie intake when the music was played. In this study, musical preferences were determined by obtaining input from family members. Interestingly it was suggested* ***that it was the familiarity of the music****, rather than the relaxation quality, that contributed to the significance of the results.*
- *And in a charming report from the Slough Public Health team on the Sing for Life programme in 6 care homes, they noted that therapeutic singing increased the weight of those participating in structured singing sessions.*

This evidence is clearly limited but music or singing may be worth trying as part of a range of interventions to increase nutrition intake for people with dementia in care home settings. What is also worth considering is whether any parts of the NoSH Programme are not currently in place in your care homes and whether they perhaps should be.

Ayela Spiro, British Nutrition Foundation, QCS Expert Nutrition Contributor