Best Practice Guidance

FOOD & NUTRITION in Care Homes for Older People

Section 6

Assessing and monitoring dietary needs

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Assessing and monitoring dietary needs

This section contains guidance on how to assess, record and monitor residents' food and drink intake and what to do when there are concerns.

Contents

Malnutrition

Malnutrition is a state of nutritional deficiency (under nutrition) or excess (over nutrition) of nutrients such as energy, protein, vitamins and minerals. Malnutrition causes health problems which can affect the composition and function of the body with serious consequences.
For the purpose of this section the use of malnutrition will refer to under nutrition.

When people are malnourished, this affects their basic health and well-being, which makes it an important safety issue.

Older people may have reduced energy requirements but the need for other nutrients is the same so they need a high quality diet rather than more quantity. This is especially important if appetite is also poor and food intakes are less.

Initial assessment of dietary habits

Section 1 already highlights the importance of preventing malnutrition in the residents that you care for, as the effect on health and well-being can be great. One of the first steps in preventing malnutrition is to ask all new residents about their usual eating and drinking habits to see if they have any current problems. This should include asking a resident about their:

- usual meal and drink pattern and timings;
- eating and drinking likes and dislikes;
- cultural/ethnic/religious requirements;
- preferences for mealtime environment;
- physical or sensory difficulties with eating and drinking;
- ability to communicate their food and drink preferences;
- the need for adapted cutlery or assistance to help with eating and drinking.

Also if there are any other specific requirements such as:

- a special diet for a medical condition;
- specific food allergy
- a texture modified diet
- the need for food fortification

This should also form part of their personal plan.

Once a full history of a resident's dietary needs is known, this should be regularly reviewed and also re assessed when there are any concerns about their intakes.

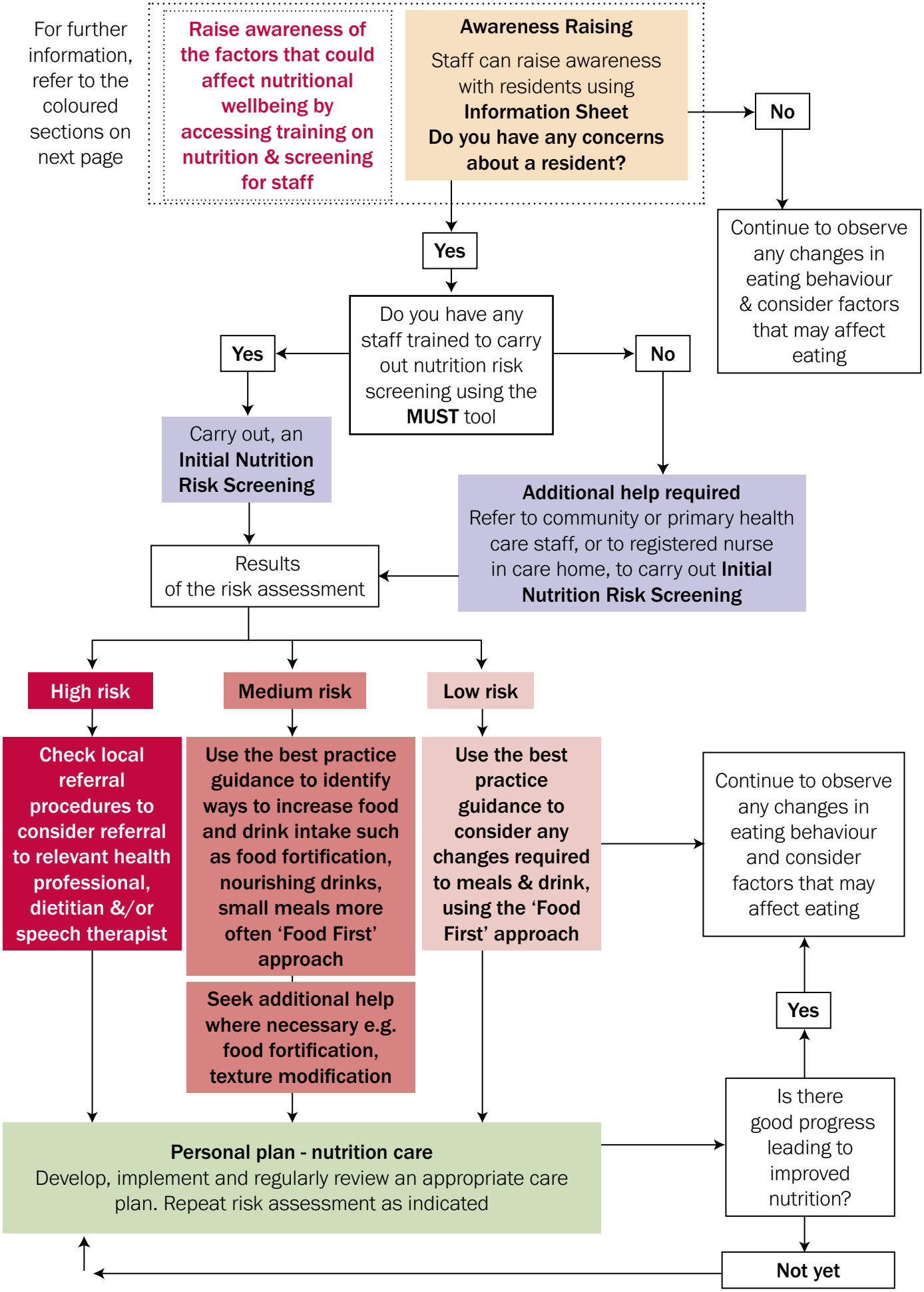
In addition, residents should receive a full mouth assessment carried out by a dentist within a week of arriving in the care home, to inform the plan and to ensure they are able to eat and drink a full range of menu choices.

Pathway for the management of malnutrition in a care home setting

The following section and diagram 1 outlines a nutrition pathway and the key questions and decisions to make when you have concerns about a resident's food and drink intake.

The long-term aim is to restore the person to the point where they can be independent and manage themselves as far as possible.

Diagram 1 – Pathway for the management of malnutrition in care home settings



Awareness raising

All staff in a care home setting should be looking out for the signs that a person has difficulties with eating and/or drinking, or is losing interest in food. Even if there are no immediate causes for concern, prevention is better than cure. You should take regular opportunities to talk with residents and raise their awareness of the importance of eating and drinking and discuss any problems that may arise. This may be due to the type of food being consumed or the quantity, a difficulty with eating, a loss of interest, or ill health. Starting a discussion about food, in a sensitive way, raising awareness and looking for the warning signs, are all part of quality care. The **Awareness raising Information Sheet** may help with those conversations.

Having a conversation about the menu choices, meal times and social aspects of eating may help you to identify any potential problems with eating and drinking. Talking to relatives, when a resident has less capacity to be able to express their feelings and thoughts about food and drink, may also be helpful.

If you feel that the resident would benefit from having small amounts of food more often or enriching food, refer to the **food first** and **food fortification** section 2A. Simple encouragement at meal times, support from relatives or assistance with meals, may also help. Also refer to Section 4 which provides tips on assistance with eating.

If you are very concerned about the food and drink intake of a resident and what you have put in place is not having the desired result, you will need to contact a health professional. Refer to your local policies and procedures for identifying when to involve a health care professional and where necessary refer to a dietitian.

Always ensure that any information about difficulties in eating and drinking and specific needs are obtained from another setting e.g. when residents have been discharged from hospital, transferred from another setting or arriving from home. Often if people have been staying in their own home for as long as possible, their nutrition and hydration are likely to be at risk.

Awareness raising – Information sheet

Is a resident you care for at risk of malnutrition?

Eating and Drinking less

Have you observed a change in eating and drinking? Eating and drinking less, not being able to finish meals or leaving meals can lead to unbalanced or inadequate nutrition.

Risk factors for malnutrition for residents living in a care home include:

Major life events

Ask about any recent events that may have a big impact on mood, mental wellbeing and may have affected food and drink intakes. These events may include the reason for being in the care home and the big change in surroundings, a bereavement, illness, surgery or falls.

Independence

People who lose independence may be less able to take an active part in the social aspect of mealtimes. This can happen in a care home if a resident is not enabled and encouraged to retain their independence as long as possible. Independence may be limited by changes in eyesight, stiffness, pain, weakness, confusion, falls or lack of confidence. Residents may also be less able to express their choices.

Health and illness

Difficulty chewing or swallowing, pain, indigestion, constipation, diarrhoea, forgetfulness, depression and breathlessness are all symptoms that can affect the desire to eat and drink.

Weight changes

Losing weight without trying to is a sign of eating less than needed. Indications of weight loss include clothes, rings and even dentures becoming looser.

Tips on how to spot weight loss and poor nutrition – look for the following signs

- A poor appetite or reduction in usual appetite.
- Clothing, jewellery, dentures becoming loose.
- Tiredness, loss of energy, muscle weakness
- Reduced physical performance and greater risk of falls.
- Constipation.
- Altered mood and changes in behaviour.
- Poor concentration.
- Poor wound healing.

These may be symptoms of other things or be exacerbated by not eating.

If you think a resident may not be eating enough then this can be monitored using a food intake chart – see Appendix 3 All Wales Food Chart.

Preventing dehydration

Every day observations have been shown to be inaccurate in detecting signs of dehydration. It is always best practice for nursing and care staff to focus on supporting residents to drink what they require to keep hydrated. Make sure you have a good plan in place to ensure that all residents are offered regular drinks and are supported and prompted when necessary. See Section 3 for more on drinking and hydration.

If you think a resident may not be drinking enough then this can be monitored using a fluid intake chart or self-assessment.

Initial Screening of nutritional risk

Screening for malnutrition should be regularly performed to identify the level of risk to each resident. Care homes in Wales are recommended to use the Malnutrition Universal Screening Tool (MUST) for community nutritional screening. This is a simple 5 step screening tool which helps to identify adults who are underweight and at risk of malnutrition. Work is ongoing to add some additional questions to the tool which is called MUST 'plus' – to make it more appropriate for use across the whole community including care homes in Wales.

The BAPEN 'MUST' resource pack contains all the information you need to undertake MUST screening including on how to measure weight and height accurately: www.bapen.org.uk/musttoolkit.html.

Practice point

You may be able to undertake **Initial Nutrition Risk Screening** yourself if you or your staff are trained in the process. Otherwise you may need to refer to community or primary health care staff, or to a registered nurse in the care home, to carry out. Check the local policy or procedures.

Results of the nutrition screening

Low risk

Identifying someone as low risk should not be a major concern, but that does not mean that no action is required. As with medium risk, the key is to act early to prevent any further deterioration and enable the person to eat and drink the required amounts independently. Repeating the screening at the regular, suggested intervals is important to identify any deterioration. Follow the advice in this guidance to assist with helping the person to eat well and for them to manage on their own.

Medium risk

It is important to take quick and decisive action to prevent further problems.
People identified as medium risk are likely to have had poor food and drink intake for a few days, may have difficulty in eating unassisted and this may be made worse by dementia or other conditions.

It is important to ensure adequate fluid and food intake. See the advice on 'Food First' in Section 2A of this guidance, and the nutrition care plans for medium risk individuals .

Food may need to be fortified and given in smaller amounts with nutritious snacks throughout the day.

Individuals should be assessed for any physical problems that affect their food intakes, such as poor oral health, ill-fitting dentures, difficulty grasping and holding utensils.

Any changes in existing medical conditions that affect food intake may need to be assessed by a health professional.

Repeating the screening at the regular, suggested intervals is important to identify any deterioration which may result in further increased risk.

High risk

If screening reveals that the person is in the high risk category but that the condition does not appear to require immediate hospitalisation, you should check local referral procedures which may recommend an immediate referral to a dietitian in the local Health Board. It may also be necessary to refer to the Speech and Language Therapy department, if there are any swallowing difficulties.

Personal Plan – Nutrition care

It is important to obtain any support required from relevant healthcare professionals, as part of devising an appropriate plan for nutrition care.

Appendix 1 contains sample nutrition care plans for high and medium risk levels identified by the nutrition screening tool. It lists the sorts of conditions and signs to look out for. Some of these are simple observations (e.g. appearance, fatigue, struggling with eating and drinking) whereas others may require simple measurements of weight loss and body mass. It also suggests what should be included in a care plan for each risk level, in order to restore the person's nutritional health. Always remember to observe and assess both food and drink intakes.

Nutrition care plans should be supported by an oral health risk assessment, there is an all Wales oral health risk assessment as part of the Gwên am Byth programme for care homes – see Section 2.

Processes must be in place to ensure nutrition care plans are written which include goals to achieve and regular monitoring of progress, with clear arrangements for recording.

Nutrition care plans may be adjusted on the advice of a health care professional. It is important that if specific recommendations about food and fluid intakes are made, a named member of staff takes responsibility for agreeing how this will be recorded in the care plan. The health care professional may provide their recommendations within your care home record keeping and/or by letter but may not necessarily specifically amend the individual care plan.

End of Life care

If an individual is receiving end of life care their needs will be very different and comfort and quality of life are the main priorities. See section 4 for nutrition and hydration care in these circumstances.

It should be stressed that, if through your observation and relationship with the resident you are made aware that their health is at severe and immediate risk due to malnutrition, seek help straight away. This might be a conversation/referral with the GP, NHS Direct or the care home senior nurse.

Progress and monitoring

If a person has a nutrition care plan in place this should be actively monitored, reviewed, and adapted as conditions change.

Regular weight checks, repeated screening, and the use of food and fluid charts, will help to monitor progress.

Residents at risk of being malnourished should have a food record chart and staff should be taught how to record accurate food and drink intakes with reference to visual food and drink portion sizes. See Appendix 2 & 3.

Close monitoring and updating the care plan will help you to track any progress. Such progress may be from high risk to medium, or from medium to low and, over time, it is hoped that the progress will be sufficient for the person to retake control of his or her own nutrition.

If the progress is slow, or your assessment reveals a need to continue with the chosen care plan, then communicate this to all staff around the person and carry on with the regular monitoring and reviews.

All Wales food and fluid charts can be found in Appendix 4.

When recording intakes it is important to record what is not eaten and drank and also, when and why, so that action can be taken and it can be corrected. Observing changes in behaviour at mealtimes can provide useful information on what needs to be introduced. For example, consider the following observations and related interventions in Table 1. These are particularly relevant for residents with dementia.

Practice point – record keeping

Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017, record keeping requirements:

- The record keeping requirements are set out in schedule 2 to these regulations. There is a requirement to record the care provided, which includes daily records.
- The requirement is for each person to have a personal plan, which sets out how an individual's care and support needs will be met on a day to day basis and how they will be supported to achieve their personal outcomes.
- These can include recording about individual food and drink needs.
- The personal plan can include dietary preferences and dislikes, allergies and specific nutritional needs.
- The nutrition care plan can document any specific dietary needs, support or assistance required and monitoring of food and drink intakes.

Table 1 Observing behaviour at mealtimes

Observation	Intervention
Food left uneaten or refused	• Offer smaller portions, smaller plate, more often with snacks • Check texture is suitable • Check likes and dislikes • Any changes in medication affecting appetite or taste? • Check if need assistance • Can they see/reach the food offered? • Have they recognised that there is a meal for them to eat? • Simple prompts/encouragement may be all the assistance required
Poor fluid intake	• Prompt and encourage regularly (this may need to be more often in hot weather) • Offer a variety of drinks, as well as usual favourites • Offer foods with high water content • Residents may need reassurance that drinking more will not worsen incontinence. See Section 5 hydration
Walks around during mealtimes	• Ensure mealtimes are calm and there are not too many distractions • Provide grazing menus or lunch boxes with finger foods • Take a walk before a meal, sit with residents to model eating • Offer more food/second helpings or additional snacks on occasions when eating well and not walking around • Consider if the walking is purposeful – for example, do they usually like to wash their hands before a meal? Can this be included in their routine earlier
Difficulties chewing or swallowing	• Use verbal cues and encouragement • Consider referral to a dentist and/or speech and language therapist as indicated • Ensure plenty of time available to eat before clearing plates • Consider how to keep food warm if taking a long time to eat
Difficulty using cutlery or drinking utensils	• Place crockery in hands • Offer finger food or assist with cutting food • Provide adapted crockery and cutlery • Consider “hand over hand’’ support
Distracted from eating	• Ensure mealtimes are calm • Make sure they have everything they need, glasses, dentures, glass of water • Verbal or manual clues • Sit together and model eating
Hoards or hides foods	• Serve smaller portions and more often • Consider why they may be hiding these items and whether reassurance could help – are they embarrassed that they couldn’t finish the meal? Are they afraid they may be asked to pay for food? Do they like a snack later in the day?

Acknowledgement – adapted with kind permission from ‘Eating and drinking well with dementia’ Bournemouth University www.bournemouth.ac.uk/nutrition-dementia.

Identifying those at risk so all staff can be alerted

Ensure that all processes are in place to support the resident and monitor progress and all staff are aware. For example, how do you alert other staff that:

- Screening is due monthly (depending on risk level)?
- Weighing is required weekly (depending on risk level)?
- A food record chart needs to be completed?
- A resident needs a specific texture modified diet?
- A resident only likes drinking weak tea?
- A resident needs extra snacks?
- There has been a change to the nutrition care plan?
- The cook or chef has been instructed to fortify foods and/or drinks?

Some of the ideas below may help

- Use of colour coding charts or clip boards, for example:
  - = high risk
  - = medium risk
  - = low risk
- A communication book to exchange ideas with kitchen staff when they are not on duty
- Enabling chefs and cooks to talk to residents on a regular basis about menu choices, and have tasting sessions
- Yellow lids on water jugs to identify those needing more encouragement or assistance with fluid
- Coloured place-mats to indicate that encouragement or assistance with food is required
- Consider the resident's confidentiality and dignity. For example place notice boards in kitchen area and away from public areas.

Meeting residents needs

Guidelines to improve nutritional intakes is covered in section 2 under Food First approaches and Food Fortification.

Accessing training

Information about training for care home staff is included in Section 7.

Contact the Dietetic department in your local health board about training on the 'MUST' tool and other nutrition training and updates.

Note: Appendix 1 contains a sample personal plan for nutrition care for an individual identified as being at high risk of malnutrition or medium risk following nutrition risk assessment.

These can be used as a guide or you may refer to local procedures and plans.

Appendix 1: Resources to support health professionals: Risk Classifications

Sample Nutrition Care Plan – High risk

Name:	Date:	
Identification of risk category		
High Risk: • Poor dietary intake >5 days • &/or swallowing/chewing problems • &/or inability to feed themselves **Plus:** • Poor mental state due to dementia • Thin/emaciated &/or unintentional weight loss >10% in 3-6 months • Compounding concerns increasing nutritional requirements, pressure ulcers etc • Recent surgery or discharge from hospital		
Aims of nutrition care plan		
• To improve nutritional status and reduce risk score • Promote achievement of desirable weight • Improve patient's oral intake		
Nutrition Care Plan	**Review Date**	**Signature**
Intakes		
Implement Food First approach. **Note any specific likes and dislikes and alert relevant staff in line with local procedure.**		
Provide snacks between meals.		
Provide homemade nutritious drinks.		

	Review Date	Signature
Ensure any assistance required for eating and drinking is provided. **Describe support required below:**		
Ensure any recommendations regarding food and fluid texture modification are followed. **Note the recommendations below:**		
Ensure any specific advice for eating and drinking is followed i.e. positioning advice or strategies to help the swallow. **List relevant strategies below:**		
Assessments		
Weigh weekly and record as per local procedure.		
Undertake Oral Health Risk Assessment.		
Use food and fluid charts to record food and drink intake for at least 3 days. Use the All Wales Food and Daily and Weekly Intake and Output Charts. **Consider if these indicate any further specific intervention and record below:**		
Repeat screening after 1 month: • If score improved, continue regime for a further month, then gradually reduce food fortification.		
If no change or deterioration consider specialist treatment below: • Consider offering over-the-counter nutritional supplements or discuss with the GP the short-term prescription of the locally agreed first line nutritional supplement. • Refer to Dietitian for more detailed assessment/advice.		

Nutrition Care Plan – Medium risk

Name:	Date:

Identification of risk category

Medium Risk:

- Poor dietary intake >5 days
- &/or swallowing/ chewing problems
- &/or inability to feed themselves
- Poor mental state due to dementia

Aims of nutrition care plan

- To improve nutritional status and reduce risk score
- Promote achievement of desirable weight
- Improve patient's oral intake

Nutrition Care Plan	Review Date	Signature
Intakes		
Implement Food First approach. **Note any specific likes and dislikes and alert relevant staff in line with local procedure.**		
Provide snacks between meals.		
Provide homemade nutritious drinks.		
Ensure any assistance required for eating and drinking is provided. **Describe support required below:**		

	Review Date	Signature
Ensure any recommendations regarding food and fluid texture modification are followed. **Note the recommendations below:**		
Ensure any specific advice for eating and drinking is followed i.e. positioning advice or strategies to help the swallow. **List relevant strategies below:**		
Assessments		
Undertake Oral Health Risk Assessment.		
Weigh weekly*.		
Use food and fluid charts to record food and drink intake for at least 3 days. Use the All Wales Food and Daily and Weekly Intake and Output Charts. **Consider if these indicate any further specific intervention and record below:**		
Repeat screening after 1 month: • If score improved, continue regime for a further month, then gradually reduce food fortification. • If no change, continue this regime, reassess monthly, then if remain stable reassess quarterly. • If deterioration, follow HIGH RISK.		

* Weigh weekly – if unable to weigh patient mid upper arm circumference (MUAC) can be used as an alternative to help assess/monitor nutritional status MUAC >23.5cm is likely to mean BMI is less than 20kg/m^2.

If really concerned about a person's swallow consider referral to Speech therapist.

If really concerned about a person's nutritional status consider referral to a Dietitian, following local referral procedures.

Appendix 2: Meal and portion size guide

Siart Cofnodi Bwyd
Food Record Chart Guide

GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

Diben yr wybodaeth hon yw eich helpu i roi gwybodaeth gywir am faint prydau ar Siart Bwyd a Hylif Cymru Gyfan ar gyfer Lleoliadau Cymunedol. Cyfeiriwch at y lluniau isod wrth lenwi'r Siart. Rhaid cofnodi pob math o fwyd a gymerir yn gywir.

This information is designed to help you with accurate documentation of portion sizes on the All Wales Food and Fluid Chart for Community Settings. Please refer to the photographs below when completing the Chart. All food intake must be recorded accurately.

Maint Prydau / Meal Sizes

Bach / Small | Canolig / Medium | Mawr / Large

Pwdin / Dessert

Faint ohono gafodd ei fwyta / Amount eaten

Dim / None | ¼ | ½ | ¾

Prif Bryd / Main Meal

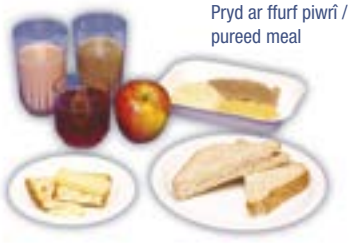
Faint ohono gafodd ei fwyta / Amount eaten

Dim / None | ¼ | ½ | ¾

Bwyd o Ffynonellau Eraill / Other sources of food

Ychwanegion maethol / Nutritional Supplements

Pryd ar ffurf piwrî / pureed meal



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Appendix 3: Fluid volume guide

Drinking vessel		Fluid Volume
Small wine glass		120 ml
Small glass		140 ml
Small cup		150 ml
Large glass		180 ml
Regular mug		200 ml
Large mug		250 ml
Pint glass		500 ml

Appendix 4: Food and Fluid

All Wales Food and Fluid Record Chart for Community Settings

Please record all Food, Nutritional Supplements, Drinks and Nourishing drinks consumed. If NONE consumed please specify the reason on the chart.

Remember to:

- Record all food and drink consumed throughout the day
- Describe the type of food e.g. beef, bread, creamed potato
- Specify the quantity and meal size actually eaten e.g. ½ a small bowl of soup
- Specify the quantity of fluid consumed

Name:	Location:	Date:	Body wt kgs:
Date of birth:	Food Chart requested by:		Date recorded:

Meal/Snack	Foods / nutritional supplements / drinks / nourishing drinks / special diets eg pureed	Amount Taken				
		Portion served (SML)	Amount eaten (None, ¼, ½, ¾, All)	Fluid consumed (mls)	Fluid Output	Action and Signature
Breakfast						
Cereal						
Milk/Sugar						
Cooked items						
Bread/toast						
Spread						
Drinks						
Mid Morning						
Snacks						
Drinks						
Lunch						
Soup						
Main item						
Potato/Rice						
Vegetables						
Pudding						
Drinks						
Mid Afternoon						
Snacks						
Drinks						
Dinner						
Soup						
Main item						
Potato/Rice						
Vegetables						
Pudding						
Drinks						
Supper						
Snacks						
Drinks						
Night Time						
Snacks						
Drinks						
Total fluids consumed in 24 hours/Total fluid output in 24 hours						
Any other nutrition						

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All Wales Food and Fluid Record Chart for Community Settings

Guidelines for Completion

- All food and fluid charts should be marked with the patient's name, date of birth and location.
- The person requesting the food chart should state how long it is required for. This document can be used for a 24 hour period. Subsequent days should be recorded on continuation sheets.
- Please record all food and all fluid, e.g. nutritional supplements, all drinks and water consumed.
- Specify the food and fluid consumed, noting if only one type of food eaten.
- Indicate the portion size – Small (S), Medium (M) or Large (L) and the fluid volume served.
- Specify the quantity of food eaten e.g. none ¼, ½, ¾ or all. When doing so please refer to the visual photographic guide for reference. Specify the volume of fluid consumed.
- If a meal is not eaten, or no fluid taken, please state the reason why e.g. refused, Nil by mouth (NBM).
- The fluid output column can be completed as appropriate e.g. wet pad or catheter output.
- Please total the fluid volume at the end of the 24 hour period.
- Specific actions required to improve food and fluid intake can be recorded in the Actions column.
- All entries should be signed.
- Please file charts in date order.