Warwickshire Nutrition and Hydration Guidelines for Care Homes 2018

To be used in conjunction with the Warwickshire Nutrition and Hydration Standards for Care Homes 2018

Endorsed by:

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Introduction

These guidelines are a practical tool for care home managers and staff to use to ensure the implementation and delivery of the Warwickshire Nutrition and Hydration Standards for Care Homes 2018.

The guidelines have been developed with health and social care partners from across Warwickshire to enable the promotion of good nutrition & hydration in care homes.

If you have any comments or suggestions about these guidelines they would be gratefully received. Please contact: Anne Davidson, Dietetic Service Manager, South Warwickshire NHS Foundation Trust. anne.davidson@swft.nhs.uk

South Warwickshire NHS Foundation Trust Dietetic service offers a range of training opportunities for staff who are responsible for the implementation of the standards & guidelines. Please contact the department information on training available dietitians@swft.nhs.uk.

Guidelines for implementing Warwickshire Nutrition and Hydration Standards for Care Homes

Where the service / setting is the sole provider of nutrition and hydration such as residential and nursing care settings (i.e. including residential & nursing homes, hospices, supported living).

Standard 1 - Meeting Nutritional Needs of Residents

Guidelines for Implementing Standard 1

1.1 ***The staff at my care home identify my nutrition and hydration needs upon admission and update them as my needs change.***

- Care plans include nutrition screening (appendix 1), religious and cultural requirements and specific dietary needs, for example:
    - ❖ Coeliac Disease
    - ❖ Modified texture diet
    - ❖ Finger foods
    - ❖ Vegetarian
    - ❖ Weight reducing
    - ❖ Diabetes.
- Fluid requirements (including consistency) should be documented and disseminated to all relevant staff including care assistants, hostesses and catering staff. (appendix 2).
- Care plans should be updated as required and changes are disseminated to all relevant staff.

1.2 ***I am enabled to choose a balanced diet in accordance with my preferences and dietary requirements.***

- Menus are balanced (appendices 3 & 4).
- Menu cycles should be of at least 3 weeks duration to ensure a variety of different foods are offered.
- Menus should be analysed to ensure they meet the required standards and re-analysed following any significant review and alterations.
- There should be evidence of seasonal reviews and special occasions and celebrations should be incorporated into the menu, e.g. Pancake Day, Easter, Christmas, Diwali, Eid etc.
- Residents should be consulted as to the content of menus, formally when planning changes and in formally on an on-going basis.

	• Menus should meet the cultural needs of residents. • Information regarding any food allergens should be available and communicated to residents as required.
1.3	***I am provided with regular meals and snacks in line with my preferences and dietary requirements.*** • Intervals between meals should not exceed 5 hours. • The interval between the last meal offered (supper) and breakfast the following morning should not exceed 12 hours. • There is evidence that mealtimes are flexible, including choice and timing to ensure residents do not miss meals. • Nourishing snacks, drinks or alternative meals should be offered to residents who are asleep during meal times. • A range of appropriate snacks should be available to the residents 24 hours day.
1.4	***I have a range of fluids available to me to meet my hydration needs.*** • Residents should have easy access to fluids and offered drinks regularly. • Fluid charts demonstrate that residents are enabled to meet the recommended minimum 1200ml of fluids per day where appropriate. 6 x 200ml or 8 x 150ml cups / glasses (Public Health Agency [PHA], 2014). Hot beverages should be offered at least 7 times per day (British Dietetic Association [BDA], Digest 2017). • Residents should be offered a variety of hot and cold fluids each day, including water, milk, squash, tea/coffee (including decaffeinated), herbal or fruit tea. Sugar free varieties should be available. Drinks should be thickened if instructed by a Speech and Language Therapist. (appendix 2). • Hot and cold drinks should be available during and after mealtimes. • A hot milky drink should be offered before bed. Milk alternatives fortified with calcium should be supplied for vegans or people who have cow's milk / protein intolerance.
1.5	***The staff who support me receive training to understand what a balanced diet is.*** • A training record is kept demonstrating that all care, nursing and catering staff have attended training that includes: ❖ What is a balanced diet ❖ Understanding their role in promoting a balanced diet

	❖ How to support residents making suitable choices for dietary requirements. • The training should be provided by a Registered Dietitian. • Evidence of training on induction and on-going training is available. • Evidence of Making Every Contact Count (MECC) training is available and staff are able to demonstrate MECC is used in discussion with residents and their families to improve the resident and their families / visitors health. • Food safety training & records must also be available.
1.6	***The menus within my care home are analysed to ensure they meet the requirements specified.*** • Menus are analysed by competent professional i.e. a Registered Dietitian or Nutritionist. (i.e. Registered with Association for Nutrition). • There is documented evidence of the analysis that demonstrates that menus meet the minimum and maximum levels stated (appendix 3) and provide a balance of food groups (appendix 4). • Standardised recipes are followed at all times to ensure the meals provided consistently meet the expected content.

Standard 2 - The Dining Experience

Guidelines for Implementing Standard 2	
2.1	***Information relating to food provision is available and accessible to me and my family.*** • Menus are displayed and communicated appropriately using written and pictorial formats. • Residents are supported to make choices. • There is evidence that staff are aware of individual dietary requirements and can assist residents with making appropriate choices. • Information regarding any food allergens should be available and communicated to residents as required.
2.2	***I am able to choose where I wish to eat.*** • Communal dining is offered to all residents. • Staff encourage residents and / or their families to eat in the location of their choice. • All reasonable measures are taken to assist the resident to the dining area of their choice
2.3	***I am enabled to eat and drink as independently as possible.*** • Staff are aware of the support individual residents require and take appropriate action such as finger foods, appropriate cutlery, crockery and assistance. • A training record is kept demonstrating that staff assisting with mealtimes have received training in maintaining dignity through offering assistance discreetly and sensitively. • When assistance with eating and/ or drinking is required, staff should: ❖ Focus attention on assisting the resident to eat and drink safely ❖ Sit at eye level or below ❖ Give information about the food or drink being given throughout the meal. • A finger food menu that meets the nutritional requirements is available (appendix 3).
2.4	***I have access to appropriate cutlery, crockery and equipment to allow me to eat***

	and drink as independently as possible and with dignity. • Care plans are updated with individual equipment requirements. • Equipment such as adapted cutlery, plate guards, non-slip mats, clothes protectors are available and are used where necessary.
2.5	***I am positioned to promote safe eating and drinking.*** • All reasonable effort is made to assist residents into a chair rather than remaining in a wheelchair or bed during the meal. • The resident is helped into and supported in an upright and comfortable position. Support equipment is used as required.
2.6	***My mealtime is not interrupted.*** • Mealtimes are protected from unnecessary interruptions. • Residents are enabled to use the toilet before the meal. • All required staff assist with the meal service. • Sufficient staff and volunteers are available to offer residents who are unable to eat independently one to one support for the whole meal time.
2.7	***The dining area where I eat is well presented and the environment is conducive to enjoying the meal.*** • The dining area: ❖ is not cluttered ❖ has sufficient lighting ❖ is a pleasant temperature ❖ has no unpleasant smells ❖ is not overly noisy. • Residents dining in their rooms have their tables cleared. • Cutlery and condiments are available. • Hand wipes are available for those unable to wash their hands. • Sufficient time is given to allow meals to be finished. • Desserts are only served once the resident has indicated they have finished what they wish to eat of their main course.

2.8	***My food is well presented and appealing.***
	• The food smells appetising. • All food is served at an appropriate temperature. • All food is well presented on the appropriate crockery for each resident.

Standard 3 - Meeting Nutrition and Hydration Needs of Nutritionally Vulnerable Residents

Guidelines for Implementing Standard 3

3.1 ***The care home I live in uses a validated nutritional screening tool e.g. Malnutrition Universal Screening Tool (MUST) to screen whether I am at risk of malnutrition on admission and monthly as a minimum or if there is concern or my clinical condition changes.***

- Residents are screened for malnutrition risk within 48 hours of admission.
- All residents are weighed monthly as a minimum.
- Alternative measures (such as mid upper arm circumference) are only used on rare occasions where residents cannot or are unsafe to be weighed.
- Care homes have appropriate grade III weighing scales (hoist, sit down, wheelchair). A record that they have been calibrated annually must be available.
- Weight, BMI, percentage weight loss and MUST score are recorded in care plans.
- Accuracy of MUST completion is audited quarterly and an accuracy rating of 90% is achieved.

MUST training including screening method, tools, charts and care plans are available from the Warwickshire Dietetic Service.

3.2 ***The staff at my care home who undertake nutritional screening have appropriate training during induction and every 2 years.***

- A training record is kept demonstrating that staff have received training on:
    - ❖ How to obtain an accurate weight, BMI and calculate percentage weight loss.
    - ❖ How to calculate MUST score and record correctly.
    - ❖ When and how to use alternative measures.
    - ❖ When screening for malnutrition is not appropriate.
- How to develop an individualised action plan/care plan.
- The training should be provided by a Registered Dietitian.

3.3 ***I have an individualised action/ care plan relevant to my nutrition risk category and it is tailored to include my dietary needs and personal preferences.***

- Care plans to include:

	❖ An individualised action plan. Local guidance is used to determine an action plan for residents based on category of risk (appendix 1). ❖ A date for review of the action plan. ❖ Individual's preferences (gained from resident or family/friends). ❖ Evidence of discussion with the resident or their family about nutrition and hydration status and, where appropriate, agreed actions to improve well-being. ❖ Evidence of referral to appropriate healthcare professionals within 2 weeks of the referral criteria being met (e.g. Registered Dietitian, Speech and Language Therapy) as necessary. ❖ Assessment of factors that may limit intake. (appendix 5).
3.4	***If I am identified as being at risk of malnutrition food and fluid charts will be initiated to monitor my intake.*** • Charts are fully completed; recording: ❖ All food (including snacks) and drinks offered. ❖ Details of how food and drink has been fortified ❖ The amount consumed. ❖ Action taken when more than ½ a meal is refused. • Charts should be completed for a minimum of 3 days after identification of malnutrition risk using MUST. • They can be discontinued if dietary intake is adequate or has improved, but must be restarted for a further 3 days if the resident remains at nutritional risk when re checked (minimum monthly).
3.5	***Updates regarding my dietary needs are communicated to myself, my family and all relevant staff.*** • Care plans are updated if MUST risk category changes or in accordance with health care professional recommendations. • Care plans demonstrate that the resident and/or their family has been informed of necessary changes and the risks associated with following or not following recommendations. • Nutrition & hydration requirements and care plans are discussed at handover. • Catering staff are provided with up to date information relating to dietary requirements for all residents.
3.6	***Staff involved in preparing or serving my food have appropriate training on meeting my nutrition and hydration needs, as a minimum every 2 years.*** • A training record should be kept demonstrating that staff have received training

	on: ❖ Causes of malnutrition. ❖ Consequences of malnutrition. ❖ Treatment of malnutrition e.g. nutrition support, food fortification, when it is appropriate to use supplements, hydration. • The training should be provided by a Registered Dietitian.
3.7	***If I am identified as 'at risk' a high protein, high energy menu is available for me to choose from.*** • Menus are capable of providing the nutrient standards for nutritionally vulnerable adults ❖ Daily energy content of menu is 2250 – 2625kcal (BDA Digest 2017) ❖ Daily protein content of menu is 60-75g protein/day (BDA Digest 2017). The BDA Digest 2017 gives examples of how this can be achieved.
3.8	***If I am identified as 'at risk' additional nourishing snacks and / or drinks are available for me to choose from.*** • Snacks should have a minimum calorie content of 300kcal and a minimum protein content of 4g (BDA Digest 2017). • There is a choice of snacks which meet residents nutritional needs including nourishing snacks that are not milk based. • A choice of nourishing drinks is available and includes a non-dairy option: ❖ Milk shakes made with fortified milk ❖ Hot milky drinks made with fortified milk ❖ Pure fruit juices ❖ Fruit smoothies ❖ Fizzy drinks (non-diet varieties). • If more than ½ a meal is refused, a nourishing snack and/or a nourishing drink are offered. ❖ An appropriate snack or drink is provided that enables a resident to meet the requirements set out in 3.7 (appendix 3). ❖ If they are a meal replacement they should provide 15g protein and 500kcal as per a main meal.
3.9	***If I am identified as 'at risk' my food will be fortified to increase the nutritional content of my meals, snacks and drinks.***

	• Meals can be made more nourishing by adding high energy ingredients to foods. For example ❖ Use fortified milk on cereal and in tea or coffee or use to make hot chocolate, milky coffee, milkshakes and smoothies. Unless residents state a preference for semi skimmed milk, full fat milk should be fortified. If not used the reason should be documented, e.g. resident preference. Fortified milk should be made by adding 4 tablespoons in milk powder to 1 pint full fat milk. ❖ Add double cream to porridge and desserts. ❖ Melt extra butter or margarine onto potatoes and vegetables or serve them with a cheese sauce. ❖ Add full fat yoghurt, custard or evaporated milk to desserts. ❖ Add syrup, honey or sugar to porridge, cereals, puddings or stewed fruit. ❖ In general avoid foods labelled low fat, low sugar or low calorie.
3.10	***My family and I will be made aware of why I require food fortification for a high protein, energy diet, and / or nourishing snacks and drinks.***

Standard 4 - Modified Texture Diets.

Guidelines for Implementing Standard 4	
4.1	***If I require a modified texture diet I will have access to food that is the correct consistency that is appealing and meets my nutritional requirements.*** The texture of meals and snacks meets the descriptions given in the Dysphagia Diet Food Texture Descriptors (2012). • A good variety of foods of modified consistency are available according to preferences and dietary requirements, including desserts and snacks. • Meals are well presented, with a variety of colours and foods are kept separate on the plate, both at time of serving and when given to the resident. • Meals smell and taste appealing. • If a resident who is assessed as having capacity refuses to consume food and drink consistencies recommended by Speech & Language Therapist then the Speech & Language Therapist should be informed to discuss and advise on the associated risks. A record of this discussion with the person, family, GP, other relevant Health Care Professionals (HCPs) as appropriate should be documented in the care plan.
4.2	***If I require thickened fluids I will have access to fluids thickened to the correct consistency as per my Speech & Language Therapists recommendations.*** • The consistency of fluids given is that recommended by the Speech & Language Therapist (appendix 2). If a resident has capacity and refuses to consume fluid of the recommended consistency, a record of this and the discussion with the resident, GP, other relevant HCPs and family if appropriate is documented in the care plan.
4.3	***Staff at my care home have appropriate training to know how to meet my nutrition and hydration needs if I need modified texture food and fluids.*** • A training record is kept demonstrating that staff have received training regarding modified consistency diets and thickening fluids. • Staff can describe the risks of not providing an appropriate texture. • The training should be provided by a Registered Dietitian and a Registered Speech and Language Therapist.

Standard 5 - Diabetes

Guidelines for Implementing Standard 5	
5.1	***I am able to choose food and fluids that provide consistency in the carbohydrate content of meals including suitable snacks, desserts and drinks.*** • 3 meals per day are provided, 2 of these are balanced meals including a source of protein, carbohydrate and fruits and vegetables. (appendix 3). • Snacks suitable for people with diabetes are available. • A range of low calorie, sugar free drinks are available. • Desserts suitable for people with diabetes are available.
5.2	***The timing of my meals will be taken into account when my diabetes medications, including insulin, are administered.*** • Trained staff can identify diabetes medications and understand timings of these in relation to meals. • A training record is kept demonstrating that staff have received training regarding diabetes medications, timing of meals and possible snacks requirements. • Snacks suitable for people with diabetes are available. • Training is provided by a Registered Dietitian. • Staff understand when and how a referral is required to a specialist team.
5.3	***The staff at my care home are trained to support me to make suitable food and drink choices taking my diabetes into consideration.*** • Staff are trained on suitable food choices to improve and maintain good blood sugar control. • Staff are trained on how to develop an individualised action plan/care plan which helps maintain good glycaemic control. • A training record is kept demonstrating that staff have received training regarding dietary advice in diabetes. • Training is provided by a Registered Dietitian. • Evidence of Making Every Contact Count training is available and staff are

	able to demonstrate MECC is used in discussion with residents and their families to improve the resident and their families or visitors health.
5.4	***I have an individualised action / care plan which is tailored to include my dietary needs and personal preferences.*** • The care plan will identify if the aim is for the resident is to minimise risk of hypoglycaemia and/or stabilise blood sugars. • The care plan will identify the food and drink choices preferred to reduce calorie intake if needed or desired. • A food record chart is used to monitor compliance with the dietary changes.
5.5	***My diet plan is communicated to myself, my family and all relevant staff.*** • Care plans demonstrate that the resident and/or their family have been informed of necessary changes and the risks associated with following or not following recommendations. • Nutrition & hydration requirements and changes to care plans are disseminated to staff
5.6	***If I have a poor appetite and/or continued weight loss MUST screening will completed as per standard 3.0.*** • Exclude poor diabetes control contributing to weight loss. Discuss HbA1c test results with the resident, GP or practice nurse to determine if this is contributing and whether a medication review is required. • Dietary choices in standard 3.0 can be followed with appropriate modification for people with diabetes. • A choice of nourishing drinks is available and includes a non-dairy option: ❖ Milk shakes made with fortified milk ❖ Hot milky drinks made with fortified milk ❖ Pure fruit juices (150ml) with a meal to minimise effect on glycaemic control ❖ Fruit smoothies
5.7	***If I need to have oral nutritional supplements my blood glucose will be monitored closely due to the hyperglycaemic effect of some supplements. I will only be prescribed these supplements under the guidance of a Registered Dietitian.*** • Evidence of increased testing of blood glucose levels is required if a) the resident already tests blood glucose levels and b) is started on, or has an increase in oral nutritional supplements. If testing is not carried out consult with

	the persons GP to determine if it should be commenced on initiating oral nutritional supplements. • Referral to a Registered Dietitian is required for guidance on prescribing of nutritional supplements.
5.8	***My care home offers suitable food and drink choices for people who have diabetes and are overweight and encourages me to be more active as appropriate to my ability.*** • See section 6.0.

Standard 6 - Obesity

Guidelines for Implementing Standard 6

6.1 ***My care home identifies and monitors if I am overweight or obese by calculating my weight and BMI.***

- The World Health Organization BMI classification system for adults is:

BMI range (kg/m^2)	Classification
< 18.5	Underweight
18.5 – 24.9	Healthy Weight
25 – 29.9	Overweight
30 – 34.9	Obesity I
35 – 39.9	Obesity II
> 40	Obesity III

- Care homes have appropriate grade III weighing scales (hoist, sit down, wheelchair). A record that they have been calibrated annually must be available.
- Weight, BMI and percentage changes are recorded in care plans.
- Plans are revised if the residents weight changes.

6.2 ***My care home offers food and drink choices suitable for me to follow a weight reducing diet.***

- Residents needing to control their weight are given a balanced healthy diet based on the Eatwell Guide (appendices 3 & 4).
- Residents on a weight reducing diet (who are able to make choices) are able to select suitable meals from a menu.
- A range of low calorie, sugar free drinks is available.
- A range of low fat choices is available (milk, spreading fats, yogurt, etc.).
- Suitable snacks are available. (appendix 3).

6.3 ***My care home encourages me to be more active, appropriate to my ability.***

- The home identifies the activities that can be undertaken with the resident to increase their calorie expenditure and reduce the risk of pressure ulcers.

	• The care plan will identify the physical activity the resident can do to increase calorie expenditure. • If appropriate a referral to Fitter Futures can be requested.
6.4	***I have an individualised action / care plan which is tailored to include my dietary needs and personal preferences.*** • The care plan will identify if the aim is for the resident is to lose weight, maintain their weight or minimise weight gain. • The care plan will identify the food and drink choices preferred to reduce calorie intake. • A food record chart is used to monitor compliance with the dietary changes. • The care plan will identify treats and gifts for the resident that are not food based. • Discussions on appropriate snacks and drinks will take place with residents, relatives and visitors as appropriate.
6.5	***My diet plan is communicated to myself, my family and all relevant staff.*** • Care plans demonstrate that the resident and/or their family have been informed of necessary changes and the risks associated with following or not following recommendations. • Nutrition & hydration requirements and care plans are discussed at handover. • Evidence of Making Every Contact Count training is available and staff are able to demonstrate MECC is used in discussion with residents and their families to improve the resident and their families or visitors health.

Standard 7 - Nutrition & Hydration in Palliative Care.

Definitions

Palliative care is the provision of comfort and symptom relief to residents who have a life-limiting disease or condition that cannot be cured.

The nutritional care required by palliative care residents depends on the stage of their illness. Information regarding a residents medical condition should be obtained from the residents GP and if appropriate consultant or Macmillan nurse.

Early palliative care

The resident may have months or even years of life remaining, and quality of life may be good. The aim of nutritional care is to maintain good nutritional status, thereby maintaining quality of life.

Late palliative care

The resident experiences a general deterioration in their condition. Their appetite decreases and they become more fatigued. The aims of nutritional care are enjoyment of food and relief from food related discomfort.

End of life care

The resident is likely to be bed-bound, very weak and drowsy, with little interest in food or drinks. Evidence suggests that when residents are close to death, they seldom want nutrition and/or hydration, and that providing them may in fact increase discomfort and suffering.

Good mouth care, rather than attempting to feed a resident, may become the more appropriate intervention.

Standards – follow standards 1 – 6 but consider the appropriateness of interventions as per the stages for palliative care below.

Guidelines for Implementing Standard 7

7.1	**Early Palliative Care – Refer to Standard 3.** • Identify people who are malnourished, or at risk of malnutrition, by nutritional screening. (appendix 1). • Proactive dietary management can reduce or reverse malnutrition when identified. (appendix 5). • Encourage a high calorie, high protein diet if appropriate. • Continue to follow any other dietary regimen to reduce symptoms that may cause discomfort e.g. raised blood glucose levels.
7.2	**Late Palliative Care** • Discontinue nutritional screening and weighing as this is not appropriate at this stage.

	• Provide reassurance for residents and relatives that this is a normal response to their illness. • Provide treatment for reversible symptoms such as e.g. nausea, diarrhoea, constipation, dry mouth. • Focus on the enjoyment of food and drink, rather than the need to maintain a normal diet. • A high calorie, high protein diet may be appropriate for some residents; however, it may prove too stressful for others. • Oral nutritional supplements may be a psychological beneficial to some residents; however, residents should not be put under pressure to take them. • Referral to a Registered Dietitian may not be appropriate at this stage, but contact should be made if the resident, relative or staff have any concerns. • It may be appropriate to relax unnecessary dietary restrictions, e.g. cholesterol-lowering diet, diabetic diet.
7.3	**End of Life Care** • The aim of care is to provide comfort. • Food and fluid requirements decrease significantly. • Weighing residents, MUST screening and Dietetic referral are not appropriate. • Offer small amounts of food/fluid as desired by the resident. • Provide reassurance for resident and relatives that this is a normal response to their illness.
7.4	**The treatment plan is communicated to all relevant staff and family.** • Care plans demonstrate that the resident and/or their family have been informed of nutrition treatment plans. • Nutrition & hydration requirements and care plans are discussed at handover.

Appendix 1: Nutritional Management of Nutritionally Vulnerable People.

MUST Score 0 = LOW RISK

- A balanced diet should be provided that helps the resident maintain a healthy weight.
- If overweight (BMI >30kg/m^2), healthier low fat and low sugar alternatives are encouraged.

MUST Score 1 = MEDIUM RISK

The care plan is updated with an appropriate action plan to include the following as a minimum:

- At least 2 nourishing drinks and 2 nourishing snacks are provided each day that are appropriate to the resident's preference and consistency requirements.
- All relevant staff are informed of the agreed action plan.
- Food charts are kept for a minimum of 3 days. These must include snacks and drinks.
- Consider factors that may affect intake. (appendix 5)

MUST Score 2+ = HIGH RISK

The care plan is updated with an appropriate action plan to include the following as a minimum:

- At least 2 nourishing drinks and 2 nourishing snacks are provided each day that are appropriate to the resident's preference and consistency requirements.
- A high energy, high protein diet is provided.
- Consider factors that may affect intake. (appendix 5)
- All relevant staff are informed of the agreed action plan.
- Food charts are kept for a minimum of 3 days. These must include snacks, drinks and a description of how food is fortified.
- Consider a referral to a Registered Dietitian if appropriate

Appendix 2: Thickened Fluids

Stage	Description	Visual Guide
Stage I	• Forms a **thin** coat on the back of a spoon • Can be drunk from a cup • Can be drunk through a straw	
Stage II	• Forms a **thick** coat on the back of a spoon • Can be drunk from a cup • Cannot be drunk through a straw	
Stage III	• Cannot be drunk from a cup • Cannot be drunk through a straw • Give using a spoon	

Appendix 3: Meal Provision in Care Homes

<table>
<tr><th></th><th>Nutritionally Well (including vegetarians, residents with diabetes)</th><th>Nutritionally Vulnerable (including residents requiring a texture modified diet)</th></tr>
<tr><td>Breakfast</td><td>The breakfast should provide 400kcals and 10g protein.
The following should be available:
Fruit juice
Cereal and milk (minimum 100ml)
Bread / toast
Preserves
Butter and unsaturated spreads.
Where a cooked breakfast is provided, food should not be fried. Vegetables such as mushrooms and tomatoes should be offered.
Coeliac Disease:
Gluten free bread and cereal should be available according to preference. Cross contamination should be avoided e.g. separate area and utensils for preparation & cooking including separate toaster or toaster bags.</td><td>The breakfast should provide 545kcals and 16g protein.
In addition to the foods listed being provided:
Fortified milk should be used to prepare cereal, porridge and hot drinks.
Additional protein and calories can be offered with pastries, full fat yogurt or a cooked breakfast.
Food fortification methods such as adding cream, sugar, preserves and butter should be used
Food can be fried in oil for a cooked breakfast.
Fruit juice and milky drinks should be available and encouraged.
Pureed Diet:
Porridge and Weetabix should be pureed to a smooth consistency and fortified using fortified milk, cream and/ or sugar.
Pureed fruit and smooth, creamy yoghurts should be available.</td></tr>
<tr><td>Snacks</td><td>At least 2 snacks a day are recommended.

Snacks should contain 2g protein and no more than 150kcals per portion.</td><td>At least 2 snacks of the correct consistency should be offered daily.

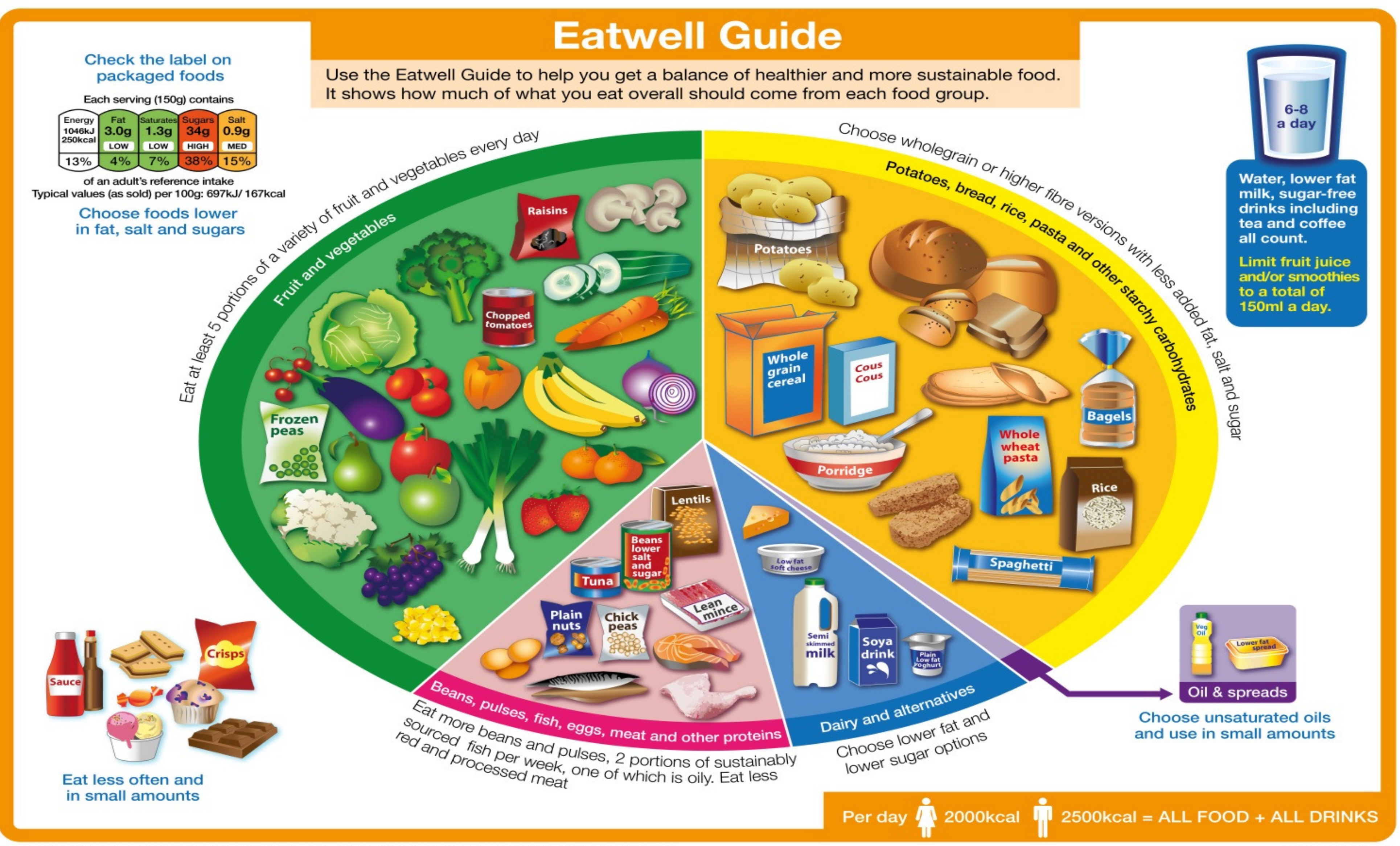
Snacks should contain at least 300kcals and 4g protein.</td></tr>
<tr><td>Milk for beverages</td><td>400ml semi skimmed milk each day should be provided.
This provides 184kcals and 14g protein.</td><td>A minimum of 400ml full fat milk should be provided, both in drinks and as milky drinks.</td></tr>
</table>

		This provides minimum 264kcals, 14g protein.
Mid day meal	A balanced meal including a source of protein, carbohydrate and fruits and vegetables should be provided. Meals (including dessert) should provide 552kcals, 15g protein. Residents with an agreed treatment plan to reduce weight should be able to choose a meal with a minimum of 300kcal, 15g protein. Suitable dessert options should be available. **Coeliac Disease:** Gluten free bread and cereal should be available according to preference. A separate toaster or toaster bags should be used to avoid cross contamination when preparing toast.	A high energy, high protein meal (including dessert) should be offered, providing 831kcals, 25g protein. The meal may be fortified with high calorie ingredients such as oil, cream, cheese and butter to meet this aim.
Evening meal	A balanced meal including a source of protein, carbohydrate and fruits and vegetables should be provided. Meals (including dessert) should provide 552kcals, 15g protein. Residents with an agreed treatment plan to reduce weight should be able to choose a meal with a minimum of 300kcal, 15g protein. Suitable dessert options should be available.	A high energy, high protein meal (including dessert) should be offered, providing 831kcals, 25g protein. The meal may be fortified with high calorie ingredients such as oil, cream, cheese and butter to meet this aim.
	Each day menus should provide: • 5 portions fruit and vegetables. • 5 portions of potatoes, bread, rice, pasta and other starchy carbohydrates. Offer wholegrain choices with meals e.g. high fibre cereals, wholemeal bread as well as white. • 3 portions of low fat milk and dairy products.	**Each day menus should provide:** • 5 portions fruit and vegetables. • 5 portions of potatoes, bread, rice, pasta and other starchy carbohydrates. Offer wholegrain choices with meals e.g. high fibre cereals, wholemeal bread as well as white.

	• 2 portions of beans, pulses, fish, eggs, meat and other proteins' group. 2 portions of fish should be included a week, 1 of which should be oily (providing omega-3 fats). • Offer and use unsaturated fats and oils where possible. • Foods with a high fat or sugar content may be offered but the emphasis will be on the groups above.	• 3 portions of full fat milk and dairy products. • 2 portions of beans, pulses, fish, eggs, meat and other proteins' group. 2 portions of fish should be included a week, 1 of which should be oily (providing omega-3 fats). Foods with a high iron content should be offered twice a week (Red meat - beef, or lamb, offal). • Fat and sugar make a useful contribution to overall requirements and a dietetic assessment can be requested to enable calorie requirements to be met.

Ref: British Dietetic Association Digest 2017

Appendix 4 – Eat Well Guide



Appendix 5

Nutrition Problems - symptoms, causes and solutions

The following table looks at a range of problems along with possible causes and suggested solutions.

Problem	Possible causes	Possible solutions / resources
Poor appetite	Illness Depression Dementia Side effects of medication Decrease in sensitivity to taste Loneliness	Explore all possible medical causes and treatments. Encourage people to eat by involving them in the choice and preparation, and talking about food when eating. Make eating a pleasant, sociable experience rather than a necessary chore. Sign post to community cafes and lunch clubs
Lack of nutritional knowledge or cooking skills	Long-term lack of knowledge could have a greater impact on poor nutrition. The person may not have prepared food for themselves before the loss of their spouse.	Raise awareness about the importance of nutrition to health and wellbeing. Try to introduce new skills or rekindle lost ones Offer support to carers Offer support while they cook some meals
Dental problems	Ill-fitting dentures may cause discomfort when eating. Dentures may also cause loss of sensitivity to taste Pain caused by mouth ulcers and other problems can reduce	Ensure older people have access to good regular dental care. Offer support with cleaning and fitting dentures in

	intake of both food and fluid	preparation for meals. Offer food that is easier to eat, e.g. softer foods.
Poor nutrition relating to dementia	Nutritional problems, loss of appetite, refusing certain foods and weight loss are common problems in dementia, especially as the severity of illness increases. Swallowing problems become increasingly noticeable as dementia worsens. Some people with dementia have increased requirements due to increased activity	Warwickshire Living well with Dementia Portal https://dementia.warwickshire.gov.uk/ The Alzheimer's Society 'Food for Thought' practice guides and advice sheets Manage swallowing disorders (dysphagia) using food thickeners with appropriate posture and feeding techniques. See 'Nutrition support in adults' (NICE) and **appendix 4** 'Eating well for Dementia' (Caroline Walker Trust) in the resources section.
Problems with eating caused by physical difficulties	Difficulty swallowing (dysphagia) could be related to dementia (see above), stroke, tumours or degenerative neuromuscular diseases. Physical difficulties which restrict ability to buy, prepare or eat food. Problems with digestion.	Explore all possible medical causes and treatments. Ensure barriers to physical difficulty are removed Provide aids to assist with particular problems.
Problems preparing food caused by physical difficulties	Conditions such as arthritis, MS, Parkinson's may prevent opening tins and jars or chopping food After a fracture or stroke people may not have the strength	Use of ready-made meals Ensure appropriate food preparation, cooking and eating and drinking equipment is available to promote independence

	or confidence to stand in the kitchen or prepare food	(refer to Occupational Therapy for assessment) Support from friends, family or carers
Toileting concerns	Poor bladder control. Lack of support to go to the toilet. Constipation caused by: • ignoring or over-riding the urge to defecate due to immobility, poor toilet arrangements, pain or confusion • poor diet, dehydration • gastrointestinal disease (including cancer) • drugs • hypothyroidism	Explore all possible medical causes and treatments. Ensure people drink enough fluids for good hydration Ensure people have support to go to the toilet as often as they feel the need to; provide reassurance for people for whom this causes anxiety. Encourage physical activity. Increase fibre intake and encourage good diet.
Low expectation and fear of complaining	Attitudes to food and eating. Poor levels of support. Poor food provision. Depression and / or anxiety	Communicate clearly what people can expect from you / your service. Raise awareness of rights to good nutrition. Encourage feedback and complaints and feedback outcomes Provide advocacy where needed.
Lack of access to good nutrition	Lack of appropriate food or help to eat it. Poor levels of identification of nutritional need.	Raise awareness of a healthy balanced diet Ensure staff or volunteers are available at mealtimes to offer

	Inadequate staffing levels and lack of training. Lack of access to appropriate food for people from black and ethnic minority groups. Lack of meal choice due to communication problems.	support Ensure staff are properly trained. Provide food appropriate for dietary and cultural needs. Provide training and support to carers and volunteers who are willing to shop for food, prepare meals or provide assistance at mealtimes. Use pictorial menus
Social issues	Poverty. People who live alone may feel that it is not worth cooking just for one person. People may be embarrassed about eating with others due to physical problems with eating.	Ensure income and benefits are maximised. Consider referral to Citizens Advice Bureau Encourage social eating through lunch clubs and community cafes Provide help with eating and drinking Encourage family members to bring food and visit at mealtimes.
Cultural/religious issues	People that adhere to strict religious diets may be wary of food served in communal or public places, or in their own home if prepared by someone from outside. Carers preparing food may use different cooking techniques or serve with different accompaniments.	Identify reputable local providers to buy from. Ensure staff have appropriate knowledge and training with regard to special dietary needs. Seek advice from the person, family members, carers or friends as to what is acceptable. Some religions allow exemptions from strict adherence (e.g.

		Muslims that are ill or frail would be exempt from fasting during Ramadan). Where necessary seek advice from specialist religious organisations to provide reassurance

Useful Documents / links

1. Warwickshire Nutrition and Hydration Standards for Care Homes 2018
2. State of the Nation. Older people and malnutrition in the UK today. Malnutrition task Force. Updated 2017 http://www.malnutritiontaskforce.org.uk/wp-content/uploads/2017/10/AW-5625-Age-UK-MTF_Report.pdf
3. BAPEN (2013) Malnutrition Universal Screening Tool
4. BDA the Association of UK Dietitians. The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services. 2nd Edition. 2017
5. Nutritional guidelines and menu checklist for residential and nursing homes. Public Health Agency 2014
6. Dysphagia Diet Food Texture Descriptors. 2012.
7. Oral health for adults in care homes NICE guidelines [NG48] Published date: July 2016
8. https://www.food.gov.uk/business-industry/allergy-guide/allergen-resources
9. http://www.hydrateforhealth.co.uk/importance-maintaining-good-hydration-older-people/
10. http://www.nhs.uk/Livewell/Goodfood/Pages/water-drinks.aspx
11. https://www.nice.org.uk/guidance/ng28/chapter/1-Recommendations#dietary-advice-2
12. https://www.diabetes.org.uk/Documents/Reports/nutritional-guidelines-2013-amendment-0413.pdf
13. https://dementia.warwickshire.gov.uk/
14. http://www.scie.org.uk/almost-there

For copies of information sheets produced by Warwickshire Dietetic Service go to:

https://www.swft.nhs.uk/our-services/adults-out-hospital-services/dietetics/patient-information-leaflets-and-related-links