## Approvals

The signatures below certify that this procedure has been reviewed and accepted, and demonstrates that the signatories are aware of all the requirements retained herein and are committed to ensuring their provision.

<table>
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<th>Signature</th>
<th>Position</th>
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Introduction

Good nutrition relies upon having a balanced food provision and carefully designed menus to meet preferences, needs and requirements as well as personalised care plans and the subsequent nutritional care to reflect current care and support. Essentially, food provision is broadly based on the eat well plate recommended by the department of health, to ensure protein, carbohydrate, fats, vitamins and minerals are provided in the right quantities at the right intervals through the day. Hydration is based on supporting individuals to consume fluids to maintain healthy fluid balance, which is often between 2 litres and 2.5 litres per day.

This policy also guides as to the appropriate care to give when there are signs of compromised nutritional status of hydration status, based on screening tools.

In doing so, this policy will ensure that Strode Park Foundation complies with all legislation to ensure that care and practice surrounding hydration and nutrition including dehydration and malnutrition is robust and promotes best practice.

Aims and Objectives

To provide service users with nutritious food and drink and nutritional care to consume food and drink
To ensure the Foundation can comply with Legislation
To ensure the Foundation has a robust practices in nutrition and hydration
To ensure that staff are trained to be able to promote best practice
To work towards food accreditations as recognition for best practice

References

Health and Social Care Act 2008 regulation 14
CQC
NACC 10 characteristics of good nutritional practice
Malnutrition Digest
The Royal Marsden Hospital Manual of Clinical Nursing Procedures (eighth edition)
British Heart Foundation “So you want to lose weight…for good”

Links

This document links to the food charter which governs the food service provision. This includes menu planning, food safety, provenance, quality, service and environment including crockery and cutlery and nutritional value. This charter is measured in quarterly food governance committee meetings. Service user choice remains at the heart of governance

CP002 Version 1 Review annually
The governance committee comprises:

3 resident representatives
Director of Care
Appropriate service managers and nominated staff
Lead Cook
Nutritional and Catering Advisor

Responsibilities

The Service Manager has overall responsibility to ensure that nursing and care staff are competent to a level suitable for their role. The Nursing Staff have overall responsibility to ensure that practices are managed effectively in each shift and that legislation is complied with and policies and procedures are kept up to date. The Director of Care line manages the Service Manager; the Service Manager line manages the Nurses or senior staff who then manage care and support staff.

The Service Manager is responsible for:

- Ensuring staff are competent in nutrition and hydration including personalised care planning in this area
- Ensure staff are trained appropriately and competent in care and support aspects of malnutrition, dehydration and obesity
- Carrying out audits in these areas
- Reporting any non-conformities which could compromise wider health issues to the Director of Care
- Ensuring that equipment (such as scales and stadiometers) are maintained to a suitable standard
- Ensuring that kitchen staff liaison is adequate to maintain adequate nutrition and hydration provision
- Ensuring good communication with Care Staff to enable Service User’s dietary requirements are adhered to and kept up to date

The nursing staff are responsible for:

- Ensuring that the MUST tool is carried out monthly as a minimum for all service users, and weekly if the screening results dictate and take suitable actions
- Ensuring that food and fluid balance charts are maintained and the information used in them to deliver appropriate care and support
- Reporting any patterns of poor practice or malpractice cases to the Home Manager
- Ensuring they follow the Foundation’s policies and procedures incorporating the Royal Marsden Hospital Manual of clinical nursing procedures (eighth edition)
- Liaising with kitchen staff regarding Service User’s dietary requirements and menu planning
Hydration

Up to 60% of body weight is made up of water. The right concentration is vital for effective reactions to occur and therefore essential to life as it assists to deliver nutrients to the parts of the body where they are needed, removes waste, assists to maintain the correct pH concentration and maintains healthy cell shape. The muscles and the brain are about 75% water, the blood and the kidneys are about 81%, the liver is about 71%, the bones are about 22% and adipose tissue is about 20%. Total body water may be intracellular or extracellular, both as relevant as each other. Body fluid itself is made up of dissolved solutes which are electrolytes (sodium, potassium, chloride, magnesium and bicarbonate) and non electrolytes (glucose, creatinine, lipids and urea).

The kidneys and hormonal mechanisms (aldosterone and antidiuretic hormones are the most relevant) are highly influential in fluid and electrolyte balance. Dehydration of only 2 – 3% can adversely affect functioning and a rapid decline.

Correct assessment of fluid status is crucial to the subsequent care and health outcomes of individuals.

We lose water every day in the form of water vapour in the breath we exhale and as water in our sweat, urine, and stool. Along with the water, small amounts of salts are also lost.

The EFSA (European Food Standards Agency) estimate average intake requirements for a male adult are 2.5 litres and for a female adult 2 litres per day. Urine output for men and women is 0.5mL per kg of body weight.

In order to calculate a normal requirement of fluid the calculation of 30ml of fluid per kg in weight of an individual...This does not take account of conditions which accelerate fluid loss such as in cases of diarrhoea or vomiting, diabetes and other conditions affecting fluid balance, extreme hot weather or extreme exercise impaired ability to drink.

Promotion of hydration

All individuals must be assessed to establish what drink preferences and drinking receptacles they require and provision made for them. All fluid is relevant for hydration purposes apart from alcohol, although increased consumption of tea and coffee may act as a diuretic. Regular consumption of tea and coffee is however hydrating although may not be selected for other health reasons or preferences.

Similarly simple cold drinks are hydrating although sugar content may raise the individual’s consumption above the daily recommended amount (a cold can of carbonated and sugared drink can contain 8 spoonfuls of sugar which is nearly half the daily recommendation of 90g).

Water is a pure hydrator and can be most refreshing if served a little below room temperature and with a slice of lemon. Average mugs contain 200ml of fluid and therefore an average female will require 10 mugs or glasses of fluid per day. If one spaces this through the day this will mean being offered at the following intervals:
1. On waking
2. At breakfast
3. With medication if applicable (a full cup on each occasion)
4. Mid morning
5. At lunch
6. With medication if applicable (a full cup on each occasion)
7. Mid afternoon
8. With an evening meal
9. With medication if applicable (a full cup on each occasion)
10. Before bed

Offering drink options (such as tea, coffee, water or juice) as opposed to asking if they want a drink can produce a more positive result and result in better hydration.

Hydration stations should be set up in each dining area of the home each day including jugs of drinks so easy access can be reached. If an individual cannot come in to the dining room, then provision of preferred fluid must be planned separately.

Handover should establish responsibilities for this daily and on days where heatwave temperatures are forecast, additional provision should be made such as iced lollies and slush drinks, which may be homemade too.

**Dehydration screening and care**

Fluid balance is a monitoring process; optimal hydration is achieved when intake of fluid equals or exceeds excretion or output.

Refer to Chapter 8: procedural guidelines 8.1 to 8.7 in The Royal Marsden Hospital Manual of Clinical Nursing Procedures (eighth edition) to establish an individual’s hydration status and determine which care pathways are appropriate.

**Summary of these procedures, with timescales**

1. Screen monthly for hydration status for all residents
2. Establish when fluid balance monitoring and intervention is needed (new admission, declining health, critical illness, return from hospital admission, signs of dehydration, condition places individual at risk from dehydration)
3. Commence appropriate assessment of fluid status (Table 8.3 page 338 of Royal Marsden Procedures)
4. Intervention established and documented in care plan including
   - Fluid Balance Chart
   - Weekly fluid input chart
   - Urine colour chart
   - As well as referral as appropriate to GP, consultant, speech and language therapist, occupational therapist, dietician or dentist.
5. Review of fluid balance including subsequent care actions.

It is worth noting that clinical signs of dehydration are similar when hydration needs may be different. For example, an individual exhibiting increased confusion, lethargy and dry lips may need fluid alone or may need electrolytes in addition to fluid.
It is also worth noting from the Royal Marsden text that overhydration is rare but possible and is a condition called hyponatraemia. Reported cases have included an individual who consumed 8 litres per day for 3 days, resulting in low sodium levels.

Continuous monitoring when fluid intake and output is evidently within safe limits is NOT NECESSARY unless an individual has been assessed as being at a high risk of change to this status. Discontinue food and fluid monitoring records if an individual is evidently hydrated and screen monthly for hydration status unless clinical signs or reported symptoms are evident.

**Nutrition**

Nutritional Status refers to the state of a person’s health as determined by their nutritional intake and body composition. Nutritional support refers to any method of giving nutrients which encourage optimal nutritional status where this may be compromised. In order to determine an individual’s need for nutritional support, assessment and screening needs to be carried out as detailed in this section.

**Promotion of good nutritional care: oral route**

In order to monitor the healthy weight of an individual, their BMI (Body Mass Index) must be carried out monthly and recorded in their care plan. Step 1 of the MUST tool is to be used for this purpose to calculate BMI score and this is to be written in to the individual’s nutritional risk assessment.

Body mass index score classifications are as follows

1. Under 18.5 – underweight (high risk of malnutrition)
2. 18.5 – 20 underweight (medium risk of malnutrition)
3. 20 to 24 – a normal healthy weight
4. 25 to 29 – grade I obesity
5. 30 to 39 – grade II obesity
6. Over 40 – grade III obesity

A balanced diet, for an individual without compromised nutritional status may be illustrated through the eatwell plate, a visual initiative instigated by the Department of Health to educate the public in balanced diets. This includes a daily balance of

- Carbohydrate starchy foods – 33% a day
- Fruit and vegetables – 33% per day
- Milk and dairy – 15% per day
- Meat, fish, beans and other non dairy protein – 12% per day
- Food and drinks high in fat and sugars – 8% per day maximum

Individual’s energy requirements can be based on table 8.4 in the Royal Marsden text which is 25 kcal per kg of body weight. Individual’s energy requirement variations are illustrated in the Pen Group Pocket Guide to Nutrition under the Adult Requirements 3 section. However these calculations whilst insightful and informative do not form part of daily promotion of a healthy diet. The following is more purposeful, based on portion control which has been calculated from kilocalories.
Whilst portion examples are listed in the British Heart Foundation Guide listed in the front of the policy, one portion of starch based food or vegetable is generally a fist size amount, proportionate therefore to an individual. Butter and cheese and fats portion is approximately a match box sized piece and a protein portion is approximately a hand sized piece.

An example of portion control is as follows based on a daily need for 1800 calories:
Fruit and vegetables – 8 or more portions
Rice, potatoes, bread, pasta or other starch based foods – 8 portions
Milk or dairy – 2 portions
Meat, fish, eggs or other non dairy protein – 3 portions
Fats and oils – 3 portions

Care and Nursing staff are expected to promote a balanced diet culture and advocate the benefits of good nutrition in a respectful and informed way. Positive nutrition has been linked to good energy, concentration and general wellbeing whereas poor nutrition has been linked to constipation, poor concentration, low energy, cardiovascular disease and diabetes.

This is done through informing service users of healthy options, encouragement to consume varied and healthy options including snacks and drinks, observing mealtimes to maximise opportunities to select healthy options as well as individualised care planning to initially understand preferences, strong beliefs and religious and cultural considerations. Using the Food Charter and Eatwell Plate is a tool to do this.

Care Plans are the most appropriate tool to identify personalised support and care that may be given to ensure consumption is made possible in line with preferences and needs. This includes providing the right utensils and unrushed support in a respectful manner (see the food charter).

Care Plans must include the following information
Strong likes and dislikes
Strong preferences
Religious requirements
Cultural considerations
Nutritional preferences
Fortification or weight loss where identified
Medical Needs and considerations

Risk assessments must be completed for specific risks including choking and malnutrition.

Mental Capacity must always be assumed unless there is an indication that an individual cannot make a choice for themselves with the knowledge of consequence. Making choices for individuals is not appropriate, even if it is a more healthful alternative. Education is an option that service users may take in order for them to make what may be deemed as more healthful decisions around food and fluid (refer to Mental Capacity Act Policy)
A range of conditions and abilities may require dietary modifications including anorexia, sore mouth, dysphagia, nausea and vomiting, early satiety. Refer to page 357 table 8.5 of the Marsden Manual listed in the front of the policy. Unplanned weight loss of more than 5% and planned weight loss also require an adapted care plan and clear recording of care given as listed later in this policy. Communication with the kitchen must be considered to ensure food is prepared in accordance with needs and this must be done using the Kitchen Referral Form.

The introduction of Nutritional Advocates is an initiative designed to ensure a consistently high level of care is promoted and communication is positive and ongoing with kitchen staff to enable a streamlined service.

Food plans can be carried out when there is no indication of malnutrition where an individual has an expressed wish for support to consume a balanced diet or to ensure preferences are met. The menu template is a 4 weekly document so can be used in conjunction with the food plan. This food plan can be submitted to the kitchen once completed.

Menus indicate the following information:

- Low saturated fat options
- Soft options
- Puree possible options
- Vegetarian options
- High Allergy risk foods
- High protein foods

Menus are available as weekly formats and operate on a 4 weekly rotation for a period of 6 months (spring summer and autumn winter). Daily choices are to be given to the kitchen in the morning by 9.30 a.m to enable provision to be made for service user needs. Failure to do so may result in a service user not receiving their chosen food although medical needs must be met as priority.

Monitoring output through faecal matter is also incredibly important. Constipation is considered to be present if an individual has not had a bowel movement for more than 3 days, and referral is necessary to the GP.

Monitoring stools can be done using a tool called the Bristol stool chart. Type 4 is considered a healthy stool and other types on a regular basis need reporting to a suitable health professional be able to gain medical advice. Changes to bowel patterns as well as blood in stools, colour change (such as white or black), texture (slimy or very dry), pain and discomfort are all indications of health conditions which should be reported immediately for further investigation.

**Promotion of nutritional care: Dysphagia, Parenteral or Enteral nutrition**

Dietary Modifications and clinical procedures must be followed in accordance with safe practice and carried out by suitably trained and competent staff for those with specific medical needs as listed below:
1 **Dysphagia** (swallowing impairment) – refer to page 360 to 362 in the Marsden Manual listed in the beginning of this policy

2 **Enteral** Nutritional Needs (complete foods delivered directly into the nasogastric tract) – refer to page 362 to 385 (procedures 8.10 to 8.17 of the Marsden Manual listed at the beginning of the policy AND the PEN group guide to clinical nutrition access route 5

3 **Parenteral** Nutrition – (direct infusion into a vein of nutrient solutions) – refer to page 385 to 389 procedures 8.18 to 8.21 where relevant

Involvement and referral to the appropriate individuals such as the Home Enteral Nutrition Team, Speech and Language Therapists and Dieticians must be made to ensure best practice is followed.

Involvement in the dining experience must still be considered to ensure social inclusion and stimulation is provided. Tasting foods is an issue to discuss with the relevant professional and may be strongly encouraged.

**Malnutrition screening and care for those with low BMI scores**

All residents in residential care must have their weight monitored and recorded on a monthly basis unless specific advice or unless the individual declines with the capacity to do so and appropriate actions taken as detailed in the policy. Appropriately trained and competent staff can undertake MUST screening – this may or may not be a trained nurse but actions from the MUST should always be discussed with named nurse.

Weight loss may be evident in ill fitting clothes, ill fitting dentures, sunken appearance as well as physical symptoms such as malaise. These are incredibly relevant and should be considered within the nutritional risk assessment in addition to the areas detailed within it. The most measured way of monitoring malnutrition however is through a 5 step process, beginning with BMI measurement.

Weight monitoring is an essential part of screening for nutritional state, also taking account of height to establish an individual’s Body Mass Index (BMI) as described on page 50 of the Royal Marsden Text. For those with a BMI lower than 18.5 or for those who have had recent weight loss between 5 – 10% of their body weight, the MUST tool must be used weekly as they are a greater risk of malnutrition.

Assessing malnutrition risk from low weight is carried out by using the MUST (Malnutrition Universal Screening Tool) before commencing any nutritional support programme as well as considering service users ability, condition and preferences. This tool is to calculate malnutrition risk – it is not suitable for planned weight loss regimes.

This screening must be carried out monthly if the service user is agreeable to this, to be able to monitor nutritional status and align the care to the needs and preferences of the service user.

There are 5 steps to completion of the MUST.
Step 1 is to calculate weight and height
Step 2 is to calculate unplanned weight loss in the past 3 – 6 months
Step 3 considers if there is likely to be or has been no nutritional intake for longer than 5 days or if the service user is acutely unwell at present
Step 4 totals the score
Step 5 provides management guidelines as to how to respond to either a low, medium or high risk score

Step 5 enhanced guidelines
In order to respond to medium and high risk service users as indicated from a MUST score of 1 or more, fortification must be evident in the care and support given. Fortification is a means by which to increase body mass through enriching existing foods that are consumed with higher calorie foods.

There are 3 main ways in which an individual must receive fortification through their existing diet

1. 3 meals a day
2. 2 snacks a day
3. 2 drinks a day

Main fortification methods are through the use of double cream, butter and cheese although other high calorie ingredients include coconut milk, peanut butter, oils and nuts added to existing foods.

Examples of fortified foods are listed in the leaflet entitled Kent Community Health NHS Trust Clinical Dietetics and Healthier Living Services High Calorie Snack List

A copy of the MUST tool can be found within each department. Documented records of the steps must be recorded in the nutritional risk assessment.

For those with compromised nutritional status, who’s MUST score is greater than 2, input from a suitable health professional is required to ascertain appropriate care which may also include supplementation.

Health professionals may include
Speech and language therapists
Dieticians
Dentists
Specialists of key gastrointestinal conditions such as the HEN team
GPs

In the first instance a dietician referral is required.

Malnutrition: Obesity and care

Obesity is a term used to describe somebody who is very overweight with a high degree of body fat. As detailed in this policy, an individual with a BMI score greater than 25 also indicates a risk. The following risk factor can also be considered; for a woman whose waste measurement is more than 32 inches and for a man, 37 inches, their health is at risk.
Malnutrition can also occur in those who are obese and so a balanced diet is essential when considering weight loss if an individual wishes to. There are also a number of health concerns associated with excess body mass including increased risk of cardiovascular complications, strokes and diabetes as well as inflammatory conditions.

Care for those who are obese should be non judgemental and sensitive. If an individual has expressed a wish to lose weight or is indicating a health condition that may be compromised by weight, they are to be given the option to find out more about how to improve health status through weight loss.

If no health condition is apparent, but BMI is greater than 25, referral to a health trainer is one option that can be done through self referral. This is suitable if an individual wishes to have one to one support for a number of sessions, aiming towards a weight goal.

GP referral is to be considered where health conditions indicate a benefit to weight loss and an individual is keen to act upon this. Direct referral to a Dietician can also be carried out where BMI is greater than 30. Currently the NHS has Health Trainers in each locality who carry out one to one coaching in this area offer an agreed time span. This service is available to any member of the community as long as they are not under health supervision from a GP or related professional already. Service users should be supported to self refer if they wish to.

In conjunction with this, the in service user may be given a copy of them weekly menus to plan and select foods to support health.

There are a number of ways a person’s weight can be assessed. The most widely used method is the body mass index.

The body mass index (BMI) is your weight in kilograms divided by your height in metres squared. You can use the NHS Choices’ BMI healthy weight calculator to work out BMI.

- if BMI is between 25 and 29, it would be considered overweight
- if BMI is between 30 and 40, it would be considered obese
- if BMI is over 40, it would be considered very obese (known as ‘morbidly obese’)

There are four main goals in the treatment of obesity:

- to prevent further weight gain
- to gradually lose weight through a combination of a calorie-controlled diet and regular exercise
- to avoid regaining any lost weight
- to improve your general state of health and reduce your risk of obesity-related complications

Service users wishing to lose weight can discuss this with their link / key nurse who can refer to the nutritional advocate as well as the GP/Dietician as appropriate to their care needs. Responses may typically be, with service user collaboration, to put together a food plan led by the service user and referral to a health trainer to help set goals and support positive steps.
Supporting to ensure that healthy snacks are available throughout the day and night is important and the kitchen should be involved in this plan to support this. Healthy snacks may include fruit, seeds, nuts, crackers and marmite, vegetables,

Monitoring and auditing

Strode Park audit their nutritional care according to the NACCs 10 key characteristics for good nutritional care which are as follows

1. Everyone is screened to identify those who are malnourished or at risk of becoming malnourished
2. Everyone using care services has a personal care support plan and where possible has had personal input, to identify their nutritional care and fluid needs and how they are to be met
3. Strode Park Foundation uses a food charter which includes specific guidance on food and beverage services, menu planning, food provenance and quality and this is incorporated into a food governance monitoring system
4. People using the services are involved in the planning and monitoring arrangements for food and beverage/drinks provision
5. An environment conducive to people enjoying their meals and being able to safely consume their food and drinks is maintained (Protected Mealtimes)
6. All staff and volunteers have appropriate skills and competencies needed to ensure the nutritional and fluid needs of people using the care services are met, including regular training and development updates on nutrition
7. Facilities and services are designed to be flexible and centred on the needs of people using them which is reflected in the menu planning specific to each service and using stakeholder feedback to produce this
8. There is a policy on food service standards within the food charter, centred on the needs of people using the service and this is monitored through local governance in line with regulatory frameworks
9. Food service and nutritional care is provided safely and in line with the food safety policy
10. Everyone working in the organisation values the contribution of people using the service and all others in the successful delivery of nutritional care