

Regulatory Guidance for Residential Services for Older People

Subject	Food and Nutrition Requirements
Audience	Service Providers

Standards and guidance relevant to this guidance include:			
Standard	No.	Regulation	No.
<i>National Quality Standards for Residential Care Settings for Older People in Ireland</i>	19	Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009	20

This guidance contains explanations of concepts that may assist in implementing standards and meeting regulations. There may be other requirements relevant to a particular service that are not addressed in this guidance. People providing residential services for older people should identify the regulations, standards and best available evidence relevant to their service. This guidance is current at the time of printing. Please check www.hiqa.ie for the latest version of this guidance.

Why is food and nutrition important?

Good nutrition plays a key role in active, successful, healthy ageing. Adults in residential care are amongst the most vulnerable older persons as they have little control over their diet, may be frail and may need help with eating. Food and nutrition is a key aspect of dignity in care provision to older persons. Good nutritional care, adequate hydration and enjoyable mealtimes are crucial to maintaining the health, wellbeing and independence of older people (Mulvihill M. & Pyper S. 2001).

Malnutrition

People who are admitted to residential centres are likely to be older, more ill and have higher needs than those living in the community. By nature of progressive illness and increasing age, the older and more ill people get, the greater the risk of being malnourished. If the standard of care (including nutritional care) in a centre is high, malnutrition should be identified on admission and appropriately addressed.

Outcomes expected in a high quality service

- Residents' food and nutritional needs are assessed and identified.
- Care plans are developed and implemented to meet the residents' needs.
- Resident's care is monitored and evaluated.
- All healthcare professionals and non-clinical staff are equipped with the appropriate level of knowledge, skills competence and confidence to address the food and nutritional needs of each resident.

Governance and policy infrastructure

High quality services have:

- clearly-defined responsibilities in planning and managing food and nutritional care
- evidence-based food and nutrition policy infrastructure in place to include protocols for actions, e.g. referral of those screened and identified as 'at risk' to an expert for more detailed assessment
- established structured linkages to medical, dietetic, dental, speech and language and occupational therapy
- robust processes for monitoring and audit to ensure provision of high quality care
- planned programmes of training and education to underpin policy, protocols and practice.

Training and education

Training and education should exist for all staff, identifying roles and responsibilities in food and nutrition provision. Educational programmes cover areas such as:

- nutritional needs of older people, particularly disease-specific residents such as a person with dementia
- feeding practice, therapeutic diets and nutrition screening
- safe food handling appropriate to role
- monitoring and documenting food/fluid intake.

Meals and mealtimes

High quality services ensure residents receive a nutritious and varied diet in pleasant surroundings at times convenient to them from a menu that offers choice and caters for specific diets. Hot and cold drinks and nutritious snacks are available at all times and offered regularly, and drinking water is readily accessible.

Menu planning puts a balanced, adequate menu cycle in place, incorporating therapeutic and modified consistency diets, and including residents' likes and

dislikes. It accounts for inclusion of favourite foods, timing of meals, challenges faced at mealtimes, and the overall dining environment. The daily menu is displayed in a suitable format and in an appropriate location so that the resident knows what is available at each mealtime.

Food, including therapeutic and modified consistency diets, is presented in a manner which is attractive and appealing in terms of texture, flavour and appearance, in order to maintain appetite and nutrition. Mealtimes are unhurried social occasions where sufficient numbers of staff participate in and view mealtimes as an opportunity to communicate, engage and interact with the residents and offer assistance discreetly, sensitively and individually when necessary.

Assessment and Care Planning

Assessment

Assessment of nutrition/hydration and food preferences is undertaken from admission, beginning with immediate risk and care needs and followed by more comprehensive assessment which includes:

- clinical review
- oral health review
- accurate weighing
- observation of eating habits/patterns, likes/dislikes
- signs of dysphagia (a swallowing disorder or difficulty)
- nutritional screening using a validated screening tool
- monitoring and keeping accurate food/fluid charts.

A detailed history of the residents' past and present medical complaints should be obtained. Consideration should be given to co-morbidities that may create a potential or actual risk for malnutrition, dehydration and dysphagia.

Care planning

Following assessment, individualised care plans are devised in conjunction with appropriate members of the multidisciplinary team, the resident and his/her family. The care plan details residents' nutritional and hydration needs and specific interventions to address these, including any onward referrals to dietetic, dental, speech and language or occupational therapy as appropriate. A good plan is specific, measurable, achievable, realistic and has a measurable time frame (S.M.A.R.T.).

Once agreed, care is implemented as per the plan ensuring all aspects of the plan are monitored and accurately reported on in the nursing notes.

The care plan is evaluated at least three-monthly (every three months) or as indicated by clinical concern for the resident's condition. Nurses should document evaluations of care at the designated review date or if the residents' condition changes, update the care plan to reflect this and make onward referrals to the multidisciplinary team as appropriate to their findings.

Nutritional screening

Residents should be screened for malnutrition using a validated screening tool on admission or within 72 hours of admission, when there is clinical concern and at least three-monthly. It is crucial to adopt a pathway of action. Screening should not be considered in isolation, rather as part of a pathway of care where results of the nutritional screening tool assessment are linked to specified protocols for action, such as referral of those screened and identified to be at risk to an expert for more detailed assessment, such as a dietician.

Maximising and promoting independence

A baseline for providing good care is getting to know the person you're caring for. By understanding a resident's strengths, food preferences and routines, their independence can be maintained and promoted. For example, if the resident has difficulty using utensils, simple adaptive eating tools can help maintain a sense of personal control while dining.

In addition, visual, verbal, sensory and physical cuing can promote independence, especially when the cues are based on lifelong habits. Sensory cues, especially those involving smell, can let the person know it is time to eat. People with more advanced dementia may also need physical prompting to initiate the process of eating or to continue eating. While physical cuing often can help, caregivers should not step in too soon. Doing so can diminish the care recipient's sense of personal control and independence.

Key concepts relevant to provision of food and nutritional care

Unintentional weight loss

Accurate and consistent recording of weights can identify whether a resident's weight is increasing or decreasing, but to do this means comparing current and previous weights and considering what any changes in weight might mean. If residents are weighed using a sitting/chair scales it should incorporate a foot rest, otherwise ensure that the residents' feet are off the ground. Unintentional weight loss is considered significant when:

- resident has a BMI less than 18.5 kg/m²
- recent unintended weight change + or - 3kgs or 7lbs

- unintentional weight loss greater than 10% of body weight within three to six months
- BMI less than 20kg/m² and unintentional weight loss greater than 5% within the previous three to six months
- residents who have eaten poorly for more than five days and/or likely to eat little or nothing for the next number of days.

Relying on weight alone for evidence of nutritional status can be misleading, e.g. patients with uncontrolled leg oedema. Best practice recommends that nutritional screening using a validated screening tool is undertaken.

Food/fluid charts

Older people entering residential care should have their food and fluid needs assessed using a food diary/chart in the first week after admission and this should be monitored regularly thereafter or as required by medical/allied health advice. However, charts are only as useful as the information which appears on them. Exact quantity should be accurately recorded. Food and fluids refused should be monitored. Records of the food provided for residents is documented in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory in relation to nutrition and otherwise of any special diets prepared for individual residents.

Dysphagia

Dysphagia is the medical term for a swallowing disorder or difficulty and is a common consequence of many different types of illness or injury in older persons. It encompasses difficulty with eating and drinking which causes problems with the transit of food from the lips and mouth to the stomach. It may be due to weakness or lack of coordination of the muscles of the mouth, the throat or the upper oesophagus (food pipe). Residents who present with any obvious indicators of dysphagia should be medically assessed, to include medication review to ascertain if the current drug formulation, route and timing of administration remains appropriate and is without contra-indications for the feeding regimen or swallowing process. Appropriate referrals should be made to a speech and language therapist for assessment and plan of management, and dieticians for advice to ensure modified consistency diets are nutritionally adequate.

Dehydration

Dehydration occurs as a result of a low fluid intake, excess fluid loss (excessive sweating, vomiting or diarrhoea), or a combination of both. Dehydration in older adults can result in reduced cognitive performance,

constipation, delirium, infections, renal failure, shock, seizures, brain damage and death.

Risk factors include:

- dysphagia
- age-related changes such as a diminished sense of thirst, loss of muscle mass, decline in renal function, bone mass and total body fluid
- inadequate fluid intake
- excessive sweating, diarrhoea, vomiting, fever
- cognitive or functional impairment
- medications that affect renal function (such as laxatives, diuretics)
- diseases associated with excessive urination, for example, diabetes, hypocalcaemia.

Symptoms of dehydration include:

- dry mucous membranes and sunken eyes
- low or absent urinary output and increased frequency of urinary tract infections
- constipation, confusion, lethargy and muscle cramps
- hypotension or orthostatic hypotension and tachycardia (Pinto, 2008).

Assessment of skin turgor alone is not a reliable indicator of dehydration in the older person due to age-related skin changes and a loss of skin elasticity (Pinto, 2008).

Food fortification and oral nutritional supplements (ONS)

Food fortification involves enriching a resident's diet using calorie-rich foods, facilitating an increase of calories without increase of food volume. Examples include adding skimmed milk powder to cereals, soups and puddings, or adding cream, butter, cheese or gravy to a daily diet where appropriate. It is imperative that food fortification is tailored to a resident's needs, likes and dislikes, and best times for eating during the day. Snacks should be provided after evening tea at suppertime or bedtime – such as milky drinks (malted drink, hot chocolate, warm milk), a piece of cake, cheese and crackers, a sandwich, or some other snack enjoyed by residents. Any food fortification/snack recommendations should be well documented, to ensure continuity of provision.

Oral nutritional supplements are commonly used as a treatment for malnutrition in the residential care setting. However, they should not be used as a sole treatment and should always be given in combination with dietary advice and advice on food fortification. They must not replace meals. The timing of when oral nutritional supplements are offered to a patient is key. Offering too near to a mealtime may

displace a person's natural eating pattern due to feeling satiated from oral nutritional supplements. Conversely, offering the supplements too soon after a meal may result in poor compliance, as the patient may be full from their meal.

Enteral nutrition

Enteral nutrition is nutrition provided through a tube, catheter or stoma that delivers nutrients directly to the gut, bypassing the mouth. Ordinary food is the first choice to correct or prevent under-nutrition in a resident. Only when ordinary food or nutritional sip feeds do not meet the nutritional requirements of the patient should artificial nutritional support be considered. Enteral nutrition should only be prescribed for residents who are malnourished or at risk of malnutrition and have inadequate or unsafe oral intake and a functional, accessible gastrointestinal tract. Interventions should be stopped when the patient is established on adequate oral intake.

All residents requiring enteral nutrition interventions should be supported by a coordinated multidisciplinary team, which includes a medical doctor, dietician, pharmacist, specialist nutrition nurse and other allied healthcare professionals (for example, speech and language therapists) as appropriate. Close liaison between the multidisciplinary team and residents and carers regarding diagnoses, prescription arrangements and potential problems is essential. A clear policy and process should underpin the management and delivery of enteral nutrition.

Monitoring and audit

High quality services carry out regular monitoring and audit. Monitoring documentation allows for change to be measured easily. For example, weight loss in a patient whose weight is checked monthly and documented in a care plan will be more easily identified than a patient with infrequent weight checks, or poor on-site documentation.

Audits allow staff to reflect on current practice and identify aspects that require attention by comparing to best practice guidelines. They also provide useful baseline data to measure any future changes to be implemented against.

Audit criteria might include assessment of the menu, snack provision, mealtimes, feeding practices, availability of therapeutic diets, for example, low fat/sugar, catering practice, food wastage, nutritional screening, and use of, or compliance with, a care plan.

Resources[¥]

Caroline Walker Trust – Eating well for older people (revised 2004)

<http://www.cwt.org.uk>

ESPEN Guidelines 2006 <http://www.espen.org>

www.fsai.ie/publications/reports/recommendations_nutrition_older_people.pdf

Menu Planning and Special Diets in Care Homes, NACC 2006 www.thenacc.co.uk

MNA <http://www.mna-elderly.com>

MUST http://www.bapen.org.uk/must_tool.html

Nutrition in Residential Care Settings – A Guide for Healthcare Professionals: Irish Nutrition and Dietetic Institute.

NICE: Nutrition Support for Adults, Oral Nutrition Support, Enteral Tube, Feeding and Parenteral Nutrition.

<http://www.nice.org.uk/nicemedia/live/10978/29981/29981.pdf>

Guidelines for Preventing Under-Nutrition in Acute Hospitals: Department of Health 2009.

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Bennett J, Thomas V, Riegel B. *Unrecognized Chronic Dehydration in Older Adults: Examining Prevalence Rate and Risk Factors*. Journal of Gerontological Nursing; 2004.

Irish Association of Speech and Language Therapists. *Standards of Practice for Speech and Language Therapists on the Management of Feeding, Eating, Drinking and Swallowing Disorders (Dysphagia)*; 2007.

Mentes J. *Maintaining Oral Hydration in Older Adults: Greater awareness is needed in preventing, recognizing, and treating dehydration*. American Journal of Nursing; 2006

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Mulvihill M & Pyper S. *Managing Nutrition for Older People in Longstay Care – A Guide for Health Care Staff*. Midland Health Board; 2001.

O'Loughlin, G, & Shanley C. *Swallowing on a Plate: A Training Package for nursing home staff caring for residents with swallowing problems*. Centre of Education and Research on Ageing, New South Wales; 1999.

[¥] All online resources and references were accessed at the time of preparation of this guidance.

