Nutrition and hydration resource pack
For Care Homes

This booklet is designed to promote excellence in Nutrition and Hydration care, in a care home setting.

If you are unsure about anything in this booklet please contact:

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Please feel free to photocopy for your own use anything from this booklet.
Alternatively an electronic version can be requested from the Dietitians.

Prepared by Prescribing Support Dietitians January 2016
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Malnutrition and Dehydration

Malnutrition is estimated to affect 41% of residents in nursing or care homes. It may occur as a result of illness or from a variety of physiological and social co-factors.

During the period of 2003-12, dehydration contributed to 1158 care home deaths.

Adverse effects include:

<table>
<thead>
<tr>
<th>Physical and Mental effects of malnutrition</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired immune response</td>
<td>Recurrent viral or bacterial infections</td>
</tr>
<tr>
<td>Reduced muscle size and strength</td>
<td>Weakness, reduced mobility, falls</td>
</tr>
<tr>
<td>Reduced respiratory muscle function</td>
<td>Chest infection</td>
</tr>
<tr>
<td>Decreasing body fat</td>
<td>Hypothermia, increased risk of pressure sores</td>
</tr>
<tr>
<td>Impaired wound healing</td>
<td>Delayed recovery of pressure sores, ulcers, broken skins</td>
</tr>
<tr>
<td>Increased fatigue</td>
<td>Tiredness, decreased mobility and independence</td>
</tr>
<tr>
<td>Apathy, depression and self-neglect</td>
<td>Decreased quality of life, decreased mobility</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>Decreased quality of life, increase nursing and care time</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Low blood pressure or Hypotension (especially on standing), falls</td>
</tr>
<tr>
<td>Confusion</td>
<td>Falls, altered behaviour</td>
</tr>
</tbody>
</table>

All of the above will result in significant reduction in quality of life, decreased independence and an increase in nursing/care time.
C.Q.C. Outcome 5

As specified by the Care Quality Commission (CQC), organisations providing care must safeguard service users from the risks of **inadequate nutrition** and **dehydration**, by ensuring:

- There is a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users’ needs
- Food and hydration meet any reasonable requirements arising from a service user’s religious or cultural background
- Appropriate support is given to enable service users to eat and drink sufficient amounts for their needs.

Adequate quantities of good quality food should be provided so the use of unnecessary nutrition support is avoided. Oral Nutritional Supplements should **not** be used as a substitute for the provision of food.

Suitable snacks, food fortification, nourishing drinks as well as over the counter (OTC) products can be used to improve the nutritional intake of those at risk of malnutrition.

**Four simple steps to effectively Detect, Prevent and Treat malnutrition and dehydration**

**STEP 1** Screen all residents for malnutrition routinely using the Malnutrition Universal Screening Tool (MUST)

**STEP 2** Initiate a local malnutrition and dehydration management pathway

**STEP 3** Evaluate existing menu/food and drinks provision to ensure it can be adapted to meet the needs of malnourished residents

**STEP 4** Document and monitor strategies implemented to ensure they meet the needs of residents

The nutritional value of uneaten food and drinks is **NIL** (Nutrition and hydration digest)
Before using the Malnutrition Universal Screening Tool

Weight:
- Where possible obtain an accurate weight, avoid estimating!

Your Checklist
- Residents weighed with light clothing?
- Weighed at the same time of the day and time documented?
- Are the scales calibrated at least once a year?
- Are the appropriate scales used? (hoist, standing or sit down)

Height:
- Use the same height measurement for all MUST scores. Reported heights preferable for those with a curved spine

Your Checklist
- Documented reported/measured or estimated height?
- If height record unavailable consider alternative method (e.g. ulna length, demispan and knee height)

Weight gain / loss:
- Re-weigh if there appears to be a significant weight loss or gain (more than 5kg over 1 month) and consider any potential causes, e.g. fluid loss from oedema, faulty scales...

Weight refusal:
Being weighed is a procedure that can cause discomfort and even distress (physical or psychological). Therefore weighing should only be undertaken to help make therapeutical decision as to a resident’s care plan, not merely to fulfil an administrative requirement.
If a resident refuses to be weighed, a gentle reminder of the importance of monitoring and reason why the procedure is being carried out should be discussed. You should not weigh a resident against their expressed wish.

Document and date all measurements in care plans
The MUST

'Malnutrition Universal Screening Tool'

**'MUST'**

'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:
- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

**The 5 'MUST' Steps**

**Step 1**
Measure height and weight to get a BMI score using chart provided. If unable to obtain height and weight, use the alternative procedures shown in this guide.

**Step 2**
Note percentage unplanned weight loss and score using tables provided.

**Step 3**
Establish acute disease effect and score.

**Step 4**
Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

**Step 5**
Use management guidelines and/or local policy to develop care plan.

Please refer to The 'MUST' Explanatory Booklet for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See the 'MUST' Report for supporting evidence. Please note that 'MUST' has not been designed to detect deficiencies or excessive intakes of vitamins and minerals and is of use only in adults.

In care home this step is almost invariably 0. Step 3 is useful in hospitals.
**Step 1**
BMI score

- BMI kg/m² Score
  - >20 (≥30 Obese) = 0
  - 18.5 - 20 = 1
  - <18.5 = 2

**Step 2**
Weight loss score

- Unplanned weight loss in past 3-6 months
  - % Score
    - <5 = 0
    - 5-10 = 1
    - >10 = 2

**Step 3**
Acute disease effect score

- If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days
  - Score 2

**Step 4**
Overall risk of malnutrition

Add scores together to calculate overall risk of malnutrition:
- Score 0 Low Risk
- Score 1 Medium Risk
- Score 2 or more High Risk

**Step 5**
Management guidelines

**0 Low Risk**
Routine clinical care
- Repeat screening
  - Hospital – weekly
  - Care Homes – monthly
  - Community – annually for special groups e.g. those >75 yrs

**1 Medium Risk**
Observe
- Document dietary intake for 3 days if subject in hospital or care home
- If improved or adequate intake – little clinical concern; if no improvement – clinical concern - follow local policy
- Repeat screening
  - Hospital – weekly
  - Care Home – at least monthly
  - Community – at least every 2-3 months

**2 or more High Risk**
Treat
- Refer to diettitian, Nutritional Support Team or implement local policy
- Improve and increase overall nutritional intake
- Monitor and review care plan
  - Hospital – weekly
  - Care Home – monthly
  - Community – monthly
- Unless detrimental or no benefit is expected from nutritional support e.g. imminent death,

**All risk categories:**
- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary
- Record malnutrition risk category
- Record need for special diets and follow local policy

**Obesity:**
- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

"Implement Local Policy"

Re-assess subjects identified at risk as they move through care settings

See the ‘MUST’ Explanatory Booklet for further details and The ‘MUST’ Report for supporting evidence.
Step 1 – BMI score (& BMI)

Height (feet and inches)

Weight (kg)

Note: The black lines denote the exact cut off points (30, 30 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.
### Step 2 – Weight loss score

#### Weight loss in last 3 to 6 months

<table>
<thead>
<tr>
<th>Current weight</th>
<th>Less than (kg)</th>
<th>Between (kg)</th>
<th>More than (kg)</th>
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<tbody>
<tr>
<td>30</td>
<td>1.6</td>
<td>1.6 - 3.3</td>
<td>3.3</td>
</tr>
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<td>1.6</td>
<td>1.6 - 3.4</td>
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<td>32</td>
<td>1.7</td>
<td>1.7 - 3.6</td>
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<tr>
<td>33</td>
<td>1.7</td>
<td>1.7 - 3.7</td>
<td>3.7</td>
</tr>
<tr>
<td>34</td>
<td>1.8</td>
<td>1.8 - 3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>35</td>
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<td>37</td>
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<tr>
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<td>2.1 - 4.4</td>
<td>4.4</td>
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<td>2.2</td>
<td>2.2 - 4.6</td>
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<td>2.2 - 4.7</td>
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<td>2.3 - 4.8</td>
<td>4.8</td>
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<td>2.3 - 4.9</td>
<td>4.9</td>
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<td>6.9</td>
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<td>63</td>
<td>3.3</td>
<td>3.3 - 7.0</td>
<td>7.0</td>
</tr>
<tr>
<td>64</td>
<td>3.4</td>
<td>3.4 - 7.1</td>
<td>7.1</td>
</tr>
</tbody>
</table>

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Alternative measurements: instructions and tables

If height cannot be obtained, use length of forearm (ulna) to calculate height using tables below.  
(See The ‘MUST’ Explanatory Booklet for details of other alternative measurements (knee height and demispans) that can also be used to estimate height).

### Estimating height from ulna length

Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

| Height (m) | men (<65 years) | 1.94 | 1.93 | 1.91 | 1.89 | 1.87 | 1.85 | 1.84 | 1.82 | 1.80 | 1.78 | 1.76 | 1.75 | 1.73 | 1.71 |
|Height (m) | men (≥65 years) | 1.87 | 1.86 | 1.84 | 1.82 | 1.81 | 1.79 | 1.78 | 1.76 | 1.75 | 1.73 | 1.71 | 1.70 | 1.68 | 1.67 |
| Ulna length (cm) | 32.0 | 31.5 | 31.0 | 30.5 | 30.0 | 29.5 | 29.0 | 28.5 | 28.0 | 27.5 | 27.0 | 26.5 | 26.0 | 25.5 |

| Height (m) | Women (<65 years) | 1.84 | 1.83 | 1.81 | 1.80 | 1.79 | 1.77 | 1.76 | 1.75 | 1.74 | 1.73 | 1.72 | 1.70 | 1.69 | 1.68 |
|Height (m) | Women (≥65 years) | 1.84 | 1.83 | 1.81 | 1.79 | 1.78 | 1.76 | 1.75 | 1.74 | 1.73 | 1.72 | 1.71 | 1.70 | 1.68 | 1.66 |

| Height (m) | men (<65 years) | 1.69 | 1.67 | 1.66 | 1.64 | 1.62 | 1.60 | 1.58 | 1.57 | 1.55 | 1.53 | 1.51 | 1.49 | 1.48 | 1.46 |
|Height (m) | men (≥65 years) | 1.65 | 1.63 | 1.62 | 1.60 | 1.59 | 1.57 | 1.56 | 1.54 | 1.52 | 1.51 | 1.49 | 1.48 | 1.46 | 1.45 |
| Ulna length (cm) | 25.0 | 24.5 | 24.0 | 23.5 | 23.0 | 22.5 | 22.0 | 21.5 | 21.0 | 20.5 | 20.0 | 19.5 | 19.0 | 18.5 |

| Height (m) | Women (<65 years) | 1.65 | 1.63 | 1.62 | 1.61 | 1.59 | 1.58 | 1.56 | 1.55 | 1.54 | 1.52 | 1.51 | 1.50 | 1.48 | 1.47 |
|Height (m) | Women (≥65 years) | 1.61 | 1.60 | 1.58 | 1.56 | 1.55 | 1.53 | 1.52 | 1.50 | 1.48 | 1.47 | 1.45 | 1.44 | 1.42 | 1.40 |

### Estimating BMI from mid upper arm circumference (MUAC)

The subject’s left arm should be bent at the elbow at a 90 degree angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.

Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug but not tight.

If MUAC is <23.5 cm, BMI is likely to be <20 kg/m².
If MUAC is >32.0 cm, BMI is likely to be >30 kg/m².

The use of MUAC provides a general indication of BMI and is not designed to generate an actual score for use with ‘MUST’. For further information on use of MUAC please refer to The ‘MUST’ Explanatory Booklet.

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Alternative measurements and considerations

Step 1: BMI (body mass index)

If height cannot be measured
• Use recently documented or self-reported height (if reliable and realistic).
• If the subject does not know or is unable to report their height, use one of the alternative measurements to estimate height (ulna, knee height or demispan).

Step 2: Recent unplanned weight loss

If recent weight loss cannot be calculated, use self-reported weight loss (if reliable and realistic).

Subjective criteria

If height, weight or BMI cannot be obtained, the following criteria which relate to them can assist your professional judgement of the subject’s nutritional risk category. Please note, these criteria should be used collectively not separately as alternatives to steps 1 and 2 of ‘MUST’ and are not designed to assign a score. Mid upper arm circumference (MUAC) may be used to estimate BMI category in order to support your overall impression of the subject’s nutritional risk.

1. BMI
• Clinical impression – thin, acceptable weight, overweight. Obvious wasting (very thin) and obesity (very overweight) can also be noted.

2. Unplanned weight loss
• Clothes and/or jewellery have become loose fitting (weight loss).
• History of decreased food intake, reduced appetite or swallowing problems over 3-6 months and underlying disease or psycho-social/physical disabilities likely to cause weight loss.

3. Acute disease effect
• Acutely ill and no nutritional intake or likelihood of no intake for more than 5 days.

Further details on taking alternative measurements, special circumstances and subjective criteria can be found in The ‘MUST’ Explanatory Booklet. A copy can be downloaded at www.bapen.org.uk or purchased from the BAPEN office. The full evidence-base for ‘MUST’ is contained in The ‘MUST’ Report and is also available for purchase from the BAPEN office.

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First published May 2003 by MAG the Malnutrition Advisory Group, a Standing Committee of BAPEN.

‘MUST’ is supported by the British Dietetic Association, the Royal College of Nursing and the Registered Nursing Home Association.
Malnutrition Care Pathway for Care Home Residents

Assess Risk of Malnutrition

Assess any underlying causes of malnutrition e.g. ill-fitting dentures, poor swallow, difficulty feeding, medical condition, constipation and mental state etc.

1. Measure resident’s height and weight
2. Calculate BMI
3. Calculate % weight loss in the last 3 to 6 months

Score 0 = Low Risk
No action necessary continue to reassess MUST monthly

Score 1 = Moderate Risk
☑ Start Food and fluid record chart for 4-7 days to monitor oral intake
☑ Add one topper per meal
☑ Provide one nourishing snack daily
☑ Provide one nourishing drink daily
☑ Weigh monthly

Score 2 or more = High Risk
☑ Start Food and fluid record chart for 4-7 days to monitor oral intake
☑ Add one topper per dish
☑ Provide two nourishing snacks daily
☑ Provide two nourishing drinks daily
☑ Weigh monthly

Reassess MUST score monthly and document in notes

Low Risk
Refer to action above

Moderate Risk
Refer to action above

High Risk
For 2 consecutive months

Resident’s weight has increased or remained stable
Continue High Risk Action Plan above

Resident’s weight has decreased after 2 months
Refer to GP for Oral Nutritional Supplements or more invasive nutritional support method

1. Measure resident’s height and weight
2. Calculate BMI
3. Calculate % weight loss in the last 3 to 6 months

Score 0 = Low Risk
No action necessary continue to reassess MUST monthly

Score 1 = Moderate Risk
☑ Start Food and fluid record chart for 4-7 days to monitor oral intake
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☑ Provide two nourishing snacks daily
☑ Provide two nourishing drinks daily
☑ Weigh monthly

Reassess MUST score monthly and document in notes

Low Risk
Refer to action above

Moderate Risk
Refer to action above

High Risk
For 2 consecutive months

Resident’s weight has increased or remained stable
Continue High Risk Action Plan above

Resident’s weight has decreased after 2 months
Refer to GP for Oral Nutritional Supplements or more invasive nutritional support method
**MUST Record Chart** (adapted from BAPEN MUST Tool)

- All steps of MUST should be followed and all boxes completed in as explained in the MUST training
- Ensure those who are malnourished or are at nutritional risk are screened and commenced on an appropriate treatment plan

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Height:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td><strong>BMI Score</strong></td>
</tr>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

**MUST = 0** - low risk of malnutrition (continue to screen monthly or if issues arise)
**MUST = 1** - moderate risk of malnutrition Follow malnutrition care pathway: 1 Calorie toppers for each meal+1 snack+1 nourishing drink
**MUST = 2 or more** - high risk of malnutrition: Follow malnutrition care pathway: 1 Calorie toppers for each dish+2 snacks+2 nourishing drinks
### Weekly Food First Prescription Chart

**Please refer to food lists and recipes**

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Week starting:</th>
</tr>
</thead>
</table>
| **Chef aware** | **Topper/snack/drink given:**
| Yes / No       | give a specific description |

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>50Kcal meal topper</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aim to add 50Kcal on top of usual meal eaten</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Breakfast</td>
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<tr>
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</tr>
<tr>
<td>Supper</td>
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</table>

<table>
<thead>
<tr>
<th>Extra snacks</th>
<th></th>
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<tbody>
<tr>
<td>Aim for 100Kcal in addition to usual intake</td>
<td></td>
</tr>
<tr>
<td>Mid-morning</td>
<td></td>
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<tr>
<td>Mid-afternoon</td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nourishing Drink</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim for 200-600Kcal in addition to usual intake</td>
<td></td>
</tr>
<tr>
<td>Mid-morning</td>
<td></td>
</tr>
<tr>
<td>Mid-afternoon</td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
</tr>
</tbody>
</table>
### Resident Name:

<table>
<thead>
<tr>
<th>Time</th>
<th>Topper/snack/drink given: give a specific description</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Signature</th>
</tr>
</thead>
</table>
| Breakfast | 50Kcal meal topper  
Aim to add 100Kcal on top of usual meal eaten (2 toppers per meal or 1 per dish) |        |         |           |          |        |          |        |           |
| Lunch   |                                                      |        |         |           |          |        |          |        |           |
| Supper  |                                                      |        |         |           |          |        |          |        |           |
| Mid-morning | Extra snacks  
Aim for 200Kcal in addition to usual intake |        |         |           |          |        |          |        |           |
| Mid-afternoon |                                                      |        |         |           |          |        |          |        |           |
| Evening |                                                      |        |         |           |          |        |          |        |           |
| Mid-morning | Nourishing Drink  
Aim for 400-1200Kcal in addition to usual intake |        |         |           |          |        |          |        |           |
| Mid-afternoon |                                                      |        |         |           |          |        |          |        |           |
| Evening |                                                      |        |         |           |          |        |          |        |           |
## Underlying causes of malnutrition and dehydration

<table>
<thead>
<tr>
<th>Nutritional Issue</th>
<th>Possible solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical condition causing poor appetite, nausea or diarrhoea e.g. cancer, COPD, Heart failure</td>
<td>Address condition with GP, review medication, seek expert support if available</td>
</tr>
<tr>
<td>Poor emotional or mental health e.g. depression, isolation, bereavement,</td>
<td>GP or mental health review</td>
</tr>
<tr>
<td></td>
<td>Check hydration is adequate</td>
</tr>
<tr>
<td></td>
<td>Review social needs</td>
</tr>
<tr>
<td>Poor dentition</td>
<td>Dental review, check oral hygiene routine adequate</td>
</tr>
<tr>
<td>Swallowing difficulties or unable to swallow</td>
<td>Contact speech and language therapists</td>
</tr>
<tr>
<td></td>
<td>Check oral hygiene needs are met</td>
</tr>
<tr>
<td>Unable to feed self or difficulty using utensils</td>
<td>Provide assistance or adequate equipment</td>
</tr>
<tr>
<td></td>
<td>Review care plan</td>
</tr>
<tr>
<td>Side effects of medication</td>
<td>Review medication with GP/pharmacist</td>
</tr>
<tr>
<td>Constipation</td>
<td>Check hydration is adequate</td>
</tr>
<tr>
<td></td>
<td>Increase fibre rich food if possible</td>
</tr>
<tr>
<td></td>
<td>Give laxative as an emergency measure</td>
</tr>
</tbody>
</table>
### Documented food and fluid charts

**Why?** Documenting food and fluid intake can be very useful in spotting eating patterns (food dislikes and likes and best times for your resident to eat in the day)

**What do you do with it?** Identify whether care plan in place is working (are toppers, extra snacks and drinks consumed), and modify/update care plan

<table>
<thead>
<tr>
<th>Issue noticed</th>
<th>Possible intervention</th>
</tr>
</thead>
</table>
| Meal being refused                        | Review taste and preferences  
Check consistency  
Assist if needed  
Review timing of snacks/drinks               |
| Poor intake at certain times of day       | Make the most of other meals  
Offer preferred foods  
Try snacks and drink rather than a full meal  
A plate of finger foods may also be useful |
| Preference for savoury over sweet or vice-versa | A nutritious diet can be met with both,  
Offer extra portions of preferred dish(es) |
| Fluid intake is poor                      | Increase encouragement given  
Ensure fluid is offered every hours  
Identify residents with specific labelling so that everyone can encourage intake  
Discuss the importance of fluid intake with resident and relatives - **See top tips page 29-30** |
| No snacks during the day                  | Discuss preferences  
Offer a snack at specific times  
Discuss importance of snacks if needed |
| Often leaves the meat                     | Review preferences  
Check consistency, my need extra sauces/puree dish  
Make up protein intake with eggs, milk powder, beans, lentils, nuts |
| Lack of a particular food group           | Discuss and review preferences  
Identify other means of providing food groups (e.g. if lack of fruit and veg, try smoothies or juices)  
Consider Vitamin and mineral supplementation (e.g. calcium and vitamin D if little dairy consumed) |

FRC should **assist you** in formulating care plan. They need to be reviewed before writing action points. Four to seven days are usually enough to get an overview of eating pattern.

If MUST is 0, individual FRC are not needed but regular quality check of catering provision should be carried out.
### Energy and Fluid Requirements

**Average older adult daily calorie requirement:** 2000kcalss  
**Average fluid requirements:** 1500mls

Example of energy and fluid intake breakdown:

<table>
<thead>
<tr>
<th>Meal</th>
<th>Contribution to total requirement</th>
<th>Calories</th>
<th>Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>20%</td>
<td>400kcal</td>
<td>300mls (milk in cereals / fruit + hot drink)</td>
</tr>
<tr>
<td>Mid-morning snack</td>
<td>5%</td>
<td>100kcal</td>
<td>150mls (hot or cold drink +/- fruit)</td>
</tr>
<tr>
<td>Main meal with a dessert</td>
<td>20% +10% =30%</td>
<td>600kcal</td>
<td>300mls (include sauces, gravy, custard...)</td>
</tr>
<tr>
<td>Mid-afternoon snack</td>
<td>10%</td>
<td>200kcal</td>
<td>200mls (hot or cold drink +/- fruit)</td>
</tr>
<tr>
<td>Light meal with a dessert</td>
<td>15% +10% =25%</td>
<td>500kcal</td>
<td>300mls (include soups, gravy, custard...)</td>
</tr>
<tr>
<td>An evening milky drink</td>
<td>10%</td>
<td>200kcal</td>
<td>250mls (hot or cold drink +/- fruit)</td>
</tr>
</tbody>
</table>

Extra calorie provided if systematic nutrition care pathway implemented

**MUST =1**
- Fortify each meal with one 50kcal topper
- Add one 100kcal snack
- Add one nourishing drink: 200-500kcal

**450-750kcal Extra**

**MUST =2 or more**
- Fortify each dish with one 50kcal topper
- Add two 100kcal snacks
- Add two nourishing drinks: 400-1000kcal

**750-1350kcal Extra**

Created by Hampshire Hospitals prescribing support dietitians in association with West Hampshire and North Hampshire CCGs - March 2015
Fortifying Food

Provide ONE of the following for EACH meal to increase the calorific content.

- MUST = 1 - moderate risk of malnutrition: provide one topper/meal
- MUST = 2 or more - high risk of malnutrition: provide two toppers/meal (1 per dish)

<table>
<thead>
<tr>
<th>Extra toppings/additions</th>
<th>Add to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 level tablespoon of butter</td>
<td>Main course, soups, vegetables, starchy foods</td>
</tr>
<tr>
<td>1 teaspoon of oil</td>
<td>Main course, soups, vegetables, starchy foods</td>
</tr>
<tr>
<td>1 level tablespoon of double cream</td>
<td>Porridge, desserts, with cakes, with fruit</td>
</tr>
<tr>
<td>½ level tablespoon of mayonnaise</td>
<td>Sandwiches, mash, vegetables</td>
</tr>
<tr>
<td>½ heaped tablespoon of cream cheese</td>
<td>Sandwiches, mash, pasta, rice, soups, vegetables, omelettes, potatoes</td>
</tr>
<tr>
<td>½ oz. of cheddar cheese</td>
<td>Mash, potatoes, soups, vegetables</td>
</tr>
<tr>
<td>½ heaped tablespoon of sugar</td>
<td>Porridge, puddings, yoghurts, tinned or fresh fruit, milky drinks, in cups of tea or coffee throughout the day</td>
</tr>
<tr>
<td>1 heaped teaspoon of honey/golden syrup</td>
<td>As above</td>
</tr>
</tbody>
</table>
| 3 heaped teaspoons of skimmed milk powder | Milk, and therefore with cereals, in custard, white sauces, milk puddings, soups  
  See fortified milk recipe              |

Establish resident’s preference, document goal in care plan and record actual intake
Nourishing Snacks

- MUST = 1 - moderate risk of malnutrition: provide one nourishing snack
- MUST = 2 or more - high risk of malnutrition: provide two nourishing snacks

Snacks can be combined to provide 200Kcal in one go if resident able, e.g. a whole croissant, or cheese AND ½ a crumpet.

You can provide your own snack, check the calorie content on the package or work it out from the recipe (e.g. homemade cakes)

<table>
<thead>
<tr>
<th>Fruit</th>
<th>Nuts</th>
<th>Dairy</th>
<th>Savoury</th>
<th>Confectionary</th>
<th>Biscuits / cakes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 small banana</td>
<td>1 small handful of peanuts</td>
<td>1 scoop of ice cream</td>
<td>1 small bag of crisps</td>
<td>1/3 of a standard Mars bar</td>
<td>2 digestives</td>
</tr>
<tr>
<td>5 dried apricots</td>
<td>5 brazil nuts</td>
<td>1 small pot of full fat/creamy yoghurt</td>
<td>2 tablespoons of hummus</td>
<td>5 jelly babies</td>
<td>1 chocolate caramel digestive</td>
</tr>
<tr>
<td>6 prunes</td>
<td>2-3 walnuts</td>
<td>1 medium slice of cheese</td>
<td>2-3 dates</td>
<td>3 squares of milk chocolate</td>
<td>2 custard creams</td>
</tr>
<tr>
<td>1 heaped tablespoon of sultanas/raisins</td>
<td>7 almonds</td>
<td>30mls of condensed milk</td>
<td>½ a crumpet and butter</td>
<td>2 Kit Kat fingers</td>
<td>2 bourbons</td>
</tr>
</tbody>
</table>

Establish resident’s preference, document goal in care plan and record actual intake
Milkshake and Smoothie Recipes

- MUST = 1 - moderate risk of malnutrition: provide one nourishing drink
- MUST = 2 or more - high risk of malnutrition: provide two nourishing drinks

Blend all the recipes below until smooth.

**Super Shake**
- 200 mls full fat milk
- 3 tbsp (45 mls) double cream
- 1 scoop ice cream
- 4 tsp milk powder (semi-skimmed)
- Add Flavourings i.e. 1 banana or 1 handful of berries or 2 teaspoons milk shake flavouring (e.g. Nesquick/Crusha)

Calories: 630kcals Protein: 19g

**Fruit Blast**
- 100 mls fresh fruit juice
- 100 mls lemonade
- 1 scoop ice-cream
- 1 tablespoon sugar

Calories: 273-387kcals Protein: 0.5-2.5g

**Yoghurt & Berry Smoothie (1)**
- 150 mls full fat milk
- 1 pot (150 mls) full fat fruit yoghurt
- 4 tsp milk powder (semi-skimmed)
- 1 banana
- 1 handful of 2 berries (strawberries, raspberries, blueberries, blackberries)
- 1 tsp honey/sugar

Calories: 410kcals Protein: 22g

**Fruit Boost**
- 150 mls orange juice
- 50 mls pineapple juice
- 1 banana
- 1 handful strawberries
- 1 handful raspberries

Calories: 190kcals Protein: 3g

**Yoghurt & Berry Smoothie (2)**
- Small pot of Greek yoghurt
- Handful of frozen berries
- 1 small banana
- 150mls full cream milk (blue top)

Calories: 395-513kcals Protein: 15g

**Banana & Peanut Butter Smoothie**
- 150 mls full fat milk
- 1 scoop ice cream
- 4 tsp milk powder (semi-skimmed)
- 1 banana
- 1 tbsp peanut butter
- 1 tsp honey/sugar

Calories: 490kcals Protein: 19g

Establish resident’s preference, document goal in care plan and record actual intake.
Fortified Milk Recipe

1. Take 4 tablespoons (~70g) of dried milk powder
2. Add a small amount of full fat milk (blue top) from 1 pint
3. Mix to a paste with no lumps
4. Add the remains of the milk
5. Stir well

1 pint of whole milk = 380Kcal, 19g proteins
1 pint of fortified whole milk = 640Kcal, 43g proteins

Use this whenever milk would normally be used:
- In tea/coffee
- Porridge/cereals
- Custard
- White sauce
- In mashed potatoes
- In milky drinks

Differences when using fortified milk

1 cup of tea or coffee, no sugar, semi-skimmed milk

15kcalss
1g protein

1 cup of tea or coffee, 2 sugars, fortified milk

75kcalss
3.5g protein

3 cups of tea/coffee a day:
180kcalss gained + 7.5g protein

Created by Hampshire Hospitals prescribing support dietitians in association with West Hampshire and North Hampshire CCGs - March 2015
Strategies to improve oral intake

General Guidance

- Discuss favourite foods/preferences with the resident and ensure mealtime card is completed on admission and referred to thereafter.
- Encourage to eat more when feeling well/alert. Ensure positioned upright and assisted if necessary during mealtimes and when giving snacks and fluids.
- Consider pictorial or larger print menus for patients with visual impairment or who have dementia.
- Encourage independence and ensure residents have their hearing aids, glasses and teeth at mealtimes.

Nausea

- Ensure nausea is controlled by giving regular anti-emetics 30 minutes prior to meal.
- Offer small frequent meals and snacks.
- Offer dry foods, such as toast or crackers, especially first thing in the morning before the resident gets up.
- Offer fizzy drinks e.g. lemonade, ginger ale or mineral water.
- Avoid giving rich sauces, fatty or fried foods as these may exacerbate nausea.
- Encourage the resident to eat at the table and remain in an upright position for at least 30 minutes after the meal.
- Offer drinks in between meals, rather than with meals to avoid filling up on fluids.
- Fresh air may help keep the dining room well ventilated, encourage the resident to sit outside or take a short walk.
- Try offering sharp, citrus or ginger flavoured foods and drinks.
Swallowing Issues

- If swallowing has been identified as an issue, refer to the speech and language therapist and ensure specified guidance is followed

Constipation

- Constipation can be caused by a number of factors such as insufficient fibre or fluid intake, lack of mobility, medication or eating less.
- Constipation can decrease appetite so alleviating constipation may improve appetite.
- Ensure the resident is well hydrated by encouraging regular fluid throughout the day.
- Encourage high fibre foods:
  - Whole grain breakfast cereals such as porridge, weetabix™, branflakes™
  - Fruits and vegetables (pureed, fresh, frozen or dried)
  - Peas, beans and lentils (especially added into soups or stews)
  - Wholemeal bread or granary bread
  - Wholemeal pasta or brown rice
  - Flapjacks or oat based biscuits
  - Fruit smoothies, blended soups
- Encourage mobility where possible.

Although a high fibre intake can ease constipation it is essential higher fibre foods are introduced **gradually** and accompanied by an **increased fluid intake** to avoid discomfort and bloating.

Changes can take a few weeks to take effect. If symptoms are not alleviated in four weeks, or are severe, contact the GP.
Dementia

Nutritional issues in dementia are common and mealtimes can become stressful for the individual with dementia, carers and other residents.

The Carolyn Walker Trust have produced ‘Eating well with dementia’ pack which gives tips on addressing many of the issues around eating and eating behaviour in dementia (see useful resources).

- Keep the environment calm with minimal distractions such as television, or play relaxing music
- Introduce routine seating plan
- Introduce a fish tank in the dining area (calming effect)
- Use pictorial menus
- Keep table settings simple – have a good contrast between table cloth, plate and food
- Interact with your residents, prompt and praise
- Avoid resident waiting for long periods of time at the table
- Know the person and their food preferences
- Avoid foods which are difficult to eat such as spaghetti
- Keep observing to check that food is accessible
- Cut food into bite size pieces before serving and try offering finger foods to promote independence
- Experiment and implement a variety of interventions
The case for good hydration

- **UTIs, continence, Kidney and gallstones**
Maintaining adequate hydration levels, rather than high fluid intake per se, is important in the prevention of urinary tract infection. Many older people are reluctant to drink during the evening to eliminate the need to go to the toilet during the night. Evidence shows, however, that the restriction of overall fluid intake does not reduce urinary incontinence frequency or severity, and can be detrimental. Good hydration can reduce the risk of kidney stone formation by 39% because dilute urine helps to prevent crystallization of stone forming salts. Consumption of fluid at regular intervals can also help by diluting bile and stimulating gallbladder emptying, which in turn helps to prevent gallstone formation.

- **Constipation**
Inadequate fluid intake is one of the most frequent causes of chronic constipation. It is more frequent in incapacitated or institutionalised older people, affecting some 42% of patients admitted to elderly care wards. In individuals who are not adequately hydrated, drinking more fluid can increase stool frequency and enhance the beneficial effect of daily dietary fibre intake.

- **Heart disease & Diabetes**
Adequate hydration reduces the risk of coronary heart disease by 46% in men and 59% in women. It also protects against blood clot formation by decreasing blood viscosity.
Fluid is an essential part of the dietary management of diabetes since dehydration can worsen diabetic control. In poorly controlled diabetic individuals, high urine output can increase the risk of dehydration. Good hydration levels also help to slow down the development of diabetic ketoacidosis during insulin deficiency in type 1 diabetes, and help maintain healthy blood glucose levels.

- **Cognitive impairment**
Dehydration adversely affects mental performance. Symptoms of mild dehydration include light-headedness, dizziness, headaches and tiredness, as well as reduced alertness and ability to concentrate. Once thirst is felt (0.8-2% dehydration), mental function may be affected by as much as 10%. Mental performance deteriorates progressively as the degree of dehydration increases. In older people this impacts on cognitive function leading to increasing frailty, functional decline and a reduction in quality of life.

- **Pressure Ulcers and Skin**
Poorly hydrated individuals are twice as likely to develop pressure ulcers because dehyrdration reduces the padding over bony points. Fluid intake to correct impaired hydration increases levels of tissue oxygen and enhances ulcer healing.
Being well hydrated is a good way to keep skin healthy and young-looking. The skin acts as a water reservoir and participates in fluid regulation for the whole body. Mild dehydration causes the skin to appear flushed, dry and loose, with a loss of elasticity.

- **Falls and Low blood pressure**
The risk of falls increases with age and in older people can result in injury and fractures. Dehydration is one of the risk factors, since it can lead to a deterioration in mental state, and increase the risk of dizziness and fainting. Many older people suffer a drop in blood pressure on standing, which sometimes causes them to pass out. Drinking a glass of fluid 5 minutes before standing helps stabilise blood pressure, and prevent fainting.
The maintenance of adequate levels of hydration in older people could be effective in preventing falls, as part of a multifactorial falls prevention strategy.

Created by Hampshire Hospitals prescribing support dietitians in association with West Hampshire and North Hampshire CCGs - March 2015
Hospitalisation:

Dehydration has been shown to increase by twofold the mortality of patients admitted to hospital with stroke. It also increases the length of stay for patient with community-acquired pneumonia.

The Role of Carers

Carers have a vital role in supporting older individuals to maintain healthy hydration levels:

- Identify the residents who will need assistance and support to drink and formulate a care plan.
- Communicate their individual’s needs to all involved, including themselves, relatives, activity organisers and kitchen staff.
- Ensure that fluids are freely available and physically accessible both day and night as well as with meals.
- Encourage them to drink: bring them a nice cool/hot drink rather than ask if they are thirsty or would like a drink.

If an older person finds it difficult to drink, it is possible to maintain adequate hydration levels by increasing the amount of moisture consumed in foods, such as fruit and vegetables, milk puddings, soups...

Written by Hilary J Forrester, Independent researcher and senior policy executive, Science and education, BMA
Further information can be obtained from Water UK (see further reading)
Tips for encouraging fluid consumption

- Encouraging your team to develop a **policy** on how you will provide fluids for your residents.
- Think of an **easy counting system** to help those with mild memory problems, confusion or dementia to consume enough fluids.
- To remind carers to encourage fluid intake for those at higher risk, hang a picture of a **drop of water** in kitchens and near residents’ beds.
- In the dining room, use **different coloured napkins** for those who are at specific risk and need their water intake monitored. Make sure that all staff are aware of the colour used.
- Older people can lose their thirst response and their taste sensation. **Never take it for granted** that they will know when they need to drink.
- Older people may need to be reminded, encouraged and even convinced to drink more. Using a **positive approach** often helps. “Here is some nice cool refreshing water for you” is often more productive than “Do you want something to drink?”
- Residents often **worry** about increased toilet visits in the night, so avoid late evening drinks. Encourage fluids consumption from when residents wake in the morning.
- Residents tend to drink all the water in their glass when they are swallowing their **tablets**. Offering slightly larger volumes of water at this time encourages them to drink more.
- Many people prefer to drink ‘**little and often**’. Try to offer fluids at mealtimes and between meals.
- Offer water and fluids **at all mealtimes**. Make sure that those who are less able can choose to drink.

...Continued next page
Tips for encouraging fluid consumption

...continued

- Where possible, inform families and friends about the importance of promoting hydration when they visit. They can help in meeting that important hydration target.

- As the weather gets warmer, increase the availability of fluids and encourage residents to drink more. Older people perspire more in warmer weather.

- Cold drinks are best served fresh and cool – not left in open jugs.

- For trips and for use in outside areas, providing residents with a personal bottle can help. These are easy to carry, to clean and to refill, and can be marked clearly with the resident’s name.

- During activities or group events, try serving drinks with slices of lemon and ice cubes at each resident’s table place when they begin. Make sure you keep refilling their glasses as the event goes on, so they can drink little and often.

- Encourage residents to participate in growing fresh mint, lemon verbena and lemon balm in the garden, if possible. Add sprigs – freshly bruised – to a pot of hot water or to jugs of cold water. It makes a fresh-tasting drink and has an appetising aroma.

- Have fun when explaining why water is good for you. Encourage local primary schools to come in and present the health benefits of drinking fluids to residents and staff. Water is now a central part of the government’s Healthy Schools programme.

- Persevere! Helping people to recognise and choose healthy options will take time and patience.

These suggestions are unattributed and have kindly been offered by care home managers, caring teams, catering staff, nurses, dieticians and related charities. All relevant medical practice and care guidance must be observed before considering these suggestions. Suggestions are reproduced with the kind permission of the Royal Institute of Public Health, Kingston Hospital, Quantum Care Homes, Leicestershire County Council, Water UK and the National Association of Care Catering.
Helping swallowing in Elderly and Dementia Care

Eating and drinking can be affected by a range of different things in the elderly and those with dementia

- Decreased attention and short term memory problems may lead the person to be distracted from the process of eating and drinking
- In the later stages they may not recognise food/drink and “forget” to swallow
- They may chew too quickly or not at all
- Sometimes food with “bits” in, and tablets may be spat out
- They can lose control of thin liquids in the mouth, causing coughing before the swallow has taken place
- Anxiety, depression and feelings of isolation may affect the need /desire to eat and drink
- They can be more prone to oral infections
- Medications can affect alertness, cause a dry mouth and make them more prone to reflux
- They may be over stimulated in a setting with too much noise or visual clutter

General advice

Positioning

- Upright position with head tipped down slightly
- The person should stay upright for 30-60 minutes after a meal in order to reduce reflux

Equipment

- Use a normal cup, rather than spouted beakers or straws
- A teaspoon may be better than a dessert spoon, if a person tends to rush when eating

Environment

- A quiet, supportive environment and an unhurried approach is best
- Verbal and physical prompts may be required
- Try to decrease any distractions
- Simplify the environment by presenting only one course at a time. Try to make each course appear appetising, even if it is a puree consistency
- Discourage talking especially if the person has food/drink in their mouth
- Consider whether it is safe and beneficial for the family to help at mealtimes

Speech and Language Therapists sometimes recommend a pureed or fork mashable diet for someone. The information overleaf will help you make sure the food you provide is the right consistency.
Dysphagia Diet

Food Texture Descriptors: Thick Puree

Dysphagia Diet C

General Description

- Food has been pureed or has puree texture. It does not require chewing
- It is smooth throughout with no ‘bits’ (no lumps, fibres, bits of shell/skin, bits of husk, particles of gristle/bone etc.) It may need to be sieved to achieve this
- It may have a fine ‘textured’ quality as long as the bolus remains cohesive in the mouth
- Any fluid in or on the food is as thick as the puree itself
- There are no loose fluids that have separated off
- It is a thick puree (*please see note below)
- The texture is not sticky in the mouth
- It is not rubbery
- No garnish
- It is moist

Definition of ‘thick’ puree

Holds its shape on a plate or when scooped
Can be eaten with a fork because it does not drop through the prongs
The prongs of a fork make a clear pattern on the surface
It can be piped, layered or moulded
Cannot be poured
Does not ‘spread out’ if spilled

Check before serving/eating:

- No hard pieces, crust or skin have formed during cooking/heating/standing
- Fluid/gravy/sauce/custard in or on the food has not thinned out or separated off

Thick puree texture examples for Breakfasts and Desserts

- The texture of thick smooth porridge made from powder (puree porridge or ready break) with no loose fluids
- The texture of wheat-biscuit breakfast cereal fully softened with milk full absorbed
- The texture of thick blancmange or mousse with no ‘bits’
- The texture of puree rice pudding

Milk must be fully absorbed leaving no loose fluid
Dysphagia Diet

Food Texture Descriptors: Fork Mashable

**Dysphagia Diet E**

**General Description**
- Food is soft, tender and moist but needs some chewing
- It can be mashed with a fork
- No thin loose fluid
- No mixed (thick-thin) textures
- No skin, bone or gristle
- It usually requires a thick, smooth sauce, gravy or custard (see next point)
- Any fluid, gravy, sauce or custard in or on the food is thick (*please see note below*)
- No hard, tough, chewy, fibrous, stringy, dry, crispy, crunchy or crumbly bits
- No pips, seeds, pith/inside skin. No skins or outer shells e.g. on peas, grapes, not husks
- No round or long-shaped foods e.g. sausages, grapes, sweets. No hard chunks e.g. pieces of apple
- No sticky foods e.g. cheese chunks, marshmallows
- No ‘floppy’ foods e.g. lettuce, cucumber, uncooked baby spinach leaves
- No juicy food where juice separates off in the mouth to a mixed texture e.g. watermelon

**Check before serving / eating**
- No hard pieces, crust or skin have formed during cooking/heating/standing
- Fluid/gravy/sauce/custard in or on the food has not thinned out or separated off
- Texture E products must be in a consistency that allows them to be mashed easily using a fork at point of service / consumption

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**Fork Mashable Examples**

<table>
<thead>
<tr>
<th>Fruit</th>
<th>Cereal</th>
<th>Desserts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serve mashed but drain away juice that has separated</td>
<td>Texture of thick, smooth porridge, no lumps Or fully softened wheat-biscuit cereal No separated milk/fluid</td>
<td>Texture of thick smooth yoghurt or stewed apple in thick custard Or texture of soft sponge cake with smooth filling, fully softened with thick custard</td>
</tr>
</tbody>
</table>

**Definition of ‘thick’ fluid**
Any fluid, gravy, sauce or custard in or on food must be thick. A light disposable plastic teaspoon would stand upright if the head were full but just covered.
Dysphagia Diet - Thickeners

Thickeners are used to thicken liquids and foods to various consistencies. They help to slow the transit of foods and fluids to allow more time to co-ordinate the swallowing process safely. This prevents foods and fluids from entering the lungs to cause serious complications e.g. - chest infections and death due to choking or aspirational pneumonia.

Thickeners have evolved in the last few years. A new range of gum based thickeners are now widely available.

<table>
<thead>
<tr>
<th>Gum-based thickeners</th>
<th>Starch based thickeners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaffected by amylase</td>
<td>Stir vigorously to avoid lumps</td>
</tr>
<tr>
<td>More palatable</td>
<td>Less palatable</td>
</tr>
<tr>
<td>Improved stability</td>
<td>Consistency alters over time</td>
</tr>
<tr>
<td>Small volume required for different consistencies</td>
<td>Additional powder can be added to achieve the appropriate consistency</td>
</tr>
<tr>
<td>Does not affect visual appearance</td>
<td></td>
</tr>
<tr>
<td>More soluble</td>
<td></td>
</tr>
</tbody>
</table>

Key recommendations

- Residents with swallowing difficulties to be assessed by a Speech and Language therapist
- Review quantity to avoid waste and over-prescribing
- Use the same thickener for all residents (unless strong rationale present)
- Contact representatives for further training
- For gum based thickeners, add the desired quantity of thickener before adding the fluid

- Avoid pre-thickened drinks e.g. Slo-drinks, Fresubin stage 1 or 2 drinks.
- Avoid sachets
- Avoid using different thickeners in a care home (to minimise source of errors and wastage)
Oral Nutritional Supplements (ONS)

ONS are products manufactured by pharmaceutical companies and prescribable under certain conditions (defined by the Advisory Committee on Borderline Substances, or ACBS). For example to treat disease-related malnutrition.

ONS typically present as a drink in a bottle or carton. Most of them provide around 300Kcal per unit, as well as proteins, vitamins and minerals.

Homemade milkshakes can be higher in calories and more palatable, therefore they should be used first (see milkshakes recipes).

What does 300Kcal look like?

- 1 slice of toast with 1 tablespoon of butter and 1 cup of whole milk
- 2oz of cheese and 4 crackers
- 1 cereal bar and 1 cup of 100% fruit juice

The first line ONS come in 3 presentation:

- A powder to mix with whole (blue top) milk
- Milkshake type drinks (but lactose free) either in standard or ‘compact’ (concentrated) form
- Juice type drinks (but contains no fat, or fruit)

ONS should not replace food, but supplement dietary intake.

ONS should be given with clear goals and regular review to monitor effectiveness/compliance.

ONS should only be considered after a Food First approach has not prevented further weight loss (see malnutrition care pathway on page 13).

Specialist ONS (e.g. Crèmes, Calogen™, Calshake™, Maxijul™ etc.) should only be prescribed under the advice of a dietitian.
Your checklist towards excellence in Nutrition and Hydration Care

- Manager(s) promotes a strong **culture** of excellence in nutrition and hydration care
- Nutrition and Hydration **policy** written and staff understand it
- Staff regularly **sit down** with residents at meal time and/or tea time
- Residents’ dignity is considered at all time: providing the right environment and equipment to promote independence when eating and drinking, and/or when feeding residents.
- Malnutrition pathway adapted to reflect **local** level of services
- Malnutrition **screening** tool used once a month for all residents
- Individual nutrition and hydration **care plans** are updated monthly following screening / assessment
- Individual nutrition & hydration care plans have **S.M.A.R.T.** objectives
- Residents at risk of malnutrition and/or dehydration **flagged up** at handover
- **All** staff aware of which resident are at risk of malnutrition and/or dehydration
- All staff is appropriately **trained** in nutrition and hydration care, including malnutrition screening and dehydration risk assessment
- Chef/catering manager regularly **visit** residents to discuss their individual requirements and preferences
- Residents **consulted** for menu planning and feedback
- Resident and **family** aware of malnutrition and/or dehydration risk and care plan
- **Monthly Audit** of malnutrition screening tool to monitor compliance and accuracy
- **Yearly Audit** of nutrition and hydration care to ensure policy is followed
- Effective and **documented** communication of residents’ nutrition and hydration needs between managers, nurses, catering, health care assistants, activity coordinators, domestic staff, GPs and Hospitals (if admitted)

* **S.M.A.R.T.** = specific, measurable, achievable, realistic and timed
Further Reading and Resources

- Age Concern Hungry to be heard campaign

- Caroline Walker Trust
  Charity that carried out extensive work in nutrition and older people including people with dementia. Very useful resources for preparing and adapting meals to suit the individual resident. Pictorial resources including normal diet, finger foods, soft food and pureed foods.
  [http://www.cwt.org.uk/publications.html#older](http://www.cwt.org.uk/publications.html#older)

- Dignity and Nutrition

- Essence of Care 2010 Acessed online

- Malnutrition task force (full of resources and examples of good practice)
  [http://www.malnutritiontaskforce.org.uk/resources/?resource=140#selection](http://www.malnutritiontaskforce.org.uk/resources/?resource=140#selection)

- National Minimum Standards for Care Homes for Older People. Dept of Health (2003). Accessed online:
  [www.dh.gov.uk](http://www.dh.gov.uk)

- The National Association of Care Catering
  [http://www.thenacc.co.uk/](http://www.thenacc.co.uk/)

- Nutrition & Diet resources
  Resources for your residents or their relatives on a wide range of diet and nutritional conditions. Many posters also available for displays

- Water UK: resources for good hydration

- Companies providing and delivering texture modified food/meals
  Apetito
  Mrs Gills Kitchen
  [http://www.mrsgilskitchen.com/texturemodified.htm](http://www.mrsgilskitchen.com/texturemodified.htm)
  Wiltshire Farm Food
References


With thanks to

Hampshire Hospitals Dietitians
Hampshire Hospitals Speech and Language Therapists
The London Procurement Project
Sarah Colson, prescribing support dietitian for North East Hampshire CCG
Medicine Optimisation teams for North and West Hampshire CCGs
Chris Gunner, Specialist Nurse for residential and nursing homes NHCCG
Maria Garrett-Marley, Development Nurse WHCCG