The Nursing and Midwifery Practice Development Unit

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The Nursing and Midwifery Practice Development Unit

Introduction

The Nursing and Midwifery Practice Development Unit (NMPDU) was established in January 2000 to support the identification, dissemination and implementation of best practice across Scotland.

The NMPDU has a responsibility for “ensuring that role and practice development in Nursing, Midwifery and Health Visiting is taken forward across Scotland in a planned and cohesive manner; that benefits gained from excellent practice in any area – clinical or geographical - might be extended systematically across Scotland to the benefit of patients, staff and the NHS as a whole” (Scottish Office 1997).

One of the key aims of the NMPDU is to identify areas of nursing and midwifery practice amenable to the development of ‘best practice statements’.

Background to best practice statements

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing and midwifery practice. The development of best practice statements reflects the current emphasis on delivering care that is patient centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

What is a best practice statement?

A best practice statement is a statement to describe best and achievable practice in a specific area of care. The term ‘best practice’ reflects the NMPDU’s commitment to sharing local excellence at national level. Best practice statements are underpinned by a number of shared principles (p.2).
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Key principles of best practice statements

• best practice statements are intended to guide practice and promote a consistent and cohesive approach to care

• best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may contribute to multidisciplinary working and other members of the health care team may find them helpful

• statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary

• information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus

• statements are targeted at practitioners, using language that is accessible and meaningful

• consultation with relevant organisations and individuals is undertaken

• statements will be reviewed and updated every 3 years

• responsibility for implementation of statements will rest at local level

• key sources of evidence and available resources are provided
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Key stages in the development of best practice statements:

A unique feature of the Gerontological Nursing Demonstration Project practice statements is that they are refined through evaluative research to enhance practice utility.

Gerontological Nursing Link Nurse Network selects topic
- Identify practice demonstration site and local project link staff
- Gather supporting evidence and examples from practice
- Review research literature, major reports, audits, existing guidelines, standards
- Draft statement
- Audit current practice within demonstration site, develop a strategy to achieve implementation
- Implement, evaluate and refine statement
- External consultation process
- Review and update statement (3 yearly)
Who was involved in developing the statement?

Steering Group

Debbie Tolson  Professor of Gerontological Nursing, Glasgow Caledonian University
Irene Schofield  Gerontological Nursing Research Fellow, Glasgow Caledonian University
Ruth Ramsay  Dietician, Forth Valley Primary Care NHS Trust
Morag MacKellar  Head of Nutrition and Dietetic Services, Forth Valley Primary Care NHS Trust
Linda Campbell  Gerontological Link Nurse Network
Sandra Cameron  Gerontological Link Nurse Network
Sue Gardiner  Gerontological Link Nurse Network

Demonstration Site Staff

Dr Joanne Booth  Nurse Consultant, Forth Valley Primary Care NHS Trust
Christine O’Donnell  Senior Clinical Nurse, Bo’ness Community Hospital. Forth Valley Primary Care NHS Trust
Avril Magill  Senior Clinical Nurse Manager, Forth Valley Primary Care NHS Trust
Ailsa Black  Head Housekeeper, Bo’ness Community Hospital. Forth Valley Primary Care NHS Trust
Morag MacKellar  Head of Nutrition and Dietetic Services, Forth Valley Primary Care NHS Trust

The Quality of Life User Group.  Bo’ness Community Hospital. Forth Valley Primary Care NHS Trust

Nurse Reference Group

Scottish Gerontological Link Nurse Network  (see Appendix 1)
How can the statement be used?

The recommended best practice statement can be used in a variety of ways, although primarily it is intended to promote evidence based practice. The statement is intended to be realistic but stretching and can be used:-

• as a basis for developing and improving the care that nurses give to older people

• to stimulate learning amongst teams of nurses

• to promote effective interdisciplinary team working

• to determine whether a quality service is being provided

• to stimulate ideas and priorities for nursing research
Best practice statement on nutrition for physically frail older people

This best practice statement has been produced by the Nursing and Midwifery Practice Development Unit to offer guidance on meeting the nutritional needs of physically frail older people within continuing care facilities such as community hospitals, nursing homes/care homes. It was developed and demonstrated within a community hospital and has the potential to inform the care of dependent older people who are experiencing delayed hospital discharge or who reside within the community. The statement has been developed collaboratively by the Gerontological Nursing Demonstration Project research team (Glasgow Caledonian University), the Scottish Gerontological Link Nurse Network (Appendix 1), staff at the Demonstration Site at Bo’ness Community Hospital and NMPDU. It is for the use of nurses and care teams and provides information for older people and their families.

The Gerontological Nursing Demonstration Project

This practice innovation research project involves the development of best practice statements, which are informed by a review of existing evidence and refined through testing and user involvement in a demonstration site. The presentation of the statement reflects the emerging definition of gerontological nursing, and an agreed set of values developed by the Scottish Gerontological Link Nurse Network. The statement reflects the beliefs of nurses and may be applied within a variety of care settings. To see the definition and list of values refer to Appendix 2, alternatively you may wish to find out more about the project by visiting the website at www.geronurse.com.
How was the Best Practice Statement on Nutrition for Physically Frail Older People developed?

Evidence from major research studies, audit reports, existing standards, guidelines and committee reports has been reviewed by an Expert Advisor guided by a team of expert practitioners and researchers. Members of the Scottish Gerontological Link Nurse Network have assisted in the identification of the nursing contribution and in ensuring that the statement reflects their beliefs about the nursing care of older people. Groups representing the interests of older people and older people themselves have contributed to the process. The statement has already been tested and revised within a Scottish Community Hospital.

Further information about the development process and evidence base is located at the website www.geronurse.com

What is the evidence base?

All recommendations are evidence based. The level and type of evidence which informs the statements, is denoted using SIGN criteria. In the majority of cases the type of evidence used to support the recommended best practice statements is that obtained from expert committee reports. This is designated as level 4 type evidence (SIGN, 2001). The evidence is given an overall grade recommendation of ‘D’ which suggests that more research is needed to strengthen the evidence base for this aspect of nursing care. You can see the other levels of evidence and grading criteria in Appendix 3.

Who is the statement for?

The recommended best practice statement is primarily for the use of registered nurses. However, other members of the professional health care team may find them helpful in understanding the nurse’s contribution to overall care, and in particular understanding the contribution which skilled nurses can make to the health of dependent older people. The statements have been written in accessible language so that care staff, older people, and their families or carers can understand them and contribute to evaluation.
Further information

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Web site www.geronurse.com
Section 1. Assessment and Care Planning

Key Points:
1. An initial screening of nutritional needs and preferences should be undertaken within 48 hours of admission.
2. Appropriate referral for specialist dietetic assessment is essential.
3. A healthy mouth is crucial for eating and drinking, and is influenced by oral hygiene (mouth care) as well as nutrition and hydration status.
4. Weighing scales and height equivalent measurement instruments are available and staff are competent to use them.
5. The older person and their carer(s) contribute to care planning and evaluation whenever possible.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Reason for Statement</th>
<th>How to demonstrate statement is being achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>A registered nurse completes an initial screening of nutritional needs and preferences on administration.</td>
<td>To identify older people at risk of malnutrition (under and over nutrition), eating problems and to establish food and drink preferences.</td>
<td>Screening includes use of an appropriate tool¹. Body mass is calculated using a recognised method of height equivalent (eg. demispan). Weight is recorded monthly and percentage weight loss calculated six monthly and appropriate action taken². Agreed criteria for referral to dietetic services is available, which draws on the NMPDU Best Practice Statement “Nutrition Assessment and Referral in the Care of Adults in Hospital”.</td>
</tr>
</tbody>
</table>


² 5% weight loss over 6 months indicates significant risk of malnutrition, 10% indicates high risk.
Section 1. Assessment and Care Planning (continued)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Reason for Statement</th>
<th>How to demonstrate statement is being achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment of swallowing function and the condition of the mouth</td>
<td>To ensure safety and identify and plan appropriate care for people with complex needs.</td>
<td>Referral criteria for specialist swallowing assessment by a Speech &amp; Language Therapist exists.</td>
</tr>
<tr>
<td>is made by a suitably competent registered nurse.</td>
<td></td>
<td>Referral criteria for specialist dental care exists.</td>
</tr>
<tr>
<td>Following screening the registered nurse develops a care plan with the</td>
<td>Care is more likely to be effective when the older person is involved in planning their</td>
<td>An evidence based mouth care policy exists1.</td>
</tr>
<tr>
<td>older person, which is implemented and evaluated.</td>
<td>own care.</td>
<td>Findings from the initial screening are documented and inform subsequent collaborative care planning.</td>
</tr>
<tr>
<td>Repeat screening is undertaken as indicated by changes in a person's</td>
<td>Needs change with health status and activity levels. Gradual changes are easy to miss.</td>
<td>An individual's care plan includes agreement on repeat screening intervals.</td>
</tr>
<tr>
<td>condition or at predetermined intervals.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Challenges:
1. Capturing a person-centred assessment.
2. Adopting risk assessment strategies to enable the older person to maintain some control in this aspect of their life.
3. Development of a validated screening tool for frail older people (no validated tool exists for physically frail older people3)
4. Reducing error in the measurement of body mass index and percentage weight change.
5. Provision and maintenance of weighing scales appropriate to the needs of older people.

1 An NMPDU Best Practice Statement on mouth care for older people is in preparation
Section 2. Promoting a Nutritious Diet to maximise health

Key Points:
1. The constituents of a healthy diet for a physically frail older person, are specific to their overall condition, underlying pathologies, treatments, activity level and preferences.
2. Older people benefit from advice on nutritious eating, suited to their individual situation. Information enables informed decisions.
3. By promoting a nutritious diet nurses have the potential to enhance the health and wellbeing of frail older people.

<table>
<thead>
<tr>
<th>Statement</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses are knowledgeable about the constituents of a nutritious diet and apply this knowledge to maximise the health of frail older people.</td>
<td>Older people in hospitals and care homes are at risk of under nourishment. Provision of an energy and nutrient rich diet has the potential to improve the health and wellbeing of frail older people.</td>
<td>Older people and their carers receive information on the benefits of a nutritious diet. Appropriate printed/other material is used when discussing food and drink with the individual and families/visitors. Factors that affect an individual’s dietary intake should be documented within the care plan, highlighting issues that are important to the person¹. The multi-disciplinary team find creative ways of promoting a nutritious diet for individuals at risk of malnutrition and monitor progress. There is an adequate supply of nutritious food and drink available outside of standard mealtimes. Full fat milk is offered in preference to reduced fat milk.</td>
</tr>
</tbody>
</table>

¹ The intake chart used within the Demonstration Site is shown in Appendix 4

Key Challenges:
1. Finding ways to make culturally appropriate information accessible and relevant to dependent older people and their families / friends.
   Identifying barriers to change and negotiating solutions acceptable to the older person.
2. Accepting that the older person may not wish to follow a therapeutic diet.
3. Problem-solving to achieve the best care solutions for individuals. For example, considering the merits of exposure to sunlight in relation to the need to boost Vitamin D levels.
4. Responding to changes in needs during episodes of acute illness/ infection.
5. Working within Health & Safety Regulations in the provision of snack foods.
Section 3. The Environment of Care

Key Points:

1. Mealtime and snack time environments influence food and drink consumption.
2. It is the responsibility of registered nurses to enhance the mealtime care environment.
3. Staffing ratios will influence the quality of the mealtime care environment and capacity to provide assistance.

<table>
<thead>
<tr>
<th>Statement</th>
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</thead>
<tbody>
<tr>
<td>Registered nurses ensure that the environment where a person eats is conducive to the enjoyment of meals.</td>
<td>Mealtimes are an important part of an older person’s day. A relaxed, comfortable, friendly atmosphere, free from distractions is likely to promote increased intake of food and drink.</td>
<td>A registered nurse supervises mealtimes. There is opportunity to take meals, in company or alone, away from bed and treatment areas. Furniture, napkins, cutlery and crockery that promote dignity, choice and independence are available and used appropriately. Levels of background noise and other distractions are kept to a minimum during meals. Individuals are encouraged to eat and drink at their own pace and there is no time limit placed upon mealtimes. Family, friends and volunteers are welcomed at mealtimes to encourage and assist their relative if this is the wish of the individual.</td>
</tr>
</tbody>
</table>

Key Challenges:

1. Locating and creating or adapting a space separate from the bedside to take meals.
2. Controlling levels of background noise.
3. Having adequate numbers of staff to assist individuals to eat without rushing meals.
4. Ensuring that individuals are comfortable and that dignity and independence are promoted throughout mealtimes.
5. Making it possible for an older person to enjoy fresh air and sunshine, if that is their preference, to stimulate appetite.
Section 4. The Managerial Role of the Nurse

Key Points:

1. Mealtime care is recognised as a complex activity which is crucial to the health and wellbeing of frail older people.
2. Registered nurses have an important managerial role to play in promoting good nutritional care.
3. Fulfilment of the nurse’s managerial role is dependent upon collaborative working with all staff and departments involved in the provision and preparation of food, in particular dietetic and catering personnel.
4. Involvement of older people, informal carers and nursing staff in menu planning is recommended.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Registered Nurses manage the provision of food and drink as a vital part of the provision of the older person’s total care. Registered nurses forge links between management, dietetic, catering and portering staff, to enhance the nutritional care older people receive.</td>
<td>The quality of nutritional care is influenced by: • Policies concerning food and drink provision • The methods used to transport food to specific facilities and to individuals • The physical, organisational and social emotional environment in which food and drink are consumed</td>
<td>There is an up to date local food and health policy on which practice is based; the policy is influenced by the views of nursing staff and the wider multi-disciplinary team. The policy specifies frequency of meetings and review/audit. Older people, their carers and nursing staff have input into menu planning and review on a regular basis. Choices are provided from a minimum of 2 main dishes at each meal, including choices for those with culturally specific needs, chewing/swallowing difficulties and reflect individual preferences. A minimum three week menu cycle is provided and reviewed at regular intervals. Menus are provided in a range of formats, for example large print and should include accurate descriptions and photographs of dishes.</td>
</tr>
</tbody>
</table>
Key Challenges:
1. Making services constrained by budgets responsive to the nutritional needs of frail older people.
2. Describing meals in language or pictures that accurately and appetisingly represent the dish.
3. Providing a range of textures and food / drink choices.
4. Avoiding menu fatigue.
5. Finding ways of serving food promptly to maintain nutritional quality, temperature and appearance.

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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Meals are selected as close to mealtimes as possible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The presentation, portion size and temperature of meals is monitored.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feedback is provided to caterers on suitability of food, wastage and menu choice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reviews of the success of food and drink provision are carried out and incorporate the views of nursing staff, patients and carers.</td>
</tr>
</tbody>
</table>
Section 5. Education and Training

Key Points:
1. Evidence based practice cannot be achieved without investment in education and training.
2. Partnerships in Active Continuous Education (PACE) packs offer the minimum acceptable level of training.
3. Investment in training enables staff to plan care that satisfies needs for food and fluids.
4. Delivering care for individuals with complex needs requires practical know how, interpersonal skills, problem solving skills and flexibility.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Reason for Statement</th>
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</thead>
<tbody>
<tr>
<td>Registered nurses and care assistants are provided with education and training on the importance of food and fluids to the health and well-being of older people.</td>
<td>Registered nurses must be able to assess older people’s needs in relation to food and drink using recognised assessment tools.</td>
<td>The PACE packs (or equivalent) for registered nurses and care assistants are used as the minimum level of training offered to staff.</td>
</tr>
<tr>
<td>Education/training programmes include training on strategies for translating knowledge into practice.</td>
<td>To ensure that individuals receive food and fluids in a manner that promotes dignity and choice.</td>
<td>Documentation demonstrates assessment and planning for nutrition care at an individual level.</td>
</tr>
<tr>
<td>Nursing staff involved in nutrition care have a minimum of 2 hours training in assisting people with food and drinks; this training is updated every 2 years</td>
<td>Food Safety Legislation requires that staff are aware of good practice in food safety/hygiene</td>
<td>In-house training and education programmes incorporate ongoing updates for staff.</td>
</tr>
<tr>
<td>Registered nurses receive training in screening of the individual’s ability to swallow</td>
<td>Nurses are skilled at recognising and responding to the specific challenges commonly found within this patient group.</td>
<td>Staff are given time to attend updates</td>
</tr>
<tr>
<td>Registered nurses receive education on the effect of dysphagia-swallowing difficulties on nutrition</td>
<td>Staff are aware of different types and consistencies of food appropriate for people at different stages with swallowing difficulties.</td>
<td>Screening of swallowing function is made by a suitably competent registered nurse.</td>
</tr>
<tr>
<td>Registered nurses receive education on the effect of dysphagia-swallowing difficulties on nutrition</td>
<td>Registered nurses are competent in planning interventions to assist people with complex needs to eat and drink</td>
<td>Referral criteria for specialist swallowing assessment by a Dietician and Speech &amp; Language Therapist exists.</td>
</tr>
</tbody>
</table>

Key Challenges:
1. Providing time for registered nurses to achieve essential skills to teach others to develop new ways of working.
2. Becoming skilled in recognising and dealing with, the specific nutritional problems of dependent frail older people.
3. Taking account of an older person’s values, beliefs and experience when inquiring about food and drink habits and preferences.
4. Changing attitudes to meal-time care so that it is seen as an important therapeutic and social event.
5. Accessing training to facilitate simple and preliminary screening of a person’s ability to swallow.
Appendix 1

Sources of evidence:

Section 1. Assessment and Care planning


Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+. These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.
Sources of evidence:

Section 2. Promoting a Nutritious Diet to maximise health


Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+. These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.
Sources of evidence:

Section 3. The Environment of Care


Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+. These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.
Sources of evidence:

Section 4. The Managerial Role of the Nurse


Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+. These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.
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Sources of evidence:

Section 5. Education and Training

British Association for Parenteral and Enteral Nutrition (1999) *Hospital Food as Treatment*, Maidenhead: BAPEN. (4)


Scottish Executive Health Department (1999) NHS MEL 54, Nursing Homes Scotland Core Standards-Nutritional Care, Edinburgh. (4)

Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+. These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.

Recommended Resources

Partnerships in Continuous Education (2001) Fundamental Nutritional Care of the Hospitalised Patient (Trained Staff), PACE, Queen Margaret University College, Edinburgh.

Partnerships in Continuous Education (2001) Nutrition an Issue for Quality Caring (Trained Staff), PACE, Queen Margaret University College, Edinburgh.

Appendix 2

Membership of the Scottish Gerontological Nurse Link Network

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Unit</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson Margaret</td>
<td>Specialist Nurse Practitioner</td>
<td>Mansion House Unit</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Bastianello Linda</td>
<td>Ward Leader</td>
<td>Ashludie Hospital,</td>
<td>Monifieth</td>
</tr>
<tr>
<td>Brown Andrea</td>
<td>Charge Nurse</td>
<td>Cameron Hospital</td>
<td>Leven</td>
</tr>
<tr>
<td>Cameron Sandra</td>
<td>Senior Nurse</td>
<td>St Johns Hospital</td>
<td>Livingston</td>
</tr>
<tr>
<td>Campbell Janet</td>
<td>Clinical Manager</td>
<td>Eastwood Court Nursing Home</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Campbell Linda</td>
<td>Clinical Ward Manager</td>
<td>Raigmore House</td>
<td>Inverness</td>
</tr>
<tr>
<td>Clarkson Duncan</td>
<td>Director of Nursing</td>
<td>Whim Hall Nursing Home</td>
<td>West Linton</td>
</tr>
<tr>
<td>Douglas Muriel</td>
<td>Senior Sister</td>
<td>Borders General Hospital</td>
<td>Melrose</td>
</tr>
<tr>
<td>Findlay Michelle</td>
<td>Staff Nurse</td>
<td>Balfour Hospital</td>
<td>Orkney</td>
</tr>
<tr>
<td>Gardiner Sue</td>
<td>Clinical Nurse Practitioner</td>
<td>Royal Victoria Hospital</td>
<td>Edinburgh</td>
</tr>
<tr>
<td>Glendye Morag</td>
<td>Charge Nurse</td>
<td>Kirkcudbright Community Hospital</td>
<td>Kirkcudbright</td>
</tr>
<tr>
<td>Hagan Stephen</td>
<td>Nursing Home Manager</td>
<td>Rowantree Nursing Home</td>
<td>Rutherglen</td>
</tr>
<tr>
<td>Howieson Jean</td>
<td>Ward Sister</td>
<td>Kirklands Hospital</td>
<td>Bothwell</td>
</tr>
<tr>
<td>Lawson Barbara</td>
<td>Senior Sister</td>
<td>Eastwood Court Nursing Home</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Macgee Mary</td>
<td>Senior General Manager &amp; Divisional Nurse</td>
<td>Ashbourne Homes</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Mann Fiona</td>
<td>Matron/Manager Tamaris</td>
<td>Buchanan Lodge</td>
<td>Bearsden</td>
</tr>
<tr>
<td>McAlloon Mairi</td>
<td>Lecturer/Practitioner in Gerontology</td>
<td>Southern General Hospital</td>
<td>Glasgow</td>
</tr>
<tr>
<td>McCrimmon Matilda</td>
<td>Deputy Sister</td>
<td>Vale of Leven Hospital</td>
<td>Alexandria</td>
</tr>
<tr>
<td>McFadyen Ann Marie</td>
<td>Deputy Ward Manager</td>
<td>Lightburn Hospital</td>
<td>Glasgow</td>
</tr>
<tr>
<td>McLeish Margaret</td>
<td>Sister</td>
<td>Lightburn Hospital</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Mulholland Marea</td>
<td>Staff Nurse</td>
<td>Southern General Hospital</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Ness Lauri</td>
<td>Sister</td>
<td>Dundee General Hospital</td>
<td>Dundee</td>
</tr>
<tr>
<td>Provan Valerie</td>
<td>Quality &amp; Effectiveness Co-ordinator</td>
<td>Ailsa Hospital</td>
<td>Ayr</td>
</tr>
<tr>
<td>Reid Helen</td>
<td>Sister</td>
<td>Mearnskirk Hospital</td>
<td>Glasgow</td>
</tr>
<tr>
<td>Reid Nancy</td>
<td>Practice Development Nurse</td>
<td>Ravenscraig Hospital</td>
<td>Greenock</td>
</tr>
<tr>
<td>Ross Lindsay</td>
<td>Specialist Practitioner</td>
<td>Royal Victoria Hospital</td>
<td>Dundee</td>
</tr>
<tr>
<td>Stones Lorna</td>
<td>Charge Nurse</td>
<td>Queen Margaret Hospital</td>
<td>Dunfermline</td>
</tr>
<tr>
<td>Tocher Ria</td>
<td>Clinical Development Nurse</td>
<td>Corstorphine Hospital</td>
<td>Edinburgh</td>
</tr>
<tr>
<td>Tongs Christine</td>
<td>Health Visitor for the Elderly</td>
<td>Health Centre</td>
<td>Shetland</td>
</tr>
<tr>
<td>Turnbull Anne</td>
<td>Sister</td>
<td>Dumfries &amp; Galloway Royal Infirmary</td>
<td>Dumfries</td>
</tr>
<tr>
<td>Warden Mandy</td>
<td>Team Leader</td>
<td>Community Mental Health Team</td>
<td>Forfar</td>
</tr>
</tbody>
</table>
Appendix 3

Definition and Principles of Gerontological Nursing

‘Gerontological nursing contributes to and often leads the interdisciplinary and multi-agency care of older people. It may be practiced in a variety of settings, although it is most likely to be developed within services dedicated to the care of older people.

It is a person-centred approach to promoting healthy ageing and the achievement of well being, enabling the person and her/his carers to adapt to health and life changes and to face ongoing health challenges.’

To achieve this, in-depth gerontological nursing knowledge and skills are required alongside a commitment to an explicit value base. The virtual practice development community of link nurses has developed a set of principles, which reflects its beliefs about gerontological nursing:

1. Commitment to person-centred care
   Understanding and acknowledging the needs and wishes of the older person and ensuring that these underpin the planning and delivery of care.
   Promoting continuity of care that values the older person's unique past, present and future individuality and recognising and respecting the person's role and contribution to family and wider society.

2. Commitment to an enabling model of care
   Recognising the uniqueness of each older person, and building on positive lifelong coping skills and strategies. Negotiating and reviewing care goals in partnership with the older person and family, according to the individual's needs and wishes.

3. Promotion of an enabling environment
   Promoting positive staff attitudes together with a supportive physical and organisational environment in order to create an enabling living, or care environment that conveys a sense of hope and achievement for the older person.

4. Respect for a person's rights and choice
   Respecting and promoting the rights of each older person as a consenting adult to make independent choices and care decisions, according to the person's wishes, and recognising when it is necessary to draw on patient advocacy services.
5. **Promoting Dignity**
   Promoting dignity in day to day care to include consideration for the older person’s privacy and confidentiality.

6. **Establishing equity of access**
   Acting as champion and striving to secure on behalf of all older people the same access to services as other age groups.

7. **Maximising therapeutic interventions**
   Developing attitudes, knowledge, and skills in order to return a caring event into a therapeutic opportunity for the older person and where appropriate her/his family.

8. **Commitment to developing innovative practice**
   Adopting strategies to promote evidence based gerontological nursing practice and advancing knowledge, skills and competencies of staff through continued education and research.

9. **Commitment to an explicit and shared set of values**
   Developing an agreed care philosophy that seeks to maintain the uniqueness of the older person, reflecting her/his needs and identifying the standards of care, which she/he can expect.

10. **Commitment to interdisciplinary working and partnership**
    Working as part of a team of experts who recognise, seek out and respect each other’s contribution to the care of the older person. Directing the collective effort towards the realisation of goals negotiated with the older person and her/his family, according to her/his needs and wishes.
Appendix 4

SIGN grading system

Levels of evidence

1++ High quality meta analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+ Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1 - Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++ High quality systematic reviews of case-control or cohort or studies
High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal
2+ Well conducted case control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
2 - Case control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

3 Non-analytic studies, e.g. case reports, case series

4 Expert opinion

Grades of recommendation

A At least one meta analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 1++ or 1+

C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 2++

D Evidence level 3 or 4; or
Extrapolated evidence from studies rated as 2+
Appendix 5
Intake Tool used within the Demonstration Site
Forth Valley Primary Care NHS Trust Older Peoples Services

Name: Ward: Date of Birth:

Please record all food and fluid intake below.

Record: N = none eaten/refused, A = all eaten or drunk, \( \frac{3}{4}, \frac{1}{2}, \frac{1}{4} \) eaten or drunk

<table>
<thead>
<tr>
<th>Date:</th>
<th>Food Intake</th>
<th>Fluid Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Fruit Juice</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Cereal/porridge</td>
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</tr>
<tr>
<td>Bread/toast</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Cream/milk</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Supplement</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Mid-Morning</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Biscuit/cake</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Supplement</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Other...........</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Soup</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Fruit Juice</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Potato</td>
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</tr>
<tr>
<td>Vegetable</td>
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</tr>
<tr>
<td>Salad</td>
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</tr>
<tr>
<td>Sandwich</td>
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<tr>
<td>Pudding</td>
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</tr>
<tr>
<td>Fruit</td>
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<tr>
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</tr>
<tr>
<td>Mid-Afternoon</td>
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<tr>
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</tr>
<tr>
<td>Main Course</td>
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<tr>
<td>Potato</td>
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<tr>
<td>Vegetable</td>
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<tr>
<td>Salad</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
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<tr>
<td>Sandwich</td>
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<tr>
<td>Pudding</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
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<tr>
<td>Supplement</td>
<td>A  ( \frac{3}{4} ) ( \frac{1}{2} ) ( \frac{1}{4} ) N</td>
<td></td>
</tr>
<tr>
<td>Before Bed</td>
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<tr>
<td>Toast/Sandwich</td>
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<td>Supplement</td>
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