Improving Nutrition . . . Improving Care

Care Home Services
Residents’ and carers’ experiences of food and nutrition in care homes

Eat Well          Get Well   Stay Well

August 2011
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Key messages

Small things can make a big difference to the way that residents feel – and are vital in helping us meet our key objectives:

• sitting with someone while they eat “even just a wee half biscuit”, or giving someone whose ability is lessened following a stroke enough time to eat independently - helping someone to have the right meal in the right way at the right time

• offering someone a whole potato – ensuring that a person’s nutrition needs and diet preferences are being met

• “now and again, [we] are asked about what we want and the staff do listen” – involving residents and carers in good nutritional care

Preparing food for someone, knowing that it is something that they enjoy and will eat, is a real expression of caring in every sense.
Section 1 Introduction

Many elderly people live in care homes in Glasgow, and undernutrition affects some 30% of people admitted to care settings. Nearly 40% of residents from care homes admitted to hospital are at risk of malnutrition, and at discharge, malnourished patients are more likely to be admitted to nursing homes and subsequently re-admitted to hospital than those who are not malnourished.

The causes of malnutrition are both social and clinical; they include underlying disease and decreased mobility. In turn, it predisposes sufferers to disease, delays recovery from illness, adversely affects wellbeing, quality of life and clinical outcomes, and has major economic consequences.

The Scottish Government published the National Care Standards, focussing on care homes for older people, and in 2002, established the Care Commission (now Social Care and Social Work Improvement Scotland) to regulate care services. Since then there has been a growing awareness of the importance of nutrition in care homes.

In 2003, Audit Scotland highlighted a number of specific concerns in nutritional care, and subsequently significant progress has been made in this area. For example, standards for food and fluids in hospital have been developed and progress on implementation has been reviewed and monitored.

The Better Health Better Care Action Plan describes the Scottish Government’s belief that access to effective primary care and specialist health services for people in care homes can help to reduce admissions to hospital, and the same document affirms its commitment to increased application of anticipatory care approaches.

A nutritional pathway is now available for care homes in Glasgow. It implements Step 5 of the Malnutrition Universal Screening Tool (MUST) and includes care management guidance. Crucially, the pathway is designed for multi-disciplinary use, including care staff, nurses (some of whom are able to prescribe nutritional supplements), and dietitians. It enables care home staff to assess malnutrition risk for each resident, and describes actions to be taken for those at low, medium and high risk.

The development of the pathway reflects the three key ambitions of Healthcare Quality Strategy for Scotland – that care should be safe, effective, and person-centred.

The Improving Nutritional Care Programme, led by Healthcare Improvement Scotland, aims to improve nutritional care for adults who are at risk of malnutrition. Priority areas for this work include the development and local testing of a communication tool to improve transitions between hospital and care home settings and the development of ‘Making Meals Matter’ resources to assist in improving meal time processes to ensure that people receive appropriate and safe nutritional care and the help they need to eat and drink.

Section 2 Aims and objectives

The aim of this project was to provide qualitative data illustrating the use of the MUST and the recently developed care management pathway, and to provide an opportunity for the sharing of learning between staff in different care homes.

The objectives were:

- to explore residents’ and carers’ perceptions of good nutritional care
- to determine whether residents’ nutrition needs and diet preferences are being met
- to determine whether residents are receiving the right meal in the right way at the right time, and
- to explore the extent to which residents and carers are involved in the provision of good nutritional care.

Section 3 Method and sample

Audit and re-audit work has been undertaken in connection with the pilot phase of the implementation of the pathway. Additionally, a baseline audit has been undertaken to assess the work that will be needed to implement the pathway in those homes in which it has not yet been initiated. This phase of activity has been undertaken to provide qualitative data about the
use of the pathway, and specifically its impact on residents.

The Care Home Services Dietitian identified four care homes as potential settings for this project. These care homes provided a cross section in terms of location and ownership, and their staff had responded constructively to the implementation of the nutrition pathway. Managers at all four accepted the invitation to take part in this project.

As preparation, staff at the homes were invited to use the Improving Nutritional Care case study template to help them to think about the range of issues associated with food and nutrition prior to the collection of data. The patient involvement facilitator made visits to two of the homes to gain an understanding of meal time organisation and processes.

A question set for semi-structured interviews was compiled. Interviews were undertaken at the care home with residents identified by care home staff as being well enough to take part, and with family carers.

Residents were interviewed at each of the care homes, and a small number of family members were also kind enough to give their time.

- Campsie View: Three residents and one family member
- Clarence Court: Four residents
- Sherbrooke Lodge: Two residents and two family members
- Westacres: Two residents

Two of the residents interviewed were quite confused as a result of dementia.

Interviews were conducted by the patient involvement facilitator. The question set was used to prompt rather than steer discussion for each interview - respondents were encouraged to express their views freely. Notes were made during each interview and transcribed on the same day. The transcripts were analysed by the interviewer, and were also read by the Care Home Service Dietitian.

Additional data were gathered through drawing on the observations made at mealtime visits, data provided from the case studies, and the nutritional care communication tool.

**Section 4 Summary of findings**

Discussions with residents and their families were largely positive as regards their experiences of food and nutrition in the care homes. Even those who commented negatively (sometimes very negatively) on the food had positive things to say about aspects such as choice and range.

**Residents’ experiences**

Much of what was said by residents provides evidence that the Food First element of the MUST is being followed.

- **Residents’ preferences.**
  
  “I’m always offered an alternative

  If I ask, they will make me something different

  Staff are always asking if residents have enjoyed things

Overwhelmingly there were descriptions of choices being available and of alternatives being offered, as evidenced by the quotes above. However, one or two people commented that many of the dishes available are mince-based, so that the range available is not as wide as it first seems.

- **Provision of meals and energy dense snacks.**
  “I enjoy the fruit and the smoothies”
  “They have a special biscuit for me”

Residents described having three meals each day, breakfast, lunch and an evening meal, and spoke about snacks being available when they wanted them. They mentioned home bakes, and smoothies made with fortified milk, and that those who have smoothies enjoyed them. People also mentioned the availability of fresh fruit.

- **Fluids.**
  “You can get a cup of tea or anything – they will give it to you”
  “There are always teas, coffees, and biscuits available”
Again, residents said that they always had drinks – fluids were served with meals and there were drinks served in the periods between meals. Many residents also described having fridges in their own rooms that they used for drinks and snacks such as yogurts.

- Monitoring of food intake.

“I’ve been encouraged to eat more and been given things that I fancy”

“Staff notice if you haven’t eaten, and do what they can to help”

There was an awareness that staff are trying to help residents to minimise weight loss. Generally, people felt that staff would notice if they were not eating – and that they would try to tempt them with an alternative. When asked about having time to eat, almost everyone said that they had plenty of time to eat, that they were not rushed. One person commented that they enjoyed having the opportunity to have small amounts to eat but often.

- Weight monitoring.

“[Resident] is weighed weekly and I’m confident staff keep an eye on this”

Several of the residents and relatives who took part in interviews described being weighed regularly. A number of other themes emerged from the discussions.

Loss of control

“You know that you are not in charge and you can’t fight against it – you just go with it”

“You have to look at it in a different way from being in your own home”

There were many comments about no longer choosing, buying, and preparing food for themselves and for others. People described this as being a big change, and part of the larger transition of moving from a (relatively) independent life at home to living in a care home. This was perhaps particularly marked for people who had been used to living by themselves and therefore having absolute freedom about what and when they ate. Conversely, one resident commented that in his own home he had had to wait for carers to arrive and help him, and tended to rely too much on filled rolls. He felt he had greater variety in his present circumstances.

Environmental issues

“It’s their condition”

“It’s not doing me any harm to talk to them”

Most people described eating their meals in the dining area. It was striking that several people expressed real tolerance as regards the behaviour of some of their fellow residents, commenting that people could not help it, that their actions were related to their condition. For most people, the benefit of being at a dining table, having company and perhaps the opportunity for some discussion outweighed the disadvantages. For one person, however, the tendency of a fellow resident to fiddle with and sometimes empty a catheter bag in the dining area had encouraged her to eat in her own room. Another resident commented that if you happen to be at a table with a number of people in wheelchairs, it can leave little room beneath the table for you to stretch or move your own legs. One resident pointed out, it can be hard to see other people enjoying foods that your own body no longer tolerates.

Help with eating

Most of the residents who took part in interviews did not need help with eating. Those that did, described getting as much help as they needed, but not more – that is to say, they were encouraged to be as independent as possible. One in particular described having movement in only one arm, and that staff continue to encourage her and to ensure that she has plenty of time to eat her meals.
Presentation

“People made a range of comments about the way that food looked – some felt that it was served as well as it would be at home, but others felt that the different elements of the meal were not always easily distinguishable on the plate. A number of people whose appetites were limited commented that it was off-putting to be faced with a very full plate – particularly if you did not find the content to be appetising in the first instance.”

Involvement in menu planning

“Now and again, people are asked about what we want and the staff do listen”

“Two people, living in different homes, described catering staff as coming to see them to ask about their preferences, in each case because of their specific dietary requirements. Both described this as being done willingly: “that’s what we’re here for”. One of these residents also described being provided with appropriate snacks to take with him to social events, so that he would not miss out. He felt very confident that he would never be given food that did not meet his dietary requirements, and did not feel that he had to check that he was being given appropriate meals.”

Pleasure from food

“Meals here are not as important as they are on the outside – it’s a routine, not like a family life.”

“Some people described getting just as much pleasure from their food as they always had done, and looking forward to it as much as they had done – or even more if they had relied on carers and filled rolls before. For others, much of the pleasure had dissipated.”

During the course of the discussions, there were some very poignant comments. For example, it was striking that when people spoke about the things that they would really like to have, they were very simple: an egg mayonnaise sandwich with some cress for example, or Pringles, or just having a whole potato rather than always mashed – “could they keep aside some whole potatoes?” Some of these preferences were spoken of as reminders of being in their own homes. One resident described how her husband sometimes brings her a piece and jam or a piece and meat because “he wants to look after me but he can’t”. It was touching to hear that one person had their own marmalade, bought at their church fair, which was kept in the dining room for his morning toast - a small thing that was important for the person and clearly valued by him.

There were some comments, too, about how difficult it is to eat when you don’t feel like it, when your appetite is poor, and the importance of being given time and encouragement. One person commented that physical symptoms can have quite unrelated impacts on the appetite: the example she gave was that her frustration with loss of hearing often puts eating right out of her mind.

Whilst there were a small number of scathing comments about the quality of food, there was also realism about what is possible: “this is a home, not a five star hotel”, “you can’t make soup like your mother made for this many people”, “and they’re trying to keep [dozens of] people happy, seven days a week.”

Carers’ experiences

Family members’ comments also suggest that the Food First element of the MUST is being followed.

• Residents’ preferences. One person said that there always seems to be a good choice – that staff seem to make what people want if they ask for it.

• Provision of meals and energy dense snacks. There was a comment that there is soup every day “and that’s a great way of getting nutrition into people.”

• Fluids. One person said that staff are constantly reminding residents about having...
enough to drink, and that drinks are always on offer.

- Monitoring of food intake. One person described the care her relative had had from staff as being the key element in her recovery following a bad experience with hospital staff. This included encouraging her to eat – following very significant weight loss in hospital – staff would sit and encourage her “even just a wee half-biscuit …. And they have managed to build her up”. Another described staff as being very patient – if his wife did not want to eat (she is unable to eat unassisted) they would leave for a while and come back and try again. He was confident that she is properly nourished.

- Weight monitoring. Family members described their relatives being regularly weighed, and one noted that weighing was not possible, but he knew that they took other measurements as a proxy.

Other comments reflected the themes identified in discussion with residents.

Environmental issues

There was some concern that the dining area can be difficult because of the behaviour of some residents whose dementia is well progressed.

Help with eating

Family members perceived staff as preferring residents to eat in the dining room so that they can see how they are doing with their food. Family presence, however, is not encouraged – and they were not sure whether this is a good thing or not. For example, they wondered whether their presence might distract their relative from eating.

Involvement in menu planning

One family member described a meeting with the owner of the home who had explained what they were trying to achieve with their catering plans.

Pleasure from food

One person commented on the provision of cakes for special occasions, and how important this can be - especially for people who do not have family to bring in, say, a birthday cake. Another commented on the availability of tea and coffee and how nice it was to be able to have a cup with her relative, or to share a meal warmed in the microwave in the small kitchen.

Whilst not the focus of this project, family members commented on the extent to which staff were, in general, very caring.

Better Together: Health and Community Care – Patient Experience

Many of the comments made by residents and relatives confirm the views of NHS staff as to what matters to patients –

- Patients want involvement in their care and good communication about it
- The system should be sufficiently flexible to meet people’s individual needs

Commentary on experience of visits

It is also, perhaps, worth commenting on the experience of the visits.

- There was a pleasant atmosphere at all the homes and it was clear that staff took an interest in residents as individuals.
- The dining rooms were initially quite daunting as regards behaviour patterns, and it was noticeable that in some cases, residents who were likely to be disruptive were seated in places where they could readily be moved, and where their behaviour was less likely to disrupt mealtimes for other residents.
- It was clear that there was strong encouragement for people to come to the dining rooms to eat.
- The interviews were lengthy – partly because food is very important to people and they had a lot to say about it, and partly because some had quite poor memory and tended to be quite repetitive in their discussion. This in itself was quite revealing – they spoke at length about the food of their childhood, the food that had been prepared for them by their mother, and the food that they had prepared for their own families.
- Food and mealtimes seemed still to play a large part in people’s lives, though sometimes very poignantly, underlining the loss of control they were experiencing in their lives, and their stoical acceptance of less than ideal circumstances.
Nutritional care

There was evidence from discussions with both residents and their family members that care was given to ensuring that residents were being properly nourished. Descriptions were given of residents being weighed regularly and appropriate action taken if necessary. It was noted that residents are not rushed at mealtimes, staff pay attention to whether individuals are eating and encourage them to do so, including offering alternatives. Smoothies were commented on as being popular, and soup as being served regularly and a good way to get nutrition into people (though in fact unfortified soup may have limited nutritional benefit). Overall, there was significant evidence that facilities follow the “Food First” guidance.

Meeting of nutritional needs and preferences

Again, there was evidence that such needs were met. Residents described being offered choices at each meal and alternatives being offered if nothing appealed. Discussion with people who have specific requirements suggested that these are well recognised and food prepared to ensure that needs are met.

Equally there was realism about what is possible in the context of a many-bedded home, and recognition that not everyone can be pleased all the time. Nonetheless, people spoke of some very simple foods that they would like to have and it would seem that ways should be found to provide these.

The right meal in the right way at the right time

Residents described having been able to make choices, having options about the timing of breakfast and the availability of snacks when they wanted them, and having dietary requirements met. They described having the option to eat in their rooms or in the dining areas. There were some concerns about portion size – feeling overwhelmed by large portions when not very hungry. Equally, there were positive views about having small amounts to eat at regular intervals.

Involvement in the provision of good nutritional care

There were descriptions of attending catering meetings (though not everyone speaks up at these) and mixed views about the extent to which these influence change and improvement. Family members felt that they were not encouraged to visit at mealtimes. Family members spoke about the importance of still being able to have a cup of tea with their relative, and valued the facility to do this.

Generally, it seems that the homes visited have a person-centred approach to provision of food and nutrition – the marmalade kept in the dining room is a helpful example of this, not least because it shows how simple it can be.

Section 6 Conclusion

Overall, there is strong evidence that in the homes visited, staff and management are working hard to ensure that residents have food which is nourishing, enjoyable, meeting the specific needs of individual residents and served at appropriate times and in a comfortable environment.

Specifically, there is significant evidence that the “Food First” policy has been embraced. This should mean that the numbers of admissions and readmissions to hospital from these care homes is reduced.

Whilst, as recognised by several of the residents, there are inevitably limitations imposed by budgets and the number and range of people for whom homes are catering, it is a matter of concern that some residents find the food to be unappetising and of poor quality.
Section 7 Recommendations

In order to continue to improve residents’ experiences of food and nutrition in care homes, a number of actions that should be taken at individual, local or national level.

Building on existing good practice; there should be discussion with residents about their general food preferences when moving into homes, as well as enquiry about particular favourites, and similar questions should be asked regularly throughout their stay. These discussions should include catering staff, so that they have a clear understanding of residents’ wishes.

• There is a need for good facilitation at catering meetings to encourage active participation, and for the provision of clear feedback on actions taken, including reasons when requested changes cannot be made, in line with the Food, Fluid and Nutritional Care Standards.

• Care home staff should be made aware of:
  – the support that is available to them from their own Nutrition Champions, Care Home Liaison Nurses, and from community dietitian services.
  – the standards and guidelines about food, fluid and nutrition available to guide and inform their work.
  – resources such as the communication tool to improve transitions between hospital and care home settings, and the ‘Making Meals Matter’ pack, developed by the Improving Nutritional Care Programme, led by Healthcare Improvement Scotland.10

• Care home managers should also ensure that:
  – relevant staff take part in the Nutrition Champions Education programme, and ensure that their colleagues are aware of these roles.
  – consider membership of the National Association of Care Catering – this would, for example, help them to remain up-to-date with standards and best practice.
  – Seek out accredited courses and education events in therapeutic catering specific to their residents’ needs.

The Food First strategy should continue, including for example, the provision of smoothies – these seem generally to be very popular and have the additional advantage of enabling minimal wastage of fruit.

This report should be disseminated to participating homes in the first instance, and subsequently more widely, to promote the sharing of learning. (It is also downloadable from www.healthcareimprovementscotland.org and www.nutritioncare.scot.nhs.uk)
Section 8 References and further reading


2. British Association for Parental and Enteral Nutrition. Malnutrition Matters, Meeting Quality Standards in Nutritional Care, May 2010


6. NHS Quality Improvement Scotland. Food Fluid and Nutritional Care in Hospitals, Edinburgh, 2003


8. NHS Greater Glasgow and Clyde. MUST Care Homes Management Guideline, 2010


Clinical Governance Support Unit

Family and resident experience of nutrition issues

Questions for residents/carers

For you/the person you care for, what are the things that are important as regards meals/nutrition generally? What is it that makes you want to eat a meal?

Prompts
Involvement in menu planning
Sufficient choice – including if you are on a therapeutic or textured diet
Nutritional content
Quantity
Meet dietary / cultural needs
Presentation
Timing
Getting appropriate help with food
Availability of snacks
Quality of ingredients
Something to drink
Comfort / environment of the dining area
Other

Food first;
Any transitions to/from hospital

For you/the person you care for, how well are those elements addressed at the moment?

Prompts
Involvement in menu planning
Sufficient choice – including if you are on a therapeutic or textured diet
Nutritional content
Quantity
Meet dietary / cultural needs
Presentation
Timing
Getting appropriate help with food
Availability of snacks
Quality of ingredients
Something to drink
Comfort / environment of the dining area
Other

In so far as those elements are addressed for the person you care for, do you feel you play a part in that?
If yes, in what way?
Do you want to play a part?
What happens if you or the person you care for wakes during the night – is it possible to get something to eat then?
Overall - on this scale,
Do you / the person you care for look forward to mealtimes?

No

Food first;
Any transitions to/from hospital

Just as much as I always did

How much pleasure do you / the person you care for get from your meals?
[For people who are eating independently / don’t need texture modification]

None

Food first;
Any transitions to/from hospital

Just as much as I always did

If you were in charge, is there anything you would change? / If there were one thing you could change, what would it be?
Any other comments?
**SCORE = 0**  
**LOW RISK**

- Care Home Resident
  - Repeat screening monthly and document the date and score (see Guideline Note 2)

  **NOTE:** All enteral feeds should be referred to the HEFT or care homes service's Dietitian (refer to contact list)

**SCORE = 1**  
**MEDIUM RISK**

1. Monitor all food and fluid intake. Weigh weekly if ongoing weight loss. Document dietary intake for 3 days, a trained nurse should evaluate. Establish and document nutritional goals
2. Treat any underlying conditions which may affect food and fluid intake e.g. nausea, vomiting, constipation, diarrhoea, low mood, dysphagia, (see Guideline Note 1)
3. Follow Food FIRST advice; provide 3 x meals and 3 x energy dense snacks daily. Remember to meet resident preferences. Encourage fluids, minimum requirement 1500mls daily. (See Dietary Management Advice sheet 2)
4. Encourage use of Build-up drinks or Complan drinks, refer to nourishing advice drinks sheet 6, offer 2 to 3 a day when patient is acutely ill e.g. chest / urinary tract infections until their appetite returns
5. For diabetic / weight management

**SCORE = 2**  
**HIGH RISK**

Take action as for medium risk and follow HIGH RISK

- Unplanned weight loss of 5 - 10% in the past 3-6 months (No improvement)
- Continue with food fortification
- Prescribe 1 x nutritional supplement daily via G.P. / Nurse Prescriber
- Review treatment goals + repeat Risk Score (See Guideline Note 3)

**REVIEW IN 4 WEEKS - Is there any progress towards nutritional goals**

- YES
  - Reinforce dietary advice as required
  - Continue until targets are met
  - Discontinue use of supplements gradually if they are used
  - Residents should be monitored monthly until goals achieved

- NO
  - Review treatment plans weekly and refer to Dietetic Service
  - If resident is on an end of life care pathway, refer to Dietetic Service may not be appropriate
  - Please contact the Community / Care Home Services Dietitian / Care Home Nurses Liaison Team if you would like further information

**REFERR TO DIETITIAN IF:**

- Nutritional supplements are a sole source of nutrition
- Resident scores high risk and already prescribed nutritional supplements for Dietetic review
- Detailed nutritional assessment needed e.g. Iron Deficiency or has dysphagia with weight loss
- Specialist advice required following diagnosis e.g Renal Disease / Coeliac Disease
- Pressure Ulcers, stage 3 or 4
- Gastrointestinal conditions e.g. active Crohns Disease
- Always seek Dietetic advice if in doubt

Contact Numbers: Care Home Services Dietitian 0141 427 8370, Care Home Nurse Liaison Service 0141 427 8364, Care Home Services Fax 0141 427 3647
### Guideline Notes

**1. Problems Affecting Nutritional Status - Checklist**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reduced ability to swallow food/fluid</td>
<td>Follow SLT guidance, refer to thickening fluids advice. (3) Refer to Dietitian if MUST Score high and weight loss</td>
</tr>
<tr>
<td>b. Poor dentures or chewing problems e.g. patient gums, badly fitted dentures</td>
<td>Encourage improved oral hygiene. Refer to community dentist if appropriate.</td>
</tr>
<tr>
<td>c. Reduction in independence to eat and drink e.g. difficulty-holding utensils, cognitive failure re cutlery</td>
<td>Consider finger foods. Refer to dietary management (5) Use small eating and drinking aids. Refer to community Occupational Therapy if available</td>
</tr>
<tr>
<td>d. Poor posture</td>
<td>Check posture and ensure food and fluid is easily reached. Refer to Physiotherapy where appropriate</td>
</tr>
<tr>
<td>e. Prolonged nausea, vomiting, and diarrhoea. Proven malabsorption e.g. Crohn’s disease</td>
<td>Review medication. Consult GP Refer to Dietitian if active</td>
</tr>
<tr>
<td>f. Infection e.g. UTI</td>
<td>+++ Infection, encourage fluids, minimum of 8 to 10 cups daily. (1500mls), check for Diabetes, refer to Hydration Guideline (8)</td>
</tr>
<tr>
<td>g. Pressure sores, leg ulcers</td>
<td>Refer to the Dietitian if stage 3 or 4. Encourage fluids 8-10 cups daily.(1500 mls)</td>
</tr>
<tr>
<td>h. Constipation (refer to Hydration Best practice Guidance).</td>
<td>Increase dietary fibres. Encourage fluids 8-10 cups daily.(1500 mls)</td>
</tr>
<tr>
<td>i. # Fractures/falls</td>
<td>Check recent weight loss Check for dehydration Consider vitamin D/Calcium Support</td>
</tr>
<tr>
<td>j. Depression/Mental Health e.g. confusion, behavioural</td>
<td>Refer to GP/CPN Check for dehydration. Encourage socialization – the company of others at mealtimes can help or vice versa</td>
</tr>
<tr>
<td>k. Disease progression</td>
<td>Assess whether nutritional intervention is appropriate</td>
</tr>
</tbody>
</table>

**2. Therapeutic Diets**

- a. If BMI > 30kg m2 – weight reduction plan. Follow advice on dietary management chart. Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity
- b. If resident has diabetes – Follow dietary management guidance. (1)
- c. Always seek advice from a Dietitian for other specific diets e.g. gluten free, renal disease

**3. Nutritional Supplements**

- Only those supplements listed, according to GCC Formulary should be prescribed. i.e. 1.5 mls/ kcal Fortisip, Fortisip Multifibre, Fortisip yoghurt style, Fortijuice. Please refrigerate before use. All other supplements e.g. Calogen, Procal require dietetic referral. - When commencing Nutritional Support, if choice of milk or juice is not known a starter pack should be prescribed to determine tolerance before a 28 day cycle prescription is requested and this should be reviewed by GP/ Care Home Liaison Nurse re: appropriateness of use. Only one supplement choice should be ordered.
- Nutritional supplements can suppress appetite & affect food intake therefore avoid at mealtimes.
- Clear directions need to be given to residents and staff requiring nutritional supplements.
- Only to be taken between meals and not as a meal replacement.
- Residents can become bored - encourage variety, request mixed flavours.
- Do not exceed 500 – 600 kcas per day (2 cartons of nutritional supplement) unless under the care of a Dietitian. Monitoring and Follow- up review required 3 to 6 monthly by Pharmacy /Dietitian
- Do not offer sipfeeds to residents not prescribed.
- Weighing Scales should ideally be sit on or hoist and be calibrated annually.

Residents identified as requiring nutritional supplements should have their prescription request form completed by CHLN or GP and a copy forwarded to the Care Home Services Dietitian for audit purposes.
### Case Study template document

Improving communication between care homes and hospital regarding nutritional care

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the problem?</td>
<td></td>
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<tr>
<td>Why did you choose this area/team to begin testing?</td>
<td></td>
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<tr>
<td>What were your aims and goals?</td>
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<tr>
<td>What was your PDSA cycle/ TEST OF CHANGE?</td>
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<tr>
<td>What were your predictions?</td>
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<tr>
<td>What did you learn?</td>
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<tr>
<td>Did this change result in improvement?</td>
<td></td>
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<tr>
<td>What were your measures? Insert data, charts or process and outcome measures</td>
<td></td>
</tr>
<tr>
<td>How did you know the process you implemented was reliable?</td>
<td></td>
</tr>
<tr>
<td>How do you plan to spread your improvement to another area/team?</td>
<td></td>
</tr>
<tr>
<td>How have staff benefited?</td>
<td></td>
</tr>
<tr>
<td>How have people in care homes and hospital benefited?</td>
<td></td>
</tr>
<tr>
<td>What lessons did you learn, what will you do differently next time?</td>
<td></td>
</tr>
</tbody>
</table>

Improving Nutritional Care Programme, Healthcare Improvement Scotland
## APPENDIX 4 Improving Nutritional Care Programme communication tool

### Nutritional Care Communication Tool

For people from care homes being admitted to and discharged from hospital

### Nutritional Screening

<table>
<thead>
<tr>
<th>Care home</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admission date:</td>
<td>Discharge to care home date:</td>
</tr>
</tbody>
</table>

**Nutritional Screening**

<table>
<thead>
<tr>
<th>Height</th>
<th>MUST Score</th>
<th>Height</th>
<th>MUST Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td></td>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>BMi</td>
<td></td>
<td>BMI</td>
<td></td>
</tr>
<tr>
<td>Date Screened</td>
<td></td>
<td>Date Screened</td>
<td></td>
</tr>
</tbody>
</table>

**Physical assistance required with eating and drinking including chewing and swallowing difficulties**

<table>
<thead>
<tr>
<th>Requires assistance with eating or drinking?</th>
<th>Requires assistance with eating or drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, specify assistance required:

- Prompting
- Cutting up food / opening packets
- Modified eating equipment eg: cutlery, plates
- Assistance with eating
- Full assistance
- Other (please state)

**Difficulties chewing certain foods/poor dental health including chewing and swallowing difficulties**

<table>
<thead>
<tr>
<th>Requires assistance with swallowing? (dysphagia)?</th>
<th>Requires assistance with swallowing? (dysphagia)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, specify reason / detail:

<table>
<thead>
<tr>
<th>Prompting</th>
<th>Cutting up food / opening packets</th>
<th>Modified eating equipment eg: cutlery, plates</th>
<th>Assistance with eating</th>
<th>Full assistance</th>
<th>Other (please state)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Personal dietary needs**

<table>
<thead>
<tr>
<th>Religious/ethnic/cultural dietary requirements:</th>
<th>Religious/ethnic/cultural dietary requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Food allergy/sensitivity:</th>
<th>Food allergy/sensitivity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, please state:

- Very Good
- Good
- Fair
- Poor
- Very Poor

<table>
<thead>
<tr>
<th>Appetite</th>
<th>Fluid intake</th>
<th>Food/Fluid likes</th>
<th>Food/Fluid dislikes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Nutritional Care Communication Tool**

For people from care homes being admitted to and discharged from hospital

### Hospital

<table>
<thead>
<tr>
<th>Admission</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admission date:</td>
<td>Discharge to care home date:</td>
</tr>
</tbody>
</table>

**Nutritional requirement**

<table>
<thead>
<tr>
<th>Texture modified diet</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gluten free</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Renal Disease Diet</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other (please state)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Solids** (please tick)

- Texture A
- Texture B
- Texture C
- Texture D
- Texture E

**Fluids** (please tick stage)

- Normal
- Stage 1
- Stage 2
- Stage 3

**Diabetic**

- Yes
- No

**Insulin dependent**

- Yes
- No

**Reviewed by Dietitian**

- SALT
- Other

**Additional comments**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

This tool was developed by the Improving Nutritional Care Programme, Healthcare Improvement Scotland in collaboration with Social Care and Social Work Improvement Scotland.
The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are key components of our organisation.

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