Acacium Group Nutrition Policy

Policy Reference | CLIN 15

Version | V4.0

Policy Name	Nutrition Policy
Purpose of Document	To achieve and maintain a high-quality nutritional care for all, this Policy provides comprehensive nutritional rationale, and instructions on oral and enteral nutrition
Target Audience	All Acacium Group workers
Version	4.0
Author	Karen Matthews-Shard
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Lead Director	Karen Matthews-Shard
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Risk and Resource Implications	Resource: Training Risks: Under-nourished clients
Associated Strategies and SOPs	CLIN 09 Safeguarding vulnerable adults CLIN 08 Safeguarding and protecting vulnerable children CLIN 01 Clinical risk management policy CLIN 06 Consent CORP 10 Policy on policies CLIN 14 Record management policy CORP 07 Equality, diversity and human rights policy ORG 06 Communication policy CLIN 26 Clinical governance policy CLIN 42 Management of TPN CLIN 22 General care policy. SOP NUT 02 Enteral Feeding (Adult and Child)
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
Draft v 1	03/01/12/	1st draft.	K. Matthews- Shard
Draft v 2	09/01/12	Karen's changes included.	K. Matthews- Shard
Checked draft v 2	12/01/12		
V2	Oct 2014	Review	KNF/KMS
V2	Oct 2016	Review	KNF/VM
V2.1	Jan 2017	Implementation of new policy template.	KNF/SJ
V2.1	Nov 2017	Updated to include new TCS bio brand description page.	LB/MS
V2.1	Mar 2018	Updated front sheet to include new review frequency date.	KMS/MS
V2.2	April 2019	Implementation of new policy template	CCR/KG
V2.3	Oct 2019	Policy review	Clinical Advisory Group
V2.4	June 2020	Food Consistency Chart mapped into policy	TJ
V2.5	Oct 2020	Update re Rebrand	CCR/CC
V2.6	Jan 2021	Update re Rebrand 2	CC
V2.7	Apr 2021	Added CHS Brand	CC
V3	Nov 2022	3 Yearly review	Clinical Advisory Group
V4	Jan 2025	Rebrand	Clinical Advisory Group

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1. Introduction

1.1 All clients have a right to the provision of food and nutrition to support their needs which are essential for the physical, mental and emotional development of children as well as the quality of life for adult clients.

1.2 It is accepted that nutrition plays an important role in maintaining optimal health. Under-nutrition results from decreased dietary intake, increased nutritional requirements or impaired ability to absorb or utilise nutrients. The results of under-nutrition vary from structural changes, such as loss of body tissue, to widespread physiological and functional effects which may include, but is not limited to:

- Impaired immune function
- Delayed wound healing
- Increased risk of tissue breakdown
- Muscle wasting and weakness affecting respiratory function, cardiac function or mobility.
- Altered structure of small intestine resulting in mal-absorption
- Apathy and depression
- General sense of weakness and illness
- Sub-optimal growth and development in children.

1.3 All Acacium Group workers are responsible for ensuring that client nutritional care is an integral part of their practice.

1.4 Acacium Group recognises that a client requires appropriate nutrition and hydration to maintain well-being and a level of good general health. By law, every client should be provided with a choice of suitable and nutritious food and hydration, in sufficient quantities and to meet any reasonable requirements such as the client's likes, dislikes, religious or cultural background or dietary intolerances.

2. Definitions

Term	Definition
Malnutrition	Malnutrition is a state in which under or over supply of nutrients such as energy, protein, vitamins and minerals causes measurable adverse effects on body composition, function or clinical outcome. Under-recognised and under-treated, **Nearly 3 million people in the UK at any one time are estimated either to live with malnutrition or to be at risk because they do not eat enough – British Nutrition Foundation, Malnutrition Matters 2019**. It leads to delayed recovery, increased visits to GP and increases the frequency and length of hospital stay. Malnutrition is both a cause and a consequence of ill health, increasing a client's vulnerability to disease. Treatment and care should take into account the client's needs and preferences. Clients with malnutrition should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals. When clients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines, a guide to consent for examination or treatment (2009). See also Acacium Group Consent policy. *Definition of malnutrition*: WHO - Malnutrition refers to deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients.15 Apr 2020 • the risk of a body mass index (BMI) of less than 18.5kg/m2

	• unintentional weight loss greater than 10% within the last 3-6 months • BMI of less than 20kg/m2 and unintentional weight loss greater than 5% within the last 3-6 months. BMI is not the only identification measure • https://www.nice.org.uk/guidance/cg32/resources/nutrition-support-for-adults-oral-nutrition-support-enteral-tube-feeding-and-parenteral-nutrition-pdf-975383198917
Risk of malnutrition	At risk of Malnutrition can be defined as: NHS notes people with a body mass index (BMI) under 18.5 are at risk of being malnourished • having eaten little or nothing for more than 5 days and/or likely to eat little or nothing for 5 days or longer. having a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism.
Good hydration	The medical evidence for good hydration shows that it can assist in the management of good health this includes, but is not limited to diabetes, helping prevent pressure ulcers, constipation, urinary infections and incontinence, kidney stones, heart disease, low blood pressure, cognitive impairment, falls, poor oral health, skin conditions and many other illnesses. Dehydration has been shown to increase by two-fold the mortality of clients admitted to hospital with a stroke, and to increase the length of hospital stay for clients with community-acquired pneumonia.
Nutrition support	• Methods to improve or maintain nutritional intake are known as nutrition support and include oral nutrition support, enteral tube feeding and parenteral nutrition.
Oral nutrition	Oral nutrition support includes prescribed diets, fortified food, additional snacks and/or Oral Nutritional Supplements.
Enteral tube feeding	Enteral tube feeding is the delivery of a liquid feed directly into the gut via a tube. See SOP NUT 02Enteral tube feeding (Adult & Child).
Parenteral nutrition	Parenteral nutrition is the delivery of nutrition intravenously.
Anorexia	Uncontrolled lack or loss of appetite for food.
Antioxidant	Natural chemicals which can counteract the damaging effects of tissue oxidation.
Dysphagia	Difficulty in swallowing
Dehydration	Dehydration caused by elevated blood sodium levels (Hypernatraemia).

3. Roles & Responsibilities

3.1 While Acacium Group acknowledges that the nutritional needs of clients is the responsibility of all individual workers there is also an organisational responsibility and accountability to ensure that the workers have the skills to manage the nutritional needs of the clients. The general roles and responsibilities of the individual carers should be set out within care plans. The key roles and responsibilities that relate to Nutrition are set out in the table below.

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.

Line Manager/ Appropriate other	Is responsible for: • Are operationally responsible for ensuring compliance with this policy within their area of responsibility.
Individual workers	Individual workers must: • assess and monitor the nutritional status of clients on a regular basis and act on assessment outcomes • ensure clients receive appropriate nutrition and hydration as set out in their care plan • ensure clients are given modified fluid and diet if required • ensure clients receive assistance to eat and drink • ensure mealtime environment is conducive to eating • ensure food and fluid monitoring charts are completed correctly and acted on where necessary • refer any concerns about a client's nutritional needs to the Line Manager/appropriate other • to complete Nutrition and Food Hygiene training as requested by the Line Manager/appropriate other.
Clinical Advisory Group	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

4. Nutrition: general Guidelines and best Practice

4.1 **Assessment of risk and nutritional screening**

4.1.1 Nutrition screening is the first step in identifying clients who may be at nutritional risk or potentially at risk, and who may benefit from appropriate nutritional intervention. It is a rapid, simple and general procedure used by nursing, medical, or other staff on first contact with the client so that clear guidelines for action can be implemented and appropriate nutritional advice provided. Some clients may just need help and advice with eating and drinking while others may need to be referred for more expert advice.

4.1.2 NICE 32 Guidance for Nutrition Support in Adults (Updated in August 2017) recommend screening for malnutrition and risk of malnutrition across all healthcare settings.

4.1.3 An accurate contemporaneous record of food and fluid intake must be kept in order to monitor those clients who might be at risk of malnutrition.

4.1.4 It is recommended that adults are initially screened using the Malnutrition Universal Screening Tool (MUST). This tool was developed by the Malnutrition Advisory Group which is a standing committee of the British Association of Parenteral and Enteral Nutrition (BAPEN), which may be found at www.bapen.org.uk, it is a nationally validated tool for use in both acute (hospital) and community settings. A summary of the Malnutrition Universal Screening Tool (MUST) may be found in Appendix L.

4.1.5 MUST screens for malnutrition by looking at current weight, weight history and likely nutritional intake. MUST categorises clients into three groups:

- Low (Score 0)
- Medium (Score 1) and

- High risk (Score >2) of malnutrition.

4.1.6 For children and young people, malnutrition can be recognised through regular weight and height monitoring, where this is possible to complete. Each child is issued with the Department of Health's Red Book/Child Growth Record or within client documentation. Where appropriate, children may be taken to a health clinic to have a nurse or health visitor accurately measure the child's weight and height and plot the result on the growth chart. Where a child is unable to attend a clinic or be weighed/measured accurately, measures should be put in place to monitor and record intake, output and any possible losses or gains. These could be indicated by a change in clothes fitting or general observations.

4.1.7 Both adults and children who are particularly vulnerable to malnutrition which includes poor fluid and food intake, should have their daily intake of food and fluids regularly documented as detailed within their care plan, so a general pattern of intake may be seen over time. When recording a client's food or fluid intake it is imperative that the record is made as soon as possible after the food or fluid has been consumed. Workers should not rely on memory to complete the record at a later time as this is likely to be inaccurate. Appendix M contains an example of a Food and Drink Diary to document 24 hourly food and fluid intake.

4.1.8 Where the MUST score is 1 or above, or there is any concern about nutritional intake or weight loss, this must be noted in the client's daily care plan records and reported to the relevant Clinical Manager/appropriate other and referrals made to appropriate professionals as necessary and as detailed within the clients escalation/care plan

4.2 **Meeting nutritional needs**

4.2.1 By law, every client should be provided with a choice of suitable and nutritious food and hydration, in sufficient quantities and to meet any reasonable requirements such as the client's religious or cultural background or dietary intolerances.

4.2.2 Workers should have a reasonable knowledge of what constitutes a healthy, balanced diet. Workers should be familiar with the Eatwell Plate, see Appendix J and the basics of menu planning, see Appendix F Healthy eating guidelines for children 0-5: Factsheet, along with Water UK's Best Practice Hydration Toolkit.

4.2.3 Should a client require a therapeutic diet or nutritional supplements, this is to be documented in the care plan and provided according to instructions given by the appropriately trained healthcare professional.

4.2.4 Food and fluid should be available for clients 24 hours per day, unless restrictions have been put in place in the clients best interest or as decided by the appropriately trained healthcare professional e.g. the dietician.

4.2.5 Where possible, Clients should be involved in planning and selecting the menu, and actively supported to prepare their own meals where this is safe, and they are able to do so. Diets and meals will respect personal, cultural and religious preferences, be it Kosher, Halal, vegetarian and so on. Most foods will indicate whether the pass criteria to meet these requirements. Allergies and intolerances likes and dislikes should be respected and catered for.

4.2.6 Making the mealtime experience as conducive to eating as possible is essential in ensuring the client's nutritional care. Meals in bed or during medical treatments should be avoided. Meals should not be interrupted, unless requested by the Client, or an emergency arises.

4.2.7 Where necessary, support must be provided for the client to eat and drink sufficient amounts. This might include supportive equipment that facilitates independent eating and drinking, or ensuring the client is in a safe and comfortable position to eat and drink. An OT or SALT team may be involved to assess this.

4.2.8 Meals are to be presented in an attractive manner. This includes food that requires texture modification i.e. pureed.

4.2.9 All food and drink is to be handled, stored, prepared and delivered in a way that meets the requirements of the Food Safety Act 1990. This applies to client's in care homes and requires good standard of food preparation and hygiene in a client's own home.

4.3 **Nutrition for physically frail people**

4.3.1 This section has been developed to ensure the nutritional needs of physically frail client are met while being cared for in their own home. It is intended primarily for the use of care workers and all people who contribute to the daily needs of physically frail people. It is not intended to replace specific medical advice given to individual clients.

4.3.2 Malnutrition affects over 10% of older people (65 & over): British Association for Parenteral and Enteral Nutrition (BAPEN) 2019. Eating well and maintaining good hydration helps a client feel their best by giving them energy and ensures their body functions well. Constipation and kidney infections can sometimes be avoided by a healthy diet and adequate fluids. Maintaining an adequate weight can help prevent bedsores and skin tissue breakdown. From a psychological point of view, eating can be social and enjoyable and provides positive benefits beyond just the nutrients. See also Appendix G, healthy eating for the senior years: Factsheet.

4.3.3 The client should contribute to care planning and evaluation wherever possible.

4.3.4 The client should have an initial assessment and re-assessment on a regular basis in order to:

- Identify if the client has recently lost or gained weight e.g. 5% weight loss over 6 months indicates significant risk of malnutrition, 10% weight loss indicates high risk
- Record what the client normally eats and drinks
- Document their likes and dislikes including preferred textures and cutlery or equipment needed for meals
- Establish if they have any food allergies
- Establish if medicines are affecting their appetite or causing them to have a dry mouth/pain etc.

4.3.5 The MUST nutrition screening tool should be employed if there are concerns about the client's nutritional status. See Appendix L Malnutrition Universal Screening Tool (MUST).

4.3.6 Weight should be recorded monthly, if possible, and appropriate action taken if weight loss is significant or the MUST score changes. Weight loss may also be determined by observation. A clinical impression may indicate that the Client is thin, obvious wasting (very thin). Clothes and/or jewellery have become loose fitting. See Appendix L Malnutrition Universal Screening Tool (MUST).

4.3.7 An oral mouth care regimen must be agreed and adopted if applicable, to ensure the client has a healthy mouth.

4.3.8 If there are any concerns about swallowing function it should be assessed by a suitably competent Healthcare professional. A care plan for a client with complex needs will be drawn up. Regular evaluation of swallowing function and repeat screening should be part of the care

plan. Swallowing Function consists of 8 levels (0-7). Levels are identified by text labels, numbers, and colour codes to improve safety and identification. See Appendix N The standardised descriptors and testing methods will allow for consistent production and easy testing of thickened liquids and texture modified foods.

4.4 **Diet**

4.4.1 Care workers should be aware of and promote a nutritious diet so to enhance the health and wellbeing of the Client.

4.4.2 Malnutrition is a risk in the physically infirm or vulnerable client and steps must be taken to ensure this risk is minimised. Preventative steps include:

- Record, in the care plan, any obstacles to achieving a nutritious diet
- Finding creative ways to avoid poor nutrition
- Monitor progress. See also Appendix D: Nutrition and People with a Disability. Appendix F: Underweight clients: Guidelines. Appendix G: Healthy Eating for the Senior Years: Factsheet.

4.4.3 The meal time environment should be conducive to eating a nutritious diet which includes:

- Creating a relaxed, comfortable, friendly atmosphere, free from distractions
- If possible take meals away from the bed or treatment areas
- The provision of furniture, napkins, cutlery and crockery that promote dignity, choice and independence
- Supervise but encourage the client to eat and drink at their own pace where applicable
- No time limit placed on mealtimes where applicable.

4.4.4 The importance of Vitamin D is understood, and the client is given access to at least 10 minutes of sunshine or outdoor time every day where possible. See Appendix H: Vitamin D: Factsheet.

4.4.5 Where possible and applicable, the client should have an input into menu planning and this is reviewed on a regular basis. Meals offered should be culturally and socially appropriate. Meals should be varied in order to avoid menu fatigue.

4.4.6 Escalation as per the clients care plan should take place where the client's dietary needs change during episodes of acute illness or infection,

4.4.7 The presentation, portion size and temperature of the meals must be monitored.

4.4.8 Where applicable, feedback should be given to caterers on suitability of food, meal choice and wastage.

4.4.9 Where there are specific dietary needs due to health concerns e.g. Risk of Aspiration, Unexplained weight loss, Use of Gastrostomy etc. A dietician and or SALT (Speech and Language Therapy team) should be involved. Their role is to review and advise on measures to support, maintain and or improve the clients health and nutritional status

5. Nutritional Support

5.1 Some clients require assistance with maintaining nutritional status through enteral feeding or parental feeding.

5.2 Gastrostomy: A surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for enteral feeding, medication administration or drainage of stomach contents.

5.3 Jejunostomy: A tube surgically inserted into the jejunum for clients who do not absorb nutrients through the stomach.

5.4 Mic-key button: A gastrostomy surgically inserted, with a low-lying button for access. There are also mini-button's available.

5.5 Trans gastro-jej button: A mic-key button surgically inserted which has two tubes; one gastrostomy and one jejunostomy which can be accessed from two access points on the same button.

5.6 Nasogastric tube: A tube that is inserted through the nose and down into the stomach.

5.7 Naso-jejunostomy tube: A tube that is inserted through the nose, through the stomach and into the small bowel for clients who do not absorb nutrients through the stomach.

5.8 Total Parental Nutrition (TPN): Is the direct infusion of solutions containing the essential nutrients in quantities to meet the daily nutritional requirements of the client into a vein.

5.9 IV Fluids.

6. Training

6.1 Acacium Group will enable workers to participate in education and training on the importance of food and fluids to the health and well-being of frail and or vulnerable clients, and where appropriate this will be included in local induction programmes. The training will be proportionate and relevant to the roles and responsibilities of each Acacium Group worker. All training provided will be mapped to the requirements of the individual.

6.2 Education/training programmes include training on strategies for translating knowledge into practice. This ensures that individuals receive food and fluids in a manner that promotes dignity, choice and wellbeing.

6.3 Workers receive education and training in:

- Food safety legislation and good practice in food safety and hygiene
- Recognising and responding to specific challenges commonly found within an elderly or vulnerable group of clients
- The different types and consistencies of food appropriate for clients at different stages with swallowing difficulties.
- The referral process if they have concerns about the client's nutrition or safety during eating.
- Where applicable Specific nutritional support routes e.g. JEJ care.

7. Implementation

7.1 **Consultation**, communication and dissemination as set out in the flowchart in Appendix D of the Policy for drafting policies and standing operating procedures (SOP). Also, the flowchart for the revision or creation of policies, procedures, guidelines and protocols.

7.2 **Ratification** see flowchart in Appendix D of the Policy for drafting, approval and review of policies and SOPs. Flowchart for the revision or creation of policies, procedures, guidelines and protocols.

7.3 **Audit/Monitoring**

7.3.1 Gaps and omissions within the Nutrition policy and procedure will be identified and monitored through the Clinical Director. Action Plans will be developed and subsequently monitored and reviewed by the CAG/Line Managers/appropriate others.

7.3.2 Client specific issues or incidents arising from problems associated with nutrition will be raised through the Risk Management System which will ensure that identified incidences are recorded and monitored. See Acacium Group Reporting and managing complaints policy, the Acacium Group Reporting and managing incidents policy, the Acacium Group Clinical risk management policy and the Acacium Group Risk assessment SOP.

7.3.3 Audits of systems, structures and compliance will be performed at a frequency determined by the Clinical Director and will include:

- Ad-hoc equipment audit
- Service user surveys
- Clinical Audits i.e. medical, dietetic, nursing

8. Associated Policies / SOPs

Policies

CLIN 09 Safeguarding vulnerable adults
CLIN 08 Safeguarding and protecting vulnerable children
CLIN 01 Clinical risk management policy
CLIN 06 Consent
CORP 10 Policy on policies
CLIN 14 Record management policy
CORP 07 Equality, diversity and human rights policy
ORG 06 Communication policy
CLIN 26 Clinical governance policy
CLIN 42 Management of TPN
CLIN 22 General care policy.

SOPs

SOP NUT 02 Enteral Feeding (Adult and Child)

9. References

- Age concern: Still Hungry to be Heard: Age concern August 2008 – updated 2011
- Age Concern UK, State of the Nation (November 2017)
- Department of Health. Essence of Care: benchmarks for promoting health (2010)
- Department of Health. Guide to Consent for Examination or Treatment (2009)
- Dignity in Care http://www.dignityincare.org.uk/Topics/practiceguide/
- Health and Social Care Act 2012 (Regulated Activities) Regulations 2010 - Act
- NICE Guidance 32 Nutrition Support in Adults (November 2012) http://www.nice.org.uk/nicemedia/pdf/cg032quickrefguide.pdf
- Water UK Hydration Best Practice Toolkit for Care Homes (October 2005)
- British Association for Parenteral and Enteral Nutrition [BAPEN], https://www.bapen.org.uk/
- Fit Futures: Focus on Food, Activity and Young People Response from the Ministerial Group on Public Health including consultation on Fit Futures Implementation Plan January 2006. UK and Ireland

- Department of Health (DoH) initiative Improving Nutritional Care (October 2007)
- Promoting good nutrition, a strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016
- Department of Health (2008) Healthy weight, healthy lives: A cross-government strategy for England, London -Act
- Food Safety Act 1990 Applicable to the UK. Only certain aspects apply to Northern Ireland - Act
- Caroline Walker Trust's Eating Well for Looked After Children and Young People and Eating Well for Under 5's in Child Care
- CQC Essential standards of quality and safety.
- Regulation and Quality Improvement Authority (2003). Northern Ireland - Act
- Health and Social Care Act 2008 – this is an Act
- Water for Health. Hydration Best Practice Toolkit for Hospitals and Healthcare. National Patient's Safety Agency and Royal College of Nursing and Water UK. August 2007
- Malnutrition Universal Screening Tool (MUST) Guide.
- www.bapen.org.uk/pdfs/must/must-full.pdf

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1. The table below sets out some of the legislation, national policies and guidance which support best practice in managing nutrition.

Acts/National Policies/Guidance	Explanation
Department of Health (DoH) initiative Improving Nutritional Care (October 2007)	This document has been prepared in accordance with the Department of Health (DoH) initiative Improving Nutritional Care (October 2007), which incorporates NICE Guidelines 32 (February 2006) and recommendations from a variety of sources including: • NHS England new guidance to raise awareness of the importance of good nutritional care (October 2015) • Dignity in Care practice guide • Age Concern UK 'Hungry to be Heard' • Water for Healthy Ageing hydration best practice toolkit.
Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition. NICE Guidelines 32 (February 2006)	The NICE clinical guideline on nutrition support in adults (November 2012) covers the care of patients with malnutrition or at risk of malnutrition, whether they are in hospital or at home. It doesn't cover malnutrition or its treatments in detail
Water for Healthy Ageing. Hydration best practice toolkit **April 2016**	This toolkit has been created as part of a resource to assist care managers, care caterers and other service providers to bring the benefits of improved water consumption to older people in care and to develop best practice.
Still Hungry to be Heard: Age concern August 2008 - updated 2011	Seven steps to end malnutrition in hospital: • Step 1 - Listen to us - We must be consulted about hospital menus, our meal requirements and our preferences, and hospital staff must respond to what we tell them. • Step 2 - All ward staff must become 'food aware' - Ward staff need to take responsibility for our food needs in hospital. • Step 3 - Hospital staff must follow professional codes - Hospital staff must follow their own professional codes and guidance from other bodies. • Step 4 - Assess us for malnourishment - As many of us are malnourished on admission to hospital, we should all be weighed, and our height measured on admission. • Step 5 - Introduce protected mealtimes

	- Protected mealtimes will ensure we are given appropriate assistance to eat meals when needed and sufficient time to eat our meals. • Step 6 - Use a red tray system - Those of us who need help with eating should be identified on admission and our meal placed on a red tray to signal the need for help. • Step 7 - Use mealtime volunteers - Where appropriate, hospital should use trained volunteers to provide additional help and support to us at mealtimes. Source: Still Hungry to be Heard: Age concern August 2008-updated 2011
CQC – Regulation 4: Meeting nutritional and hydration needs	Making sure people who use the service have adequate nutrition and hydration to sustain life and good health
Department of Health guidelines, a guide to consent for examination or treatment (2009)	Consent for examination or treatment
Fit Futures: Focus on Food, Activity and Young People Response from the Ministerial Group on Public Health including consultation on Fit Futures Implementation Plan January 2006 UK and Ireland	The Fit Futures taskforce was established by DHSSPS in response to concerns about rising levels of overweight and obesity in children and young people. A stakeholder engagement process was implemented to consider the themes and priorities and included children and young people.
Promoting good nutrition **a strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016**	Raising awareness, and identifying those individuals most at risk of malnutrition, in health and social care settings, including those we care for in their own homes, are the cornerstones of good nutritional care
Department of Health (2008) Healthy weight, healthy lives: A cross-government strategy for England, London	This cross-government strategy was the first step in a sustained programme to support people to maintain a healthy weight. It was followed up with a public annual report that assesses progress, looks at the latest evidence and trends, and makes recommendations for further action.
Healthy Lives. Healthy People. A call to action on obesity (October 2011)	Past efforts were not successful. There are a range of Partners working to combat causes and consequences of excess weight by 2020
Food Safety Act 1990 Applicable to the UK. Only certain aspects apply to Northern Ireland	The Food Safety Act 1990, is an Act of the Parliament of the United Kingdom. It is the statutory obligation to treat food intended for human consumption in a controlled and managed way. The key requirements of the Act are that food must comply with food safety requirements, must be "of the nature, substance and quality demanded", and must be correctly described (labelled).
NHS Quality Improvement Scotland's Food, Fluid and	Standards focus on: • policy and strategy development

Nutritional Care in Hospital Standards (June 2014)	• nutritional assessment, screening and care planning • planning and delivery of food and fluid • provision of food and fluid • patient information and communication • education and training for staff.
NHS Quality Improvement Scotland Nursing and Midwifery Practice Development Unit: (2007) Edinburgh	Best practice statement: This statement aims to offer guidance to nurses, midwives and health visitors on best practice relating to the care of children in the community receiving enteral tube feeding.
Nutritional Essential, Nutrition and Hydration Royal College of Nursing (August 2019)	RCN have reviewed malnutrition as a comment health problem and have reviewed signs and effects of malnutrition and expectations of nursing staff.
Nursing and Midwifery Practice Development Unit (NMPDU) (2002). Nutrition for physically frail older people: best practice statement Edinburgh	This best practice statement offers guidance on meeting the nutritional needs of physically frail older people within continuing care facilities including community hospitals, nursing homes and care homes. It includes the following sections: • assessment and care planning • promoting a nutritious diet • the environment of care • the management role of the nurse • education and training.
Department of Health, Social Services and Public Safety (DHSSPS) Northern Ireland (Nov 2007): Nursing care standards for patient food in hospital	The 10 care standards were developed in partnership by the DHSSPS Directorate of Nursing and Midwifery and the Royal College of Nursing's Northern Ireland Office. They have been developed for use in all inpatient facilities in the health and social care trusts across Northern Ireland.
Clinical Resource Efficiency Support Team (2004) Guidelines for the management of enteral tube feeding in adults Belfast Crest	These guidelines cover the management of enteral tube feeding and apply to both primary and secondary care.
European Society for Clinical Nutrition and Metabolism: Guidelines and position papers. A range of guidelines from ESPEN including:	These guidelines were commissioned by the British Society of Gastroenterology and cover the indications, benefits, administration and problems of enteral tube feeding in adult hospital practice. • Adult enteral nutrition, paediatric parenteral nutrition, and percutaneous endoscopic gastrostomy (PEG). Stroud, M., Duncan, H. and Nightingale, J. (2003) • Guidelines for enteral feeding in adult hospital patients, GUT, 52, vii1-vii12. M Stroud, H Duncan, J Nightingale
National Association of Care Catering and Sustain (NACC) (2006) Sustainable food in care catering: briefing paper: 2006, Faygate	This report examines what is meant by sustainable food and the reasons for using it in care catering including obstacles and opportunities for doing so. It includes useful sources of further information.
Nutritional Guidance for Early Years: Scottish Executive, 2006	Nutritional guidance for children and young people.

Caroline Walker Trust's Eating Well for Looked After Children and Young People and Eating Well for Under 5's in Child Care	Nutritional guidance for children and young people.
Water for Health. Hydration Best Practice Toolkit for Hospitals and Healthcare. National Patient's Safety Agency and Royal College of Nursing and Water UK. August 2007	The Hospital hydration best practice toolkit is an online resource developed through partnership working with nurses, patient groups and key stakeholders, to encourage hydration best practice in the hospital environment.
CQC Essential standards of quality and safety. March 2010	Regulator standards.
Regulation and Quality Improvement Authority (2003). Northern Ireland	'The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.' The reviews undertaken by RQIA are based on the 2006 'Quality standards for health and social care'. In 2009 the duties of the Mental Health Commission were also transferred to RQIA.
Health and Social Care Act 2012	The relevant part of this act to this policy is introduction of the Care Quality Commission which is an integrated regulator for health and adult social care bringing together existing health and social care regulators into one regulatory body, with new powers to ensure safe and high-quality services.
Social Care and Social Work Improvement Scotland (SCSWIS) September 2011 Core Inspectorate	The independent regulator of social care and social work services across Scotland. They regulate, inspect and support improvement of care, social work and child protection services for the benefit of the people who use them.
International Dysphagia Diet Standardisation Initiative (IDDSI)	The International Dysphagia Diet Standardisation Initiative (IDDSI) is a global standard with terminology and definitions to describe texture modified foods and thickened fluids used for individuals with dysphagia of all ages, in all care settings, and for all cultures.
Health & Safety at Work Act 1974	The Health & Safety at Work Act 1974 requires that all organisations with more than three staff have in place processes to promote the health and safety of their staff.
Control of Substances Hazardous to Health (COSHH) Regulations 2002	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

2. Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: Nutrition and People with a Disability: Guidelines

1 Eating a healthy diet can be a challenge for most people but for a person with a disability it may be a greater challenge. Their disability may be a physical disability, an intellectual disability i.e. from childhood or after an accident or stroke, or a mental illness. Any disability has the potential to impact on the person's ability to eat healthily.

2 People with disabilities have a higher incidence of diet related health problems than the general community. Health statistics tell us they are more likely to experience one or more of the following:

- Obesity
- Underweight
- Constipation
- Malnutrition
- Dehydration
- Heart disease
- Diabetes.

The food we eat, and the activities involved in planning, preparing and eating meals are important to our enjoyment of life. Certain foods and meals make up our cultural identity and give us a sense of belonging.

3 There are many reasons why a person with a disability may be at risk of missing out on the social, emotional and physical benefits of a healthy diet. Reasons include:

- Physical abilities may limit access to shopping, involvement in cooking, independent eating or being able to chew and swallow lumpy foods
- Sometimes healthy eating and balanced meals seem far less important than all the other challenges of daily life
- Medications or certain disorders may alter metabolism and change appetite making it difficult to maintain a healthy weight
- Financial constraints can reduce choice and options
- Depression, boredom or emotional problems can make it difficult to keep motivated about self-care and healthy eating
- Communal and institutional living or difficulties communicating may limit opportunities to be involved in meal planning and having access to preferred food choices.

4 Changing towards a healthier eating plan can result in health benefits and improved wellbeing for people with disabilities. It is important to identify the obstacles the person might have in achieving a healthy diet and creatively thinking about how these obstacles can be overcome. The first step may be ensuring a regular adequate intake of fluids. A good level of hydration can reduce headaches and constipation. Being involved in meal planning, preparation and shared meals can also have social and emotional health benefits.

Appendix D: Underweight Clients: Guidelines

1. Being underweight can make it difficult to stay healthy and may indicate that nutritional needs are not being met. Eating a variety of healthy foods each day will meet the nutritional needs of most people.

2 Some people have special nutritional needs that make it important to choose foods more carefully to prevent weight loss and malnutrition. These include people with:

- Poor appetite
- Illness increasing nutritional needs such as cancer or respiratory problems, lung disease
- Eating disorders
- Physical disabilities.

3 Eating a variety of foods will help to meet nutritional needs. However, some dietary areas that may need special attention include:

- **Energy:** Energy (calories or kcal) will help to promote weight gain and health
- **Protein:** Protein is needed to build and repair body cells
- **Vitamins and minerals:** Vitamin and mineral needs must be met for body cells and organs to stay healthy and function properly.

4 Ideas that can help people who are underweight include:

- Eating small frequent meals and snacks to fit in more food throughout the day
- Having milk drinks between meals. Choose full fat (blue top) milk
- Adding more mono or poly-unsaturated oil (such as olive oil) and margarine to food in cooking will enrich a meal
- Adding skim milk powder or cream to soups, stews and drinks
- Adding grated cheese to cooked foods
- Snacking on cheese and crackers, nuts and dried fruit during the day
- Liberalising fats and sugars in the diet – cakes, biscuits, pastries, crisps and chocolate can provide extra energy when taken alongside meals. Take care that they don't spoil the appetite for more nourishing meals
- Alcohol in small amounts can stimulate the appetite. Check with the doctor or chemist that some alcohol taken before a meal won't interfere with prescribed medicines
- Aim for 6-8 cups of fluid every day. This includes tea, coffee, fruit juice, milk, water and soups. Try taking drinks after a meal if drinking before or during the meal causes fullness ensuring the meal time environment is pleasant and social.

Appendix E: Healthy Eating Guidelines for Children 0-5 Years: Factsheet

1. Healthy eating and physical activity are an essential part of growth and development in childhood. Many of the food habits that are formed during childhood will be retained throughout life. Food should not only be nutritious but should help to meet the social, cultural and educational needs of children. To help children develop healthy eating patterns, from an early age, it is important that the food and eating patterns to which they are exposed, both at home and outside the home, are those which promote good health and positive attitudes to nutrition.

2 Growing children need plenty of energy and nutrients to ensure they grow and develop well. They need a good variety of foods to ensure they receive all the nutrients they need. There is evidence however, that the diets of British children under 5 are:

- Too low in vitamins A and C
- Too low in the minerals iron and zinc
- Too much of the sugars that contribute to tooth decay and obesity
- Too much salt which can contribute to high blood pressure
- Low intake of fruit, vegetables, meat and fish.

3 **Nutrition for Under 5s**

3.1 Good nutrition is the balanced eating of a variety of foods. The foods we eat should provide our bodies with the nutrients needed to stay healthy. This is especially important for children, who are growing and developing.

3.2 Healthy eating not only involves food itself, but also food safety and hygiene, good dental hygiene and dental care, and promoting healthy attitudes to food. Providers of child care are recommended to undertake training in basic food safety and hygiene. Detailed information regarding dental hygiene is available from local dental health teams, but dental care is referred to throughout these guidelines, particularly with reference to drinking vessels and foods offered at snacks. The promotion of healthy attitudes to food should underlie all activities involving or including food. Food should not be offered as a 'treat' and junk food should never be given as a reward or as praise.

3.3 Opportunities to celebrate special occasions with 'junk' or unhealthy food are frequent. However, it is recommended that creativity is used during these celebrations, so that either healthy food is still offered at all times, or that occasions are celebrated without food i.e. offer healthy red-coloured foods on Valentine's Day such as peppers, tomatoes etc. and paint eggs at Easter, rather than using chocolate as a focus.

3.4 Fussy eating and food refusal needs to be addressed at an early age and these guidelines include a small section on fussy eating. Exploratory food play, messy play, and involvement in food activities can be made as part of the child's learning.

3.5 Physical activity is also essential for optimal growth and development in children. The Department of Health recommends that all children from 2 years of age should achieve a minimum of 60 minutes of moderate intensity activity every day. Recent surveys have found that one third of under-5s do not take part in 60 minutes of moderate activity every day. Children should be encouraged to regularly participate in enjoyable activities and decrease time in sedentary activities such as watching television.

3.6 Multi-vitamin and mineral supplements are generally not recommended for children unless a need has been identified. However, the Department of Health recommends all children aged between 1 and 5 years take a vitamin supplement containing vitamin D. Healthy Start vitamins are issued by the NHS can be obtained from the child's health visitor or health clinic.

4 The 'Food Groups'

The food groups we use to describe foods are:

- **Bread, other cereals and potatoes:**
  These should be eaten at every meal. Foods in this group include bread, potatoes, rice, pasta, yam, sweet potato, corn, couscous and wholegrain breakfast cereals. It is not necessary to offer wholemeal bread or pasta as too much fibre in a child's diet can disrupt iron absorption and cause early satiety at a meal. These foods provide energy, fibre, B vitamins and some minerals such as calcium and iron.

- **Fruit and vegetables – 5 a day**
  Children and adults are advised to eat at least 5 portions of fruit and vegetables every day – preferably 3 portions of vegetables and 2 portions of fruit. A child's portion of fruit and vegetables can be described as the size as their own handful. Fruits and vegetables should be offered to children as part of all their main meals. Snacks are also a good opportunity to include fruits and vegetables. These foods contain fibre, vitamins A & C, iron and folate. Fruit or vegetable juices are not a good substitute for fresh, dried or tinned fruit or vegetables. Fruit juice can contribute to tooth decay.

- **Milk and dairy foods**
  Dairy foods should be taken every day. Milk is the main source of calcium for the under-5s and it also contributes significantly to their protein, riboflavin, vitamin A, iodine and zinc intakes. Whole milk (full-fat) is recommended, unless advised by a health professional. For those children who cannot take milk, a suitable alternative that contains calcium and vitamins must be recommended by a health professional.

- **Meat, fish and alternatives**
  Foods from this group should be eaten at least for two main meals every day. This group includes meat, poultry, fish, shellfish, eggs, legumes, beans, peas, lentils, quorn for 2-year olds and over, and soya products, nuts. These foods provide protein, iron and zinc. Highly processed or pre-formed meat, fish and vegetarian products i.e. turkey twizzlers, fish fingers, hot dogs should be avoided or limited.

- **Fats and oils:**
  Some fat is essential in the diet, but a lot of fat is not needed. The best choices for cooking are oils such as olive oil, rapeseed oil, sunflower oil and soybean oil. The best spreads for bread are those that are high in mono-unsaturates or poly-unsaturates i.e. those made from sunflower, soybean or olive oils.

- **Other foods:**
  These include cakes, biscuits, sweets, chocolate, crisps and other savoury snack foods, soft drinks, ice cream and lollies and foods with a high proportion of fat and/or sugar such as pies, pastries and puddings. These foods are usually of poor nutritional quality, contribute to tooth decay and can contribute to obesity. These foods should only be included occasionally, and it is strongly discouraged that these foods are offered as a 'reward' or 'treat'.

5 Recommendations for Menu Planning

Food Group	How much to serve?	Good choices	Notes
Bread, other cereals and potatoes	Foods from this group should be offered at every meal and can be part of snacks. These foods should make up about **one third of the food served each day**.	All types of **bread** – white, granary, soda bread, potato bread, chapattis, naan bread, rotis, rolls, bagels, pitta bread, wraps, tortilla. **Potatoes or sweet potatoes:** boiled, mashed or baked. **Pasta and noodles.** **Rice.** **Yam, plantain, cocoyam, cassava and other starchy root vegetables:** boiled, mashed or baked. **Other grains** – such as couscous or bulghar wheat, maize (polenta) and cornmeal. **Breakfast cereals:** low sugar, low salt cereals i.e. porridge, puffed wheat, Weetabix, crisped rice or flaked wheat.	Look for lower salt breads. Avoid processed potato products like waffles and smiley faces. Avoid dried or canned ready-prepared pasta in sauce as these are very salty. Avoid fried rice or flavoured dried rice in packets. Avoid sugary breakfast cereals (10g sugar per 100g is high in sugar) and bran-based cereals.
Fruit and Vegetables	Offer different fruits and vegetables at meals and snacks. Aim for each day's menu to consist of: **1-2 types of fruit**	**All types of fresh, frozen and canned vegetables.** **All types of salad vegetables.** **All types of fresh fruit.** **All types of canned fruit in juice.** **Stewed fruit i.e.** stewed apples, plums or rhubarb.	Avoid vegetables canned with added salt and sugar. Try to avoid over-cooking vegetables, avoid cutting and soaking in water before cooking, and avoid cooking then reheating, these practices all reduce vitamin and mineral content. Avoid dried fruit with added sugar and vegetable oil.

	2-3 types of vegetables.	**Dried fruit** such as raisins, apricots, dates, dried figs, prunes.	Note – dried fruit should not be served as a snack. To be eaten with main meals only.
Milk and Milk Products: milk, cheese and yoghurt	Foods from this group should be offered at **2-3 meals and snacks each day.**	**Milk:** Expressed breast milk or formula milk should be given to children under 12months. **Whole milk** should be served. **Cheese** **Yoghurt and fromage frais**	Avoid unpasteurised milk and drinks with added sugar. Skim milk is inappropriate. Vegetarian cheese can be used where required. Avoid high sugar yoghurt and fromage frais. More than 15g sugar per 100g is high sugar.
Meat, Fish and Alternatives	**Main meals i.e. lunch and evening meal should always contain an item from this grou*p***.	**Meat** – including beef, lamb, chicken, pork and turkey. **Fish includes:** **White fish:** cod, haddock, coley and white fish from sustainable fish stocks such as pollack, saithe, blue whiting. **Omega 3 oil-rich fish:** herring, mackerel, salmon, trout, sardines, sprats, pilchards. Canned tuna does not count as an oil-rich fish but is a good source of nutrients. **Eggs:** boiled, poached, scrambled or in an omelette. **Pulses:** all sorts of beans and peas, such as butter beans, kidney beans,	Avoid processed or crumbed meat products**.** Choose good quality products. Make sure fish dishes are free from bones. Try to avoid processed fish products such as fish fingers. Aim to offer an omega-3 rich fish at least once a week. All eggs should be well cooked.

		chickpeas, lentils, processed peas or baked beans. **Meat alternatives** i.e. tofu, quorn (for over 2's), soya mince or textured vegetable protein.	Look for canned pulses with no added salt or sugar. Choose low-salt, low-sugar baked beans. Processed products made from meat alternatives i.e. vegetarian sausages, burgers, pies can be high in fat and salt and should not be served more than once in a week.

6 Portion sizes

The appetites of young children can be variable and it is important that children are allowed to eat to appetite from the meal items they are offered.

7 Snacks

7.1 Between-meal snacks are typically offered to children. Snacks provide an opportunity for socialising, development of language skills and can offer additional nutrition for growing children.

7.2 Snacks should be limited to once only, between main meals. Frequent snacks or grazing can contribute to tooth decay and can lead to poor intake at main-meals. Too many snacks can also contribute to obesity.

7.3 Suitable snacks include:

- Fresh fruit * - chopped into finger sized pieces – seeds and stones removed from the fruit where necessary. Note – fruit does not need to be peeled
- Chopped vegetables with dips such as salsa, houmous, cheese & chive
- Cheese cubes
- Yoghurt pots
- Any type of bread or toast (bagels, crumpets, muffins, pitta bread) with thin spread of sunflower/olive oil margarine and/or marmite
- Toasted teacake with thin spread of margarine
- Homemade popcorn (no added salt)
- Low salt bread sticks
- Low salt rice cakes

See snack list below for some more ideas.

***NB:** Dried fruit is not suitable as a snack as it is known to cause tooth decay if given in between meals.

8 Puddings or desserts

8.1 Pudding or dessert is a pleasant and often traditional way of finishing a meal. They should not be seen as a sweet treat, but as an important vehicle for giving children nutrients from dairy foods and fruit.

8.2 Puddings or desserts should be either milk-based, or fruit-based. They need not be complicated. Children often prefer simple foods and even cool, light ones are suitable even in winter.

8.3 Milk-based pudding ideas:

- Yoghurt: fruit yoghurt or plain yoghurt with fresh fruit added
- Custard: served plain or with banana
- Blancmange
- Junket/Milk jelly
- Creamed rice i.e. rice pudding or creamed tapioca

8.4 Fruit-based pudding ideas:

- Fruit salad – fresh or canned in juice
- Finger food size pieces of fresh fruit
- Baked apples or pears served with yoghurt or custard
- Fresh or dried fruit, stewed
- Frozen bananas – place in plastic wrap and freeze to make a banana ice-block
- Fruit flapjack, fruit slice or malt loaf

9 **Salt**

9.1 Recommended maximum for salt, for children, in one day:

- Babies and up to one year old less than 0.4g sodium (1g salt) a day
- 1 to 3 years 0.8g sodium (2g salt) a day
- 4 to 6 years 1.2g sodium (3g salt) a day

NB these are the maximum amounts. Do not add salt to cooking or at the table and choose low-salt packaged or pre-prepared products.

9.2 How can I tell if a food is high in salt?

Look at the nutrition information panel. The 'per 100g' column is where the answer is:

High salt = more than 1.5g salt per 100g or 0.6g sodium per 100g

Low salt = 0.3g salt or less per 100g or 0.1g sodium per 100g

(Food Standards Agency, 2008)

10 **Drinks**

10.1 Children should have access to drinks throughout the day and should be offered drinks at all meals and snacks so as to promote good hydration. All children over one year of age should be offered drinks in an open cup. This means that bottles, feeder cups, sports bottles including 'fruit shoot' type drink containers, or any cup with a spout that would encourage sucking, rather than a sipping action, are all

unsuitable for a child over one year of age. Open cups are the only vessel that drinks should be offered in for any child over one year of age – regardless of what happens at home.

10.2 From the age of 6 months, children may be introduced to a 'trainer cup' or 'doidy cup' that allows children to practice drinking from an open cup, with assistance. Suitable drinks are:

- Milk
- Water

Breast milk or formula milk is the main milk drink for children under one year of age.

Full fa t/ full cream / whole milk is suitable as a main drink for children over the age of one.

10.3 It is not advisable to give the following drinks: fruit juice*, squash, sugar-free squash, cordial, fizzy or soft drinks, hot chocolate or other chocolate drinks, herbal drinks, tea or coffee. Even if diluted, these drinks contain either too much sugar and will cause tooth decay or contain a high level of acid and/or preservatives and should not be given to children, especially under the age of 3. Tea and coffee contain substances that interfere with iron absorption and should not be given to children.

* Fresh fruit juice contains vitamin C and 150ml contributes towards one portion of fruit per day. However, it still contains (natural) sugars (fructose) and will contribute to tooth decay – especially if consumed outside of meal times. Providing the child is consuming fruit and vegetables, it is unnecessary to rely on fruit juice as a source of vitamin C. Advice for nurseries and child minders is to avoid offering fruit juice.

11 Meal times

11.1 Meal times provide a great opportunity for learning. Children learn through sensory exploration and language is fostered in small group situations. Meal times are an obvious place to put these principles into practice. Groups of children seated around a table and serving themselves will communicate particular values. Opportunity will also be provided for children to develop social skills such as sharing, negotiating and estimating as opposed to listening, sitting and learning only restraint and self-control. A certain amount of experimenting with food is to be expected from young children. Too strong an emphasis on table manners, rules and finishing all food on the plate may distract attention from the true learning potential of meal times. Appropriate meal time behaviour can be demonstrated through positive methods of guidance and redirection.

11.2 Children will enjoy being involved in the preparation of the food, setting the tables and clearing away afterwards.

12 Special diets

12.1.1 Vegetarian Diets

A vegetarian diet may be followed for a variety of reasons. It is possible for a child to get all the nutrients he/she needs from a vegetarian diet. The main point to remember when planning a vegetarian diet is that main meals must contain a non-meat item from the 'meat, fish and alternatives' food group. If the child eats fish, then meat can be replaced with fish. Eggs, pulses and meat alternatives i.e. pulses are to be offered in place of meat otherwise.

12.1.2 The following examples of vegetarian meals provide adequate protein and essential nutrients:

- Wholemeal egg and cheese quiche, sweet corn and peas, banana
- Fried tofu, stir-fried vegetables, noodles, soya yoghurt
- Potato curry and rice, dhal, chapatti, orange
- Veggie-burger, jacket wedges, baked beans, rice pudding with apricots
- Vegetables couscous, chickpea salad, apple crumble
- Scrambled egg on toast, grilled tomatoes, raspberry fool
- Baked sweet potato, rice and peas, callaloo, pineapple chunks

12.1.3 **Vegan Diets**

A vegan diet contains only plants such as vegetables, grain, nuts and fruits. Vegans do not eat foods that come from animals including dairy products and eggs. For the advice on vegan diets, it is recommended to discuss healthy eating with an appropriate qualified dietician.

12.2 **Allergies and food intolerances**

12.2.1 Dietary restrictions for children with true food allergies must be taken seriously as the ingestion of allergic foods can be life-threatening. Children with true food allergies can have severe reactions to some foods. Ask parents to provide detailed written information on foods their child can't eat. Some parents may choose to prepare meals for the child themselves. Parents should be encouraged to have the child seen professionally by either a doctor or registered dietician before requesting an allergy diet that may require a lot of extra effort and cost and may otherwise put the child's nutritional intake at risk.

12.2.2 Checklist for food allergies and intolerances:

- What food/s is the child allergic/sensitive to?
- What is the nature of the reaction?
- Refer to a written list of the food and ingredients that the child must avoid which should be given by the parents. Preferably a letter from the doctor or dietician that outlines the child's requirements
- How long will the child be on the special diet for?
- Does the planned diet have adequate substitutes for the missing food group?
- What action should be taken if the child accidentally ingests the prohibited food?
- Review every six to twelve months, obtain details of any changes.

12.3 **Fussy eaters or food refusal**

Variations in appetite are to be expected. Refusal to eat is best treated in a matter-of-fact manner. It is important that a good variety of foods are offered and that children are allowed to make choices about what they do or don't eat. If a child refuses a food or meal, gentle encouragement should be given, but a child should never be forced to eat. It is not good practice to reward a child for eating something they don't want to eat i.e. with a pudding or sweet snack. Children who refuse their main meal or do not wholly complete it should still be offered a pudding or dessert. However, a larger portion size is not warranted. Words of praise and encouragement are all that is needed to promote children to try new foods and a variety of foods.

If a child continually refuses a certain food, wait a few days then try again. Avoiding the disliked food completely will only entrench the child's refusal. Encourage the child to prepare the food – research suggests that they will be more likely to try it. Food preparation activities, food play and simple cooking with healthy food can encourage children to taste and eat new or previously disliked foods.

13 Food hygiene and safety

13.1 Extra care with food safety and hygiene is required for young children, as their immune systems are still immature and therefore they have a lower resistance to food poisoning. It is a requirement that carers handling food for young children complete a Food Hygiene Certificate course.

13.2 Hand washing is essential for good hygiene. Hands must always be thoroughly washed before handling any food or helping children to eat, after changing nappies, toileting children and handling rubbish.

13.3 All bottle-feeding equipment should be sterilized in a recommended sterilizing unit. Feeding bottles and teats should be sterilized until the baby is at least 1 year old, or as long as milk is given from a bottle.

13.4 All feeding equipment (bowls, spoons etc.) must be washed in hot soapy water, and left to drain dry (or dried with a fresh clean tea towel) before storing in a clean dry cupboard.

13.5 Hot food should always be cooked thoroughly and served as soon as possible. Food should not be left at room temperature for long periods of time. Food should never be reheated more than once. Special care needs to be taken when using microwave ovens. Microwaves heat food unevenly, so hot spots can occur. Food must be stirred thoroughly to ensure an even distribution of heat. It is not recommended that milk is warmed in microwave ovens.

13.6 Allow food to cool and test the temperature before offering it to a baby or young child.

13.7 All food should be checked for use-by dates and consumed before the date shown.

References

- Early Years Foundation Stage (2008) DCFS
- Food Standards Agency (2008)
- Healthy Start vitamins: www.healthystart.nhs.uk

Recommended Reading

- Caroline Walker Trust (2006) 'Eating Well for Under-5s in Child Care' – website: www.cwt.org.uk

Appendix F: Healthy Eating for the Senior Years: Factsheet

1 Good nutrition is important at every age but is especially important in the senior years. Eating well and maintaining good hydration helps people feel their best every day, giving them energy and ensures their bodies function well. Eating well can also help prevent heart disease, diabetes, osteoporosis and some types of cancer. Constipation and kidney infections can sometimes be avoided by a healthy diet and adequate fluids. Maintaining an adequate weight in the senior years can help prevent bedsores and skin tissue breakdown. From a psychological point of view, eating can be social and enjoyable – providing positive benefits beyond just the nutrients.

2 The ability to meet nutritional needs can become increasingly difficult as we age. Some common factors that affect food intake in senior people include:

- Altered taste and smell
- Dentures or dry mouth
- Foods requiring texture modification i.e. pureed meals
- Chronic illness
- Living and eating alone
- Poor mobility and inability to shop for food
- Side effects of medications.

3 Below are some ideas to help senior people living in the community achieve a well-balanced diet:

- Aim to eat at least 3 meals a day. Skipping any meal, but especially skipping breakfast will make it difficult to get all the nutrients needed each day
- Offer 1-3 snacks per day in addition to main meals – especially in cases of poor appetite.
- Meals on Wheels or healthy ready meals may need to be considered if there is no assistance for cooking
- Eat a variety of foods as outlined by the Eatwell Plate. See Appendix J
- Drink adequate amounts of fluids, at least 8 glasses each day
- ensure enough calcium-containing foods are consumed. Good sources of calcium are milk and dairy products, fortified foods such as soy or rice milk
- Choose foods low in salt.

4 **Fluids**

Fluids are essential to life, yet many seniors do not drink enough. As we age, our sense of thirst declines so we need to drink regularly whether we feel thirsty or not. Aim for at least eight glasses of fluids each day. Satisfy thirst with water first, but remember that juice, milk, soup, tea and coffee also count towards the total fluid intake. There is also fluid in the foods we eat.

5 **Meal time environments**

Sharing meals with others can help make eating more enjoyable. Creating an environment conducive to eating may also help those who struggle to eat enough. Pleasant music, flowers and a clean and designated eating area, appropriate utensils and food textures may assist the enjoyment of a meal.

6 Eating smaller but more frequent meals during the day, rather than trying to eat three larger meals, may also help to increase food intake. If dentures are impacting on food intake, choose soft and easily chewed foods such as minced meats with additional gravies, bread without crusts and pureed fruit and custards.

7 **Other considerations**
Vitamin D deficiency in the elderly is common. See Appendix H: Vitamin D for more information.

8. Some nutritional concerns that may benefit from professional advice include:

- Dehydration
- Constipation
- Weight and/or poor food intake
- Anaemia
- Osteoporosis.

9 As people grow older, it is important that their nutritional needs are met by the foods they eat. Good nutrition is a key factor in maintaining a healthy body weight and can also reduce or minimise the risk and burden of certain illnesses.

Appendix G: Vitamin D: Factsheet

1. What does vitamin D do for health?

Vitamin D is often called the 'sunshine' vitamin as the skin is able to make the vitamin when exposed to sun. Vitamin D is best known for its role in keeping bones healthy. It is also involved in fighting infections, keeping blood pressure within a healthy range and helping control insulin production. Recent research suggests that vitamin D may also have benefits in preventing some types of cancers, especially colorectal cancer. It may help prevent diabetes and multiple sclerosis as well. As yet, we do not fully understand the role of vitamin D in these three conditions.

2 **What are food sources of vitamin D?**

Vitamin D is provided in a limited number of foods, either occurring naturally or added to the product. Only fatty fish such as salmon, mackerel, sardines and tuna naturally contain substantial amounts of vitamin D. Cow's milk, infant formula, margarine and plant-based beverages (e.g. soy beverages) are fortified with vitamin D, as required by the government. Vitamin D is now fortified in some ready-to-eat cereals and orange juice, and yogurt made with vitamin D-fortified milk. To determine if a packaged food contains significant amounts of vitamin D, look for food labels that show greater than 20% Daily Value (RDA) for vitamin D per serving.

3 **Who is at risk of being deficient in vitamin D?**

Some people may be at risk of not getting enough vitamin D because they don't get enough in their diet or because they have more limited sun exposure which reduces the amount of vitamin D their bodies make.

4 **Adults over 50 years** may not produce vitamin D in skin as well as when they were younger.

5 **Children** under the age of 5 may not get adequate vitamin D and therefore are at risk of developing rickets. It is recommended that all children aged between 6 months and 5 years take vitamin D supplement. The Healthy Start vitamins are issued by the UK Department of Health and contain vitamins A, C and D. They are available from the child's health visitor or health clinic and are often issued free of charge.

6 **Breastfeeding mothers** are also advised to take a vitamin D supplement and again these can be obtained from health clinics – Healthy Start vitamins for women.

7 **People with limited sun exposure**

If sun exposure is limited due to mostly living or working indoors, being unwell and housebound, wearing clothing such as long robes and head coverings, or living in the more northerly regions of UK then it is wise to carefully choose vitamin D rich foods (see above) or to speak to a doctor, dietician or health visitor about taking a vitamin D supplement.

8 Try to spend about 10 minutes outside each day, even in the winter, as sunshine helps the body to make vitamin D, which has a role in keeping bones strong.

Appendix H: Overweight and Obesity: Factsheet

1 **Successful weight management** requires a life-long commitment to a healthy lifestyle, which is focused on eating healthy foods and keeping physically active in a way that is both sustainable and enjoyable.

2 **Body Mass Index**

2.1 Overweight and obesity are commonly defined in adults by body mass index (BMI) which compares height and weight. The following BMI groupings are generally accepted:

- <18.5 kg/m ^{2} = underweight
- 18.5 - 24.9 kg/m ^{2} = healthy
- 25.0 - 29.9 kg/m ^{2} = overweight
- 30.0 kg/m ^{2} and above = obese

2.2 To calculate BMI, the formula is:

(weight in kilograms) divided by (height in metres)^2.

For example, someone who is 65kg and is 1.7m tall, BMI = 65 ÷ (1.7x1.7) = 22.49kg/m^2. This is in the healthy weight range.

2.3 Research indicates that the location excess body fat is most closely associated with health risk.

3 **Body shape**

- **Apple shape**: Abdominal obesity, excess body fat around the abdomen carries higher health risk
- **Pear shape**: Fat deposited on the hips, thighs and buttocks carries lower health risk.

The waist to hip ratio (WHR) can identify abdominal obesity. WHR is determined by dividing the waist measurement by the hip measurement.

A WHR greater than:

- 0.9 for men
- 0.8 for women

Indicates an increased health risk

4 **Associated health problems**

Overweight and obesity are risk factors for other diseases such as:

- Diabetes
- Heart disease
- High blood pressure
- High blood cholesterol levels
- Gall bladder disease
- Some cancers
- Arthritis.

5 Contributing factors

5.1 There are many factors that influence the development of overweight or obesity including:

- Eating more food
- Eating food higher in energy (calories)
- Weight loss and regain (yo-yo dieting)
- Following restrictive weight loss diets
- Being less physically active
- Genetics.

○ In order to lose weight and keep it off, lifestyle changes made must be:

- Realistic
- Achievable
- Able to be maintained for the long-term.

Weight lost quickly on restrictive diets is usually regained and people often end up heavier than they were before starting the diet.

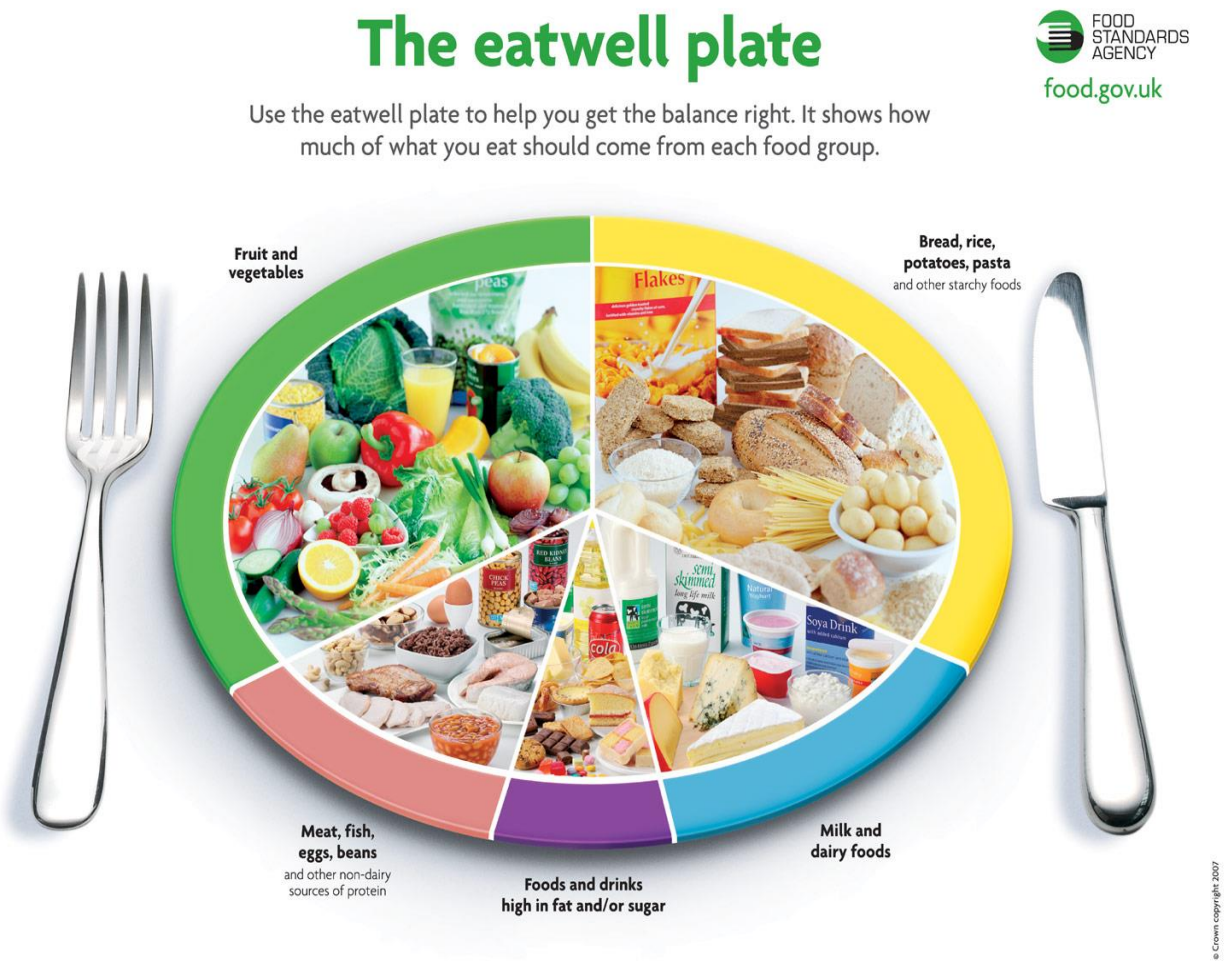
5.3 Losing weight and staying healthy

The following ideas may help those wanting to lose weight:

- Try to eat**:**
  - Five portions of fruit and vegetables every day
  - Wholegrain or granary breads and cereals – these are high in fibre
  - Low fat dairy food (skimmed or semi-skimmed milk) and lean meats
  - Small amounts of foods high in fat, sugar and salt
- Avoid or reduce alcohol intake
- Aim to eat breakfast every day
- Drink plenty of water each day
- Keep physically active and exercise regularly
- Eat when hungry - getting too hungry can lead to overeating
- Eat slowly and stop eating once comfortably full.

If emotional eating is a concern, think about other activities that make you feel better as eating only provides short term comfort. Successful weight management requires a long-term commitment to a healthy lifestyle, which is focused on eating healthy foods and keeping physically active in a way that is both sustainable and enjoyable.

Appendix I: The Eatwell Plate



Appendix J: Malnutrition Universal Screening Tool (MUST) Guide

To access this 6-page PDF document, please use this link:
http://www.bapen.org.uk/pdfs/must/must_full.pdf

Summary of the document

1. MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, under nutrition, 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.

2 The 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.

3 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.

4 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.

5 **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 the 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

Appendix K: Food and Drink Diary

Name:

Date:

Food and Drink Diary

Time	Food/Drink	Amount

Appendix L: Essence of Care 2010: Best Practice – General Indicators

Source: Essence of Care; Benchmarks for Food and Drink.

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues that must be considered with every factor. These are:

1 **People's experience**

- People feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of people are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

2 **Diversity and individual needs**

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services.

3 **Effectiveness**

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development.

4 **Consent and confidentiality**

Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care. People's best interests are maintained where they lack the capacity to make particular decisions.

- Confidentiality is maintained by all staff members.

5 **People, carer and community members' participation**

- People, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities.

6 **Leadership**

- Effective leadership is in place throughout the organisation.

7 **Education and training**

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people*'s and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care.

8 **Documentation**

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised.

9 **Service delivery**

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies
- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available.

10 **Safety**

- Safety and Security of people, carers and staff is maintained at all times.

11 **Safeguarding**

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people*'s welfare are minimised.

12 **Agreed person-focused outcome**

People are enabled to consume food and drink (orally) which meets their needs and preferences.

Factor	Benchmark of best practice
Promoting health	*People* are encouraged to eat and drink in a way that promotes health.
Information	*People* and carers have sufficient information to enable them to obtain their food and drink.
Availability	*People* can access food and drink at any time according to their needs and preferences.
Provision	*People* are provided with food and drink that meets their individual needs and preferences

Presentation	*People's* food and drink is presented in a way that is appealing to them.
Environment	*People* feel the environment is conducive to eating and drinking.
Screening and assessment	*People* who are screened on initial contact and identified at risk receive a full nutritional assessment.
Planning, implementation, evaluation and revision of care	*People's* care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink.
Assistance	*People* receive the care and assistance they require with eating and drinking.
Monitoring	*People's* food and drink intake is monitored and recorded.

Department of Health Essence of Care 2010

Appendix M: IDDSI - The International Dysphagia Diet Standardisation Initiative global standard