Nutrition and older people

This guide has been funded by

Department of Health

£3.50
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Nutrition Essential Guide
Summer :: 2009
NURSING STANDARD
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Introduction

‘Thousands of patients are annually starved in the midst of plenty, from the want of attention to the ways which alone make it possible for them to eat’ (Nightingale 1859).

Nutrition has made headlines in the national media and the nursing press in recent years. Stories have emerged of hungry patients, a lack of support with eating and drinking, and patients being ignored. Most of these stories relate to older people. Today, beds in all acute hospital specialties are mainly occupied by people aged more than 65 (Department of Health (DH) 2001).

In response to the issue of inadequate and poor nutrition the nursing profession has implemented a range of initiatives including: red trays (Bradley and Rees 2003) and red jugs for healthcare professionals to identify people at nutritional risk, protected mealtimes (DH 2003) and improved nutritional assessment. But have these been enough?

Nutrition and hydration are fundamental human needs. When people are ill, old or vulnerable, nutrition becomes even more important in managing their recovery. Incapacity from physical frailty can be compounded by mental incapacity, loss of sight, communication problems, and an inability to express hunger or not being able to access food. This is also cyclical as poor nutrition in itself can be the cause for these effects.

Helping people to eat and drink is at the core of nursing, and care is required at the most fundamental level if we are to ensure that patients have the best chance of recovery and rehabilitation. This is a complex nursing intervention that requires knowledge and skill to, for example, assess someone’s potential in terms of swallowing, manual dexterity or rehabilitation. ‘Incomparably the most important office of the nurse, after she has taken care of the patient’s air, is to take care to observe the effect of his food’ (Nightingale 1859).

This guide outlines the importance of nutrition and hydration, the nurse’s role and highlights some examples of good practice.

The scope of the problem

The prevalence of malnutrition increases with age. A large survey of hospitals, care homes and mental health units (British Association for Parenteral and Enteral Nutrition (BAPEN) 2008) identified that, while a quarter of people aged under 70 were at risk of malnutrition, nearly a third of those aged 85 and over were at risk; in hospitals 28 per cent of patients were found to be at risk of malnutrition and 30 per cent in care homes.

Despite recommendations from the National Institute for Health and Clinical Excellence (NICE) (2006) nutrition screening is not widespread. The Healthcare Commission (2007) reported that only about 40 per cent of people admitted to hospital or care homes receive any form of nutritional screening and, while nearly nine out of ten hospitals reported having a screening policy, less than half weighed patients on all wards (BAPEN 2008).

These findings reinforce those of Hungry to be Heard (Age Concern 2006), which highlighted the ‘scandal of malnourished older people in hospital’. Nearly two thirds of older people admitted to hospital were becoming malnourished and their nutritional state tended to deteriorate following admission. The report suggested that the Standards for Better Health (DH 2004) had not been implemented across all services; overall, malnutrition in older people remains under-recognised and under-treated (BAPEN 2008).
Initiatives and campaigns
In 2006 DH England launched its Dignity in Care campaign to address the woeful lack of dignity experienced by some patients. This has encompassed important initiatives including the formulation of a nutrition action plan that brought together key stakeholders including: older people, clinical experts, professional organisations and regulators, to work on an action plan to improve nutrition and hydration for vulnerable patients. The campaign intended to:

- Raise awareness of the link between nutrition and good health and that malnutrition can be treated.
- Ensure that accessible, relevant, appropriate and user-friendly guidance is available across all sectors.
- Strongly encourage nutritional screening for all people using health and social care services with particular attention to groups known to be vulnerable.
- Encourage the provision of, and access to, relevant training for front line staff and managers on the importance of nutrition for good health and nutritional care.
- Clarify standards and strengthen inspection and regulation.

Actions to support these priorities were agreed. They include:

- The Essential Skills series developed by the Nursing and Midwifery Council (NMC) that must be incorporated into all pre-registration nursing programmes from September 2009. Essential Skill 27 focuses on nutrition (www.nmc-uk.org) (NMC 2007).
- The largest screening survey and audit ever undertaken on adults on admission to hospitals, care homes and mental health units (BAPEN 2008).
- A training programme on nutritional care and assistance with eating which is now available to all NHS and social care staff (NHS Core Learning Unit) (Food Nutrition and Hydration in Health and Social Care elearning programme www.nationalskillsacademy.co.uk).
- Tougher regulation and inspection. Building on the work already done, DH England will work with regulators to ensure that standards of nutrition and dignity are central to quality inspections.
- The requirement of NHS trusts to appoint modern matrons and ward housekeepers (www.dh.gov.uk/en/Managingyourorganisation/DH_081760).

A range of best practice guidance has been developed by the Nursing and Midwifery Practice Development Unit, NHS Scotland and Glasgow Caledonian University on nutritional care. For example, Nutrition for Physically Frail Older People – www.nhshealthquality.org/nhsqsis/files/BPSNutrition_frail_elderlyMay02.pdf; Getting Sufficient Nourishment When Going into a Hospital or Care Home – www.nhshealthquality.org/nhsqsis/files/nourishment%20Companion%20Statement%202005.pdf; and Working with Dependent Older People to Achieve Good Oral Health – www.nhshealthquality.org/nhsqsis/files/21412%20NHSQIS%20Oral%20BPS.pdf.

Why older people become undernourished or dehydrated
Older people are particularly at risk of malnutrition. Physical causes are partly attributable to body changes that occur with increasing age. Other factors include: impaired vision and hearing, loss of taste or smell, dementia or depression. Chronic illness and disability – particularly associated with neurological, respiratory or musculoskeletal...
conditions – can cause difficulty with eating, including swallowing disorders. The effects of medication can reduce appetite or sensory awareness and certain drugs interact with the absorption and metabolism of nutrients (Cowan et al 2004, Kelly and Wright 2009).

Psychosocial factors, for example the loss of a loved one, can reduce the motivation to eat. Shops may not be within easy access and economic hardship reduces the resources available to buy food. Religion and culture can also affect nutrition, for example if a person is unable to obtain kosher or halal foods. People with dementia or depression are particularly at risk, for example when forgetting to eat, and not recognising or being disinterested in food.

Malnutrition is defined as ‘a state in which a deficiency of energy, protein and/or other nutrients causes measurable adverse effects on tissue/body form, composition, function or clinical outcome. Malnutrition and obesity are both causes and consequences of ill-health and are both common in the UK’ (NICE 2006). Malnutrition impairs the functioning of bodily systems, including the immune response, fluid and electrolyte balance and thermoregulation. It increases vulnerability to ill health and infection and precipitates general deterioration. If insufficient nutrition is taken, even for a few days, older people can become malnourished to a degree where their potential for recovery is impaired.

The effects of undernourishment can accumulate, particularly in older people who are frail, and set in motion a cascade of changes leading to deterioration of many body functions, and even to death (Heath and Phair 2009). Age-related changes in the gastrointestinal tract and the outcomes of these for older adults are summarised in Table 1.

There is a correlation between nutritional status and problems with oral health, such as ill-fitting dentures or dry mouth; older people might have problems in accessing advice on oral care for practical or economic reasons. There are also problems that

<table>
<thead>
<tr>
<th>Change</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Decreased taste acuity</td>
<td>Diminished taste and reduced enjoyment of food leading to reduced intake</td>
</tr>
<tr>
<td>Decreased saliva production</td>
<td>Xerostomia (dry mouth), soreness, choking</td>
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<tr>
<td>Brittle teeth</td>
<td>Decay and loss of teeth</td>
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<tr>
<td>Receding gums</td>
<td>Difficulty chewing</td>
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<tr>
<td>Articulation of upper and lower jaw</td>
<td>Difficulty chewing</td>
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<tr>
<td>Decreased oesophageal peristalsis</td>
<td>Dysphagia, feeling of fullness and heartburn.</td>
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<tr>
<td>Decreased gastric secretions</td>
<td>Indigestion – reduced intrinsic factor</td>
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(Adapted from Watson 2005)
are becoming increasingly common with ageing such as gastro-oesophageal reflux and diverticulitis, which can lead to bowel irregularities and constipation, in particular if food intake is restricted (Watson 2005). **Dehydration** Water is a basic nutrient of the human body and essential for life. The kidneys play a vital role in regulating the amount of water in the body and their function deteriorates with age. Impaired renal function can result in salt or electrolyte imbalance. Age-related changes, such as alterations to hormone levels, also mean that water balance takes longer to be restored, even after a drink has been consumed.

The body's natural response to dehydration has been shown to be impaired in older people (Bevan 2005). Although fluid balance can usually be maintained under normal circumstances, dehydration can occur as a result of changes in cognitive functioning or physical functional ability, and medicines such as diuretics, laxatives or hypnotics. People who have had a stroke or have Alzheimer's disease can be particularly insensitive to thirst (Water UK 2006).

**Screening and assessment**

Nutritional assessment is fundamental and nurses need to be able to assess nutritional needs to give good and safe nutritional care (NICE 2006). It is important that nurses listen to what older people and their carers are saying (Age Concern 2006) and that appropriate equipment, such as scales and height meters, are available and working correctly for assessment purposes.

The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool developed by BAPEN (2003) to identify adults who are malnourished, at risk of malnutrition or clinically obese. It also includes management guidelines that can be used to develop a care plan (Box 1).

**BOX 1**

**The Malnutrition Universal Screening Tool**

- **Step 1:** Gather nutritional measurements (height, weight, body mass index (BMI)). If weight, height or BMI cannot be measured, assess risk subjectively using other criteria, such as self-report weight and height, fit of clothes, history of food intake or predisposing factors to malnutrition.
- **Step 2:** Note percentage unplanned weight loss and score.
- **Step 3:** Consider any changes or effects that occur as a consequence of acute disease.
- **Step 4:** Determine the overall risk score or category of malnutrition.
- **Step 5:** Using the management guidelines and/or local policy, form an appropriate care plan.

BMI can be calculated using the equation:

\[
BMI = \frac{\text{Weight (kg)}}{\text{Height}^2} \\
\text{(BAPEN 2003)}
\]

Priorities for implementing screening and assessment identified by NICE (2006) are that:

- Screening for malnutrition and the risk of malnutrition should be carried out by healthcare professionals with the appropriate skills and training.
- All inpatients on admission and all outpatients at their first appointment should be screened. This should be repeated weekly for inpatients and when there is clinical concern for outpatients. People in care homes should be screened on admission and when there is a clinical concern.
- Hospital departments who identify groups of patients with low risk of malnutrition can opt out.
Opt-out decisions should follow an explicit process via the local clinical governance structure and involve experts in nutrition support. BAPEN (2008) and NICE (2006) also recommend that the results of nutritional screening should be linked to care plans, which can vary according to local resources and policies. Access to nutritional advice and nutrition support teams should be available and consistent strategies to detect, prevent and treat malnutrition should be in place in all care settings, including the community, where most malnutrition originates. When assessing oral health it is important to (Clay 2005):

- Identify a patient's usual routine – unless contraindicated this should be included in the care plan.
- Establish the baseline, that is, the condition of the person's mouth and teeth on admission.
- Identify actual or potential problems and treat to prevent them escalating.
- Re-assess regularly to evaluate the effectiveness of mouth care interventions.

Nurses are ideally placed to assess a patient's nutritional status. Green (2005) recommends observing what the person is eating – quantity, quality, nutritional value in the context of individual needs and energy output. Recall from memory can be vague for many people so cross-checking with precise questions, such as 'how many cups of tea', and 'how many slices of bread' can be helpful, as can keeping a food diary containing information on exactly what food was eaten, the amount or size of the portion, how much was left on the plate, or even taking photographs of the plate before and after eating, and placing this in the food diary.

Nursing assessment should also include a person's physical appearance, skin condition in terms of malnutrition or dehydration risk, oral and dental health, and how clothes or jewellery fit his or her body size. Discussing diet with patients can also be helpful in assessing their perspectives, how they feel about food, what issues and priorities they have, and how their food intake or body weight might have changed.

While body weight can be a key indicator of malnutrition risk, it is important to consider this alongside other factors, such as the amount of muscle in the body and any collections of fluid or oedema, particularly around the legs or waist if cardiac or renal function is impaired, or in other areas if there are tumours.

In assessing body hydration, Woodrow (2005) recommends key questions:

- Does the skin look or feel dry?
- Does the skin look or feel loose? (Subcutaneous fat and muscle wasting indicate fewer water reserves.)
- Does the skin look or feel oedematous? Is it pitting oedema?
- Does the skin look poorly perfused, for example is it discoloured white, blue or purple? Are there ulcers?
- Do the lips or the mouth look dry?
- Does the hair look or feel dry?
- Is urine output normal?
- Are there any problems with passing urine, for example incontinence or pain?
- Are there any other sources of fluid loss, for example stomas or surgical drains?
- Does the patient have any disease that affects water loss, for example diabetes mellitus or pyrexia?
- Does the person have any disease or treatments that affect internal fluid balance, for example heart failure or steroids?
- Do any treatments affect water loss, for example diuretics or dry oxygen?
Are there signs of hypovolaemia, for example hypotension or a weak, thready pulse?
Biochemical analysis of blood can be useful – for example haemoglobin, serum protein values, blood lipids, liver function tests, urea and electrolytes – but it is important to recognise that some blood values, including serum iron, serum vitamin B₁₂ and serum calcium, can change in older age (Somerville 1999).
The findings from the nursing assessment can then be compared with data from clinical examination. Box 2 provides an example of how assessment was implemented in one clinical setting.

The nurse’s role in nutrition and hydration
The MUST tool (BAPEN 2003) recommends that, following assessment for malnutrition, the risk category is calculated and the following actions taken:

Low risk: routine clinical care
Repeat screening. In hospital this should be weekly, in care homes it should be monthly and in the community annually for special groups, for example those aged 75 and over.

Medium risk: observe
The dietary intake should be recorded for three days if the patient is in hospital or a care home. If there is improvement or adequate intake, there is little clinical concern. If there is no improvement then it is of clinical concern. Follow local policy and repeat screening. If in hospital this should be weekly, if in a care home at least monthly, or if in the community at least every two to three months.

High risk: treat unless detrimental or no benefit is expected from nutritional support, for example imminent death
Refer to a dietician, nutritional support team or implement local policy. Improve and increase the patient’s overall nutritional intake. Monitor and review the care plan. If the patient is in hospital, this should be done weekly, and if in a care home or in the community it should be done monthly.

Nurses have a key role in providing help and advice on food, in offering choice in an appropriate manner for the individual – if necessary by obtaining help with shopping and cooking – and in providing food in formal care settings. It is important that food is tasty, attractive and of good nutritional value (O’Regan 2009). To enjoy meals people should feel clean and comfortable, they should also have been offered the opportunity to go to the toilet and/or to wash their hands.

Care settings should provide a pleasant environment, that is quiet and calm, and offer as many sensory clues as possible, such as cooking smells, to stimulate the appetite. Some patients might benefit from specially designed cutlery and other eating utensils, but these should not infantilise.

In formal care settings, and particularly care homes, The Caroline Walker Trust (2004) and O’Regan (2009), recommend that staff should:

- Ensure that information about each person's food preferences is in the care plan and is acted on. The information might be from the person or from relatives or friends.
- Be present and involved at mealtimes.
- Respect the need for quiet and calm during meals.
- Review the timing of meals to ensure they are appropriately spaced.

In helping people to eat:

- The same carer should stay with the person throughout the meal for continuity.
- Make sure the patient is wearing his or her glasses, dentures and/or hearing aid for good communication.
- Make sure the person is in an upright position.
BOX 2

**Nutritional assessment in a mental health inpatient service**

The average risk of malnutrition in mental health inpatient units is 14 per cent but, in people over 65, this increases to 24 per cent. Berkshire Healthcare NHS Foundation Trust has implemented the Malnutrition Universal Screening Tool (MUST) (BAPEN 2003) in pilot areas and intends to extend it to other wards.

Although weight and body mass index were recorded on admission, the staff wanted to implement the NICE (2006) guidance, that was to also screen on a weekly basis.

A multidisciplinary team – comprising nurses, healthcare assistants, dieticians and catering staff – developed an implementation plan that included defining the process and developing a training programme for staff.

As a result the team reported that:

- All staff are more aware and involved in the patients’ nutritional needs.
- Weight and the MUST score are discussed at weekly multidisciplinary team meetings.
- Where necessary, supplements are prescribed, having been initiated by the nurses, and the action plan is discussed with the patient.
- Promotion of healthier eating, food choice and well-being is occurring far more often.
- Food presentation has improved through working with the catering team, for example smaller portions are offered to patients with poor appetites and snacks are available between meals.
- When a patient continuously refuses to eat and drink, intervention and treatment are offered early.

What made it work:

- Motivated and enthusiastic teamwork.
- Strong ward leadership.
- Support from nurse consultant and dietician.
- Staff received training the day before the implementation of the MUST tool, therefore the information was fresh in their minds.

For further information about implementing MUST, contact Tina Howe, specialist dietitian at tina.howe@berkshire.nhs.uk

- Sit at eye level to the person who needs help.
- Give small mouthfuls and allow time to swallow between each mouthful.
- Use verbal prompts and talk about the food you are offering (Box 3).

**Stroke**

A significant number of people with stroke are undernourished on admission to hospital and their condition tends to worsen after admission. Also, undernutrition in hospital is a strong and
independent predictor of morbidity and mortality after stroke (British Geriatrics Society (BGS) 2006).

**Dysphagia**
The prevalence of oropharyngeal dysphagia is estimated currently to be 60 per cent in nursing home residents and about 12 per cent in patients in hospital and there is a close link between dysphagia and nutritional compromise (NICE 2006). Dysphagia might present with a range of symptoms.

Indicators include: difficult, painful chewing or swallowing, regurgitation of undigested food, difficulty with controlling food or liquid in the mouth; drooling; hoarse voice, coughing or choking; nasal regurgitation, feeling of obstruction, and unintentional weight loss, for example in people with dementia.

**Encouraging eating and drinking in care homes**

Maintaining optimum nutrition and hydration for residents, most of whom have complex needs, is a major aspect of the work in care homes. In well-run homes, time and trouble are taken to identify what residents like or dislike, and to offer what is most acceptable to each individual while ensuring that his or her nutrition and hydration needs are met.

To maintain homely environments and, as far as possible, the experience of everyday life for residents, emphasis is placed on the ‘normal’ and social aspects of eating and drinking. For example:

- A selection of food is available during the day and there is maximum flexibility in what is offered.
- Tea, coffee and cold drinks are available at all times with biscuits, cakes, fruit or low calorie snacks available between meals.
- Special occasions such as birthdays are celebrated.

Measures are taken to stimulate appetite, for example the smell of food before mealtimes and some care homes have a bar so that residents can have a drink before or with meals.

Crucially, all residents should be able to influence what they are offered to eat and drink. In well-run homes chefs are happy to work with residents on developing menus that are determined by residents. Particularly for people who are unable to express likes and dislikes, such as those with advanced dementia, staff work closely with families and use observational and interpersonal skills to identify how the person responds to hot/cold drinks, sweet/savoury foods and items with different textures.

There are many innovative schemes in care homes around the UK. Barchester Healthcare has developed an academy to train chefs in all aspects of cooking for older people, including how to prepare attractive soft and pureed foods, to serve tasty finger foods and to understand the best way to preserve nutritional content. ‘Great food is not an option, it is essential for the wellbeing of our residents.’ Terry Tucker, Barchester Healthcare. terry.tucker@barchester.com.
**Dementia**

Anorexia, weight loss and also dysphagia are common in people with advanced dementia. In these patients, infection, environmental change, depression, poor carer rapport, pain, oral hygiene, ill-fitting dentures and nursing availability are just some potentially reversible and treatable causes of reduced food and fluid intake (BGS 2006) (Box 4).

People with stroke, dysphagia and eating problems consequent to dementia should be referred to professionals with relevant skills and training in swallowing diagnosis, assessment and management.

**Protected mealtimes**

These are ‘A period of time when patients are allowed to eat their meals without unnecessary interruptions and when nursing staff and the ward team are able to provide safe nutritional care’ (RCN/NPSA 2007), which has been recommended in various reports (Age Concern 2006).

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**BOX 4**

**Supporting people with dementia at mealtimes**

Some people with dementia can have difficulty using a knife and fork to eat at mealtimes or struggle to lift a cup to their mouths to drink. This can give the impression that they do not want the food or drinks offered as food and fluids are left untouched, consequently this increases the risk of dehydration and malnutrition.

It is vital to offer people with dementia the prompts and cues they need to support them at mealtimes as they might be struggling to remember what to do with the cutlery or cup placed in front of them. Offer verbal encouragement to help remind them how to eat and drink. Place the cutlery in their hands and start them off by guiding their hands from plate to mouth. Use the same approach with drinks: help patients to manoeuvre the cup to their mouth and encourage them to drink.

If a person’s co-ordination is poor and cutlery is difficult to use, offer a selection of finger foods. These help to maintain independence at mealtimes. Finger foods are simply foods that can be eaten easily without the need of a knife and fork, for example small sandwiches and pieces of fruit or cake. Continue to provide regular verbal prompts to remind patients to eat and about the food they are eating.

**Further guidance:** Food For Thought: Acute Care and Care Homes Practice Guides are available on the Alzheimer’s Society website.

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Email gcoleman@alzheimers.org.uk
The key principles of protected mealtimes are that:

- Activity is focused on the meal and the patient.
- The patient is ready to eat.
- The environment encourages eating.
- Assistance is provided.
- Observation/monitoring are carried out (Box 5).

Many care areas have tried to implement protected mealtimes. However, the uptake varies between hospitals and wards across England and Wales (www.dh.gov.uk/managingyourorganisation/DH_081760). There are inconsistencies about which mealtimes are protected. Barriers include: visitors, including healthcare professionals, ward rounds and diagnostic tests. Critical success factors have been identified as: having an NHS trust or provider company policy related to protected mealtimes, promotion of the initiative, good communication and good leadership at all levels of the organisation (Berkshire Healthcare NHS Foundation Trust, Box 2).

### BOX 5

**Protected mealtimes in an NHS trust**

Tips for successful implementation of protected mealtimes from Surrey and Sussex Healthcare NHS Trust include:

- Plan the date for implementation well in advance.
- Tell everyone that the ward will be starting protected mealtimes on that date.
- Tell everyone what that means, for example the aim is to enable patients to eat and drink safely so that they can get better quicker. At mealtimes patients should be allowed to eat and not be disturbed unless it is urgent.
- Put protected mealtimes into action on that date. Do not put it off because of short staffing. Tomorrow never comes.
- Believe that it will make a difference because it does.
- Be strong but sensitive. Encourage doctors and other staff to have their own lunch, then come back to see the patient.
- Evaluate and audit what difference it has made. Consider the patient experience, food wastage and staff morale.
- Congratulate and celebrate with the team the difference it has made.

Implementing protected mealtimes has been really positive. It is hard work but my patients can now eat their food and the staff are happier. They have the time to support our patients. Ultimately it is an essential part of nursing and is not an option.’ A ward manager, Surrey and Sussex Healthcare NHS Trust.

**Further guidance:** More information about protected mealtimes can be found at: www.npsa.nhs.uk/nutrition or from Marian.Bulley@sash.nhs.uk
Relatives can also encourage and help people who are unable to eat independently, and their support helps to ease the transition between hospital and home.

Some areas have also employed dining support workers, who are usually care assistants who help people to eat and drink.

The Royal College of Nursing launched Nutrition Now – a campaign designed to raise standards of nutrition and hydration in hospitals (RCN 2008). The West Hertfordshire Hospitals NHS Trust was one of four pilot sites in the UK chosen to take part (Box 6).

**Hydration care**
The optimum fluid intake for an older person is not less than 1.6 litres per day (RCN/NPSA 2007), ideally two litres a day – that is six to eight good-sized glasses. Mild dehydration is common, especially in older people. Good hydration can help to prevent conditions, such as constipation, urinary tract infections, incontinence, pressure ulcers, falls and low blood pressure.

*Hydration Best Practice Toolkit for Hospitals and Healthcare* (RCN/NPSA 2007) recommends:
- Ensuring fluids are readily available and physically accessible day and night, as well as with meals.
- Never taking for granted that older people recognise when they need a drink.
- Encouraging patients to drink little and often.
- If people are concerned about using the toilet at night, encouraging water consumption from the time they wake up in the morning.
- Involving carers and families in encouraging patients to drink.
- Identifying people at risk of dehydration and those who require assistance with drinking. Fluid intake should be monitored and recorded.
- Urine is a useful guide to hydration levels. It should

**BOX 6**

**Nutrition Now: West Hertfordshire Hospitals NHS Trust**

The West Hertfordshire Hospitals NHS Trust’s achievements included a relaunch of the *Protected Mealtime Initiative* in September 2008 and the development of a bookmark for staff featuring top ten tips for nutrition on one side and guidance for managing nutritionally at risk patients on the reverse. The trust will also be launching a new *Nutrition Now* (RCN 2008) placemat for use by patients who have a particular nutritional need that requires monitoring.

Tracy Moran, deputy director of nursing and the *Nutrition Now* project lead, said: ‘Participating in the *Nutrition Now* project provided the organisation with a unique opportunity to raise the profile of nutrition in the trust locally and nationally. The work of the trust’s nutritional focus group will continue beyond the RCN’s campaign to further progress standards of nutrition in the trust.’

Dietetic manager Smita Ganatra added: ‘This campaign has enabled us to enhance nutritional care for our patients through early identification of malnutrition, improve menu choices and protect the mealtime. Our key campaign message has been to “Stop, serve and observe – make food a priority”.’

For further information contact Tracy Moran at tracy.moran@whht.nhs.uk
be plentiful, pale in colour and odourless. The *Thirst 4 Life* initiative by Buckinghamshire NHS Trust and Buckinghamshire County Council led to a 45 per cent reduction in A&E attendances at Wycombe General Hospital from care homes between November 2004 and March 2005 (Water UK 2006).

**Nutritional support**

Nutrition should be given via the gastrointestinal tract whenever possible, including:

- Modified foods – the consistency of the food is altered to help the person swallow it more easily.
- Food fortification – additional nutrients are added to food.
- Moulded foods – the food is pureed or modified to aid swallowing and digestion but, to avoid presenting uniform piles of food to the patient, it is moulded into a shape resembling the original food.
- Finger foods.
- Snacks.

Decisions on when to offer nutritional support can be difficult, even within multiprofessional teams, and these need careful consideration. NICE (2006) defines nutritional support as ‘the provision of nutrition beyond that provided by normal food intake using oral supplementation or enteral tube feeding and parenteral nutrition’. The overall aim is to try to ensure that total nutrient intake (food + nutrition support) provides enough energy, protein, fluid and micronutrients to meet all the patient’s needs.

NICE (2006) also recommends that nutrition support should be considered in people who are malnourished as defined by any of the following:

- A body mass index (BMI) of less than 18.5kg/m$^2$.
- Unintentional weight loss greater than 10 per cent in the past three to six months.
- A BMI of less than 20kg/m$^2$ and unintentional weight loss greater than 5 per cent in the past three to six months.

Nutrition support should be considered for patients at risk of malnutrition, which is defined as those who have: eaten little or nothing for more than five days and/or are likely to eat little or nothing for five days or longer, or have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism.

Healthcare professionals should consider using oral, enteral or parenteral nutrition support, alone or in combination, for people who are either malnourished or at risk of malnutrition. Dysphagia or potential swallowing problems should be taken into account and referral made to a speech therapist and/or a nutrition specialist.

**Monitoring nutrition**

All individuals identified as being at risk of malnutrition should be monitored on a regular basis to ensure that their care plan continues to meet their needs (BAPEN 2003). NICE (2006) suggests that monitoring protocols will usually include:

- Basic clinical observations: temperature, pulse and oedema.
- Observations specifically related to feeding technique and any possible complications.
- Measures of nutritional intake.
- Weight.
- Fluid balance charts.
- Laboratory data (for example, haemoglobin concentration, red cell count and haematocrit levels to identify anaemia and serum cobalamin (vitamin $B_{12}$) to identify pernicious anaemia).
- Outcome factors: complications, improvements in aspects of nutritional status and length of hospital stay.
Change in the psychosocial state that might influence nutrition.

**Conclusion**

The role of nursing in the assessment, management and monitoring of nutrition and hydration is essential in ensuring that older people have the maximum opportunity to recover and rehabilitate. The complex delivery of essential care is as important in the therapeutic process as the administration of medicines or care of wounds. Nursing is the essence of recovery and its skilled execution makes a real difference to patient outcomes.

**References**


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