# Nutrition & Hydration Policy

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<table>
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## Document Review History

| Previous Document:    | No                                         |
| Amended (Y/N):        | No                                         |
Nutrition & Hydration Management Algorithm

Person

No Clinical Concern

Healthy eating guidelines
Monthly weight checks

Clinical Concern
Unintentional weight loss
Underweight
Poor appetite
Poor wound healing
Eating Drinking Swallowing Disorders
Acute illness

Action Plan
Food and fluid record
Little & often meal /snack pattern
Food fortification & high protein high energy meal ideas (Appendix 12)
Hydration management plan (Appendices 13/14)
Liaise with nutrition champion at site level

NB. Consider referrals to other health professionals as appropriate.

Reassess dietary intake and weight after 4 weeks

Has there been an improvement?

NO
Complete Referral to Dietitian.
Include details of actions already taken.
Continue with Action Plan as above

YES
Continue with dietary advice as above.
Re-Assess in 1 month

Has there been an improvement?
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Introduction
This Policy sets out COPE Foundation’s approach to food, fluid and nutritional care within its services. It supports a person-centred approach, and is underpinned by evidence based practice. Staff members should use this Policy in conjunction with:

- Cope Foundation Standards on Management of Eating, Drinking & Nutrition (2013);

This is a living document and is subject to change, as research, knowledge and experience continue to impact on the care we provide to people.

PART 1: Policy

1.1 Policy Statement
Cope Foundation recognises the absolute importance of optimal nutrition & hydration for each person that we support (the person/people), and will make every effort to ensure that their nutrition and hydration needs are met.

1.2 Policy Purposes
The purposes of this Policy are:
- To create awareness of the nutrition and hydration needs of people we support;
- To create an environment inclusive of good practice recommendations;
- To promote positive nutritional health throughout the lifespan of each person;
- To identify the roles and responsibilities of staff;
- To provide guidance to staff to maximize the nutritional health of each person;
- To prevent nutrition and hydration problems arising.

1.3 Policy Scope
These guidelines apply to all Cope Foundation staff in any setting where care is provided.

1.4 Definitions/Terms (Appendix 1)
- **Clinical Concern**: includes unintentional weight loss, fragile skin, poor wound healing, apathy, wasted muscles, poor appetite, altered taste sensation, eating, drinking and swallowing disorders; altered bowel habit; loose fitting clothes; prolonged illness; or an acute episode of illness. (NICE, 2006)
• **Nutritional Support**: Refers to methods used to improve or maintain nutritional intake. These include: oral nutritional support such as additional snacks; food fortification; and oral nutritional supplements. (ONS)

• **Malnutrition**: a state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes measurable adverse effects on body composition, function or clinical outcome. (NICE, 2006) The term includes over-nutrition and under nutrition. (Elia et al, 2005).

• **For further Definitions see Appendix 1.**
PART 2: General Principles & Research

2.1 General Principles

- This Policy is founded on an interdisciplinary approach to maximising nutrition and hydration.
- The person’s rights, choices and needs form the basis for any nutrition and/or hydration intervention plan.
- Prior to the introduction of any change to a person’s food and fluid intake, he/she is consulted with and agreement is sought, and where required, his/her family is consulted.
- The Policy advocates for the least restrictive practices. This means that the person will have the most typical and normal diet possible, whilst at the same time acknowledging any nutrition and hydration issues.
- There will be a firm evidence base for modifying a person’s diet, or for introducing nutritional support practices, such as oral nutritional supplements or enteral feeding.
- This Policy requires staff and families/guardians/advocates to be aware of the importance of achieving a diet which meets the nutrition and hydration needs of the person.
- This Policy requires that staff and families are aware of the risks and consequences for the person, where adequate and appropriate nutrition and hydration is not achieved.

2.2 Some Points from Research

- There is considerable evidence that people with intellectual disabilities (ID) are more likely than those in the general population to have nutritionally related ill-health. (Appendix 2)
- Research has identified that people with more severe disability are often most at nutritional risk. (Appendix 3)
- It has been common for severe under nutrition to go unrecognized by support staff and health professionals, particularly when it has been longstanding.
Almost all studies report greater levels of obesity among people with Intellectual Disability than among people without intellectual disability. (McGuire et al, 2007) (Appendix 4)

Poor hydration is a hugely significant concern for people with intellectual disability. (Appendix 5)

Research indicates that improved nutritional status is directly associated with improved quality of life.

2.3 Effects of Medication on Nutrition & Hydration Status

- Many people with intellectual disabilities take a number of different medications. Many of these medications affect appetite, food & fluid intake, and ultimately nutrition & hydration status.

- Between 20% and 50% of people with intellectual disabilities are prescribed psychotropic medication for treating mental illness, behaviours that challenge, anxiety and depression. The side-effects of some of these medications include weight gain, raised blood cholesterol levels, increased incidence of diabetes, dry mouth, poor hydration, and constipation, among others.

- Special consideration must be given to the person’s nutrition and hydration requirements when on psychotropic medications. (Appendices 12, 13, 14)
PART 3: Roles & Responsibilities

3.1 Introduction
A team-based approach (which includes all staff that work with the person) is essential to ensure the effective delivery of good nutrition. Staff should have a heightened awareness of the close association between intellectual disability (ID), complex health care needs and malnutrition.

3.2 Leadership Team
- To ensure this Policy is implemented, reviewed regularly and updated as required;
- To ensure the guidelines for implementation of the Policy are adhered to by all staff.

3.3 Manager
- To ensure the Policy is available to staff;
- To ensure staff have read and understood the Policy;
- To ensure staff are familiar with the guidelines, and adhere to them

3.4 Staff
- To read and understand the Policy;
- To adhere to the Policy and guidelines;
- To ensure that timely interventions are initiated in accordance with the guidelines;
- To be alert to over-nutrition (overweight and obesity) and mindful of healthy eating guidelines;
- To be aware of the importance of optimal hydration and engage in strategies to prevent dehydration and its negative consequences.

3.5 Nutrition Champions
- Nutrition Champions at site level will endeavour to promote implementation of this Policy, in conjunction with COPE Foundation’s *Standards on Eating, Drinking & Nutrition* (2013).

3.6 Dietitian
- To oversee implementation of this Policy;
- To endeavour to provide clinical support and intervention to the people we support;
- To be a support resource to staff.
PART 4: Guidelines

4.1 Healthy Eating Guidelines (Appendix 6)

4.2 Eating & Drinking Assessment

- Each person should have the option of having an Eating & Drinking Assessment completed on an annual basis, or more often, if clinically indicated/ concerns arise.
- The Assessment will aid staff to identify people that are experiencing eating and drinking difficulties in a timely manner, so that interventions can be put in place.
- Completion of the Eating & Drinking Assessment will be facilitated by the nutrition champion at each site.

4.3 Weight Recording (Appendix 7)

- Each person should have the option of having their weight checked and recorded by local staff, on a monthly basis.
- If a person’s weight cannot be recorded, the reason should be documented.
- Weighing Guidelines: (Appendix 8)

4.4 Unintentional Weight Loss (Appendix 9)

- Where weight loss is observed on consecutive weight checks, the amount of weight loss should be noted and addressed.
- Weight loss in a child should never be ignored. Consult with Dietitian.

4.5 Body Mass Index (BMI) (Appendices 1 &11)

- BMI should be calculated for individuals who are mobile, and where an accurate height is available.
- BMI should not be calculated for persons who have limited or no mobility.
- If calculating BMI for a child, consult with Dietitian for interpretation of the result.

4.6 Subjective Global Assessment (SGA)

- When weight cannot be recorded, SGA will provide valid information.
- SGA includes visual and clinical impressions of the person, based on observation of changes. For example, the person’s ability to perform daily activities, weight loss, loose clothing, loss of appetite etc. In the absence of weight measurements, etc.,
such observations should be recorded; for example: ‘based on observations, appears normally nourished/ over nourished/ under nourished.’

4.7 Food & Fluid Records (Appendix 10)

- Where there is concern about a person’s nutritional and/or hydration status, a food and fluid record should be commenced and maintained. (Booth et al, 2005).
- Appropriate interventions must be implemented to support the person to meet their nutrition and hydration needs. (Appendix 12)

4.8 Hydration & Nutrition Supports

4.8.1 Hydration Support

- As a general rule, each person should achieve a minimum of 1500mls fluid daily.
- When concerns regarding hydration are noted, a fluid intake and urinary output (where possible) chart should be completed.
- A Dehydration Checklist is also available as an aid in identifying people at risk of dehydration. (Appendix 13).
- Where risk is identified, Hydration Management Strategies should be implemented. (Appendix 14).
- If fluid intake remains inadequate, or a person is unable to tolerate oral fluids and is demonstrating signs of dehydration, the use of alternative methods of hydration e.g. sub-cutaneous fluids, enteral feeding, should be discussed with the person’s medical team.

4.8.2 Nutrition Support

A fortified (high energy, high protein) diet should be followed in the following circumstances:

- Appetite/intake is poor.
- Person is unintentionally losing weight.
- Person is already underweight (BMI < 18.5).

In addition to normal food provision, additional nutritional support should be considered for these individuals.

Types of Nutritional Support include:

- Food fortification (Appendices 12 &15);
- Oral nutritional supplements (Appendix 16);
- Enteral tube feeding (Appendix 17).
More than one approach may be required. The aim is to re-establish the person back onto a normal oral diet.

4.9 **Dysphagia & Modified Diets**

- There is a high incidence of dysphagia (eating, drinking and swallowing difficulties) among people with intellectual disabilities. (Appendix 18: Signs & Symptoms).
- People exhibiting signs/symptoms of dysphagia should be referred to the Speech and Language Therapy Department (SLT) for assessment.
- Following an assessment, the SLT will recommend the appropriate food and fluid consistencies to promote the safety of the person during the meal-time experience.
- The SLT’s recommendations must be followed carefully.
- Where food and fluid intake is reduced, the person will need:
  - Nutritional support;
  - Regular weight checks;
  - Recording of food and fluid intake.
- Refer to the Dietitian, if support strategies prove ineffective following a 4 week intervention period. (Appendix 20)
- Refer to Information in the *Nutrition Information Manual* for meal-time ideas for people on modified consistency diets.
PART 5: Referral to Dietitian

5.1 Nutritional Concern (Appendix 19)
When a nutritional concern is identified, staff are advised to take the following steps, prior to making a referral to the Dietitian:

- Commence food and fluid records.
- Provide regular meals and snacks; high protein high energy foods; fortified foods and drinks.
- Consider *Hydration Management Plan* (Appendix 14) where hydration status is a concern.
- After 4 weeks, reassess dietary intake and weight.
- Where initial measures implemented by staff are successful, continue with intervention and reassess monthly.
- Where initial measures are unsuccessful and clinical concern remains, a referral to the Dietitian is warranted. (appendix 20)

- The referral should include details of interventions already implemented by staff and results of same.

5.2 Role of Dietitian in Management of Under-Nutrition

- The Dietitian will complete Nutritional Screening as the first step in verifying level of nutritional risk, including calculation of % weight change in past 3-6 months.
- If a person is deemed at moderate to high risk, the Dietitian will complete a full Nutritional Assessment.
- Where a decision regarding nutritional support is to be made, the Dietitian will liaise with the relevant personnel as appropriate (person; family; interdisciplinary team; etc.).
- It is the responsibility of the Dietitian to review the interventions put in place, in order to ascertain their efficacy, and to adjust/alter the nutritional care plan as appropriate.
PART 6: Staff Training & Policy Review

6.1 Staff Training

- Training on implementation of the Policy will be facilitated by the Nutrition and Dietetics Department, in conjunction with the Nutrition Champions in each site on a phased basis.

6.2 Policy Review

- Cope Foundation undertakes to review this Policy at intervals not exceeding 3 years. Where necessary, the Policy will be reviewed and updated more frequently to reflect new research and changes to practice recommendations.
APPENDIX 1: Definitions/Terms

**Body Mass Index (BMI):** A standard calculation to estimate an individual’s weight for height. Calculated as weight (kg) ÷ height (m²).

Example: weight: 59.1 kg    Height: 1.676 m

\[
\text{BMI} = \frac{59.1}{1.676 \times 1.676}
\]

BMI is a suitable and useful tool for assessing weight status of persons who are mobile.

BMI is *not* a suitable assessment tool for persons who have limited or no mobility and therefore should not be applied when evaluating weight status of such individuals. This relates to altered body composition, e.g. Reduced muscle mass due to absence of weight bearing activity, etc. (British Dietetic Association, 2008).

<table>
<thead>
<tr>
<th>Classification for Adults</th>
<th>BMI</th>
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<tr>
<td>Under-Weight</td>
<td>&lt; 18.5</td>
</tr>
<tr>
<td>Healthy-Weight</td>
<td>18.5 – 24.9</td>
</tr>
<tr>
<td>Over-Weight</td>
<td>25 – 29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>&gt; 30</td>
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**Note:** Classification of BMI for Children varies according to age as the amount and distribution of body fat changes as a child grows. Using the adult classification for children is inappropriate and unsafe.

**Subjective Global Assessment (SGA):** Where weight measurements are not practicable and where BMI is deemed inappropriate, subjective and non-specific markers are used for assessment purposes. Observations such as reduced ability to perform daily activities; reduced subcutaneous fat stores; signs of muscle wasting; reported loose clothing; ill-fitting dentures etc., all form part of an SGA. Such visual / clinical impressions of a person’s nutritional status should be recorded, for example: *Appears normally nourished / over nourished / under nourished.*
Dehydration: an abnormal depletion of body fluids. (Medline, 2008)

Dysphagia: Eating, drinking and swallowing disorders.

Over-Nutrition: The state of nutrition in which there is an excess of energy stores represented by body fatness, causing measurable adverse effects on body function and clinical outcome.

Under-Nutrition: The state of nutrition where there is a deficiency of energy, protein and other nutrients, including minerals and vitamins, causing measurable adverse effects on body function and clinical outcome.

Enteral Tube Feeding: the delivery of a nutritionally complete feed directly into the gastrointestinal tract via a tube.

Food Fortification: A process for enriching a diet without increasing food volume using calorie rich foods or proprietary supplements.

Oral Nutritional Supplements: Commercially produced high energy and/or high protein products given for the purpose of providing additional nutrients.

Hydration Support: Methods used to improve or maintain fluid intake. These include oral hydration, subcutaneous fluids, enteral and thickened fluids.
APPENDIX 2: Research

- Issues relating to body weight (both underweight and overweight), swallowing difficulties, gastro-oesophageal reflux disorder, diabetes, bowel disorders, bone disorders, etc. are frequently reported among people with intellectual disabilities. (BDA, 2008; Caroline Walker Trust, 2007).

APPENDIX 3: Research

- A review of 25 studies by Gravestock (2000) concluded that between 35% and 72% of people with severe learning disabilities were significantly underweight (BMI < 17). This was mostly confined to those who were immobile, unable to feed themselves and those who experienced eating, drinking and swallowing difficulties.

- Significant underweight /under nutrition is associated with increased susceptibility to infection; poor wound healing; enhanced muscle weakness and reduced cough reflex; poor concentration and impaired learning; bone demineralization / fractures; impaired gastrointestinal/ cardio respiratory/ cerebral function; increased hospitalizations; increased morbidity. (Carter, 2006) It is essential that all staff are alert to under nutrition and are trained to identify signs that food intake is inadequate as early as possible. (Caroline Walker Trust, 2007)

APPENDIX 4: Research

- Evidence also suggests that people with intellectual disabilities will experience obesity at a younger age than the general population.(Melville et al, 2005) It is known that overweight (BMI 25 ï 29.9) and obesity (BMI 30 or above) are linked to an increased risk of developing coronary heart disease, type 2 diabetes, certain cancers, stroke and osteoarthritis. (WHO, 2002)

APPENDIX 5: Research

- The medical evidence for good hydration demonstrates that it can assist in preventing or treating problems, such as: pressure ulcers; urinary infections and incontinence; heart disease; diabetes; dizziness and confusion leading to falls; poor oral health; skin condition; cognitive impairment; low blood pressure; kidney stones; constipation. (Royal College of Nursing/NHS, 2007)
APPENDIX 6: Healthy Eating Tips & Food Pyramid Guidelines

Variety: Enjoy a wide variety of foods from the five food groups.

Physical Activity: Find enjoyable ways to be physically active every day. Balancing food intake with active living will protect against disease and prevent weight gain.

Serving Sizes: Watch serving sizes. Choose smaller portions and add plenty of vegetables, salad and fruit.

Healthy Weight: Wholemeal breads, cereals, potatoes, pasta and rice (eaten plain) are the best foods for providing calories for a healthy weight. Meals should be based on these simple foods with plenty of vegetables, salad and fruit.

Vegetables, Salad and Fruit: Eat plenty of different coloured vegetables, salad and fruit - at least 5 a day.

Low Fat Dairy: Low fat milk, yogurt and cheese are best. Choose milk and yogurt more often than cheese.

Meat/Poultry/Fish and Alternatives: Choose lean meat and poultry; include fish (oily is best) and remember peas, beans and lentils are good alternatives.

Fat Spreads: Use polyunsaturated and monounsaturated spreads and oils sparingly. Reduced fat spreads are best.

Cooking Methods: Grill, bake, steam or boil food instead of frying or deep frying.

Other Foods: Healthy eating can be enjoyed with limited amounts of other foods like biscuits, cakes, savoury snacks and confectionery. These foods are high in calories, fat, sugar and salt so remember NOT too MUCH and NOT too OFTEN.

Salt: Limit salt intake.

Fluids: Drink plenty of water.

Vitamin D: Everyone should make sure they are getting enough Vitamin D. Taking oily fish once or twice a week is best. People choosing a supplement should be advised to take 5 micrograms of Vitamin D3 per day. People over 50 years may take 10 micrograms per day.

Folic Acid: All women of child bearing age who are sexually active should take a folic acid supplement (400 micrograms) every day to help prevent neural tube defects in babies.

Breast is Best: Breastfeeding should be encouraged and supported by everyone in Ireland, because it gives babies the very best start in life and helps protect women’s health.

Food Safety: Prepare and store food safely.
Use the **FOOD PYRAMID**

to plan your daily healthy food choices

**Alcohol weekly lower risk limits**

**Men:**
- 17 standard drinks (170g alcohol over a week)

**Women:**
- 11 standard drinks (110g alcohol over a week)

**Standard drinks (SD)** contain roughly 10g of pure alcohol

**Foods and drinks high in fat, sugar and salt**

Limit to sometimes, **not every day.**

**Reduced-fat spreads and oils**

Use as little as possible. Choose reduced fat or light spreads. Choose rapeseed, olive, canola, sunflower or corn oils.

**Meat, poultry, fish, eggs, beans and nuts**

Choose lean meat and low-fat cooking methods (grilling, baking, steaming or boiling).

Choose fish twice a week — oily fish is best.

**Milk, yogurt and cheese**

Choose 3 servings a day.

Aged 9-18 years — choose 5 servings a day.

Reduced-fat or low-fat varieties are best.

**Fruit and vegetables**

Choose 5 or more servings a day.

**Breads, cereals, potatoes, pasta and rice**

Choose at least 6 servings.

High-fibre varieties are best.

Include in each meal.

**Food Pyramid for adults and children aged 5 years and over.**
Drink at least 8 cups of fluid a day – water is best

Foods high in fat, sugar and salt: portions equivalent to approximately 100 calories
- 4 squares of chocolate (half a bar)
- 1 small or fun-sized chocolate coated bar
- 1 bag lower-fat crisps
- 1 small cupcake (no icing) or 1 plain mini muffin
- 2 plain biscuits or 1 chocolate biscuit
- ½ can or 200ml of sugary drink
- 1 scoop of vanilla ice-cream
- ½ or 1 cereal bar – check the label for calories

Reduced-fat spreads and oils
- 1 portion pack of reduced-fat spread for 2-3 slices of bread
- 1 teaspoon of oil per person when cooking
- Mayonnaise and salad dressing also contain oil

Meat, poultry, fish, eggs, beans and nuts
- 50-75g cooked (100g or size of a pack of cards uncooked) lean beef, pork, mince or poultry
- 100g cooked fish, soya or tofu
- 6 dessertspoons of peas, beans or lentils
- 2 eggs
- 40g unsalted nuts

Milk, yogurt and cheese
- 1 glass milk (200ml)
- 1 carton yogurt (125g)
- 1 yogurt drink (200ml)
- 1 matchbox size (25g) of hard or semi-hard cheese such as cheddar or edam
- 50g soft cheese such as brie or camembert

Aged 9-18: 5 servings

Fruit and vegetables
- 1 medium sized fruit – apple, orange, pear or banana
- 2 small fruits – plums, kiwis, mandarin oranges or 10 grapes
- ½ cup or 4 dessertspoons of cooked vegetables – fresh or frozen
- 1 bowl of salad – lettuce, tomato, cucumber
- 100ml unsweetened fruit juice

More is better

Active men and teenage boys - up to 12 servings a day
Active women and teenage girls - up to 8 servings a day

Breads, cereals, potatoes, pasta and rice
- 1 thin slice of bread
- 2 breakfast cereal wheat or oat biscuits
- 3 dessertspoons of dry porridge oats or muesli
- 4 dessertspoons of flake type breakfast cereal
- 3 dessertspoons of cooked pasta, rice or noodles
- 1 medium or 2 small potatoes

Get active
To maintain a healthy weight you need to be physically active regularly.

Adults
At least 30 minutes of moderate intensity physical activity on 5 days a week, or
At least 150 minutes of moderate intensity physical activity a week.

Children and young people
At least 60 minutes of moderate intensity physical activity every day.

To lose weight – adults only
60-75 minutes of moderate intensity physical activity at least 5 days a week may be required.
If you are extremely inactive or have a high BMI (30 or above) start with bouts of 10 minutes and gradually increase duration and intensity.
APPENDIX 7: WEIGHT MONITORING CHART

- Weight checks should be carried out at the beginning of each month.
- Mark left axis with weights in Kg. Draw line linking monthly weights. Note trends.

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<td>CLIENT ID</td>
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<td>LOCATION</td>
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| Start Weight (Kg) |  |
| Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |  |
APPENDIX 8: WEIGHING GUIDELINES

- People should have the option of having their weight checked on a regular basis.
- Weight checks should be carried out at the beginning of each month, preferably at the same time of the day, and if possible by the same person.
- Weights should be recorded on reliable and calibrated scales, and the same scales should be used each time.
- Weights should be recorded preferably in Kg.
- If in doubt about accuracy of weight, always re-check.

Clothing
- Person should be weighed in light clothing, and shoes should be removed.

Bladder
- Bladder should be emptied prior to weight check.
- If person has a urinary catheter, then the person’s catheter bag should be emptied.
- If person wears a pad, the pad should be dry.

Bowels
- Person should be weighed preferably when bowel is empty.
- Note: If person is constipated this may add 1-2 Kg weight.

Mobility
- If person is able to mobilize independently, stand-on scales may be used.
- If person is unable to stand independently, sit-on scales should be used.
- If person is weighed in their wheelchair, make sure to get an accurate weight of the chair each time, as adjustments to chair can make a significant difference to the weight of the chair e.g. addition / removal of head rest; foot plates; etc.

General Rule
- A recent unintended weight change of 3Kg (6.6lbs) is considered significant and warrants investigation and action.
APPENDIX 9: UNINTENTIONAL WEIGHT LOSS

Unintentional weight loss is considered significant as follows:

- Recent unintended weight loss of 3kg (6.6 lbs.) in an adult
  
  Or

- More than 10% of body weight within 3 ï 6 months (NICE, 2006)
  (Consult with Dietitian re: calculation of same, if required).
APPENDIX 10: FOOD & FLUID RECORD CHART

<table>
<thead>
<tr>
<th>TIME</th>
<th>DESCRIPTION OF FOOD &amp; DRINK OFFERED</th>
<th>QUANTITY OFFERED</th>
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TOTAL FLUID VOLUME TAKEN: _____ MLS
## APPENDIX 11: BMI Chart

### BMI Chart (Kgs/m²) for use with the Weight Management Treatment Algorithm

**A Quick Reference Guide For Primary Care Staff**
(See www.icgp.ie/weightmanagement or www.hse.ie for additional online resources)

<table>
<thead>
<tr>
<th>Underweight (&lt;18.5 kgs/m²)</th>
<th>Healthy weight (18.5 - 24.9 kgs/m²)</th>
<th>Overweight (25 - 29.9 kgs/m²)</th>
<th>Obese Class I (30 - 34.9 kgs/m²)</th>
<th>Obese Class II (35 - 39.9 kgs/m²)</th>
<th>Obese Class III (&gt;40 kgs/m²)</th>
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<tbody>
<tr>
<td><strong>Stone</strong></td>
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**BMI:**
- **Weight (Kg)**
- **Height (m²)**
APPENDIX 11 (CONTINUED): MEASURING HEIGHT

How to Measure Height of People Who Can Stand Upright

- Where possible, a height measure should be used in order to obtain the most accurate measurement.
- If a height measure is not available, choose a wall that is clear of hanging objects, etc., and which has a flat floor surface beneath.
- The individual to be measured should be barefoot or in thin socks.
- The person should stand with their back to the wall with weight distributed evenly on both feet.
- Heels should be together and the back of the heels should touch the wall if possible.
- The person is required to look straight ahead so that their line of vision is perpendicular to their body.
- A pencil mark should be placed on the wall at the exact top point of the head.
- The person can then move away and a measuring tape can be used to obtain the measurement.
- If height cannot be measured, use a reported or recently documented height.

For People Who Are Unable to Stand Upright, but Can Maintain a Flat Lying Position, Use a Measuring Tape as Follows:

- Individual should be lying down on their back on their bed or on a soft mat on the floor.
- Measure the length of the body in small sections.
- Add these together to provide a total length.
- If the person has marked scoliosis, measure both sides and take the average.

(NHS, Tayside, 2012)
Alternative Height Measurements

- For individuals who are unable to stand upright or maintain a flat lying position (e.g. due to spinal contractures, kyphosis, scoliosis), the use of alternative height measurements can be considered.
- Possible methods include: Ulna Length; Knee Height; Demispan.
- Please note that specialized equipment is required in order to perform these measurements accurately.
- Contact the Dietitian if you require further information.

Where it is not possible to obtain a height measurement, please document in the care plan the reason for same.

HEIGHT CONVERSION CHART

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<th>Feet</th>
<th>Inch</th>
<th>Metre</th>
<th>Feet</th>
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APPENDIX 12: Food Fortification

- For people requiring additional calories in their diet, the focus, where possible should always be on ‘food first’.
- Useful food fortification strategies include addition of cream; ice-cream; butter; cheese; sugar/glucose; jam/honey etc., to appropriate foods to increase the calorie content.
- Food fortification strategies may be implemented by staff as a first line of treatment and without prescription from the Dietitian or Physician.

APPENDIX 13: FOOD FORTIFICATION IDEAS / HIGH ENERGY, HIGH PROTEIN

13.1 A Fortified (high energy, high protein) Diet should be Followed When:
- Appetite/ intake is poor;
- Person is unintentionally losing weight;
- Person is already underweight (BMI < 18.5).

13.2 To Increase Protein & Energy Using Everyday Foods:
- Encourage little and often meal pattern with nourishing snacks in between meals.
- Aim for 1 pint/day. Can be used to make up sauces, soup, hot drinks.
- Include protein sources at least 2-3 times a day, if possible.
- Good sources of protein include dairy foods, meat, fish, poultry, pulses, nuts and eggs.

13.3 To Fortify Foods & Drinks:
- **Fortified Milk:** Whisk 4 tablespoons of milk powder (E.g. Marvel) into 1 pint of full fat milk to increase calories and protein.
- **Yoghurt:** Can be used on desserts, milkshakes, and can be mixed with fruit.
- **Cream:** Add to soup, desserts, drinks, potatoes, scrambled eggs, sauces.
- **Ice Cream:** Add to milk shakes and puddings.
- **Butter:** Add to potato & vegetables; spread thickly onto bread, scones.
- **Sugar/Glucose:** Add to drinks, cereals and puddings.
• **Jam/Honey**: Spread on bread or scones.
• **Eggs**: Can be used in many ways (poached / boiled / scrambled).
• **Cheese**: Sprinkle grated cheese into soups, sauces, egg dishes or onto fish, potatoes and vegetables.

### 13.4 Ideas for Light Meals/ Snacks

- Cheese/beans on buttered toast.
- Small sandwich / roll with fish, meat, cheese or egg (add mayonnaise).
- Cheese on crackers  
  or  
  Savoury biscuits with cheese spread.
- Scrambled egg / omelette with added cheese/ham/mushrooms.
- Tinned/packet soup make up with milk. Add chopped cooked meat if liked, and cream for extra calories. Serve with buttered bread.
- Cereal with fortified milk and sugar.
- Scone/biscuits with butter and jam  
  or  
  Toast/crumpets with butter and jam.
- Baked potato with butter/margarine filled with cheese/beans/minced meat.
- Small portions of pizza /quiche /flan.

### 13.5 Ideas for Desserts

- Milk puddings tinned or made with milk, add extra cream.
- Yoghurt / Fromage Frais - thick & creamy varieties instead of diet or low fat.
- Pot of mousse / trifle / jelly and ice cream.
- Custard and fruit (fresh, tinned or stewed).
- Milk shakes add cream or ice cream.
- Apple tart and cream.

### 13.6 Ideas for Nourishing Drinks

Sometimes if a person’s appetite for solid foods is poor, nourishing drinks may be a better option. Offer some of the following:

- Hot milky drinks e.g. Horlicks, Ovaltine, Cocoa.
- Cold drinks, e.g. Cold milk, Milk shakes with added ice cream/fruit juice.
- Soup made with milk instead of water.
- Complan, Build-Up, etc. (make with milk). Available from pharmacies/supermarkets.
APPENDIX 14: SIGNS AND SYMPTOMS OF DEHYDRATION CHECKLIST

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<td>Poor Skin Turgor</td>
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<td>Laboratory Values Within Previous Month Indicative of Dehydration</td>
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(Lab Values: Increased Blood Urea Nitrogen; Elevated Haematocrit; Elevated Potassium; Elevated Chloride; Elevated Serum Osmolality)

Comment: ________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Reviewer: ____________________  Title/Position: ______________________________
APPENDIX 15: CARE PLANNING FOR HYDRATION MANAGEMENT

Usual Hydration Management
1. Provide fluids consistently throughout the day.
2. Ensure each person receives a daily intake of a minimum of 1500mls of free fluids in 24 hrs.
3. Aim for 75% of fluid intake with meals and 25% at other times such as snack times and when taking medications.
4. Have a jug of fresh water and glasses available for visitors and staff to offer to the residents throughout the day
5. Use a standardized amount of 100mls of fluid when administering medication
6. Schedule additional fluid rounds other than snack time.
7. Offer a drink at the end of each meal to cleanse and refresh the mouth.
8. Offer a variety of fluids – water; milk; juice; tea; coffee; soup; fruit smoothies etc.

Unwell: Day Hydration Management
1. Record food and fluid intake on Food & Fluid Record Sheet. (Appendix 10 above)
2. Offer 30 ï 60mls fluid per hour when awake.
3. In order to maximise intake, ensure fluids are provided consistently throughout the day and when awake at night.
4. Offer a variety of fluids – water; milk; juice; tea; coffee; soup; fruit smoothies etc.
5. Offer hydrating foods for main meals/snacks – cereal with milk; soup; jelly and ice-cream; yogurt drinks; etc.
6. Offer a drink every 2 ï 3 mouthfuls of food in order to maximise intake.
7. Use a standardized amount of 100mls of fluid when administering medication
8. Schedule additional fluid rounds other than snack time.
9. Offer a drink at the end of each meal to cleanse and refresh the mouth.
10. Monitor for fluid loss related to vomiting; diarrhoea; fever.
11. Discuss administration of sub-cutaneous fluids with Physician.
APPENDIX 16: Oral Nutritional Supplements

- Where food fortification strategies are unsuccessful or are not deemed adequate to meet the nutritional requirements of the person, a referral to the Dietitian is warranted to assess the need for oral nutritional supplementation.
- Oral nutritional supplements should only be commenced when advised by the Dietitian following a nutritional assessment, and should be charted in the person’s Prescription Chart by the person’s Physician.
- Oral nutritional supplements include: Standard adult 1.0 – 1.5Kcal/ml sip feeds; Standard paediatric 1.0 – 1.5Kcal/ml sip feeds; High calorie sip feeds (2.4Kcal/ml); specialised disease specific sip feeds; Protein/energy supplements; Vitamin & mineral supplements.
- The need for oral nutritional supplements should be reviewed by the Dietitian on a routine basis, to ascertain if oral nutritional supplements remain necessary.
- Wherever possible, the aim is to re-establish the person back onto normal oral diet.

APPENDIX 17: Enteral Feeding

- When a person has been assessed by SLT & Dietetics as unsafe to feed orally, or unable to meet their nutrition and hydration needs with oral intake, a decision may have to be made by the interdisciplinary team to advocate for alternative feeding. Alternative feeding methods include insertion of a Nasogastric tube; a PEG tube; or a jejunostomy.
- At all times, this decision is to be made in the context of quality of life, nutritional and hydration needs, and the health and safety of the person.
- The decision making process should be carried out in consultation with the person themselves (where the person is an adult); the person’s family/guardian/advocate, and relevant members of the interdisciplinary team.
- Where a decision to commence enteral feeding is made, the Dietitian must complete a comprehensive nutritional assessment to ascertain the person’s nutrition & hydration requirements, and must develop a feeding regime to meet the nutrition and hydration requirements of the person.
APPENDIX 18: DYSPHAGIA: SIGNS & SYMPTOMS

- Signs and symptoms of dysphagia include: coughing and/or choking before, during or after swallowing; difficulty controlling food and drink in the mouth; change in breathing patterns; recurrent chest infections; unexplained weight loss; wet voice; hoarse voice; drooling; frequent throat clearing; eating more slowly or avoiding certain food groups; negative behaviours specifically at meal-times; etc.
NUTRITION & DIETETIC DEPARTMENT - REFERRAL FORM

NAME OF PERSON BEING REFERRED: _____________________________________________

DATE OF BIRTH: ___________________  CLIENT NUMBER: __________

ADDRESS / LOCATION: __________________________________________________________

CONTACT NUMBER: ____________________________________________________________

☐ Early Intervention  ☐ School Age Services  ☐ Adult Services

REASON FOR REFERRAL:
☒ Tube feeding e.g. Nasogastric / PEG / Jejunostomy
☒ Underweight / unplanned weight loss in adults
☒ Faltering growth in children
☒ Eating Drinking Swallowing Difficulties (Dysphagia)  i  Children / Adults
☒ Constipation/diarrhoea
☒ Coeliac disease
☒ Diabetes
☒ Elevated blood lipids / raised cholesterol
☒ Overweight l/ obesity
☒ General healthy eating advice
☒ Other i  Please specify: (E.g. Iron deficiency/Bone disorder/etc.) ___________________

____________________________________________________

Additional Information: _________________________________________________________

____________________________________________________

Medications: ________________________________________________________________

____________________________________________________

Current Weight: _______________  Height: __________

Weight 3 months ago: _____________  Weight 6 months ago: _____________

☐ Person is mobile  ☐ Reduced mobility  ☐ Person is not mobile

Is Person / Family aware of the referral: ____________________________________________

REFERRED BY: ___________________  TITLE / DISCIPLINE: ________________________

DATE OF REFERRAL: ___________________  

Please return completed referral form to:
Michelle Hurley, Senior Dietitian, COPE Foundation, Montenotte, Cork. Tel: 021-4643342

Nutrition & Dietetic Dept. Use Only:  Date Received: ______________________

Priority Code: ___________  Signature: ________________________________
APPENDIX 20: Referrals to Dietitian: Priority Code

Referrals to the Nutrition & Dietetic Service are categorized according to the following priority rating system:

**Priority 1: Selected Children & Adults**

- Children & Adults on artificial nutrition support (Nasogastric feeding; PEGs; PEJs; etc.);
- Faltering growth in children;
- Significant weight loss in adults (>10% in past 3-6 months);
- Severe underweight in adults (BMI 17 or less);
- Significant FEDS difficulties (Feeding, Eating, Drinking & Swallowing) with associated complications - weight loss/dehydration/aspiration;
- Syndromes requiring specific nutritional management.

**Priority 2: Children**

- Overweight; Obesity; Constipation; Other.

**Priority 3: Adults**

- Overweight; Obesity; Lipid lowering; Type 2 Diabetes; Constipation; Other.

**Please Note:**

- Prior to making a referral to the Dietitian, staff are encouraged to implement basic nutrition and hydration strategies as first line treatment. Please refer to Cope Foundation *Nutrition Information Manual* (2014).
- When such strategies are unsuccessful, referral to the Dietitian should then follow.
- Upon receipt of a referral, the referral will be coded according to the above priority coding system.
- A decision re: acceptance of the referral will be determined by the *Priority Code* the referral receives, in conjunction with availability of dietetic resources.
APPENDIX 21: Nutrition & Hydration Management Actions

SUMMARY OF ACTIONS

21.1 People in Residential Settings

The following support is available from staff:

- Eating and Drinking Assessment Tool once yearly.
- Monthly weights and assessment of weight change:
  - Recent unintended weight change ± 3 kg/ 6.6lbs is significant in an adult.
  - Weight loss in a child should never be ignored.
- BMI Calculation:
  - If person is mobile, BMI may be calculated to ascertain if underweight / healthy weight / overweight / obese.
  - If person is not mobile or has limited mobility, do not calculate BMI.
  - Consult with Dietitian if calculating BMI for a child.
- Observation for changes in nutrition and/or hydration status - weight changes; changes in appetite; food and fluid intake etc.
- Food and Fluid Record where there is clinical concern.
- Side-effects of medications to be considered.
- Implementation of Strategies based on concerns / findings:
  - Food fortification if reduced appetite / losing weight / underweight.
  - Hydration Management plan if hydration is a concern.
  - Healthy eating guidelines if no concerns regarding nutrition and hydration status.
- Refer to additional information in Cope Foundation Nutrition Information Manual.
- After a 4 week period, where clinical concerns remain (reduced appetite; unintentional weight loss; underweight, etc.), complete referral to Dietitian.
21.2 People Living Independently/ In Supported Accommodation

The following support is available:

- Eating and Drinking Assessment Tool.
- Support re: implementation of *Healthy Eating Guidelines*.
- Support/education from staff re: healthy choice making; food shopping; cooking.
- Observation for changes in nutrition and/or hydration status - weight changes; changes in appetite; food and fluid intake etc.
- Side-effects of medications to be considered.
- Implementation of Strategies based on concerns / findings:
  - Food fortification if reduced appetite / losing weight / underweight.
  - Hydration Management plan if hydration is a concern.
  - Healthy eating guidelines if no concerns regarding nutrition and hydration status.
- Refer to additional information in Cope Foundation *Nutrition Information Manual*.
- After a 4 week period, where clinical concerns remain (reduced appetite; unintentional weight loss; underweight), complete referral to Dietitian.
References/Bibliography