KARE
Founded in 1967

Promoting Inclusion for People with Intellectual Disabilities

Management of Nutrition and Hydration Policy.

KARE Policy Document.

Policy Owner: Chairperson of the Nurses Group.

Rev. No.	Approved by OMT	Approved by KARE Board	Launched at Heads of Units	Launched at Heads of Units
Rev. 1	March 2015	March 2015	April 2015	April 2015 – Sept 16
Rev. 2	September 2016	Sept 2016	Oct 2016	Oct 16 - Sept 2019
Note: Rev. 2, was approved for continuation by KARE Board in Oct 2019 for an interim period while a major review and update is completed.				
Rev. 2.1	Amendment to 2.1.1 re Must assessments and review to make accommodations for Covid Crisis. Approved by SPG April 8th, 2020.			
Rev. 3	February 2021	March 2021	April 2021	April 2021 -

Section 1: Policy

1.1 Background to this Policy.

KARE recognises that eating and drinking well has an important part to play in the health and wellbeing of people of all ages and that food and drink brings enormous pleasure to our lives. It is important that staff are aware of the differing Nutritional needs of young people, adults, and older people with Intellectual Disabilities. Poor nutrition at any stage of life for individuals with Intellectual disability will contribute to poor health outcomes in later life. This policy was developed in line with the following legislation, regulation, and guidelines:

- Health Act 2007, Government of Ireland.
- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013
- HIQA National Standards for Residential Services for Children and Adults with Disabilities, 2013.
- Health Act 2007 (Care & Welfare of Residents in Designated Centres for Older People) Regulations, 2009.
- The Management of Feeding, Eating, Drinking, Swallowing (FEDS) Difficulties in the Residential Care Setting (IASLT (Irish Association of Speech and Language therapy) and INDI, - Irish Nutrition and Dietetics Institute) 2014)
- Food Nutrition and Hydration Policy For adults accessing Disability Residential services HSE Draft 2020
- Food Nutrition and Hydration Policy For adults accessing Disability Residential services HSE Draft 2020 – Implementation Tool Kit
- HIQA guidance Food and Nutrition
- Restrictive practices Policy
- Food Safety Guidelines
- Safe administration of Medication Policy
- PEG Feeding Guidelines
- Total Communication Policy
- Managing record Policy

1.2 Aim of this Policy.

The aim of this policy is to ensure that all adults who use KARE Services are provided with good nutritional and Hydration supports.

1.3 Scope of this Policy.

This policy applies to KARE staff including CE and LTI participants, students on placement and volunteers involved in supporting adults who use KARE services

1.4 Non-Scope of this Policy.

This policy does not apply to Preschool children and children availing of Short Breaks

1.5 Policy Details – Glossary.

- **Food nutrition and hydration support plan** - This should include an individual's food preferences, good mealtime routines, specific nutritional needs, hydration support if required and details of modification/supplements of their diet if prescribed. It should also include the level of support required enabling the individual to be as independent as possible.

- **FEDS plan** – Feeding, eating, drinking, and swallowing (FEDS) plans are developed for individuals who have dysphagia, who are at risk of choking and/or at risk of aspirating. FEDS plans are developed by the speech and language therapist.

- **Therapeutic Diet** – Special diet designed (by a dietitian) for people with certain medical conditions such as diabetes, coeliac disease, cardiovascular disease.

- **Malnutrition** – The condition that develops when the body does not get the right amount of vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function.

- **Obesity** - This is an abnormal accumulation of body fat, usually 20% or more over an individual's ideal body weight. Obesity is associated with increased risk of illness, disability, and death.

1.5.1 Supporting Good Nutrition.

1.5.1.1 Individuals using KARE services should have a Nutrition and Hydration support plan as identified in their Assessment of Need, which should include, their food preferences, good mealtime routines, specific nutritional needs, hydration support if required and details of modification/supplements of their diet if prescribed, level of support required enabling the individual to be as independent as possible. Where an Assessment of Need has not been completed – Nutrition and Hydration supports will be identified by the Individual, their family and team supporting the Individual including relevant Clinicians – e.g. – Nurse, Dietitian / Speech and Language Therapy, Psychology etc. This information will support the completion of a Nutrition and Hydration plan by the Leader and Keyworker.

1.5.1.2 An individual's rights, choices and identified needs forms the basis for any Food, Nutrition and Hydration support plan. Staff will continue to support good nutritional choices; an Individual has the right to choose differently. Each person must be given information in a manner they can understand to assist them to make decisions.

1.5.1.3 KARE will not support the use of restrictive practices around food or access to fluids

unless there is clear evidence that this is damaging to the individual's wellbeing and at this point an Individual Risk Assessment and Restrictive practice assessment must be completed to ascertain is a Restrictive practice plan should be put in place

1.5.1.4 The individual and/or their representatives must be consulted prior to the introduction of any changes or modifications to the Individuals Food, Nutrition and Hydration Support Plans; for example, a specialised diet recommended by Dietitian / texture modification recommended by SLT or medically recommended fluid intake.

1.5.1.5 Staff will report any concerns regarding an individual's nutrition, eating and/or drinking as they arise to the Nurse, and they will work together to make an appropriate referral for further screening and / or assessment. Staff will ensure that Individuals have access to appropriate Nutrition and Dietetic Services when required**.** Dietitian referrals are managed through the clinical supports team. For Individuals supported by Outreach, staff can support the person to make referral directly to the Clinical Team

1.5.1.6 Staff will follow through on the implementation of any recommendations from a specialist assessment with regard to an individual's nutrition, hydration and eating and drinking, and ensure they are incorporated into the person's Individual Support Plan.

1.5.1.7. Staff will also ensure that agreed records are kept as outlined in the person's Food, Nutrition and Hydration support plan. The support plan will be monitored and updated based on the advice of the GP/ Dietician/ member of Clinical support team

1.5.1.8. Food, Nutrition and Hydration Support Plans will be reviewed annually (as per individualised planning), or more often to meet the changing needs of Individuals as indicated.

1.5.1.9 Dietary/Oral nutritional supplements will only be prescribed by the individuals GP or Dietician. Staff will ensure that any recommendations made by the GP or Dietician will be detailed on the individual's Food, Nutrition and Hydration support plan as part of the daily supports required.

1.5.1.10 Dietary supplements and thickener will be included on the Individual's KARDEX /Medication management plan

1.5.2 Managing Hydration.

1.5.2.1: Adequate hydration is essential for the health of the service user. The medical evidence for good hydration shows that it can assist in preventing or treating ailments such as:

- Constipation
- Pressure ulcers
- Urinary infections and incontinence
- Kidney stones
- Heart disease
- Low blood pressure
- Diabetes (management of)
- Cognitive impairment
- Dizziness and confusion leading to falls
- Poor oral health
- Skin conditions

1.5.2.2. Service users should be provided with fluids daily to meet requirements as specified below:

- Age between 18-60years 35ml/kg/day
- Age greater than 60years 30ml/kg/day

1.5.2.3. Any service user on a fluid restriction may require an individualised care plan for hydration.

1.5.2.4. Considerations when offering fluids.

- The service user must have access to fresh drinking water throughout the day.
- Drinking water should only be obtained from confirmed suitable sources.
- Ice should be made from a drinkable water source only.
- Service users should be offered drinks with and between meals.
- Drinks should be served at a suitable temperature for safety and palatability.
- Appropriate support to drink should be offered (including drinking aids and assistance to drink). This must be in line with specific eating, drinking and swallowing care plans.
- High sugar fluids such as sugar sweetened beverages are recommended to be taken in small amounts only.
- Fruit juices and smoothies, although high in sugar, do provide water and other nutrients. Only one small portion (150ml) of fruit juice or smoothies per day is recommended.

1.5.2.5. If fluid intake is of concern, a fluid balance chart should be maintained. Fluid balance should be reviewed every 8 hours or more frequently if required.

1.5.2.6. Service users identified as dehydrated or at risk of dehydration should have an appropriate plan of care devised and implemented which may include referral to other healthcare professionals.

1.5.2.7. Recognising dehydration: Obvious symptoms include thirst, dry mouth, dry skin. Other signs like headache, increased heart rate and confusion can also be signs of dehydration.

1.5.3 Meal and Mealtimes

1.5.3.1 Staff will support individuals to be as independent as possible in planning, shopping, and preparing meals.

1.5.3.2 KARE facilitate individuals through a number of approaches and programmes to support them to understand the importance of good nutrition and Healthy eating. Staff will support individuals to gain as much insight as possible to good nutrition and healthy eating. (See Appendix 2), list of courses available to Individuals.

1.5.3.3 Staff will support individuals living in Community Houses/ Residential Short Breaks to agree a Menu which considers the preferences and identified needs of individuals while, at the same time, being as nutritious as possible.

1.5.3.4 The daily menu is displayed in an accessible format and in an appropriate location so that the Individual knows what is available at each mealtime. (Ref; HIQA _ Food and nutrition.

1.5.3.5 Staff will keep a record of the menus provided in KARE Community/ Residential Short Break houses as per Managing records policy.

1.5.3.6 Staff will support individuals, who require assistance to eat and drink, in a sensitive and appropriate way. Recommendations by Clinical team members will be documented into an Individual **FEDS Support plan / Food, Nutrition and Hydration support plan** through CID.

1.5.3.7 Staff will ensure that meals are,

- respectful of individual's food preferences, religious and cultural requirements.
- wholesome and nutritious
- appetizing and attractively served
- provided at times suited to the individual's needs where possible

1.5.3.8 Staff will ensure individuals have access to adequate amounts of food and drink, including snacks.

1.5.3.9 The meals will be prepared to with each individual's dietary needs (e.g., gluten free, lactose intolerant) and/or diet modifications (e.g., puree, soft). This should be documented in the individual's Food, Nutrition and Hydration support plan and/or FEDS plan. Where an individual might refuse a dietary restriction and/or diet modification, this should be documented on a recording chart/contact sheet.

1.5.3.10 Staff will ensure enough time is given to eat and drink and that, where necessary, food is kept warm safely during the meal for those who eat and drink slowly. Ref – Food Safety Guidelines

1.5.3.11 Staff will sit with the people they support during meals and snacks and where appropriate share the same foods and drinks to make mealtimes a time of pleasant social sharing.

1.5.3.12 Mealtimes should be a protected time, where there is little or no interruptions and appointments are not scheduled during mealtimes (exceptions may include recommendations from Eating, Drinking, Swallowing assessment)

1.5.4 Training, Education and Continuous Improvement.

1.5.4.1 KARE will provide training to ensure that staff who work in its Community and Residential Short Break Houses have basic understanding of nutrition and providing healthy, nutritious meals (HIQA 2013).

1.5.4.2 Kare will provide additional QQI Level 5 Training in Nutrition training for frontline staff. – (See Appendix 1).

1.5.4.3 Individuals who use the service will be supported to:

- Have information on healthy eating and a healthy lifestyle
- Understand the potential implications of poor diet
- Gain skills in meal preparation and cooking.

1.5.4.4 Staff supporting individuals in their living arrangements must have training about:

- Understand the profile of the service users that we support and the nutrition risks and consequences for them (signpost to therapeutic diets and referral procedure).
- Understand what basic nutrition is.
- Understand the food pyramid – scientific side
- Understand food labelling.
- Understand food safety.
- Supporting choices around food.
- Menu planning.
- Understand the importance of good nutrition to the health of people.
- Factors contributing to poor nutrition and hydration and problematic eating and drinking.
- Supporting individuals to make good food choices and maintain a healthy lifestyle.
- Preparation of wholesome and nutritious meals.

1.5.4.5 Line Managers will ensure that staff supporting individuals with specific nutrition, eating and drinking needs will be given training so that they can provide the appropriate support, e.g., PEG Feeding, Modified fluids, and food textures.

1.5.4.6 Non-Nursing staff will not administer a PEG Feed unless they have completed approved training.

1.5.4.7 KARE will carry out periodic checks on the meals provided and audit compliance with individuals' Food, Nutrition, and Hydration support plans. An Annual Audit will be completed on site to ensure compliance. Audit criteria may include assessment of the menu and meal preparation, snack provision, meal times, Nutrition and Hydration Support Plans, availability of therapeutic diets e.g., low fat/sugar, food wastage, management of Food safety, nutritional screening, staff training and compliance with care plans

1.6 Supported Nutrition and Hydration

1.6.1. Nurses administering PEG Feeds should ensure that their knowledge and skills are up to-date and have a responsibility to seek additional training if required.

1.6.2 Sub-cutaneous (Sub Cut) fluids may be recommended by a palliative care team or a consultant in a hospital. This is a nurse led, individualised, specialist hydration plan.

1.7 Management of PEG Feed

1.7.1. Some people supported by KARE may be fed via a PEG (Percutaneous endoscopic gastronomy) feeding tube, A PEG feeding tube is used to deliver nutrition, hydration, and medicines directly into the persons stomach in cases

where the person has been assessed as unable to swallow safely. Each person who has a PEG feeding tube will have the prescribed food and flush written on their Kardex, and an individual Personal and Intimate Care plan will be developed.

1.7.2 The Individuals PEG feeding guidelines will be developed with the person, the nurse, the family and the team supporting the person.

1.7.3. The individuals PEG feeding guidelines will contain the following details;

- Person's name
- Persons PIN
- Location of care plan
- Date plan developed
- Date of review
- Name of people involved in developing the care plan • Individuals preferred method of communication

1.7.4. The Individuals PEG feed and flush will be prescribed and signed by the GP on the persons Kardex

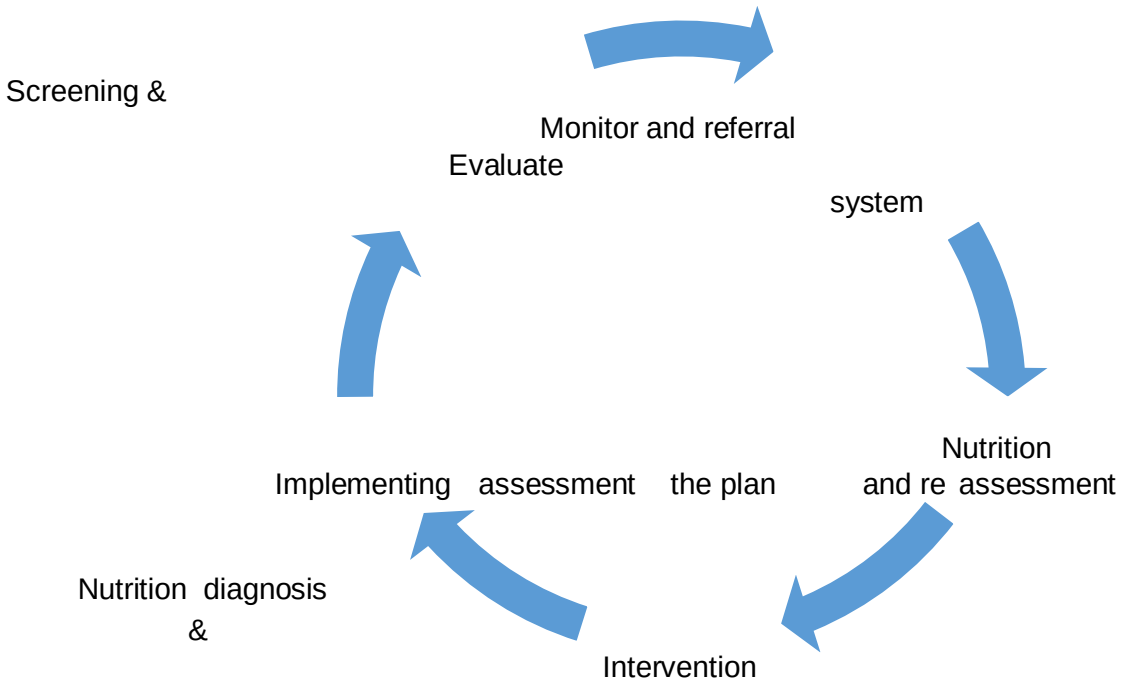
1.7.5. The Individuals PEG feeding guidelines will detail the

- Procedure for preparation of equipment
- Procedure for administration of PEG Feed
- Procedure for administration of medication via PEG Tube
- Procedure for disposal of equipment to prevent cross contamination
- Management and care of the PEG site
- Record of monitoring checks during administration of Feed
- Completion of relevant documentation
- Procedure for staff in managing complications

- Procedure for storage, cleaning, and maintenance of equipment

1.7.6 Staff will use the "Management of PEG Feeding" document as a resource when completing the Individual PEG feeding guidelines. (This document can be found on KARE connect).

Section 2 Process for Managing Nutrition



2.1 SCREENING

When to screen?

- Opportunistically - On first admission to residential community services.
- Upon clinical concern - examples include unplanned weight loss, appearing thin, fragile skin, poor wound healing, pressure ulcers, apathy, muscle wasting, poor appetite, difficulty swallowing, altered bowel habit, loose fitting clothes or prolonged intercurrent illness.
- Also consider groups at risk of malnutrition
- Chronic disease (consider acute episodes): chronic obstructive pulmonary disease (COPD), cancer, gastrointestinal disease, renal or liver disease and inflammatory conditions such as rheumatoid arthritis, inflammatory bowel disease
- Progressive neurological disease: dementia, Parkinson's disease,
- Acute illness: where adequate food is not being consumed for more than 5 days
- Debility: frailty, immobility, old age, depression, recent discharge from hospital.

2.1.1 The Nurse in the area will ensure individuals living in KARE Community Houses will be screened using a validated screening tool (e.g., MUST, Appendix 1)

2.2 REFERRAL

2.2.1 The Nurse will ensure that any individual who presents with a nutrition and/or hydration concern, is referred to the appropriate specialists, with consent from the individual as appropriate.

2.2.2 KARE staff will collaborate with Nutrition and Dietetic services to ensure the best Care for people they support.

2.2.3 Where specific nutritional needs or therapeutic diets are identified – e.g., bone health, dementia, swallowing difficulties, assistance/aids with eating, a referral to clinical supports is completed.

2.3 NUTRITION ASSESSMENT, INTERVENTION, AND PLAN

If an individual has been highlighted at risk of malnutrition, regular screening and monitoring is recommended to determine any improvement or deterioration and action required.

2.3.1 Following an assessment and recommendations by a Dietician/GP/ SLT, the Nurse in the area in conjunction with the relevant planner will ensure recommendations are incorporated into the person's Individual's Support Plan,

2.3.2 KARE staff will implement the recommendations that are in the Individuals Support Plan with consent from the individual.

2.3.3 KARE staff will support individuals living in Community Houses to keep their appointments with the dietician/specialist.

2.4 NUTRITION MONITORING AND EVALUATION

2.4.1 KARE staff will keep records as outlined in the person's Individual's Food, Nutrition and Hydration Support Plan (e.g., fluid intake, food diary, dietary supplements) and as required to support the referral process.

2.4.2 The records should include agreed goals to help assess the effectiveness of intervention. These can include:

- Increasing nutritional intake.
- Improving the individual's quality of life or ability to undertake activities of daily living.
- Reduce infections, recurrence, or exacerbation of a condition.
- To optimise recovery e.g., pressure ulcers, post-operatively.
- Improving mobility.
- Reducing risk of frailty and falls.
- Preventing further weight loss.
- Increase weight/muscle mass.
- Improving strength.

2.4.3 Regular weight monitoring only needs to be carried out if a specific need has been highlighted in the persons support plan, this should be done with the consent of the individual. Decisions regarding the frequency of weight monitoring should be made based upon various factors, such as:

- Outcome of an assessment by a health professional.
- History of a health condition affecting nutrition and weight.
- Medication with possible side effects of loss/gain of appetite, gastrointestinal problems etc.
- Apparent, rapid weight loss/gain.
- Food refusal decreased or increased appetite.
- A degenerative condition. • Risk category as per 'MUST' score.

Obesity and Weight Loss Management

Moderate weight loss can be achieved by teaching the service user and support staff how to manage meals, portion sizes and eating patterns, by collaborating with the service user in decision-making with support staff and by engaging in regular physical activity. Research would suggest that outcomes are improved when support staff are motivated and educated in supporting people to manage their weight.

However, it is important to note that it is not always easy to lose weight and it may be particularly difficult for people with learning disabilities if they have mobility difficulties, are chairbound or bedbound or if they have significant behavioural issues around food. It is therefore useful to consider the following questions before starting attempts at weight loss, and to be realistic about what can be achieved:

1. Is it really necessary for the person to lose weight?

If health and mobility are not affected by a person's weight and it is stable, then be cautious before recommending weight loss. If someone has a BMI of between 25-30, but eats well (i.e., has a varied balanced diet that is low in saturated fat and refined sugar and high in lean proteins, fibre, vitamins, minerals, and antioxidants), is active and their weight is stable, intervention may be counter-productive and impact on quality of life. If someone is over the age of 65, extreme caution should be taken in encouraging weight loss unless there is a clear rationale for doing this.

2. Is weight increasing rapidly?

If someone is gaining weight rapidly and consistently – for example, if they have gained 3kg or more per year for a number of years – this may well require intervention to maintain weight. It can be more successful to encourage weight maintenance than weight loss to start with and this can seem more achievable.

3. What weight is ideal?

It may be more constructive to aim for an achievable and comfortable weight than aiming for an "ideal" weight whose achievement would require considerable discomfort and sacrifice. To keep the need for weight loss in perspective, it is important to balance a healthy body weight with a person's need for quality of life and the circumstances in which they may be living.

Appendix 1

Using the MUST to monitor an individual's Nutritional Status

This tool will highlight whether an individual is at a low, medium, or high risk of being compromised in this area. The nature of response will differ depending on level of risk identified.

Following the completion of the screening tool, there are **three** possible outcomes:

i. If someone is identified as being LOW risk, then it is sufficient for those supporting that person to support them by using *guidance in relation to menu planning to plan weekly menus with them (Appendix 3).*

Or

ii. If someone is identified as being MEDIUM risk, then staff supporting the person should *record daily what that person is eating and drinking (e.g., Food Diary) in addition to weekly menu planning.* It may also be necessary to support the person to monitor their weight at this point. A tool to help with this is included in (Appendix 3). Food Diary

Or

iii. If someone is identified as being HIGH risk, then staff supporting the person should *complete an internal referral form and forward it to clinical supports team in addition to daily recording of food and fluids.*

Risk	**Response**
LOW	Menu Planning
MEDIUM	Menu Planning Daily Recording
HIGH	Menu Planning Daily Recording Onward referral to Clinical Supports

Name: _____ PIN: _____ Location: _____

Date of Assessment: _____

Step 1	BMI Score	Total	

Calculate BMI

Weight (kg) _____

Height (m) _____

BMI (kg/m^2) _____

BMI Score

>20kg/m^2	= **Score 0**
18.5 - 20kg/m^2	= **Score 1**
<18.5kg/m^2	= **Score 2**

OR Subjective measurements of BMI

If height and weight can not be measured, BMI can be estimated using the mid upper arm circumference (MUAC)

MUAC >24 cm	= **Score 0**
MUAC >22 and <23.5	= **Score 1**
MUAC <21.5 cm	= **Score 2**

Step 2	Weight Loss Score	Total	

Unplanned weight loss in the past 3 – 6 months

<5%	= **Score 0**
5-10%	= **Score 1**
>10%	= **Score 2**

OR If you are unable to weigh the person, use the following subjective criteria:

If you answer "Yes" to any of these questions, Score 1.

Is the person's clothes loose fitting? **Yes No**
Is the person's jewellery loose fitting? **Yes No**
Is there evidence of muscle wasting? **Yes No**
History of decreased food intake or reduced appetite? **Yes No**

Step 3	Acute Disease Effect Score	Total	

If the person is acutely ill and there has been or is likely to be no nutritional intake for > 5 days

Score = 2

Step 4	Total MUST Score	Total	

BMI Score _____

Weight Loss Score _____

Acute Disease Effect Score _____

0 LOW RISK Weekly Menu Planning	1 MEDIUM RISK Daily Recording and Weekly Menu Planning	2 or more HIGH RISK Onward Referral

Step 5	Categorise the Person

- **0 – Low Risk** ☐
- **1 – Medium Risk** ☐
- **2 – High Risk** ☐

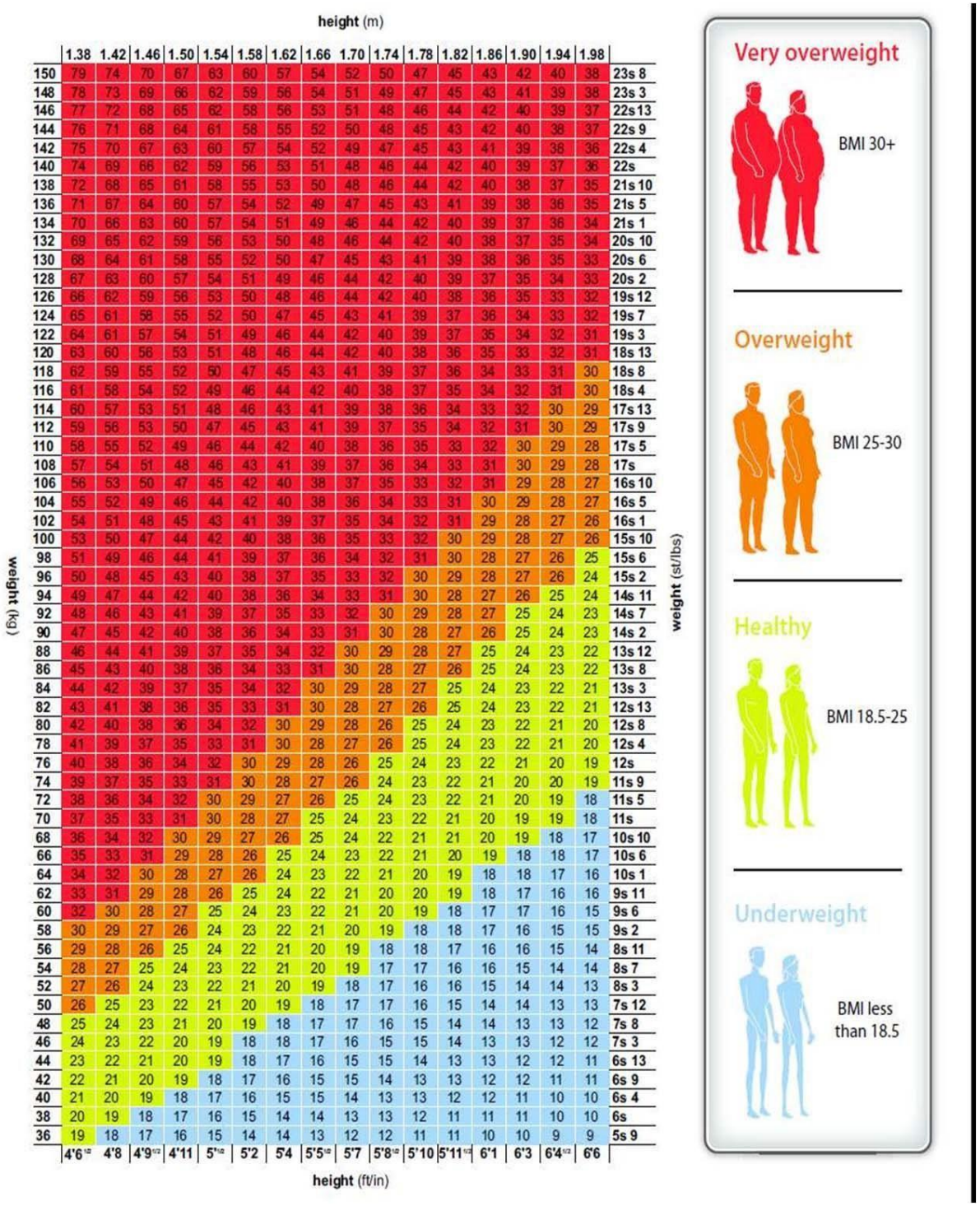
Low Risk- Score 0	Medium Risk – Score 1	High Risk- Score 2
Routine clinical care -review/re: screen: Monthly in care homes. Annually in community -Consider more frequent rescreening in high-risk groups (see appendix 1 for list) -If BMI>30kg/m2 (obese) treat according to local policy/national guidelines	**Observe** -Dietary advice to maximise nutritional intake. -Encourage small frequent meals and snacks, with high energy and protein food and fluids. -Refer to information leaflet "Make Every Bite Count" -Review progress/repeat screening after 1-3 months according to clinical condition or sooner if condition requires -If improving continue until 'low risk' -If deteriorating, consider treating as 'high risk'	**Treat** -Provide dietary advice as 'medium risk' -GP to prescribe thiamine 100mg three times daily for 10 days and Centrum Advance or Renavit once daily for 1 month as service user may be at risk of refeeding syndrome -If appropriate GP to monitor U&E, Ca, Mg, PO4 within 2448 hours of commencing high protein high calorie diet -Refer to dietitian

BMI: Body Mass Index: A standard calculation to estimate an individual weight for height. Calculated as weight (in kgs) ÷ height (in $m^{2)}$ (NICE, 2006).

BMI values (NICE,2006b): **Classification BMI (kg/m^2)**

Malnourished	< 18.5
Underweight	18.5-19.9
Healthy weight	20–24.9
Overweight	25–29.9
Obese	> 30

BMI Chart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100 53 50 47 44 42 40 38 36 35 33 32 30 29 28 27 26 15s 10
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60 32 30 28 27 25 24 23 22 21 20 19 18 17 17 16 15 9s 6
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44 23 22 21 20 19 18 17 16 15 15 14 13 13 12 12 11 6s 13
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40 21 20 19 18 17 16 15 15 14 13 13 12 12 11 10 10 6s 4
38 20 19 18 17 16 15 14 14 13 13 12 11 11 11 10 10 6s
36 19 18 17 16 15 14 14 13 12 12 11 11 10 10 9 9 5s 9
4'6 4'8 4'9 4'11 5' 5'2 5'4 5'5 5'7 5'8 5'10 5'11 6'1 6'3 6'4 6'6
height (ft/in)
weight (kg)
weight (st/lbs)
Very overweight
BMI 30+
Overweight
BMI 25-30
Healthy
BMI 18.5-25
Underweight
BMI less than 18.5

Appendix 2

- Lifelong learning courses.
- QQI accredited training in food and cookery.
- QQI accredited training in food and nutrition.
- Health for living programme.
- Diabetes programme (Community based module).
- Dietician training for staff specifically around labelling, healthy foods etc.

Appendix 3

Food Diary

Name: _____ Date: _____

DOB: _____

You can use this diary to record everything you eat and drink, or any supplements that you are taking. Record each day separately on the pages provided. Try to record all food and drinks that you take, along with the approximate quantity, and the time of day they are taken.

	FOOD	FLUID / SUPPLEMENTS
BREAKFAST		
MID - MORNING		
LUNCH		
MID - AFTERNOON		
DINNER		
SUPPER		
SNACKS		