



Department of  
**Health, Social Services  
and Public Safety**

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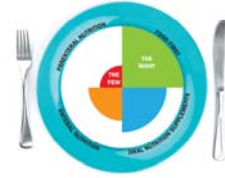
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## Promoting Good Nutrition

**A Strategy for good nutritional care for adults in all  
care settings in Northern Ireland  
2011-2016**

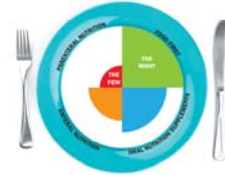




“Every careful observer of the sick will agree in this, that thousands of patients are starved in the midst of plenty, from want of attention to the ways which make it possible for them to take food.”

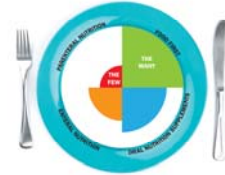
*(Florence Nightingale)*





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## FOREWORD

Raising awareness, and identifying those individuals most at risk of malnutrition, in health and social care settings, including those we care for in their own homes, are the cornerstones of good nutritional care.

Key to the success of this strategy will be partnership working, and I am encouraged that public and professional feedback supports the development of a Nutrition Coalition, ensuring good nutritional care can become everyone's business.

The Coalition will be the public voice of the strategy, raising awareness and fronting campaigns, which build public confidence, so that people will know what to expect from our health and social care services.

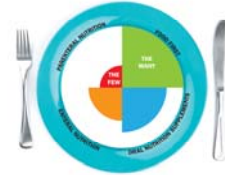
Individuals quite rightly expect to be supported with eating and drinking when they are ill or, have a long term condition which requires support, or are frail and require care and assistance. The environment and the quality of food, beverages, and help with feeding are often cited as a benchmark by which people judge the quality of care.

In ***Promoting Good Nutrition! A Strategy for Good Nutritional Care for Adults in all Care Settings in Northern Ireland***, the 10 Key Characteristics of the Council of Europe Resolution on Food and Nutritional Care in Health and Social Care Settings, sets the scene for the development of a framework for action, by describing what good nutritional care looks like for each characteristic.

Promoting Good Nutrition presents a significant challenge over the next 5 years, however building on the progress of, "Get Your 10 a Day" to include all health and social care settings including peoples own homes, we will aim to ensure that everyone identified as requiring nutritional support, experiences good nutritional care.

This will require everyone to work together to improve the quality of nutrition through a better focus on this vital aspect of care.

**MICHAEL MCGIMPSEY**  
**Minister of Health, Social Services and Public Safety**



## INTRODUCTION

Promoting good nutritional care is everybody's business, and requires champions in the board room and at the bedside. Good nutrition and the meal experience are of vital importance for individuals recovering from illness, or for those who are at risk of malnutrition.

Not only is food necessary for life, but it is also a source of great pleasure, with important social, cultural and religious functions.

However as highlighted recently by Age UK in "Still Hungry to be Heard" we do not always get it right.

"Get Your 10 a Day! The Nursing Care Standards for Patient Food in Hospital" was developed as a Northern Ireland response to the RCN's Nutrition Now campaign.

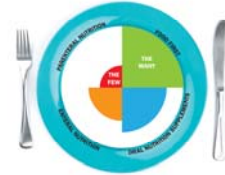
***Promoting Good Nutrition! A Strategy for Good Nutritional Care for Adults in all Care Settings in Northern Ireland***, aims to build on Get Your 10 a Day to include all health and social care settings including peoples own homes. This will be achieved through the adoption and translation of the Council of Europe Alliance UK's **10 Key Characteristics** which form the basis of good nutritional care.

Key to this process is outlining actions to support good care based on prevention, identification and management of malnutrition.

Whilst the term 'malnutrition', the clinically agreed national term, can encompass both over nutrition and under nutrition, for the purpose of this strategy it will be considered as 'under nutrition'.

**MARTIN BRADLEY**  
Chief Nursing Officer





## VISION FOR GOOD NUTRITIONAL CARE

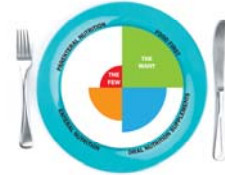
**The overall vision of the strategy is to improve the quality of nutritional care of adults in Northern Ireland in health and social care, whether delivered or commissioned, through the prevention, identification, and management of malnutrition in all health and social care settings including peoples own homes.**

This will ensure that any adult identified as being at risk of malnutrition will have a nutritional care plan appropriate to their needs to work towards their agreed outcomes.

To make this vision a reality will require the adoption and translation of the Council of Europe Resolution on Food and Nutritional Care in Hospitals<sup>1</sup> to all Health and Social care settings including people's own homes and into a framework for action by describing what good nutritional care looks like.

The Council of Europe Alliance UK, a multi-professional multi-agency group was set up to take forward the implementation of the Council of Europe Resolution across the UK. The Alliance produced 10 Key Characteristics (Figure 1) that form the basis of good nutritional care which have been amended in 2010 to cover all health and social care settings.

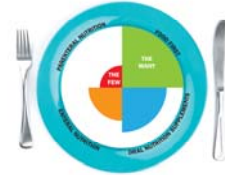
The framework for action will describe what good nutritional care looks like and promote food first as the preferred option, for meeting nutritional requirements, however when food or food alone is not an option for whatever reason, the framework will give direction to support effective nutritional strategies including enteral and parenteral nutrition based on prevention, anticipatory management and timely intervention.



**Figure 1: 10 KEY CHARACTERISTICS**

1. Everyone\* using *Health and Social Care services*<sup>†</sup> (healthcare and care services) is screened to identify those who are malnourished or at risk of becoming malnourished.
2. Everyone using care services has a personal care support plan and where possible has had personal input, to identify their nutritional care and fluid needs and how they are to be met.
3. The care provider must include specific guidance on food and beverage services and nutritional care in its service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and beverage/drinks provision.
5. An environment conducive to people enjoying their meals and being able to safely consume their food and drinks is maintained (NB this can be known as 'Protected Mealtimes').
6. All staff/volunteers have the appropriate skills and competencies needed to ensure that the nutritional and fluid needs of people using care services are met. All staff/volunteers receive regular training on nutritional care and management.
7. Facilities and services are designed to be flexible and centred on the needs of the people using them.
8. The care-providing organisation has a policy for food service and nutritional care, which is centred on the needs of people using the service. Performance in delivering that care effectively is managed in line with local governance and regulatory frameworks.
9. Food service and nutritional care is provided safely.
10. Everyone working in the organisation values the contribution of people using the service and all others in the successful delivery of nutritional care.

(\*Everyone – refers to all individuals at the points in the care journey as identified by NICE guidelines) <sup>†</sup>Adapted from Council of Europe Alliance UK 10 Key Characteristics for good nutritional care.



## SECTION 1

### INTRODUCTION

- 1.1 In order to prevent, anticipate and treat malnutrition we must first understand what we mean by malnutrition.

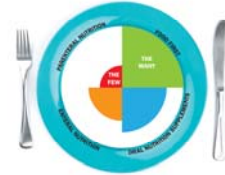
Malnutrition is defined as:

‘a state of nutrition in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition) and function, and clinical outcome’<sup>2</sup>.

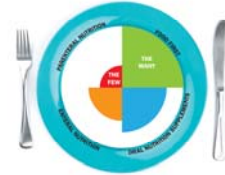
It is the result of nutritional intake that does not meet nutritional requirements.

#### Scope of the strategy

- 1.2 This strategy relates to adults in all health and social care settings including individuals in their own home. For the purpose of this strategy malnutrition will be considered as under-nutrition and does not cover obesity or eating disorders.
- 1.3 It is not intended to cover the nutritional needs of children given the very specialist needs of children and young people. However it will acknowledge the transitional care of young people into adult services as outlined in Strand 3 of the Integrated Care Pathway for Children and Young People with Complex Physical Health Needs, 2008<sup>3</sup>.
- 1.4 The strategy which has been developed within the existing legal framework recognises that people must be considered and cared for as individuals with reasonable adjustments made accordingly. This requires responsive care and support that is designed to meet their specific needs coordinated across all care settings.
- 1.5 Health and social care staff have an ethical duty to recognise and treat malnutrition usually by attention to drinking and eating as part of optimal care for patients<sup>4</sup>. They should also take appropriate steps to help those participating in the decision making<sup>5</sup> to understand the assessment of the patients’ requirements for nutrition or hydration<sup>6</sup>.
- 1.6 It recognises that people are considered and cared for as individuals, and acknowledges that nutritional care should be provided with an equitable, person centred approach respecting the diversity of people , including their beliefs and cultures, patients, their family and carers.
- 1.7 In addition, the strategy recognises the significant contribution of people, families, volunteers, independent, and the community and



voluntary sectors. It promotes their role in the inter-disciplinary and interagency teamwork that is essential for good nutritional care.



## SECTION 2

### CONTEXT

#### Policy Context

- 2.1 This strategy builds upon a number of policies, guidelines and regional work which have and will contribute to the continuous improvement of nutritional care for adults (Appendix 2). The table in Appendix 3 illustrates how the 10 Key Characteristics map across the other key nutrition policies, standards and guidelines, specifically Get Your 10 a Day<sup>7</sup>, Hungry to be Heard<sup>8</sup> and Essence of Care Benchmarks for Food and Drink<sup>9</sup>.
- 2.2 A number of societal trends look set to exacerbate the burden of malnutrition in the future<sup>10</sup>. These trends include: an ageing population; continuing shifts in the pattern of food distribution; and an increase in long term conditions associated with malnutrition.

#### Prevalence of malnutrition in adults

- 2.3 A UK wide nutrition screening survey was carried out by the British Association of Parenteral and Enteral Nutrition (BAPEN)<sup>11</sup> in order to establish the current prevalence of malnutrition risk on admission to different care settings. Results of the 2008 survey based on MUST\* risk scores are as follows:

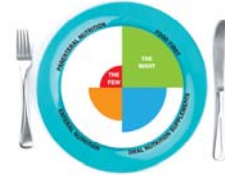
Care Setting	All ages	> 65 years
Hospital	28%	32%
Care Home	42%	42%
Mental Health units	20%	27%

- 2.4 In 2007 BAPEN<sup>12</sup> estimated that there were 3 million people malnourished in the UK, 93% of whom are in the community. This represents 5% of the population and this incidence increases to 14% for those over 65 years of age.

#### Public Health

- 2.5 Malnutrition is a major public health issue and there is a need to raise awareness of the risks of malnutrition and steps that can be taken to prevent, identify and manage malnutrition. Raising awareness will ensure that the individuals, family and carers are better able to monitor nutrition and prevent malnutrition from occurring. The public need to understand the social and psychological causes of malnutrition in the community which include (Figure 2)<sup>13</sup>.

\* MUST refers to [Malnutrition Universal Screening Tool](#).



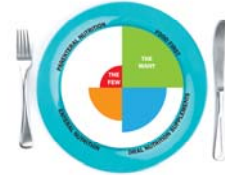
**Figure 2: Social and psychological causes of malnutrition**

Poverty	Functional Constraints	Mobility	Psychological Factors
Inability to access good food Inability to afford good food	Inability to prepare food Poor dental / oral health Sensory disability Difficulty using food containers Difficulty reading food labels	Poor mobility Disability Poor transport links Difficulty accessing local shops	Isolation and loneliness Confusion Depression Anxiety Dementia Bereavement

- 2.6 Public health and societal issues are covered in other DHSSPS and PHA policy areas (Appendix 2)
- 2.7 A decreased appetite is frequently seen among elderly adults, and no cause may be found. However, sadness, depression, grief, or anxiety, are common causes of weight loss that is not explained by other factors, especially among the elderly.
- 2.8 The use of multiple prescriptions and over-the-counter medications (Polypharmacy), is also a risk factor for malnutrition.

#### Disease related Malnutrition

- 2.9 There are three main causes of disease related malnutrition and examples of each are illustrated in Figure 3.



**Figure 3: The causes of disease related malnutrition**

Increased nutritional requirements	Infection Involuntary movement Trauma Major surgery
Reduced nutritional intake	Dysphagia Pain
Increased nutritional losses	Malabsorption/Diarrhoea Wound exudate

2.10 Malnutrition from all of these aspects is inextricably linked and the purpose of this strategy is to anticipate and ensure timely intervention of malnutrition irrespective of the cause.

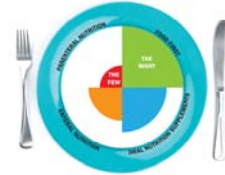
#### Why address malnutrition?

2.11 The detrimental effects of malnutrition are well documented as illustrated in Figure 4.

**Figure 4: Detrimental effects of malnutrition**

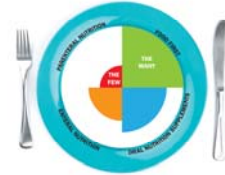
<b>Physical</b>	
Impaired growth & development	
Reduced fat & lean body mass	↑ pressure sore risk
Reduced strength & lethargy	↓ mobility & ↑ falls
Reduced ability to cough	↑ risk of respiratory infections
<b>Physiological</b>	
Impaired immune function	↑ risk of infection/complications
Impaired organ function	
Impaired wound healing	↑ convalescence
Altered drug metabolism	↑ side effects
Reduced gastro-intestinal secretions	↑ malabsorption
<b>Psychological</b>	
Apathy & depression	↓ quality of life

These may exist individually or collectively where they contribute to increased length of hospital stay and mortality. Providing good nutritional care is therefore a matter of quality<sup>14</sup>.



### Cost of disease related malnutrition

- 2.12 The annual cost of disease related malnutrition in the UK in 2007 was estimated to be more than £13 billion<sup>10</sup>. This results from the health care cost of treating those at medium or high risk of malnutrition as a result of more frequent and more expensive hospital inpatient episodes, and greater need for long term care. Having a strategy in place for prevention, early identification and timely management of malnutrition can improve quality of patient care and outcomes and make savings at the same time. NICE<sup>15</sup> has identified nutritional care as potentially the 4<sup>th</sup> largest cost saving within the NHS.

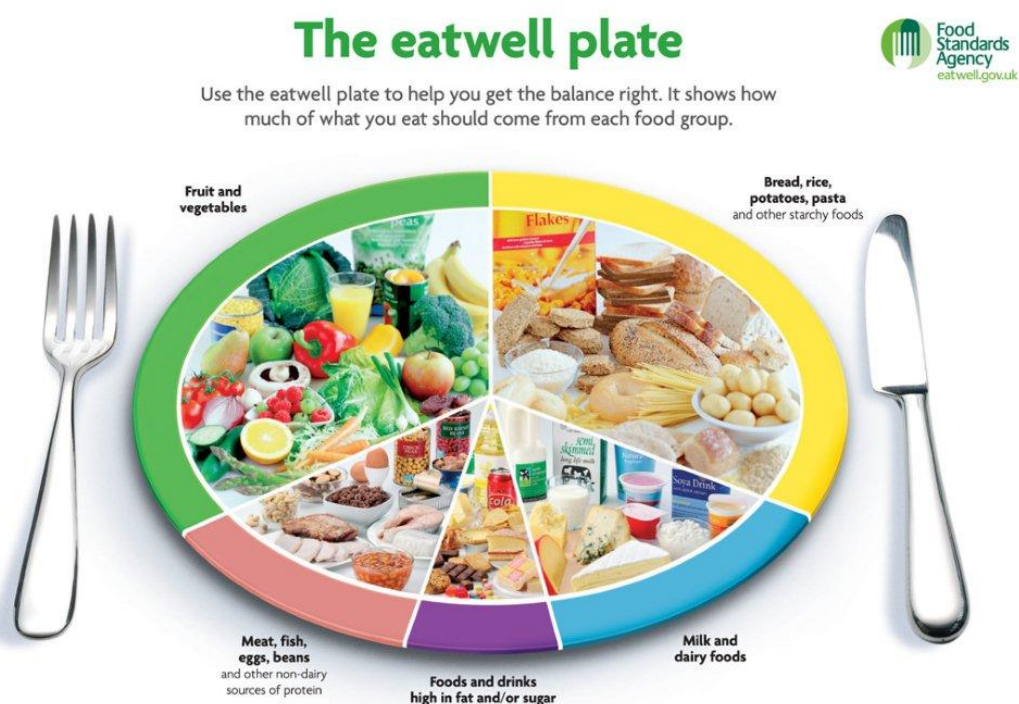


## SECTION 3

### PREVENTION OF MALNUTRITION

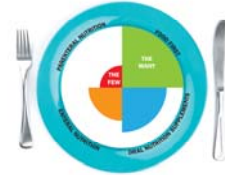
- 3.1 The majority of people in the community may be classified as 'nutritionally well' and their nutritional needs do not differ from that of the general adult population. Healthy eating advice inline with the Eatwell Plate (Figure 5) ([www.eatwell.gov.uk](http://www.eatwell.gov.uk))<sup>16</sup> should be encouraged with these adults.

**Figure 5 : The Eatwell Plate**



- 3.2 However, as malnutrition affects 5% of the population and 14% of those over 65 years it becomes a public health issue. Thus to prevent malnutrition it is important to raise awareness of this issue amongst the public, relatives, carers and health and social care professionals in all sectors/settings.
- 3.3 As adults get older it remains important to include a wide variety of foods in the diet. As people get older they have lower energy (calorie) requirements. However the same amount of vitamins and minerals are needed as younger adults.
- 3.4 It is important to recognise the social and psychological causes of malnutrition and any possible trigger events that may cause malnutrition.

Irrespective of setting the environment should support a positive dining experience to ensure that people achieve optimum nutritional intake.



## ANTICIPATORY MANAGEMENT

- 3.5 As well as preventing malnutrition it is important to anticipate those people who may be at risk of malnutrition. This is achieved through nutritional screening. In 2006, NICE<sup>15</sup> estimated that only 30% of patients were screened for malnutrition on admission to hospital. To address this, the following four core questions are currently being used in hospitals in NI to inform the need for more detailed nutritional screening.

<b>1. A history of recent unintentional weight loss</b>
<b>2. Altered/decreased appetite for 7 days or more</b>
<b>3. A risk of under nutrition due to current illness e.g. difficulty eating/drinking</b>
<b>4 A need for assistance with feeding</b>

- 3.6 In other health and social care settings including people's own home, these questions may act as a trigger for the beginning or continuation of a comprehensive assessment of need.

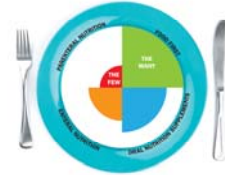
### Screening

- 3.7 Screening for malnutrition and the risk of malnutrition should be carried out on people in a range of settings (Figure 6)<sup>15</sup>.

### **Figure 6: Example of Settings**

<ul style="list-style-type: none"> <li>• All inpatients on admission to hospital</li> <li>• On admission to care homes</li> <li>• All patients at their first clinic appointment</li> <li>• On initial registration with a general practice surgery</li> <li>• Repeat screening should be carried out weekly for inpatients and where there is clinical concern in other settings.</li> </ul>
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- 3.8 Screening should assess body mass index (BMI) and percentage unintentional weight loss and should also consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of further impaired nutrient intake<sup>15</sup>.



### MUST – Malnutrition Universal Screening Tool

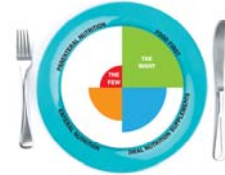
- 3.9 Nutritional screening should be undertaken using a validated screening tool. MUST has been validated for all health and care settings and for use by a range of professionals. Building on “Get your 10 a Day” regional implementation for hospitals, MUST<sup>17</sup> is being adopted and is recommended as the first line tool for nutritional screening in all care settings including people’s own home. MUST recommends that people at high risk of malnutrition (i.e.  $\geq 2$ ) should be referred to a Dietitian, Nutrition Support Team or implement local policy. This will allow for a full nutritional assessment and treatment plan to be delivered in conjunction with nursing staff and carers and those providing food.
- 3.10 Specialist screening tools may also be used for specific clinical conditions or client groups e.g. Malnutrition Screening Tool (MST) for patients undergoing cancer treatment
- 3.11 There may be other reasons why people need input from a dietitian – e.g. other medical conditions that require special dietary intervention (for example coeliac disease) but where malnutrition is not present. These people should be referred to a dietitian in the normal way.

### Enhanced Recovery Programme

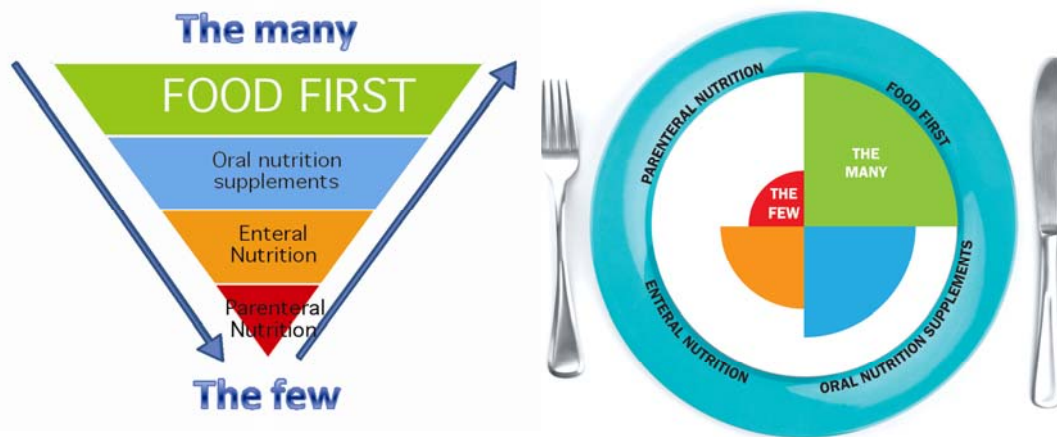
- 3.12 The Enhanced Recovery Programme<sup>18</sup> is a new approach to the preoperative, intraoperative and postoperative care of people undergoing surgery. It improves quality of care by helping people get better sooner after major surgery and reduces length of hospital stay. From a nutritional perspective it involves carbohydrate loading (high energy drinks) presurgery and early oral nutrition and hydration postsurgery.

### **TIMELY INTERVENTION**

- 3.13 People may need different forms of nutritional intervention during their life and the course of any illness which can be provided in all health and social care settings.
- 3.14 Nutritional care can be illustrated as below where most people have their needs met by ‘food first’, a smaller number require oral nutrition supplements, fewer still need enteral nutrition and a small minority require parenteral nutrition (Figures 7a and 7b). All of these may also be used in combination.



**Figures 7a and 7b : From food to parenteral nutrition.**



Adapted from BAPEN<sup>19</sup>

- 3.15 Food should be considered the first line of intervention and other interventions considered when nutritional requirements cannot be met by food and fluid alone. In promoting good nutrition, it is important to progress with timely intervention from food first through to parenteral nutrition where indicated. Of equal importance is the need for timely reassessment to achieve the goal of food first where additional forms of nutritional intervention are no longer indicated.

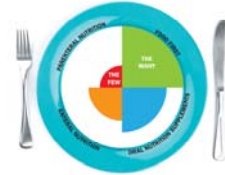
The decision making process for timely intervention is illustrated as a flow chart (Appendix 4)<sup>20, 10</sup>

## **FOOD FIRST**

- 3.16 The 'food first'<sup>21</sup> approach is the term used for general dietary guidance to improve food intake. It includes strategies such as increasing food frequency, modifying food intake and fortifying foods to increase the consumption of energy and nutrient-dense foods.
- 3.17 Providing a range of nutritious and appetising food and fluids for people not only improves their health and well-being but contributes towards individuals enjoying a pleasant experience and supporting those recovering from illness. Providing a conducive environment and protecting the mealtime without unnecessary interruption is fundamental to ensuring that activity is focused on the meal and making sure people are ready to eat.

## **ORAL NUTRITION SUPPLEMENTS**

- 3.18 Oral nutrition supplements are prescribable products that can be used as a simple, effective method of providing nutrition support to people who are malnourished. It is important that there is a regional standardised approach to prescribing these products.



- 3.19 Options for oral nutrition supplements should be considered for any people taking inadequate food and fluid to meet their requirements. Proprietary oral nutrition supplements can be prescribed for conditions, including disease related malnutrition, as detailed in British National Formulary<sup>22</sup> and may be first line where clinically indicated.
- 3.20 The aim of oral nutrition supplements is to complement the patient's overall nutritional and fluid intake in order to improve clinical outcomes. It is important that the total intake from normal food plus oral nutrition supplements provides a balanced mix of energy, protein and micronutrients.
- 3.21 Oral nutrition supplements should be stopped when the patient is established on adequate oral intake from normal food.

### **ENTERAL NUTRITION**

- 3.22 "Enteral feeding" refers to the delivery of a nutritionally complete feed containing protein, carbohydrate, fat, water, minerals and vitamins directly into the stomach, duodenum or jejunum<sup>4</sup>.
- 3.23 Enteral tube feeding should be considered in people who have an inadequate or unsafe oral intake and a functioning, accessible gastrointestinal tract. Enteral tube feeding should be stopped when the person is established on adequate oral intake<sup>15</sup>. Nutrition support teams are in the best place to supervise the standards of care required for people on enteral nutrition<sup>23</sup>.

### **PARENTERAL NUTRITION**

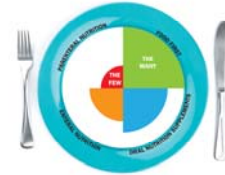
- 3.24 Parenteral Nutrition is a method of providing nutrition support where nutrients are delivered directly into the blood via a dedicated venous catheter.
- 3.25 Parenteral nutrition can be of benefit to people in both the short and long term. It should be considered in people who have either an inadequate or unsafe oral and/or enteral nutrition intake or have a non-functioning gastrointestinal tract. Parenteral nutrition should be stopped when the person is established on adequate oral and/or enteral nutrition support<sup>15</sup>.
- 3.26 Timely intervention and monitoring of parenteral nutrition is essential to achieve safe and effective care under the management of a nutrition support team<sup>24</sup>.
- 3.27 People on long term parenteral nutrition require a regional service framework to ensure access to appropriate and high quality care as close to home as can be safely and cost effectively provided<sup>25</sup>.



## **SECTION 4**

### **The 10 Key Characteristics from the Council of Europe Resolution on Food and Nutritional Care in Health and Social care settings.**

- 4.1 These are being adapted within the framework for action to fit the context within Northern Ireland and form the basis of the principles for our NI Strategic Direction.



## KEY CHARACTERISTIC 1

**Everyone\* using Health and Social Care Services is screened to identify those who are malnourished or at risk of becoming malnourished.**

### Why is this important?

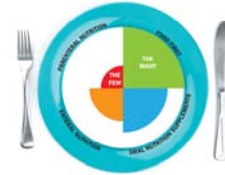
Screening for risk is the first step in good nutritional care. Through nutritional screening we can identify adults at low, medium and high risk of malnutrition and provide timely intervention to manage the level of risk appropriately.

### What does good nutritional care look like?

Patients who need help with eating are being identified on admission to hospitals in NI. At the Ulster Hospital magnetic symbols on patient status boards identify people at ward level. Whilst in Daisy Hill Hospital red trays are provided by catering to people who have been identified as needing help at mealtimes.

- Screening for malnutrition and the risk of malnutrition is carried out on people at specific points<sup>15</sup>
- People who need assistance with eating are clearly identified
- People with swallowing difficulties are screened
- Organisations across NI are building on the implementation and learning from the 'Get your 10 a Day' standards across all health and social care settings including people's own home
- Systems and guidance are in place for appropriate and timely decisions in relation to the need for enteral or parenteral nutrition
- People on multiple medications (polypharmacy) will have regular medication reviews

\* this includes any contact formal or informal which triggers a comprehensive assessment or its continuation



## KEY CHARACTERISTIC 2

**Everyone using care services has a personal care support plan and where possible has had personal input, to identify their nutritional care and fluid needs and how they are to be met.**

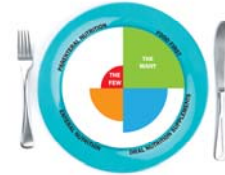
### Why is this important?

The outcome from nutritional risk screening should be acted upon to reduce malnutrition, and improve nutritional care and hydration.

### What does good nutritional care look like?

In Cedarhurst Lodge Care Home residents are involved in the planning of menus and participate in their personal care plan working in partnership with the care home staff to achieve realistic goals for them. This includes clear signposting to dining rooms, colour preference table cloths availability of finger foods etc. It is a whole team approach with the chef taking feedback in the dining room.

- All adults at risk of malnutrition have a personal nutritional care plan
- All people who require assistance with eating and drinking are receiving assistance when required
- All adults identified as having a swallowing difficulty have a full swallow assessment by a Speech and Language Therapist
- All people, their relatives/carers and members of the multidisciplinary team are involved in decisions on the appropriateness of the nutrition care plans



### KEY CHARACTERISTIC 3

**The care provider must include specific guidance on food and beverage services and nutritional care in its service delivery and accountability arrangements.**

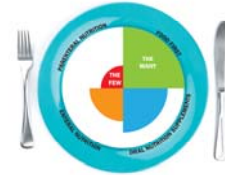
#### **Why is this important?**

When people do not receive the support they need to eat and drink they are at risk of malnutrition and dehydration<sup>26, 27</sup>.

#### **What does good nutritional care look like?**

In Durham and Darlington Primary Care Trust dietitians worked with Age UK and catering colleagues to redesign menus for their community hospitals. Based on patient stories, unwanted and inappropriate menu items were removed. Dietitians provided advice and training on fortification of food at kitchen and wards levels to increase its nutritional content to ensure patients are well nourished<sup>28</sup>

- Menus are planned to achieve optimum nutrition and hydration
- The design of menus and content is appropriate to the client group and approved by a dietitian<sup>29</sup>
- For residential, nursing homes and community meals, menus are inline with relevant menu checklists in NI<sup>30, 31</sup>
- Food and beverage consumption is monitored where appropriate
- Enteral and parenteral nutritional care is delivered inline with evidence based guidance



## **KEY CHARACTERISTIC 4**

**People using care services are involved in the planning and monitoring arrangements for food service and beverage/drinks provision.**

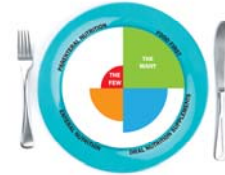
### **Why is this important?**

Advice and feedback from people using food and nutritional care services help to understand what will improve their experience.

### **What does good nutritional care look like?**

Surveys in Northern Trust reveal that people are unable to complete their main meal at lunch time as they feel it is too soon after breakfast. As a result the Trust now provides the main meal in the evening.

- Regular surveys/questionnaires about the quality of service, staff, food and environment are undertaken
- People's views and stories about their experience of food and nutritional care are sought
- People and relatives are encouraged to contribute to monitoring their food and beverage intake
- There is a nutrition coalition in established



## KEY CHARACTERISTIC 5

**An environment conducive to people enjoying their meals and being able to safely consume their food and drinks is maintained (NB this can be known as 'Protected Mealtimes').**

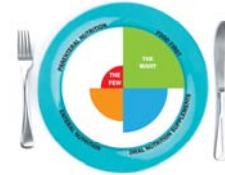
### Why is this important?

People should be able to eat and enjoy their meals in an environment conducive to eating, and staff should be focused on encouraging and supporting a safe meal and nutritional experience<sup>32</sup>.

### What does good nutritional care look like?

In Velindre Cancer Centre protecting meal times is discussed in the ward handover and planned as an integral part of other aspects of clinical care. Pre-mealtime rounds have become embedded into the daily routine to ensure patients are able to achieve their personal preferences and nutritional goals, and fresh fruit milkshakes are available throughout the day.

- Mealtimes are protected without unnecessary interruption
- Ensure the environment encourages eating e.g. by removing distractions
- Ensure people are ready to eat in a safe and comfortable position
- People clean their hands before eating
- Appropriate assessment and provision of equipment to assist people to eat is available when required



## KEY CHARACTERISTIC 6

**All staff/volunteers/carers have the appropriate skills and competencies needed to ensure that the nutritional and fluid needs of people using care services are met. All staff/volunteers/carers receive regular training on nutritional care and management.**

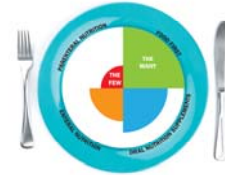
### Why is this important?

All people providing nutritional care should have the appropriate skills and competencies to ensure patients receive good nutritional care. Training in itself is not just a key characteristic of good nutritional care; it also underpins all of the others<sup>32</sup>.

### What does good nutritional care look like?

Hereford Hospitals NHS Trust developed a scoring tool to monitor fluid balance to speed up interventions and improved mealtimes. Volunteer helpers have been trained to assist those who need help with eating and drinking. This includes using 'red-lidded' jugs to identify people who need help with drinking<sup>28</sup>.

- Delivery of appropriate training for all health and social care professionals who may be required to screen for malnutrition in adults
- All health and social care staff will have raised awareness of the causes and consequences of malnutrition.
- All staff/volunteers/carers are competent and appropriately trained to a standard that is commensurate with their role.
- The management of malnutrition will be included in the pre-registration curriculum for all health and social care professionals who have this as part of their role.
- Educational opportunities are in place for all people who are involved in the identification, assessment, preparation of and delivery of food and nutritional support.



## KEY CHARACTERISTIC 7

**Facilities and services are designed to be flexible and centred on the needs of the people using them.**

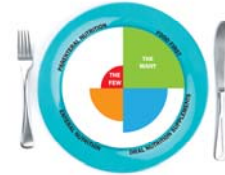
### Why is this important?

All people should have access to food and beverages at all times. This can be achieved through well designed facilities and service delivery<sup>32</sup>.

### What does good nutritional care look like?

A patient with dementia and swallowing difficulties who was consuming 8 oral nutritional supplements a day was referred for dietetic and swallow assessment. The nutritional plan included reintroduction of textures to increase food intake. The outcome is that this person now enjoys a full soft diet with reduced supplements.

- Food service provision/design will allow for food and beverages to be available 24/7 where applicable
- Nutrition care plans are flexible to encourage people to progress towards food first as and when appropriate
- Flexibility and anticipatory management is evident in the transition of children to adult services
- Services and staffing to support the aims of this strategy are realigned or developed and those which do not are scaled down or stopped.



## KEY CHARACTERISTIC 8

**The care-providing organisation has a policy for food service and nutritional care, which is centred on the needs of people using the service. Performance in delivering that care effectively is managed in line with local governance and regulatory frameworks.**

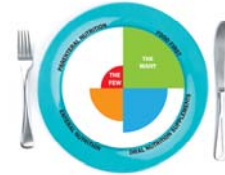
### **Why is this important?**

It is important that all health and social care providers have a policy for food service and nutritional care that addresses the promotion of good nutrition, the prevention of ill health due to inappropriate nutrition and the treatment of nutrition-related disease<sup>32</sup>.

### **What does good nutritional care look like?**

Belfast Trust has a policy for community meals provision that is designed and focused on the needs of the client groups based on a needs assessment that meets dietetic guidelines and hygiene regulations. Client feedback is sought at least every six months and is evaluated to ensure the service continues to meet client needs.

- Organisations and Trusts have a multidisciplinary Nutrition Support Group with leadership and responsibility at executive level.
- Governance and performance management arrangements are in place in relation to food and nutritional care.
- Regional and structured approaches to the management of long term enteral and parenteral nutrition are in place.



## KEY CHARACTERISTIC 9

**Food service and nutritional care is provided safely.**

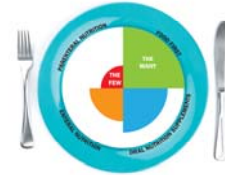
### Why is this important?

Poor nutritional care threatens the safety of people in all health and social care settings. Safety issues should be identified and action taken to improve care.

### What does good nutritional care look like?

Trusts in NI are using the patient safety method of Nutrition Care Bundles to ensure patients are screened for risk of malnutrition on admission to hospital. Many are reporting this via their patient safety forums and agreeing actions to increase reporting and so reduce the risk through appropriate nutritional care planning. As a result screening has increased by as much as 100% in some areas.

- All opportunities for identifying and responding to triggers that may cause malnutrition are realised
- MUST is embedded in all health and social care settings including peoples own home
- Nutritional care is inline with evidence based guidelines on the safe management and administration of enteral and parenteral nutrition
- Health and safety legislation is an integral part of delivering safe nutritional care
- A range of indicators will be in place that measure and demonstrate continuous improvement in safe nutritional care.



## KEY CHARACTERISTIC 10

**Everyone working in the organisation values the contribution of people using the service and all others in the successful delivery of nutritional care.**

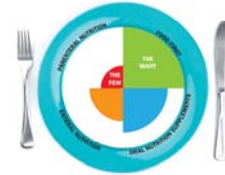
### **Why is this important?**

Safe and effective nutritional care can only be delivered if all those involved feel valued and work together.

### **What does good nutritional care look like?**

Staff at Lancashire Teaching Hospital NHS Foundation Trust have streamlined the use of total parenteral nutrition (TPN), making significant cost savings and improved care for this vulnerable group of patients. Multidisciplinary daily ward rounds including a nurse, pharmacist and dietitian ensure patients get the most appropriate artificial feeding devices and full support to meet their nutritional requirements<sup>32</sup>

- Preventing, identifying and managing malnutrition is everyone's business
- Protected mealtimes are respected by all health and social care staff
- Nutrition support teams are visibly working with others to prevent, identify and manage malnutrition
- People and staff are supported to sustain a culture where quality nutritional care can thrive.



## CONCLUSION & IMPLEMENTATION

“Promoting Good Nutrition” aims to improve the quality of nutritional care of adults in Northern Ireland through the prevention, identification and management of malnutrition in all health and social care settings including peoples own homes.

Raising awareness of the causes of malnutrition, identifying those at risk and ensuring timely intervention will support the implementation of the 10 Key Characteristics for good nutritional care.

A regional implementation group led by the Public Health Agency will be established to prioritise and develop an action plan to realise the vision of the strategy. The regional groups which exist and are already taking forward improvements in nutrition will either be part of the implementation board, be represented on it, or function as a subgroup.

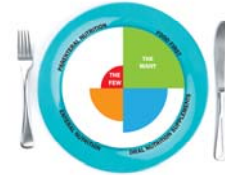
As part of this process a Nutrition Coalition will be established as a subgroup of the main group consisting of representatives from the Patient and Client Council, public, patients, clients and key stakeholder groups from the community and voluntary sector. The role and purpose of the coalition will be determined by the group however in response to the consultation it is envisaged that this group will be the public face of the strategy, communicating the wider public health messages, gaining public confidence and partnership for good nutritional care.

Key to the success of the strategy will be a workforce which values the role food, fluids and timely nutritional intervention make towards health and well being, and recovery from illness. An education sub group will be established to ensure education programmes are developed which build on the knowledge and skills profile to achieve improved nutritional outcomes.

The development of quality indicators and the measurement of outcomes in nutritional care through standardised audit and practice will ensure the continuous improvement of nutritional care.

Promoting Good Nutrition presents a significant challenge over the next 5 years, however building on, “Get Your 10 a Day” to include all health and social care settings including peoples own homes, through adoption and translation of the 10 Key Characteristics will make this vision a reality.

In order to achieve this, providing good nutritional care needs to be everybody’s business.



## Appendix 1

### Programme Board Members

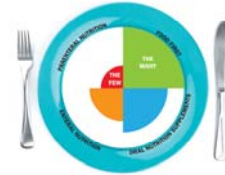
Member	Position	Organisation
Mr Martin Bradley	CNO	DHSSPS
Maeve Hully	CEO	Patient and Client Council
Jim McCall	CEO	Four Seasons
Michelle Tennyson	Deputy Director with responsibility for AHPs and PPI	Public Health Agency
Brenda Creaney	Director of Nursing	Belfast Trust
Charlotte McArdle	Director of Nursing	South Eastern Trust
Keith Gardiner	Consultant	Belfast Trust
Sharon Lowry	Nutrition Specialist Nurse	Belfast Trust
Elizabeth Moore	Lead Nutrition Support Dietitian	Belfast Trust
Rita Devlin	Practice Development Officer	RCN
Lesley Megarity	Domiciliary Care representative	Domestic Care NI
Maire Bermingham	Assistant Director NHSCCT	Regional Support Services Steering group
Mark Timoney	Pharmaceutical Officer	DHSSPS
Conrad Kirkwood	Health Estates Investment Group	DHSSPS
Dr Martin Donnelly	Office of the Chief Medical Officer	DHSSPS
Anne Mills	Nursing Officer	DHSSPS
Pauline Mulholland	Project Manager	DHSSPS
Roisin Perkins	Project Group	DHSSPS

The following groups have provided invaluable contribution.

- Regional Nutrition Standards Implementation Group
- Regional expert Group on Nutritional Services
- Older Peoples Service Framework Group for NI



- Regional Support Services Steering Group
- BAPEN
- Age NI
- British Dietetic Association



## Appendix 2

This strategy builds upon a number of policies, guidelines and regional work which have and will contribute to the improvement of nutritional care for adults:

- [DHSSPS Regional Strategy “A Healthier Future” \(2004\)](#)<sup>33</sup>
- [CREST Guidelines for the Management of Enteral tube Feeding in Adults \(2004\)](#)<sup>4</sup>
- [Primary Care Strategic Framework “Caring for People Beyond Tomorrow” \(2005\)](#)<sup>34</sup>
- [Hungry to be Heard, Age Concern, \(2006\)](#)<sup>8</sup>
- [National Institute of Clinical Excellence \(NICE\) guidance on Nutrition Support for Adults \(2006\)](#)<sup>15</sup>
- [RCN Nutrition Now Campaign \(2007\)](#)<sup>35</sup>
- [‘Get your 10 a Day, The Nursing Care Standards for Patient Food in Hospital, \(2007\)](#)<sup>7</sup>
- [DHSSPS Minimum Standards for Nursing Homes, \(2007\)](#)<sup>36</sup>
- [DHSSPS Minimum Standards for Residential Care Homes, \(2007\)](#)<sup>37</sup>
- [“Improving the Patient and Client Experience”<sup>38</sup> which was published in November 2008 set out five standards relating to: respect, attitude, behaviour, communication and privacy and dignity clearly stating what people can expect from the health and social care service](#)
- [Essence of Care. Benchmarks for Food and Drink 2010](#)<sup>9</sup>
- [Still hungry to be Heard 2010](#)<sup>39</sup>
- [A Mixed Bag Report. National confidential Enquiry into Patient Outcome and Death. \(2010\)](#)<sup>25</sup>

Cognisance will be taken of other strategies that are currently under development or consultation including:

- DHSSPS Catering Strategy
- Long Term Condition Management Strategy

Policies which cover public health and societal issues.

- [Investing for Health](#)<sup>40</sup>
- Older Peoples Service Framework for NI, under development
- [Oral Health Strategy for NI , DHSSPS 2007](#)<sup>41</sup>
- [Delivering Better Oral Health – An evidence-based toolkit for prevention. 2<sup>nd</sup> ed. Department of Health and the British Association for the Study of Community dentistry, 2009](#)<sup>42</sup>
- Oral Health Guidelines for Older Adults Cared for in Residential and Nursing Homes (GAIN NI, pending )



## Appendix 3

## Cross Reference with other Strategic Documents

	<b>Council of Europe Resolution</b>	<b>10 a Day</b>	<b>Hungry to be Heard Seven Steps</b>	<b>Essence of Care</b>
1	Everyone using <i>Health and Social Care services</i> (healthcare and care services) is screened to identify those who are malnourished or at risk of becoming malnourished.	Standard 1	Step 4	7
2	Everyone using care services has a personal care support plan and where possible has had personal input, to identify their nutritional care and fluid needs and how they are to be met	Standard 3	Step 1 Step 2	7, 8, 9
3	The care provider must include specific guidance on food and beverage services and nutritional care in its service delivery and accountability arrangements	Policy	Step 2	5
4	People using care services are involved in the planning and monitoring arrangements for food service and beverage/drinks provision.		Step 1	10
5	An environment conducive to people enjoying their meals and being able to safely consume their food and drinks is maintained (NB this can be known as 'Protected Mealtimes')	Standard 7 Standard 8	Step 5 Step 6	6, 9



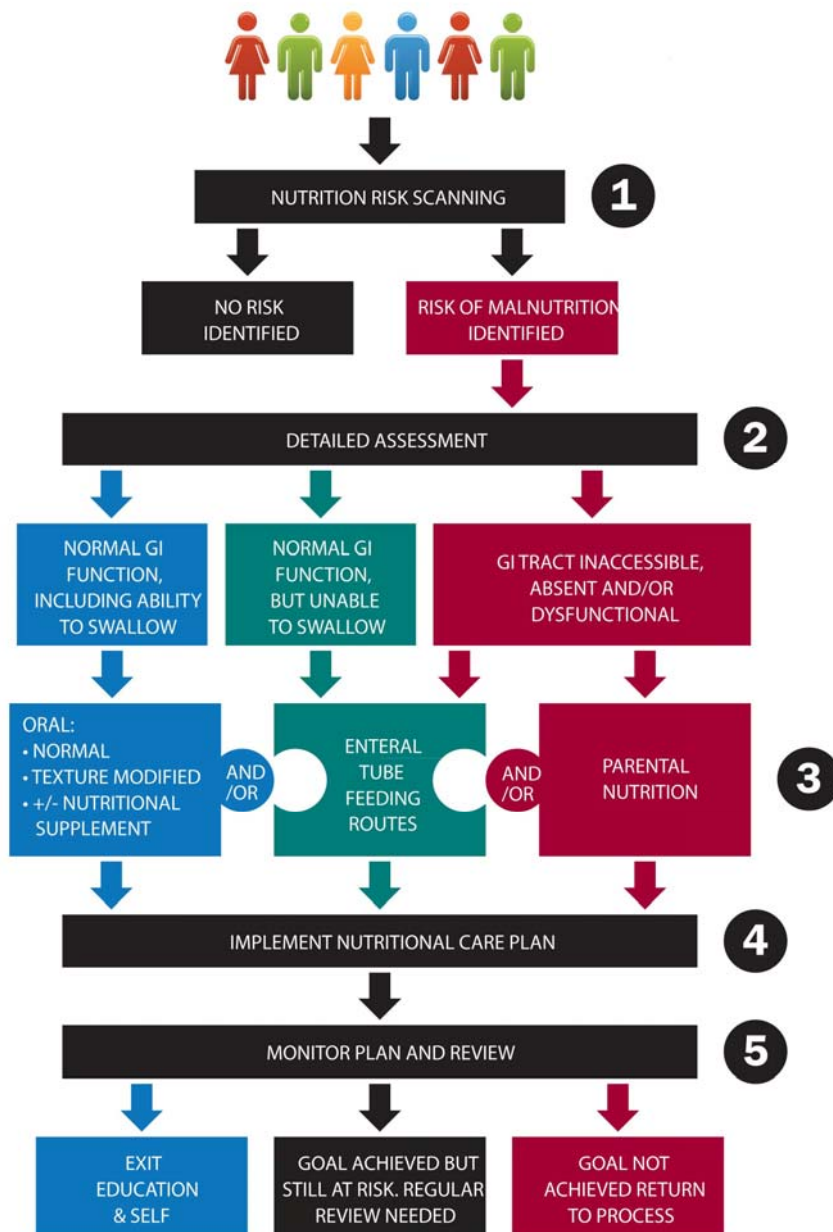
6	All staff/volunteers have the appropriate skills and competencies needed to ensure that the nutritional and fluid needs of people using care services are met. All staff/volunteers receive regular training on nutritional care and management.		Step 3 Step 7	
7	Facilities and services are designed to be flexible and centred on the needs of the people using them	Standard 9	Step 5 Step 7	3, 4
8	The care-providing organisation has a policy for food service and nutritional care, which is centred on the needs of people using the service. Performance in delivering that care effectively is managed in line with local governance and regulatory frameworks	All standards	Step 1	1
9	Food service and nutritional care is provided safely	Standard 1, 2,3,4,5,6	Step 2	
10	Everyone working in the organisation values the contribution of people using the service and all others in the successful delivery of nutritional care		Step 1	



## Appendix 4

### Decision making process for management of malnutrition

#### Malnutrition Care Plan The Assessment Process



Ref: Adapted from BDA and BAPEN and combined



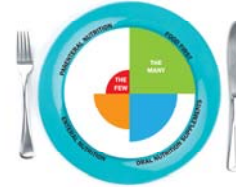
## Appendix 5

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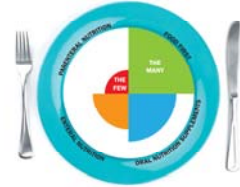
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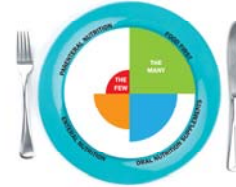
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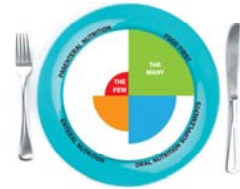
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