SCOTTISH EXECUTIVE

Health Department

St Andrew's House
Regent Road
Edinburgh EH1 3DG

NHS
MEL(1999)54

9th July 1999

Dear Colleague

NURSING HOMES SCOTLAND CORE STANDARDS

Summary

1. NHS MEL(1997)34 attached a Core Standards document relating to the care of residents and the inspection and management of registered nursing homes in Scotland.

2. This letter attaches:

(a) a Chapter addition to the Core Standards –on nutrition standards in nursing homes;

(b) a Nutrition Action Plan – to be read with the chapter on nutrition standards in nursing homes; and

(c) a further Chapter addition to the Core Standards –on hygiene standards in nursing homes.

3. The attached chapters and guidance are equally relevant to the standards expected of NHS care facilities as they are for nursing homes.

Action

4. Health Boards are requested to make this MEL and attachments available to all with an interest in the registration and inspection of nursing homes. The Health Board registration and inspection teams are requested to pass copies of the guidance and attachments to all nursing homes registered in the Health Board area and to make copies available to any prospective nursing home owner on request.

5. Health Boards and NHS Trusts are requested to note the application of these standards to all NHS care facilities.

Yours sincerely

for **KEVIN J WOODS**
Scottish Executive Health Department

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NURSING HOMES SCOTLAND
CORE STANDARDS

SECTION 6

NUTRITIONAL CARE

1999

NUTRITIONAL CARE STANDARDS

EXECUTIVE SUMMARY

Purpose

Nutrition is vital for improving health and quality of life, particularly so for those in continuing care. Every effort should be made to avoid inadequate dietary intakes and poor nutritional status of residents within care settings. Under nutrition gives particular cause for concern due to the link with increased mortality and morbidity.

Early identification and corrective action, appropriate food and fluid, adequate assistance to eat and drink and a suitable physical and social environment can lead to immediate improvements in nutritional state.

The nutrition standards set out within this chapter focus on the key organisational and management issues required to assist establishments improve the quality of nutritional care of those in their care and as a result tackle the problem of under nutrition. Overall, the guidance highlights the importance of organisations viewing nutritional care as an integral part of overall resident care and underlines the need for multi-disciplinary team working in respect of nutrition.

Key Standards

It is expected that each home will have appropriate active policies and protocols to accompany each of the following standards and a communication policy for those with sensory impairment. For some standards it is essential that the General Practitioners be involved in the care plan and that criteria is agreed for access to local Professions Allied to Medicine eg, State Registered Dietitian, Registered Speech and Language Therapists.

1. Assessment of Nutritional State

- All residents will be screened for their risk of under nutrition/dehydration, by a qualified member of staff. This is to be carried out on admission and at monthly intervals thereafter using a validated screening tool, which has been developed or approved by a State Registered Dietitian.

- Homes will have appropriate weight and height measuring equipment, in working order and calibrated annually.

- As part of the nutritional assessment, body mass index (BMI) will be recorded using weight and height or estimated height.

- Results of the nutritional screen and any action taken will be documented in an identified area within residents' care plans.

(Those having palliative/terminal care may not require to be weighed, but this requires prior agreement with the clinician in charge of their care.)

2. Assessment of Diet and Dietary Issues

- Information on residents' current food intake, preferred eating and drinking times, food and fluid likes and dislikes, social and environmental preferences at meal and snack times, oral health and any physical or mental health factors which may affect eating and drinking habits will be sought. This information will be recorded on admission at 6 monthly intervals thereafter, or whenever needs change.

- Realistic resident preferences in relation to food and fluid, meal, snack times social and physical environment will be met at all times. Staff involved with residents' nutritional care will have access to this information at all times.

- It is essential that staff are aware of what residents are consuming and if more than one meal, snack or drink is missed or if significant proportions (eg, 25% by comparison to their usual intake) is not consumed repeatedly, the reasons should be explored and the problem addressed. Records of such incidents and remedial action taken will be documented in the resident's care plan.

- Where, through clinical observation, there is concern through clinical observation in relation to dehydration, fluid balance charts should be compiled. The General Practitioner/other trained professional should be involved at the first indication of concern. Any action should be documented in the resident's care plan.

- Nutritional supplements should not be used over a prolonged period unless advised by the General Practitioner or State Registered Dietitian.

- Staff requiring to refer residents to other professional disciplines will do so by agreed referral criteria. Any action recommended will be documented in the resident's care plan and followed. General Practitioners should be consulted when appropriate.

3. Dietary Provision

- The diet planned and provided to residents will meet current UK Department of Health Dietary Reference Values. Individuals' needs and preferences with regard to cultural, ethnic, religious, social and other diversity (vegetarian, vegan) will be taken into consideration when planning and providing meals, snacks and fluids. Menus will be assessed using a recognised menu-planning programme or by a State Registered Dietitian/Registered Public Health Nutritionist. Menus will be planned taking into account resident preferences and in consultation with a multi-disciplinary team and residents and/or their representatives. This group will meet at least every 6 months to discuss all aspects of dietary provision.

- Cooks will be trained to a specific standard and be able to provide therapeutic diets as necessary (eg, diabetic, soft, high energy). A choice will be provided for those on therapeutic diets.

- Snacks and refreshments will be made available outside the meal times for those who have missed a meal time or on request. No more than 14 hours should lapse between evening meal and breakfast, with snacks available as required during this period. Meal orders will be taken as close to the point of serving as possible but be no more than 2 meals in advance. Choice at the point of service will be explored.

- Care and catering staff will ensure that residents are properly prepared (eg, hands cleaned) and comfortable before and after each meal and snack. They will also ensure that food is served at the correct temperatures, using appropriate crockery and cutlery and that appropriate condiments, sauces, drinks and table covers are provided. Meals will be checked for completeness and residents' orders have been provided as requested.

- There will be adequate staff numbers available at meal times to ensure residents receive a pleasant eating experience which is not rushed, particularly if they require assistance to feed or be fed. Staff assisting residents to eat should be seated beside them. Residents with dementia should have the same qualified member of staff throughout their meal.

4. Training

- All staff involved with caring for residents will have a minimum of 2 hours nutrition education within their specific client group, which is updated at least every 2 years. General health, safety and food hygiene training will form part of staff induction. Training will also be provided to staff in assisting residents to eat. Staff training records will be maintained and there will be a training co-ordinator in each home.

5. Monitoring

- Homes will develop and monitor their nutritional care policies/protocols on an ongoing basis and formally at least at yearly intervals.

All provisions in this chapter should be read with the general core standards for nursing homes set out in the Core Standards 1997 guidance issued under cover of MEL(1997)34

NURSING HOMES SCOTLAND CORE STANDARDS NUTRITIONAL CARE

Introduction

The standards which follow set the minimum nutritional standards required for registration. They are supplementary to the Nursing Homes Scotland Core Standards and should be considered in conjunction with them.

The standards are for all homes which provide care to adults. Such homes will be assessed by these standards as part of the statutory registration and inspection process.

The guidance states that many action requirements "will" be done. Nevertheless, Health Board registration and inspection teams should always ensure that this does not limit the scope of homes to be responsive to individual residents' needs.

The role of any registered Home will be to provide nutritional care which meets the individuals specific nutritional needs in consultation with local specialists (eg State Registered Dietitians, Speech and Language Therapists) and with the residents and, as appropriate, with their General Practitioners.

For those residents with a communication difficulty (or dementia), the views of their relatives and (former) carers should be sought as to known likes and dislikes. Every effort should be made, using advocacy services etc, to determine the residents' preferences at first hand.

Different care sensitive arrangements and considerations will apply for those in palliative/hospice care. Special consideration to the different needs and priorities should be applied in such cases.

An increased liaison between homes and local dietitians will be a necessary outcome of compliance with these standards. It will be for Health Board Inspection Teams to seek advice from a State Registered Dietitian on nutritional issues.

All references in this guidance to "dietitian" should be taken as "State Registered Dietitian".

Background

"Working Together for a Healthier Scotland" (1998) highlights that good quality health is not only about long life but also about quality of life. Nutrition plays an important role in maintaining health and quality of life. As far as food, drink and nutrition are concerned, quality of life means improving health and functional ability

with good nutritional care and enjoyable meals. Therefore, nutrition is a central issue in the continuing care of individuals in care homes.

Promoting the health of those in long-term care is an important element in developing services to improve quality of life and health promotion activity should be core to the development of policies and practice affecting staff and residents.

As part of the Scottish 'health promoting health service', long-term care establishments should seek to provide a health promoting environment; encourage participation by staff and residents in developing services; facilitate healthy lifestyle choices and ensure equitable access to information, skills development, health and other care delivery.

General nutritional guidelines for fit healthy people are not appropriate for some groups in long term care. Certain groups have special requirements for example due to dietary intakes and nutritional indices such as weight decreasing as the degree of illness or dependency increase. Undernutrition should not ordinarily occur in a long-term care setting. Those in long-term care may, however, be undernourished for a number of reasons, including:

- insufficient help for the bed bound;
- inadequate diet (inappropriate nutrient composition of diet);
- degree of mobility and/or disability eg, hearing and sight problems, communication difficulties generally;
- swallowing difficulties;
- poor dentition (poor teeth, ill fitting dentures etc);
- impaired absorption of food and drink;
- disease and mental state, particularly dementia;
- depressed mood, anxiety, reduced motivation or mobility;
- slowness in eating;
- drug-nutrient interactions;
- drug induced nausea or dyspepsia;
- poor identification of people who are or may be at risk of undernutrition;
- lack of prosthetic aids to enable the disabled to eat without assistance;

- lack of awareness of the importance of nutrition and the factors which can cause undernutrition;
- inappropriate packaging of food;
- poorly cooked food;
- poor quality food;
- food served at inappropriate temperatures;
- poor social and physical eating environment;
- appetite suppression (side effect of some medications).

Most of these identified topics are potentially correctable by very simple measures. The main issues are awareness and consideration.

Undernutrition raises concerns as it is linked with increased mortality and morbidity. It impacts on both physiological, psychological and biochemical systems leading to impaired immune response and respiratory function, delayed wound healing, increased complications and longer rehabilitation.

These core standards have been devised from a number of documents which have been produced to tackle the problems associated with undernutrition and improve the nutritional care provided to individuals. Nutritional care should encompass:

1. The identification of individuals' nutritional needs taking account of their cultural, religious, social and therapeutic dietary needs, food and drink preferences and the provision of a diet which meets individuals' needs in each of these respects.
2. Monitoring nutritional risk, nutritional state and dietary intake.
3. Providing a pleasant eating experience, both physically and socially.
4. Ensuring all members of the care team are aware of their potential in providing good nutritional care.

Standards

Homes must provide good quality nutritional care. To ensure this, homes will have:

- a written policy on nutritional care;
- a communications policy for those with sensory impairment;

- clear evidence that key catering, nursing, care and managerial staff are meeting regularly to discuss nutritional issues. (Evidence of resident consultations also);

- appropriate staff/resident ratio at meal times (this will vary from home to home, but be agreed with the registration and inspection teams);

- access to a multi-disciplinary team including a dietitian as required;

- staff (catering and nursing/carer) educated in nutritional care on induction and formally at least every 2 years thereafter;

- weighing and height measuring equipment.

Policies/Protocols

Homes should:

- have active policies and/or protocols in assessment of nutritional status, assessment of dietary intake, organisational issues relating to food and drink provision and dietary provision and scope for personal choice;

- ensure that these policies and or protocols are followed by staff within the home through in-service training;

- be able to provide documentary evidence of ongoing monitoring these policies/protocols and follow-up action taken.

All Nursing Homes should have written policies/protocols on:

1. Assessment of Nutritional Status

To include: measurements to be undertaken, by whom and how frequently; nutritional screening tools used; assessment result consideration and action taken as a result; information recording; annual calibration of all scales and measuring equipment; use of height and weight charts.

2. Assessment of Dietary Intake

To include: details of assessments conducted (always discretely, to avoid intrusion), by whom and how frequently; assessments made of nutritional content of menus and client's plate/tray at each meal; responsibility for assessing the percentage or proportion of the meal eaten; drinks consumed; what assessment results mean and what action taken as a result; where dietary information will be recorded and how this information can be relayed to all necessary staff.

3. Organisational Issues Relating to Food and Drink Provision

To include: identifying staff roles for delivery, issuing and collecting meals; staff numbers at meal and snack times; positioning of clients for meals; timing of medical and drug rounds; timing of meals; food hygiene regulations.

4. Dietary Provision

To include: nutritional specifications; information detailing the number of choices available and offered at each meal; fruit and vegetable content; information on vegan/vegetarian choice and therapeutic diets available; menu planning, who should be involved, how often menus should be reviewed, length of cycles; availability of food; food and fluid commodities to be used; monitoring activities and who should be involved.

STANDARDS

Standard Statement 1 - Nutritional Screening

On admission and at regular intervals every individual's nutritional status is assessed by suitably qualified staff in order to identify malnutrition or those at risk of becoming malnourished. Malnourished and "at risk" individuals are assessed regularly and appropriate action taken. Residents should also be screened for malnutrition if a change in their condition, both physically or mentally indicates a change in eating or drinking pattern or habits.

Structure Criteria

1. Each Home will have a validated nutrition-screening tool* and all relevant staff will know how to use it.

2. Care plans will include a nutritional care plan where information regarding nutritional screening can be documented including any remedial action taken or proposed to improve the patient's nutritional status.

3. There will be a written protocol for initial and on-going screening and assessment of nutritional status/risk which includes the following:

   - Height (including height on admission) (using standing height if available or estimated height using the knee height or demi-span method – see Nutritional Action Plan)
   - Weight (including weight on admission)
   - Body Mass index (BMI)
   - Dietary assessment (see Standard Statement 2)
   - Appetite suppressing medication
   - Excessive weakness, apathy
   - Other risk factors eg, dementia, infection
   - Pain

(Those responsible for recording/assessing should be trained in that function).

4. Chair scales with a footrest will be available for weighing individuals in each home (each house where more than one house constitutes the "home"). Wheelchair or hoist scales to be used as appropriate.

5 There will be agreed criteria for referral to local professionals allied to medicine.

*** It will be for the Home to adopt a nutritional screening tool developed or approved by a State Registered Dietitian which is valid, reliable and client group specific.**

Process Criteria

Consideration will be given to those with a condition or medication associated with weight loss or gain, where regular BMI assessment may have a negative impact on wellbeing.

1. All new residents will be weighed within 1 week of admission and (while individual resident circumstances will dictate) at least monthly intervals thereafter. Weighed measurements will be recorded in care plans. Residents should be given a clear understanding of the purpose behind these steps. (By agreement with the clinician in charge of care those having palliative/terminal care may no longer need to be weighed).

2. Oral health will be examined within one week of admission and (at least) six monthly intervals thereafter.

3. All new residents' heights will be measured or estimated within one week of admission. Height measurements will be recorded in care plans.

4. Within one week of admission and at monthly intervals thereafter, all residents' body mass index (BMI) (body weight (Kg)/ Height (m^2)) will be calculated and recorded in care plan. Measurements should be displayed prominently so that trends can be noted.

5. Within one week of admission and at monthly intervals, all residents will be screened for malnutrition/dehydration or their risk of malnutrition using the home's nutritional screening tool.

6. Any resident identified as malnourished/dehydrated or at risk will be treated appropriately as indicated in the screening tool and action taken will be recorded in the resident's care plan. The General Practitioner should be involved at the first indication of concern. There should be no question of forced feeding.

7. Nutrition screening tools should reflect, appropriately, patients at risk of undernutrition. Risk should then be considered along with clinical condition when deciding on intervention. Guidelines on intervention, developed or approved by a State Registered Dietitian should be available which should include appropriate referral to medical and dietetic services.

8. Unexpected or unintentional weight gain or loss should be recorded and action taken per item 7 and the General Practitioner consulted.

9. All scales will be in working order and calibrated annually.

Standard Statement 2 - Dietary Assessment

All residents' diet and issues which affect eating and drinking will be assessed on admission and on an ongoing appropriate to needs basis thereafter, but with (at least) six monthly formal reviews, in order to identify:

1. residents with poor food and fluid intake;

2. factors which may put the resident at risk of inadequate or inappropriate dietary intake (for example, swallowing difficulty, poor dentition, digestive difficulties etc);

3. residents' dietary preferences (cultural, ethnic, religious observance, food allergies etc);

4. those residents' on long-term diuretics who are particularly at risk of dehydration if oral intake is reduced.

Residents' diet and dietary issues should be addressed and, where appropriate action taken to improve food and fluid intake. No nutrient supplements should be offered without prior discussion with the resident's General Practitioner.

Structure Criteria

1. Each resident will have an individual nutritional care plan (separate or separately identified within the individual care plan) where information regarding food and fluid intake, preferences and factors which affect intake is recorded. All staff should be aware of the information within this section.

2. Each home will have a system in place to ensure communication of this information to staff.

3. Each home should have the facility to provide a softer or liquidised diet for those with swallowing problems. If choking is a major hazard, advice from speech and language therapists on swallowing ability is recommended.

4. Each home will have a written protocol for initial and on-going assessments of food and fluid intake and factors which affect intake, these should be recorded in the care plan:

   - Diet history
   - Dietary needs, (eg liquid/soft and therapeutic)
   - Food and fluid likes and dislikes – food allergies or intolerences

- Social and environmental preferences at meal and snack times
- Physical and mental factors
- Oral health

Process Criteria

1. All residents will within 1 week of admission have the following documented in their care plans:
   - Current food and fluid intake
   - Preferred eating and drinking times
   - Food and fluid likes and dislikes
   - Social and environmental preferences at meal and snack times
   - Physical and mental factors which affect eating and drinking
2. The information recorded will be updated where preferences and needs change. Realistic food and drink preferences will be met at all times. A full assessment should be conducted every 6 months (at least) or more frequently as needs dictate.
3. All staff involved with nutritional care will be aware and have access to the information within the nutritional care plan as required.
4. Staff will know what residents consume. If more than one meal is missed or significant proportions (eg 25%) of the meal, snack or drink (by comparison to the resident's known usual consumption) is not consumed repeatedly, the reason should be explored and consequent problems addressed. A full record of such incidents and action taken as a result should be kept within the nutritional care plan. Nutritional supplements should not be used as a permanent item in the diet unless advised by the General Practitioner or a State Registered Dietitian.
5. In relation to dehydration, clinical observation of dry mouth or dark urine and weight loss should be followed by fluid balance charts. The General Practitioner/other trained professional should be involved at the first indication of concern. Any resident identified as dehydrated should be treated appropriately and any action taken should be recorded in the resident's care plan.

6. By applying the agreed criteria staff will identify those residents who require referral to another discipline eg dentist/oral hygienist, dietitians, occupational therapists, speech and language therapists, in respect of their eating and drinking abilities. Referral will be documented in the care plan and any action recommended by the specialist should be followed and recorded. The General Practitioner should be consulted where and when appropriate.

Standard Statement 3 – Dietary Intake

Operational policies will reflect the current Department of Health Dietary Reference Values and individuals' food and drink needs/preferences/requirements where menu planning and dietary provision are concerned.

Structure Criteria

1. Each Home will have an operational (written) policy on the following:

   - Menu planning (including perhaps consultation with residents and relatives). (See source documents)
   - Assessment of nutritional content of menus
   - Provision of therapeutic or soft (pureed-blended) diets
   - Ordering of meals
   - Production of meals
   - Serving of meals
   - Distribution of meals
   - Availability of second helpings

2. Each home will ensure that all members of the care and catering team are aware of the policies and monitor implementation at regular intervals.

3. Each home when recruiting new Cook staff should seek to recruit those with City and Guilds 7061/7062 or the equivalent standard General Scottish Vocational Qualification (GSVQ) in hospitality.

Process Criteria

1. Home management will develop operational policies on meal and snack provision, ensure all staff involved are aware of the policy and monitor it on a yearly basis.

2. All menus will be planned to provide essential nutrients for the client group they are to serve (see Nutritional Specifications Section).

3. All menus will be checked to ensure they meet current UK Department of Health Dietary Reference Values at the planning stage by a State Registered Dietitian or Registered Public Health Nutritionist or using a recognised menu planning programme.

4. Menu planners will listen to residents preferences and ensure they are familiar and are addressing the cultural, ethnic, religious and social and other diversity (vegan, vegetarian etc) of the residents.

5. Menus will be planned by the cook/chef in consultation with the multi-disciplinary team including caterers, nurses, care staff, residents and/or their representatives

6. By involving residents in the menu planning process and having multidisciplinary nutritional meetings at least every 6 months, individuals' particular needs will be identified and views sought with regard to the following:

   - Menu choices
   - Names of dishes
   - Recipes
   - Length of menu cycle (3-6 weeks)
   - Snack and drink choices
   - Number of choices on menu
   - Colour and flavour of meals
   - Portion sizes
   - Meal and snack times
   - Meal and snack physical environment eg table heights, music, seating arrangements
   - Meal and snack social environment eg eating with friends
   - Preference for eating alone
   - Presentation of meals
   - Availability of second helpings.

7. All homes will be capable of providing therapeutic diets as necessary. (For example, liquidised or soft, diabetic, weight reducing or energy enhancing).

8. Where there is a need for a resident to be on a therapeutic diet eg diabetic, consistency, alterations etc, a choice will be provided.

9. Appropriate nutritious snacks and refreshments will be made available outside meal times for residents who have missed a mealtime or on request.

10. The maximum period between the last main meal at night and the following breakfast will not exceed 14 hours, with snacks available when required during this period. Snacks should include a range of foods including some of a reasonably substantial nature.

11. Meal orders will be taken either on the same day that meals are served or no more than two meals in advance. Choice at the point of service will be explored.

12. The serving of meals at dining room level by care staff or residents should be explored, where this is a safe and practical alternative. Resident choice should be considered.

13. Home and catering staff will be aware of their responsibility where food service is concerned and this will be documented in a procedures manual.

14. Before the meal service starts, both catering and care staff will ensure the following:

- Residents hands are washed before and (where appropriate) after meals.
- Condiments and other seasoning are available
- Food service equipment is at the correct temperature
- Plates are at the appropriate temperature depending on what is being served
- Appropriate cutlery and crockery is provided
- Tables are not set for eating more than 30 minutes before any meal where perishable items are involved and where the dining area also doubles as a lounge
- Appropriate eating and drinking aids are available and being used if necessary
- Cold sauces and salad dressings are available (where appropriate)
- Residents are prepared for their meal eg in the correct (most comfortable) eating position
- Cold drinking water is available at the table
- Table napkins or appropriate alternatives are provided

15. Each time food arrives it will be checked by the agreed personnel for quality and temperature (ensure above 63°C for 'hot' food and below 5°C for cold food) before being served to residents.

16. Where a plated or tray meal system is in operation, meals will be checked for completeness and served to residents immediately they are ready for it.

17. Residents' orders will be checked to ensure they obtain the food and portions requested

18. Where plated/trayed systems are used, not all courses will be served at once.

19. Senior staff will ensure that there are sufficient qualified staff numbers available at mealtimes to ensure residents are eating, or are helped to eat, including those residents who cannot eat without assistance, even with special equipment.

20. For residents with dementia, the same qualified member of staff should be present throughout the whole meal. This standard should apply whenever possible for other residents also.

21. Staff helping residents to eat should do so sitting beside them and every effort should be made to make this a pleasurable experience, ie eye contact etc should be maintained.

22. Subject to safe and hygienic practice, and to relieve repetition and offer variety and the catering service should endeavour to be flexible and sensitive to residents needs for privacy, dignity and independence for example by providing (subject to any relevant medical advice):

- Opportunities for residents to eat on their own, (or where appropriate, eating out) if they wish
- Have easily available water or soft drinks to which residents can help themselves when they wish
- Special facilities for residents to entertain friends and family
- Take-away picnics, cream teas
- Birthday parties
- Celebration dinners
- Barbecues
- Home get togethers
- Opportunities for residents to do their own cooking where they wish and where this is a practical and safe option.
- "Seasonal" foods (ie hot cross buns, fresh raspberries etc)

Standard Statement 4 – Training

All staff involved with nutritional care of residents will have appropriate training in nutrition, on induction with periodic updates and refreshers and at least every two years thereafter.

- See Nutritional Action Plan

Structure Criteria

1. All staff involved in nutritional care will receive a minimum of 2 hours nutrition education appropriate to the client group.

2. General, Health, Safety and Food Hygiene training should form part of staff induction.

3. Records of staff training will be maintained.

4. Training should be given to staff in assisting those residents who require assistance to eat.

5. Each home will have a named training co-ordinator, whose remit will include nutritional care training. (See process criteria below).

Process Criteria

1. At least one member of qualified staff per establishment should have undertaken a more intensive course in nutrition and be responsible for co-ordinating nutrition activities and training within the establishment.

2. Details of suitable training courses are detailed in the Nutrition Action Plan. Local dietetic departments may also be able to advise on local courses.

Standard Statement 5 – Monitoring

All Homes will be monitored subject to ongoing in year inspection to ensure that adequate standards of nutritional care are being maintained.

Structure Criteria
1. Homes themselves will monitor their nutritional activities to ensure their nutritional care standards are maintained or improved.

Process Criteria
1. Homes will develop monitoring tools to monitor their nutritional care policies and protocols. 2. Homes will monitor the nutritional care they provide at on an ongoing basis and formally at (least) yearly intervals.

Nutritional Specifications

Among residents, low body weight, small appetite and poor food and fluid intakes are common and can cause more problems than overweight. To ensure that residents are being provided with a diet that meets the needs of the majority of residents, menus should be designed to meet the following nutrient specification. These are the Department of Health's (1992) Dietary Reference Values (DRVs) and are quantified nutritional guidelines for energy and nutrients. They apply to groups of people and are not intended for assessing individual diets. The Estimated Average Requirement (EAR) represents the amount which satisfies 50% of the people in the group; the Reference Nutrient Intake (RNI) is the amount of a nutrient that is required to meet the dietary requirements of about 97% of the people in a group.

It must be noted that there will be residents who require more of certain nutrients depending on a number of factors. The Home should be able to supply a diet which meets all resident's nutritional needs including those who require specific diets (eg soft, diabetic). The assistance of a dietitian at this stage is recommended to ensure that individual needs are met.

Therefore, daily provisions of food and fluid should meet the following specification:

Nutrient	DRV	Specification per day for adults aged 50+ years
Energy (calories)	EAR	Women aged 51-74 years: 7.96MJ (1900kcals) Women aged 75 years + : 7.61MJ (1810kcals) Males aged 51-59 years: 10.6MJ (2550kcals) Males aged 60-64 years: 9.93MJ (2380kcals) Males aged 65-74 years: 9.93MJ (2330kcals) Males aged 75years+: 8.77MJ (2100kcals)
Protein	RNI	Women; 46.5g Men: 53.3g
Non-starch polysaccharide	EAR	18g
B Vitamins **Thiamine**	RNI	Women: 0.8mg Men : 0.9mg
Riboflavin	RNI	Women; 1.1mg Men: 1.3mg
Niacin	RNI	Women: 12mg Men: 16mg
Folate	RNI	200mcg
Vitamin C	RNI	40mg
Vitamin A (retinol equivalents)	RNI	Women: 600mcg Men: 700mcg
Vitamin D	RNI	10mcg (supplied as a supplement, DoH, 1998)
Calcium	RNI	700mg
Iron	RNI	8.7mg
Zinc	RNI	Women: 7mg Men: 9.5mg
Potassium	RNI	3500mg
Sodium	RNI	1600mg
Fluid		1500mls (30 mls per kg body weight)

Nutrient	DRV	Specification per day for adults aged 19-50
Energy (calories)	EAR	Women aged 19-50 years: 8.1MJ (1940kcals) Males aged 19-50 years: 10.6MJ (2550kcals)
Protein	RNI	Women: 45.0g Men: 55.5g
Non-starch polysaccharide	EAR	18g
B Vitamins **Thiamin**	RNI	Women: 0.8mg Men : 1.0mg
Riboflavin	RNI	Women: 1.1mg Men: 1.3mg
Niacin	RNI	Women: 13mg Men: 17mg
Folate	RNI	200mcg
Vitamin C	RNI	40mg
Vitamin A (retinol equivalents)	RNI	Women: 600mcg Men: 700mcg
Vitamin D	RNI	10mcg (supplied as a supplement, DoH, 1998)
Calcium	RNI	700mg
Iron	RNI	Women: 14.8mg Males: 8.7mg
Zinc	RNI	Women: 7mg Men: 9.5mg
Potassium	RNI	3500mg
Sodium	RNI	1600mg
Fluid		1500mls (35mls per Kg body weight)

Portions and measures

The following are standard portion sizes for specific foods. When the food items are provided in the quantities listed and appropriate number of servings provided (see the food table below), then the above nutritional specifications would be met. Recognition should be made of residents' individual appetites and effect any medical or other condition has on intake.

Portion sizes

	Metric	Imperial
All Meat (cooked)	90-120g	3-4oz
Fish (cooked)	90-120g	3-4oz
Egg	90g	3oz
Cheese	60g (included in dish)	2oz
Porridge	120-150g	4-5oz
Potatoes (cooked)	90-120g	3-4oz
Vegetables (cooked)	60-90g	2-3oz
Milk Pudding	120g	4oz
Soft Fruit	60g (fresh, frozen or canned)	2oz
Cake	60g	2oz

Food Servings

The following measures from the food groups should be offered daily

Food Group	Recommended servings per day	Serving sizes	Other information
Milk and dairy	2-3 measures	Large glass whole milk (300ml;1/2 pt) 2 slices cheese (60g; 1-2 oz) 1 bowl milk pudding (120g; 4 oz) 1 carton yoghurt (150g; 4-5oz)	Whole milk should be used (not low fat milk) and the milk should not be watered down. Milk can be used in cereals and drinks.

Food Group	Recommended servings per day	Serving sizes	Other information
Bread **Breakfast cereal** **Pasta** **Rice** **Potatoes** **Chappati** **Yam** **Sweet Potato**	Minimum of 1 or more measures from this group at each main meal, minimum 3 measures per day	1 roll (50g; 2 oz) 1 slice bread (30g; 1 oz) 1 bowl breakfast cereal (30g, 1oz) 2 tbsp cooked rice, pasta, noodles (90-120g; 3-4 oz) 2 egg size potatoes (90-120g; 3-4oz) 1 (60g, 2oz) scone, slice tea bread	Try and encourage higher non starch polysaccharide varieties eg wholemeal bread, whole-wheat flakes branflakes, porridge and weetabix.
Meat **Fish** **Eggs** **Nuts** **Pulse vegetables eg beans peas and lentils** **Cheese**	2 measures from this group per day.	2 slices meat (90-120g; 3-4oz) 1 large fish fillet (90-120g; 3-4oz) 1 chicken breast (90-120g; 3-4oz) 2 eggs 3 tbsp baked beans or other tinned or soaked pulse vegetables (120-150g; 4-5oz) 1tbsp peanut butter (25g; 1oz) 60g, 2oz cheese	Red meats and offal are good sources of iron Oily fish (eg mackrel, sardines) are good sources of vitamin D Pulses are a good alternative to meat and can be used in soups and casseroles Cheese is acceptable for the basis of a main course meal
Vegetables eg fresh or frozen **Salad** **Fruit eg fresh, stewed, dried or tinned** **Fruit juice** **Vegetable juice**	Minimum of five measures per day Aim for five Include a mixture of fruit and vegetables daily	2tbsp cooked vegetables (60-90g; 2-3oz) 2tbsp raw vegetables (60-90g; 2-3oz) 1 side portion of salad 1 apple, orange, banana 1 small bowl of stewed or tinned (60-90g; 2-3oz) 1tbsp dried fruit (30g; 1 oz) ½ cup fresh fruit juice or fortified fruit juice (60g; 2oz)	These add non starch polysaccharide, vitamins and some minerals to the diet. Include green leafy vegetables or salad at least three times per week

Food Group	Recommended servings per day	Serving sizes	Other information
Fatty foods	Use in moderation *	1tbsp butter or margarine (20g; ¾ oz)	Only decrease fatty foods if weight reducing diet required
Sugary Foods	Use in moderation *	1tsp preserve (30g; 1oz)	Only decrease sugary food if weight reducing or diabetic diet required
Fluids	At least 1500mls daily	8 x 200ml cups of water, tea, coffee, milk, fruit juice, squashes, fizzy drinks	Use full fat milk and drinks high in vitamin C Only use low fat milk and low calorie drinks if resident on weight reduction or healthy eating diet.

* The energy content of the diet requires to be increased in a form which residents find acceptable.

Minimum Daily Amounts

The following foods should be available to individuals daily

	Metric	Imperial
Whole Milk	600ml	1pt
Bread	90-120g (3-4 slices)	3-4oz
Butter or Polyunsaturated Spread or Margarine	20g	2/3oz
Preserves	30g	1oz

To achieve appropriate intakes, some individuals (for example those with poor appetites) may require additional quantities of the above. When patients are found to be having difficulties through regular nutrition screening, initial steps should involve appropriate dietary modification/food fortification. This will require appropriate provision from catering services and staff training on this area of care. Catering services should also be able to provide some nourishing drinks such as Complan or Build-Up for patients with short term or intermittent problems with poor appetites/intakes. Only when clinically indicated and when agreed by the residents

GP should prescribable products be initiated. Where used there must be appropriate measures taken to monitor their use.

Source Documents

1. ***The Scottish Office - Eating for Health, A Diet Action Plan for Scotland (1996)*** *- This document gives a plan of action for the private and public sector to improve the diet and health of people in Scotland including the elderly.*

2. ***The Caroline Walker Trust - Eating Well for Older People (1995)*** *-A document which provides practical and nutritional guidelines on providing nutritional care in residential, nursing home and community care.*

3. ***Advisory Body for Social Services Catering - Recommended Standards for Community Meals (1995)*** *- Guidance on all aspects of catering for welfare meals in the community are set out in this document.*

4. ***The Department of Health - Health of the Nation's Nutrition Guidelines for Hospital Catering (1995)*** *- Nutritional standards setting minimum requirements for hospital catering are outlined.*

5. ***The Department of Health – The Nutrition of Elderly People (1992)*** *– A report from a working group on the nutrition of elderly people. A report which sets dietary reference values for elderly people in the UK.*

6. ***The Department of Health – Dietary Reference Values for Food Energy and Nutrients for the United Kingdom (1991)*** *– A report from the Committee on Medial Aspects of Food Policy. This report sets a range of dietary reference values for the UK population.*

7. ***The Department of Health – Nutrition and Bone Health; with particular reference to calcium and Vitamin D (1998)*** – A report from the Committee on medical aspects of food policy on nutritional advice for bone health.

8. ***Royal College of Nursing -Nutrition Standards and the Older Adult (1993)*** *- A document which outlines standards for nutritional care of older people in care.*

9. ***NHS Executive - Hospital Catering Delivering a Quality Service (1996)*** *-this document provides a comprehensive list of good practices for NHS hospital catering. It builds on the Patient's Charter catering standards.*

10 ***British Association for Parenteral and Enteral Nutrition (1996)*** *– this document provides standards and guidelines for nutritional support of patients in hospital but some standards could also apply to care homes*

11. ***Voluntary Organisations Involved in Caring in the Elderly Sector (VOICES) – Eating Well for Older People with Dementia (1998)*** *– A good practice guide for residential and nursing homes and others involved in caring for older people with dementia*

12. ***Greater Glasgow Health Board Food and Health Policy Guidelines for the Frail Elderly and Elderly Mentally ill (1998)*** – *A food and health policy by Greater Glasgow Health Board for elderly people in long term care in the Glasgow area*

13. ***Highland Health Board – Food and Health Policy – The Nutritional Policy for Older People (1996)*** – *A policy on up-to-date information on nutrition and older adults produced by a multi-disciplinary working party for Highland Health Board.*

14. ***Forth Valley Health Board in conjunction with Central Regional Council – Guidelines for Nutritional Care of Older Persons*** – *A document for management of residential and nursing homes and a reference for staff concerned with the nutritional needs of elderly people.*

15 ***CORA – Menu Planner Caroline Walker Trust (1998)*** – Outline of the materials and course structures for Eating Well Nutrition Training for those caring for older people and older people with dementia.

Nutrition Action Plan

A Toolkit for Organisations Caring for People in Long-term Care

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Contents

Appendices

Background

Nutrition has a vital role to play in maintaining health and improving quality of life. Despite this, nutritional care can have a low priority in some care settings. It is known from a number of studies that dependent residents are particularly vulnerable to undernutrition.

Results from a recent national nutritional audit in elderly long-term care funded by the Clinical Resource and Audit Group (CRAG) provide an evidence base which indicates that to gain improvements in the area of nutrition in long term care it is important to adopt a comprehensive and holistic approach. This can be developed by the application of the Health Promoting Health Service Framework and used within any adult long-term care setting.

What is the Health Promoting Health Service Framework?

Programmes to promote and improve health require careful thought and planning to achieve successful outcomes. Frameworks to assist in the planning and focussing of health promotion interventions have existed for a number of years. The Health Education Board for Scotland's Health Promoting Health Service Framework (HPHS) comprises eight components, these are:

- Policy development
- Environment
- Community participation
- Staff health
- Skills/training
- Communication/co-ordination
- Resident programmes
- Research and evaluation

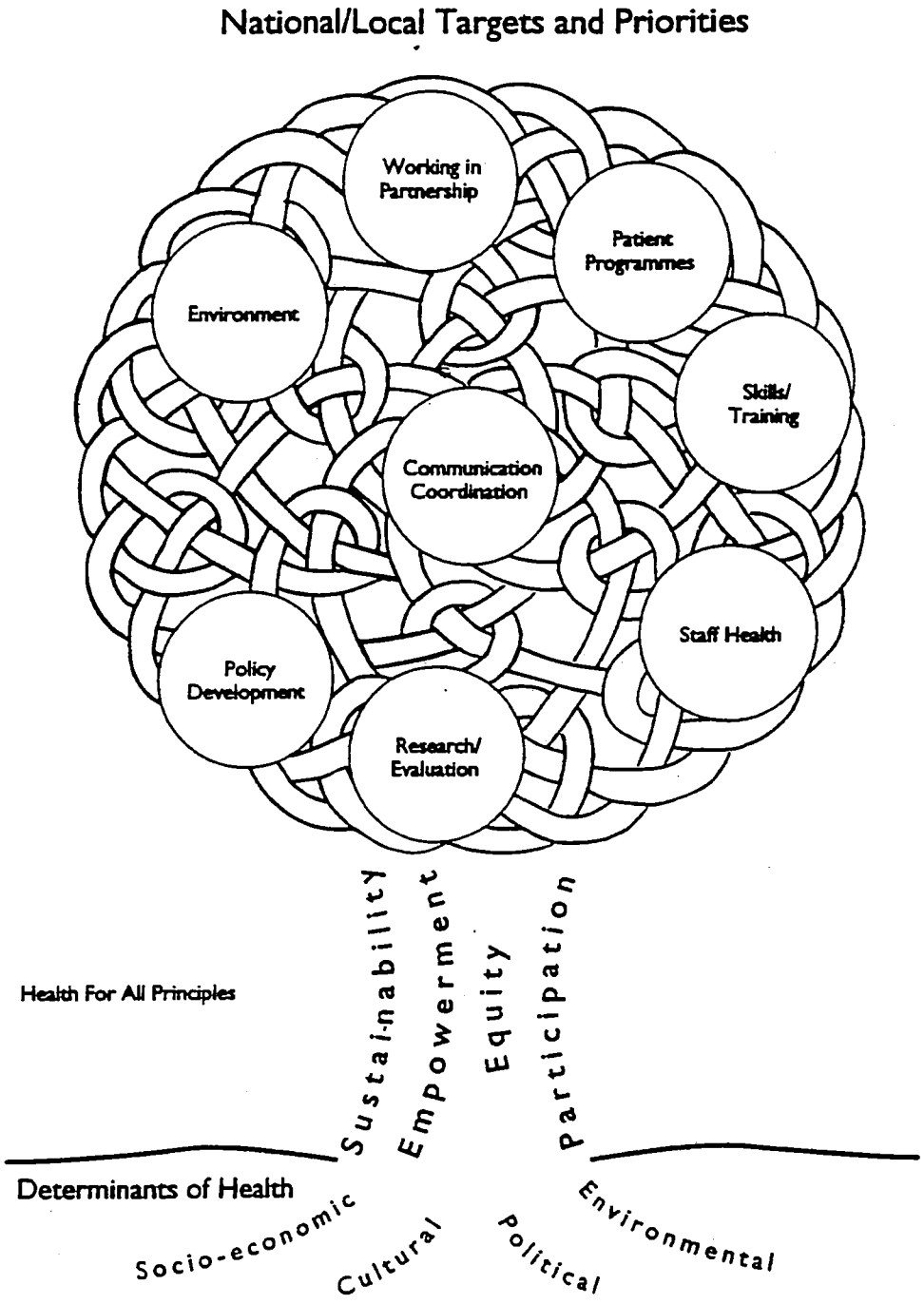
(See Figure 1)

Consideration of these inter-linking components helps us ensure that key issues are addressed and that key personnel are identified. In health promotion, it has been recognised for a number of years that success in improving health is more likely if we work in partnership. Use of this framework helps identify key players and encourages those involved to consider partnership issues.

Context for this Toolkit

To address nutrition in a holistic manner, each of the above components should be addressed. The following is a worked example from a long-stay care establishment of how the Framework can be used. Health professionals attending a series of seminars to disseminated the results of the CRAG national nutrition audit in long-term care generated the issues illustrated in Appendix 1, these also give some ideas on what could be covered under the 8 component headings. Therefore, the points you see within this Toolkit are real examples of what people felt needed to be addressed and were addressed.

Figure 1



Health Education Board for Scotland

Components of the Health Promoting Health Service

The components are listed below with some examples of questions you might ask when beginning to address the issue of promoting good nutritional care:

Table 1: Possible questions for steering groups

Component	Possible questions you might ask in the early planning stages
Policy development	Do we have a policy on nutrition for our care group? What would be the purpose of such a policy? Do we have different policies on nutrition for different care groups? What would they contain?
Environment	What are the components of an optimal environment? How does our environment facilitate the provision of adequate nutrition? What standards should we be trying to develop/achieve in relation to eating environment?
Community participation	Who in the wider community should we involve? Is there a role for them in the nutritional care of our residents? What should that role be?
Staff health	What are the issues in relation to staff health and nutritional care? Are there issues in relation to lifting and handling which need to be addressed? Are there hygiene issues for staff?
Skills/training	Have staff had recent training on nutrition in the elderly? What training is available? How can we ensure that staff have the skills they need to deal with this issue effectively?
Communication/co-ordination	What are the communication issues? Who needs to know? How can we ensure that staff, residents and visitors are kept informed? Is there adequate communication between different groups regarding nutritional/dietary issues?

Component	Possible questions you might ask in the early planning stages
Resident programmes	What information do residents need? What information do staff require on residents' preferences? How accessible is that information? What needs to be highlighted in the resident's care plan? Are there any nutritional screening process, which we should be undertaking? What is the role of the carer?
Research and evaluation	What are the gaps in our knowledge? What are the research priorities? How will we measure any improvements made because of implementing this programme?

What is the best way to use this toolkit?

The toolkit can be used at a number of levels – commissioner (eg health board, local authority), provider (eg NHS trust, nursing and residential home), Ward and Project. One approach is outlined below along with a suggested process to help improve the chances of success.

Step 1

- **Set up a steering group** – this should comprise key individuals who can help drive the programme forward. Steering groups may be set at commissioner and/or provider level. At commissioner level it may be more efficient and effective to develop partnership approaches with a number of provider units. Membership of these area steering groups could comprise those defined at provider level plus a health promotion officer and dietitian. Membership of steering groups at provider level could include:

NHS setting	*Private care establishment setting*
Nursing Officer	Matron
Dietitian	Catering Manager
Hotel Services Manager	Care Staff
Catering Staff	
Ward Manager	

In our pilot project, a simple brainstorm using the headings from the framework and asking some of the questions detailed in Table 1 was required before the concept of

the Framework made sense to people and a greater level of understanding was achieved.

Step 2

- **Assess the current situation-** Select each component of the framework and assess – Where are we now?
  This can be accomplished through a variety of means e.g. focus groups, questionnaires, observation

Step 3

- **Define the task** – from results of the above assessment highlight key issues in relation to each of the branches and agree the task.

- **Consider – Where do we want to be?** From the answers to this question you should be able to clearly define your **objectives**.

Step 4

- **Decide – How will we get there?** – At this stage use your objectives to develop your action plan (see Appendix 2). This should include clear milestones, timescales and intended impacts/outcomes. It may also help at this stage to identify possible opportunities which could arise from implementing your project. This can help motivate staff and give them a sense of purpose and ownership. Equally important is the need to identify possible constraints. These should be raised with managers and the steering group should develop a plan to deal with these constraints. This will help prevent staff becoming disheartened when difficulties arise, and can provide a sense of accomplishment when barriers are overcome.

Step 5

- **Decide – How will we know we've arrived?** – Agree evaluation and monitoring procedures at the outset.

Step 6

- **Action**

Experience has indicated that to reach step 6 may take around six meetings, each lasting one-two hours.

Where do standards fit into this process?

In attempting to promote health it is felt important to identify key standards. It was also important to incorporate the Scottish Office minimum Standards of Nutritional Care. Some of these have been included in the action plan below and the tools within the Action Plan should assist in the implementation of all the Scottish Office standards. Therefore, standards have been developed for most of the HPHS components, but you may wish to develop additional standards, which apply in the local situation.

An example of a possible action plan is provided on the following pages. Tools which have been developed as part of the pilot have been included in the appendices. These tools can be reproduced freely and used within your area.

Action Plan for Policy Development

Rationale: The development and implementation of a food and health policy for staff and residents will help create an environment where healthier choices (age appropriate) are easier to make.

Objectives:

1. Produce a policy which promotes resident and staff health.
2. Produce a policy which takes into account the nutritional needs of people in long-term care.
3. Produce a policy which takes account of the Scottish Office Standards of Nutritional Care.
4. Increase awareness of policy among staff, residents and families.
5. Support all those concerned in making health related changes.
6. Monitor the implementation of the policy

Standard:

The Commissioner/Provider will implement a food and health policy (see outline in Appendix 3)

Milestones:

A Food and Health Policy Group is set up.
Awareness raising seminars are implemented.

Intended outcomes:

The policy and review systems are in place.
Staff and residents are aware of the policy.
The establishment is eligible to apply for a "Healthy Choices" award.
The policy is monitored continuously and reviewed annually

Action Plan for Improving the Eating Environment

Rationale:
The establishment should ensure that the eating environment (physical and social) impacts in a positive manner on the dietary intake and nutritional status of the resident. It should reflect the health promoting aims of the establishment.

Objectives:
1. To assess peoples' impressions of the eating environment through undertaking nominal groups and focus groups with staff, residents and relatives/carers (see Appendix 4 and 5).
2. To identify environmental issues that promote/constrain dietary intake and a good nutritional state in residents (see Appendix 6).
3. To identify resource implications in improving the environment
4. To request support of senior management in developing an action plan to improve the environment.

Standard:
Issues identified in the survey will be reflected in a written action plan to improve the environment. Effective monitoring procedures should be established to ensure maintenance of an environment to promote optimum dietary intake and nutritional status in residents.
Awareness raising in staff in relation to what constitutes an optimal environment should be a regular agenda item at staff meetings.

Milestones:
Survey to identify environmental issues is designed and implemented
Action plan for addressing environmental issues is produced
Resource implications highlighted and requested.
Presentation to senior management to obtain backing.

Intended outcome:
Environmental improvements are implemented
Schemes/structures are in place to enable staff/residents/relatives/carers to suggest environmental improvements

Action Plan for Community Participation

Rationale:
Care Establishments are in a unique position to promote the health of the communities they serve, as well as caring for their sick.

Objectives:
1. To ensure that residents/staff and visitors are aware of the role of the establishment in promoting optimum nutritional care.
2. To ensure that staff are aware of the factors influencing nutrition in the community
3. To involve the establishment in promoting events/situations to raise awareness of nutritional issues
4. To identify individuals/groups in the community who can support the establishment in improving nutritional status/dietary intake of residents

Standard:
A written statement on community involvement in relation to nutrition will be provided. This will identify:

Which groups/individuals are involved?
The type of support they provide
How the establishment maintains and monitors community involvement

Milestones:
Identification of key groups/individuals in the community who can work in partnership to improve nutritional status/dietary intake of residents.

Intended outcomes:
Awareness of nutritional issues is raised in staff/residents/visitors/local community
Appropriate involvement of key individuals/groups in improving nutritional status/dietary intake of residents

Action Plan to Address Issues in relation to Staff Health

Rationale:
Staff health promotion helps to create opportunities that have an impact on the individual.

Objectives:
1. To ensure that information is available and accessible to all staff on occupational health and health and safety issues
2. To identify issues in relation to nutritional care of residents which impact on staff health eg lifting and handling
3. To ensure that training appropriate to the issue of staff health is provided to staff e.g. lifting and handling, hygiene etc

Standard:
Uptake of information by staff on staff health issues is monitored at ward level. Activities to promote staff health are implemented at least on an annual basis.

Milestones:
A portfolio of information to promote staff health is provided and accessible as a reference in each ward area.
Reduced absence rates

Intended outcomes:
Absence due to work related incidents is reduced
Staff are healthier

Action Plan to address Skills/Training Issues

Rationale:
Staff training/development are essential in ensuring that staff are using evidence based and up to date practice. A recent audit indicated that 50% of nursing staff have not had training in nutrition and 64% have had no training in nutrition in long term care.

Objectives:
1. To improve skills and knowledge of staff in relation to nutrition of the group they are caring for
2. To identify appropriate training/development opportunities
3. To ensure that staff have access to appropriate training/development
4. A training needs assessment in relation to nutrition elderly should be implemented at ward level every two years.
5. To ensure that the Scottish Office Standard for training are met

Standard:
All staff involved with nutritional care of residents will have at least 2 hours appropriate training in nutrition every 2 years.

Milestones:
Results of training needs assessment to inform action to address staff skills/training needs
One member of staff is identified to undertake responsibility for co-ordinating nutrition training

Intended outcomes:
Increased knowledge and skills in all levels of staff in relation to nutrition
Opportunities for relevant staff training are available to all members of staff
All staff involved in nutritional care will have received a minimum of 2 hours nutrition related education appropriate to the resident group every two years

Action Plan to address Communication/Co-ordination Issues

Rationale:
Co-ordination and effective communication should lead to greater efficiency and effectiveness in promoting optimal nutritional status in residents.

Objectives:
1. To identify a senior manager to take responsibility for ensuring effective communication and co-ordination in relation to nutritional issues
2. To identify effective communication channels at every level in the organisation
3. To ensure effective use of communication channels
4. To undertake nominal and focus groups with staff and staff/residents on communication and co-ordination of nutritional issues (see appendix 4 and 5)

Standard:
The means of communication should be clearly stated and accessible to staff/residents/visitors. Establishments should have a statement that clearly defines mechanisms to monitor effective communication.

Milestones:
Senior manager appointed to take lead role in relation to communication/co-ordination of action to improve nutritional status/dietary intake

Intended outcomes:
Improved communication and co-ordination of nutritional issues
Staff/relatives/residents make effective use of communication channels

Action Plan to Implement Programmes for Residents

Rationale:
Programmes of resident education or health promotion can increase an individual's awareness and understanding of nutritional issues. Examples of programmes include provision of information on nutrition and nutritional screening.

Objectives:
1. To increase resident knowledge of nutritional issues where possible and appropriate.
2. To correct misunderstanding of nutritional issues
3. To ensure implementation of effective nutritional screening/assessment/dietary assessment (see Appendices 7-12).
4. To encourage/increase compliance in attempts to increase nutritional status and dietary intakes of residents
5. To ensure that the Scottish Office Standards for nutritional screening, dietary assessment and intake are met

Standard:
On admission and at regular intervals every resident's nutritional status/dietary intake/factors which affect dietary intake are assessed in order to identify malnutrition or those at risk of becoming malnourished. Malnourished and "at risk" individuals are assessed regularly and appropriate action taken.

Milestones:
Range of resident information materials available and accessible for residents
Nutritional assessment recorded in nursing notes
Dietary intakes and factors which affect intake are recorded in nursing notes
Residents are involved with menu planning

Intended outcomes:
Greater awareness of nutritional issues in residents
Increased knowledge of nutritional issues
Increase in personal efficacy of residents
Improved health and quality of life outcomes for resident

Action Plan for Research and Evaluation

Rationale:
All health promotion activity should be developed from a sound theoretical basis and build on/ contribute to evidence for good practice.
Evaluation should take account of the processes undertaken, the impact on residents, carers and relatives, and health outcomes as a result of the programme.

Objectives:
1. To provide evidence and examples of good practice in relation to nutritional care (see Appendix 13)
2. To improve targeting of resources
3. To monitor effectiveness of nutritional action plans (see Eating Matters Document listed in Appendix 13).
4. To identify research issues in relation to nutrition in the elderly
5. To agree priorities and undertake research in relation to nutrition
6. To meet Scottish Office Standard regarding monitoring standards of nutritional care

Standard:
Local needs and priorities in relation to nutrition will be used to assist in the identification of research priorities. The nutritional care provided will be monitored to ensure it is of an adequate standard.

Milestones:
Production of a research plan which identifies research priorities for nutrition
Production of monitoring tools to assess implementation and effectiveness of nutritional care programmes.
Production of evaluation plan, which addresses all intended outcomes

Intended outcomes:
Greater emphasis on research based practice
Improved understanding of research priorities
Results of research inform local practice

Appendix 1
Work Group Issues

The following were issues generated from multidisciplinary and multi-agency meetings held in five locations in Scotland. Numbers within brackets eg (4) indicate the numbers of groups which generated that issue.

Resident Programmes

(4 Seminars)

Issues

Catering

- Involve residents in menu planning (1)
- Improve mealtime flexibility/ meals at appropriate times / accessible of food (4)
- Bulk v plated meals – improve portion sizes, choice, presentation, temperature, separate menus, therapeutic diets, outside catering, make toast , advance ordering of meals(4)

Ward

- Environment - smell, dining room v bedside(2)
- Appropriate cutlery (2)
- Nutritional screening - weight, mid-arm circumference, appropriate screening tools(2)
- Dietary assessment (2)
- Development of care pathways for use in establishment and community (1)
- Dietary preferences – in care plans, meeting preferences (2)
- Other disciplines overlapping with mealtimes -protect time for meals (1)
- Drugs (1)
- Busy ward means low priority at mealtimes (1)
- Food hygiene, health and safety (2)
- Flexible approach to feeding and portion sizes (1)
- Differences in standards - family involvement (1)

Management

- Training – staff and residents (2)
- Residents training - fluid, diet, need for assessments, increased health gain (2)
- Team working (staff, multi-disciplinary, multi-agency) (2)
- Dissemination of individual choice/needs (3)

Resident

- Individual programmes (1)

Action Priority

1. Nutritional screening holistic approach
2. Simple dietary assessment
3. Develop care pathways
4. Involve residents and carers in menu planning
5. Improve choice for mealtimes/flexibility
6. Improve portion sizes – more individual -revert back to bulk food delivery system, use menu cards appropriately and have more varied portion sizes available
7. Staff training
8. Competing priorities – food as part of treatment
9. Improve choice
10. Adequate staffing – skill mix

Barriers

- Cost
- Training
- Time
- Staffing levels
- Health and Safety Legislation
- Difficulties in meeting individual choice in large establishment
- Policies
- Lack of joint working between NHS and non-NHS

Skills and Training

(4 seminars)

Issues

1. Lack of staff training/knowledge (1)
2. Staff feel they have sufficient knowledge (1)
3. Require to raise resident/resident awareness – may pick up wrong messages (1)
4. Training should have a wide remit –all staff should be involved (4)
5. Training should be multi-agency –interface with social services, relatives, GP's (2)
6. Training must be practical based and resident centred and local (2)
7. National policies/standards – training must tie in with these (3)
8. Access to dietitians, all PAMs to do training (3)
9. Training required also into specific issues – those requiring fed, consistency altered diets, quality food preparation, choice of food to residents, nutritional screening, limitations of equipment (scales), weighing residents, other assessment methods, ethical issues, weight reduction, seamless service food hygiene (2)
10. Financial constraints – food budget, staff release, availability of snacks/drinks, limited resources (3)
11. Quality formal training (2)
12. Putting training into practice (1)

Action Priority

1. National policies/standards for nutrition/catering need to marry with local policies
2. Train all staff – resources are crucial
3. Education and communication to involve the Health Council
4. Training required for the policy makers/ senior management/budget holders
5. Identify mechanism for multi-disciplinary sharing of good practice
6. Development of good practice and training should be developed from these
7. Identify ways of disseminating good practice
8. Identify adequate resources through audit eg length of time to feed a resident
9. Verbal communication –multi-disciplinary/multi-agency working groups - to develop pathways of care
10. Monitor and assess use of knowledge, important that training is put into practice
11. Educate those who impact on resident's lives ie relatives, carers
12. Link person – good model + flexible model + approaches training
13. Assessment tools
14. Involving residents and carers – active participation
15. User-friendly leaflets eg literature

Barriers

- Time
- Resources
- Finances
- Acting
- Geography in some areas
- Depth of knowledge overestimated

Communication & Co-ordination

(3 seminars)

Issues

1. Communication with who – nursing teams, relatives, medical and paramedical staff, catering staff, residents, agencies outwith the NHS (3)
2. Communication is vital (1)
3. Ethos (1)
4. Relatives – assist staff with feeding, bring in appropriate food , discuss residents' food preferences (1)
5. Nursing staff to relay information regarding residents' likes and dislikes to catering staff –database of best choices (1)
6. Nursing auxiliaries/care assistants on one-one basis with residents at mealtimes – these are important times for communication (1)
7. Residents likes and dislikes require to be recorded and handed over so the previous carer and present carer are consistent (2)
8. Internal and external research and evaluation (1)

9. Information documented is not multidisciplinary even though it is meant to be (1)
10. Information handed over verbally (1)
11. Dependant on amount of support staff available (1)
12. Lack of face to face contact (1)
13. Focus on communication priorities – critically assess roles and responsibilities (1)
14. Equal opportunities for all residents (1)
15. Management not fully aware of needs of Trust (1)
16. Lack of resources including management time (1)
17. Lack of evaluation of own practice including new systems (1)
18. Lack of disseminating information and using it effectively (1)
19. Volume of paper (1)
20. Resident held records (1)
21. Access to appropriate IT – cross boundaries (1)
22. Accurate information to residents in all mediums (1)

Action Priorities

1. Move away from blame culture - move towards a more facilitative style of management. Meaningful, participative involvement
2. Improve individual professionals evaluation skills and recognise importance of feedback and dissemination
3. Create equal opportunities for residents in practice and policy
4. Promote face to face communication where possible. Evaluate care plans towards integration
5. Develop core standards for communication and co-ordination nationally and locally
6. Disseminate across areas multi-agency good practice
7. Resident held multi-disciplinary records
8. Guideline development on salient points
9. Listen to resident groups/share information/good practice through all mediums
10. Consider geography

Policy

(3 seminars)

Issues

1. All staff should be involved with policy development at all levels = ownership (3)
2. Policy for NHS and non-NHS (1)
3. Policies inappropriate/not specific enough for long-term care elderly or not available (3)
4. Low priority given to elderly people and nutrition (2)
5. Lack of monitoring, audit and support for change (1)
6. Policies should cover -
    - Training
    - Screening
    - Menu choices
    - Communication
    - Individual needs considered
    - Assessments

- Flexibility of service delivery
- Monitoring
- Funding
- Staffing
- Nutritional specifications
- Hygiene
- Access to professionals
- Eating environment ([3])

7. Link to core standards (1)

Action Priority
1. Education/training at all levels
2. Involvement at all levels in policy development
3. Ongoing monitoring
4. Health promotion (staff and resident)
5. Develop policy
6. Implement policy
7. Set realistic targets
8. Update policy document

Barriers
- Staffing high turnover
- Finances
- Low priority
- Access to professionals
- Attitude of staff
- Lack of multi-disciplinary approach

Environment
(5 seminars)

Issues
Physical Environment:
1. Lack of policy (1)
2. Institutional (2)
3. Seating (2)
4. Feeding Aids/utensils (3)
5. Space/room layout (2)
6. Kitchen facilities (3)
7. Number of people (2)
8. Staffing levels (4)
9. Smell (1)
10. Noise level (2)
11. Time to feed/timing of meals (4)
12. Choices/finger foods etc (4)
13. Presentation (4)
14. Lighting (1)

15. Furnishings (1)
16. Lack of access to dietitians (1)
17. On-going monitoring/ monitoring (1)
18. Nutritional specifications should pertain to the client group (2)
19. Research environment (2)

Social environment

1. Staff support (1)
2. Tradition (2)
3. Residents' views – likes/dislikes (2)
4. Seating –friendship circles (2)
5. Co-operation and communication between staff (1)
6. Visitors –help with feeding, encourage eating (1)
7. Catering –resident centred, catering review groups (2)
8. Sensory losses, cognitive impairment (2)
9. Residents do not always mix (1)
10. Recording information which leads to action (1)
11. Poverty in community (1)
12. Education / poor knowledge at more senior level and private sector/ disseminate good practice/target knowledge (1)
13. Build relationships (1)

Other

1. Are policies for Trust or residents? (1)
2. Limited meal choice on menu (1)
3. Seasonal menus/ site specific (1)
4. CORA Menu planner / computer printed menus (1)
5. Small meals, increased nutritional content (1)
6. Finances (1)

Action Priority

1. ***Policy*** -monitoring
2. ***Nursing*** - time to feed
   - staffing levels
   - communication
   - assessing needs
2. ***Facilities*** - furnishing / layout / lighting / noise / space
3. ***Social*** - activities / use of facilities
4. ***Dementia*** - special case
5. ***Training*** - **VITAL**
   - **ALL**

Barriers

- Lack of standards and action by management for staffing levels
- Balance required between staff and resident priorities
- Relative priority of mealtimes vs drug/ward rounds
- Food hygiene regulations
- Lack of facilities on wards eg fridges, microwaves
- Lack of flexibility/choice eg snacks

- Staff attitudes –mealtimes
- Finances
- Lack of training resources
- Practicable implementation of policies, involving staff in change process, attitudes

Research and Evaluation

(1 seminar)

Issues

Environment

1. People want to do things differently
2. Catering arrangements require to be more flexible eg time, foods available, out of 'normal hours'
3. Require to be achievable therefore may not be ideal
4. Staff : resident ratios - 6 staff : 30 residents –breakfast/lunch; 4 staff : 30 residents – lunch and evening meal
5. On average the number residents requiring fed is 50%
6. Staff health/lifting and handling issues re transfer of residents from wheelchair to dinning room chair, time element also
7. Extra assistance at mealtimes to allow staff mealtimes
8. Audit tool should address individual needs in terms of culture; creed; dietary requirements; preferences etc
9. Available facilities on wards in relation to food, health, hygiene etc
10. Training pertinent issues for appropriate staff members – ongoing
11. Resources

Action Priority

- Evaluate –does it make a difference?
- Literature review
- Effective methods
- Research – social and environment
- Education – target specific group
- Research – does extra money make a difference – on staff or food?
- Dissemination
- Need follow up especially meals on wheels?
- Research –what do people like?

Barriers

- Staffing levels –particularly at mealtimes, number of assisted feeders
- Are relatives available/willing to assist etc ,voluntary organisations
- Inflexibility of mealtimes
- If at home they could have what they want when they want
- Peoples' homes can be the establishment setting – what can be done to address inequalities between NHS and non-NHS facilities?

Appendix 2 – Action Plan

Planning and Evaluation

Subject to be evaluated:

Rationale i.e. why is work being carried out?

Description of consumer of service, consumer needs and how these needs were assessed

Aims:

Objectives:

Priorities for action

Priority/Objective	**Action**	**Timescale**	**Person/Agency Responsible**	**Desired Outcome**

Resources required/used:

Process /method proposed (e.g. policy development, training, research etc.):

Reason for choosing method:

Performance indicators and measurement tools:

To be completed at end of project

To what extent have the objectives been met?

Was the intended process used?

If not, what were the reasons for change?

What changes are necessary if the activity is to be repeated?

Recommendations for future action

Appendix 3

Food and Health Policy for long-term Care

Background

As part of the CRAG national nutritional audit of elderly people in long-term care (but which has relevance to all long term care groups) health boards, trusts and local authorities were asked to complete a questionnaire which focused on their current food and health policy and nutritional specifications. The results indicated that all health boards but not all trusts had a food and health policy. Unfortunately, only one of the five boards questioned had a policy which was specific to the nutritional needs of individuals in long-term care. This indicated the need for developing a food and health policy for long-stay groups.

The Scottish Diet Action Plan (Scottish Office Department of Health 1996) indicated that all health boards, trusts, directly managed units and other providers should have active food and health policies in place which are monitored through the contracting and quality assurance process. The Plan also states that there is an obligation on the whole public sector within Scotland including local authorities to set the standard in terms of food and health. This does not exclude the private sector, in that where it is contracted to a public sector body, they are also expected to comply to the Model Nutritional Guidelines for Catering Specifications for the Public Sector in Scotland. Therefore, various policies, and specifications from NHS trusts and health boards around Scotland were consulted along with appropriate standards (core nutritional standards), recommendations and reports to develop a national nutritional policy for use in NHS or non-NHS settings. The aim of the policy is to provide commissioners and providers of care with a template which they can use to develop or update their own local food and health policy for people in long-term care.

Aim

The policy should aim to provide professionals working with people in long term care with up-to-date information on appropriate nutritional care. When implemented and monitored, throughout all provider units, the policy should allow people to receive appropriate and consistent nutritional care which meets their needs and decreases their risk of malnutrition. This, in turn, should improve their health and quality of life.

The Commissioners Role

Commissioners of care (local authorities and health boards) should ensure that the policy is:

- Incorporated into all contracts with providers caring for long-stay people
- Implemented in all units providing long-term care
- Monitored at least annually in provider units
- Supported and promoted within the provider units

The Providers Role

Providers of care (NHS trusts, private and charity organisations, local authority establishments) should ensure that the policy is:

- Implemented throughout all areas where care is being provided to residents and that all staff are trained appropriately in the policy
- Used as a basis for the provision of total nutritional care
- Monitored and evaluated at least annually

Who will use the policy?

1. Commissioners of care will use the policy within their contracts with providers, to ensure that consistent quality nutritional care is provided to people at all times
2. Management of provider units will use the policy to ensure that they are providing consistent total nutritional care of a high standard
3. The policy will be used by caterers and dietitians to ensure appropriate and nutritionally adequate food and fluid are provided
4. Nursing and medical staff, social workers, care staff and staff from the professions allied to medicine will use the policy in the ward, home or community setting to provided total nutritional care.

Policy standards for total nutritional care

All establishments must provide good quality nutritional care. To ensure this, each establishment will require to have:

- a policy on nutritional care
- evidence that key catering, nursing, care and managerial staff are meeting regularly to discuss nutritional issues
- adequate staff/resident ratio at mealtimes
- access to a multidisciplinary team including a dietitian and other professional staff as required
- staff educated in nutrition care on induction and at least every 2 years
- appropriate weighing and height measuring equipment.

1. Policies/protocols

Management should:

- Have active policies/protocols in assessment of nutritional status, assessment of dietary intake, organisational issues relating to food and drink provision and dietary provision.
- Ensure that these polices/protocols are being followed by staff
- Be able to provide evidence of monitoring these polices/protocols and action taken as a result

All establishments should have active policies/protocols on:

1. Assessment of nutritional status

This should include: what measurements are to be undertaken, by whom and how frequently; what nutritional screening tools are to be used; what the assessment result mean and what action should be taken as a result; where this information is to be recorded; how frequently scales and measuring equipment are to be calibrated.

2. Assessment of dietary intake

This should include: what assessments are to be conducted, by whom and how frequently; what assessments are to be made of resident's plate/tray at each meal; who is responsible for assessing the percentage or proportion of the meal eaten and any plate waste; what the assessment results mean and what action should be taken as a result; where dietary information will be recorded and how this information can be relayed to all necessary staff.

3. Organisational issues relating to food and drink provision

This would include: identifying staff roles for delivery, issuing and collecting meals; staff numbers at meal and snack times; positioning of residents for meals; timing of medical and drug rounds; timing of meals; food hygiene regulations.

4. Dietary provision

This should include: nutritional specifications; information detailing the number of choices to be available at each meal; information on the therapeutic diets available; menu planning, who should be involved, how often menus should be reviewed, length of cycles; availability of food on homes; food and fluid commodities to be used; monitoring activities and who should be involved.

Nutritional Specifications

For some, low body weight, small appetite and poor food and fluid intake are common and can cause more problems than overweight. To ensure that residents are being provided with a diet that meets the needs of the majority of residents, menus should be designed to meet the Department of Health's (1991) Dietary Reference Values (DRVs) and are quantified nutritional guidelines for energy and nutrients as indicated in the Scottish Office Nutrition Standard document. They apply to groups of people and are not intended for assessing individual diets.

It must be noted that there will be individuals within an establishment who will require more of certain nutrients depending on a number of factors. The establishment should be able to supply a diet which meets all resident's nutritional needs including those who require specific diets eg soft, diabetic. The assistance of a dietitian at this stage is recommended to ensure that individual needs are met.

Appendix 4

Nominal group technique

This method enables a group (5-10 people) to generate ideas and reach consensus through a 5 stage structured process:

1. Each member of the group is given a pen and paper and asked to record their **individual** ideas about a topic, eg *" What in you opinion are the most important factors in providing good nutritional care to your residents?"* or *" What in your opinion are the essential elements in a good eating environment?"*

2. The group facilitator then asks each member of the group for one idea and transfers it onto a flip chart, this continues until everyone has put **all** their ideas on the flip chart.

3. Each item on the flip chart is then discussed for clarification.

4. Each member of the group is then asked to study the items on the flip chart and choose the 10 items he/she considers the most important. With the 10 items selected, they are then asked to choose the most important and award it 10 points. The exercise is repeated with the remaining 9 items, the chose item is awarded 9 points, and so on, until each item has been given a descending score.

5. The last stage of the exercise is to transfer the individuals scores onto the flip chart, count up the totals and rank the items according to the highest score.

This technique should take 1 hour approximately.

Results of a nominal group held in a long-term care establishment follow:

Number in group = 7

Issue	**Score**
Appropriate diet for residents	68
Adequate fluids	48
Well cooked meals	35
Time for eating meals	42
Meal presentation	41
Resident supervision	35
Correctly seated	32
Homely environment	20
Individual assessment	45
Resident personal hygiene	23

This group generated 10 items (it is common for a group of this size to generate between 10 and 20 items) of which *" appropriate diet for residents"* was felt to be the most important. Focus groups were then held with between 4-7 members of the ward care team to explore these items further.

Appendix 5

Focus Groups

This technique is used to explore issues in depth with a group of about 5-10 people. It can be used with staff and/or resident/resident groups and should last one hour approximately.

The group are provided with the following brief which provided the structure for the group.

1. The issue (s) which are to be explored are placed on a flip chart for everyone to see eg *"Appropriate diet for residents"* (taken from nominal group) or *"Communication and co-ordination"* (taken from Framework).

2. The group is then asked to brainstorm the issue, all discussion points are placed on the flip chart whether they are positive or negative. The facilitator ensures that everyone has had their point of view transferred onto the flip chart before action priorities are discussed.

3. Using the issues generated from the brainstorm, action priorities are generated and placed in order of importance.

4. The group then discussed the opportunities and barriers to the actions being implemented.

The issues generated in Appendix 1 were created using this technique.

As a result of a nominal group (see above), held with a mixture of ward staff, the issue of "*appropriate diet for residents* " was identified as the most important factor in providing good nutritional care. To explore this issue further, a focus group was conducted with 7 care staff (qualified and unqualified).

Appropriate Diet for Residents

Issues

- ◊ Current menu not appropriate at lunch and evening meal (breakfast is adequate)
- ◊ Choices frequently too modern for resident group
- ◊ Names of some dishes unrecognisable for residents
- ◊ Texture/consistency of certain dishes (vegetables particularly) either too soft, too hard, tough or with lumps
- ◊ Temperature of food/plates
- ◊ Timing of meals – staff or resident orientated?
- ◊ Portion sizes not consistent this may be both a catering and nursing staff issue
- ◊ Plated vs bulk – bulk would allow staff to provide seconds and portion food according to residents' appetite. But, bulk is time consuming and the portion size issue in plated meals may be overcome
- ◊ Menu planning – lack of involvement of ward staff and residents in menu planning
- ◊ Snacks frequently inappropriate for resident group

Priority Actions

1. **Involve ward staff and residents/resident representatives in menu planning**
2. **Involve ward staff and residents/resident representatives in reviewing meals eg choices, names of dishes, texture, temperature of food on a regular basis eg monthly**
3. **Highlight problems foods on menu - survey**
4. **Conduct a portion size review at ward and kitchen level**
5. **Laminate menu cards for tables and use again**

Opportunities

→ Pilot site for HEBS
→ Good communication between staff groups
→ Funding for one member of staff to concentrate on making change

Barriers

→ Time if funding not provided
→ Current structure of planning and reviewing mechanism

Four focus groups were held covering all of the topics generated from the nominal group. The priorities generated from the groups were then placed in order of importance and an action plan generated.

Focus Group Work Brief

Use this to record your thoughts and please retain for future reference

TASKS

1. ***Brainstorm of issues***

2. ***Identify action priorities***

3. ***Identify opportunities for action***

4. ***Identify barriers for action***

Appendix 6
WARD MEALTIME MONITORING SHEET

Ward _____ **Date** _____

Audit undertaken by: _____

Breakfast Service

1. Environment Tables set/table mats	**Comments**
Appropriate condiments provided	
Plates at the appropriate temperature	
Special eating aids provided	
Cutlery/crockery suitable for elderly people	
Atmosphere	
Was the mealtime hurried	
2. Meal Delivery System Time food trolley arrived in Ward	
Time trolley plugged in	
Time trolley removed from Ward	
3. Meal Service How many residents are able to choose food from menu	
How many residents do choose from menu	
Meal by meal ordering	
Duration residents were seated at the table	
Time meal service began	
Temperature of food	
Meal served course by course	
Presentation of meal	
Number of residents who require assistance to feed	
Number of residents who need fed, were they fed individually	
Number of residents on therapeutic diets	
Therapeutic diets served to the appropriate residents	

How many courses are most residents choosing	
How much plate waste	
Meals served table by table	
Residents satisfaction	
4. Staffing Number of staff available to serve food and feed residents Did this number appear adequate	 Domestic staff Nursing staff
Supplements – mid morning – scones Were all residents offered supplements Were all residents offered a choice of snack/drink	
Service of beverages Were domestic staff supervised by Nursing staff	
Time of service	

Any other comments:-

Appendix 7
Assessment of Nutritional Status

Knee Height
Knee height can be used to estimate standing height. It is an estimate of height with an error margin of between 7-9 cm on average
Equipment -
Knee height callipers

Technique -
1. With subject lying on their back or sitting in a chair, bend both the left ankle and the left knee to 90°
2. Open knee height calliper and place the fixed blade under the heel. Press the sliding blade down against the thigh about 2 inches behind the knee cap.
3. Read the measurement to the nearest 0.1 cm.
4. Repeat the measurement, both should be within 0.5 cm of each other. If not, take a third measurement and take the mean value of the two closest values.

Equation –
Using the following equation standing height can be estimated.
Females (19-59 years)
Height in cm = (knee height (cm) x 1.86) - (age (years) x 0.05) + 70.25
(SEE= 7.20 cm)

Females (60+ years)
Height in cm = (knee height (cm) x 1.91) - (age (years) x 0.17) + 75.00
(SEE= 8.82 cm)

Males (19-59 years)
Height in cm = (knee height (cm) x 1.88) + 71.85
(SEE = 7.94 cm)

Males (60+ years)
Height in cm = (knee height (cm) x 2.05) + 59.01
(SEE = 7.84 cm)

Demispan
Like knee height, demispan (half armspan) can be used to estimate height if standing height is unobtainable. It is an estimate with an error margin of 3.3cm on average.
Equipment
Felt tip pen
Non-stretchable tape measure

Technique-
1. Locate and mark the edge of the right collar bone (in the sternal notch) with a felt pen
2. Ask the subject to place their left arm in the horizontal position
3. Place the tape measure at the finger root between the middle and ring finger of the subjects left hand
4. Check the subject's arm is horizontal and in line with the shoulders (give assistance if necessary)
5. Take the tape measure in left hand and extend to the mark on the neck (check arm is flat and wrist is straight) and take the reading in centimetres (cm)

Equation –
Females
Height in cm = (1.35 x demispan (cm)) + 60.1

Males
Height in cm = (1.40 x demispan (cm)) + 57.8

Body Weight
Equipment-
Portable wheelchair weighing scales (calibrated at least once per year)

Technique-
1. Remove subject's heavy shoes or clothes
2. Weigh chair or wheelchair and tare scales prior to subject's weight being taken
3. Weigh subject sitting on chair or wheelchair and record reading to 0.1 kg.

Percentage Weight Loss
Equation-

$$\% \text{ weight loss} = \frac{\text{usual weight (kg)} - \text{current weight (kg)}}{\text{usual weight}} \times 100$$

Body Mass Index (BMI)
BMI is a technique that is used to assess resident's nutritional status and is more useful than weight alone as the individual's height is taken into account.
Technique -
1. Take subject's weight and height (or estimated height from knee height equation)

Equation
$BMI = \text{Weight (kg)}/\text{height (m)}^2$

Undernourished:- BMI less than 20
Desirable:- BMI between 20 and 30
Obese:- BMI greater than 30

Mid Arm Circumference
Mid arm circumference can be used as a means of assessing nutritional state if the subject can not be weighed.
Equipment
Felt tip pen and non-stretchable tape measure

Technique –
1. Subjects should stand or sit upright.
2. Bend subject's left arm at right angles at the elbow and lie their palm flat against their body.
3. Measure the distance between the bony protrusion surface of the upper shoulder and the bony point of the elbow.
4. Mark the mid-point of this distance on the arm and note for future reference.
5. Hang the subject's left arm loosely by their side with the palm of their hand facing inwards.
6. Position the tape at the previously marked mid-point and tighten snugly, but not so snugly as to cause indentation or pinching. Record the measurement taken in centimetres (cm).

For subjects who cannot stand or sit upright, measurements can be made while the subject is lying down.

1. Ask the subject to lie on their right side with their left arm topmost.
2. Bend the arm at right angles at the elbow and place the palm of the hand flat against the body.
3. Measure the distance between the bony protrusion surface of the upper shoulder and the bony point of the elbow.
4. Mark the mid-point of this distance on the arm and note for future reference.
5. Lie the arm with palm flat against the subject's side and place a small soft pillow between the body and the elbow.
6. Position the tape at the previously marked mid-point and tighten snugly, but not so snugly as to cause indentation or pinching. Record the measurement taken in cm.

Interpretation of results

Subject's current measurements should be compared with previous measurements to determine possible change. Also compare current values with age and sex specific percentile charts below. Values below the 5th percentile indicate that the subject has evidence of fat and muscle depletion and may be undernourished.

Reference Values for mid arm circumference

Male

Age group (years)	*Percentile(cm)*		
	5th	*10th*	*25th*
18-24	25.7	27.1	28.7
25-34	27.0	28.2	30.0
35-44	27.8	28.7	30.7
45-54	26.7	27.8	30.0
55-64	25.6	27.3	29.6
65-69	20.6	21.8	23.8
70-74	20.9	21.9	23.6
75-79	19.7	20.8	22.6
80-84	19.3	20.2	21.9
85+	18.9	19.8	21.3

Female

Age group (years)	*Percentile (cm)*		
	5th	*10th*	*25th*
18-24	22.1	23.0	24.5
25-34	23.3	24.2	25.7
35-44	24.1	25.2	26.8
45-54	24.3	25.7	27.5
55-64	23.9	25.1	27.7
65-69	21.2	22.3	24.3
70-74	20.1	21.3	23.3
75-79	19.3	20.6	22.6
80-84	17.9	19.2	21.2
85+	16.4	17.6	19.8

Percentiles from ages 18-64 years from Bishop et al (1981) and for ages 65-85+ years from Burr and Phillips (1984). Body assessments techniques were sourced from Gibson, 1990 and Parenteral and Enteral Nutrition Group, 1997

Appendix 8 NUTRITIONAL SCREENING TOOL (Check with your local Dietetic Department that this tool is suitable for your client group)

Name: _____ Height (m): _____

Unit : _____ DOB _____

				DATE								
				WEIGHT (kg)								
				B.M.I.								
WEIGHT	**0** Usual weight, steady BMI 20 - 30	**1** Recent weight loss up to 3.5kg (7lbs) in three months	**2** Recent weight loss more than 3.5kg (7lb), within three months	**3** Extremely thin - emaciated BMI < 20.								
APPETITE	**0** Good appetite Meals finished	**1** Meals frequently unfinished. Reduced appetite.	**2** Needs encouragement. Poor appetite. Reluctant for meals.	**3** Little or no appetite. Refuses meals.								
ABILITY TO EAT	**0** Able to eat and drink independently, normal consistency diet.	**1** Slow eater. Poor dentition. Requires assistance to be fed.	**2** Choking episodes. Swallowing difficulties. O	**3** Unable to take food or fluid orally.								
CLINICAL CONDITION	**0** Medical condition not affecting food intake.	**1** Repeated short term infections. Constipation. Nausea.	**2** Condition affecting food intake e.g. G.I. disorder Laxative use Long bone fractures Parkinson's Disease Stroke, tremor.	**3** Multiple medical condition. Cancer Marked tremor Sepsis Severe infection Severe leg ulcers								
PRESSURE SORE	**0** Pressure sore Grade 0 - 1.	**1** Pressure sore Grade 2.	**2** Pressure sore Grade 3.	**3** Pressure sore Grade 4 - 5.								
FLUID INTAKE	**0** 8 or more cups daily.	**1** 6 - 7 cups daily.	**2** 4 - 5 cups daily.	**3** 3 or less cups daily.								
MENTAL CONDITION	**0** Alert, orientated.	**1** Apathetic, unco-operative, mildly confused	**2** Confused, depressed.	**3** Dementia.								
				TOTAL SCORE								
				INITIALS OF NURSE								

ACTION PLAN

Aim: To determine the nutritional risk of the individual and take appropriate action to maintain or improve their nutritional state.
Action: The individual will be weighed and screened on admission and then at monthly intervals. Appropriate action will be taken and recorded as necessary depending on risk score. Height measurements or estimated height will be recorded yearly.

AUTOMATIC REFERRAL TO THE DIETITIAN

1. The individual score is in any shaded area
2. The individual scores10 or more
3. The individual requires a therapeutic diet e.g. diabetic
4. The individual has a BMI > 30

AUTOMATIC REFERRAL TO THE SPEECH AND LANGUAGE THERAPIST (SALT)

1. The individual has swallowing difficulties ○

SCORE:

LOW RISK SCORE 9 OR LESS	HIGH RISK 10 OR MORE
Action: ▪ **Weigh and repeat screen monthly**	**Action:** ▪ **Weigh and repeat screen monthly** ▪ **Encourage meals and snacks eg sandwiches, milk** ▪ **Refer to dietitian** ▪ **Monitor dietary intake**

DATE	AIM	ACTION	Signature

Appendix 9 - Nutritional Care Plan (Check with your local Dietetic Department that this tool is suitable for your client group)

Unit: .....
Name: .....
Unit Number .....
Care plan Number .....

Section 1 – Dietary Intake

Record the normal eating and drinking pattern of the individual on admission and then at one month. Thereafter, assess every six months.

Date				
	Food and Drink	Food and Drink	Food and Drink	Food and Drink
Breakfast				
Mid- morning				
Lunch				
Mid-afternoon				
Evening-meal				
Supper				
Bed-time				
During night				
Therapeutic diet				
Aim				
Action				

Section 2 - Social aspects of eating

Please detail any social preferences the individual has at mealtimes (eg where they want to eat, with whom, what seating they like)

Breakfast: .....
Lunch: .....
Evening Meal:.....
Other: .....

Section 3 – Preferences

Record individual's food and drink preferences for meals and snacks on admission. Update as required.

	Dislikes	Likes
Drinks (hot/cold)		
Breakfast cereals		
Bread/rolls		
Soups		
Main courses		
Vegetables/potatoes		
Puddings		
Snacks/biscuits		

Section 4 – Factors affecting dietary intake

Please document any factors (physical or social) which have an effect on the individuals dietary intake on admission and as condition changes.

Factor	Aim	Action

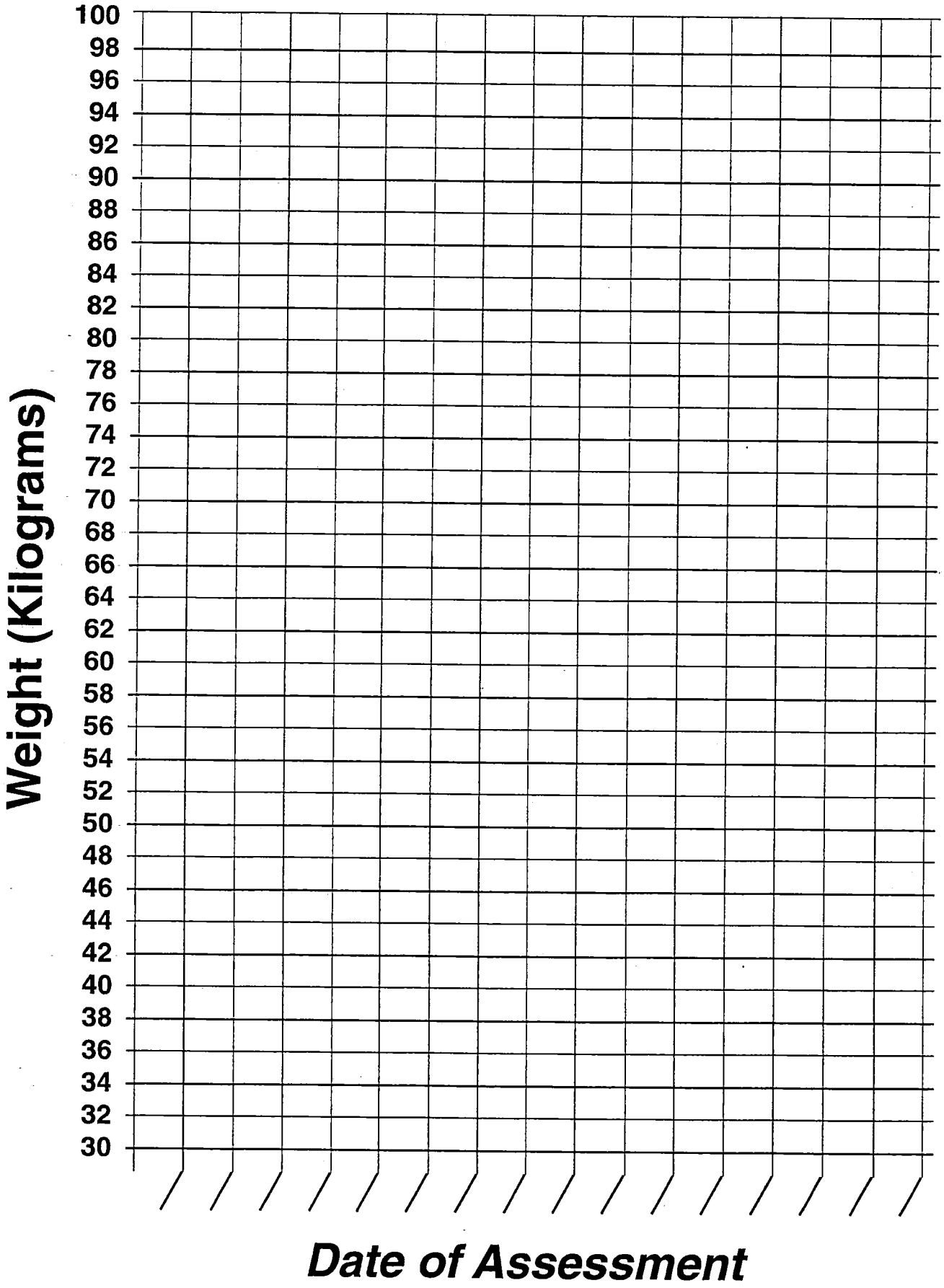
Section 5 – Nutritional Status

Please use the nutritional screening tool on admission and at least once every month. Record score and action on the screening tool

Appendix 10

Weight Chart

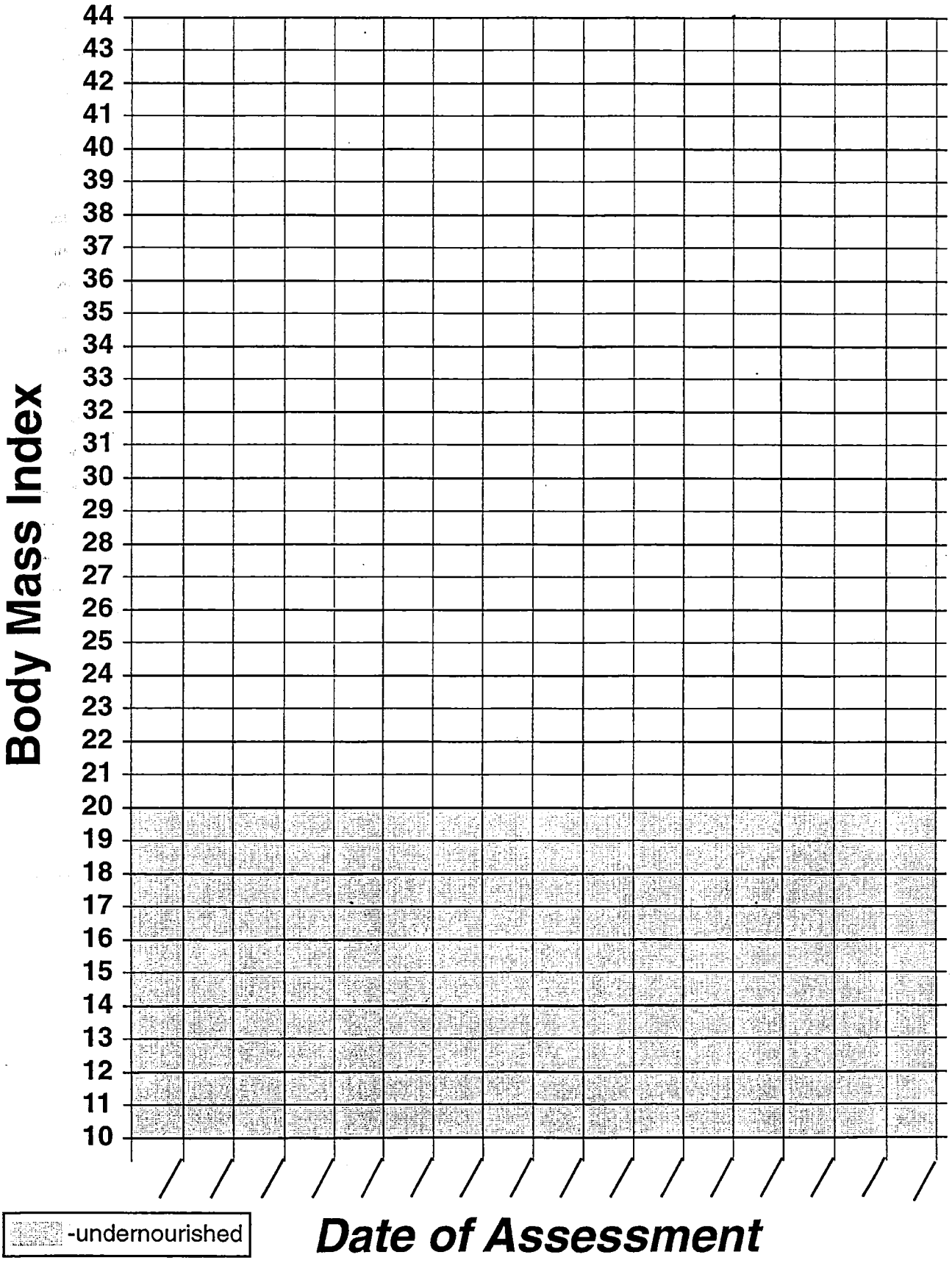
Patients Name.....



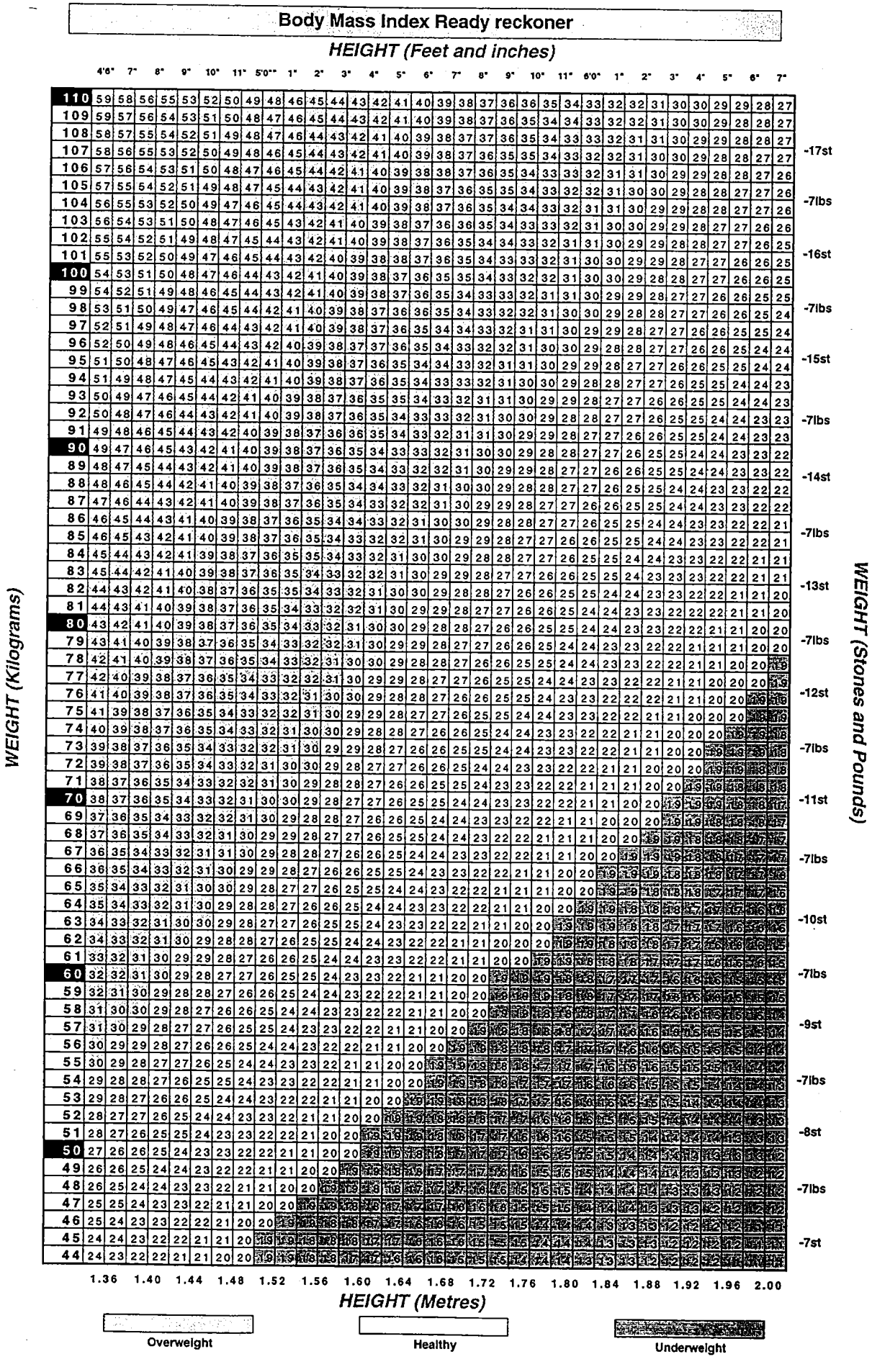
Appendix 11

Body Mass Index Chart

Patients Name.....



Appendix 12


Body Mass Index Ready reckoner
HEIGHT (Feet and inches)
4'6" 7" 8" 9" 10" 11" 5'0" 1" 2" 3" 4" 5" 6" 7" 8" 9" 10" 11" 6'0" 1" 2" 3" 4" 5" 6" 7"
WEIGHT (Kilograms)
WEIGHT (Stones and Pounds)
-17st
-7lbs
-16st
-7lbs
-15st
-7lbs
-14st
-7lbs
-13st
-7lbs
-12st
-7lbs
-11st
-7lbs
-10st
-7lbs
-9st
-7lbs
-8st
-7lbs
-7st
1.36 1.40 1.44 1.48 1.52 1.56 1.60 1.64 1.68 1.72 1.76 1.80 1.84 1.88 1.92 1.96 2.00
HEIGHT (Metres)
Overweight
Healthy
Underweight

Appendix 13

Useful Reading

1. **Eating Matters** (1998). A must for any unit, this is an excellent working document which covers the background to nutrition and the problems encountered in long-term care. It provides worked examples and tools eg audit/monitoring tools which can be copied and used in your area. Centre for Health Services Research, University of Newcastle upon Tyne, Claremont Place, Newcastle NE2 4AA.

2. **The Caroline Walker Trust - Eating Well for Older People (1995)** -A document which provides practical and nutritional guidelines on providing nutritional care in residential, nursing home and community care. The Caroline Walker Trust, 6 Aldridge Road Villas, London W11 1BP

3. **Advisory Body for Social Services Catering - Recommended Standards for Community Meals (1995)** - Guidance on all aspects of catering for welfare meals in the community are set out in this document. ABSSC 45 Palace View, Bromley, Kent BR1 3EJ

4. **The Department of Health - Health of the Nation's Nutrition Guidelines for Establishment Catering (1995)** - Nutritional standards setting minimum requirements for establishment catering are outlined in this document. Department of Health, PO Box 410, Wetherby LS23 7LN

5. **The Department of Health – Dietary Reference Values for food Energy and Nutrients for the UK (1991)** A report which sets dietary reference values for people in the UK. HMSO,PO Box 276, London, SW8 5DT

6. **Royal College of Nursing -Nutrition Standards and the Older Adult (1993)** - A document which outlines standards for nutritional care of people in care. RCN, 20 Cavendish Square, London W1M 0AB

7. **Voluntary Organisations Involved in Caring in the Elderly Sector (VOICES) – Eating Well for Older People with Dementia (1998)** – A good practice guide for residential and nursing homes and others involved in caring for people with dementia. VOICES, c/o Association of Charity Officers, Beechwood house, Wyllyotts Close, Potters Bar, Herts EN6 2HN

8. **Diet and the Cancer Resident.** A useful reference for diet ideas for those individuals suffering from cancer. BACUP, 3 Bath Place, Rivington Street London EC2A 3JR.

Equipment manufactures and suppliers

1. Marsden Weighing Machine Group Ltd., 388 Harrow road, Paddington, London W9 2HU
This company supply adult weighing scales (stand on, seated and portable), height measures and food weighing scales.

2. Scotway, 10 Lathallan Drive, Polmont, Falkirk, FK2 0PE
This company sells a range of weighing scales and measuring equipment.

3. BRASH Weighing Equipment, Glasgow Depot, D Brash & Sons LTD, 37 Stamerland Crescent, Clarkston, GLASGOW G78 8LH
This company sells a range of weighing scales and measuring equipment.

4. CMS Weighing Equipment Ltd., 18 Camden High Street, London NW1 0JH
This company supplies weighing equipment and also callipers designed specifically to measure knee height.

Computer software suppliers

The CORA menu planner is a computerised software package that can help plan nutritionally balanced menus for older people in long-term care. It aims to improve the nutritional quality of the food and drink served to older adults and enables the user to ensure that the menu includes a wide variety of appetising meals which met UK dietary reference values for the older adult. Both DGAA Homelife and The Caroline Walker Trust publish the menu planner.
For more information contact: CORA Menu Planner. Eating Well for Older People. DGAA Homelife, 1 Derry Street, London W8 5HY Tel: 0171 396 6739

Training

1. Local nutrition and dietetic departments may be able to advise on local courses being run in nutrition.

2. Queen Margaret University College has developed a range of distance learning units on nutritional aspects of client care for nurses and carers working in long-term care facilities. These learning materials have been designed to allow participants to reflect and draw on their own work experience.
   Learning units of particular interest to all staff working in long-term care include:
   Nutrition – A caring approach (certificated learning), developed as part of the CRAG funded National Nutritional Audit in Long-term Care
   Nutritional screening (certificated learning).
   Units for those interested in securing academic credits (degree level):
   Understanding nutritional needs of the older adult (Level 3 – module 1)
   Recognising nutritional risk (Level 3 – ½ module)
   For further information contact: Win Woolard, Administrator, Partnerships in Active Continuous Education, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS Tel: 0131 317 3446 Fax: 0131 317 3517

3. The Eating Well Training Consultancy run 1-day courses on eating well for older people and older people with dementia. The aim of the training is to increase knowledge about eating well and good nutrition for older people. The course is divided into 6 modules and provides accurate and up to

date information, it also provides practical tools to aid assessment of nutritional status, menu planning and helping older people eat well. The course also includes a demonstration of the CORA menu planner computer programme. A detailed training pack for this course has been developed with support from the Department of Health.
The course is suitable for homeowners and managers, caterers, nursing staff, care staff, registration and inspection officers, health professionals and housing officers or others involved in monitoring and planning care facilities.
The course can be organised locally for groups of 10 or more people.
For more information contact: Dr Helen Crawley, Eating Well Training Consultancy, Dillon Roberts Associates, 42 Kensington Heights, 81-89 Campden Hill Road, London W8 7BD Tel: 0171 243 3434 Fax: 0171 727 8154

4. One day courses on nourishing people in long-term care are run being by the Royal Institute of Public Health and Hygiene. For more information contact: The Royal Institute of Public Health and Hygiene, 28 Portland Place, London W1N 4DE Tel: 0171 580 2731

5. The Department of Human Nutrition, University of Glasgow run short courses and conferences in Human Nutrition which include:
   An introductory course on human nutrition
   An advanced course on human nutrition
   Diet and diabetes
   Diet and the elderly
   Nutrition for caterers
   They also run tailor-made courses to fit a group on a topic of their choice and budget.
   For further information contact: Carolyn Fraser, Department of Human Nutrition, Yorkhill Hospitals, Glasgow G3 8SJ Tel: 0141 201 9264.
   A programme of distance learning in human nutrition is also being developed, for more information contact: Joe Murray, Department of Human Nutrition, Yorkhill Hospitals, Glasgow G3 8SJ Tel: 0141 201 9353

6. For information on current training for people with dementia organised by the Dementia Services Development Centre, University of Stirling contact: Alan Chapman, Dementia Services Development Centre, University of Stirling, Stirling SK9 4LA Tel: 01786 467740

7. Perth College run a National Vocational Qualification (NVQ) in catering for therapeutic dietary needs. This is a course for catering staff, preferred entry level, experience of food production cook/chef in care establishment. For further information contact: Louisa Bissett, Faculty of Caring and Service Professions, Perth College, Crieff Road, Perth PH1 2NX Tel: 01738 621171

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NURSING HOMES SCOTLAND
CORE STANDARDS

SECTION 7

HYGIENE STANDARDS

1999

FOOD HYGIENE STANDARDS

EXECUTIVE SUMMARY

Given the vulnerable client group cared for, it is all the more important for nursing homes to achieve a high standard of food hygiene. These core standards are intended to ensure a high standard is achieved and maintained in all nursing homes within Scotland.

Key Standards

It is expected that each home will provide suitable facilities for the preparation and serving of food, supported by effective policies and procedures. The following key requirements are addressed more fully within the chapter.

1. General Requirements

- To avoid contamination risks, the food reception and preparation areas require to provide a logical flow of food production from receipt to serving.
- Adequate ventilation and lighting require to be provided to allow effective cleaning.
- All areas require to be maintained in a good state of repair.

2. Hazard Analysis and Critical Control Points System (HACCP)

- The hazard analysis approach requires to be applied as a systematic approach to ensuring food safety within the catering operations.
- The HACCP system, including monitoring activities undertaken to verify the system, requires to be fully documented.
- The HACCP system requires to undergo review monthly or in line with the frequency of alteration to catering operations (ie, menu alteration).

3. Cross-Contamination Risks

- Separate areas require to be provided for the preparation of raw and "high risk" foods. Where not feasible, low and "high risk" foods require to be prepared at different times and after each stage require proper cleaning and disinfection of all surfaces used.

4. Cleaning

- There requires to be separate written schedules for the cleaning of every piece of equipment and every area of the catering premises.

5. Pest Control

A pest control contractor requires to be contracted on an annual basis to carry out regular inspections.

6. Personnel

- A policy for training of food handlers and for other staff ie, carers, nursing staff, cleaners or contract staff requires to be available for inspection.

- All food handlers, and visitors to the catering area, require to wear suitable, clean protective clothing.

- Management require to have suitable arrangements in place for the health screening of staff for any personal health condition that could result in contamination either directly or indirectly of food.

All provisions in this Chapter should be read with the general core standards for nursing homes set out in the Core Standards 1997 guidance issued under cover of MEL(1997)34

NURSING HOMES SCOTLAND CORE STANDARDS

FOOD HYGIENE STANDARDS

Introduction

The standards which follow set the minimum food safety standards required for homes registered to provide nursing home care. They are supplementary to the Nursing Homes Scotland Core Standards and should be considered in conjunction with them.

The standards are for all nursing homes. Homes will be assessed by these standards as part of the statutory registration and inspection process.

Given the vulnerable client group, nursing homes require to meet a higher standard than the minimum legal standard reflecting the often vulnerable clients group cared for. Therefore these core standards require Nursing Home staff to provide additional documentary evidence that demonstrates certain activities are undertaken. Written records are essential tools for quality control and assessment purposes.

The statutory responsibility for environmental health compliance remains the responsibility of the local Environmental Health Department. The following standards in no way compromise those arrangements. Health Board Inspection Teams will wish to liaise closely with the local Environmental Health Department in ensuring compliance with these standards.

Background

Promoting the health of those in long-term care is an important element in developing services to improve quality of life and health promotion activity should be care to the development of policies and practice affecting staff and residents.

As part of the Scottish 'health promoting health service', long-term care establishments should seek to provide a health promoting environment; encourage participation by staff and residents in developing services; facilitate healthy lifestyle choices and ensure equitable access to information, skills development, health and other care delivery.

The particular circumstances attaching to the outbreak of E.coli 0157 in Lanarkshire (1996) underline why food safety standards in nursing homes must be of the highest possible standard. This guidance details food safety standards that nursing homes will require to achieve and maintain to reflect the aim of safeguarding residents' welfare.

The guidance is based on existing relevant general legislative provisions, particularly the Food Safety (General Food Hygiene) Regulations 1995 and should be read with those provisions and industry guides (see "Source Documents" section).

Assistance on legislative aspects relating to food safety can be obtained from local environmental health departments. However, enforcement authorities are only able to request that food businesses meet the minimum legal standard.

Standards

1. All nursing homes must provide a high standard of food safety and must have:

   - a written policy on food safety;
   - a documented hazard analysis and critical control points (HACCP) system (see paragraph 9);
   - a training policy for all staff (catering and others) on food safety issues;
   - documentary and other evidence that key catering, nursing care and managerial staff meet monthly to discuss food safety issues.

2. Food safety policy should include appropriate conditions needed for serving foods outwith the kitchen, for example, temperature controls when transporting foods, food hygiene for carers etc.

3. The management (the person registered in terms of the 1938 Act) will ensure that all policies and protocols are being implemented by staff and will on request provide evidence of associated monitoring and follow-up action(s).

Premises

1. General Requirements

To avoid contamination risks, the food reception and preparation areas will provide a logical flow of food production from receipt to serving. The premises will have adequate ventilation and lighting to ensure food safety and allow effective cleaning. The area(s) will be maintained in a good state of repair.

2. Washing Facilities

Separate washing facilities will be provided that allow the cleaning and disinfecting of all tools and equipment used in the receipt, preparation and serving of food. This will include all plates and utensils that come into contact with food. Ideally, twin sinks large enough to deal with all food equipment used in the premises should be provided, one for washing and one for rinsing purposes. Where this is not feasible, one sink for food preparation and equipment washing may be adequate, it is essential for proper cleaning and disinfection to be carried out between operations. Signs will be provided above sinks to indicate their

designated use. Automatic washing facilities may of course be provided for washing of plates and utensils.

5. Separate wash-hand basins will be provided for hand washing purposes only. Numbers will depend on the size and layout of each home. The aim should be for wash-hand basins to be located close to toilet facilities and at strategic points in the catering facility. A wash-hand basin will (wherever possible) be sited by the entrance to the kitchen. Signs will be provided above wash-hand basins to indicate their designated use.

6. Hot and cold water or water at a controlled temperature must be available at all times.

7. A supply of good quality soap or detergent must be provided for cleaning hands. Drying will be by either disposable paper, roller paper cabinet towels, washable fabric "roller towels" in cabinets or warm air dryers. Neither the washable fabric "roller towels" nor warm air dryers should be used in areas where food is being prepared or served or indeed in any clinical areas.

Food Preparation

Practices

Hazard Analysis and Critical Control Points System (HACCP)

8. Home owners will need to be aware of the provisions of the documents "Assured Safe Catering" and "Systematic Assessment of Food Environment" (see "source documents").

9. The hazard analysis approach will be applied as a systematic approach to ensuring food safety within catering operations of nursing homes. The HACCP system, including monitoring activities undertaken to verify the system, will be fully documented. The system will consider the operation step by step, from the selection of ingredients through to the service of food. Critical points are steps at which the hazards must be controlled to ensure hazards are eliminated or reduced below safe levels. Control targets will be set for critical points and will be as precise as possible. Controls set will be monitored. A frequency of monitoring checks will be set for each control.

10. The HACCP system will undergo review monthly or in line with the frequency of alteration to catering operations, (ie, menu alteration).

11. Health Board registration and inspection teams will be aware of the principles and aims of the HACCP system. Environmental Health Departments will continue to routinely inspect kitchens and ensure HACCP is in place.

Temperature Control

12. Certain foods require to be maintained at appropriate temperatures. Where doubt exists, reference should be made to "The Industry Guide to Good Hygiene Practice: Catering Guide". Equipment capable of maintaining these temperatures must be used. Calibration of temperature recording equipment is essential in this regard. Temperature probes or

temperature dials of equipment relied upon to provide temperature readings require to be calibrated to ensure accuracy. Certificates of calibration must be available for inspection.

13. A system for monitoring of temperatures and corrective action where necessary must be deployed. A system for monitoring and recording temperatures and corrective action taken requires to be recorded.

Date Coding

14. All foods, including prepared or part-prepared foods, must be provided with "best before" detail, clearly recorded and the dates must be adhered to. A system for stock rotation should be in place.

Cross-Contamination Risks

15. Separate areas will be provided for the preparation of raw and "high risk" foods. Where not feasible, low and high risk foods will be prepared at different times and after each stage will require proper cleaning and disinfection of the surfaces and equipment used. "High risk" foods are those that support the growth of micro-organisms and are intended for consumption without further treatment that could destroy pathogenic micro-organisms or their toxins. Examples include cooked meats, prepared salads, soft cheeses etc.

16. Vegetables, raw meat and "high-risk" foods must be stored separately. If these have to be kept in the same chill store, they must be kept apart and/or wrapped to prevent cross-contamination risks. "High-risk" foods (paragraph 12 refers) must be stored above raw foods. Vegetables require a storage temperature of 0°C-2°C, raw meat and poultry - 1°C-1°C.

17. Separate colour-coded equipment and utensils must be available for the preparation of raw and "high-risk" foods.

Cleaning

18. There will be separate written schedules for the cleaning of every piece of equipment and every area of the catering premises. The cleaning schedule will identify:

- task responsibility and expected standards (including time necessary for proper completion of the task);
- the task to be done;
- frequency;
- the cleaning material(s) and chemical(s) to be used;
- the method to be followed;
- protective clothing to be worn;

- safety precautions.

19. The effective application of cleaning schedules must be assessed. Where monitoring identifies deficiencies, corrective action must be taken immediately. Corrective actions and following outcomes taken will be recorded.

20. A suitable bactericidal agent must be provided for cleaning purposes. Easy to follow dilution rates specific to any cleaning chemical(s) in use will be incorporated within cleaning schedules. Rinsing after cleaning is required to avoid chemical contamination of foodstuffs.

Pest Control

21. A pest control contractor will be contracted on an annual basis to carry out regular inspections for the presence of all infestation, both flying and crawling. A system for monitoring related activities including corrective actions will be undertaken and made available for inspection. The responsibility for ensuring a pest free environment remains with the owner/operator. Checks should be routinely conducted to look for:

- live or dead bodies of pests;
- droppings;
- scratch or other marks on packaging or equipment;
- unusual smells;
- rodent smears.

22. Fly screens to be provided to all opening windows. Electronic insectocutors must be fitted in the catering area(s), but not close to windows or draughts to prevent insects being blown around. Similarly the machines should not be sited immediately above food preparation areas.

Personnel

Hygiene Training

23. A policy for training of food handlers and for other staff ie, carers, nursing staff, cleaners or contract staff must be available for inspection. The level of training provided will be appropriate to tasks. The policy will identify the level of training appropriate for all staff members and detail a timescale for delivery of the training package and for refresher courses. The effectiveness of the training should be routinely examined. The training programme should always include 'hand hygiene'. In all cases the minimum training is to elementary food hygiene certificate level or equivalent. It will be appropriate for those in a supervisory capacity to have training to a higher standard.

Exclusion Criteria

25. There will be arrangements in place for the health screening of staff prior to appointment and for example on return from holidays abroad. This will involve staff completing an appropriate health questionnaire. A list of relevant conditions to be included in a health questionnaire will be available from the Director of Public Health at the Health Board.

26. All food handlers on appointment will be provided with written guidance and be required as a condition of employment to disclose any personal health conditions that could result in contamination either directly or indirectly of food. A full list of relevant risk conditions will be available from the Director of Public Health at the Health Board or your local authority environmental health department. Food handlers will be instructed to inform management immediately if suffering from any such conditions, or where doubt exists. Management are legally responsible to take any necessary action such as exclusion from work or exclusion from certain tasks as a result of such personal health conditions. In some circumstances, exclusion from work or certain tasks will be lifted on the basis of stool or other clearance tests.

Food Poisoning Outbreak

27. In the event of an outbreak of infection or related concern, the Nurse in Charge must without delay notify the potential outbreak to the Director of Public Health at the local Health Board and the Director/Head of Environmental Health of the local authority.

Protective Clothing

28. All food handlers will wear suitable, clean protective clothing (coat, tunic, uniform or similar, plus head covering). Protective head coverings will require to enclose all hair. Changing facilities will be provided for staff. A protocol for the effective laundering of protective clothing will be in place.

29. Visitors will require to wear clean protective clothing before being allowed to enter food preparation area(s).

Jewellery Policy

30. A policy will be established that allows the wearing of "sleepers" in pierced ears and plain wedding bands only. This is to avoid risk of physical contamination.

Advice

31. Further advice is available from local authority environmental health departments. Some Health Boards have community infection control advisers available to offer advice on the development of protocols and suitable opportunities for food hygiene training.

Source Documents

Legislation

Food Safety Act 1990
Food Safety (General Food Hygiene) Regulations 1995
Food Safety (Temperature Control) Regulations 1995
Food Labelling Regulations 1996

Guides

- Industry Guide to Good Hygiene Practice: Catering Guide
- Assured Safe Catering Department of Health
- Food Handlers - Fitness to Work Department of Health
- SAFE (Systematic Assessment of Food Environment) British Hospitality Association
- Horton R and Parker L (1997) – Informed Infection Control Practice. Churchill Livingstone, Edinburgh.
- Redway K, Knights B, Bozoky Z (1994) Hand drying. University of Westminster, London
- Risk Assessment for the Small Food Business – The Scottish Food Co-Ordinating Committee.
- Guidelines on the Control of Infection in Residential and Nursing Homes (1996) DoH (Eng).