



Eating and Drinking Well: Supporting People Living with Dementia

Workbook

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The Centre for
**Leadership, Impact
and Management**
in Bournemouth

Eating and Drinking Well: Supporting People Living with Dementia



The training film can be found at:

[https://research.bournemouth.ac.uk/project/
understanding-nutrition-and-dementia/](https://research.bournemouth.ac.uk/project/understanding-nutrition-and-dementia/)





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Foreword

Welcome to this workbook on supporting people living with dementia to eat and drink well.

Older people living with dementia have complex needs and ensuring appropriate food, nutrition and hydration should be at the heart of providing person-centred care in any setting, whether the person is cared for at home or is living in a care home. We know that eating and drinking becomes increasingly difficult as dementia progresses and if not supported appropriately can lead to a more rapid decline in health and impact for all those supporting the individual.

In response to the need to address these problems, we were asked by one of our local providers to provide nutrition education and training for caregivers, particularly for care staff working in care homes. However, we were unable to meet this need at the time, given the lack of systematic evidence on how best to deliver appropriate food and hydration for people living with dementia to provide the best care.

Therefore we undertook a two year research project to understand the quality and delivery of nutritional care for people living with dementia to be able to design and develop evidence based education and training. We were fortunate enough to have a number of partners across health and social care and caregivers who provided significant input and shared their valuable knowledge and expertise for the research.

The findings of our research have enabled us to design and develop this workbook. We hope it will support care workers to improve their practice and develop their knowledge and skills to provide better eating and drinking for people living with dementia. It is linked with a training film (DVD enclosed) that was developed during the project and can be used with the workbook.

We would like to thank the Project Steering Group for working in partnership and ably guiding us along the project's journey. We would also like to extend our gratitude to all the people and organisations who have helped and contributed to the research process. Finally, we gratefully acknowledge the Burdett Trust for Nursing who provided generous support for the project.

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Introduction

Good food and nutrition is important to promote and maintain health and wellbeing for all people. As people age and dementia develops, they are more likely to suffer from a variety of age-related conditions or incidents so good nutrition is even more vital to ensure the best recovery and maintain general physical, social and psychological wellbeing.



Food and meal times can remain the highlight of the day for those living in residential care and in the community. Every effort should be taken to ensure that it is an enjoyable experience at the centre of care. Living with dementia can bring many complex problems to ensure nutrition and hydration needs are met. These are associated with poor appetite, lost ability to recognise thirst, swallowing difficulties, food cravings such as sugary foods and forgetting to eat due to memory loss. Moreover, the overall enjoyment of food and pleasure of eating and what that brings to promote wellbeing can be lost as dementia progresses.

Every provider organisation is required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 14) to make sure the individuals in care have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so. Individuals “must have their nutritional needs assessed and food must be provided to meet those needs”.

Despite best efforts of many organisations and individuals, meeting these regulatory requirements to support people living with dementia to eat and drink enough can become even more challenging and will impact significantly on everyone who provides care.

Therefore, this is an accessible and informative workbook for caregivers (care workers, care staff, family members, relatives) on providing good nutritional care for people living with dementia. It is packed full of case studies and scenarios, activities, signposted resources and advises how to maintain a personalised approach for those receiving care with dignity and respect. It provides examples of the problems encountered on a daily basis and a range of practical tips and simple approaches gathered from our research to help overcome them. There are a number of reflective questions, which encourage you to consider your own working practice in delivering good nutritional care for people living with dementia.





How to use the workbook:

The workbook has three sections that focus on the following areas and learners are encouraged to work through each part:

Section 1 Food and drink availability

Section 2 Importance of activity: encouraging food and drink intake through activity

Section 3 Importance of communication and relationships

The workbook can be completed independently but it is recommended that the learning outcomes are discussed in formal settings with the care provider/manager - linked with performance review and assessment of training competencies and skills as part of the Care Certificate (<http://www.skillsforcare.org.uk/Learning-development/Care-Certificate/Care-Certificate.aspx>).

The workbook does not consider nutritional considerations for people in the advanced stages of dementia who are likely to require specialist nutritional support from a healthcare professional.

Each section is linked with the training film – a DVD is supplied with the workbook and can also be accessed via Bournemouth University: Understanding Nutrition and Dementia Website at: <https://research.bournemouth.ac.uk/project/understanding-nutrition-and-dementia/>

The workbook presents tasks, essential reading and web links, reflection on your practice and case studies/scenarios which are highlighted by the icons below.

Model answers are provided for the case studies at: <https://research.bournemouth.ac.uk/project/understanding-nutrition-and-dementia/>



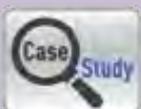
Tasks



Essential reading and web links



Reflection upon practice



Case study/scenario





Learning outcomes:

By using this workbook, caregivers will be able to improve practice to increase confidence in the provision of appropriate food, nutrition and hydration for those living with dementia.

This workbook will enable the learner to:

- Apply and explain why food and nutrition has an important role in the management of people living with dementia.
- Apply an understanding of the factors that influence meal times.
- Be able to monitor food and nutritional care using appropriate tools.
- Know where to find evidence-based information and resources.
- Know when to refer for more specialist advice from a registered dietitian or registered nutritionist.



Section 1



Food and drink availability

For people living with dementia, the daily routine of eating and drinking, is not straightforward. This can lead to changing behaviours that can cause challenges and difficulties for the caregiver. As we age, eating habits change and our sense of taste, thirst, smell and sight declines but this is at a faster rate in people with dementia. This means that managing eating and drinking becomes even more difficult. In this section we look at the consequences of poor nutrition and common problems that might occur as dementia progresses, monitoring nutrition and practical solutions to help provide better food, nutrition and hydration.



1.1 Consequences of poor nutrition

Poor nutrition (or malnutrition) can mean not enough (undernutrition) or having too much nutrition (overnutrition) including fats, carbohydrates, protein and other nutrients. Poor nutrition causes measurable adverse effects on body shape, size and composition as well as on body functions. Although some residents in care homes may be at risk of being overweight and obesity, it is much more likely that they are at risk of undernutrition. This can result in significant personal costs to individuals and their families.

The following signs are indicators of poor nutrition:

- Loss of appetite.
- Weight loss – clothes, rings, jewellery, dentures may become loose.
- Tiredness, loss of energy.
- Muscle weakness.
- Reduced physical performance – for example, not being able to walk as far or as fast as usual.
- Reduced ability to perform normal tasks.
- Greater risk of falls.
- Constipation.
- Altered mood and changes in behaviour – malnutrition can be associated with lethargy and depression.
- Poor concentration.
- Poor wound healing.
- Increased risk of pressure sores.
- Increased risk of heart failure.
- Increased risk of pneumonia and other respiratory tract infections.



More details about malnutrition and its prevalence in the UK can be found at:

<http://www.bapen.org.uk/information-and-resources/publications-and-resources/bap-en-reports/nsw-reports/nsw07-11-amalgamated-data>

<http://www.bapen.org.uk/pdfs/economic-report-short.pdf>

Monitoring and screening for malnutrition (undernutrition)

The most important way to identify older people who might be at risk of malnutrition living either in residential care accommodation or in the community is by regular weighing and by observing and reporting changes in weight.

The Malnutrition Universal Screening Tool 'MUST' is a clinically validated tool to identify older people who are malnourished. It is supported by many governmental and non-governmental organisations including the Royal College of Nursing (RCN) and the Registered Nursing Home Association (RNHA) and is the most commonly used screening tool in the UK. It primarily uses measurements of weight and height, and weight change.

NICE (National Institute for Health and Care Excellence) recommends the use of a validated screening tool such as MUST for staff working in hospitals, primary care and care homes to aid implementation on the new NICE Quality Standard for Nutritional Support of Adults: <https://www.nice.org.uk/guidance/qs24>.

Nutritional screening on admission and on a periodic basis are now regulatory in care homes (as part of CQC Key Lines of enquiry E3). The need for nutritional screening for those living in residential care accommodation who might be at risk of malnutrition has been well documented.



Task 1

What is Nutrition Screening?

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Explore the web links below to find out more about nutrition support and screening.

Nutrition Support in adults (CG32)

<http://www.nice.org.uk/CG32>

<http://www.nice.org.uk/guidance/qs24/resources>

Improving Nutritional Care (2007)

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079931



Explore the web link to MUST

MUST (Malnutrition Universal Screening Tool)

<http://www.bapen.org.uk/screening-for-malnutrition/must/must-toolkit/the-must-itself>



Reflection 1

- Have you used MUST in your practice? Describe how MUST has been used in your place of work to support an individual.

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- What other tools do you use to recognise undernutrition and other nutrition-related problems e.g. screening tools, food charts, checklists?

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Explore the web link below

See Caroline Walker Trust Guidelines for examples of checklists and food records charts.

<http://www.cwt.org.uk/publications/>



Reflection 2

- How does your place of work currently measure height?

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- What problems do you encounter?

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Reflection 3

- How does your place of work currently measure weight?

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- What problems do you encounter?

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- What type of scales do you use?

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Explore the web link below

Digital grade 3 medical scales (NPSA alert April 2008, LACoRS report Aug 2008)

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_085721.pdf



Task 2

If you have no measure of weight and height to calculate body mass index (BMI), what approach is recommended as an alternative measure?

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Reflection 4

- What actions should occur as a result of the following MUST assessment?

MUST score = 0 low risk

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MUST score = 1 medium risk

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MUST score = 2 high risk

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Explore the web links below

http://www.bapen.org.uk/pdfs/must/must_full.pdf

<http://www.bapen.org.uk/pdfs/must/e-learning-flyer.pdf>

Tipton, P.H., Aigner, M.J., Finto, D., Haislet, J.A., Pehl, P.L., Sanford, P., & Williams, M. (2012) Consider the accuracy of height and weight measurements. *Nursing* 42, 50-52.



1.2 Specific challenges that can be encountered by those living with dementia

There are many reasons why a person with dementia may say no when offered food and drink.

These may include:

Communication – As difficulties with language develop, the person living with dementia may have problems communicating that they would like something to eat or that they dislike the food they have been given. Names of foods might become confusing or elude them. Food preferences can change as dementia progresses, which are difficult to communicate. They may communicate their needs through their behaviour. For example, they may refuse to eat, spitting foods out or storing or cramming food in their mouth.

Mood changes – Can affect how a person is feeling towards food. Simple daily activities may become difficult and frustrating. These may contribute to how a person feels about meal times. They may feel confused or embarrassed from making mistakes. Withdrawing from an activity of eating is often the simplest solution.

Poor concentration – Leading to not finishing their meal and wandering off. Eating and drinking involves carrying out a series of complex skills at the same time that a person living with dementia may not be able to maintain. This may mean that the person with dementia may repeat actions many times, be agitated and show angry behaviour. Food may be refused or spat out.

Confusion – Non food items may be eaten or foods may not be recognised. There may be reduced or limited recognition of hunger. The person may develop altered eating patterns, for example, being more hungry during the night. A person may experience difficulties adjusting to a new environment and this could be overwhelming for them (for example, if moving into a care home) and this can continue to cause confusion. Dining areas need to be clearly signposted with a variety of cues to enable understanding.

Dependency – Loss of ability to feed oneself and reduced coordination to use cutlery or drink from a cup or glass. Dependency can make a person feel isolated and less able to tackle their changing and confusing circumstances. Pouring soup into a glass or eating a dessert with a knife may be indicative factors of struggling at meal times.

Depression and paranoia – Loss of interest or being suspicious of food can be a sign of depression or paranoia. Depression is common in people living with dementia. There are effective treatments for depression, including medication and other therapies.

Tiredness – Caused by sleep disorders such as insomnia or night-day reversal. It can lead to other difficulties such as problems with concentration or difficulties with coordination.

Difficulties in chewing and swallowing – Can result in behavioural changes that lead to food being refused, thrown or spat out, often shown by anger and frustration. An infection or illness may increase this risk. Position in a chair can affect how the muscles move and consequently impact on chewing, swallowing and arm movement. The dependence on texture modified foods may not be accepted.

Discomfort with the mouth – The person with dementia may be in pain, causing eating to be an uncomfortable experience. Oral problems can include issues with their dentures, sore gums or painful teeth. Oral hygiene and regular mouth checks are important. There might also be sensitivity to certain types of foods and if too hot or cold such as ice cream.

Medication – Side effects from medication or changes to dosage can lead to appetite changes, dry mouth, taste changes and constipation. If you think this may be the case, speak to the GP.

Constipation – This is a common problem and can result in the person feeling bloated or nauseous, making them less likely to want to eat. Try to prevent constipation by encouraging activity, offering fibre-rich foods and providing plenty of fluids. If constipation becomes a problem, speak to the GP.

Overeating – Can be an issue if the person living with dementia forgets they have eaten. There might also be a craving or desire to eat certain foods such as sugary foods.

Environmental issues – Can cause confusion such as extraneous noise, too much visual stimulation, poor lighting, glare, unpleasant odours and uncomfortable room temperature can all lead to distractions and challenge eating. Unnecessary items on the table or in the eating area can lead to confusion.

Time – Lack of caregiver support, time and feeling rushed.

Physical activity – If the person living with dementia is not very active during the day, they may not have a good appetite. Encouraging movement will be good for their wellbeing and may increase the person's hunger and encourage them to eat bigger meals. Equally, if the person is very active, restless or agitated (pacing about or fidgeting) they may use extra energy and need to eat more.



1.3 Increasing food intake

Food and fluid diaries can be useful tools to record and monitor intake and action needs to be taken if people with dementia are not eating or drinking enough and are identified as moderate or high risk using 'MUST' - Malnutrition Universal Screening Tool.



High Risk RED

Ways to increase food intake can be achieved through food fortification and/or using oral nutritional supplements.



Medium Risk AMBER

Documenting individuals risk and alerting all staff (including kitchen staff and chefs) can be done easily through a colour coding system.



Low Risk GREEN

Food fortification

Food fortification is a way of adapting meals and snacks by adding small quantities of everyday foods, such as cream, butter, full-fat milk, cheese or milk powder which increases the energy and nutrient content without increasing portion sizes. Some examples of foods which are practical to increase the energy and nutrient content include mashed potato, custard, milk puddings, milky drinks, porridge, gravy, fruit fools.

The table below shows a standard meal and for the same portion size, the impact of adding water which may be required if the person with dementia has swallowing difficulties and adding foods to increase the numbers of calories and protein. The addition of water to the standard meal reduces the number of calories in a meal by nearly 50%. However the addition of both fortified milk and margarine can more than double the number of calories in comparison to the original meal.

Food (average portion)	kcal normal food	kcal puréed with water	kcal semi-skimmed milk	kcal fortified milk (whole milk & SMP*)	kcal fortified milk & margarine
Cottage Pie	300	150	220	350	400
Carrots	20	10	20	70	100
Broccoli	20	10	20	70	100
Jelly	70	70	140	250	(250)
TOTAL	410	240	400	740	850

kcal - kilocalories

* Skimmed Milk Powder (SMP)





Explore the web links below

BDA. 2012. Malnutrition - Overcoming the Problem: Food Fact Sheet. The Association of UK Dietitians

<https://www.bda.uk.com/foodfacts/MalnutritionFactSheet.pdf>

<https://www.dorsetforyou.com/article/407934/Worried-about-nutrition>

Oral nutritional supplements

Whilst it is best to fortify food as a first step, high energy and protein meals in a drink (oral food or nutritional supplements or sip feeds) can be a useful and easy way in the short term if appetite is poor. They are used to replace a meal or boost energy intake between meals. Additionally, prescribed commercial powders (energy, protein and nutritional balanced powders) are available that can be added to food and drinks to provide extra calories and nutrients. These are commercial supplements and a prescription is required for these from the doctor, GP or dietitian. There are also some powdered supplements that can be bought in some supermarkets (e.g. Complan) that can be made up into milkshakes, soups, hot or cold drinks.

In addition to food for nutrition and prescribed supplements, consider the following foods to boost energy intake;

- Milkshakes made with fruit, ice cream and milk
- Smoothies made from whole milk yoghurt and fruit, e.g. bananas
- Flapjacks with dried fruit
- Cakes
- Milk puddings
- Mousses with full fat cream





Case Study 1

Gail

Gail is a 93 year old lady. She was recently admitted into the care home and tends to eat well. She has porridge made with fortified milk for breakfast, a two-course lunch consisting of main course and dessert and afternoon tea normally consisting of a sandwich and cake. She always eats everything presented to her and is partial to biscuits in-between meals. She consequently consumes the recommended daily intake of energy each day which is approximately 2000 kcal/d. She is happy to sit down and eat but is very active in-between meals and often only sleeps for a few minutes at a time before getting up and walking around again. Her movement was measured one day and it was found that she is using 2700 kcal/d whilst pacing around and because she does not sleep properly. Her weight has dropped to 42 kg (previously she weighed 48 kg). Her height from recall is 5ft 1 inches.

- How much less energy does Gail consume than she expends and why is this occurring?

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- Would you expect Gail to be at risk from malnutrition?

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- Calculate her MUST score

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- What could you consider doing to help Gail consume enough energy and food to account for her considerable energy expenditure?

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Case Study 2

Peter

Peter is 84 years old and has Alzheimer's disease. He is active walking around all day and although he sleeps for a few hours at a time he is often awake and paces around at night. He is unable to sit for long enough to eat his meals and will often only consume a few mouthfuls before moving again. He consumes about 700-800 kcal/d of energy which is less than half of the recommended 1955 kcal/d for his age group. His movement was measured one day and it was found that he is using approximately 1800 kcal of energy during a 24-hour period. His weight has dropped to 80 kg (previously he weighed 90 kg). His height was measured on arrival at the care home with a stadiometer and is 180 cm.

- How much less does Peter eat than he expends?

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- Would you expect Peter to be at risk from malnutrition and why?

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- Calculate his MUST score

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- What types of foods could you offer Peter to encourage him to eat considering his need to pace around?

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- What else could you consider doing to boost Peter's energy intake?

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1.4 Promoting fluid and hydration

Fluid is essential to life but is often overlooked in assessment of nutritional status. While humans can survive for a period of weeks without food, we can only survive without fluid for a few days (or even hours) depending on size and hydration status. Regulation of body fluid is under tight control and to maintain fluid balance, a person's intake should equal fluid output.



Explore the web links to see which groups of the population are at high risk of dehydration.

<https://www.bda.uk.com/foodfacts/fluid.pdf>

<https://www.nutrition.org.uk/nutritionscience/nutrients-food-and-ingredients/liquids.html>

<http://www.nutrition.org.uk/healthyliving/hydration>

Dehydration is defined by the World Health Organisation as 'the loss of water or body fluids from an individual'.

Older people are at risk of dehydration due to the following factors;

- The thirst mechanism becoming less sensitive with age and even more so in people living with dementia who are often unable to recognise thirst.
- Thinning skin can mean older people are vulnerable to greater water loss.
- Illness related factors such as vomiting and diarrhoea.
- Discomfort in the mouth such as poor fitting dentures and illness.
- The effect of medication can impact on the amount of fluid we need as well as recognition of thirst sensation.
- Lack of understanding of the effect of becoming dehydrated e.g. continence issues.
- Being dependent on others to access and be supported to drink.

As a result of dehydration older people and especially those living with dementia can find themselves at risk from a number of health conditions including:

- Reduced cognitive status further reducing the ability to concentrate and increasing confusion
- Blood pressure problems
- Urinary infections
- Incontinence
- Constipation
- Poor oral health
- Dizziness and confusion, leading to falls
- Pressure ulcers
- Low blood pressure
- Increased tiredness
- Loss of skin elasticity
- Unpleasant taste in mouth

Despite its important role in health and quality of life, no national or regional audits on hydration status are undertaken in the UK or European Union. This means dehydration remains largely unmonitored despite the significant impact it can have on the general health of an older person.

Symptoms of dehydration:

- Skin and membranes of nose and eyes become dry
- Confused and sluggish
- Light headed/faint when standing
- Darker coloured urine

NOTE: Currently unlike malnutrition there is no agreed tool to measure if someone is dehydrated. Individuals will demonstrate different symptoms and a holistic approach needs to be undertaken to assess whether someone is at risk.

How much fluid do we need?

On average an adult loses between 1500-3000ml daily. Approximately 20% of our fluid intake comes from food and the other 80% from fluids/drinks of all types. Guidelines vary on how much fluid we should be consuming. Recommendations based on the average adult suggests 6-8 standard glasses per day although it is not always clear what a standard glass is and how this relates to an elderly person with dementia. Other recommendations are based on complex formulae per kg of body weight. A general consensus from the evidence suggests that a typical elderly person should consume at least 1500ml per day, although this should be increased when the weather is particularly warm. This can include water, juices, squashes, tea, coffee, hot chocolate and a variety of other drinks as preferred by the residents.



NOTE: The impact of caffeine as a diuretic from tea and coffee is negligible in comparison to consuming the drink of choice. Recent studies have shown that many residents living in care homes consume less than 1500ml of fluid a day.



Task 3

Measure how much fluid the various cups and glasses used by someone you care for contain and list here (ensure you measure a typical drink consumed by the person living with dementia):

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On average how many cups/glasses do you estimate are needed to ensure they drink at least 1500ml fluid?

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How to increase fluid intake

Offer a good variety of different drinks. Options could include:

- Water served in jugs, small decanters, with ice in summer or water dispensers.
- Squashes including those served in cool drink/slush puppy machines or mini cartons for variety.
- Hot drinks such as tea, coffee, hot chocolate. Consider a variety of different ways these can be served including an old-fashioned tea trolley.
- Smoothies (although the term smoothie may not be understood so offer the actual drink).
- Milkshakes and other shakes.
- Ice lollies.
- Foods with a high water content can also contribute such as melon, cucumber and jellies.
- If medication and the older person's condition allows remember the odd alcoholic drink can stimulate appetite e.g. sherry before the meal.



Take the opportunity to serve drinks at all times of the day;

- Introduce different settings such as afternoon cinema event, afternoon tea, outside in the garden if weather permits, celebrations and parties, tea dances, community events, morning coffee, 50's milk bar with jukebox, hot drinks after a meal.
- Knowing the resident and consulting with family regarding drink preferences and observing changes in these preferences too. Be aware that the person may be losing the thirst sensation.
- Remember to consider the preferences of an individual from the care plan but also try new drinks. As sweeter tastes become preferred it is worth considering sweeter drinks, although look at the low calorie/sugar versions as options.
- Caffeine free teas and coffees have been reported to calm residents.
- Offer a hot milky (where appropriate) drink at night as a way of increasing calories.
- Chilled drinks can stimulate appetite although take care not to offer them too close to meal times as they may have the reverse effect and fill someone up.
- Cups should help maintain the older person's dignity. Use lightweight cups, mugs, etc. that consider the needs of the person but maintain their dignity as much as possible.
- Jugs should be kept half full to allow residents to lift themselves.
- Seek professional guidance from Speech and Language Therapists and adhere to it when using cups with spouts/straws etc. as they can be inappropriate and cause further choking.
- Take time to prompt the person with dementia to drink in different ways:

For example:

- Caregiver suggests having a drink as they are having one and asks if the person with dementia would like one too.
- Making a drink rather than always asking.



Task 5

Try the drinks you have on offer for your residents.

What improvements, if any, can you suggest?

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How could you find out the views of the people you support?

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Explore the web links below

This article is from a blog written by family carer Beth Britton and gives a personal view of drinks on offer.

<http://d4dementia.blogspot.co.uk/2013/05/hydrated-and-happy.html>Reflection



Reflection 5

- Describe some of the underlying reasons that the people you support may not drink enough?

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- What alternatives could you offer your residents?

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1.5 Developing menus

Menus should take into account the different cultural, religious and food preferences of the residents within the care setting. People living with dementia may prefer foods that were familiar many years ago and are associated with certain times in their lives (see Section 3).

Chefs, kitchen staff and all those involved with providing meals should be encouraged to:

- Review food preferences on care plans.
- Take the opportunity to talk to the residents, families and friends to discuss food preferences, old favourites and family food traditions. This can be done through dedicated monthly meetings but also individual conversations with residents in their own rooms or in the dining room at meal times.
- Consider the need for cultural menus such as Gujarati, African and West Indian where applicable.
- Dietary needs of individuals need to be considered by incorporating into menus, e.g. diabetes, gluten intolerant, vegetarian, other health conditions and medication. Ensure that there is sufficient choice and not the same option available on a daily basis.
- There should be different main options to allow food choice. Chefs should be encouraged to explain the ingredients and make up of different foods/dishes to care staff before these are taken out to residents. Care staff should be encouraged to try these foods so they can not only name foods but describe them to help residents to make decisions.
- Meals should be presented in an appealing way. Strong colours can help to identify the foods but also differentiate between foods on plates etc.
- If puréed food has to be consumed then consider the use of food moulds to help identification through familiar shapes.



Variety can be introduced by considering some of the following practical tips:

Seasonal foods - Consider using fruit and vegetables that have been grown by family or set up a community garden in the care environment. Apart from the nutritional benefits associated with home grown food that provides more vitamins, this offers opportunity for an outdoor activity for the person with dementia (see Section 2). If space is restricted, herbs, salad leaves and some vegetables can be grown on the window ledges or in containers on patios and decking.

Incorporate regional dishes and using appropriate terms for different dishes e.g. haggis.

Fresh food being prepared will induce appetite especially if the kitchen is opened up in a safe way to allow the aromas to be released into the wider care home.

Taste changes - As dementia develops older people will prefer stronger tastes e.g. cauliflower cheese, sweet and sour, use of mild spices etc. Also play on recipes to allow familiar foods to be enhanced with stronger taste/flavour e.g. Balti pie (curry potato on top).

Soup is easy to eat but also filling. It can add valuable fluid to the intake but may decrease overall energy intake. Consider fortifying it with added cream, butter, lentils or other pulses.

Meal times - Remember meal times don't work for everyone. Some older people will not be able to sit down for long enough to eat a complete meal. They may be hungry at unconventional times of day or night. Think about having a variety of ready available different meals 24 hours a day and not only within kitchen shift patterns.

Small meals – 'Mini-meals' - Often older people living with dementia are less daunted if they are given small manageable meals and offered seconds rather than being presented with large quantities of foods.

Consider offering more frequent smaller meals. Three courses can sound appealing and may suit the organisation management of the care home for instance but can be considered to be daunting if appetite is small.

Grazing menus and snacks can help boost food intake and enable those who struggle to concentrate to pick food up and wander around with it. Examples could include: bowls of chopped up fruit, soft pieces of banana, moist finger foods, milky ways, mini rolls, sausage rolls, scotch eggs, sandwiches with crusts cut off and in bite size pieces.

Refer to Caroline Walker Trust Guidelines for many examples of finger foods for grazing menus. (See link on pg. 28).

Breakfast cereals are nutritious and when consumed with full fat milk are a useful source of energy. Consider having these easily available as part of the grazing menu/ night-time meals.

Access to food and drink -If appropriate have a variety of snacks freely available on tables or counters within the care setting. If this is not possible think about having a tuck shop/trolley visit residents in their rooms once or twice a day.



Task 7

Discuss with the chef how to make foods available 24 hours a day and to extend the range of foods available.

Was this achievable?

.....
.....



1.6 Other dietary requirements and special diets

It is important to consider the individual needs of every older person with dementia and it is likely that there will be another co-existing problem that may be managed by diet. Some people may be required to follow a special diet or have particular dietary requirements as recommended by a dietitian or doctor, for a specific medical condition such as high blood pressure, high cholesterol levels or because they have diabetes or need a gluten-free diet. Most people on a special diet will receive specialist advice from a dietitian. It is important to check what advice each person has been given as it may vary between individuals.

For more information about useful organisations see Appendix A4.

Dementia and diabetes

People with Type 2 diabetes may have twice the risk of developing dementia compared with people without diabetes. In combination, dementia makes management of diabetes difficult, and poorly controlled diabetes can also impact on the safety and wellbeing of people with dementia.

This poses a series of challenges as people with dementia may have lost their diabetes self-management ability. These include: defining glucose targets, choosing the most suitable insulin regime (if insulin is needed), aligning nutritional needs to diabetes treatments.

Most people with diabetes can eat the same healthy diet as that recommended for the rest of the population. However people with dementia may have additional needs as already outlined (see Section 1.2 - Specific challenges that can be encountered by those living with dementia) and strategies to improve dietary intake should be considered and referral to a registered dietitian may be required (see Appendix A2).



Explore the web links below

Living with Diabetes and Dementia

https://www.diabetes.org.uk/Documents/Guide%20to%20diabetes/Care%20homes/DL_Dementia_leaflet_Final.pdf

Diabetes and Dementia. Guidance on Practical Management

https://www.diabetes.org.uk/Documents/Professionals/Professional%20resources/Diabetes_And_Dementia_Guidance_2013.pdf

Good clinical practice for care home residents with diabetes

<https://www.diabetes.org.uk/Documents/About%20Us/Our%20views/Care%20recs/Care-homes-0110.pdf>

Swallowing difficulties

There is a high prevalence of swallowing difficulties in older people living with dementia. As a result, they are at increased risk of undernutrition and dehydration, breathing in food particles, which can lead to respiratory tract infections.

What you can do

If a person has any of the symptoms of a swallowing problem, it is very important to seek advice from a Speech and Language Therapist. The person with dementia may need to have the texture of their food and drink changed, eat and drink in a different position, or avoid eating and drinking certain foods.





Case Study 3

Judith

Judith is 86. She was diagnosed with vascular dementia last year. She also has Type 2 diabetes. She was admitted into the care home after a formal carer became concerned that she was becoming increasingly confused and unable to live independently in her flat. Judith is fully mobile and very active and sleeps very little. In the last few weeks Judith has been losing weight and her MUST score has been identified as high risk. When asked by care staff what meal she would like at dinner time, Judith expresses interest by nodding in accordance to which meal choice she would like. However, when the meal arrives Judith expresses little interest in eating the food and pushes away the plate.

In the last few weeks, Judith has shown a greater interest in puddings and any other sweet food items offered and/or available throughout the day. Judith is often seen walking with a sweet food item in her hand.

In Judith's care plan it was noted that Judith likes to drink water. However, in the dining room there is one cordial drink available for residents. Judith is unable to help herself to a drink. When Judith is asked if she would like a drink she refuses. Judith has expressed concerns that she fears the tap water in the kitchenette may be poisoned.

If you were responsible for Judith think about the following:

- What factors could be causing Judith to lose weight?

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- If you were responsible for Judith what would you initiate to encourage her to eat the food offered to her?

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- Considering Judith's diabetes and her interest in sweet foods, what could you offer her to encourage her to eat?

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- From the observations above what could you do to ensure Judith consumes more fluid?

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- In order to deliver person-centred care what needs to be done with the observations made above?

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Explore the web links below

Caroline Walker Trust Guidelines

<http://www.cwt.org.uk/wp-content/uploads/2014/07/EW-Old-Dementia-Practical-Resource.pdf>

<http://www.cwt.org.uk/publications.html>



1.7 Maintaining independence

Eating and drinking should be a good experience for everyone and where possible a social activity. Meal times are the highlight of the day as they break it up and act as a social point where people can come together and communicate with each other or members of staff in a care home or with a care worker or family member if living at home.

The process of eating is important. Eating is an inherent motor memory, whereby the process of cutting our food up, using cutlery to bring the food to our mouths, chewing and ultimately swallowing the food are actions that are embedded within our brain as consecutive actions. By eliminating the first one or two the chewing or swallowing actions can be affected ultimately leading to choking issues. As eating is one of the last actions those living with dementia can continue with it is important to facilitate independence for as long as possible.

Residents should be enabled to eat where they wish, be that in their own rooms, dining room or other appropriate places. Whilst social interaction can increase food and fluid intake, residents who choose to eat in their own rooms are more likely to lose weight. Residents should be enabled to not only make their decisions on where to eat but also to retain as much independence as possible whilst eating.



Practical Tips:

- Give constant prompting/encouragement.
- Put spoon in hand and then help someone to eat to help enable some independence.
- Also putting hand over hand and helping person to eat as dementia advances.
- Offer choices of meals at point of delivery visually on the plate to help decision making. Allow 10 seconds for someone to make a decision.

If it is necessary to have to make menu choices earlier in the day then allow for people who may have forgotten what has been chosen. To have other options available and for people to be able to change their mind immediately and be offered e.g. a sandwich, an omelette or chips and sausage.

Think about using picture cards or screens to help identify foods on menus.



Tools:

- Use of plate guards.
- Use of lightweight plates such as melamine (although take care if non-microwavable).
- Specialised lightweight glasses or cups.
- Lipped plates.
- Different colour plates to help differentiate food. Plain red, plain green, plain yellow, plain blue have all been shown to help increase appetite and colour requirements may vary with different individuals living with dementia.
- Weighted handle cutlery.
- Use of memory cues such as serving fish and chips in paper.
- Tray of options e.g. red tray, white doily.
- Non slip plain colour placements.

NOTE: Placemats may be confusing depending on how they blend in with the table, tablecloth etc.

Many of the points raised will apply to caring for someone with dementia at home. A few additional points to consider might be:

- The dining area should be familiar, particularly if the person has lived in the same house for a number of years. There might be visual cues (e.g. flowers, family photographs, ornaments).
- Setting a table to eat rather than remaining in the same day time chair or with distractions e.g. in front of the TV. This provides visual cues that it is a meal time. Consider if the person prefers to eat with family members or friends.
- Having a meal together allows time to talk, reminisce and recount long-term memories and as such provides an important opportunity to learn more about the person with dementia and their life history (see Section 2).



Explore the web links below

Assisted eating

Department of Health. 2014. Dementia Friendly Environments: Eating: dos and don'ts for assisted eating. Australia: State Government of Victoria

<http://www.health.vic.gov.au/dementia/strategies/assisted-eating.htm>

Further information

SCIE. 2013. Eating well for people with dementia 3: Promoting independence at mealtimes. Social Care Institute for Excellence.

Available from: <http://www.scie.org.uk/publications/dementia/living-with-dementia/eating-well/files/promoting-independence.pdf>



1.8 Changing preferences



Task 8

Write down FIVE of your favourite foods and FIVE of your least favourite foods. Think about what influences your food preferences with these foods.

Favourite

Why?

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.....

.....

.....

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Least Favourite

Why?

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Now compare these foods and what influences your preferences with a partner. Do you like the same foods?

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What about the reasons we like and dislike different foods? Can you see any trends developing?

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A general reduction in the senses of taste occurs as part of the ageing process. As the brain starts to change, the innate liking for sweet foods can once more be a dominant factor in food choice. We are born with over 10000 taste buds in our mouth but by 75 years of age these can be reduced to 5000. As dementia progresses this reduction in our ability to taste, smell and see foods can significantly impact on our ability to not only recognise foods but also the impact they have on enjoyment.

Practical tips:

- Preferences will adapt towards salty, spicy and sour foods and opportunities should be taken to make good use of flavour enhancers such as herbs, tomato puree, cheese, Marmite, spices, paprika. Avoid adding too much salt to foods because of its direct impact on increasing blood pressure.
- We all have some meals that are eaten better than others. Talk about the types and timings of meals eaten when living at home. Many of the 80+ years generation would have their main meal at lunchtime but younger people living with dementia may have been used to evening main meals. Some enjoy a large cooked breakfast and others might like a dainty well presented afternoon tea. Think about the times when people are most awake and alert.
- Sleep patterns vary in dementia and for some people who have little sleep this could impact on when food is preferred.

Therefore, care plans should account for the different food preferences. These can be learnt from the person themselves, their family and friends, other carers, as well as documents such as the Alzheimer's Society 'This is me' tool.



Explore the web link below

<https://www.alzheimers.org.uk/thisisme>

Our food preferences are affected by many different factors which can include:

- The types of food we are exposed to during our life.
- Innate likings and dislikes.
- Genetic predisposition to different foods.
- Medical conditions such as allergies, effect of medication.
- Personal experiences with food. Positive experiences can help us to develop a positive reaction to a food and conversely a negative experience can have the opposite effect.
- Peer and family influence over time.
- Religious and cultural beliefs: For example, certain foods are not permitted for different religions, festival days, being vegetarian or vegan.
- Food availability. For example, the impact of rationing during the second world war, availability of fresh fruit and vegetables from allotments and gardens.
- Social influences such as peers, family and ethnicity.
- Health beliefs.
- Weight management.
- Mood – for example comfort eating certain foods when we are depressed or feeling miserable.
- Budget available.
- Involvement with food.
- Social aspects of eating.
- Activity.



Task 9

Think about a person you are caring for with dementia in your organisation for a while. Review their care plan and reflect on their current food preferences. Can you see any changes? Are there any trends in how food preferences are developing?

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Explore the web link below

Alzheimer's Society. 2013. Eating and drinking - Factsheet 511LP

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=149



1.9 Environment

Attention to the eating environment is important to enable those living with dementia to focus on consuming food and drink in a relaxed manner.

Living with dementia means people are not able to remember many things but also are not able to make memories. For instance the new environment of the care home may cause confusion and increase stress levels for the person with dementia. As such, this may impact on a willingness to eat and drink but also their recognition of where to go to eat.

A relaxed environment is required for eating whether the person is living in their own home or at a care home which might focus on the dining room or could be in a variety of different places throughout a care home. Avoid distractions and ensure there are sufficient cues to identify the area as somewhere to eat.

Practical tips to improve the environment for meal times:

- Using signage with photos.
- Sensory stimulation – smell of food being prepared, visibility of chefs preparing food, and photos of food.
- Set tables and dining room in different ways for different meals e.g. breakfast, lunch, tea.
- Care needs to be taken when setting tables so as not to be a distraction. Contrasting colours help to identify different tools. Crockery offers more dignity for eating than plastic. Consider using pasta bowls with deep sides to help people retain independence when eating.
- Creating a restaurant atmosphere encourages appetite e.g. flowers. But restaurants can signal not being homely, try using subtle colour scheme shades - pumpkin orange, creams and beiges.
- Lighting is important and can enhance vision.
- Ensure plenty of space between tables for wheelchairs and those with limited mobility.
- Use of stimuli – smell; music, lighting so people can see food and drink to create the right mood and atmosphere.
- Sight issues – ensure food is visual – good use of colours, plain colour crockery.
- Background music is soothing and no distractions such as TV, vacuuming or distracting sounds.
- Correct positioning of recliner chairs.
- Comfort of residents – ensure tables and chairs are positioned so individuals can see those they are sitting with.



Explore the web links below

SCIE. The dementia environment in a care home (video online) Available from:

[http://www.scie.org.uk/socialcaretv/video-player.asp?v=dementiaenvironmentina carehome](http://www.scie.org.uk/socialcaretv/video-player.asp?v=dementiaenvironmentina%20carehome)

SCIE. 2013. Eating well for people with dementia 4: The eating environment. Social Care Institute for Excellence. Available from:

<http://www.scie.org.uk/publications/dementia/living-with-dementia/eating-well/files/the-eating-environment.pdf>

<http://dementia.stir.ac.uk/design/good-practice-design-dementia-and-sight-loss>

More detail how to optimise lighting can be found at:

<http://dementia.stir.ac.uk/design/good-practice-guidelines/lighting>



Case Study 4

Tom

Tom is 67. He was admitted to the care home earlier this year. It is suspected that Tom has the early stages of dementia though he is awaiting an official diagnosis. Tom has recently been diagnosed with age related macular degeneration. Tom has begun to lose weight. Tom does not have any of his own teeth and wears dentures. Tom has not visited the dentist since being at the care home.

On admission to the care home, it was noted in Tom’s care plan that he has a strong preference for drinking tea as opposed to other drinks. However when offered a cup of tea by a carer Tom will often say no.

When Tom’s wife Margaret visits and makes Tom a cup of tea, Tom will often drink it with her. He also recently pointed to his wife’s cup of coffee and when she offered the drink to him he drank some. Margaret was surprised by this as Tom had never expressed an interest in drinking coffee before. Tom has days where he is very confused and other days where he is less so.

It is noted in Tom’s care plan that Tom used to be a gardener who took great pride in his work and loved being outdoors. At a recent birthday event held for Tom in the garden, Tom enjoyed eating the buffet style food available and especially the birthday cake. Whilst this was an observation made by a few care staff and family members on the day, it was not formally recorded.

If you were responsible for Tom think about the following:

- What other factors could be causing Tom to lose weight?
.....
.....
- If you were responsible for Tom what would you initiate to try to encourage him to eat more food?
.....
.....
- From the observations above what could you do to help Tom consume more fluid?
.....
.....
- In order to deliver person-centred care how would you formally record the information about Tom consuming more food at the birthday buffet.
.....
.....

Section 2



Importance of activity: encouraging food and drink intake through activity

It can be challenging to provide care for someone living with dementia and to develop routines and activities that are meaningful as well as do-able and significant to the person. As the disease progresses, the person with dementia may find it becomes increasingly demanding to combine social, physical, mental and spiritual needs. Abilities, interests and motivation can challenge activity provision. Whilst responses can be limited, small responses such as tapping the fingers, opening and closing eyes and moving feet are important.

In this section the value of encouraging activity in different ways is presented with many suggestions to provide structure, promote appetite and help increase overall wellbeing. Many of the suggestions will apply to those living with dementia in care as well as those living at home and in sheltered accommodation.



2.1 Encourage independence through meaningful activity

We all undergo activity in different forms in our everyday lives.

These include:

- Personal care such as washing, going to the toilet, cleaning our teeth.
- Daily routine activities such as washing up, cooking, washing clothes, cleaning, mending.
- Hobbies such as gardening, sewing, knitting, reading, caring for a pet.
- Physical activity such as running, swimming, football.
- Social activities such as eating with friends and family, going to the cinema or theatre.

Activity can promote a sense of shared purpose and a strong sense of belonging. All types of meaningful activity can promote a sense of independence and wellbeing which can consequently positively impact on appetite.



Task 10

During 30 minutes write down everything you do and for how long. This does not need to be food related and can be at any time of day.

Record in this table.

Time (mins)	Time spent doing activity (mins)	Activity

Now do the same exercise observing a person with dementia. Try to do at the same time of day for comparison.

Time (mins)	Time spent doing activity (mins)	Activity

What are the differences?

.....

.....

How could you enable this resident to be undertaking more meaningful activity.

.....

.....

Are there any food related tasks this resident could help with?

.....

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As much as possible, people with dementia should be encouraged to integrate with the entire meal time process such as helping to prepare food, set the table, pull out the chairs, or put dishes away. Meal times are one of the most important temporal anchors for those living with dementia. The inherent motor memory within the brain associates all aspects of meal preparation, feeding oneself, chewing and swallowing. By retaining a level of involvement with all aspects of these activities those living with dementia are enabled to retain a level of independence during eating. Doing so helps the recipient experience eating in a larger social context and as part of daily activity, rather than as an isolated task. Moreover, participating in the meal time process helps the person with dementia maintain functional skills and feelings of independence and personal control.



Explore the web link below

<https://www.nia.nih.gov/alzheimers>



2.2 Life histories

We are all different and we all have different interests and those living with dementia are no different. Life stories are becoming increasingly used by carers to appreciate the roles that those living with dementia had prior to living within the care environment and to understand individuals interests. Life histories give opportunities to share with those living with dementia experiences that are relevant and help coordinate activities that are meaningful. Care providers are being encouraged to work with a person's experience rather than against it. Drawing on aspects of these past lives can help draw the person into activity that has meaning to them. These activities need not be complicated but inclusion in the daily lives of those living with dementia will enable them to become more alert and interested in what is going on. Imagination is often required to do this and there are many examples to draw from.



Explore the web links below

Examples of case studies of how to integrate meaningful activity into peoples lives can be found at:

Skills for Care 2013. Supporting people in the advanced stages of dementia: A case study-based manager's guide to good practice in learning and development for social care workers supporting people in the advanced stages of dementia. Leeds: Skills for Care

All staff within the care home should be encouraged to be involved with the resident's life. This can include the kitchen staff as well as others not directly involved with care. Many residents will have had a life history of preparing food, cooking and caring for others. They will have looked after their spouse/partner, children, grandchildren, entertained friends and family to varying extents. Meals would have been an important part of their daily activities and for many they will have continued to be involved with some preparation up to arriving in the care home. This part of their daily lives will have given them a purpose and feeling of independence and being valued by their community. By working with that person and understanding these histories it could be possible to encourage them to once more become involved with their new care community. As a carer, you might feel apprehensive about enabling this situation as you do not want someone to come to harm. You may wish, as a care team, to look at assessments to enable positive risk taking.

Consider ways that you can assist the resident to continue with these daily tasks by sharing the responsibility with them.

- Laying tables with cutlery or napkins.
- Clearing away dirty plates.
- Washing or drying up.
- Placing condiments on tables.
- Sandwich making.
- Peeling or washing vegetables.
- Stirring cake mixtures or desserts.



Conversations about food can evoke memories and help to establish and understand food preferences. This might help to develop an interest in meal times. Things to consider:

- War time rationing memories.
- Food from childhood.
- Growing their own food.
- Helping their parents prepare food.
- How they like to drink their tea/coffee.
- Experiences of shopping for food e.g. market, supermarket, corner stores, queuing during rationing.

Does your care environment employ a gardener, maintenance person or cleaner? Encourage them to talk to the residents as they might have common interests or experience. Maybe they could sit and have a drink with them and share with them their daily activities.





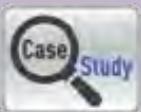
Explore the web links below

A template for life story work can be found at:

<https://www.dementiauk.org/information-support/life-story-work/>

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1671

<http://www.careuk.com/care-homes/dementia-care/getting-to-know-the-individual>



Case Study 5

Charlie

Charlie is 85 years old. He was admitted into the care home about 3 months ago and had lost weight prior to arriving. On admission he had a MUST score of 2. He was prone to wandering and was not able to communicate well, although he did not show much sign of anger he often tried to get outside and carers were often called because he had set off the emergency exit alarms. He has not regained much appetite. Prior to arriving at the home Charlie had occupied the house he and his wife had lived in for 50 years. This house had a garden much of which was laid down to lawn. This had been observed prior to admission when the manager had made a home visit. At that point he was proud of the fact he had managed to keep the garden tidy despite being diagnosed with Alzheimer’s disease. His family all live in other parts of the country. One day his son came to visit and brought some photos of his Dad many years before growing his own vegetables and fruit on his allotment.

- How could you use this information about Charlie’s life history and try to encourage him to eat more?

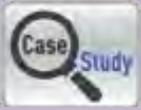
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Case Study 6

Betty

Betty has recently arrived at the care home. She was diagnosed with Alzheimer’s disease 10 years ago but has gradually and slowly deteriorated and is no longer able to look after herself. Up until recently she has been living in an annexe of her daughter’s large house. Her daughter is no longer able to give her the care she needs partly because she has had to increase her working hours but also because her mother has started significantly wandering during the night. When she was younger, Betty worked as a school kitchen chef and has always enjoyed socialising. She has actively been involved with the lives of her children and grandchildren. She enjoyed teaching them all how to bake and has many well used cookery books she has brought with her.

- How could you use this information about Betty's life history to retain her sense of purpose and independence?

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2.3 Activity to enhance appetite

Involving people living with dementia in activities around food particularly before meals can help them prepare for the act of eating and also stimulate hunger. Digestion and appetite can also increase. These activities can give meaning to the day and stimulate the senses in preparation for meal times.

Activities can include simple tasks involved with food or dining room preparation as well as conversations based on memory of food experiences during a lifetime. The kind of activity will depend on the stage of dementia. It is important activities are within the ability of the person with dementia and they do not feel frustrated and defeated. Careful consideration of these is required to ensure confidence and independence is boosted whilst undertaking the activity.

Consider involving people with dementia in activities as part of your routine:

- Sorting the post/papers.
- Unpacking a small food delivery.
- Dusting the dining room.
- Wiping over tables.
- Clearing coffee and tea cups.
- Water pot plants.
- Feed the birds.
- Helping to lay tables with cutlery, serviettes, condiments.
- Picking herbs in the garden.

Activities that involve movement can help stimulate appetite as well as improving other aspects of health including:

- Muscle mass might develop or not waste away.
- Balance and posture remain coordinated.
- Less risk of falls.
- Mobility is maintained.
- Immune function continues to be effective.
- Blood circulation improves and reduced incidences of deep vein thrombosis and gravitational oedema (swelling of lower legs and feet).
- Socialisation and sense of purpose is maintained.
- Easier to relax and sleep patterns improve.
- Retain a level of independence.
- Reduce anxiety and stress levels.
- Reduced incidence of pressure sores.
- Less likely to be constipated.

Examples might include:

- Helping with cleaning.
- Walking in the garden.
- Throwing a ball/bean bag.
- Pushing a large exercise ball.
- Swaying/dancing/moving to music.
- Stretching exercises.
- Chair based exercises.



Explore the web links below

Examples of chair based exercises can be found in:

Gawler, S. & Hanna, S. 2011. Chair based home exercise programme. Later Life Training
<http://www.laterlifetraining.co.uk/llt-home-exercise-booklets/>

Further information

SCIE. 2013. Keeping active and occupied 1: Why activity matters. Social Care Institute for Excellence.

Available from: <http://www.scie.org.uk/publications/dementia/living-with-dementia/keeping-active/files/why-activity-matters.pdf>

Other activities that can help stimulate appetite:

- Involving residents to plan meals with either monthly meetings, individual visits by the chef to residents rooms or touring around at the end of meal times.
- Going shopping to local quiet shops, supermarkets to look at and buy favourite foods.
- Baking;
 - Stirring cake mixes, making muffins, fairy cakes, biscuits.
 - Lick bowls from making cakes.
 - Cake decorating.
- Make desserts or treats such as: banana splits, sundaes, Eton mess, fruit salad, dipping, different toppings for people to add to fruit dipped in melted chocolate, pancakes with different fillings for self serve.
- Celebration events: cream teas, birthday cakes and parties with small sandwiches, crisps.
- Themed events:
 - Cinema events with popcorn and other snacks in TV room.
 - Tea dances.
 - Cultural awareness days e.g. Chinese, Indian.
 - Taster days e.g. pizza, barbecues in summer, fish and chips.
 - Celebratory events e.g. Christmas, St George's day, St Patrick's day.
- Cooking group including men's cooking group.
- Washing up in dining room.
- Opportunities to prepare vegetables.
- Helping to make own drinks maybe by spooning coffee into a cup or adding sugar to a cup of tea or pouring juice into a glass.
- Especially adapted outside space for residents to wander and get involved with growing and picking fruit and vegetables in specially adapted gardens.
- Trips outdoors e.g. to local pub/coffee shop/tea rooms/garden centre/children's farm can all help relive memories and promote conversation about food related topics.
- Fruit picking – local pick your own/grown strawberries in containers in garden/window boxes with herbs in.
- Visit a local farm/fruit orchard.



Explore the web links below

More information about dementia friendly gardens can be found at:

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2592&pageNumber=2

<http://dementia.stir.ac.uk/design/good-practice-guidelines/outdoor-spaces>



Explore the web links below

SCIE. 2013. Eating well for people with dementia 7: Activities based around food. Social Care Institute for Excellence.

Available from:

<http://www.scie.org.uk/publications/dementia/living-with-dementia/eating-well/files/activities-based-around-food.pdf>

College of Occupational Therapists. 2014. Living well through activity in care homes - the toolkit. London: College of Occupational Therapists

<https://www.cot.co.uk/living-well-through-activity-care-homes-toolkit-0>

General fact sheet –activities in care homes

http://www.pssru.ac.uk/pdf/MCpdfs/Activities_factsheet.pdf



2.4 Activity to evoke the senses

As we get older our five senses (hearing, touch, smell, taste, vision) become less sensitive. These are natural physiological processes but dementia can intensify their deterioration. Weakening of the following senses can have immediate impact on ability to enjoy foods.



Smell – As we age it becomes more difficult to identify odours. This can be compounded by a history of smoking and some medications. It can become more difficult to identify foods through smell alone or appetite to be induced through the smells of cooking.

Taste – The ageing process induces a reduction in the number of taste buds within our mouth. In addition, we produce less saliva whilst eating. Saliva is needed to help break down food and release the chemicals that contribute to taste and smell. Our sensitivity to three main tastes: sour, bitter and salty become reduced whereas sensitivity and enjoyment of sweet tastes can remain the same or increase. This can influence food preferences and many people living with dementia will prefer sweet foods or want to add increased salt to foods. Enjoyment of many foods may diminish. Remember to encourage a healthy balanced diet unless other specialised advice has been given (see Appendices). Remember too much salt can have detrimental health effects especially increasing blood pressure so do not encourage adding salt at the table.

Vision – Deterioration in vision is common and maybe multidimensional:

- Difficulty seeing in the dark as older people become less sensitive to changes in light.
- Reduced peripheral vision so it is difficult to see objects to the side.
- Loss of ability to see detail.
- Thickening lens making objects appear cloudy.

Consider the following to stimulate the senses prior to and during meals:

- Use of aromas (these can be bought for certain smells) and spices/herbs and other food products can be used to evoke memories.
- Food taster sessions – different fruits, cheeses, different vegetables, smoothie and milkshake samples.
- Use of flavour enhancers to stimulate the senses at meal times e.g. spices, herbs, tomato puree, parmesan cheese, mushrooms, low salt soy sauce.
- Take time to make food look appealing. Presentation is important to determine our initial reaction to food. If it looks attractive we are more likely to consume it.
- Encourage good oral hygiene. Investigate any mouth problems and consult with a dentist as required.
- Puréed food can be particularly bland. Consider careful use of herbs and spices to maximise flavour.
- Encourage switching between different foods. Taste buds and odour sensors can become saturated quickly making it difficult to continue tasting the same foods.



2.5 Breaking down activity into components

One approach that has been successful in the care environment is to break the activity into several components, people can then become involved at different levels. Ensuring the activity meets the abilities of the person is important. Being able to participate will continue to offer a sense of achievement and involvement.



Task 11

Your care home is considering having a fruit based activity.



Break this activity down into steps e.g.

Step 1 – Contact chef for fruit and kebab sticks.

Step 2 – Select suitable fruit to use etc.

.....

.....

Now consider which residents in your care home could help with each component of the activity.

.....

.....

What might the benefits of this activity be for the person with dementia?

.....

.....

Section 3



Importance of communication and relationships



3.1 Person-centred care

Person-centred care is a common phrase heard in health and social care today; what does it mean in practice and why is it important for supporting people living with dementia to eat and drink well?

The way we perceive things is affected by our 'view of the world'. These perceptions affect the way we do things. But different people thinking about the same thing, may 'see' it differently, rather like looking through different pairs of spectacles.



Task 12

So let's think about working with people living with dementia; what sorts of ideas come into your mind? Think for a moment about this; put a tick next to five statements below that reflect your first thoughts when caring for people with dementia:

No cure		Need help to do most things	
Living well with dementia		Sufferers	
Need to be cared for		Work with fluctuating mental capacity	
Empower and enable		Finding out what matters to the person	
Focus on what can be done		Deterioration	

Some people view people living with dementia primarily as a disease. Someone to be pitied perhaps, because there is 'no hope' as currently there is 'no cure'. Others see the person first and foremost, (for example the woman, mother, grandmother, former teacher) who happens to have dementia. It does not really help people with conditions like dementia to be viewed as 'sufferers'. Most people want to live the life they have left to the full. When we take a person-centred view of people living with dementia, we tend to make the effort to imagine what it might be like and therefore to imagine what we, as fellow human beings, would want from care and caregivers. The alternative is to focus on the disease and to treat 'sufferers' almost like objects not individuals, giving the same care to everyone regardless of their needs and desires. So the way we view or think about people living with dementia affects what we expect and therefore how we work with them.

Whilst all ten statements you considered in Task 12 may be applied to people at different stages of their journey living with dementia, taking a person-centred approach or view tends to be more positive and result in a better quality of life for those we care for:

Disease-centred	Person-centred
No cure	Living well with dementia
Need help to do most things	Focus on what can be done
Need to be cared for	Empower and enable
Deterioration	Work with fluctuating mental capacity
Sufferers	Finding out what matters to the person

Humanising healthcare

Health and social care today has become increasingly fast-paced and technical. This can lead to a focus on meeting targets rather than on the person receiving our care. Kate Galvin and Les Todres are professors studying modern healthcare and they concluded that something is missing from healthcare today and this is an attention to the things that make us feel human (Galvin and Todres, 2013, see further reading pg. 55). Staff are the key to humanised care in care homes; however if we focus purely on getting the task completed, this can be detrimental to the wellbeing of the resident. After all we do not work in a factory, dealing with objects on a production line, but with vulnerable individuals.



Reflection 6

Think about the last time you or someone close to you was seriously ill and sought help from healthcare professionals. You will have taken it for granted that they know what they are doing, but what else would be important to you? Make some notes and then read this short article below:

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Scammell, J (2015) Making a connection: the key to humanised care. *British Journal of Nursing*, 24 (15):786

Good care is based upon genuine empathy from caregivers; this humanises care for residents by responding to the basic human need for:

- Security
- Meaning
- Feeling valued
- Respect
- Dignity
- Compassion



Good nutrition and hydration is also a fundamental human need. When people are older, ill or vulnerable this is even more important in managing their recovery, promoting wellbeing and contributing towards a good quality of life. This has always been central to care, indeed Florence Nightingale herself wrote extensively about its importance. This workbook has highlighted the special reasons why people with dementia become undernourished and dehydrated – physical reasons as well as practical issues like ill-fitting dentures. But there are also psychosocial reasons, such as the loss of a loved one and with it the motivation to eat. Care using a humanised approach encourages you as the carer to try to see the world from the residents viewpoint and thereby understand why they might feel as they do or behave like they do when offered food. For example you know that the environment for eating is important; for most people it is a pleasant social experience. When it does not feel like that because of disagreeable smells, noise or a sense of hurry, then perhaps we would not feel like eating either. Knowing what food means to people shows a respect for their humanity.

To summarise, there is a far greater focus now on ensuring that care is not only technically sound but is also humanised. This is in part a response to the poor standards uncovered at Mid-Staffordshire Hospital (Francis Report, 2013, see further reading on pg. 55). Learning lessons from this, a new nursing strategy for England was developed; this is known as the 6 Cs and emphasises the key values that must underpin all care work:



Source: NHS England (2012)

Head, heart and hand approach

As mentioned before, humanised care asks us as carers to think about the care experience from the perspective of the person receiving care. Knowing the resident is fundamental to this, for example, through the 'This is me' document. Knowing what I know about this person, if they cannot tell me themselves, what do I think they would want in this situation? Of course we need to base our decisions about what to do on the best evidence or knowledge; but to humanise care, Galvin and Todres (2013) suggest that we use three different types of knowledge. We need to know facts to give the right care (head knowledge); we need to understand that feelings influence wellbeing (heart knowledge); then this head and heart knowledge comes together to guide our hands to provide humanised care (hand knowledge).

Applying this to meeting nutritional and hydration needs:



Knowledge for the head (facts; literature; policy; research):

For example, pathophysiology of dementia; the Malnutrition Universal Screening Tool (MUST); signs and symptoms of discomfort (e.g. pain, constipation).



Knowledge for the heart (experiential; feelings):

For example, what's important to the resident about eating and drinking; knowing the person.



Knowledge for the hand (what we do and how we do it; skills, attitudes)

For example, person-centred care not task-centred; making eating and drinking a social and enjoyable event rather than a task to be completed.



Further reading

Galvin, K. M. & Todres, L. 2013. Caring and well-being: a lifeworld approach. New York: Routledge, Taylor & Francis Group.

Francis Report, 2013

<https://www.england.nhs.uk/tag/francis-report/>



Case Study 7

Rita

Rita is an 87 year old woman with vascular dementia who has lived in a nursing home for the past six months. Prior to that she lived with her son and daughter-in-law until they could no longer care for her at home. She has limited verbal ability, can use her hands with one-on-one coaching, and needs assistance to walk and move from chair to bed. On this particular day, she has been brought, along with all the other residents who need help to eat to the activity area for lunch. When a care assistant tries to help Rita feed herself, Rita turns her head away and even grabs a towel to cover her face. After trying again, the care assistant who has other people to help decides to come back later. At the end of lunch Rita's plate is sent back to the kitchen basically untouched.

Adapted from: http://www.nursingceu.com/courses/376/index_nceu.html

Activity

Imagine you are helping to care for Rita. What **head** knowledge would you use to plan good care? What **heart** knowledge and what **hand** knowledge? Here are some ideas to help you start...

 head	 heart	 hand
Good communication skills including smiling and eye contact helps to put people at ease.	I'll sit and eat or drink something with Rita. Perhaps the situation will seem more homely.	Why is Rita covering her face? Is she embarrassed at being helped to eat?



Explore the web links below

Useful resources

Ensuring compassionate, humanised care in busy health and social care settings is a concern across the world. For example, in the USA the Schwartz Centre was set up by Ken Schwartz who had terminal cancer. His experience taught him that 'what matters most during an illness is the human connection between patients and their care-givers'.

Find out more about this: <http://www.theschwartzcenter.org/>

In the UK, the Department of Health Compassion in Practice (6Cs) website is a great source of really useful information about humanising care:

<http://www.england.nhs.uk/nursingvision/>

Following the success of the 'Games-maker' volunteers at the 2012 Olympic Games in London, the Chief Nurse for England launched 'Care-makers'. These are people who work in care and are passionate about making the 6Cs a reality. Perhaps you would like to be a care-maker?

Check out the website:

<http://www.england.nhs.uk/6cs/care-makers/about/>



3.2 Communication

Good communication is a fundamental aspect of successful relationships – to be able to express oneself, to be listened to and be understood. As dementia progresses communication skills become increasingly more difficult and challenging for both the person living with dementia and the caregiver.

Communication is not just about talking but also non-verbal communication including body language and movement, facial expression and tone of voice.

Respecting and knowing the person behind the condition will help understand how best to communicate and establish strong relationships. Any form of social contact helps those living with dementia to feel less isolated and ignored.

In this section, consideration is given to practical ways to communicate with people living with dementia to enhance the provision of food, nutrition and hydration.

Verbal communication

- Use simple language as appropriate.
- Keep sentences short and to the point.
- Don't raise tone of voice or be sarcastic or patronising.
- Speak clearly and at a relaxed pace as information may take longer to understand and process. Speaking quickly may cause distress.
- Try not to offer too much choice e.g. on the menu as too much can be confusing.
- Allow plenty of time to respond, 10 seconds is not abnormal.
- Be aware that residents might be able to hear if not able to express themselves. Be respectful. If a conversation has to be had about a specific resident do this away from them. Do not talk over residents heads when they are eating unless absolutely necessary.

Non-verbal communication

Listening

- Allow the person to express their feelings about food.
- Listen and show understanding.
- Be patient and offer encouragement if the person with dementia has difficulty finding correct words.

Gaining attention

- Before assisting with eating and drinking, try to have the person's attention.
- Ensure the person with dementia is able to see what is about to happen and making eye contact will help.
- Minimise any distractions – TV, other conversations.
- Approach the person so they can see you.
- Explain what you are doing so actions are not a surprise. For example, describe your actions out loud.
- Take time to introduce yourself especially to new residents.
- Ask if you can help.

Body language

- Try to be calm and unhurried to show that you are focusing attention on the person with dementia e.g. if feeding the person or eating with them. Whilst this is not easy moving quickly or showing agitation may cause confusion.
- Reassurance by holding the person's hand or providing comfort if appropriate may help to focus on what is being said or the activity.

Anxiousness

- If a resident shows signs of anxiousness at meal times try to find out why by talking to family and friends about past experiences.
- Observe signs that start to bring on anxiousness. Try to work with the person living with dementia to alleviate these situations. For example, if eating in the dining room causes anxiety then consider why - Do they need to be accompanied into the room? Face in a certain direction? Eat elsewhere?



Explore the web link below

Further information can be found at:

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1211&pageNumber=2



Task 13

Take time to observe those you care for whilst they are eating or drinking. Look for non-verbal cues that they are communicating.

What are these and are they showing positive or negative forms of communication?

- 1.....
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- 2.....
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- 3.....
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- 4.....
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- 5.....
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Within the care home environment, relationships can be formed and built to encourage positive social interaction between residents. Remember as verbal communication becomes more difficult then these relationships will become less evident.

Meal times – Support and enable people to choose where they would like to sit. Negotiation may need to be employed to prevent conflicting personalities sitting together but never move people against their wishes unless by negotiation.

Seating plans – Dignity and respect should be given to where people sit in the dining room - e.g. those who eat in ways others may find unusual may upset others who are able to use utensils.



Task 14

Take time to observe residents in your care home.

Do they form small friendship groups and if so where do they tend to assemble?

Are there patterns of behaviour that you can observe when they are within these groups? Think about the different communication strategies available both verbal and non-verbal.

Do the same groups tend to eat together? Try to encourage these residents to eat together and observe any changes in behaviour. What are these? Does it effect eating and drinking behaviour?

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Case Study 8

Jolene

Jolene is 84 and was diagnosed with Alzheimer’s Disease two years ago. She has been classified as having moderate to severe dementia. She was admitted to the care home one year ago and has recently been diagnosed with depression. Jolene had a moderate stroke two years ago and has left sided paralysis as a result.

Jolene’s weight has gradually been declining and she has a high risk MUST classification. Jolene is unable to eat and drink independently and is assisted by a carer with one-to-one support.

Recently it has been observed that Jolene has had difficulty chewing and swallowing some of the food items, in particular different meats. Her carer has had a discussion with the care home manager about this. The care home manager is consulting a Speech and Language Therapist and Dietitian as to whether Jolene should be referred for a puréed diet.

If you were responsible for Jolene think about the following:

- What types of foods could be offered to Jolene to boost her food and energy intake?

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- What other factors could be causing Jolene to have difficulty chewing and swallowing?

.....
.....

- If Jolene needs to go onto a puréed diet what can be done to boost the calorie content of her food?

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.....

- What should you consider to ensure person-centred care when supporting Jolene to eat?

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.....

- What other aspects of Jolene’s care could you consider that might improve her appetite?

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.....

Support of families and relatives

Family members and relatives can be of help but if present at meal times and not eating themselves can discourage residents from eating. They may distract the person living with dementia from eating or the resident may feel under pressure to finish their meal quickly as they do not wish to be watched eating.

Family and relatives relationship with the resident and carers can influence the behaviour of residents. Encourage families to become involved in meal times and food choices.

As memory loss develops long standing cultural and religious beliefs may be forgotten. This is difficult for families to understand. Every effort should be made to consider the needs of the resident and their family but conflict between food preferences and these principles must put the needs of the person living with dementia first.

Encourage families to undertake activities with the resident:

- Joining in organised activity.
- Talking to residents and using memory cues (e.g. picture cards/photos/old objects) to communicate.
- Recognise body language.
- Walking together around the garden.
- Visits out to coffee shop/pub/garden centre/local shops/craft centre.
- Smelling herbs/flowers/plants.
- Sharing food such as cut up fruit/sweets/biscuits/treats.





3.3 Protected meal times

Protected meal times have been introduced into many hospitals successfully and should be considered in any care setting. Non-essential activity stops, the dining area is tidied and should be made ready for their meals. It gives opportunity for residents to enjoy their meals and for all carers to assist those who need it.

Key principles:

- Safe staffing levels.
- Minimise non-essential interruptions including medicine rounds.
- Ensure food and drink is within easy reach.
- Provide assistance where required (open packets, cut up food, pour drinks).
- Support people to eat and drink where required.
- Family, friends and volunteers may assist if this will encourage food and fluid intake and is safe to do so.
- Provide positive encouragement to increase food and fluid intake.
- Allow sufficient time for food and drink to be enjoyed.



Task 15

Take time to observe the three main meals served in your care setting and take a note of the number and type of interruptions. If the meal is not served in the dining room, take a sample of a few residents eating in their rooms:

Breakfast

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.....

Lunch

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.....

Dinner / evening meal

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.....

Now consider if these interruptions should be prevented and if so how.

Things to consider:

- Can the task be delayed to after the meal?
- If the interruptions are by visitors do they have a positive impact on the food and drink consumption of the resident?
- Is sufficient assistance available and being directed appropriately?



Explore the web links below

http://www.healthcareimprovementscotland.org/programmes/patient_safety/programme_resources/making_meals_matter_pack.aspx

<https://www.gov.uk/government/publications/essence-of-care-2010>



3.4 Self-leadership and personal resilience

To put much of the learning presented in this workbook into practice requires a level of self-leadership within your care environment. Self-leadership has emerged as a 'key requirement' based on research by Professor Keith Brown and Jane Holroyd MBE on leadership within Health and Social Care.

They have shown:

- Leadership is everybody's business and we all have some responsibility for this in our working lives.
- The foundation of any good leadership is being able to manage oneself.

The background and requirements of self-leadership are discussed further in a short paper that can be found in Appendix A3.

A few final words...

Improving the lives of people living with dementia through good nutrition and hydration is an essential requirement for those working in care. We hope that the material presented in this workbook has been helpful and together with the accompanying training film will enable you to enhance the food and drink delivery and provide better nutrition overall for those you care for living with dementia.



A1 Core principles of nutrition

The science of nutrition is the study of the relationship between the dietary intake (providing energy and nutrients) and the requirements of the body to establish and maintain function.

It is not simply just about food eaten!

As energy and nutrients are derived from food it is important to understand what food should be eaten and how different foods can make up a balanced intake to meet the body's demands.

Clearly there are a wide range of social and environmental factors that influence what we eat, some of which may have harmful effects and may cause ill health. To be able to provide the best care and advice for older people, it is important that you have a sound knowledge and understanding of some of the key concepts and principles of nutrition but also know when to refer to a registered dietitian or nutritionist for guidance and advice.

Diet, Food and Nutrients

Food is absolutely essential for life. Human metabolism is a complex process that is constantly active and depends on a supply of specific chemicals, or nutrients in food.

Some nutrients can be produced (or synthesized) by the body but some cannot and rely on a dietary intake.

The maintenance of a stable metabolic state requires sufficient energy and nutrients to satisfy the body's metabolic demand.

Dietary carbohydrate

Carbohydrates provide energy for all our body requirements. This includes physical activity and all body functions known as basal metabolic rate (such as blood circulating, heart pumping, body tissue function). All carbohydrates are ultimately broken down by the body into simple sugar glucose which is then transported around the body in the blood.

Dietary carbohydrates are found in many foods and can be classified according to the number of sugar units (or saccharides) that make up their structure:

Sugars: Simple carbohydrates are sugars with a simple structure of one (monosaccharide) unit e.g. glucose, fructose (commonly found in fruit) and galactose, or two (disaccharides) sugar units e.g. sucrose ('normal' sugar), lactose (found in milk) and maltose.

Complex carbohydrates: Starches consist of many sugar units (polysaccharides). Principal sources are foods such as bread, pasta, rice and potatoes.

Fibre: It is not digested and is vital for good dietary health. Insoluble non starch polysaccharides (NSPs) include cellulose (important for peristalsis and defecation). Soluble NSPs include gum and pectin important for the health of the colon and to maintain bacterial fermentation. Good sources are brown pastas, rice, bread, most fruits and vegetables and bran based breakfast cereals.



Explore the web link below

Further information can be found at:

British Nutrition Foundation

<https://www.nutrition.org.uk/nutritionscience/nutrients-food-and-ingredients/carbohydrate.html>

Dietary fat

Dietary fats have a number of essential functions for the human body. These include providing the body with energy, essential fatty acids and acting as a carrier for fat soluble vitamins as well as being an essential component of all cells including the brain.

Dietary fats consist primarily of triglycerides but also contain other components such as cholesterol, phospholipids and sterols.

Types of fatty acids:

Saturated fatty acids (SFA) Saturated fats are found in animal sources such as meat, poultry, milk, butter, cheese and cream. Saturated fats are usually solid at room temperature. Some vegetable oils like coconut and palm nut oil are also high in saturated fat. They tend to raise the level of 'bad' cholesterol (non high-density lipoprotein (HDL) cholesterol) and hence total cholesterol in blood. A high intake therefore enhances the risk of cardiovascular disease.

Monounsaturated fatty acids (MUFA) Found mostly in vegetable oils – olive and rapeseed oil. Most beneficial type of fatty acid as they lower low-density lipoprotein (LDL) cholesterol.

Polyunsaturated fatty acids (PUFA) Found in nuts and vegetable oils such as sunflower, safflower oils and fatty fish. PUFAs are divided into 2 types omega-6 and omega-3 and they have an essential role in enabling many body processes e.g. blood clotting.

Trans fatty acids Trans fats are also known as trans fatty acids. They are formed during food processing when liquid vegetable fats are converted into solid fats such as hard margarine. This process of hydrogenation gives foods a longer shelf life. Trans fats also occur in small quantities naturally in some meat and dairy produce. Foods that are high in trans fats are snack foods and baked goods with partially hydrogenated vegetable oil like cakes, biscuits and some margarines. Research has shown that trans fats can increase LDL cholesterol levels and may increase the risk for cardiovascular disease. However, recent reports show that about 1% of energy consumed is from trans fats.



Explore the web links below

Further information can be found at:

British Nutrition Foundation

<https://www.nutrition.org.uk/nutritionscience/nutrients-food-and-ingredients/fat.html>

British Dietetic Association

<http://www.bda.uk.com/foodfacts/omega3.pdf>

Dietary protein

Proteins are essential for the structure and effective functioning of the human body. Many different proteins are found in the human body each with a different role.

The building blocks of proteins are called amino acids. There are about 20 different amino acids found in plant and animal proteins. Some amino acids can be made by the body as needed whilst others must be provided by the diet (termed non-essential, essential and conditionally essential amino acids). There are 8 amino acids that have to be provided in the diet and are therefore essential. These are: Leucine, Isoleucine, Valine, Threonine, Methionine, Phenylalanine, Tryptophan, and Lysine. Proteins can be found in both plant and animal sources.



Explore the web link below

Follow the web link below to explore what are the best sources of protein in food.

British Nutrition Foundation

<https://www.nutrition.org.uk/nutritionscience/nutrients-food-and-ingredients/protein.html>

Vitamins and minerals

Vitamins are a diverse range of chemicals that are required in very small quantities to enable the body to function correctly. A dietary intake of most vitamins is essential to prevent symptoms attributable to deficiency.

There are some exceptions such as vitamin D that can be made by the action of sunlight on the skin, vitamin K (made by intestinal bacteria), although a dietary requirement may be necessary if the body's demands are not met. Vitamins can be classified as water-soluble or fat-soluble.



Explore the web link below

More detail can be found about each of the vitamins at:

British Nutrition Foundation

<https://www.nutrition.org.uk/nutritionscience/nutrients-food-and-ingredients/vitamins.html>

Minerals and trace elements are required in small or even trace quantities for normal body function. Most are found in unrefined and unprocessed foods. Minerals are inorganic substances required by the body in small amounts for a variety of functions. These include the formation of bones and teeth; as essential constituents of body fluids and tissues; as components of enzyme systems and for normal nerve function.

Some minerals are needed in larger amounts than others, e.g. calcium, phosphorus, magnesium, sodium, potassium and chloride. Others are required in smaller quantities and are sometimes called trace minerals, e.g. iron, zinc, iodine, fluoride, selenium and copper. Despite being required in smaller amounts, trace minerals are no less important than other minerals.



Explore the web link below

More detail can be found about each of the minerals at:

British Nutrition Foundation

<https://www.nutrition.org.uk/nutritionscience/nutrients-food-and-ingredients/minerals-and-trace-elements.html>

Food and nutritional requirements for older people

Ageing affects people at different rates. The ageing process is influenced by genetics, environment and lifestyle factors.

Nutrient based guidance for older people

The nutrient standards for older people are based upon the needs of those aged 75 and over (from Dietary Reference Values for Food Energy and Nutrients for the United Kingdom (1991). The guidance will be sufficient in most cases but not all cases for all older people in care in the community.

*It is difficult for most older adults to obtain the full daily requirement of vitamin D from the diet alone. The action of sunlight on the skin is the major source of vitamin D. Government advice is that older adults (over 65 years) who do not have adequate exposure to sunlight should take a 10 mcg daily vitamin D supplement.



Explore the web links below

Guidance on food served to older people in residential care

<http://www.food.gov.uk/multimedia/pdfs/olderresident.pdf>

Crawley, H. & Hocking, E. 2011. Eating Well: Supporting Older People and Older People with Dementia, Caroline Walker Trust.

Available from: <http://www.cwt.org.uk/publications/>

NACC Recommended Standards For Older People In Residential, Day Care and Community Meals

<http://www.thenacc.co.uk/assets/downloads/105/NACC%20Nutrition%20Standards%202010.pdf>

Simply providing food that meets these guidelines will not necessarily mean that older people consume the necessary food and nutrients. It is important to create the right sort of environment for eating and to provide food which tastes good, looks good and is well presented in order to increase the likelihood that the older person will enjoy and eat the complete meal. Portion sizes are also important as serving portion sizes that are too large can be off putting. On the other hand, portions that are too small may be inadequate and increasing the energy and nutrient density may need consideration to meet the older person's need.



Explore the web link below

Care Quality Commission

<http://www.cqc.org.uk/content/provider-handbooks>

Dietary guidelines and tools

A healthy diet is one that provides sufficient energy and nutrients to prevent deficiency but also helps to optimise health and reduce the risk of disease. The need for energy and nutrients varies from individual to individual and with age, gender or physiological state of the individual. To maintain healthy populations, most developed countries have established reference standards for energy and nutrient intake based on the needs of most healthy population groups.

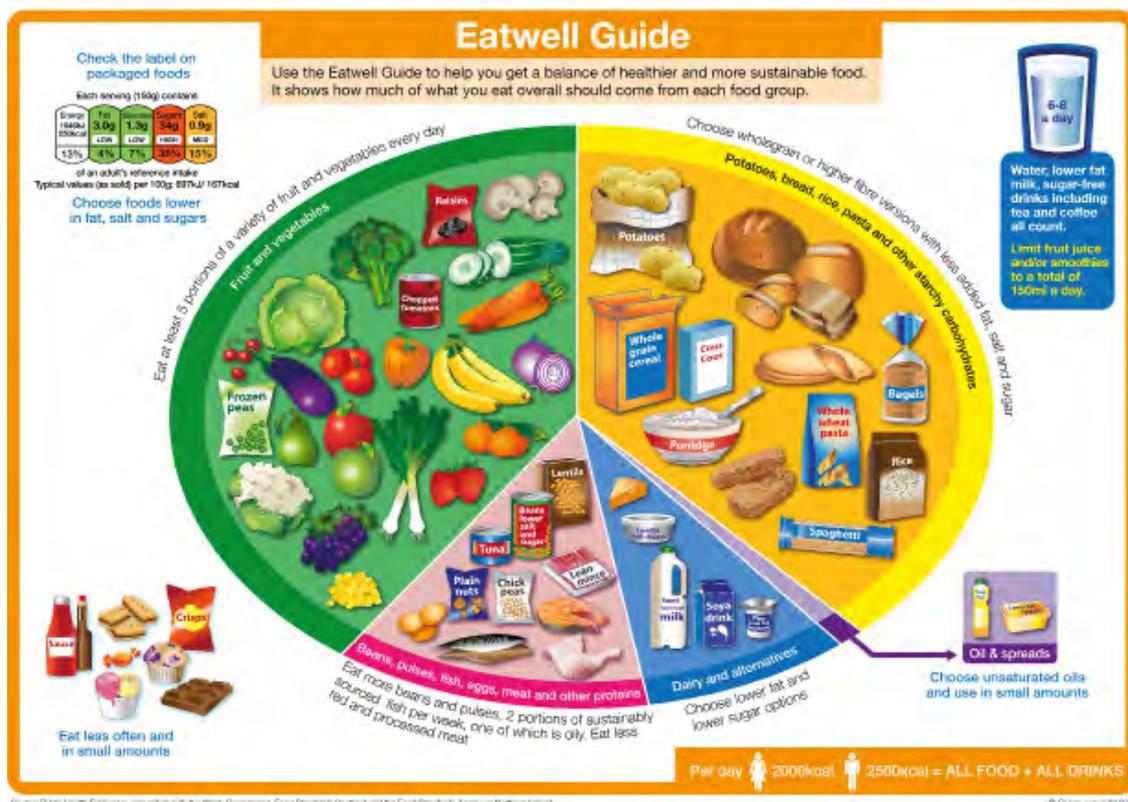
In the UK, the Recommended Intake of Nutrients was first published in 1969 as a guide for planning and acquiring food supplies and promoting good nutrition.

The recommendations were updated in 1991 as the Dietary Reference Values (DRVs) to keep up with increasing scientific information and concerns about nutrition and health. More recently, the Scientific Advisory Committee on Nutrition (SACN) have reviewed the energy requirements for the UK given that the levels of overweight and obesity in the UK have risen sharply and the evidence base has moved on.

The DRVs consider an individual's gender, age group and are not limited to preventing deficiency diseases as they also take into account nutritional status and long-term health. Importantly the DRVs are derived for normal healthy people on a normal intake and can only be used with caution in a clinical context. As such they are a useful guide to the nutritional requirements of healthy people and a valuable tool for the dietitian and nutritionist.

The Eatwell Plate

The 'Eatwell Plate' was developed to show the five main food groups and the proportions of each group required as part of a healthy diet. It forms part of an integrated approach to have a well-balanced and healthy diet which includes fluid, physical activity and includes the 'Eight steps for healthy eating'.



https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/528196/Eatwell_guide_600dpi.jpg

Eight steps for healthy eating.

1. Base your meals on starchy foods.
2. Eat lots of fruit and vegetables.
3. Eat more fish – including a portion of oily fish each week.
4. Cut down on saturated fat and sugar.
5. Try to eat less salt – no more than 6g a day for adults.
6. Get active and try to be a healthy weight.
7. Drink plenty of water.
8. Don't skip breakfast.



Further Reading

Department of Health (1991) Dietary Reference Values for Food Energy and Nutrients for the United Kingdom no. 41. London: HMSO.



Explore the web links below

<http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx>

Eatwell Guide https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/528200/Eatwell_guide_booklet.pdf

http://webarchive.nationalarchives.gov.uk/20140507012657/http://www.sacn.gov.uk/reports_position_statements/reports/the_nutritional_wellbeing_of_the_british_population

Scientific Advisory Committee on Nutrition (2011) Dietary Recommendations for Energy London: TSO.

http://www.sacn.gov.uk/reports_position_statements/reports/sacn_dietary_reference_values_for_energy.html

<http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx>

<http://www.nhs.uk/Livewell/Goodfood/Pages/eight-tips-healthy-eating.aspx>

<http://www.dh.gov.uk/health/2012/06/about-the-eatwell-plate/#Guidelines%20for%20use%20and%20reproduction>



A2 Referral to the nutrition experts

What type of professional do you refer your patients to for more specialist nutritional advice?

Reflect upon the criteria you use for referral? Is there a simple process for referral?

Whilst there is some overlap, it is important that the roles of the Registered Dietitian and Registered Nutritionist are understood to ensure appropriate help and support (see Table below).

The Registered Nutritionist (on the UK Voluntary Register of Nutritionists – see Association for Nutrition) provides evidence-based information and guidance about the impacts of food and nutrition on the health and wellbeing of humans (at an individual or population level). They do not provide specific clinical dietary advice to individual patients – this is the role of the dietitian.

A dietitian uses the science of nutrition to devise eating plans for patients to treat medical conditions. They also work to promote good health by helping to facilitate a positive change in food choices amongst individuals, groups and communities under statutory regulation with the Health and Care Professions Council (HCPC) (see Health & Care Professions Council).

The professional association for UK dietitians is the British Dietetic Association www.bda.uk.com.

The main differences between a Registered Dietitian and a Registered Nutritionist

Registered Dietitians	Registered Nutritionists
Both therapeutic and preventative role	Mainly preventative role
Work with “ill” people and “healthy” people	Work with “healthy” people
Mainly work on a one to one basis	Mainly work with groups

It is also important to recognise the fundamental differences between the work and the registration requirements of registered nutritionists and nutritional therapists to avoid misunderstanding.

The Registered Nutritionist (on the UK Voluntary Register of Nutritionists) are committed to the promotion of strong evidence-based nutrition and registrants must meet science based competencies in nutrition and agree to abide by rigorous Code of Ethics.

This is in contrast to the many areas of work of the nutrition therapist (British Association for Applied Nutrition and Nutritional Therapy (BANT) that does not have UK Voluntary Register of Nutritionists or HCPC recognised qualifications.



Explore the web links below

How can I find a registered dietitian or nutritionist?

<http://www.nhs.uk/chq/pages/find-a-registered-dietitian-or-nutritionist.aspx?categoryid=51&subcategoryid=168>

Association for Nutrition

<http://www.associationfornutrition.org/>

British Dietetic Association

<https://www.bda.uk.com/>

Health and Care Professions Council

<http://www.hpc-uk.org/>



A3 Self-leadership and personal resilience – The key to good professional judgement.

Professor Keith Brown and Jane Holroyd M.B.E

Unacceptable care within Health and Social Care has been an increasing theme within a number of reports from the sectors. A yawning and snowballing awareness of the importance of compassion and culture has resulted, together with a focus on the quality of leadership and implicitly an emphasis on better leadership development.

Our research over a number of years has led to two major conclusions:

Firstly, that leadership is everybody's business, it is not just for the 'Leaders'. We all have some leadership responsibility in our working lives, something that we are responsible for and which we can 'lead'. Secondly far too much leadership theory is taught which teaches us about theory and tools. We believe that the foundation of any good leadership is being able to manage oneself. Managing your own stress and ability to think clearly under pressure is the key to strategic leadership. We call this 'Self-Leadership' and it is a concept and idea we have worked on for a number of years, based on helping individuals to have clear minds, great communication skills and in-built resilience to help manage the challenges and pressures of each day in order to exercise the best professional judgement under pressure.

Self-leadership has emerged as a constant requirement for it applies to anyone, whether they hold the job title of leader or not. It is the ability in the moment to access the best of our potential with the clarity of thinking required to make the soundest professional judgements in all areas and aspects of care. Leadership therefore becomes everyone's business with the central tenant self-leadership which promotes a focus on developing the best of all of us with an emphasis on building resilience rather than overwhelm.

If you would like to explore this concept further then take a look at:

Self-Leadership and Personal Resilience in Health and Social Care. Jane Holroyd with contributions from Keith Brown and Aaron Turner (2015). Sage Publication. Or contact me.

Professor Keith Brown

Director of NCPQSW and Director Centre for Leadership, Impact and Management at Bournemouth University.



A4 Useful websites and organisations



Age UK: www.ageuk.org.uk

Alzheimer's Society - enquiries@alzheimers.org.uk www.alzheimers.org.uk

Care Quality Commission (2011) Dignity and nutrition for older people. Care Quality Commission. Available from: <http://www.cqc.org.uk/content/national-report-dignity-and-nutrition-review-published>

Caroline Walker Trust: <http://www.cwt.org.uk/>

Coeliac UK Helpline: 0845 305 2060 / www.coeliac.org.uk

Council of Europe - 10 key characteristics of good nutrition care: <http://www.thenacc.co.uk/assets/downloads/139/10%20key%20Characteristics%20of%20Good%20Nutritional%20Care%20poster.pdf>

Diabetes UK: info@diabetes.org.uk / www.diabetes.org.uk

Hungry to be Heard (Age Concern): <http://www.ageuk.org.uk/latest-news/archive/older-patients-still-hungry-to-be-heard/>

National Care Association: info@nationalcareassociation.org.uk / www.nationalcareassociation.org.uk

National Family Carer Network: 01883 722 311 / info@familycarers.org.uk
www.familycarers.org.uk

NHS Confederation (2012) Delivering Dignity: Securing dignity in care for older people in hospitals and care homes. Available from: <http://www.nhsconfed.org/Publications/reports/Pages/Delivering-Dignity.aspx>

NHS choices: <http://www.nhs.uk/Pages/HomePage.aspx>

NICE National Institute for Health and Clinical Excellence: <http://www.nice.org.uk>

NHS Patient Safety Resources – Nutrition fact sheets: <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59865>

NICE National Institute for Health and Clinical Excellence: <http://www.nice.org.uk>

NOTES



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