

# Food, Fluid and Nutrition

## NHSGGC Nurse Induction



[www.nhsggc.org.uk/foodfirst](http://www.nhsggc.org.uk/foodfirst)

- Appreciate the importance and impact of appropriate nutrition and hydration for patients
- Appreciate the need for accurate and appropriate nutritional screening, assessment and care planning
- Understand the nutritional interventions which can be undertaken to ensure patients nutrition and hydration needs are met
- Familiarise yourself with the NHSGGC documentation relating to Food, Fluid and Nutrition



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Welcome, this presentation is one of the essential learning resources that you have been asked to work through within the first two weeks of your role within NHS Greater Glasgow and Clyde (NHSGGC). The focus of this resource is Food, Fluid and Nutrition and should take no longer than 1 hour to complete; by the end you will be able to:-

Appreciate the importance and impact of appropriate nutrition and hydration for patients

Appreciate the need for accurate and appropriate nutritional screening, assessment and care planning

Understand the nutritional interventions which can be undertaken to ensure patients nutrition and hydration needs are met

Familiarise yourself with the NHSGGC documentation relating to Food, Fluid and Nutrition

# Nutrition – what's the fuss?

- Provides body with energy
- Health and wellbeing
- Everyone's nutritional needs are different
- Balanced diet is best
- Imbalance in diet can result in malnutrition



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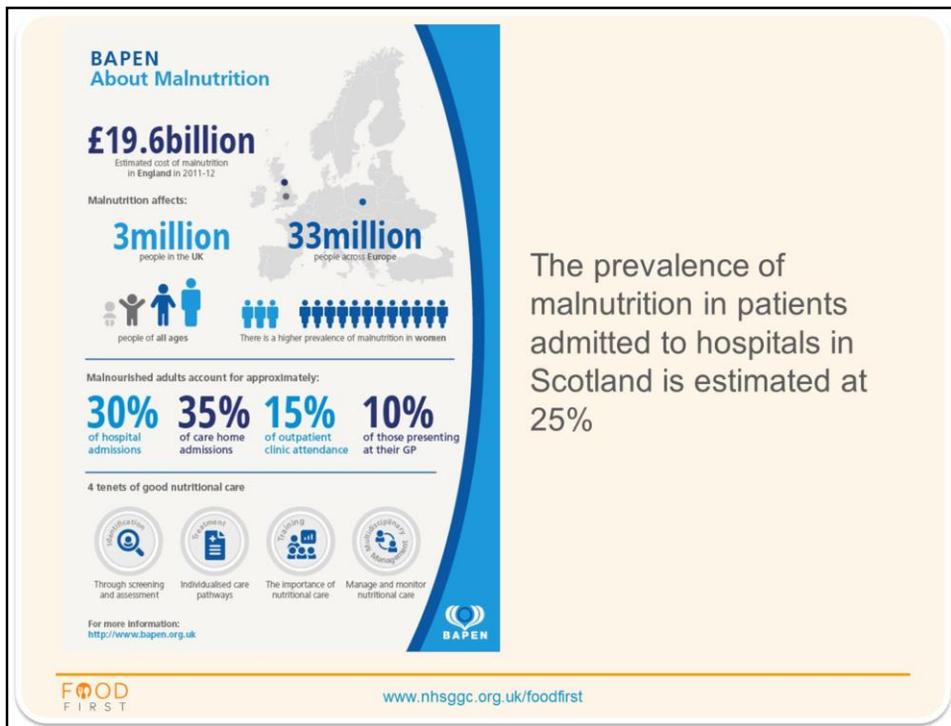
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So lets begin with what's the fuss about Nutrition and Hydration?

The major function of food and fluid is to provide the body with energy to support our organs and allow us to carry out our everyday tasks. Good nutrition is crucial to our health and wellbeing and its important to understand that everyone's nutritional needs are different and this depends on their age, weight, gender, activity and medical conditions.

Eating a balanced diet means we have the correct proportions of protein, carbohydrates, fats, vitamins and minerals that our bodies needs to maintain good health and this balance is shown in the eatwell plate above. An imbalance in the proportions can lead to or result in malnutrition.

Delivering the right amount of food and fluid to each patient is important during their stay in hospital. By supporting people to eat and drink 'what's normal for them' can help them recover from their illness or surgery and can support a quicker discharge from hospital.



The prevalence of malnutrition in patients admitted to hospitals in Scotland is estimated at 25%

You may be surprised to know that malnutrition literally means ‘bad’ nutrition i.e. under or over nutrition and therefore also refers to obesity.

The term malnutrition is generally used to mean under nutrition within the hospital setting. It can be caused by physical, psychological and social reasons and it can effect anyone. However people over 65, those with long term or chronic progressive condition, and those who abuse alcohol or drugs are most susceptible and it is estimated that 25% of patients admitted to hospital in Scotland are malnourished.

Malnutrition can often be very difficult to recognise , particularly in patients who are overweight or obese. Malnutrition can happen very gradually, which can make it very difficult to spot in the early stages. It can have short term or long term effects on the function of the body with patients at risk of malnutrition having longer recovery times, hospital stays and be less likely to be discharged to their own home. It is important to identify malnourished patients as early as possible to allow intervention strategies to be put in place to prevent and/or treat the adverse consequences of malnutrition.

# Identification of Malnutrition

Malnutrition Universal Screening Tool  
(MUST)



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# Nursing assessment – Hydration and Nutrition

5. Hydration and Nutrition
Do you have any food allergies or food intolerances?  <i>Mary has an intolerance to Gluten</i>
What do you like to eat and drink?  <i>Mary likes plain foods like mince and potatoes, sausage and mash She prefers a hot cup of tea (milk with 2 sugars)</i>
What do you not like to eat and drink?  <i>Mary doesn't like fizzy juice or spicy foods</i>
<b>N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission</b>

Within the first 24 hrs of a patient being admitted to hospital you must gather information about their nutritional needs. Section 5 within the Nursing admission document known as the 'My Admission Record' allows space to document information about any food allergies or intolerances and their likes and dislikes as well as prompting the completion of the Malnutrition Universal Screening Tool ('MUST'). A completed example of the nutritional assessment is displayed on this slide and the next.

This may not seem important when first admitted but not eating or drinking the correct food or drink or eating 'whats normal for them' can make a patient more susceptible to a hospital acquired patient harm (such as infection, pressure ulcer, fall, delirium).



# Nutritional Screening – Why bother?

- Simple and validated tool
- Early identification of nutritional problems
- All adult inpatients who stay > 23hours
- Completed at least every 7 days
- Rescreen on transfer

Patient Label		MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)		NHS Greater Glasgow and Clyde	
Date	Time	Actual	Patient reported	* If unable to obtain height and / or weight (check postal / track for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition	
* Obtain accurate height/weight and rescreen as soon as possible					
Patients reported normal weight <input type="checkbox"/> Unable to Recall <input type="checkbox"/>					
Any unplanned weight loss in the last 6 months: Yes <input type="checkbox"/> how much: <input type="text"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/>					
Date	Time	Ward	Orderlies	Assistants	present Y/N
Scales Used ST = Standing, Ok = Chair BT = Bed, Ok = Unable to weigh, record reason and document subjective assessment of risk to nursing notes					
Weight (kg)					
BMI					
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days.					
Step 1 BMI Score					
-20 = 0 -18.5 to -1 = 1 -18.5 = 2					
Step 2 Weight loss score					
+5% = 0 5-10% = 1 +10% = 2					
Step 3 Acute disease effect					
Patient is acute ill and has had one or is likely to be ill, or virtually no food intake for 1 day = score 2 not applicable = score 0					
Step 4 Overall Risk of Malnutrition TOTAL					
Rescreen on: <input type="text"/>					
Signature: <input type="text"/>					
Step 5 Management Guidelines (excludes patients who are Nil by Mouth)					
Overall Risk of Malnutrition: <input type="text"/> Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan					
0 LOW RISK - Repeat screening every 7 days					
1 MEDIUM RISK - Follow the flowchart for MUST 1 overall					
2 or greater HIGH RISK - Follow the flowchart for MUST 2 or greater overall					



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Why do we have to screen all patients who are admitted to hospital for malnutrition?

As mentioned earlier sometimes malnutrition can be difficult to spot particularly in those who may have some weight to lose. The Malnutrition Universal Screening Tool (shown in the slide) is used in NHSGGC to identify patients at risk of malnutrition. MUST is a simple 5 step screening tool to identify nutritional risk and further information about MUST can be found at <https://www.bapen.org.uk/screening-and-must/must-calculator>

The next few slides will break down some of the key components of the document and the screening process to ensure you are able to calculate an accurate MUST score for each patient.

**MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)**

Patient Label

Date <u>06/06/20</u> Time <u>10:00</u> of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>154</u> cm	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Portal :last weight on previous admission March 20 was 58kg
Admission Weight <u>55</u> Kg	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Obtain accurate height/weight and rescreen as soon as possible			
Patients reported normal weight <u>9st/ 58kg</u> Unable to Recall <input type="checkbox"/>			
Any unplanned weight loss in the last 6 months Yes <input checked="" type="checkbox"/> how much <u>3kg</u> No <input type="checkbox"/> Don't Know <input type="checkbox"/>			

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On admission to hospital or as soon as is practical the MUST document should be completed for all patients

Here are some key points

The information at the top of the form is important to establish a baseline on admission to hospital, the information in this top box should be transcribed onto any new MUST charts should the patient require a new one during their hospital stay.

If you are unable to obtain an accurate weight and height on admission to hospital, there are other places within the electronic patient record that you can look for a previous weight in order to complete nutritional screening as accurately as possible. Check clinical portal for previous admission documentation (including previous MUST charts); the dietetic summary record or SCI gateway referrals.

Asking a patient their normal weight and whether they have had any unplanned weight loss in the last 6 months supports an accurate initial weight

loss score (Step 2) – this will be shown in the next slide.

Date	06/06	07/06	14/06	19/06	26/06	03/07		
Time	10:00	13:30	11:00	13:00	09:00	14:00		
Ward	ARU4	51	51	3C	3C	3C		
Oedema/ Ascities present Y/N	N	N	N	N	N	N		
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	UW	CH	CH	CH	CH	CH		
Weight (kgs)	55	56.4	55.2	53.7	51.2	49.9		
BMI	23	23	23	22	21	21		
<b>Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days</b>								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0	0	0	0	0	0		
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	1	0	0	1	2	2		
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0	0	0	0	0	0		
Step 4 Overall Risk of Malnutrition TOTAL	1	0	0	1	2	2		
Rescreen on	13/06	14/06	21/06	26/06	03/07	10/07		
Signature	EH	LR	AK	MN	KH	EH		



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Here is an example of a completed MUST for a patient who was admitted via a receiving unit and then transferred twice during their hospital stay. They were unable to be weighed on admission, therefore the nurse checked Clinical Portal for their previous admission to get an accurate picture of the patients weight history as well as the information that was given during the initial nutritional assessment.

Below is a quick reminder of how to calculate MUST

**Step 1- BMI Score:** find out the patients height and weight (using scales where possible), calculate the patients BMI. Use the BMI guide below Step 1 in the document to work out the BMI score e.g. this patient's BMI is 23 on admission, therefore the patient scores a 0 for Step 1

**Step 2 – Weight Loss Score:** calculate how much weight the patient has lost weight within the last 6 months (only unplanned weight loss) and then calculate their % weight loss score. There is a chart at ward level (shown on the next slide) which helps you work out the weight lost score otherwise you can use the MUST calculator on the BAPEN website <https://www.bapen.org.uk/screening-and-must/must-calculator>

For the initial MUST on admission, this patient reported a weight of 55kg on admission, they weighed 58kgs on their previous admission 3 months ago, therefore this patient had lost 3kgs in the last 3 months which is just over 5% of their body weight therefore they score 1 for step 2

**Step 3- Acute Disease Effect:** this requires your clinical judgement to work out whether the patient is likely to have no or virtually no food intake in the next 5 days due to their clinical condition. E.g. if they are eating and drinking they score 0, if they are unlikely to eat and drink in next 5 days and are acutely unwell then they would score a 2. For this example the patient scores 0

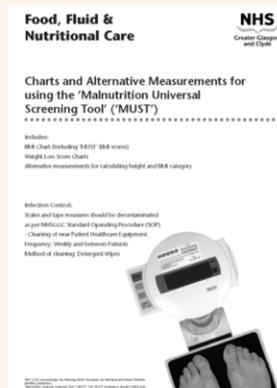
**Step 4- Overall Risk of Malnutrition:** add up all the scores to calculate their risk score e.g. step 1= 0, step 2= 1, step 3= 0 therefore 0+1+0= 1

**Step 5- Management Guidelines:** Detail what we should do for the patient depending on their risk of malnutrition and this will be discussed on a later slide

Take some time to look over this completed MUST document

# Common pitfalls with MUST

- Reported normal weight/ unplanned weight loss
- Equipment used
- Unable to weigh
- Total weight loss
- Overall MUST score



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## Common pitfalls in documenting MUST scores

- The patients reported normal weight and the amount of unplanned weight loss sections at the top of the form are not filled out on admission which can lead to an inaccurate MUST score
- Using different weighing equipment may cause fluctuations in weight- these fluctuations may not always be a weight loss or gain for the patient but the use of different scales on different wards
- Unable to obtain a weight: important to estimate risk of malnutrition using Mid Upper arm circumference (MUAC) and subjective measurements
- Total weight loss: Weight loss score is worked out from the reported normal weight or initial weight to ensure ALL weight loss is included. The chart above should be available at ward level and can support accurate scoring of MUST
- Overall MUST score is not added up correctly

Its really important that each screening episode is carried out independently of the screening episodes that have already been documented. Have confidence in what you document and if you are unsure check it or clarify it with someone else.

## So what next?

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)	
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

- MUST management guidelines (above)
- Medium risk flowchart (reverse of form)
- High risk flowchart (reverse of form)

A patient will either fall into the low, medium or high risk category for malnutrition and its really important that you follow the management guidelines which are both at the bottom and the reverse of the chart. These guidelines are there as prompts to ensure you develop a care plan which is appropriate to the patients needs. All interventions that you feel are required should be documented on the patients care plan under Section 5- Hydration and Nutrition

# Care Plan

5. Hydration and Nutrition		
06/06/20	EH	Mary medium risk- weigh weekly
06/06/20	EH	Commence F+D chart and review daily
06/06/20	EH	Ensure Gluten free meals and snacks are available
06/06/20	EH	Ensure food is cut up for Mary due to R arm in plaster
06/06/20	EH	Offer gluten free snacks with milk between meals



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Here is an example of a Medium risk care plan for Mary that was documented when she was admitted on the 6<sup>th</sup> June

As you can see from the management guidelines and the completed care plan there is a focus on the ' food first approach' to support Mary to receive adequate nutrition.



You might ask what does 'food first' mean?

Across NHSGGC we encourage staff to offer 'food first' where appropriate, to support patients to receive adequate nutrition to support recovery and rehabilitation.

Key interventions include

- Supporting patients to select higher calorie choices / energy dense meals at meals times
- Offering regular snacks throughout the day – these may be the patients own or the dedicated MUST snack that can be ordered daily from catering
- Offering full fat milk with and between meals

Furthermore increasing the opportunities that patients have access to food and drinks through regular enquiry and prompting during care rounds, tea rounds and mealtimes can support the 'little and often' approach. These simple dietary interventions can help reduce the number of patients who lose weight during their hospital stay.

For more information about the Food First approach please see the Food and Fluid Myths in Hospital presentation within the recommended learning resource section

# Hospital Catering



- A la carte breakfast served by ward staff
- 2 week menu cycle, 2 courses each for lunch and dinner
- Patient Choice
- Alternative Menus
- Missed Meals/ New Admissions
- Hospital Catering Manager can be contacted at any time



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The food that we offer our patients in NHSGGC is cooked in house by our own staff in the two Cook Freeze Production Units at the Royal Alexandra Hospital and Inverclyde Royal Hospital, the dishes are made using fresh and where possible, local ingredients and then blast frozen before being regenerated 90mins before each mealtime.

Each day patients are offered an a la carte breakfast with tea or coffee, cereal, bread, toast (where available) and rolls.

Lunch and Dinner follow a two week menu cycle and two courses are offered at each sitting. It is important that every patient has the opportunity to select their own meal from the hospital menu.

For lunch, patients are offered homemade soup or fruit juice to start, followed by a choice of sandwiches, salad, filled baked potatoes or a hot meal with vegetables and potatoes. This is followed by a selection of desserts such as trifle, fresh fruit, yogurt, rice pudding, jelly and ice cream or cheese and biscuits.

In the evening there is a choice of hot meals with vegetables and potatoes or rice plus either a hot or cold dessert.

At each mealtime there is always a meal option for vegetarians, a healthier option and choice for those who need more calories.

Many patients require a special diet for medical, cultural, religious or other reasons.

Every meal time we provide a range of alternative menus to meet the needs of the more frequently asked for diets such as: Gluten free, Food allergies, Low Fibre/Low residue, Low potassium/No added salt, Vegan, Kosher, Halal, patients can ask for an alternative menu.

Catering can supply patients with food allergies alternatives to bread, milk and snacks such as gluten free bread, soya milk and yogurts – it is important to contact catering to organise this.

Patients can move wards or not be on the ward at the mealtime, they should not go without food, contact catering to see what's available (usually sandwich or a snack) until the next mealtime.

If the patient does not like the food or has a query, question or complaint please contact the hospital catering manager as soon as possible to that this can be resolved in a timely manner

For more detailed information on what catering provide speak to your ward catering assistant or you can find information available to the public on <https://www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-first/>

# Food Hygiene Legislation

- All aspects of hospital catering in NHSGGC (including ward kitchens) must comply with Food Hygiene Laws
- Each Food Handler is bound by the Food Hygiene Legislation
- Premises can be inspected by enforcement officers at any time (including ward kitchens)

## At ward level –food handlers must:

- Maintain high standards of personal hygiene; wash hands, keep hair back
- Be aware of the temperature controls for food
- Ensure patient eating areas are clean and tidy
- Ensure ward kitchens are kept clean and tidy
- Ensure food is stored appropriately (staff food should be stored separately from patient food) and that there is good stock rotation
- Ensure that monitoring and recording ward kitchen fridge temperatures is completed

Learn Pro GGC 146: Food Hygiene



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All aspects of our hospital catering (including ward kitchens) must comply with food hygiene laws and each food handler is bound by food hygiene legislation.

Any member of staff who gives food or snacks to patients must be aware of the standards described on the slide above. There is a learnpro module regarding Food Hygiene which you should aim to complete within your first 3 months of your new role

## Mealtimes

- **Prepare** patients for mealtimes - handwashing, patient positioning, eating area clean and tidy
- **Mealtime Coordinator** - one person on ward, usually HCSW, who will coordinate the mealtime for everyone
- During mealtimes- **assistance**, choice of drink, condiments
- After mealtimes - **mealtime sweep** to ensure everyone has a meal or an alternative is offered

For many patients mealtimes can be the highlight of their day and ward staff have a responsibility to ensure that all non-essential activity is stopped at mealtimes and staff are able to concentrate on supporting and helping patients to eat and drink.

The key points are described in the slide above

# Snacks

- Snacks for ALL
- Snacks for patients with a MUST of 1 or more

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### Snacks for ALL Patients

All patients who are hungry, have a small appetite, or need encouragement to eat should be offered a snack between meals from our ward provisions

At tea rounds why not offer a biscuit as well?

Cereal, bread with butter and jam and biscuits should be available at all times

In addition to tea and coffee, fruit squash can be routinely offered

Do your patients know fresh fruit is available on request?

**All pantries should have the following items available for patients:**

- Bread, butter/spread and preserves
- Biscuits (Custard Creams, Rich Tea & Digestives)
- Tea and coffee
- Milk
- Sugar/sweetener
- Hot chocolate
- Malted milk drink
- Fruit squash (Orange & blackcurrant)
- Cereal (Branflakes, Rice Krispies, Cornflakes, Wheat Biscuits)

To contact catering, call:

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As well as the food served at mealtimes we have a range of drinks and snacks available at all times – including tea, coffee, hot chocolate, fruit squash, bread, cereal and biscuits. This poster should be visible in each ward kitchen/ pantry, it highlights what's available at ward level that can be offered to support patients intake both at and between meals.

For patients who have a MUST score of 1 or more they are able to access one additional snack per day from catering using the MUST snack form.

Snacks include

- Pancake and Butter/Jam
- Scone
- Doughnut
- Full fat thick and creamy Yoghurt
- Crackers, Butter and Cheese
- Custard Pot
- Creamed Rice Pot

The order process for these snacks vary on each site so it is best to contact the local catering team

# Food and Drink Recording Chart

Why do we need to record intake for this patient?

Recording of between meal snacks are important for patients with a MUST of 1 or more

Guidance on what to record in the chart

Evaluation, so what? Is the amount eaten enough for the patient or do we have to change what we are doing as a result of this information

**Food and Drink Recording Chart**

Reason for recording intake: \_\_\_\_\_

Date: \_\_\_\_\_ Day Number: \_\_\_\_\_

Food and Drink Intake		Food and Drink Intake	
Breakfast:		Breakfast:	
Snack:		Snack:	
Lunch:		Lunch:	
Snack:		Snack:	
Evening Meal:		Evening Meal:	
Supper:		Supper:	
Overnight:		Overnight:	

Is the patient's intake 'normal' or improved for them?  
 Yes  No  Unsure

Continue:  Discontinue:

Rationale: \_\_\_\_\_  
 Signed: \_\_\_\_\_ Printed: \_\_\_\_\_

Is the patient's intake 'normal' or improved for them?  
 Yes  No  Unsure

Continue:  Discontinue:

Rationale: \_\_\_\_\_  
 Signed: \_\_\_\_\_ Printed: \_\_\_\_\_

FOOD FIRST logo and [www.nhsggc.org.uk/foodfirst](http://www.nhsggc.org.uk/foodfirst)

When someone is at risk of malnutrition it is important that we know how much they are eating so that we can work out if they are managing 'what's normal for them'. We use the Food and Drink recording chart to document any food and drink the patient consumes or refuses. This can support decision making regarding the need for more specialist intervention and dietetic referral. It also supports dietetic nutritional care planning and nutritional support strategies.

Its important to remember

- To record why the patients intake is being monitored
- To record amounts and volumes as specifically as possible and also when the patient does not want to eat what has been offered
- To record snacks and drinks between meals as these can make a significant difference to dietary intake
- To evaluate the chart using your clinical judgement and clearly documenting rationale for decision to continue or discontinue

## When to refer to the Dietitian?

- Inadequate intake after following MUST Step 5 management guideline
- Referral via TrakCare
- Continue to follow MUST Step 5 until assessed



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In some cases, patients may need referred to the Dietitian, before a referral can be made its important that a MUST score has been completed.

For those who are managing to eat and drink, there should be evidence of inadequate intake (of what's 'normal' for them) on a food and drink recording chart and the Food First approach has been followed along with the provision of the right level of assistance to eat and drink.

For those who are eating very little or nothing at all its important that you get advice or refer early regardless of the patients BMI or MUST score in case artificial nutrition support is appropriate.

A referral to the Dietitian is made via TrakCare, ask one of the nurses on the ward to talk you through your first referral. Once the referral has been received it will be added to the Dietitians' workload, the dietitians endeavour to see appropriate referrals within 3 working days. Whilst waiting for the patient to be seen by the dietitian its important to continue recording food intake and promoting the Food First ('little and often') approach.

For more information on the role of the dietitian and further food first resources visit the NHSGGC Dietitians webpage <https://www.nhsggc.org.uk/your-health/health-services/allied-health-professionals-ahps/dietetics/>

## Role of the Dietitian

- Assessment
- Treatment Planning
- Education
- Monitoring plan

Dietitians are qualified and regulated health professionals that assess, diagnose and treat dietary and nutritional problems.

They use the most up-to-date public health and scientific research on food, health and disease which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. They are members of multi-disciplinary teams which treat complex clinical conditions including malnutrition.

They **assess** patients unable to be nutritionally managed at ward level with MUST step 5 management guidance. By using the information gathered by ward staff, obtaining additional dietary information alongside medical treatment they will discuss with the patient what their needs are and how they may be able to support them in their recovery. After discussing with the patient and the multidisciplinary team they agree an appropriate **treatment** plan. They discuss this with the patient and inform the nursing staff of the agreed plan. For those who are nutritionally vulnerable they will put a **monitoring** plan in place. They also **educate** the patient, their family members and carers as appropriate to help them manage their nutritional requirements when they are discharged from hospital.

# Patients with swallowing difficulties

- Patient's swallow assessed with STOPSS
- Yellow Safer Swallowing Recommendations form indicates safe level of food and fluid the patient MUST receive
- Thicken fluids using Nutulis clear
- Level 4-6 individual menus
- Level 7 (Easy to chew) on the regular menu

**Safer Swallowing Recommendations**

Ward Use

Name:  CHI:

Date:  Ward:

**VISITORS:**

Please consult Ward Staff before giving any food or drink.

<p><b>Food</b></p> <p>Level 7 (regular Diet) <input type="checkbox"/></p> <p>Level 7 (Easy to Chew) <input type="checkbox"/></p> <p><small>Coded with ☺ (easy to eat/soft on standard menu)</small></p> <p>Level 6 (soft and bite-sized) <input type="checkbox"/></p> <p>Level 5 (minced and moist) <input type="checkbox"/></p> <p>Level 4 (pureed) <input type="checkbox"/></p> <p>Level 3 (liquidised) <input type="checkbox"/></p> <p>No Oral Food <input type="checkbox"/></p>	<p><b>Fluids</b></p> <p>Level 0 (Normal/Thin) <input type="checkbox"/></p> <p>Level 1 (slightly Thick) <input type="checkbox"/></p> <p><small>Nutulis Clear 1 scoop per 200mls</small></p> <p>Level 2 (Mildly Thick) <input type="checkbox"/></p> <p><small>Nutulis Clear 2 scoops per 200mls</small></p> <p>Level 3 (Moderately Thick) <input type="checkbox"/></p> <p><small>Nutulis Clear 3 scoops per 200mls</small></p> <p>Level 4 (Extremely Thick) <input type="checkbox"/></p> <p><small>Nutulis Clear 7 scoops per 200mls</small></p> <p>No Oral Fluids <input type="checkbox"/></p>
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- Sit upright at a 90 degree angle (as much as possible)
- Patient should be awake and alert
- Keep sat upright for 30 minutes after oral intake
- Maintain good oral hygiene

**Additional strategies**

Ward Staff (Name):  Designation:

Signature:

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Some patients may have problems with their swallowing which makes them more at risk of aspirating food into their lungs and causing an aspiration pneumonia. In patients where their swallowing is impaired, we screen them using the Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). STOPSS is a procedure for determining safety of swallowing. It is a set of decision making processes designed to establish the appropriateness of referral to Speech and Language Therapy (SLT) for formal dysphagia assessment. The STOPSS is not simply a Water Swallow Test.

If STOPSS indicates a referral to SLT, this referral can be made on TrakCare. The SLT will aim to see the patient within 2 working days and will assess the patients ability to swallow. At the end of this assessment the SLT will leave the patient with a Yellow Safer Swallowing recommendation sign above the patients bed, to indicate the most suitable and safe food and fluid the patient must receive.

Fluids are measured in Levels 0-4, these levels can be achieved by using a thickener called Nutulis Clear. The instruction of how to make up Nutulis Clear are on the side of the tin and also on the Safer Swallowing sign.

Food is indicated by levels 3-7, level 3 is very limited in choice and should not be the only source of nutrition for the patient (they should also be referred to the dietitian). Level 4-6 diets are ordered from an individual menu and Level 7 Easy to Chew can be ordered on the standard patient menu Level 7 Easy to chew is indicated by a smiley face on the standard patient menu.

The SLT may also ask for particular strategies to be used to support the patient to eat and drink e.g. Head in a particular position when drinking and its important that these strategies are followed to ensure patient safety.

More information about the role of the SLT and supporting patients with swallowing difficulties can be accessed by watching the 12 min video entitled Communication and Swallowing difficulties which is in the recommended learning section of the induction page. If you have any questions about the Safe swallowing recommendation please ask at ward level or contact your local SLT department for advice

# Specialists

- **Dietitian**
  - Assess patients at high nutritional risk
  - Can recommend additional foods or supplements if required
  - will record supplements on the Drug Kardex
  - Assess patients requiring artificial nutrition support (e.g. nutrition via a nasogastric tube)
- **Speech and Language Therapist (SLT)**
  - Assess patients who have failed STOPSS and determine a safe level of Food and Fluid for the patient
- **Nutrition Support Team**
  - Provide support and guidance to staff and patients who require complex nutrition e.g. enteral or parenteral nutrition



[www.nhsggc.org.uk/foodfirst](http://www.nhsggc.org.uk/foodfirst)

Nutritional care is everyone's business and there are a number of specialists available to contact who can support you care for patients who may not be able to eat and drink ('what's normal for them')

Each hospital site will have access to Dietetics, SLT, Nutrition Nurse Specialist and the Nutrition Support Team. These specialists all play an important role in supporting patients with the most appropriate food, fluid or artificial nutrition support- find out locally how you can make contact with them

## What do we need 'YOU' to do

- Accurate and timely nutritional screening
-  approach
- Timely and appropriate referral

As a newly qualified staff nurse or an experienced staff nurse new to the organisation we need YOU to ensure that our patients are provided with safe, effective and person centred-nutritional care during their stay in hospital. Our role as nurses is crucial, we identify those patients at risk of malnutrition through **accurate and timely nutritional screening** and act of the outcomes detailing the interventions within the patient care plan. Most importantly we support patients with the **food first approach**, allowing them to eat and drink 'what's normal for them'. When patients are not able to do this we **refer onto specialists** such as the dietitian, speech and language therapist or nutrition support team for further assessment and interventions. By doing this we have the opportunity to help patients recover from illness or surgery and support a quicker discharge from hospital.

Thank you for taking the time to read through this presentation