

Steps**Method**

A. NUTRITION

- Nutrition for the elderly is as important for health as for the younger person even though they are not as active.
- Residents' nutritional needs include:
 - The same amount of vitamins and minerals as for any age with an increased need for calcium
 - Protein (1g/kg of ideal body weight) for tissue repair and maintenance
 - High calorie requirements due to medical conditions particularly dementia and Parkinson's Disease where there is constant involuntary movement or wandering. Low fat and sugar free meals and snacks are not recommended for the elderly.^{1(p.119)}
- Better health is achieved by maintaining weight or by being slightly overweight.^{1(p.119),4}
- Residents are offered a variety of nutritious meals and snacks and drinks to maintain weight and to ensure optimum physical and mental function, and increased resistance to infection.
- The Australian Guide to Healthy Eating for people over the age of 70yrs with respect to the numbers of serves for each food group per day is encouraged²:

Food group and serves for > 70 yrs	Women	Men
Vegetables and legumes/beans	5	5
Grains (cereal) foods, mostly wholegrain and/or high cereal fibre	3	4.5
Milk, yoghurt, cheese	4	3.5
Fruit	2	2
Lean meat, poultry, fish, eggs, nuts & seeds & legumes/beans	2	2.5

- Refer also to [Catering Services \(26.0\)](#), [Continence Management \(41.7\)](#), [Mobility and Falls Prevention \(41.9\)](#), [Care of a Resident with Diabetes \(41.15\)](#).

B. HYDRATION

- Residents may have a diminished thirst perception and should be offered 1,500 – 2,000mls (or 30ml/kg/d) per day, to maintain a urinary output of 1,200 – 1,800ml per 24 hours.^{3(pp.70-71)}
- Inadequate fluid intake or losses of fluid (dehydration) can occur quickly in the elderly;
 - from sweating in hot weather
 - with air conditioning/heating systems

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- with some medications such as, diuretics
 - if the resident has to rely on staff to assist
 - if the resident limits intake to limit trips to the toilet or episodes of incontinence
 - if the resident has swallowing disorders
 - if the resident has dribbling/drooling
 - when there is sensory loss.^{1(p.6)}
- Actions staff should take to reduce the risk of dehydration:
 - Offer fluids including thickened fluids regularly throughout the day and provide assistance as required
 - Offer fluids after each time the resident has been to the toilet
 - Encourage a glass full of fluid with medications
 - Encourage high fluid foods like soup, ice-cream, stewed fruit
 - Serve soup in a mug if a resident is unable to use a spoon
 - Serve fluids at the resident's preferred temperature.^{1(p.7)}
 - Encourage ice blocks, icy poles and ice creams in the hotter weather or if a resident's input is reduced. Refer also to the [Heat Wave procedure \(22.7\)](#).
 - Monitor input and / output on a [Fluid chart on Manad](#) to assess hydration.
 - Signs of dehydration include; dry mouth and lips, weakness, fatigue, sunken eyes, increased pulse and respiratory rate, with a decreased blood pressure, confusion, strong smelling, dark urine, reduced urinary output and constipation.^{1(p.6),3(p.70)}
 - If a resident is showing signs of dehydration offer frequent drinks of a variety of fluids at the preferred temperature and reduce coffee intake as it acts as a diuretic.
 - Commence a [Fluid chart on Manad](#) to monitor input and output. Contact resident's medical practitioner for large or consecutive negative fluid balance.
 - Refer also to the [Heat Wave procedure \(22.7\)](#) for heat related illness.
 - Some residents may be placed on fluid restrictions by their medical practitioner for example; 1000ml/day.
 - A Restricted Fluids Plan is developed in consultation with the resident/representative to allow for the resident's preferred meals and drinks to be catered for within the fluid restriction.

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- C. NIL ORALLY
- Some residents may not be able to have food or fluid (nil orally) before prior to a pathology test or they may be receiving enteral nutrition.
 - Nil orally is also communicated to care staff on the Handover and catering staff on the [Resident's Dietary alteration form \(41.5.2\)](#)
- D. ASSESSMENT
- The Nutrition and Hydration Assessment on Manad is used to identify residents';
 - current diet and assistance requirements
 - Nutritional status – weight assessment.
 - A set of baseline vital signs, weight and height are taken on admission. Refer to the Weight Monitoring section below.
 - The [Resident Dietary Alteration notice form \(41.5.2\)](#) is used to identify residents' needs and preferences related to;
 - type and texture of meals and drinks
 - special dietary requirements
 - size of meals
 - likes and dislikes for food and drinks
 - cultural/religious requirements
 - preferences related to breakfast, lunch and evening meals including location. A copy is provided to the kitchen and a copy is scanned into the residents file on Manad.
 - A 3 day Food and Fluid intake Chart on Manad is completed to identify the level of assistance required.
 - This information is summarised on the Nutrition and Hydration Assessment on Manad and in the progress notes.
 - If changes occur during or after assessment staff are to complete a [Resident Dietary Alteration notice form \(41.5.2\)](#). A copy goes to the kitchen and another copy is scanned onto Manad into the residents file.
 - For respite residents complete the [Resident Dietary Alteration notice form \(41.5.2\)](#) form and the [Resident Dietary Requirements form \(41.5.1\)](#).
 - Assessment data is used to formulate a Care Plan on Manad, Nutrition and Hydration section in partnership with the resident/representative to ensure the resident receives adequate nourishment and hydration according to

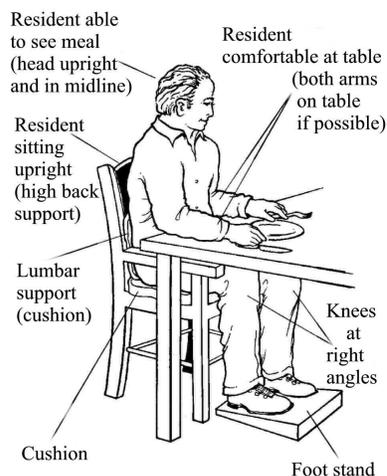
Steps**Method****E. STRATEGIES & INTERVENTION**

From: Johns, K., Dixon, K. and Bennett, N. 1993, *Mealtime Issues for the Elderly*, Julie Farr Centre Foundation, Unley.

her/his health status and individual preferences.

- Other members of the health care team are involved, in consultation with the resident/representative as appropriate, such as, the dietitian, dentist, dental technician, speech pathologist, occupational therapist.
- A range of assistive devices are provided to assist residents to maintain independence with meals and drinks.
- Speciality assistive devices require an Occupational Therapist assessment.
- There are a wide range of reasons why a resident may not be able to be independent at meal times or maintain adequate dietary intake for example;
 - Sensory loss such as; vision impairment, a decline in smell and taste,
 - Hand tremor
 - Physical disability
 - Pain
 - Discomfort whilst chewing
 - Ill fitting dentures
 - Dry mouth due to less saliva
 - Decreased intake due to constipation
 - Memory loss
 - Agitation and confusion
 - Depression causing loss of skill
 - Posture inhibiting poor dietary intake
 - Reduced ability to swallow
 - Illness such as; UTI, chronic wound
- Refer also to [Oral & Dental Care \(41.10\)](#) and [Communication and Sensory Loss \(41.11\)](#).
- Care staff provide residents assistance according to their individual requirements to maximise independence, dignity, safety and enjoyment at meal times.
- Assistance with meals and drinks includes but is not limited to;
 - Varying the shape, size and colour of the crockery and good presentation of food. Refer to [Catering Process \(26.0\)](#).
 - Appropriate texture of food and fluids including finger foods for those with a need
 - Positioning in chair or in bed. Refer to diagram opposite.

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Adapted from: Johns, Dixon & Bennett
1993, p.70.

Where ever possible wheelchairs must only be used to transport residents to the meal table and not to sit in them during the meal. The reason is that the resident may not be able to be seated in a good position for eating in the wheelchair and the wheelchair depicts the “sick role” which negatively impacts on the resident’s dignity.

- Appropriate cutlery and tableware/assistive devices e.g. 2 desert spoons, plate guard, cup with a spout
- Verbal prompting
- Setting up
- Encouraging to eat and maintain independence
- One to one assistance with all meal time activities
- Reducing noise and minimise distractions
- Providing soft, relaxing music
- Removing covers/opening packets
- Providing 1:1 physical assistance
- Providing 1 course at a time to reduce distraction
- Monitoring residents who have difficulty detecting hot and cold
- Monitoring residents at risk of choking.

F. SWALLOWING

- Residents’ ability to manage their food and drinks is monitored on a day to day basis.
- Signs of swallowing problems include;
 - Coughing or choking whilst eating although, aspiration can be silent.
 - Decrease in cough / gag reflex
 - Chest infections
 - Drooling and constant open mouth
 - Taking longer to eat
 - Messy eating
 - Moist voice after swallowing
 - Needing to chew more.^{3(p.33)}
- Staff need to be alert during meal and drink times to monitor residents’ safety and to administer first aid if required for aspiration or choking.
- There must be at least 1 care staff member in the dining room with residents at all times during meals and drink times.
- In addition, staff must monitor residents eating and or drinking in their rooms.
- When a resident has chewing or swallowing difficulties a

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review by a Speech Pathologist occurs in consultation with the resident/representative.

- If required, texture modified food and or thickened drinks are provided according to the Speech Pathologist recommendations for example;
 - **Meal texture;**
 - **Unmodified/regular food:** which is of various textures such as; hard, crunchy, soft
 - **Soft:** which may be naturally soft or cooked/cut to modify the texture
 - **Minced and Moist:** food can be mashed easily with a fork, lumps are smooth and rounded
 - **Smooth Pureed:** food is smooth, moist, lump free however may have a grainy quality.⁴
 - **Thickened fluid levels of modification;**
 - **Unmodified / regular:** Levels of thickness can vary from thin (water) to thicker (fruit nectar)
 - **Mildly Thick:** Runs freely from a spoon but leaves a mild coating on the spoon
 - **Moderately Thick:** Slowly drips in dollops off the end of a spoon
 - **Extremely Thick:** Sits on a spoon and won't flow off it.^{4,5}
 - Refer to the [Australian Standards for Texture Modified Foods and Fluids Poster](#).

G. SMELL & TASTE

- Changes in smell and taste can result in a loss of appetite and enjoyment of food which can lead to weight loss and malnutrition.^{6(p.2)}
- Refer also to [Communication and Sensory Loss \(41.11\)](#)

H. DINING ENVIRONMENT

- Catering, care and lifestyle staff can assist residents to enjoy their dining room experience in the following ways:
 - Providing coloured tablecloths and flowers/table ornaments
 - Having soft background music
 - Giving residents a choice of seating arrangements
 - Providing residents with assistance as needed during meal times
 - Working together to provide alternative settings e.g. BBQ lunch or morning/afternoon tea in the garden
 - Working together to assist with special events e.g. birthdays, cultural and religious celebrations.⁷



Steps**Method****I. VOMITING & DIARRHOEA**

- Refer also to [the Leisure, Interest and Activities Program \(42.3\)](#).
- If a resident has vomiting or diarrhoea she/he should be assessed by a Registered Nurse and/or the attending medical practitioner.
- For vomiting stop all food including milk and commence on clear fluids, lemonade, ice and or icy poles. Gradually increase to free fluids and soft to normal diet as tolerated.
- For diarrhoea unless contraindicated stop all food, including milk and commence;
 - Gastrolyte 1-2 sachets (1 sachet to 200ml of water) after each bowel motion to replace fluid and electrolyte loss. Follow the instructions in the packet or on the bottle.
Check the Consumer Product Information sheet for medication contraindications prior to commencing Gastrolyte. Check with the pharmacist or medical practitioner if unsure.
 - Commence on ice to suck, icy poles and or sips of lemonade.
 - Day 2 – Gradually return to normal diet by reducing the gastrolyte and increasing fluids and diet, such as, clear soup, jelly, lemonade, ice, icy poles, then toast and cereals.
- Contact the resident's medical practitioner if the vomiting or diarrhoea has not eased within 24 hours, or sooner if resident's condition deteriorates significantly.
- Refer also to [Care of Resident with Diabetes \(42.15\)](#) and [Gastroenteritis Outbreak Management \(23.2\)](#).

J. WEIGHT MONITORING

- When weighing a resident it is important that staff have the competence to perform this task and ensure that;
 - The resident is weighed before breakfast after going to the toilet.
 - The resident is weighed in the same clothing, usually in her/his underwear. Continence pads should not be wet or soiled as this will add to the weight. And drainage bags should be empty.
 - The resident is weighed on the same scales (floor, chair, lifter with scale) each time she/he is weighed
 - The scales are functioning correctly by turning them on and checking that they are displaying zero.⁷
 - Equipment is held by a staff member to ensure it does not add to the resident's weight

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- The weight is read correctly in kilograms to 2 decimal points e.g. 64.25kg.
- If the resident is unable to stand or if there is severe curvature of the spine height is calculated using Ulna Length and the corresponding reference table
- The resident's Body Mass Index (BMI) is then calculated by the dietician using the below formula. BMI provides a ratio of weight and height rather than relying on weight alone.^{3(p.120)}

$$\frac{\text{Weight (Kg)}}{\text{Height (m)}^2}$$

- Baseline weight and BMI is recorded on the: reportable levels on the weight chart and in the residents progress notes.
- Health monitoring of vital signs and weight occurs monthly or when directed to by Allied Health Professional and is recorded on the:
 - Weight Chart on Manad
 - Mini Nutritional scale on Manad
 - Observation chart on Manad

K. WEIGHT MANAGEMENT

- Unintentional weight loss is a serious problem as malnutrition is associated with; a reduced immune response, impaired muscle and respiratory function, slow wound healing and death.
- Early recognition and correction of weight loss is important. It is often easier to stop a resident losing weight than getting them to regain lost weight.^{3(p.120),4}
- Unintentional weight loss occurs when calorie intake is less than the body's requirements. The cause can be varied for example; eating difficulties, wandering, and excessive involuntary movements.^{3(p.119)}
- Unintentional weight gain occurs when caloric intake exceeds the body's requirements. The cause can be varied from example; increased appetite, eating extra foods high in fat/sugar, reduced exercise.
- However, overweight does not necessarily equate to being well nourished, it may be due to oedema associated with low albumin in the blood.^{3(p.119)}
- Implementing a weight reduction diet should occur with Dietician advice as weight loss is often associated with

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muscle wasting and not necessarily fat loss.

- Health monitoring includes the calculation of Mini nutritional cart on Manad to be completed monthly. This chart will automatically give you the residents BMI.
 - If there has been a change in weight from the previous monthly weight refer to the dietician if weight loss is > 2 kg or < 2kg
 - A Registered Nurse can initiate additional snacks for short term issues however referral to a Dietician should be made where a resident has renal impairment
 - A referral to a dietician should be considered for all incidence of unintended weight loss.⁷
 - Nutritional supplements such as; Sustagen, Nutrica Pudding must only be commenced on the advice of a Dietician.
 - When nutritional supplements are commenced the supplement intake for each resident is recorded on the Meal planning form on Manad under assessment and supplements.
 - When the resident and resident documents are reviewed monthly for ROD the supplements and weights are reviewed and outcomes are documented in the progress notes.
- L. REVIEW & EVALUATION
- When exceptions to the care plan occur these are documented in the progress notes.
 - Resident's nutrition and hydration review and care plan evaluation includes:
 - Weight management monthly. Refer to the Weight Management section above.
 - Ability to manage the current texture of food and fluids
 - Consideration of the requirement of high energy – high protein diet for wound healing
 - Consultation with the resident/representative and other members of the health care team members, as appropriate.
 - Changes to the care plan occur as necessary in partnership with the resident/representative.
 - Changes are communicated to the kitchen by the nurse/carer in charge, using a [Dietary Alteration Notice form \(41.5.8\)](#).

Steps**Method****References**

- ¹ Bartl, R. and Bunney, C. 2004, *Best Practice Food and Nutrition Manual for Aged Care Facilities*, Gosford ANHECA, Central Coast Health, , p.6.
- ² NHMRC, Feb. 2013, *Australian Guide to Healthy Eating*, Eat for health and wellbeing brochure, available at: http://www.nhmrc.gov.au/files/nhmrc/publications/attachments/n55g_adult_brochure.pdf
- ³ Kilworth, L. Nutrition, in Carmody, S. and Forster, S. 2003, *Aged Care Nursing, A Guide to Practice*, Ausmed \ Publications, Melbourne, p. 66.
- ⁴ DAA, September 2009, *Nutrition Manual*, edn. 8, Dietitians Association of Australia.
- ⁵ DAA and SPA, Australian Standards for Texture Modified Foods and Fluids, Poster, 4/11/2009 available at: http://www.daa.asn.au/files/Info%20for%20Professionals/Texture_Mod_Poster.pdf
- ⁶ Joanna Briggs Institute, Evidence Summary: Taste and Smell Assessment, 15 December 2008, (21/2/2012) available at: http://www.jbiconnect.org/connect/docs/cis/es_html_viewer.php?SID=6780&lang=en®ion=AU
- ⁷ DoHA 2009, *Encouraging best practice in residential aged care: Nutrition & Hydration, Tool Kit Introductory Materials*.
- ⁸ Leading Nutrition, The Dietitian Centre, 2013, *Diet Manual for Aged Care, A guide to modified diets with sample meal plans for residential aged care*, Melbourne. www.leadingnutrition.com.au

Further References

- DoHA, Standards and Guidelines for Residential Aged Care Services Manual (St. 2.10, 3.8,4.8), available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/Residential+Care+Manuals-1>
- DSS, The Residential Care Manual, Jan 2014, Classification of Residents, available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/Residential+Care+Manuals-1>