

# Nutritional Assessment

## The need for nutritional assessment

The National Minimum Standards and Care Homes regulations require Homes to assess the needs of the service users. Standard 3.1 states that: -

New service users are admitted only on the basis of a full assessment undertaken by people who are trained to do so, and to which the prospective service user, his/her representatives (if any) and relevant professionals have been party. While Standard 3.3 details the areas that such an assessment must cover and clearly states that it includes diet and weight, including dietary preferences.

It is therefore necessary to use a simple screening tool to identify the nutritional risk of service users, both existing and new. From this information it is then possible to ensure that their nutritional needs are met.

## How to assess the nutritional risk

The screening tool has been developed by the Community Dietician for Southern Derbyshire Health Authority and is an adapted version of the one used in hospitals. The Manager using information from the Service User their family and/or carers must complete the assessment, which is in two parts.

Part 1 - records general information about the service users, their eating patterns, likes, dislikes and other dietary information.

Part 2 - requires more detail that allows the manager to identify the nutritional risk category for each service user i.e. high, medium or low.

## Action following the assessment

Having identified the nutritional risk of each service user the 'Nutritional Guidance Risk Chart' outlines the most appropriate course of action.

An important part of the assessment process is to record the weight of each service user. It is best to weigh an individual dressed and with their shoes on at approximately the same time of day on the same scales to ensure the accuracy of the measurement. This information must be recorded on the 'Weight Recording Chart'.

Service users who are found to be in the high and medium risk categories need to have their food intake monitored for 3 days. This needs to be a very accurate record of the food that an individual consumes rather than is offered. Therefore it must be very specific i.e. ½ slice of white bread, teaspoon of jam, ¼ cup of tea. This information needs to be recorded on the Food intake chart.

If it is necessary for a doctor or a dietician to visit a resident because there is concern for their nutritional risk, copies of the following must be made available to them: -

- Nutritional Assessment Forms
- Weight Record Chart
- Food Intake Charts

It is advisable to retain the assessment, weight recording chart and any food intake charts in a specified place e.g. as part of the residents care file or a separate 'Nutrition' file.

## Nutritional Assessment - Part 1

This assessment must be completed when a new resident is admitted.

Home		Date of birth	
Name		Room number	

### General Questions

Do you usually eat?

	Yes	No
Breakfast		
Mid-day meal/lunch		
Tea/evening meal		

Has your weight changed in the last year?

	Yes	No
Gained weight		
Lost weight		

Are you on a diet? (This includes any cultural or religious diets)	Yes	No
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If yes, what type.....

Are there any foods that you either can't eat or don't like to eat?	Yes	No
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If yes, what type.....

Are you taking any food/drink supplements?	Yes	No
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If yes, what type.....

Are you taking any laxatives, vitamin supplements, cod liver oil, iron tablets etc.	Yes	No
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If yes, what type.....

Are you taking any prescribed medicines?	Yes	No
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If yes, refer to medical records

How many cups of tea/coffee/juices/water do you drink daily?	
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**The next sections are a more in depth analysis to identify an individuals nutritional risk. To complete it: -**

- Circle a score from each section
- Select the highest score that applies
- Add up the circled figures to determine a total Score
- Weigh the resident and record this on both the Nutritional Assessment and Weight Recording chart.

Remember a resident can be nutritionally at risk although they are overweight, especially if they are over 75.

**Nutritional Assessment, Part 2 – Initial Assessment.**

Date.....Completed by.....(Unit Manager)

	<b>Initial Assessment</b>
<b>Section 1 – Body weight</b> <ul style="list-style-type: none"> <li>▪ Female age 75+ less than 45Kg. (7st)</li> <li>▪ Male 75+ less than 53 Kg. (8st 5lb)</li>   <li>▪ Female age 55-74 less than 50Kg. (7st 10lb)</li> <li>▪ Male age 55-74 less than 57 Kg. (9st)</li>   <li>▪ No weight problem</li> </ul>	 2  1  0
<b>Section 2 – weight loss in last 3 months (Unintentional)</b> <ul style="list-style-type: none"> <li>▪ 6 Kg or more (1 st)</li> <li>▪ 3- 5.9Kg weight loss ( ½ - 1 st)</li> <li>▪ 0-2.9 Kg weight loss ( ½ st)</li> <li>▪ No weight loss</li> </ul>	 3 2 1 0
<b>Section 3 – Appetite</b> <ul style="list-style-type: none"> <li>▪ Appetite virtually nil or unable to eat</li> <li>▪ Poor appetite, poor intake – leaving half of meals provided</li> <li>▪ Good appetite</li> </ul>	 3 2 0
<b>Section 4 – Ability to eat</b> <ul style="list-style-type: none"> <li>▪ Unable to take food orally, unable to swallow, severe vomiting and/or diarrhoea. ( More than 2-3 times a day)</li> <li>▪ Difficulty in swallowing, requiring modified consistency. Problems with dentures/teeth/gums affecting food intake. Moderate vomiting and/or diarrhoea. (More than once a day) Needs help feeding.</li> <li>▪ Assistance and encouragement required Problems handling food, e.g. needs adapted cutlery</li> <li>▪ No difficulties eating</li> </ul>	 3  2  1  0
<b>Section 5 – Other factors</b> <ul style="list-style-type: none"> <li>▪ Severe: Multiple injuries, infections, fractures or burns. Cancer</li> <li>▪ Moderate: Major surgery, moderate infections, fractures, pressure sores/ulcers, digestive disorders, bereavement, depression or mental ill health.</li> <li>▪ Mild: Minor surgery, infections,(temperature or fever) stroke, diabetes, alcohol.</li> <li>▪ No other factors</li> </ul>	 3 2  1  0
<b>Score</b>	
<b>Body weight (Kilos)</b>	

**Now refer to the Nutritional Risk Guidance Chart**

**Nutritional risk identified**    Low             Medium             High   
 (please tick appropriate box )

**Aids required as identified in section 4.....**

**Nutritional Assessment, Part 2 - Re-assessments sheets**

Completed by.....(Unit Manager)

<b>Date of reassessment</b>					
<b>Section 1 – Body weight</b>					
▪ Female age 75+ less than 45Kg. (7st)	2	2	2	2	2
▪ Male 75+ less than 53 Kg. (8st 5lb)					
▪ Female age 55-74 less than 50Kg. (7st 10lb)	1	1	1	1	1
▪ Male age 55-74 less than 57 Kg. (9st)					
▪ No weight problem	0	0	0	0	0
<b>Section 2 – weight loss in last 3 months (Unintentional)</b>					
▪ 6 Kg or more (1 st)	3	3	3	3	3
▪ 3- 5.9Kg weight loss ( ½ - 1 st)	2	2	2	2	2
▪ 0-2.9 Kg weight loss ( ½ st)	1	1	1	1	1
▪ No weight loss	0	0	0	0	0
<b>Section 3 – Appetite</b>					
▪ Appetite virtually nil or unable to eat	3	3	3	3	3
▪ Poor appetite, poor intake – leaving half of meals provided	2	2	2	2	2
▪ Good appetite	0	0	0	0	0
<b>Section 4 – Ability to eat</b>					
▪ Unable to take food orally, unable to swallow, severe vomiting and/or diarrhoea. ( More than 2-3 times a day)	3	3	3	3	3
▪ Difficulty in swallowing, requiring modified consistency. Problems with dentures/teeth/gums affecting food intake. Moderate vomiting and/or diarrhoea. (More than once a day) Needs help feeding.	2	2	2	2	2
▪ Assistance and encouragement required Problems handling food, e.g. needs adapted cutlery	1	1	1	1	1
▪ No difficulties eating	0	0	0	0	0
<b>Section 5 – Other factors</b>					
▪ Severe: Multiple injuries, infections, fractures or burns. Cancer	3	3	3	3	3
▪ Moderate: Major surgery, moderate infections, fractures, pressure sores/ulcers, digestive disorders, bereavement, depression or mental ill health.	2	2	2	2	2
▪ Mild: Minor surgery, infections,(temperature or fever) stroke, diabetes, alcohol.	1	1	1	1	1
▪ No other factors	0	0	0	0	0
<b>Score</b>					
<b>Body weight (Kilos)</b>					

Now refer to the Nutritional Risk Guidance Chart

Record any change in the nutritional risk

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Aids required as identified in section 4.....

## Nutritional Risk Guidance Chart

### High Risk – Scored between ( 6 – 14 )

- Refer to G.P. or Primary Health Care Team.
- Assist the resident to eat and drink.
- Offer additional snacks and beverages between meals, see suggestions below, and assist in food choice.
- Record food/fluid intake for 3 days.
- Educate resident and relatives as to the importance of food.
- Re-assess weekly.

### Medium Risk – Scored between ( 4 - 5 )

- If resident is regularly not eating 2 full meals a day offer additional snacks
- Assist food choice and encourage eating at meal times with snacks as necessary.
- Record food and fluid intake for 3 days.
- Weigh resident weekly and record result.
- Educate resident and relatives as to the importance of food.
- Re- assess monthly. Refer to GP or Primary Health Care Team if score does not improve.

### Low Risk – Scored between ( 0 - 3 )

- Weigh resident monthly and record result.
- If there has been a significant weight loss or gain (3 kg/6 ½ lb.) or there are other areas of concern e.g. loss of appetite; re-assess weekly.

## Suitable Snacks

The following snacks are suitable to serve between meals to a resident who has been identified as being at high or medium risk.

- |                                     |                             |
|-------------------------------------|-----------------------------|
| Buttered toast                      | Buttered tea cakes          |
| Buttered crumpets                   | Fruit loaf                  |
| Ginger bread                        | Drop scones                 |
| Cereal bars                         | Cheese on toast             |
| Muesli bars                         | Marmite on toast            |
| Pate on toast                       | Dried apricots and prunes   |
| Biscuits with butter eg digestive   | Cheese and biscuits         |
| Bowl of cereal with full cream milk | Yoghurt/rice desert         |
| Sandwich                            | Buttered malt loaf          |
| Milky drink/milk shake              | Instant soup made with milk |
| Peanut butter on toast              |                             |



## Food Intake Chart - Service Users at high and medium risk

Name .....

Room.....

Date.....

***Give careful description of the type and quantity of food in handy measures e.g. slices, scoops, tablespoons and teaspoons. For drinks state cup, mug, glass etc.***

	Food/Drink Supplements/ Snacks	Quantity Eaten or Drunk	Comments	Completed by
B R E A K F A S T				
Mid am				
L U N C H				
Mid pm				
T E A  T I M E				
Bed time				