Unit Manager Operating Guidelines for People Living with Dementia

Dignified Dining

COMPASS GROUP

Contents

Acknowledgements

Project lead:

Rachel Chamings, Contract Director, Senior Living, Compass Group, UK and Ireland

Lead Technical Authors:

Maxine Cartz, Registered Dietitian, Healthcare, Compass Group, UK and Ireland
Helen Ream, Registered Dietitian, Senior Living, Compass Group, UK and Ireland

With contributions from:

Allan Brazier, Operations Director Senior Living, Compass Group, UK and Ireland
Leon Jones, Group Manager, Senior Living, Compass Group, UK and Ireland

Review of the research conducted by Lucie Nield (MSc, MPhil, PGDip, RD, RNutr. (Nutritional Science)) , Dr Cecile Morris (FIFST, FHEA) and Norman Dinsdale (MBA, PgCert (HACCP), MIH, Master Chef of Great Britain) from Sheffield Hallam University

The Dementia and Nutrition Report published by Compass Group and Alzheimer's Disease International for providing an in depth overview of all available evidence regarding nutrition to the onset and clinical progression of dementia, alongside best practice to improve nutritional care for individuals living with dementia

With thanks to:

We extend our thanks to Lee Martin for his kind permission to reproduce the Dementia Meal Assessment Tool.

We also extend a special thank you to the Alzheimer's Society for training our people to become Dementia Friends and helping us gain a better understanding of how to support individuals living with dementia.

Preface

The Dignified Dining toolkit outlines our approach to providing nutritional care to people who are living with dementia. It outlines our 10 nutritional care guidelines which will be rolled out throughout our healthcare business. It also provides guidance around menus and menu planning, food service and the environment in which food should be served. There are also a number of tools included that can be used to support the nutritional care of people living with dementia.

This toolkit has been piloted within two care homes. The results of this pilot have demonstrated that the toolkit helped us to facilitate individiualised nutritional care to the residents of the two homes. We look forward to seeing further positive results as a result of using this toolkit in the future.

This document was produced by a working group comprised of registered dietitians and experienced operators and managers from within Compass Group UK and Ireland and Ireland healthcare and senior living sectors. It was critiqued by representatives from Sheffield Hallam University and the Alzheimer's Society. The principles within were trialled at 2 pilot sites Eachstep CIC and Queen Elizabeth Court RMBI Llandudno; we express our thanks for all the support of the teams there.

Introduction

What is Dementia?

Dementia is a syndrome which affects memory, thinking behaviour and the ability to perform everyday activities. It is usually chronic or progressive by nature and is caused by a variety of brain illnesses of which Alzheimer's and vascular dementia are the most common[1]. It is estimated that 850,000 people in the UK[2] and 44 million people worldwide are living with dementia, and that worldwide 7.7 million new cases are diagnosed each year[1].

One of the main features of dementia is a loss of cognitive abilities which is severe enough to interfere with social or occupational functioning. Cognitive abilities include memory, thinking, learning, attention and concentration, orientation, problem-solving, calculation, language and judgement. It is also common to see a change in emotional control, social behaviour or motivation whereby people can become anxious, restless, agitated, or conversely they can lack motivation and show signs of depression or blunting of emotional responses. Dementia therefore affects people in different ways and it is essential that any care provided is tailored to individual needs as much as possible.

This toolkit is designed to help the organisations and individuals caring for people with dementia to improve the quality of life of those within their care. As caterers providing a service to people in hospitals or residents in care settings, our aim is to provide good quality food that will be eaten, enjoyed and which fulfils individual nutritional and social requirements. Food contributes enormously to health outcomes and quality of life and we therefore have an important contribution to make to the quality of care that our clients with dementia receive. This document will give guidance and provide examples of best practice on our commitments as a food and food service provider. Much of this paper relates to food and beverage services and it brings together guidance from a number of documents and research papers.

Our 10 Nutritional Care Guidelines for People Living with Dementia

1. **Nutrition and Nutritional Capability** – Our menus will reference and comply with the guidance in the NACC Nutritional Standards for Adults[3] and the BDA Nutrition and Hydration Digest[4]. Our menus will be checked and approved for suitability and ability to meet these national standards by our Healthcare dietitians, registered professionals with experience in the nutrition and dietetic aspects of food service.

2. **Supporting Malnutrition** - Our teams will support those people who need nutrition intervention and will work with carers and nursing teams to ensure people's individual nutritional needs are met. This will include adhering to local protocols for screening, monitoring intake and the provision of appropriate food and drink.

3. **Training** - All our teams working in environments will be suitably trained to understand the implications of dementia and the actions required for meeting nutritional needs. Where appropriate, training will be accredited by national dementia organisations.

4. **Environment** - We will fully support and encourage facilities and an environment conducive to allowing people to eat well in pleasant and encouraging surroundings. This will include the cessation of distracting activities, the reduction of inappropriate and distracting noise during mealtimes, and the provision of appropriate equipment to support and encourage eating.

5. **Choice and Variety** – Our menus will provide suitable choices for the person with dementia and we will ensure that there is sufficient variety to cope with extended lengths of stay, differing personal preferences and eating patterns. They will also meet the needs of people with special dietary requirements including those with diabetes, food allergies, dysphagia, individuals requiring fortified/higher energy diets and meals for cultural or religious preferences. Menus will also support food provision in different formats and textures including finger foods and modified textures.

6. **Menus** – The style and provision of menus will be appropriate for people with dementia, care staff, visitors and relatives. Menus will be attractively presented and displayed appropriately using large print, translated into appropriate languages and offering pictorial or photographic representation as appropriate in each setting.

7. **Availability** – People with Dementia will be offered a replacement meal (or snack) if they miss a meal/eating opportunity and this will be provided 24 hours a day, 7 days a week, in all circumstances.

8. **Respect** - Individuals food preferences, whether personal, cultural or medical will be respected and provided for appropriately. Personal preferences will be respected and tools will be put in place to ensure this guidance can be met.

9. **Quality and Customer Care** – By working as an integral part of the care team we will always strive to ensure the person with dementia receives good quality food, which is attractively presented and served in a manner which will encourage their intake, in order to prevent the risk and development of malnutrition.

10. **Review and Observation** – We will develop and conduct reviews and audits to monitor our practices and ensure we are meeting our standards of good nutritional care through food and beverage provision.

1.1 Diet and Nutrition

Dementia can greatly affect a person's relationship to food and eating. As dementia progresses, eating can become more difficult, and weight loss more prevalent, the reasons for which are multi-factorial. Possible causes of this can be linked to brain damage and its effect on appetite control, cognitive impairment e.g. forgetting to eat and reduced ability to prepare food; psychological symptoms including apathy and a disinterest in food; behavioural symptoms leading to aversive feeding behaviours, and social factors[1].

Research has also been conducted on changes in the ability to taste and smell and the effect this has on eating patterns in a person with dementia. Although much more research is required in this area, it is understood that people with dementia may have a diminished ability to detect odours and recognise familiar foods. It is assumed that these could be two contributing factors for reduced food intakes in people with dementia, however adding extra flavour to food doesn't appear to increase intakes when this was tested, although there is a reported increase in the liking of sweet foods. However, the use of finger food as snacks between meals does show some more promising results[5], and is featured as part of our approach.

Studies have also been conducted looking at environmental factors and their effect on nutritional intake. Studies suggest that experimenting with different environmental settings - especially with light, sound and colours within dining room areas, serving utensils, and by minimising distractions - can support improvements in the nutritional intakes of people with dementia[6].

It is therefore important that we recognise the contributing factors which reduce nutritional intake within individuals and groups of people with dementia, and provide a varied meal choice, presented in appropriate ways to encourage individuals to eat adequately. By taking this approach we feel that it is possible to provide care in a way that allows mealtimes to be as enjoyable as possible, whilst providing good nutritional care.

1.2 Nutritional Targets for People with Dementia

Whilst there are existing nutrition targets for the general population of differing ages and sexes, there are no specific guidelines for people with dementia. We can differentiate between the requirements of individuals who are nutritionally well or those who are nutritionally vulnerable, but this also isn't specific to individuals with dementia.

Some people with dementia are excessively physically active which will increase their requirement for energy, but this is not inevitable in all cases. The NACC Nutritional Standards for Adults[3] is a useful 'go to' guide offering support for all those involved in care catering - as is the BDA nutrition and hydration digest[4]. Good nutrition and wellbeing are strongly linked, so the promotion of nutrition and hydration for people in care settings is essential. Appendix 1 outlines the energy and protein requirements of the general population, but, as a guide, menus should be capable of meeting an energy target range of 1888 – 2820kcal per day, and 55.5g protein per day. Menus need to be developed in a way that ensures that each individual can meet these requirements from the range of dishes on offer. Guidance is also offered in Appendix 1 on how both nutritionally well and nutritionally vulnerable clients should be provided for from the menus on offer.

1.3 Sample Menus

It is vital for all care settings to have a menu plan and a menu structure in place as this supports good food and food service practices. Menus should be planned using standard recipes with approved ingredients from approved vendors. This will ensure a consistent quality of meal, and for the nutritional content of the menu to be calculated and available for those providing and auditing the catering service. Menus with menu categories should be 'published' and accessible to inform staff and relatives about the meal service. Consideration should also be given to the style and format of the menu. For many people, a pictorial or large print menu will be easier to understand and it is also good practice to publish daily posters e.g. "Today's lunch is..."

The content of menus should include well recognised, familiar and popular foods as well as some energy dense choices for people who are nutritionally vulnerable and may only eat small amounts. The dishes on menus should also take into account the textures and mode in which they will be eaten. Some may prefer to eat with their fingers, whilst others may require a pureed or soft dish. Separate menus incorporating different textures may need to be developed in some care settings. It is important that we are aware of diminishing tastes when menu planning and include a variety of dishes with a good balance of ingredients and a mixture of flavours.

Whilst it isn't clear whether menu fatigue occurs in people with dementia, it is important that menus are revised, changed and updated on a regular basis. Different foods provide different nutrients and by eating a wide variety of foods, people are more likely to have sufficient intake of the micro-nutrients they require, whilst preventing menu fatigue that may occur.

When catering for people with dementia, it is best practice to involve each person in the process of choosing their meals. This should be done as near as possible to each meal service – to avoid the person changing their mind or forgetting what they have chosen.

Where people aren't able to make their own choice of meal, personal preferences should be taken into account when a meal order is made on their behalf, perhaps using the food passport (see section 5.1) or other care records.

Further details of 3 different menu types commonly required by people with dementia are highlighted on the following 3 pages.

1.4 Finger Food Suggestions

People with dementia may not sit at a table to eat and may eat better 'on the go.' Others may also struggle to use cutlery and eat better using their fingers. To support this way of eating, finger foods can be strategically placed so that people are more likely to eat as they move around, and may find it easier to eat this type of food without the use of cutlery. There is also evidence that finger foods provided as snacks between meals can improve food intake.

Here are some ideas for finger foods:

- Cornish Pasty/Cheese and Onion Pasty
- Sausage Roll/Vegetarian Sausage Roll
- Pasta Pieces
- Garlic Bread
- Fish Fingers
- Crispy Cod Bites
- Cheese and Tomato Pizza
- Chicken Goujons
- Vegetable Nuggets
- Jacket Wedges/Roast Potatoes/ Croquette Potatoes
- Chicken Nuggets/Chicken Breast Strips
- Cold Meat
- Carrot Sticks/Cucumber sticks/Celery Sticks Cherry Tomatoes
- Cooked Vegetables such as Broccoli or Cauliflower Florets, Courgette Sticks
- Cheese Portions
- Crackers
- Sandwiches/Toasted Sandwiches/Wraps

1.5 Food Fortification

Undernutrition and low body mass index are common in people with dementia but there are interventions that can help. Some people will be prescribed or have access to nutritional supplements, and evidence suggest that these can improve the intake of nutrients in some individuals. It is also possible to enrich food with other food ingredients to increase the calories and/or protein in meals. Snacks can also be provided in between meals to increase food intake. Enriched or fortified diets are sometimes called high protein, high energy/calorie or energy dense diets and allow a person to meet their nutritional needs through smaller portions of food, which is often the quantity eaten by individuals with dementia. Caterers will therefore need to provide meals that contain as many nutrients as possible in the smallest amount of food, and the ideas outlined here can support this:

Serve regular meals with a portion of protein at each meal

- Provide at least a pint of milk each day (full fat if it can be tolerated)
- Serve regular snacks between meals such as sandwiches, cheese and biscuits, cakes and sweet biscuits
- Purchase full fat dairy desserts including yoghurt, mousses or creamy rice desserts
- Enrich full cream milk – add four tablespoons of milk powder to 1 pint of full cream milk to double the protein content. If skimmed milk with added vegetable fat is used, this will increase the calories.
- Use fortified milk instead of ordinary milk in drinks, cereals, porridge, soups, milk puddings and sauces.
- Soups - add cream, evaporated milk, fortified milk, milk powder, grated cheese, croutons, pasta or dumplings
- Breakfast cereals/porridge - add enriched milk, evaporated milk, cream, creamy yoghurt, syrup, jam, honey, sugar, fresh or dried fruit
- Serve main dish with an enriched sauce. Meat, fish and cheese or eggs should be included at each mealtime.
- Sauces - add cream, evaporated milk, grated cheese
- Potatoes and Vegetables – add extra fat such as butter, margarine, grated cheese, cream, salad cream, fried onions, enriched milk based sauce
- Puddings – serve with cream, custard made with enriched milk, evaporated milk, ice cream, jam, honey, syrup, dried fruit
- Use enriched milky drinks for between meal drinks
- Add sugar to drinks and jam to puddings. Use a glucose based calorie fortifier such as Maxijul or Polycal for extra calories without the sweet taste

1.6 Texture of Food and Liquid Modification

It is reported that between 13-57% of people with dementia suffer from swallowing difficulties[5]. It is essential that these requirements are provided for using well presented meals of the correct consistency that meet the nutritional requirements of individuals as outlined in section 1.2. Puréed meals will often need to be enriched or fortified to allow them to meet minimum requirements for energy. Some care settings may choose to have separate menus for modified consistency diets, whist others may choose to incorporate soft and puréed dishes as part of the main menu. Where the latter is the case, some flexibility will be required to meet the personal preferences of individuals.

The national descriptors for modified texture meals are shown below.

B = Thin Purée Dysphagia Diet

Category B meals should be smooth throughout with no 'bits' (no lumps, fibres, bits of shell/skins, bits of husk, particles of gristle/bone etc.). The meal may need to be sieved to achieve this.

These meals do not hold their shape on a plate or when scooped and cannot be eaten with a fork - as the food will slowly drop through the prongs. The prongs of a fork do not make a clear pattern on the surface, and the food cannot be piped, layered or moulded, but can be poured.

C = Thick Purée Dysphagia Diet

This is food that has been puréed or has a purée texture. It does not require chewing, holds its shape on a plate or when scooped and can be eaten with a fork because it does not drop through the prongs. A fork makes a clear pattern on the surface. It can be piped, layered or moulded.

D = Pre-mashed Dysphagia Diet

Food is soft, tender, moist and needs very little chewing. It has been mashed up with a fork before serving. Any fluid, gravy, sauce or custard must be very thick. It holds its shape on a plate or when scooped, cannot be poured and does not 'spread out' if spilled.

E = Fork Mashable Dysphagia Diet

Food is soft, tender and moist but needs some chewing. It can be mashed with a fork. Any fluid, gravy, sauce or custard in or on food must be thick – a light disposable plastic teaspoon would stand upright if the head were fully but just covered. Those on a Texture E diet must therefore be able to cope with thinner fluids .

1.7 Our Menu Development Principles

- Catering and care staff should work together to develop appropriate menus for people with dementia, and involve them and/or their carers wherever possible
- Menus should be approved by a Registered Healthcare Dietitian to ensure that all the nutritional requirements are met
- Menu changes must be communicated and agreed well in advance of any changes
- Menus should be appropriate to the dietary requirements and preferences of the people we serve.
- Menus should offer a choice of meals appropriate to people's cultural and religious beliefs
- Therapeutic and specialist diets shoud be specified and provided for appropriately
- Menus will be well balanced and contain a variety of choices
- Menus will be planned using approved standard recipes
- People will have access to sufficient fluids to meet their requirements
- Menus are available in agreed styles and formats
- A range of energy dense or high protein meals should be available for those who have been identified as undernourished or at risk of malnutrition
- The nutrient content and the portion size of the food should be audited/ checked regularly
- All care units will have a menu plan and a menu structure
- Mealtimes should be spread out to cover most of the hours that patients/ residents are awake
- Snacks, including finger foods and nourishing drinks between meals should be offered on a routine basis

2.1 Communication to Enhance the Experience of the End User

It is essential that our colleagues communicate in a positive way and understand the communication difficulties that people with dementia experience. We need to understand that everything we do with a person with dementia provides an opportunity for communication and can have a positive or negative effect even in the absence of memory.

In a care environment, a person with dementia may be restricted to only a few minutes of interaction for large periods of the day.

Highlighted below are some best practice tips for communicating with people with dementia:

- Use simple, appropriate words and short sentences.
- Use facial expressions and tone of voice to reassure.
- Make sure the person can see your face and make eye contact.
- Respond to communication even if you are struggling to understand.
- Use gentle touch if appropriate.
- Use pictures and signs where possible

2.2 Protected Mealtimes

A protected mealtime policy should be implemented in all care settings to ensure that people with dementia have the most positive meal experience possible. This should include the cessation of non urgent activities, allowing care staff to concentrate on providing mealtime care, whilst not excluding visitors or family members who may provide encouragement with meals.

All staff should work as a team, paying particular attention to the following:

Making sure that the person is ready to eat

- Positioning people – ensuring a safe and comfortable eating position
- Providing appropriate equipment – for example: adapted cutlery, single cutlery, coloured crockery, plate guards, non slip mats
- Washing hands and distributing hand wipes
- Understanding the likes and dislikes, special dietary needs and mealtime assistance required

Ensuring that the person can eat their meal

- Physically assisting the person to eat their meal
- Non essential activities to cease to allow all to concentrate on the mealtime
- Opening packages and cutting up food
- Providing prompts and encouragement.
- Ensuring adequate diet and fluid intake

Reducing the risk of malnutrition and dehydration

- Observation/monitoring and making sure that people are eating
- People have the appropriate diet and fluids and action taken if concerns are observed.
- Monitoring for swallowing problems

2.3 Service Times

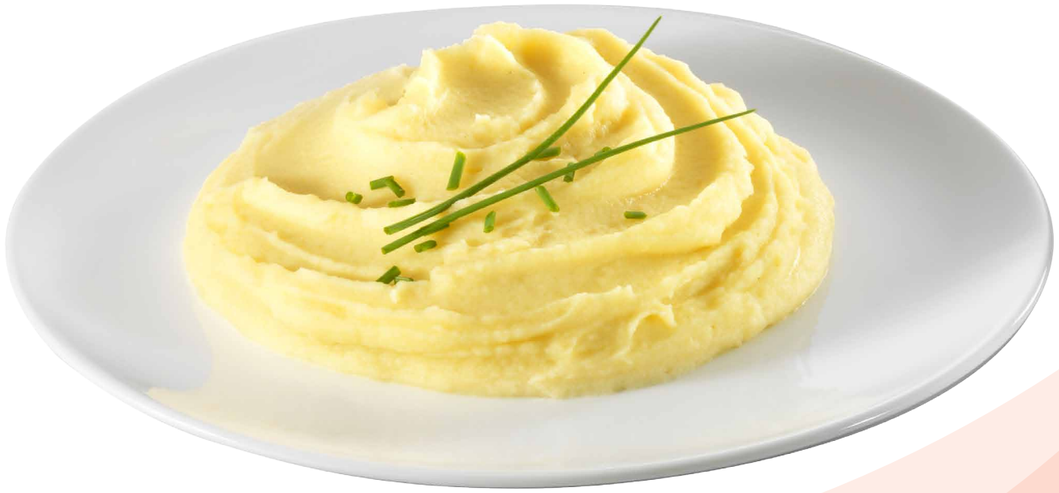
To ensure that adequate food and fluids are offered throughout each 24 hour period, main meals should be served every 4 to 6 hours with beverages every 2 to 3 hours. The maximum gap between dinner and breakfast the following day should be no more than 14 hours, with an evening snack offered in between these times.

To encourage food intake at all hours, some snacks should be made available at all times. These can be finger foods or softer items, strategically placed to encourage their consumption whether a person with dementia is seated or 'on the go.' These low risk items can be made available for care staff to produce when the catering team is not on site.

2.4 Presentation and Service

Meals should be served and presented in the most appropriate way to support a person's needs. This may include:

- Serving food in front of a person to allow them to have a choice about what is put onto their plate
- Presenting meals already plated
- Serving only a single or small number of different food items onto a plate and adding extra food as this is eaten
- Serving one course at a time
- Serving food items so the person can distinguish between items e.g. not covering food in sauce or gravy, or mixing food items together on a plate



2.5 A Service Journey

Compass Group UK and Ireland considers it good practice to undertake regular food service journeys. This is a system designed to map out the complete journey of a meal from the menu and meal ordering to when the meal is served. This process includes:

- Tasks for each stage of the journey are listed in time frame order, followed by suggested timings
- An objective view is then taken to confirm or predict any potential shortfalls in service or problems that may occur to complete each task
- Analysis of any service shortfalls is then required to aid with identifying remedial actions in order to improve the meal service

Due to the changing needs of people with dementia, food service journeys should be conducted regularly to identify any new potential shortfalls. A blank copy of the service journey and some examples of this in practice are shown in Appendix 2.

2.5 Food Service Journey Guide

SERVICE LEVELS	Obtain service level agreements for current service provision
SERVICE AREAS	Observe food service over a number of meals in each food service area. Meet with care staff in service areas to assess suitability of current service in respect of: • Menu options • Alternative options • Service equipment • Timings • Short notice requirements Gain understanding of people's needs in each service area. Useful tool would be the Food Passport. Assess with care service staff any shortfalls in service provision.
PRODUCTION AREAS	Observe food production over a number of services. Meet with catering team to assess: • Menu ordering • Meal production timeframes • Service provision timeframes • Service equipment • Short notice provision Assess what information is known by catering team in respect of people's requirements and how any changes are notified. Review Food Passports with catering team.
OUTCOMES	Based on reviews conducted in all service and production areas, compile recommendations to address any shortfalls in service provision. Meet with staff in all areas to brief in recommended changes and obtain any feedback or suggestions. Instigate service changes for trial period
SERVICE LEVELS	Review service level agreement to update any requirements following completion of service journey.
MONITORING	Conduct regular observations in food service areas at different meals to ensure any changes in residents' needs are being met. Hold regular meetings with care staff in food service areas to update and review any processes and Food Passports.

3 The Environment and Ambiance

It is easy to explain away all changes in behaviour to "a symptom of dementia". However, a poor environment can actually cause a lot of problems and increase confusion, so having a good understanding of how to support people is essential to ensure a good quality of life.

It is vital to ensure that people with dementia are given the opportunity to eat in the most appropriate environment using appropriate equipment. We need to make the environment as homely as possible and appear less 'institutional.'

3.1 Mealtime Equipment

Below we have outlined our recommendations for creating an appropriate mealtime ambience in order to encourage a positive meal experience for people with dementia.

Tableware

- Choose crockery that contrasts with the colour of the tablecloth or table - for e.g. white or light colour plates placed on a dark tablecloth or placemat

- Coloured plates (e.g navy blue) are a good colour contrast to white table cloths as the tone does not distract from the food. Bright colour plates such as “fiesta ware” can also be beneficial for later stage dementia. (Churchill Art de Cuisine - Future Care offer plates with a high and wide couped rim aiding handling - designed with the ageing population in mind, providing better independence and dignity)

- Some people may eat better with their main meal served in a bowl instead of a flat plate to aid eating independently. Plate guards can also be used

- Occupational Therapists may advise on special or adaptive equipment

Mugs

- Mugs should have large handles and ideally be in colour that contrasts to the probable contents. Avoid dark mugs and dark interiors for coffee and other hot drinks.

- The opening at the top should be wide in order to allow a person’s nose to fit inside when the cup is tipped

- Evaluate the weight of the mugs

Cups

- Plastic may have a negative tactile feel for residents with later stage dementia

- “Sippy” cups may appear as infant dishware. Look for adult version or lids for existing mugs that have a mouth unit

Cutlery

Where appropritate, offer one utensil at a time for people with later stage dementia as this may simplify the dining process.

Appendix 3 outlines a list of crockery that should be used by catering teams to enhance the meal service experience of people with dementia, with some possible beneficial outcomes.

3.2 Signage to Define Geographical Areas

Signage is an important part of any strategy to support people living with dementia or memory impairment. Signage helps build confidence enabling someone to maintain independence without fear of getting lost. Effective signage can assist with:

- A reduction in slips, trips and falls – a person can easily identify with confidence where they want to go and get there quicker

- Reduced agitation and challenging behaviour due to easy recognition of environment, appropriate stimulation and lack of need for support

- Improved continence as active lifestyle and healthy appetite may make it easier to find the toilet in time

Good quality signage should:

- Use clear, legible writing and icons or pictures that are easy to understand

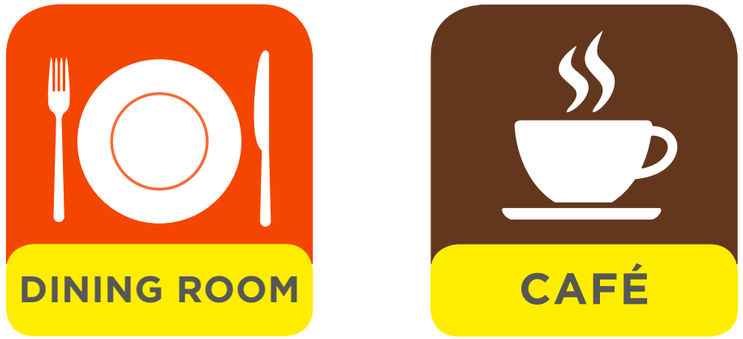
- Include easily recognisable images to identify the purpose of each room

- Use colour as an additional clue to help with identifying a room (i.e. do not use the same colour for the toilet sign as the dining room sign)

- The product should be made from antiglare materials to avoid confusion

- Signage should always be at the appropriate height

Examples



3.3 Dining Areas

It is crucial that we consider the environment of the dining area, and design eating areas in a way that will enhance the mealtime experience. Ideally dining areas will be used only for the purposes of eating and drinking and smaller rooms with less noise and fewer distractions should be provided where possible.

Adequate lighting is required in all areas of the dining room - to respond to the needs of individuals with reduced contrast sensitivity, declining eye sight and degenerative disease such as macular degeneration, which is common in the elderly.

- Natural lighting is ideal, with minimal glare
- The table top and tableware should ideally be contrasting colours. Avoid all white surfaces
- Colour contrast walls, doors and other surfaces
- Avoid high gloss floors and reduce glare
- Consider mesh window shades to minimize glare and reduce noise

Noise is disorienting to older adults, especially those with hearing loss. Controlling acoustics and minimising noise and distractions should be a high priority in our environmental assessment

- Avoid having people with dementia sit near a serving pathway
- Evaluate the noise level in the dining room, such as: ice machines, refrigerators, squeaky wheels on carts, clanging crockery, scraping of dishes, staff conversations
- Evaluate noise absorbing equipment and surroundings and use where possible, including for e.g. floor coverings, pictures and soft material items which will all absorb noise

There are many different types of tables to consider. Square tables provide the greatest flexibility in terms of table arrangment, but round tables can encourage greater social interaction - therefore table shape should be chosen to meet the needs of the people in each unit. Tables should be arranged in a way that encourages eating and minimises distractions. Table tops or linen should be solid colours, and a different colour to floors and chairs where possible.

4 Dementia Training Programmes

Training can make a real difference in the support of caring for people with dementia and can enhance their day to day lives and activities. Training for all people working in environments housing people with dementia is therefore recommended.

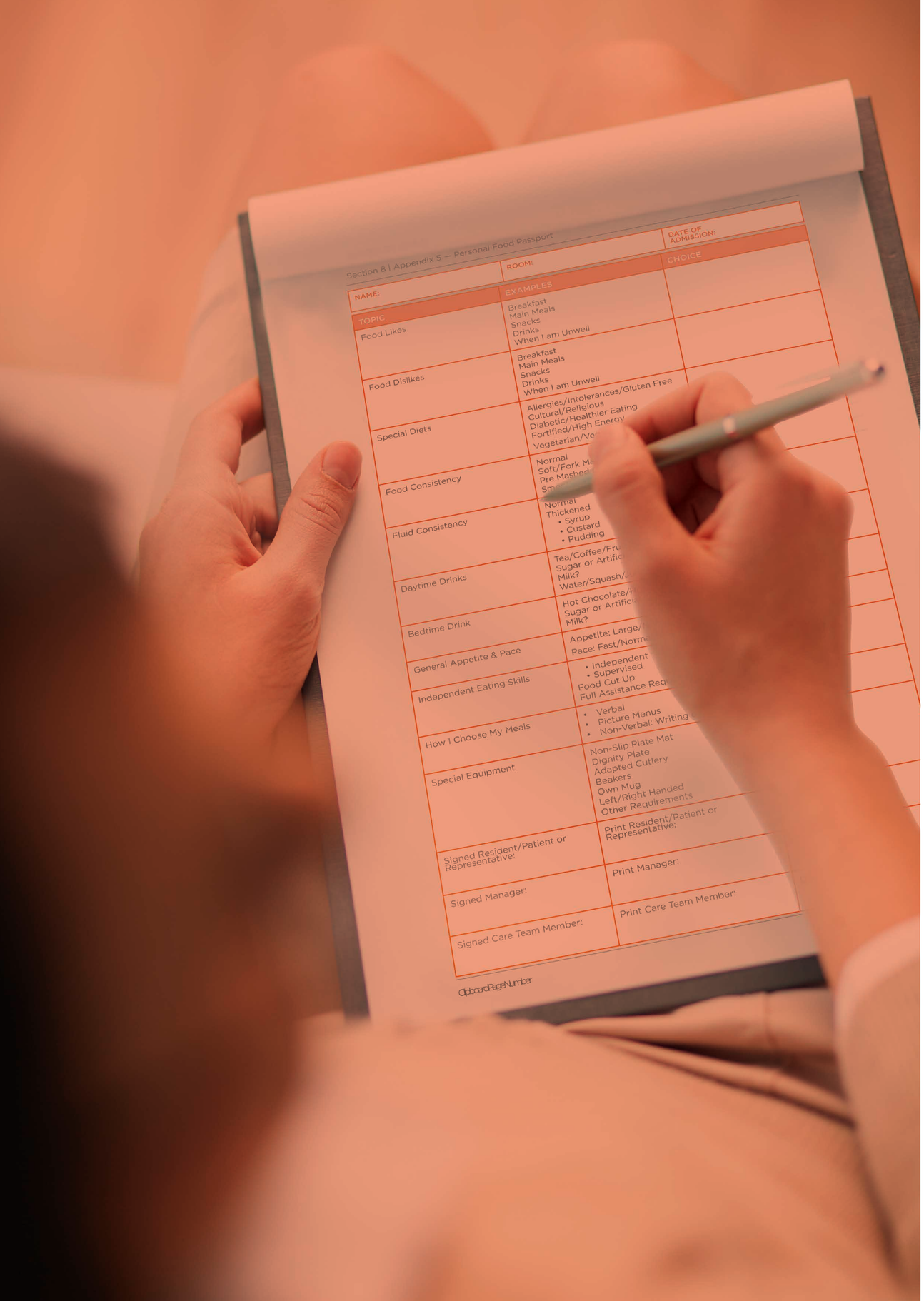
Our training is centred on 4 main areas; general awareness and understanding, nutrition and dietary needs, behavioural eating difficulties and safeguarding.

In partnership with The Alzheimer's Society, we have commissioned the design of a bespoke Compass Group UK and Ireland course module for our front line teams designed to help people understand more about Dementia. Additional modules developed by Compass Group UK and Ireland teams about nutrition, eating behaviours and safeguarding will complete this course.

Alzheimer's Society | Leading the fight against dementia

COURSE	AUDIENCE	DURATION	CONTENT
General Dementia understanding and awareness	All Compass Group UK and Ireland personnel working in an environment with people with dementia	1 day	Includes the disease progression and manifestation and considers the best environment, behaviours and work practices.
Nutritional Considerations for People with Dementia	All front and back of house teams involved in food service	1/2 day	This course includes food preparation, menu provision, menu presentation, eating difficulties, food presentation and service including modified textures and food fortification.
Safeguarding	All Compass Group UK and Ireland personnel in environments with people with dementia	E-learning 2 hours	This course gives an understanding about safeguarding vulnerable people

Appendix 4 outlines the content of each course.



5.1 Food Passport

Introduction

Individuals' food preferences, both personal and cultural/religious, are part of their individual identity and must always be respected. People have different likes and dislikes and this can make a difference as to whether food gets eaten or not; even something simple such as gravy poured over food could ruin a meal for some. Where possible these personal preferences should be ascertained on admission to a care provider and continue to be used whilst the person is in our care. However occasionally due to communication difficulties such as dementia, people may not be able to express their likes and dislikes themselves and we may rely on information from friends and relatives. The Food Passport can be used on admission by nursing or care staff and will help us understand peoples' likes and dislikes so that preferences can be recorded and observed.

Who should complete this and when?

The Food Passport is best filled in on admission or transfer. Ideally it should be completed with the help of someone who knows the individual patient or resident very well; perhaps a relative, close friend or carer.

Where this document should be kept?

Every ward, care home or patient care area will have its own policy regarding the location and maintenance of nursing and care plans. The Food Passport is no different. It can be kept with other care plan documentation or alternatively remain in the individual's room or near their bed space. Alternatively, these can be kept in a folder in the ward pantry, kitchen etc.

Confidentiality and dignity

Whilst safety overrides confidentiality and dignity, care must be taken to use this document with discretion and not to abuse it. It should be stored carefully and the content should not be discussed with anyone other than the carer, nurse or relative/friend next of kin.

How will the Food Passport be used?

It can be used to assist our colleagues taking peoples' meal orders and is also helpful during beverage rounds. In some settings, nursing or care staff may choose to make selections for people in their care and the Food Passport will make this easier. Alternatively, it can be used to help the Food Service Assistant choose the most suitable food for the person and assist during the meal service.

Updating process following improvement or deterioration

The Food Passport should be changed as appropriate. Changes may be required if a person's condition changes - either improving or deteriorating. To avoid confusion, any out of date Food Passports should be discarded. If someone is regularly re-admitted, it may be simpler to store the Food Passport with any other care plans.

Tailor-made

The questions on the Food Passport may not be exactly pertinent to every person, so use the document wisely and amend it to suit each individual's needs. Remember, the aim of the Food Passport is very simple: to enable patients or service users to receive the food and drink they prefer, so that they are likely to eat more.

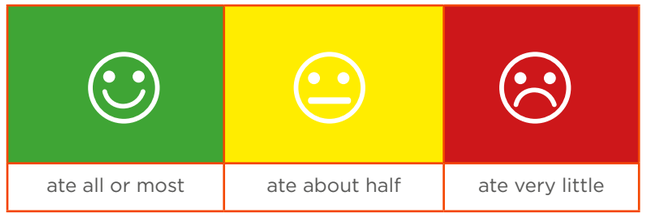
A copy of the Food Passport is in Appendix 5.

5.2 Recording Food Intake

Food not eaten has no nutritional value. For certain individuals, it may be helpful to record food intake in order to assess nutritional intake and therefore decide whether interventions or nutritional supplements are required.

We have devised a simple Food Intake Record Chart for people who are nutritionally at risk. It is a simple sheet on which the person removing the tray after the mealtime can make a simple assessment of how much food has been eaten. There are only 3 choices for each mealtime and the food service assistant or carer will simply put a tick in the relevant box after each meal.

The 3 options are:



This record chart can then be used by the relevant clinical teams to assess whether any nutritional interventions are required.

A copy of the Food Intake Record Chart is in Appendix 6

5.3 Screening Tools for Malnutrition

Although we are not directly involved in nutrition screening, it is important that as part of the multidisciplinary team we are conversant with the general aspects of it and any consequences of this. Nutrition screening is designed to detect people either suffering from or at risk of malnutrition.

The Malnutrition Universal Screening Tool or 'MUST'[7] is one example of a screening tool to identify adults who are malnourished or at risk of malnutrition (under nutrition). It also includes management guidelines which can be used to develop a care plan.

MUST is for use in hospitals, community and other care settings and can be used by all care workers. Height and weight are measured to get a Body Mass Index (BMI) score using a chart. Unplanned weight loss is also recorded and scored using tables provided. The affect of any acute disease is also included. The scores from steps 1, 2 and 3 are added together to obtain the overall risk of malnutrition; local policy guidelines then determine the next steps.

5.4 DMAT and Feeding Behaviours

The Dementia Mealtime Assessment Tool (DMAT) is a resource which can be used by a healthcare professional (e.g. nurse), or a non-healthcare professional (e.g. carer). It was developed by Registered Dietitian Lee Martin. The DMAT is designed to identify many common behavioural feeding difficulties during a mealtime in someone with dementia. The DMAT can also provide suggestions on how to overcome these identified behavioural feeding difficulties. You use the DMAT as a checklist when observing someone with dementia at a mealtime and record your observations.

The aim of the DMAT is to help enable people with dementia to feed themselves and remain as independent as possible by giving their carers a simple resource to identify and correct mealtime difficulties. *A copy of the DMAT tool is shown in Appendix 7. For more information visit www.thedmat.com.*

We extend our thanks to Registered Dietitian Lee Martin for his kind permission in reproducing this information.

6 Summary of Research for Prevention of Dementia

To date, there is a limited amount of evidence about the effectiveness of a particular type of diet on the prevention of dementia, and this is subject to ongoing research. However, the themes that exist in the literature are outlined below[1].

- There is some evidence that regular intake of fish, fruits and vegetables and specific diets (e.g. Mediterranean diet) could lower the risk of developing dementia
- More research is required on the role of specific nutritional deficiencies (vitamin b12, anti-oxidants, omega-3, etc.). Most of the evidence is inconsistent, therefore supplementation of specific nutrients cannot yet be recommended
- Diabetes and hypertension (both linked with adiposity) in mid life have been linked to increasing the risk of developing dementia in later life, but more research is required to discover whether this is the case
- More research is required on the role of specific dietary deficiencies and the link to dementia in later life
- Maintaining a healthy lifestyle is the most sensible approach to follow in the absence of strong evidence to the contrary. This includes maintaining a healthy weight, exercising regularly, not drinking too much alcohol, not smoking and maintaining healthy blood pressure. This should be combined with following a Mediterranean diet rich in fish, nuts, wholegrains, olive oil, and abundant fresh produce

7 References

1. Alzheimer's Disease International and Compass Group UK and Ireland
   Nutrition and Dementia - A review of available research - February 2014

2. Alzheimer's Society UK
   http://www.alzheimers.org.uk/infographic

3. National Association of Care Catering
   http://www.thenacc.co.uk/shop/product/Nutritional+Standards+for+Adults

4. British Dietetic Association Nutrition and Hydration Digest BDA 2012
   https://www.bda.uk.com/publications/NutritionHydrationDigest.pdf

5. Morris (2014)
   Taste and olfaction impairment in dementia and food manipulation for increased liking and intake. Unpublished

6. Dinsdale (2014)
   Environmental factors affecting food intake in dementia patients: A review of the literature. Unpublished

7. BAPEN (2006) Malnutrition Universal Screening Tool
   Available at http://www.bapen.org.uk/must_tool.html

Alzheimer's Disease International
The global voice on dementia

Alzheimer's Society
Leading the fight against dementia

Sheffield Hallam University

Appendix 1
Nutritional Targets for People with Dementia

Table 1: Estimate Average Requirements (EAR) in MJ/day (kcal/day) of energy for groups of older adults based on BMI of 22.5kg/m² (SACN, 2011)

AGE RANGE (YEARS)	MALES			FEMALES		
	less active	population	more active	less active	population	more active
45-54	9.9 (2366)	10.8 (2581)	11.8 (2820)	8.0 (1912)	8.8 (2103)	9.6 (2294
55-64	9.9 (2366)	10.8 (2581)	11.8 (2820)	7.9 (1888)	8.7 (2079)	9.5 (2271)
65-74	9.0 (2151)	9.8 (2342	10.7 (2557)	7.3 (1745)	8.0 (1912)	8.7 (2079)
75+	8.8 (2103)	9.6 (2294)	10.5 (2510)	7.0 (1673)	7.7 (1840)	8.4 (2008)
All adults	10 (2390)	10.9 (2605)	11.9 (2844)	8 (1912)	8.7 (2079)	9.5 (2271)

Table 2: Protein Requirements for older adults (DH, 1991)

AGE	REFERENCE NUTRIENT INTAKE* PROTEIN G/D
Males 50+ years	53.3
Females 50+ years	46.5

The BDA Digest[4] recommends the categorisation of people into 2 groups

1. Nutritionally Well

The estimated average energy requirements for nutritionally well individuals - at various ages, weights and physical activity levels, at current mean height for age and based on a BMI of 22.5kg/m^2 - is based on the Estimated Average Requirements (EARs) for energy from the Dietary Reference Values (DRVs) for Food Energy and Nutrients for the United Kingdom (SACN, 2011). These recommendations estimate the lowest energy requirement at 1673kcal/day for women aged over 75 years, and the highest target at 3011kcal/day for more active men aged 19-24 years.

The protein target for nutritionally well individuals is based on the Reference Nutrient Intake (RNI). For men aged 19-50 years, this is 53.3g (DH, 1991). For females of the same age bracket the RNI is 46.5g.

2. Nutritionally Vulnerable

The energy target range for nutritionally vulnerable individuals is based on BAPEN's recommendations by Allison (1999). This recommends that the energy requirements are 1.3 to 1.5 times resting energy expenditure. This equates to 30-35kcal/kg body weight/day (1800-2100kcal/day for a 60kg individual and 2250-2625kcal/day for a 75kg individual) (Allison, 1999).

The protein target for nutritionally vulnerable individuals is based on BAPEN recommendations (Allison, 1999). This recommends 1g/kg body weight/day and is based on a 60-75kg individual (60-75g protein/day).

Table 3. Summary of Nutrient Standards for Adults[4]

NUTRIENT (/DAY)	NUTRITIONALLY WELL	NUTRITIONALLY VULNERABLE	PROVIDED
Energy (kcal)	1810 – 2550	2250 – 2625	Daily
Protein (g)	56*	60-75	Daily

We would recommend that the day parts approach in the BDA Digest is used to assess menus to ensure they meet these standards. For practical purposes, the total nutrition provided on menus should be in the order of 2200kcal and 60g of protein a day. This can be from 3 main meals, lighter meals, snacks, daily milk allowance and drinks.

In general, whole meals should provide a minimum of 500kcal of energy.

For nutritionally vulnerable people, whole meals should have the capacity to provide 800kcals for the whole meal.

Meals should provide a minimum of 15g of protein.

Between meals snacks' throughout the day should provide at least 150kcals and 2g protein for nutritionally well people and 300kcals and 4g protein for nutritionally vulnerable.

7 beverages per day must be provided plus the use of at least 400ml of milk, for drinks and use throughout the day.

Table 4: An example of the breakdown of energy and protein across a whole day

	KCAL	PROTEIN
Breakfast	400 - 500	10 - 12
Lunch	500 - 800	15 - 23
Dinner	500 - 800	15 - 23
Snacks[2]	150 - 300	2 - 4
Milk Allowance (400mls)	200 - 265	13 - 14
Approx Totals	1800 - 2665	56 - 75

The following tables from the BDA Digest have a more detailed approach.

Table 5

HEALTHIER EATING
RECOMMENDED INPATIENT MENU CODE 'H' FOR HEALTHIER OR ♥
SUITABLE FOR PEOPLE WHO ARE NUTRITIONALLY WELL

AIM OF DIET	CRITERIA FOR CODING	
• To maintain good general nutrition and meet DRVs • To support public health messages on eating to protect and promote health • To support the clinical management of people with metabolic syndrome, diabetes mellitus, dyslipidaemias and cardiac risk, overweight and obesity, hypertension	**Fat** • Entrée should contain no more than 15g total fat, and no more than 5g saturated fat • Desserts should contain no more than 5g total fat, and no more than 2g saturated fat • Dishes containing oily fish - menus should offer fish dishes prepared with minimal additional fat at least twice weekly, and oily fish at least once weekly (NHS Choices, 2011a) • Dishes containing partially hydrogenated oils (a major source of trans-fatty acids) to be avoided **Sugar** • To be of suitable nutritional quality, desserts should be based on reduced fat milk or fruit. See notes • Recipes for desserts should be designed to have no more than 15g of added sugar per portion as served (including accompaniment) providing a realistic upper limit for controlling sugar content **Salt** • Main courses should contain no more than 1.5g salt, with an aim to achieve relevant government guidance (SACN, 2003). **Fruits and Vegetables** Menus should provide at least 5 servings of fruit and vegetables daily and a variety of sources of dietary fibre. This should include raw fruit and salad daily (NHS Choices, 2011b).	• The eatwell plate provides the menu model (NHS Choices, 2011b) • Overall, total fat, salt and added sugar should be low • Where practical, fats should be unsaturated rather than saturated • Carbohydrate sources of lower glycaemic index should be incorporated on a menu • Wholegrain or higher fibre starchy foods should be offered daily • The total figure of 15g added sugar should include the equivalent in jam, syrup, honey etc. • Diabetes UK Nutritional Guidance (2011) advises that people with diabetes do not require a specialised diet and should eat a balanced diet in line with population advice • People with diabetes follow a variety of personalised management plans. Relevant nutrition and dietary information must be available to accommodate patient requests (see Leeds sample menu) • Restricted calories ('reducing') Starter plus entrée courses ≤300kcal and desserts ≤75kcal; allowances must be made for this when assessing standard menu capacity • Restricted fat diets for clinical use may fall to ≤8g fat entrée; no added fat to potatoes, vegetables and sauces; use of skimmed milk and lower fat products ≤5g total per dessert.

Table 6

HIGHER ENERGY
RECOMMENDED INPATIENT MENU CODE 'E' FOR ENERGY OR ↑
SUITABLE FOR PEOPLE WHO ARE NUTRITIONALLY VULNERABLE

AIM OF DIET	CRITERIA FOR CODING	
• To improve general nutrition and meet or exceed DRVs • To promote energy intake in those patients with small appetites • To provide a high intake of protein, vitamins, minerals and other essential nutrients • To provide a diet which can meet increased nutritional requirements in modest portion sizes and presentations which are appealing and easy to eat.	• Together the starter (if provided) and main course at the both the mid-day and evening meals should provide c.450 - 500 calories so that at least 800kcal is provided by the starter, main dish and dessert when eaten together. This should also enable the menu to provide ≥ 70g protein per day and supports meeting the recommendation for people who are nutritionally vulnerable. • In terms of balance, a starter plus main course should provide ≥ 500kcal and desserts should provide ≥300 calories, including accompaniments such as custard or other sauces as in the example scenarios for calorie provision shown below: • Snacks of ≥150kcal should be provided twice daily; nutritionally vulnerable patients may require double this energy intake through suitable calorie-dense drinks and snacks • 400ml whole milk should be provided daily for drinks across the day (for those who like it) in addition to milk for breakfast cereals and snacks • Five servings daily of fruit and vegetables should be provided in presentations which are easy to eat and nutrient dense. Government salt targets are common to everyone. Primarily food must be appetising so as to encourage a good appetite. Recipes may need added interest to achieve appealing flavours. Some end users may need added salt and/or sauces to suit their personal tastes and to encourage or improve their food intake.	• Energy density should be high, to promote adequate energy intake in small portion sizes. This may require the use of foods cooked with, or fortified with, added fat and sugar • Care should be taken to ensure dishes are appealing to people with small appetites • Patients who miss meals should be provided with a suitable alternative • Appropriate foods should be available for 24 hour services • For people who have diabetes and are unwell, it can be more important to have increased energy intake than to abide by any usual dietary concerns. • Snacks providing >150kcal include some creamy yoghurt, cheese and crackers or two cream-filled biscuits

STARTER + MAIN COURSE	DESSERT	WHOLE MEAL TOTAL
350	450	800
400	400	800
450	350	800
500	300	800

Appendix 2
Food Service Journey Template

Table 7: Food Service Journey Blank Template

TASK	TIME	BY WHOM	POTENTIAL ISSUES	POTENTIAL SOLUTIONS
Menus				
Preparation for Service (back of house)				
Preparation for Service (Front of House)				
Service				
Clearing				
Feedback				

Examples of the food service journey in practice

A care home has two mid stage dementia house groups for a maximum of 10 people each. Both house groups were experiencing problems with food service provision. Food service journeys were conducted in each house group together with observation visits.

It was found that house group A had a proportionally high amount of residents on soft diets, many of whom were able to eat unaided. House group B had no residents on soft diets, however most needed some form of assistance when eating meals and ate at different times.

In conclusion, where previously identical hot trolleys were sent at the same time, House group A undertook a total menu review in order to better meet their residents' needs and also restructured meal collection times.

House group B split their requirements as to when the residents were able to eat ensuring a fresher, more person-centred approach to their meals.

Table 8: Lunch Food Service Journey - An example

Trolley service to House Groups

TASK	TIME	BY WHOM	POTENTIAL ISSUES	POTENTIAL SOLUTIONS
Complete menu request and pass on to the kitchen, highlighting any issues with suitability of the menu.	By 11.00	Care staff	Arriving late or not at all. Miscommunication between care staff and catering staff as to what is expected regarding pureed meals and diabetics.	Collect the menu requests ourselves. Regular updates of resident profiles and food passports. Standardised puree presentation as demonstrated by photograph on kitchen wall.
Preparation for Service (back of house)	12.30	Duty Chef	Insufficient food. Resident changes mind from order sheet.	Send extra portions to allow for flexibility. Double check requirement and suitability with carer on collection.
Hotplates collected and taken to wings	12.30	Care staff	Hotplates collected late	Fill hotplates on arrival of carer. More communication when delays are expected. Individual timings if this is to be a regular occurrence.
Lunch served in relevant location.	On arrival in wing	Care staff	Food not served immediately or presentably. More food required. Different choices required.	Visit wings to ensure correct service and standard of service. Issue more food if requested, either to carer or self delivery. Add extra portions to menu requests.
Hot plates returned to kitchen for cleaning in readiness for supper meal	At end of Service	Care staff/ Catering assistants	Hot plate returned late or not at all. No time to clean them or heat them up before next service.	Raise the issue in management meeting. Collect them ourselves.
Visit locations during meal service to ensure the quality and quantity are as required and that the residents are happy.	On collection of hot trolleys	Manager / Duty Chef	Insufficient time to check on all three locations before end of service.	Still check location after service to ensure there were no issues. Ensure that any wing that have been missed, are checked during service the following day.

Appendix 3 Recommended Crockery and Tableware

Table 9: Recommended Crockery and Tableware

ZCAFFC101	Future Care	Art De Cuisine	 Plate 10” Box
ZCAFPF251	Future Care	Art De Cuisine	 Dinner Plate Flat Base 10”
ZCA PO6 1	Menu Porcelain	Art De Cuisine	 Mid Rim Plate 6.75”
WHF FC7 1	White Future Care	Churchill Super Vit	 Stacking Cup 7.5Oz
ZCAFFCS 1	Future Care	Art De Cuisine	 Saucer 6”

Table 9 (continued): Recommended Crockery and Tableware

D7782BL	Melamine	Broad Rimmed	Dessert Plate 8.5” / 21.5cm
D7783BL	Melamine	Broad Rimmed	Dinner Plate 9.5” / 24cm
D7786BL	Melamine	Rimmed	Bowl 6.75” / 17cm
D7780BL	Melamine	Narrow Rimmed	Tea Plate 6.75” / 17cm
D7795BL	Melamine		Handled Beaker – 10oz / 28cl

All products listed above are available from Churchill, except the contrasting colour plates which are available from ‘Find Signage.’
The benefits of choosing these products include:

- Improved manipulation and enhanced presentation of food
- Reduction of waste and improved nutritional intake
- Contents stay warmer, longer
- Reduced transfer of heat through mugs
- Cost saving through high durability
- Dishwasher safe
- Perfect weight
- Proportions aid portion control
- Intelligent design supports good nutrition and maintains dignity
- Broad rim for a better grip
- Broad base for greater stability
- Lipped rim reduces spillages
- Hard-wearing integral colour

Table 10: Speciality Cutlery also available from Bunzl

A7455	Straight knife black handle	Single	1=1x1
A7456	Straight fork black handle	Single	1=1x1
A7457	Straight spoon black handle	Single	1=1x1
A7458	Special disability knife black handle	Single	1=1x1
A7459	Right handed fork black handle	Single	1=1x1
A7460	Left handed fork black handle	Single	1=1x1
A7461	Right handed spoon black handle	Single	1=1x1
A7462	Left handed spoon black handle	Single	1=1x1

Appendix 4
Training Plan Outline

1 Day: Understanding Dementia

Indicative learning outcomes:

- Understand how the experience and progression of dementia is unique to the person
- Understand how a person with dementia can live well within society

Understand how the experience and progression of dementia is unique to the person

Participants, starting with themselves, will reflect on their own strengths, preferences, coping strategies and responses. Learning activities are then designed to build on this recognition, and through the adult learning cycle, support reflection on why dementia is experienced by different people in different ways. Every person is a unique individual and will experience their dementia in their own unique way. Some people will still have abilities and capabilities that others may lose sooner. People living with dementia have all had personal experiences and have talents and skills that they have developed throughout their life.

This links to the person-centred approach and also to the principle highlighted by Kitwood (1997) that being person centred towards oneself and colleagues sets the foundation for being person centred with clients / people living with and affected by dementia.

In order to understand how dementia affects the way a person interacts with others and with their environment it is important for participants to also have a basic understanding of key areas of the brain and their main functions, e.g. sight, perception, balance, mood, orientation, problem solving, organisation and sequencing, smell, taste, touch, sound etc.

Participants will be guided to appreciate how dementia creates challenges for people and how by making minor changes a person can be supported to live well.

The information in this section of the course will provide a firm knowledge base for the more practice driven elements of designing menu choices, food preparation, food presentation, use of food cues, the dining environment etc. which will be covered in section B.

Understand how a person with dementia can live well within society

A diagnosis of dementia is important to be able to rule out other, sometimes reversible, causes of memory problems. There are over a hundred identified conditions that lead to memory problems. In this section of the course we work on the features of the four most common types of dementia; their differences and how they may affect people. This part of the course links to work on environment, risk and support relating to eating and drinking which will be a component of part B.

Assuming a person cannot do something based on the fact that they have a diagnosis of dementia can mean that we increase the experience of disability, however well meaning, doing for instead of doing with will undermine a person and could cause frustration. In order to support a person effectively it is important to recognise how memory works and how memory is processed, as well as the ways that more global brain function can affect a person’s daily living. Through this element of the course participants will gain insight into the basic skills of connecting with people with dementia.

Alzheimer’s Society
Leading the fight against dementia

With the right support and understanding people can live well with dementia and still contribute to their local community and the community within their care setting. The course will end with an exploration of dementia friendly communities will enable participants to appreciate the importance of supporting people to continue to feel part of their local community links and also supporting the `community' within the care setting.

Participants are invited to sit the exam on the day of the cascade if the course takes place in an accredited centre, or to register with an accredited centre to take the exam at a later date.

Nutrition Considerations in People with Dementia (1/2 day course)

Aims

To enable participants to have an understanding of basic nutrition for people living with dementia in care settings and the provision of various special diets

To enable participants to put this into practice in their environment and be competent to cascade the relevant parts of the training as appropriate

Objectives

To enable participants to:

- Have a basic knowledge of nutrition
- To have an understanding of why specific diets are requested
- To have information in order for them to cater for the diets appropriately
- To have the opportunity to share ideas and practices around food service

Content Overview

A general course covering basic nutrition, special diets, effect of illness, working with dietitians, responsibilities of ward host/hostess role plus privacy/dignity/illness scenarios

Who Should Attend?

Catering Managers, Catering Supervisors and Training Managers can attend. Attendees should be capable of onward training.

Topics will include

- Basic Nutrition/Balance of Good Health/ Catering for Vegetarians and Vegans
- Catering for people in care settings
- Reasons why people living with dementia may struggle to meet their nutritional needs
- Protected Mealtimes – Different types of people and their needs for food services
- Basics of Menu Planning and Nutritional Needs
- Special diets
- Healthy eating/low fat diets for diabetes/the overweight/cardiac patient
- Malnutrition, fortification, nutrition screening
- Modified Textures
- Liver and Kidney Diseases
- Gluten Free Diets
- Food Allergies and Labelling Regulations
- How diets, snacks and supplements are ordered – review of local systems
- Self Audits – monitoring service delivery

Materials to support the training and to enable onward training will be provided.

Appendix 5
Personal Food Passport

A person centred care approach to residents / patients living with dementia

When catering for people with dementia, it is best practice to involve each person in the process of choosing their meals. This should be done as near as possible to each meal service – to avoid the person changing their mind or forgetting what they have chosen.

Where people aren't able to make their own choice of meal, personal preferences should be taken into account when a meal order is made on their behalf. The Food Passport is a useful tool to help with food or beverage selection.

NAME:	ROOM:	DATE OF ADMISSION:

TOPIC	EXAMPLES	CHOICE
Food Likes	Breakfast Main Meals Snacks Drinks When I am Unwell	
Food Dislikes	Breakfast Main Meals Snacks Drinks When I am Unwell	
Special Diets	Allergies/Intolerances/Gluten Free Cultural/Religious Diabetic/Healthier Eating Fortified/High Energy Vegetarian/Vegan	
Food Consistency	Normal Soft/Fork Mashable (E) Pre Mashed (D) Smooth Puree (C)	
Fluid Consistency	Normal Thickened • Syrup • Custard • Pudding	
Daytime Drinks	Tea/Coffee/Fruit Tea Sugar or Artificial Sweetener? Milk? Water/Squash/Juice	
Bedtime Drink	Hot Chocolate/Horlicks/Hot Milk Sugar or Artificial Sweetener? Milk?	
General Appetite & Pace	Appetite: Large/Normal/Small Pace: Fast/Normal/Slow	
Independent Eating Skills	• Independent • Supervised Food Cut Up Full Assistance Required	
How I Choose My Meals	• Verbal • Picture Menus • Non-Verbal: Writing or Signing?	
Special Equipment	Non-Slip Plate Mat Dignity Plate Adapted Cutlery Beakers Own Mug Left/Right Handed Other Requirements	
Signed Resident/Patient or Representative:	Print Resident/Patient or Representative:	Date:
Signed Manager:	Print Manager:	Date:
Signed Care Team Member:	Print Care Team Member:	Date:

Appendix 6
Food Intake Record Chart

Supper																					ate very little
Supper																					ate about half
Supper																					ate all or most
Lunch																					ate very little
Lunch																					ate about half
Lunch																					ate all or most
Breakfast																					ate very little
Breakfast																					ate about half
Breakfast																					ate all or most
Name																					Tick the box above which best describes how much the person has eaten

Appendix 7
DMAT Tool

Table 11: Copy of the DMAT tool

STYLE	
Slow eating / prolonged meal times	Serve food on warmed plates. Offer smaller portions more often. Allow 1 hour to eat.
Unable to cut meat	Provide cut meats, soft meats or finger foods. Special knives may help if reduced grip strength is identified
Spills drinks when drinking	Offer a straw or a two-handled cup if acceptable, offer small amounts of fluid at a time in suitable cup
Difficulty getting food onto utensils	Try a plate guard or lipped plate, use a deeper spoon or trying finger foods may take the pressure off cutlery use
Incorrectly uses spoon, fork or knife	Use custom or large handled utensil. Try verbal cues & show correct use, refer to OT. Try finger foods
Incorrectly uses cups or glasses	Offer cup with handles or straw, use verbal or manual cues and show correct use, use coloured cups & liquids
BEHAVIOURS	
Stares at food without eating	Use verbal cueing & prompting to encourage self-feeding & demonstrate eating motions so the person can imitate Lighting - make sure adequate light over meal place / move person to or away from window bed
Verbally refuses to eat or states: "No More, Finished, Not Hungry"	Remove meal for 5-10 minutes & then serve again. Investigate cause e.g. food preferences (esp. cultural foods) or food consistency; consider soft & possibly single textured food & check for underlying physical or swallowing difficulties Person may benefit from receiving assistance from one specific carer or have consistency in feeding practices
Shows agitated behaviour / irritability	Check the environment* Calming music may help reduce agitation (esp. verbal & physically non-aggressive behaviours) If person is being fed consider using the same carer to feed rather than using different carers, check pain assessment
Eats small amounts and leaves table & Wanders / unable to sit still for meals	Encourage the use of finger food to take away or have while wandering. Check environment* is calm. Walk person before meal & plan route that ends with the mealtime. Ensure good intake at more appropriate times e.g. breakfast
Difficulty chewing	Provide softer food options. Check dental health
Holds food in mouth	Use verbal cue to chew. Massage cheek gently. Experiment with different food textures & flavours Try foods with heightened sensory input e.g. salty, cold, carbonated, spicy, crunchy. Liaise with SLT.
Spits out food	Check for bites that are too big or food is liked, or temperature or texture is appropriate. Reassess if this food is still liked - if you don't like a food you spit it out! Check seasoning & cultural / religious preferences
Prolonged chewing without swallowing	Use verbal cue to chew & swallow. Provide soft, easy to swallow foods. Liaise with SLT
Doesn't open mouth	Use verbal cue to open mouth. Touch lips with spoon. Manually assist with food. Try straws for drinks Softly stroking someone's arm & talking to them about the food can help
Difficulty swallowing	Liaise with speech & language therapist. Stroke throat to encourage swallowing.


COMPASS
GROUP