BDA The Association of UK Dietitians

1st Edition

Care Home Digest

Menu planning and food service guidelines for older adults living in care homes

Produced by the Food Services Specialist Group and the Older People Specialist Group in consultation with the British Dietetic Association.

1st Edition
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Foreword

The Care Home Digest is the result of a huge amount of work from the British Dietetic Association's Older People and Food Services Specialist Groups, alongside the National Association of Care Catering. Our thanks go to all of those involved in this mammoth effort.

The Digest is the result of the synthesis of a considerable body of evidence and provides an invaluable tool for staff working in care homes. The Digest is going to be incredibly important in the nutritional care of residents across the sector.

In bringing together the latest evidence to support staff with everything from meal preparation, through to special diets, screening for malnutrition risk and menu planning and design, the Digest will undoubtedly become the go to tool for all involved in protecting health via the care catering sector.

As dietitians, we are the only qualified and regulated health professionals that assess, diagnose and treat dietary and nutritional problems at an individual and wider public health level – we are proud that the BDA has been able to support and contribute to the creation of the Digest.

It's a brilliant and informative guide and we hope it is used widely.

Caroline Bovey
Chair of the British Dietetic Association

Introduction

The Food Services Specialist Group and Older People Specialist Group of the British Dietetic Association (BDA) are proud to have worked with the National Association of Care Catering to develop the first menu planning and food service guidelines for care homes for older adults, to support residential and nursing care homes to provide high quality food and drink services for residents in their care. The guidelines provide information and tools that care home managers, nursing staff, carers and catering teams can use to understand how to ensure that menus meet residents' nutritional needs, together with guidance about how food service delivery can both enhance mealtime experience for residents and support them to meet their nutritional needs.

The BDA has for some time produced the Nutrition and Hydration Digest, a resource for all involved in the provision of food and drink services in hospitals which is part of the National Standards for Healthcare Food and Drink. This means that all NHS Trusts in England must comply with the nutrition standards outlined in it as part of their legally binding NHS standard contract.

Until now, no similar national food service standards have existed to support care homes for older adults to meet the nutritional needs of their residents. We are therefore delighted to launch this Care Home 'Digest' which provides similar standards to support care homes for older adults.

Food is an important aspect of quality of life for many older adult care home residents. Mealtimes may be the highlight of many resident's days and something they look forward to in their daily routine. Food can enable residents to express who they are and what is important to them, and food service can enable residents to connect with each other as well as with carers and family members. It is often during religious and culturally significant days that the central role and importance of food to who we are as people can be seen most clearly.

The following information and checklists are intended to support care homes to review their services to understand what they are already doing well and where improvements could be considered and made. We hope these guidelines will be widely used and become a nationally trusted resource for information about food service and menu planning in care homes for older adults across the UK.

Using these guidelines

These guidelines have been developed to support the teams working in residential and nursing care homes for older people, to develop menus and food services that support residents to meet their nutritional needs using food and drink. Many care homes will not have access to a dietitian to support them with menu development. This resource has been developed to provide some guidance about how to ensure that a menu can be offered, which includes balanced meals and a varied choice, that will tempt residents to eat. A secondary objective of this guidance is to support dietetic colleagues who work in this sector but the intended audience are care home teams.

Whilst these guidelines are extensive, it is anticipated that they will be used as a 'toolkit' where care home teams can navigate from the headings to the sections they are reviewing at any particular time. We recognise that there is large variation in care homes in the way they currently provide food and beverage services. It is understood that any changes that homes can make towards complying to these guidelines will be beneficial for residents and changes can be made over a period of time.

Whilst the information in each section is comprehensive, it is hoped that it gives care home teams the information they may need if they are new to menu planning.

Care homes for older adults have a varied but slightly different set of requirements for food and drink from the rest of the population. A smaller proportion of residents follow a vegetarian or vegan diet compared to the wider population and culturally diverse meals are often considered to be 'special' or 'different' diets from the standard menu. For these reasons and to be consistent with the BDA Digest for hospitals, these sections have been added into chapter 4 'Special diets.' It is recognised where residents follow these types of diet within a home that some homes may need to add these dishes to their main menus and this is considered within those sections of this document.

It is also recognised that sustainability is important to us all and there is a small section in chapter 3 that addresses this. However, it isn't deemed appropriate to specifically recommend plant-based diets in this population group as residents often struggle to eat an adequate amount and prefer to eat familiar foods. Plant based food items can be offered if a resident follows a plant-based diet or would like to try something new.

There has been representation from all four nations on the working group developing this document. Standards, guidelines and regulations from all nations have been referenced in this document. The Care Home Digest is intended to provide specific 'food service' guidelines as opposed to a

more holistic 'dietetic resource,' making them different to the guidelines in Wales, Scotland and Northern Ireland. It is intended that these guidelines therefore complement and dovetail with other existing guidelines in all nations.

N.B. These guidelines are intended to support care home teams. The guidelines shouldn't be used in place of seeking advice where this would normally be sought from a dietitian or other health professional.

1

Nutrition and hydration needs, screening for malnutrition and care planning

Good nutrition and hydration, combined with being active is essential for everyone and is important throughout the entire lifespan from before birth to older age.

Good nutrition and hydration, combined with being active is essential for everyone and is important throughout the entire lifespan from before birth to older age. However, nutrition and hydration means more than just the intake of food and drink, and eating is, for many people, a social and enjoyable activity. Furthermore, the process of shopping, preparing a meal and washing up after it are all part of our day-to-day routine. When someone moves into a care home this day-to-day routine usually changes, with food and drink provision being almost entirely the responsibility of the care home rather than of the older adult themselves.

In care homes for older adults, mealtimes can be particularly significant because residents may experience them as the main times of the day when they can engage and interact with others, however they may also:

- Have become less active and be more at risk of frailty which is often associated with malnutrition
- Feel less purposeful because of disability or social and emotional concerns
- Experience temporary illness, long term health conditions or physical difficulties as a result of the ageing process, which can affect their ability to eat, drink and enjoy food,
  - For example, difficulties with swallowing, holding cutlery or other utensils, dentition, vision, taste, smell and recognising food
- Feel lonely and isolated, embarrassed because of disability/other difficulties, or distracted by difficulties experienced by other residents.

Eating well in care homes

Nutritional needs for older adults (those aged 65 years and over) are slightly different from the rest of the adult population. Having a nutrient-rich diet is important which means choosing foods which contain slightly more protein, calcium, folate (folic acid) and vitamin B12 than are needed by younger adults. The amount of carbohydrate (starchy food), sugar, fibre, fat, and salt required is about the same as for the rest of the adult population[1].

Like all adults, older adults need to eat a balance of all the major food groups and nutrients, including protein, milk and milk-based foods, fruit and vegetables, starchy carbohydrates, fibre and fat as well as drinking enough fluid every day[2]. Figure 1 outlines what a balanced diet for people aged 65 years and over should look like[1]:

Figure 1: Eating, drinking and ageing well

BDA The Association of UK Dietitians

Eating, drinking and ageing well

Having a nutrient-rich diet over the age of 65 is important for everyone, which means choosing foods with slightly more protein, calcium, folate (folic acid) and vitamin B12. The amount of carbohydrates, sugar, fibre, fat, and salt you need are likely to remain the same as for younger adults.

Enjoyment of eating and drinking

Taking pleasure in food and drink can help you eat well and maintain your health.

Enjoyment can be increased by getting involved in choosing food and drinks that you like and preparing, cooking and serving meals. For some, sharing a meal with friends or family helps or for others eating alone is more beneficial.

Cultural and religious identity is often linked with food and drink too and is there to be celebrated.

Weight

As you get older maintaining your weight is usually best for good health, giving you enough energy to stay well, socialise and be active.

If you have a low body weight you may need some support. If you are very overweight, losing weight may be good for your health but it is important to still eat a nutrient-rich diet, take regular activity and maintain muscle. If you are slightly overweight, losing weight might not actually improve your health.

Activity

Moving more and keeping active, together with eating a nutrient-rich diet keeps your muscles, bones and joints strong.

** Infographic reproduced from UK Chief Medical Officers' Physical Activity Guidelines 2019 - Contains public sector information licensed under the Open Government Licence v3.0 https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report*

Vitamin D

Vitamin D supports bones, muscles and teeth. It helps preserve muscle strength, preventing falls, the softening of bones and the risk of fractures.

Vitamin D supplements purchased from a supermarket or pharmacy should provide 10micrograms (400 IU) each day and are the most effective way to meet your needs.

They should be taken in winter but you may benefit from them all year round. Vitamin D3 is your best choice, however, people following a vegan diet may find vitamin D2 more useful.

Supported by: Friends of the Elderly, BGS

BDA The Association of UK Dietitians Older People Specialist Group

Eating, drinking and ageing well. A nutrient-rich diet is...

Fruit and vegetables

Fruit and vegetables provide a wide range of vitamins and minerals. Have at least five varied portions every day. Pick leafy greens like kale, spinach, and lettuce which are good sources of folate.

1 portion =	
80g	fresh, frozen or canned
30g	dried

Carbohydrate (Starchy)

Carbohydrates provide energy, especially for the brain. Have one portion of something starchy at each meal.

1 portion =	
190g	cooked pasta, rice or grains
80g	bread or chapati/roti
30g	breakfast cereal or flour
150g	potato, sweet potato, yam, cassava, plantain

Protein

Protein is good for muscle strength, so have at least one portion with each meal. Consider having two or more portions of fish per week, one of which is oily, such as salmon or mackerel. Limit processed meats.

1 portion =	
90g	cooked meat or poultry
140g	fish or shellfish
2	eggs
100g	meat alternative
150g	cooked beans or lentils
30g	nuts

Milk and milk-based foods

Milk and milk-based products are a key source of calcium. Have three portions of milk and milk-based products per day such as milk, yoghurt, or cheese. If you don't like, or can't have milk and milk-based foods, choose calcium-fortified milk-free alternatives.

1 portion =	
200ml	milk
30g	cheese
125g	yoghurt

Fat

Fats are high in energy and should be eaten sparingly but they can help you absorb vitamins like A, D, E and K. Limit high-fat foods like processed meats and pastries. Swap butter/ ghee for unsaturated vegetable, rapeseed, olive and sunflower oils and spread. Nuts and seeds are also good choices.

Vitamin B12

Intake can be low in older adults but vitamin B12 can help maintain energy levels and health. Regularly have foods fortified with it, for example breakfast cereals or yeast extract, or have animal products including lean meat, fish, poultry, eggs, milk and milk-based foods as outlined above.

Fibre

Fibre gets your gut working normally, supporting good gut bacteria and it can also help mental health. To help maintain a healthy gut choose wholegrain carbohydrate options and eat fruit, vegetables, beans and lentils.

Drinking enough?

Fluid is also important as you age. As you get older, you might not recognise the feeling of thirst as you used to, but you still need to drink. All fluids count, not just water. Other fluids include tea, coffee, milk, squash, fruit juice, fizzy drinks, hot chocolate and weak alcoholic drinks (up to 4% strength (ABV). Water, tea, coffee (without added sugar) and milk are the best choices for your teeth. Men and women have slightly different fluid needs:

WOMEN at least **1600 ML** per day = 3 PINTS

MEN at least **2000 ML** per day = 3½ PINTS

- Cups & glasses can be lots of different sizes so it's important to know how much fluid they hold.
- Drinking often during the day can be the key to getting all the fluid you need.
- If you drink less than the amount advised and are worried that drinking more might cause you problems controlling your bladder, please discuss this with a healthcare professional.

Alcohol Alcohol isn't an essential nutrient and intake should not exceed national recommendations of 14 units per week. Spread your intake across the week, rather than drinking in large quantities in one go – and have some alcohol-free days.

Sugar Sugar doesn't provide the body with anything it needs to keep well. Limit your intake of sweet snacks, sugary drinks and confectionery.

Salt Salt can make food tastier but too much can increase your risk of high blood pressure. Limit it and try replacing with herbs, spices, garlic, vinegar and lemon juice. Reduce your intake of processed meats and salty snacks, as well as the amount of salt you add when cooking or at the table.

Malnutrition

Malnutrition is more common in older, frail and more dependent people, with the key symptoms being low body weight and unplanned weight loss. When a resident does not eat the right balance of nutrients their risk of developing malnutrition can increase.

Risk of malnutrition

Older adults living in care homes are at high risk of developing malnutrition. Malnutrition is both a cause and consequence of ill health in older adults, increasing the chance of a resident becoming unwell. Older adults are also at high risk of developing dehydration which can also increase a resident's risk of becoming unwell.

Malnutrition (undernutrition) can be defined as:
'Poor nutrition, commonly caused by not eating enough or not eating enough of the right food to give your body the nutrients it needs. A balanced diet should provide enough nutrients like calories, protein and vitamins, to keep you healthy'[3].

Dehydration can be defined as:
'A serious condition which can occur when your body does not get enough fluid to meet your needs. Dehydration can be due to low intake of fluid (known as low intake dehydration) over a period of time. In people who are acutely ill it can occur over a short period of time'[4].

Up to 70% of people in care homes are living with dementia and dementia greatly increases risk of malnutrition and dehydration. As dementia progresses, a reduction in eating ability is common and nutritional care can become more difficult for carers to support[5].

Frailty (increased vulnerability due to ageing, physical and cognitive decline which reduces ability to cope with everyday stresses and ill health) and malnutrition are strongly linked. People who are malnourished are almost four times more likely to become frail. In addition, 50% of people who are frail are likely to also be malnourished[6]. It is important to note that frailty is not always associated with malnutrition, as it can also be due to physical difficulties and disablement.

Factors which can increase the risk of malnutrition

There are many social, physical and medical factors which can contribute to an altered food intake which are outlined in Table 1 below:

Table 1: Factors which can increase the risk of malnutrition

Social factors

- Living in isolation
- Limited knowledge of nutrition
- Limited cooking skills
- Alcohol or drug dependency
- Poverty
- Limited mobility or lack of transport resulting in difficulty accessing food.

Physical factors

- Poor dentition
- Loss of appetite due to loss of smell or taste
- Physical disability which reduces ability to cook, eat or shop independently.

Medical factors

- Conditions causing a lack of appetite (such as cancer or liver disease)
- Mental health conditions such as depression
- Dementia
- Any condition that reduces the body's ability to absorb or use nutrients
- Swallowing difficulties (dysphagia)
- Vomiting or diarrhoea
- Eating disorders
- Taking multiple medications and medication side effects.

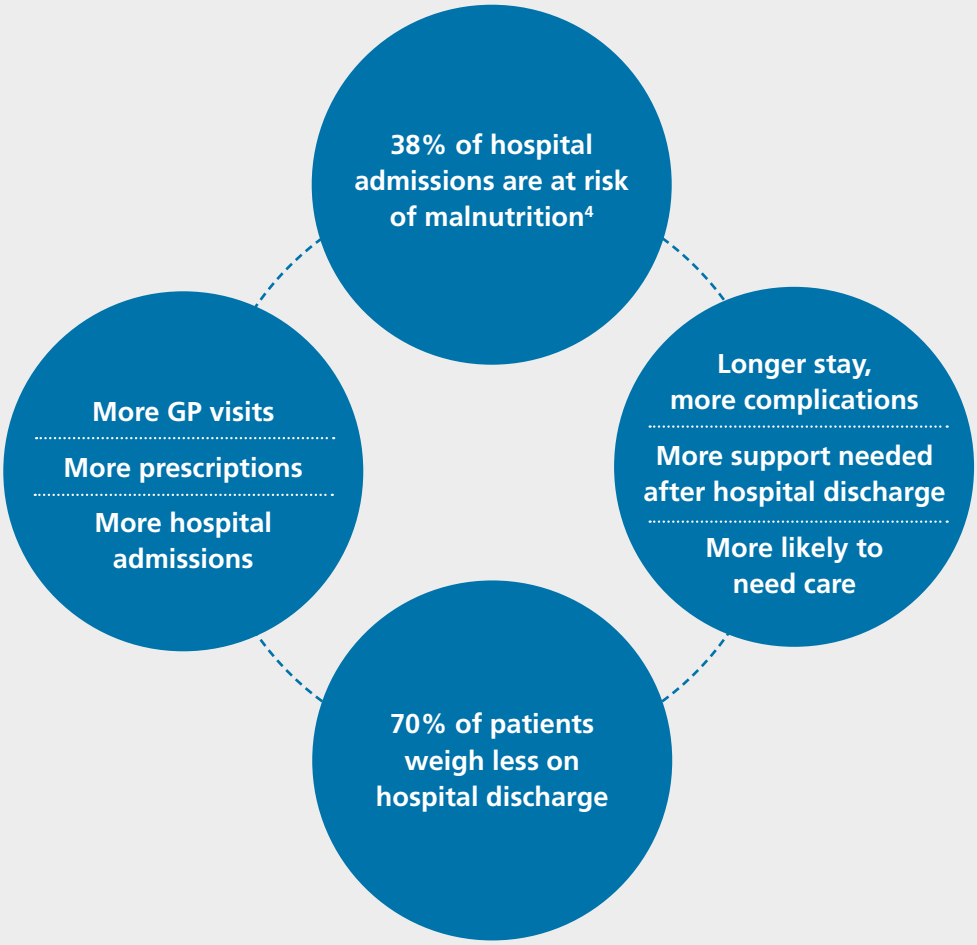
Consequences of malnutrition

Consequences of malnutrition can include:

- A reduction in muscle mass and function which reduces strength and/or ability to undertake normal tasks. This is called 'sarcopenia' and increases the likelihood of frailty, falls, broken bones, disability and death[7]
- Reduced ability to fight infections and impaired wound healing
- Inactivity and reduced ability to look after oneself
- Low mood
- Death.

Figure 2 below shows the impact that these consequences can have on health services and the individual.

Figure 2: Consequences of malnutrition



Ultimately, the risk of malnutrition and dehydration as a result of decreased food and fluid intake are serious risks and require action to try to limit their effect on the body.

Screening for malnutrition risk

In England, Regulation 14 of the Health and Social Care Act stipulates that in order to identify the risk of malnutrition, nutrition assessment in a care home should follow nationally recognised guidance[8].

NICE Clinical Guideline 32 is nationally recognised guidance on nutrition support in adults, which includes screening for malnutrition[9]. NICE Quality Standard 24 also defines clinical best practice within this topic area and states that people in care settings should be screened for risk of malnutrition using a validated screening tool[10].

The most commonly used screening tool in all care settings in the UK is the 'Malnutrition Universal Screening Tool'('MUST')(BAPEN*), which relies on measurement of Body Mass Index (BMI), unplanned weight loss over the last 6 months and presence of acute disease, (acute disease effect is unlikely to apply outside hospital). It categorises people as being at low, medium or high risk of malnutrition and signposts care teams to management guidelines based on level of risk[11].

MUST scores can be calculated manually or calculated within electronic notes systems. Scores should always be checked for accuracy whatever method is used to generate them. An online MUST calculator is available at http://www.bapen.org.uk/screening-and-must/must-calculator[12].

The Patients Association Nutrition Checklist, which does not require any measurements, could be used instead of MUST to screen residents in care homes[13].

Nutrition and hydration care plans

Good quality care plans (may also be called support plans) are essential to underpin safe, effective, compassionate, high-quality care. They should communicate the right information clearly, to the right people (including catering teams), when they need it, to ensure person-centred safe care and treatment is provided.

Care plans are only as good as the information recorded, so time should be taken to ensure they are as detailed as possible and that all the right assessments have been considered. Care plans should be regularly updated and shared with all relevant teams within the care home. In England the importance of this area of care is made clear in the Health and Social Care Act, particularly regulations 9 and 12 [14]. The regulations for the other nations are outlined in Table 3.

A clear and detailed nutrition and hydration care plan should be produced for every resident before they move in (pre assessment). This should be updated at admission (initial assessment) and then regularly reviewed and updated as an ongoing process during their stay. Residents' nutrition and hydration care plans should consider their support and environmental preferences as well as their dietary needs.

Nutrition and hydration care plans could include advice received from healthcare professionals such as:

- **Dietitian**
  Person-centred or care home specific advice on special diets. Dietitians may also be involved in auditing nutritional care
- **Occupational therapist**
  Seating and positioning at meals, adaptive crockery and cutlery or lighting
- **Speech and language therapist**
  Communication disorders or swallowing difficulties
- **Dentist**
  Oral health, tooth friendly food and fluid choices or timing of meals and snacks
- **Pharmacist**
  Combining food and medications
- **Doctor**
- **Palliative care team.**

Nutrition and hydration care plans should be stand-alone documents just like other care plans covering key risks such as swallowing difficulties (dysphagia).

Hydration

Dehydration can be life threatening and is a frequent cause of hospital admission but is often preventable. The main causes and consequences of dehydration are listed in Table 2 below[15].

Table 2: Causes and consequences of dehydration

Causes of dehydration	
▶ Reduced sense of thirst	▶ Taste changes
▶ Diarrhoea and vomiting	▶ High body temperature (fever)
▶ Concerns about continence	▶ Medicines
▶ Swallowing difficulties	▶ Reduced access to fluid/preferred drinks
▶ Reduced ability to drink	▶ Reduced kidney function.
▶ High environmental temperature (hot weather)	

Consequences of dehydration	
▶ Urinary tract infections	▶ Seizures
▶ Constipation	▶ Poor temperature regulation
▶ Low blood pressure	▶ Pressure injury
▶ Confusion	▶ Poor wound healing
▶ Falls	▶ Harmful drug levels in the body
▶ Kidney failure	▶ Death.

Screening for dehydration risk

There is no reliable assessment or screening tool to identify dehydration.

Fluid intake requirements
(per day)

Older women
need to drink at least

1,600ml

Older men
need to drink at least

2,000ml

As a general rule older women need to drink at least 1,600ml fluid per day and older men need at least 2,000ml fluid per day, but in reality drinking these amounts can be challenging for some residents. However, every sip of fluid matters and residents do not have to be encouraged to only drink water if they prefer other drinks. All fluids count towards meeting hydration needs including drinks containing caffeine[14] and low alcohol drinks up to 4% alcohol by volume (ABV) (within recommended limits). For residents who are malnourished the focus should be on drinks which also provide nutrition e.g., whole milk, milkshakes and hot milky drinks e.g., hot chocolate, malted milk and milky coffee.

Carers should take responsibility for ensuring that residents preferred drinks are always provided and left in easy reach and that residents who rely on carers to access their drinks are clearly identified and supported to drink regularly[16].

If a resident has been advised to have thickened drinks due to swallowing difficulties their risk of dehydration is likely to be higher (see **Chapter 4**).

Foods naturally high in fluid (soup, yoghurt, ice-cream, fresh fruit) can be advised to help meet hydration needs. However, they should not be relied on in place of drinking as they can be low in nutrients and filling, so may not be the best choices for those who are also at risk of malnutrition.

How to support good hydration for residents

The BDA Nutrition and Hydration Digest (3rd Edition) highlights the following for people in hospital and these are just as relevant for residents in care homes[17]:

- **Availability of drinks**
  Drinks should be available everywhere, at all times, at the right temperature and of the right type. There should always be a range of options that meet all needs and preferences
- **Opportunistic drinks**
  When medications are provided, a full glass of fluid should be given, rather than just a few sips
- **Accessibility**
  Help and support to access a drink and whilst drinking should be provided. This may mean using adapted drinking cups/glasses which meet residents' needs. Health professionals (such as Speech and Language Therapists or Occupational Therapists) may be able to advise on these
- **Social interaction**
  Drinking with others can encourage fluid intake
- **Cup and glass sizes**
  Carers should know the volume of all commonly used cups, mugs and glasses within their care home and how that relates to the amount that residents need to be encouraged to drink each day
- **Attractive options**
  Try to make the drink look appealing and recognisable to encourage intake
- **Reassurance**
  Residents may need to be discreetly reminded that there is support if fear of incontinence is a barrier to drinking well
- **Education**
  Supporting the resident, relatives and carers to understand the importance of drinking regularly.

Most fluids count towards meeting hydration needs

Current care home guidelines

There are a number of guidelines, standards and training tools about nutrition and hydration for health and social care. It is useful to know about key documents when establishing workplace specific protocols, training and policy as they can underpin good practice. Table 3 below is a list of some guidelines that might be useful:

Table 3: List of useful resources and guidelines

Resource	Organisation	Description and web links
	Advisory Committee on Borderline Substances (ACBS)	ACBS is a scientific advisory committee that is established and sponsored by (but independent from) the Department of Health and Social Care. ACBS is responsible for advising on the prescribing and use of borderline substances (oral nutritional supplements and tube feeds) in NHS primary care (community) https://www.gov.uk/government/groups/advisory-committee-on-borderline-substances
	Ageing & Dementia Research Centre (ADRC) Bournemouth University	The ADRC focuses on research expertise in areas of ageing and dementia. They produce a toolkit that can be useful for care homes: https://www.bournemouth.ac.uk/research/centres-institutes/ageing-dementia-research-centre/eating-drinking-well-dementia-toolkit
MUST (Malnutrtion Universal Screening Tool)	British Association for Parenteral and Enteral Nutrition (BAPEN)	Validated screening tool for malnutrition: https://www.bapen.org.uk/screening-and-must/must/introducing-must
Food Factsheets	British Dietetic Association (BDA)	Evidence based factsheets: https://www.bda.uk.com/resource/hydration-in-older-adults.html https://www.bda.uk.com/resource/malnutrition.html https://www.bda.uk.com/resource/pressure-ulcers-pressure-sores-diet.html

Eating, drinking and ageing well	British Dietetic Association (BDA)	Evidence based healthy eating guidance for adults aged 65 and over produced by the BDA: https://www.bda.uk.com/resource/eating-drinking-and-ageing-well-a-new-bda-resource-for-older-people.html
Nutrition & Hydration Digest (3rd Edition)	British Dietetic Association (BDA)	Evidence based guidance for hospital food provision: https://www.bda.uk.com/asset/176907A2%2DF2D8%2D45BB%2D8213C581D3CCD7BA/
Regulations - Scotland	Care Inspectorate (Scotland)	The Care Inspectorate hub (Scotland) provides specific guidance for Scotland: https://hub.careinspectorate.com/how-we-support-improvement/improvement-programmes-and-topics/eating-and-drinking-well-in-care-good-practice-guidance-for-older-people/
Guidelines - Scotland	Care Inspectorate (Scotland)	Guidelines to support vegetarian and vegan residents. These include information on how to follow residents' choices and needs. Good_care_for_vegetarians_and_vegans.pdf (careinspectorate.com)
Regulations - Wales	Welsh Government	The Welsh Government standards and regulations for Care Homes in Wales Guidance for providers of care home and domiciliary support services	GOV.WALES
Guidelines - Wales	Welsh Government	Government care home guidance for food, nutrition & hydration in Wales: https://www.gov.wales/food-and-nutrition-guidance-older-people-care-homes
Regulations – Northern Ireland	The Regulation and Quality Improvement Authority (RQIA)	RQIA is an independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services: https://www.rqia.org.uk/RQIA/files/7b/7bce7e39-bcb5-48b5-8dc1-b9058f1f1d4f.pdf
Standards – Northern Ireland	Department of Health, Social Services and Public Health – Northern Ireland	Care Standards for Nursing Homes https://www.rqia.org.uk/getattachment/7dec5d24-796a-440a-9a60-7deb7112c994/Care-Standards-for-Nursing-Homes-Dec-2022.pdf.aspx

Standards – Northern Ireland	Department of Health, Social Services and Public Health – Northern Ireland	Residential Care Homes Minimum Standards https://www.rqia.org.uk/getattachment/ea7c184c-8bb5-41e3-a270-db34fc2fad9a/Residential-Care-Homes-Minimum-Standards-Dec-2022.pdf.aspx
Nutritional Guidelines for Residential and Nursing Homes – Northern Ireland	Public Health Agency – Northern Ireland	Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. https://www.publichealth.hscni.net/publications/nutritional-guidelines-and-menu-checklist-residential-and-nursing-homes
Promoting Good Nutrition Strategy and Guidance - Northern Ireland	Department of Health - Northern Ireland	Northern Ireland strategy for promoting good nutrition and guidance and resources to support the use of MUST across all care settings. https://www.health-ni.gov.uk/publications/promoting-good-nutrition-strategy-and-guidance
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	UK Government	In England the Health and Social Care Act is the basis for all guidance and regulatory frameworks in care homes: https://www.legislation.gov.uk/uksi/2014/9780111117613/contents
Food allergy	Food Standards Agency (FSA)	Guidance and training on food allergies: https://www.food.gov.uk/safety-hygiene/food-allergy-and-intolerance
Modified texture food and fluid	International Dysphagia Diet Standardisation Initiative (IDDSI)	https://iddsi.org/ Endorsed by Royal College of Speech and Language Therapy (RCSLT) and British Dietetic Association (BDA)
	National Association of Care Catering (NACC)	The NACC is a membership organisation, comprising care suppliers and providers. They offer seminars and good practice guidelines as well as campaigning for relevant issues to secure a quality service in care catering: http://www.thenacc.co.uk/

A strategic document of diabetes care for care homes	National Advisory Panel on care home diabetes (NAPCHD)	NAPCHD is a multi-professional group of specialists working with people living with diabetes and other key stakeholders who worked together to produce the Strategic Document of Diabetes Care specifically to support care homes to manage residents living with diabetes. Appendix B sets out the most appropriate dietary advice for healthcare professionals and carers supporting older residents with diabetes to follow and is written by diabetes specialist dietitians with experience in the care home setting. http://fdrop.net/wp-content/uploads/2022/05/PDF-APPENDIX-B-NAPCHD-for-fDROP-website-08-05-22.pdf
Clinical Guideline 32 Nutrition support for adults: Oral nutrition support, enteral feeding and parenteral nutrition **and** **Quality Standard 24 Nutrition support in adults**	National Institute for Health and Care Excellence (NICE)	NICE is part of the Department of Health and Social Care and is responsible for publishing guidelines relating to clinical practice and treatment for both England and Wales https://www.nice.org.uk/guidance/cg32 and https://www.nice.org.uk/guidance/qs24
Coeliac UK guidance on preparing gluten free meals for catering teams	Coeliac UK	Provides information about a gluten free diet for those living with coeliac disease and those preparing gluten free meals. https://www.coeliac.org.uk/information-and-support/
Framework for Enhanced Health in Care Homes	NHS England	Supports the delivery of minimum standards and sets out practical guidance and best practice for organisations in England. It is intended to ensure that people living in care homes have access to NHS services: https://www.england.nhs.uk/community-health-services/ehch/

Creating a Fortified Diet for Caterers	PrescQIPP	Evidence based resource designed to support catering teams to provide nutrient dense food for residents at risk of malnutrition. It is endorsed by both the British Dietetic Association and the NACC: https://www.prescqipp.info/media/6292/creating-a-fortified-diet-for-caterers-recipe-booklet-20.pdfand https://www.thenacc.co.uk/what-we-do/share-knowledge/creating-a-fortified-diet-for-care-home-caterers
Position statement and Position paper on use of thickened fluids	Royal College of Speech and Language Therapists (RCSLT)	https://www.rcslt.org/news/our-statement-on-thickened-fluids/ https://www.rcslt.org/news/new-position-paper-on-the-use-of-thickened-fluids/
Supporting good mouthcare resources	Various	ER-Mouthcare-for-Older-People-Information-for-Carers-BSG1205upload.pdf Oral_health_a_quick_guide_for_care_home_managers.pdf (nice.org.uk) Mouth care and oral health for people with dementia – Dementia UK, YouTube How To Clean a Denture Animation – Mouth Care Matters, YouTube Supporting patients hospital who are resistant to mouth care YouTube Gwên am byth Public Health Wales (nhs.wales)

2

Delivering a positive mealtime experience

On all occasions it is important to ensure that mealtimes are an enjoyable experience that are well suited to all residents.

For most people, eating a meal isn't about meeting nutritional requirements; enjoyment of the meal, meal experience and environment are just as important as (or more important than) the nutritional content of the food.

Research tells us that:

- Eating together is a core human activity and is important for building social groups
- Mealtimes reflect identity and enable us to make and maintain connections with others
- Eating with others can also help to increase appetite and food intake
- Food is often an important part of living with purpose for older adults, including for those who are resident in care homes[18].

On all occasions it is important to ensure that mealtimes are an enjoyable experience that are well suited to all residents. This chapter outlines the actions that care teams can take to enhance the food service for residents, providing them with both a good dining experience and optimised nutritional intake from food and drink. When thinking about a resident's mealtime experience all aspects of food service should be considered including traditional mealtimes like breakfast, lunch and dinner and also between mealtimes, snack times and overnight or 'out of hours.'

Approach to food service

The delivery of food and beverage services needs to be well planned and well organised to ensure residents individual needs can be met.

Both catering and care teams should receive information about a resident's food and dietary needs and preferences before the resident moves in. Once they have moved in, the care team should gather detailed dietary information with the resident to record their needs and preferences. This detailed dietary information should be used when the catering team meets the resident to introduce themselves, ideally within 48 hours, so that the resident is made aware of the food and beverages services available and they understand what type of food and food services are most important to the resident. Information shared with the resident (or their relative where appropriate) by the catering team could include the following (over a period of time if appropriate):

- Catering team introductions with photos
- Current menus and alternative choices available
- Mealtimes and locations for meals
- Room service delivery
- Visitors and meals
- Policy on food for residents brought in by visitors
- Catering for specific dietary needs
- Special requests
- Any catering team meetings and dates
- Food available all day and night
- Comments and complaints / comments book.

Whole home approach

The care home team need to ensure that food and beverage service planning is resident centred and takes into account all requirements including specific personal preferences, religious or cultural needs, food allergies and other special dietary requirements including modified texture diets. All these needs should be captured on a summary dietary information sheet or equivalent and this summary dietary information sheet should be available to and actively used by staff at all meal and snack times (see **Appendix 1** for an example).

All team members (including managers, catering team, nurses and carers) should be actively involved and engaged in supporting mealtimes in the home. To support this, team member breaks should not coincide with resident mealtimes and all team members need to understand their role in supporting meal service.

Where possible all residents should be encouraged to enjoy their meal in the dining room as this can enhance the mealtime experience, add meaningful social engagement and can encourage residents to eat better. However, some residents will genuinely prefer to eat elsewhere e.g., in their room, and this should be respected but should not be assumed. Where residents do wish to eat somewhere other than the dining room, thought needs to be given to providing them with an equally good dining experience.

Fresh cold and hot beverages should be available throughout the day and night and at every mealtime. Some homes provide 'destination hydration stations' but if there isn't the space for this, hot drinks should be made to order and a variety of cold drinks should be available in clean jugs e.g., water, juice and fruit squash.

The dining room environment

Below are some guidelines for making the dining room space a place that will encourage residents to want to eat there:

- Clear routes around the dining room can help encourage independence and mobility, enabling social interactions during mealtimes
- Tables should be set at least 30 minutes in advance of any mealtime, so the residents walk into a clean and fresh-looking environment which informs them that a mealtime is approaching
- Make sure that the resident's summary dietary information sheet or equivalent is available in the dining room for team members to refer to (see **Appendix 1** for an example)
- A standard table setting which is appealing and appropriate for residents being served should be adopted for tables. Where tables need to be personalised to suit a specific resident's needs this should be done to the same standards where possible. This might include the provision of adaptive cutlery or shatterproof crockery or glassware and include the discreet use of anti-slip mats under the crockery
- Ensure that there is enough space in between tables so the dining room does not feel too crowded at mealtimes and that table settings can accommodate an adapted chair where the use of a standard chair is not appropriate
- The size of rooms and potential noise levels should be assessed to ensure that dining rooms aren't inappropriately sized and/or noisy during the meal service.

In addition to the points above the following might help enhance the dining experience further:

- Best practice for table setting could include the use of a linen tablecloth and linen napkins, use of clean, matching, polished cutlery laid out in a presentable format with suitable glassware for juice or water. Fresh flowers in a bud vase always adds a nice touch and can be well received, but if plastic flowers are used, these should be of a good quality and be cleaned regularly
- Before a mealtime it is quite common for residents to make their way to the dining room early. Where possible there should be a separate area which could be a lounge area offering comfortable seats with tables and refreshments for residents to sit and wait comfortably if the dining room is not quite ready

- Soft furnishings can add colour, comfort and some style to the dining room and can make the difference between residents wanting to spend time in the dining room versus the mealtime experience being purely functional
- Storage areas for equipment such as walking frames should be available to help avoid equipment cluttering up the pathways in between tables and around the dining room, but these aids should still be easily reachable should the resident wish to leave the table
- Good lighting and appropriate background music can support the whole dining experience and ambience. Most care homes will be well lit, but this can be enhanced with additional mood lighting.

Preparation for meal service

Before the meal service begins, teams should consider the following:

- Daily menus should be displayed at an appropriate height for residents to be able to read them, in a font size and typeface that makes them easy to read. Table menus stating the meal choices at each mealtime should be available and should also use a suitable font size and typeface. Pictorial menus should also be available for those who might need different support to be able to choose their meal. Menus can be used with residents before the meal service to talk about the next meal as this might support them to be tempted to eat
- Any signage should be well lit and easy to follow to allow residents to find their way to the dining room independently wherever possible
- Where safe and appropriate to do so, consider involving residents in preparation of foods
- Prior to mealtimes, cues that a mealtime is approaching can support eating and drinking (e.g., the smell of cooking/food, preparing for a mealtime by setting the table, visiting the toilet and washing of hands may also help)
- Before the meal service begins there should be a ‘safety pause’ to ensure all members of the team are alerted to anything relating to residents, about which they need to be aware which could affect residents ability to eat safely or meet their needs
- Prior to and during any meal service it is vital that all team members know what their roles are to ensure the mealtime runs smoothly and that there are enough team members to enable this. The meal service needs to be a well thought through process, with all team members having received training to understand how the team needs to work together most effectively to meet residents’ needs. This should include:

- Making sure there is an agreed person in charge of the overall meal service (mealtime co-ordinator)
- Having a pre meal briefing to ensure all team members:
  - Know their roles for each meal service
  - Understand both the menu and choice of meals, and alternative meals and snacks that are available if a resident declines all choices
  - Understand any special dietary requirements of residents
  - Provide assistance where required in a coordinated way
  - Know who will meet and greet residents with a drink of their choice while they get settled.

During mealtimes

- Where possible residents should be enabled to choose their meal at the point of service (this may not always be possible for residents with special dietary needs). This can be done in several ways depending on the residents and care home service system, including ordering from the table menu, offering 'show plates' of the meal choices available or using pictorial menus. Residents should not be asked to order in advance, but where this is considered essential in the home, residents should be allowed to change their mind at the mealtime and receive an alternative choice
- A member of the catering team should be in the dining room or service area to help support the team with information around the day's meals, so this can be relayed to the residents in the correct way
- If a member of the catering team is not available, 'show plates' need to be sent from the kitchen to demonstrate best practice for food presentation for each dish
- When residents have made their meal choice, food should be served in an appropriate portion size and be well presented on the plate. Different foods in the meal should be spaced correctly, include variety of colour and servers should always ask if (rather than assuming that) a resident wants gravy or sauce. Gravy or sauce should be offered from a gravy/sauce boat at the table. Lastly, all spillages should be cleaned from the rim of the plate or bowl before it is served to a resident
- Condiments, including salt and pepper, should be available for every mealtime and be in clean dispensers that are see through or very clearly labelled to help residents make the choice between them. Other mealtime condiments that complement the meal of the day,

e.g., mint sauce, apple sauce, mustard should be available where the meal is served. These should be actively offered to residents at the table as a visual/interactive prompt

- Each meal should be checked by a member of the care home team to ensure that it is in line with the resident's needs
- Residents must be served their meals course by course and shouldn't be offered their next course e.g., dessert, until they have eaten all they want of the main course
- Residents should be offered second portions where appropriate
- Attention should be paid to the sitting/positioning of residents to ensure that they are supported to be upright in order eat their meal comfortably and safely
- If a resident has one sided weakness, e.g., from a stroke, loss of hearing in one ear or better sight in one eye, place food and drink on their 'good side'
- Used plates should be removed before the next course is served to avoid the table becoming cluttered
- Where this is indicated (usually only for short periods of time) individual resident's food intake should be documented before plates are removed from the dining area, to enable accurate recording
- At mealtimes it must be understood that meals are often a highlight of the day for residents, which means that interactions should engage residents and be meaningful and informative. Residents should be actively encouraged to eat, which might include carers eating their lunch with residents in some cases
- It is important to remember that mealtime etiquette (avoiding eating with hands or dropping crumbs on the floor) is not a priority for care.

Each meal should be checked by a member of the care home team to ensure that it is in line with the resident's needs

After mealtimes

Residents should be asked to give regular feedback about all aspects of food and beverage services, and this can be done in several different ways.

Food can be an emotive subject, so requesting feedback and holding regular meetings allows the home to keep in touch with residents' mealtime preferences and make changes to the menu where needed.

Feedback could be in the form of:

- A suggestion book made available in the dining room
- Feedback cards to capture how the meal was today (this can be very helpful for the catering team especially when trying new or different dishes)
- Regular resident/relative meetings or food forums about food and beverage services
- Surveys for residents, friends and families
- Where a resident is unable to verbalise their views or where they choose not to, observations and waste records can be helpful.

Room service delivery

Meal service to individual resident's rooms needs to be coordinated in conjunction with the dining room service to include:

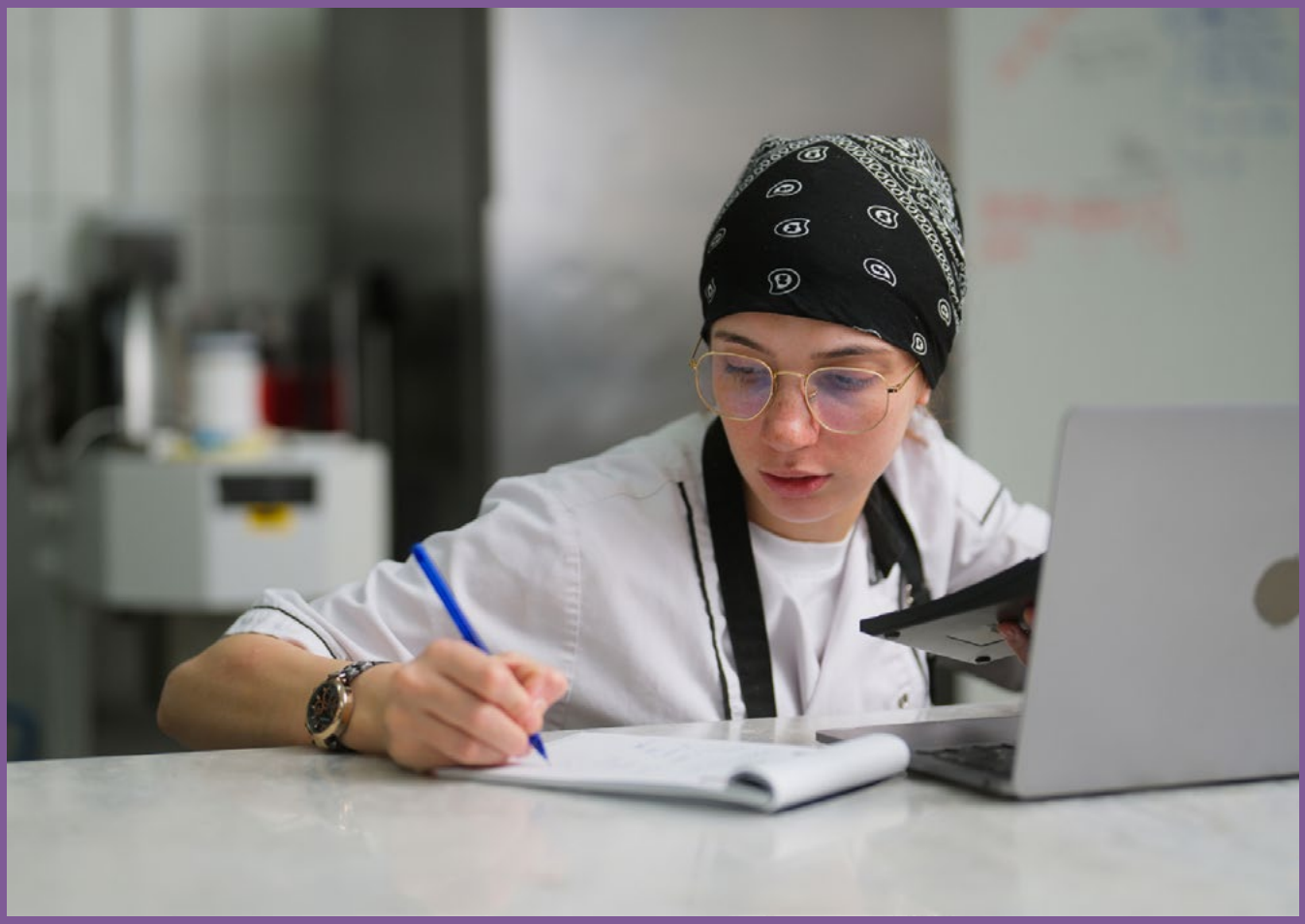
- Enough team members available to deliver meals together with enough time to assist residents to eat, making sure the meal service isn't rushed. To enable this to happen, the times of meal service may need to be staggered between the dining room and residents eating in their own rooms
- Offering residents a choice of beverage at the start of the meal service
- Discussing meal options with residents at point of service to ensure they are able to make their preferred meal choice
- Ensuring residents meal choice is relayed to the catering team and each course is served separately
- Making sure that resident's summary dietary information sheet or equivalent is available for team members to refer to (see **Appendix 1** for an example)
- Serving each meal on a clean well-dressed tray with the correct protection e.g., a cloche, choice of condiments and correct cutlery
- Clearing each course away before the next is served and food and fluid intake is documented where required.

NHS Greater Glasgow and Clyde Care Home Collaborative have produced a mealtime experience poster that can be shared and used where this would be helpful [19].
https://www.nhsggc.scot/downloads/mealtime-experience-poster/

A checklist tool for homes to use to observe and measure their meal service can be found in **Appendix 2**.

3

Menu planning and design



The aim of this chapter is to provide practical guidance to support menu planning and the design of menus to meet residents' food preferences and basic nutritional needs.

Enjoyment of eating is always going to be more important to residents than whether that food is nutritionally balanced, and residents should always be able to choose meals and snacks that they prefer.

This chapter outlines what a **menu** should contain so that care and catering teams can assure themselves that residents' nutritional requirements could be met through the provision of food and drink. The portion sizes given are 'standard' portion sizes which should be available for residents should they be able to eat those amounts. Portion sizes can be adjusted according to an individual resident's appetite, but it is recommended that balanced meals are served where possible. Further notes about implementing these guidelines are included at the end of this chapter.

To support implementation of the guidelines in this chapter a Menu Assessment Checklist can be found in **Appendix 3**.

The benefits of menu planning

Menu planning allows care home teams to:

- Ensure residents preferences are built into menus using resident feedback and knowledge of the most popular menu choices
- Ensure all residents nutritional requirements are considered and built into the menu where possible [2]
- Plan a menu taking into account the most commonly required special diets
- Ensure a suitable number of meal choices are consistently available to provide adequate choice and minimise repetition
- Calculate potential food costs and agree a realistic budget
- Make use of seasonally appropriate choices and minimise waste
- Facilitate food ordering and minimise food production waste
- Consider contingency plans for occasions where products are not available
- Identify food allergens in ingredients and introduce methods to reduce the risk of cross contamination.

Menu Planning

The process of menu planning can is shown in Figure 3.

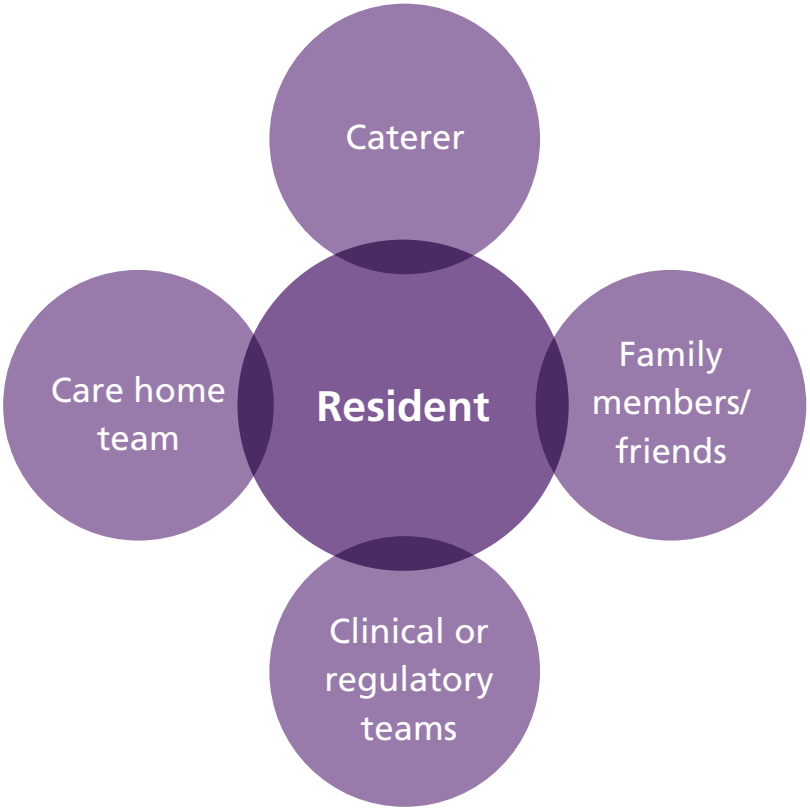
Figure 3: Adapted from BDA Nutrition and Hydration Digest 3rd Edition 2023 [17]

1. **Establish who should be involved in menu planning**
2. **Resident group assessment**
3. **Review national standards and local NHS guidance**
4. **Determine the budget and available resources**
5. **Sustainability**
6. **Menu type**
7. **Menu structure**
8. **Menu content**
9. **Menu analysis**
10. **Menu launch**

1 Establish who should be involved in menu planning

Before thinking about designing or reviewing menus consider who should be consulted, considered or asked to take part in the menu review. Figure 4 highlights who could support the design of menus in care homes and places the residents' needs and preferences at the centre, and promotes their active involvement in this process.

Figure 4: Resident focused menu planning model



Some residents will have received specific advice from a healthcare professional regarding the food and drinks that they need or how they receive them. Relevant advice from this healthcare professional should be recorded in the resident's care plan and communicated to all appropriate team members.

It may not be practical to involve all of the above groups every time the menu is being reviewed but as a minimum, residents, dedicated carers, the care home manager and catering teams should be part of the process.

1a. Resident family and friends involvement

Families and friends may be able to advocate for a resident in their best interests if they struggle to communicate their own needs, although family and friends may be less aware of the residents most recent preferences, especially if the resident has lived in the care home for a while. It is therefore also helpful to consult the resident's dedicated carers about their current preferences. Relatives may have the legal power to make major decisions regarding significant aspects of residents' healthcare (this means they hold a lasting power of attorney for a resident's health and welfare) but this does not include a right to make day to day care decisions such as food choices.

1b. Care home team

Chefs or catering teams will often take the lead on menu planning, but involving the whole care team is essential to ensure that the menu can both meet residents' preferences and their nutritional requirements. Managers, nursing staff, carers and nutrition champions should be encouraged to be part of a menu planning group to share their knowledge around how the home can best meet residents' needs and preferences. The care home manager is uniquely placed to determine the budget and should work with the chef to determine how this can be managed most effectively.

When supporting the design of a menu that meets residents' food preferences and nutritional needs, catering and care teams should review previous menu options, food waste and service user feedback and consider what has worked well and not so well. Recent care inspection reports should also be reviewed and considered by the team.

2 Resident group assessment

When menus are being reviewed, the following must be considered:

- The total number of residents in the home
- Residents' different needs and routines, for example between older adults in residential care, those living with dementia or those requiring full nursing support.
- Residents' length of stay – including respite, longer stays or palliative care

- Residents' physical needs – including specialist eating equipment required
- Residents' food preferences – involve the resident or their representative in this process. If the resident is not able to say what their preferences are, their preferences can often be identified from other sources such as their admission assessment sheet, from care staff supervising meals, the resident's nutrition and hydration care plan, or from the summary dietary information sheet such as the example in **Appendix 1**
- Residents who require special diets e.g., nutrient dense, modified texture food and/or fluids, diabetes, renal, gluten free, food allergy (see **Chapter 4**)
- Religious and cultural dietary needs (see **Chapter 4**)
- Portion control, taking into consideration resident's individual needs.

3 Review national standards and local NHS guidance

More information on national guidance can be obtained in **Chapter 1** and it is also important to know about any local NHS guidance. Reviewing both national and local NHS guidance allows the new menu to adhere to both.

4 Determine the budget and available resources

Care homes have to be mindful of the need to design menus that are value for money. The aim of care catering is to meet residents' preferences and nutritional needs for food and fluid. In line with homes contractual requirements, budgets must be sufficient to buy both enough food to meet residents' needs and to provide appropriate equipment for its safe production and service.

Effectively designed menus which plan for the use of seasonal produce and minimise food waste ensures the efficient use of a food budget. It is important to know how much a menu will cost and to agree the budget and period covered (daily/weekly/monthly) from the start of any menu planning cycle. It is expected that the budget for food will be increased at each review to ensure that inflationary increases in food costs are planned for.

The following factors may influence which dishes can be included in a menu:

- Equipment needed, including food service equipment
- Availability of kitchen space and food storage facilities
- Existing staff availability, rosters and skill level
- Food production methods
- Method of meal distribution and style of service
- Procurement of food
- Site logistics
- Sustainability and seasonality
- Food hygiene and safety requirements
- Food waste.

5 Sustainability

Care homes can play a key part in protecting future generations by providing more sustainable food for residents.

When considering sustainability, thought needs to be given to how food is grown, bought, stored, cooked and wasted. Recommending a plant based diet is less appropriate for residents in care homes but the following ideas could be considered:

- Use meat, dairy products and eggs that are produced within high animal welfare standards and fish that is from a sustainable source
- Recycle packaging
- Work with suppliers to determine the sustainability of the food being ordered
- The number of ingredients and the cooking methods used
- Purchase seasonal foods with a shelf life that allows it to be used up before going out of date
- Minimise food waste and use left over food where possible and safe to do so.

Further information can be found on Delivering a 'Net Zero' NHS [20]

6 Menu type

Most care homes follow a cyclical menu structure, but in some cases either an a la carte menu or hybrid of the two menu types might be provided. Menus should be reviewed seasonally, at least 6 monthly or more frequently if feedback requires it to be adjusted sooner.

When designing menus, a variety of dishes that are visually appealing should be included and a 3 or 4 week menu cycle used to reduce the risk of menu fatigue. Flexibility will be needed to accommodate small and frequent meal patterns.

7 Menu structure

The following pages describe the breakfast, main meal, simple (second) meal and snacks that should be provided as a choice for residents as a minimum each day. Providing regular hot and cold drinks and meals are essential for meeting residents' nutrition and hydration needs.

During the day there should be no more than 5 hours between each meal, and overnight no more than 12 hours from evening snack to breakfast. Food should also be available 24 hours per day for those who may be awake during the night [21].

8 Menu content

This section outlines the content of the menu that is required to ensure that food and drink offered can meet the nutritional needs of residents.

The aim is to meet all residents' nutritional requirements within the standard menu, and it is therefore necessary to factor in residents whose needs are at the top end of normal requirements for calories and protein as well as those with lower needs. The **menu** therefore needs to be able to provide approximately 2000 calories and 75grams protein per person, per day. In the tables below the protein content of foods is stated to allow homes to understand how to meet residents' protein requirements within menus, which can be more difficult than meeting residents' energy (calorie) needs.

The energy (calorie) content to be provided by the menu is stated for the benefit of homes which have access to systems that detail the energy content of their recipes. However, it is understood that many homes don't have access to such systems and by following the guidance below, residents' energy and protein requirements should be met by the menu.

Table 4 outlines the food groups that menus should include in order to offer meals that provide balanced meal choices for all residents:

Table 4: Food groups that menus should include (refer to Tables 5 and 7 for specific items [22]).

Breakfast	
Fruit or fruit juice	1 piece fresh fruit, 80grams tinned fruit, 30grams dried fruit or 150ml fresh or long life fruit juice.
Protein	Aim for a minimum of 20grams protein using foods from Table 6 below.
Cereal	A minimum of 1 serving (refer to Table 5 below). Residents should be able to select the portion size that is appropriate for them.
Milk	A minimum of 150ml whole milk should be encouraged unless inappropriate for the individual resident.
Bread items	A minimum of 1 serving and a variety of options should be available. Residents should be able to select the portion size that is appropriate for them.
Unsaturated Spread/Butter	Average amount per slice bread/toast.
Jam/ Marmalade	Average amount per slice bread/toast.

Continues ↓

Main meal	
A minimum of two courses (main course and dessert) and two or preferably three choices for each meal should be provided. Consider the need for one of these options to be a vegetarian choice	
Protein	Aim for a minimum of 30grams protein spread across the 2 courses, (refer to Table 7 below) Protein source: a minimum of 100grams (raw weight) meat or poultry/120grams fish/2 eggs/60grams cheese/90grams pulses, beans, chickpeas (uncooked weight)/60grams lentils (uncooked weight)/60grams nuts/100grams Quorn™ or soya protein/60grams seitan. For processed meat/fish or dishes with a combination of protein sources, see further information below.
Carbohydrate	A minimum of 180grams potatoes (dependent on cooking method)/120grams of cooked rice, pasta, noodles, couscous, bulgar wheat, buckwheat, cornmeal, maize, wheat, barley, rye, sweet potato, cassava, yams or plantain/2 slices of bread.
Vegetable	A minimum of two 80gram portions of vegetables. These can be prepared from fresh or frozen or a combination of both.
Dessert/ pudding	A minimum of 1 hot and 1 cold dessert to be available. One of the options to be made from nutrient dense ingredients e.g., a milk-based pudding with a fruit compote, custard served with a fruit crumble or sponge. At least 1 dessert option should contain a portion of fruit (80grams). The fruit can be fresh, tinned in fruit juice, dried or frozen and can be incorporated into the dessert such as crumbles or fruit-based cakes. The following alternative desserts should always be available: yoghurts, tinned fruit, fresh fruit, ice cream, cheese and biscuits.

Continues ↓

Simple (second) main-meal	
A minimum of 2 courses (main course and dessert) and two options should be available (see paragraph below for meal suggestions)	
Protein	Aim for a minimum of 25grams protein spread across the 2 courses, (refer to Table 7 below) Protein source: a minimum of 100grams (raw weight) meat or poultry/120grams fish/2 eggs/ 60grams cheese/90grams pulses, beans, chickpeas (uncooked weight)/60grams lentils (uncooked weight)/ 60grams nuts/100grams Quorn™ or soya protein/60grams seitan. **Please note** that all protein-based sandwich fillings should be generous i.e., providing two thirds of the amounts suggested above in 4 sandwich quarters. For processed meat/ fish or dishes with a combination of protein sources, see further information below.
Carbohydrate	A minimum of 180grams potatoes/120grams of cooked rice, pasta, noodles, couscous, bulgar wheat, buckwheat, cornmeal, maize, wheat, barley, rye, sweet potato, cassava, yams or plantain/2 slices of bread.
Vegetable	A minimum of one 80gram portion of vegetables should be available. These can be prepared from fresh or frozen or a combination of both.
Dessert/ Pudding	Should include selection of cakes (where possible include some made with nutrient dense ingredients) served with custard, cream or ice cream, fruit tarts, cream cakes, creamy desserts including panna cotta, cheesecakes, trifle, creme caramel. The following alternative desserts should always be available: yoghurts, tinned fruit, fresh fruit, ice cream, cheese and biscuits.

Breakfast

This can be the most important meal of the day as there may be a long gap between the last meal or snack of the day before and breakfast (although this should be no longer than 12 hours). Some residents may get more tired as the day progresses impacting on their appetite for other meals. It is good practice to have a rotation of both hot and cold breakfast foods to ensure a good variety is offered.

The following items should be included every day:

- **Fruit or fruit juice:** There should be a choice of either, fresh, tinned or dried fruit with a varied selection throughout the week. Fruit, including dried fruits such as figs, dates or prunes are a good opportunity to provide fibre which may help maintain good bowel function. Fruit juice could be either long life or fresh. Many concentrated squash type drinks do not provide beneficial nutrients such as vitamin C so should not be used instead of fruit juice at breakfast
- **Cereals:** There should be a choice of both hot and cold cereals daily with a range of fibre content. Cold cereals can include Cornflakes, Rice Krispies™, Bran flakes™ and wheat biscuits. Hot cereal choices can include hot oat cereal e.g., Ready Brek™, porridge or hot milk on wheat biscuits
- **Bread/toast/baked goods:** White and wholemeal sliced bread or rolls should be available. Bread should be offered to residents toasted if they wish and served as hot fresh toast if that encourages residents to eat it. Unsaturated spread and butter should both be offered as a daily choice. Use unsaturated spreads where a preference isn't stated as this is a healthier type of fat. It is good practice to offer (on a rotational basis) items such as crumpets, English muffins and croissants to add variety to the meal
- **Hot items:** It is recommended that hot breakfast items are offered daily on a rotational basis, to provide a wider choice. These can provide a good range of nutrients, especially protein and can improve overall nutritional intake at a time of day when residents often have a good appetite. Hot items can include bacon, eggs, sausages or fish and can be served alongside accompaniments such as baked beans, tomatoes and mushrooms
- **Preserves:** Assorted jam, marmalade and honey should be offered as a daily choice alongside other items such as peanut butter or Marmite.

Table 5: Average nutritional content of a continental breakfast [23, 24]

	Portion size (grams unless otherwise stated)	**Energy per portion** (kcal)	**Protein per portion** (grams)	**Average energy** (kcal)	**Average protein** (grams)
Bran flakes™	30	100	3		
Cornflakes	30	113	2		
Rice Krispies™	30	112	2		
Wheat type- 2 biscuits	37.5	125	4	**113**	**3**
Porridge made with whole milk	160	180	8		
Semi skimmed milk	150ml	69	6		
Whole milk	150ml	90	6	**81**	**6**
Greek yoghurt	150	200	9		
White bread	36	85	3		
Wholemeal bread	36	78	3	**82**	**3**
Banana, small without skin	80	65	1		
Tinned pears, in own juice	80	26	0		
Prunes, stewed without stones	30	24	0		
Orange juice	150ml	51	0	**41**	**0**
Polyunsaturated spread	7	24	0		

Butter	7	52	0	**40**	
Jam	20	52	0		
Marmalade	20	52	0	**52**	**0**
Nutritional content of continental breakfast				**409**	**12**

Table 6: Average nutritional content of cooked breakfast items [23, 24]

	Portion size (grams)	**Energy per portion** (kcal)	**Protein per portion** (grams)
Egg, scrambled - 1 egg	60	90	9
Egg, boiled – 1 egg	60	75	6
Eggy bread/French toast – 1 slice	100	188	10
Sausage, chipolata	20	62	3
Bacon, back	25	72	6
Lorne sausage	75	231	10
Black pudding	75	222	8
Mackerel	100	283	20
Kipper	100	245	21
Lentils, uncooked	60	143	11
Baked beans (regular tomato sauce)	135	109	7

Tomatoes, grilled	85	14	1
Mushrooms, fried	44	47	1
Potato scone/bread	42	62	1

Main meal of the day

The main meal of the day usually provides the most nutrients, and it is important that it is well balanced and meets the needs of residents. It is good practice to have a minimum of two courses and the recommendation is that these are main course and dessert instead of starter and main course and two or three choices should be available. If there are no residents following a vegetarian diet, some vegetarian meals can still be offered, but this doesn't have to be at every mealtime.

Main meal

Protein: Protein is needed to prevent muscle loss/weakness (sarcopenia). There should be an adequate portion of a protein source served as part of the meal (see portion sizes in Table 7 below). This can be in the form of meat, poultry, fish, cheese, eggs or plant-based meat alternatives (including products such as soya, Quorn™, seitan), tofu, pulses such as beans (not green beans), chickpeas, lentils and nuts.

Processed meats e.g., sausages are often popular menu items but do not provide as much protein per portion as unprocessed meat. They should therefore only be on the menu alongside dishes containing better quality sources of protein and/or should be served with other sources of protein e.g., sausages with Yorkshire puddings or ham and cheese pasta.

For a vegetarian or vegan dish, it is essential to ensure there is an appropriate source of protein to meet the minimum protein content of the meal (e.g., cheese, eggs or meat alternatives (including products such as soya and Quorn™), tofu, pulses such as beans (not green beans), chickpeas, lentils and nuts). The carbohydrate, vegetables and accompaniments should be similar to the main menu and appropriate for the dish with which they are served.

Carbohydrate: There should be a source of carbohydrate served at every main meal. Carbohydrate foods that can be provided include potatoes, pasta, rice, noodles, bread, bulgar wheat, cornmeal, barley, yams, maize, plantain, couscous, buckwheat, rye, plantain, sweet potato and cassava.

Wholegrain carbohydrate foods provide a source of fibre which can help maintain good bowel function. When fibre is increased in a resident's diet, residents should also be encouraged to drink enough fluid.

Vegetables: A minimum of two 80gram portions of vegetables should be available/ served as part of the main meal. This is in addition to any vegetables used as ingredients in composite dishes such as casseroles and stews. (**Please note** - Potatoes are classed as a carbohydrate food and not a vegetable and so are not included within this food group). A variety of vegetables should be provided across the menu cycle with variation in colour and type e.g., root vegetables or broccoli/cauliflower/cabbage (brassicas)/spinach and should be appropriate for the main course items with which they are served. It is often easier to incorporate vegetables in season as they are most readily available. Both fresh and frozen vegetables or a combination of both can be served depending on cost, availability and quality.

Accompaniments: Gravy and sauces should be served as appropriate, and encouraged as they often make food less dry and therefore easier to eat.

Composite dishes: e.g., cottage pie, lasagne, risotto may also be served. They should contain a source of protein and carbohydrate and be served with appropriate vegetables.

Dessert: A minimum of one hot and one cold dessert should be available at the main meal.

Simple (second) main meal (lunch or evening meal):

A minimum of two courses (main course and dessert) should be offered and 2 options should be available for each course.

- Simple meal options should include a source of high-quality protein (described above), alongside a source of carbohydrate and vegetables. This could include jacket potato with protein based filling and salad, baked beans or eggs on toast, quiche, omelette with fillings, plated salad with a source of protein and carbohydrate (see above for examples).

- If sandwiches are a menu option, a minimum of 3 sandwich fillings should be offered (all should include a good source of protein e.g., tuna, egg, ham, cheese, chicken, beef, houmous/nut butter, etc) and a choice of white and wholemeal bread. Residents should be offered a minimum of 4 quarters of sandwiches as part of this meal.

- Where soup is offered it should be homemade rather than made from an instant soup mix and offered as part of a soup and sandwich meal. For those at risk of malnutrition, soup can also be fortified with nutrient dense ingredients (refer to **Chapter 4**).

- Desserts could include a selection of cakes served with cream, custard or ice cream, fruit tarts, cream cakes, creamy desserts including panna cotta, cheesecakes, trifle, creme caramel. (Avoid jelly as a dessert, unless it's a milk jelly made with evaporated milk due to jelly's poor nutritional value).

Table 7: Energy and protein content of some commonly used foods [23, 24]

Main Meal	**Average portion size per resident** (grams) Uncooked unless otherwise stated	**Energy per portion** (kcal)	**Protein per portion** (grams)
Protein			
Beef mince	100	225	20
Beef, roast	100	145	21
Beef burger	100	291	17

Chicken, roast	100	201	19
Lamb mince	100	196	19
Sausage	110 (2 sausages)	323	16
Kidney beans, cooked	150	150	13
Quorn™	100	73	14
Tofu	100	73	8
Whole milk	150ml	90	6
Cheddar cheese	60	250	15
Eggs	120 (2 eggs)	150	12
Carbohydrate			
Jacket potato	180	175	5
Potatoes, roast	200	322	5
Potatoes, mashed with butter	120	122	2
White rice, cooked	120	175	4
White pasta, cooked	120	175	6
Couscous, cooked	120	213	9
White bread, 1 slice	36	79	3
Vegetables			
Broccoli	80	4	3
Cabbage	80	14	1
Carrots	80	22	1

Cauliflower	80	22	1
Cauliflower cheese side dish, whole milk	90	91	5
Parsnip	80	49	1
Sweetcorn	80	62	2
Peas	80	56	5
Soups			
Carrot and coriander	200	90	2
Cream of chicken, canned	200	116	3
Vegetable, canned	200	80	3
Lentil, canned	200	90	6
Sauces			
Gravy, instant (made up with water)	50	15	0
Bread sauce (made with whole milk)	45	49	2
White sauce	62	65	1
Composite dish			
Cottage pie	310	390	20
Steak and kidney pie	160	488	23
Fish pie	400	400	34
Spaghetti bolognese	400	600	32

Desserts			
Crumble, fruit (retail)	170	372	4
Fruit trifle	170	279	4
Custard tart, individual	100	263	7
Rice pudding, homemade (made with whole milk)	200	290	8
Cheesecake, fruit	120	316	12
Instant dessert (59g powder made up with 300ml whole milk = 4 servings)	90	120	4
Tinned mixed fruit in juice, with double cream	115 (fruit) 30 (cream)	110	1
Tinned mixed fruit in juice	115	52	0
Ice cream, dairy, vanilla soft scoop	100	169	3
Cheddar cheese and 2 cream crackers	30 (cheese) 16 (2 crackers)	303	10

Snacks

There should be structured snack times that are co-ordinated with the beverage service and if possible, with activities. It is good practice to consider a rotational menu of snacks to aid variety and tempt residents to eat.

Whilst residents should always have a choice of snacks to meet their preferences, nutritionally speaking, snacks can be described in different ways:

- **Snacks that are nutrient dense** i.e., contain a range of different nutrients including protein, vitamins and minerals
- **Snacks that are calorie dense** i.e., contain fat and/or sugar but little protein, vitamins and minerals
- **Snacks that provide little by way of calories and protein** but do provide a range of vitamins, minerals and fibre e.g., fruit.

It is recommended that homes provide snack choices from all of the categories above, but residents at risk of malnutrition should be steered towards nutrient dense snacks. Examples of snacks that are nutrient dense include cheese and biscuits, yoghurts, custard pots, crumpets with nutrient dense toppings e.g., peanut butter.

Snacks that provide predominantly calories, with fewer other high-quality nutrients, include biscuits, cakes, ice cream, cheese straws and some processed meat items.

The snack service should include a choice of snacks for residents every day. If residents who are not at risk of malnutrition choose a nutrient dense snack, this choice shouldn't be restricted unless it's not in line with their nutrition and hydration care plan.

In addition to daytime snacks, the evening snack should include sandwiches, toast, cereals, toasted teacakes or pancakes alongside a milk-based drink because in most cases this is the last opportunity to eat before breakfast service the following day. Snacks should also be available overnight for residents who might wake up during the night and would like to eat something.

Table 8 provides the average energy and protein content of some common snacks to help homes understand the varied nutritional content of different options. Some snacks are more nutrient dense and should be available in addition to other snacks for residents every day.

Table 8: Range of snack options with nutrient dense options (*) in descending order of protein content [23, 24]

Snack	**Portion size** (grams unless otherwise stated)	**Energy per portion** (kcal)	**Protein per portion** (grams)
*Cheese and pickle sandwich	30 (cheese) 15 (pickle) 2 slices bread	293	15
*Ham sandwich	25 (ham) 2 slices bread	182	11
*Cheddar cheese and 2 cream crackers	30 (cheese) 16 (2 crackers)	303	10
*Bowl of cereal with whole milk	2 Weetabix 150ml whole milk	215	7
*Toast with pate	36 (toast) 40 (pate)	217	8
*Greek yoghurt	100	133	6
Mini/Snack pork pie	50	185	5
Toasted currant bun	55	171	5
*1 pot smooth and creamy yoghurt (Fruit)	115	122	5
*1 pot custard (ready to eat pot)	150	147	4
Mini scotch egg, 2	36	98	4
Fruit scone with butter and jam	78	361	3

Crumpet with butter	50	157	3
Mini/Snack sausage roll	30	90	3
Toast with butter	36 (toast) 5 (butter)	130	3
Ready salted crisps	30	148	2
1 pot vanilla ice cream	60	101	2
Cheese straw	16	82	2
Pancake, sweet- 1	30	76	2
Slice Madeira loaf cake	40	129	1
Chocolate Swiss roll	30	124	1
Tinned mixed fruit in juice with double cream	115 (fruit) 30 (cream)	110	1
Digestive biscuit	13	60	1
Pink wafer	8	38	0
Tinned mixed fruit in juice	115	52	0

Table 9 shows an example of how snacks can be offered as part of a rotational snack menu to add variety alongside snacks that are always available.

Table 9: Example of a rotational snack menu

	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Always available	Sweet and savoury biscuits, cake, yoghurts, chopped fruit						
Morning & Afternoon	Custard pot/ 2 mini scotch eggs	Cheese straw/ Rice pudding pot	Thick and creamy yoghurt/ Mini sausage roll	Mini Pork pie /2 scotch pancakes	Custard pot/ Toasted currant bun	Cheese on toast fingers/ Fruit scone	Sweet pancake/ Cheese & biscuits
Additional evening snacks should always include:	Cereals with milk, sandwiches, toast with toppings, biscuits, milky drinks, yoghurts						

Beverages

The aim is to support residents to drink enough and meet their fluid requirements. Each day, a minimum of 1600ml fluid should be encouraged for women and 2000ml fluid for men. Drinks should be available at any time during the day and night, just as they would be in any private home [16].

Daily fluid requirements

Older women
need to drink at least
1,600ml

x7 full (250ml) mugs **OR**
x11 full (150ml) cups

Older men
need to drink at least
2,000ml

x8 full (250ml) mugs **OR**
x13 full (150ml) cups

There should be a choice of cups and mugs in different sizes and if possible, in different colours to suit the needs and preferences of residents. To ensure staff have an understanding of the volume of each cup/mug/glass, it is advisable to provide visual guidance to enable efficient and accurate calculations of fluid intake if required. Adaptive cups, mugs and glasses can support independence for residents and advice may be available from health professionals (such as occupational therapist or a speech and language therapist) about the most appropriate cup to use.

The provision of beverage choices should reflect the needs and preferences of residents. There should be a wide variety of hot and cold drinks available. Hot drinks should include caffeinated and decaffeinated tea and coffee, milky coffee, hot chocolate, malted milk-based drinks (e.g., Ovaltine™ and Horlicks™), speciality teas such as fruit teas, chai, peppermint. Cold drinks should include sugar free fruit squash options, water and cold milk.

For residents at risk of malnutrition, drinks are an opportunity to offer nutrient dense fluids such as whole milk, fruit-based smoothies, fortified milk, milk/plant-based shakes (made as per standard recipes, see **Chapter 4**).

9 Menu analysis

After a draft menu is written following the points outlined above, the menu should be assessed to ensure all areas outlined in Figure 5 below are considered before launching.

When conducting a menu tasting session the quality of the food and the variety, taste, texture, aroma and appearance of the meals, including special diets, should be rated. Evaluating food waste, assessing meals against IDDSI guidance, reflecting back on the ordering, storage, preparation, and serving of meals is also paramount when analysing draft menus.

From this information, it may be necessary to change the menu to reflect the results obtained. Teams should ensure that the final version of the menu is sent to the menu-planning group for final approval.

Figure 5: Considerations when reviewing implementation of a new menu

10 Menu launch

Ensure the whole care home is ready for the menu changes (e.g., purchasing of new ingredients/ products, running down old stock, updating meal-ordering systems).

Communication

To support residents in making food choices that meet both their food preferences and nutritional needs, written and pictorial menus and information should be designed based on the full range of foods and beverages available. Information should be provided in the language/s most familiar to residents and be readily available. Any previous menus should be disposed of and new menus with appropriate allergen information should be available.

Training about the new menu should be provided to food service teams and carers, covering key updates on the menu and any operational changes.

Food, nutrition and hydration policy

Every care home's nutrition and hydration policy should be updated to reflect changes to the menu including details regarding potential allergens.

Process of feedback and reflection

The process of menu planning is an ongoing process and should involve continued:

- Mealtime observations to ensure quality standards are being met
- Seeking of feedback from residents, carers, care home staff and clinicians about meal satisfaction and the mealtime experience. This can be sought through:
  - Noting verbal feedback received
  - Running stakeholder engagement sessions
  - Surveys
- Monitoring of menu choice uptake and food wastage to adjust ordering and production, and considerations for the next menu review period
- Reflection on how the home is meeting residents' expectations around food service, their food preferences and nutritional needs.

Implementing the guidelines

Implementing these guidelines may require homes to make a number of changes to their food service and menus which for some homes may include reviewing the budget for food. The checklist in **Appendix 3** is intended to support homes to identify what they are already doing well as well as areas where changes may need to be considered. When starting to implement these guidelines it is important to be aware that:

- Implementation shouldn't create additional food waste and homes are not expected to produce or provide extra food which they know residents will not eat

- To avoid food wastage but still provide adequate choice for residents, catering teams should consider how they can offer choices on the menu that use stock items that can be prepared quickly should a resident choose it e.g., an omelette or toast with toppings. This may be particularly helpful in smaller care homes with fewer residents

- Care and catering teams should aim to spend the food budget as wisely as possible on products that aren’t more expensive that they need to be e.g., homemade cakes can be less costly than purchased cakes or chocolate bars; purchasing breakfast cereals in bulk are less costly than individually wrapped versions and more economical cuts of meat are often more tender and flavoursome when cooked e.g., chicken thigh rather than chicken breast.

4

Special diets

What to do if someone needs an unfamiliar special diet or has unusual preferences.

The information in this chapter provides background information and shouldn't be used in place of specific advice received from health professionals. It shouldn't also be used instead of seeking dietary advice from a dietitian where this is appropriate.

Definitions

The term special diet is used in this chapter to describe a broad range of different diets, including those that are commonly found in society, e.g. vegetarian and vegan diets. Within care home settings these are found less frequently, hence the positioning of this section within this chapter. This chapter will therefore cover diets that are:

- Therapeutic or medically required to treat/manage a medical condition
- Culturally required
- Personal preferences.

If the catering team are not familiar with the special diet a resident requires, they should discuss:

- General dietary needs with the nursing or care team
- Specific needs with:
  - The resident
  - The resident's family and/or friends where appropriate
  - The medical team that has recommended the therapeutic diet. Usually this would be a specialist dietitian e.g., a Specialist Renal Dietitian.

Food-based nutrition support for residents who are at risk of malnutrition

Malnutrition is common in older adults living in care homes for many different reasons. Malnutrition can be both a cause and a consequence of ill health and increases the chances of the resident becoming unwell.

Chapter 1 briefly discussed how to identify a resident who is at risk of malnutrition. As mentioned in Chapter 1, anyone at risk of malnutrition will need a personalised nutrition and hydration care plan that outlines how their nutrition and hydration needs will be addressed.

Catering and care teams have an important role in the management of residents with or at risk of malnutrition, and this is likely to be the most frequently requested special diet that will need to be provided within the home. There needs to be clear and transparent communication between the catering and care teams so that catering teams are aware of the nutrition goals agreed with the resident or put in place in their best interests [25].

Chapter 3 discussed the importance of encouraging and supporting all residents to eat a variety of different food groups. Residents who are at risk of malnutrition need this variety of food groups as well. However, as those with or at risk of malnutrition will usually have a small appetite or have higher nutritional needs, they may find it difficult to eat and drink enough and so may not be able to obtain all the nutrients they need from the main menu alone. For these residents, the focus should be on using nutrient-dense food fortifiers and offering more nutrient-dense snacks and drinks to help bridge this 'nutritional gap'.

Nutrient-dense foods are foods which contain a wide range of nutrients that the body needs, including energy, protein, vitamins, minerals and may also include fibre. Providing a wide range of nutrients is an important aspect of nutrition support [10, 26].

A 'nutrient dense' diet should follow these four principles:

- Be individualised, based on the needs and preferences of the resident
- Be based around using nutrient-dense ingredients to fortify food
- Does not significantly increase portion size
- Uses ingredients to fortify that do not negatively affect the taste or texture of the food that is being fortified.

1. Nutrient dense snacks

- Providing and encouraging snacks in between meals and before bed can make a significant contribution to someone's overall nutritional intake

- Whilst biscuits and cakes can be popular snacks, they will often offer little nutritional content other than calories. Where possible and if made in-house, chefs should think about ingredients which they could use to increase the nutrient density of biscuit and cake recipes
  - For example, including eggs, milk, yoghurt and/or ground nuts in recipes to improve their nutritional content

- Other nutrient-dense snack options should also be made available, see below.
- If a resident prefers to have a slice of standard cake or an ordinary biscuit, offering a milky drink with it can optimise their nutritional intake
- If residents wake up during the night, there should be nutrient-dense snacks and drinks available for them.

Table 10 gives examples of nutrient dense snacks with suggested portion sizes, but any snacks that use eggs, milk, yogurt and/or ground nuts (e.g., quiche, cake using these ingredients) are more likely to be nutrient dense [26].

Table 10: Nutrient-dense snacks

Ready-made nutrient dense snack	**Portion size**	**Approx protein content** (grams)	**Approx energy content** (kcal)
Cheese and cracker	1 cracker + 1 small chunk of cheese	6	115
Cheese scone	½ scone	6	120
Custard	150grams tub	4	145
Falafel	2x 22grams	4	110
Greek yoghurt	150grams tub	9	200
Hard-boiled egg	1	7	75
Nuts	Small handful (40grams)	9	245
Rice pudding	150grams tub	5	140
Breakfast cereal with fortified milk	30grams + 150ml fortified milk	15	250

2. Nutrient dense drinks

- Drinks that contain some nutrition can be very helpful in supporting residents who are at risk of malnutrition to meet both their nutrition and hydration needs
- Nutrient dense drinks include milk-based drinks such as milk, malted drinks (Horlicks™/ Ovaltine™), hot chocolate, lassi, milky coffee, smoothies and milkshakes
- The nutrient density of milk can be enhanced by mixing 4 heaped tablespoons (60grams) skimmed milk powder** into each pint of whole milk to make fortified milk. This can then be used as a base for all milky drinks as well as using it in appropriate foods
- Nutrient dense drinks should be offered between meals. Avoid offering them just before meals when they could make residents feel too full to eat a meal.

3. Food fortification for those who have or are at risk of malnutrition

Butter, cream and sugar add flavour to foods, and as we know this can make eating more pleasurable e.g., adding butter to mashed potato and cream to a dessert. However, adding lots of extra cream, butter or sugar as food fortifiers really only adds extra calories without adding many other nutrients. Nutrient dense food fortifiers however, add multiple nutrients which will support residents to meet their full nutritional needs and maintain/ improve their quality of life.

Dishes should only be fortified for individual residents who are at risk of malnutrition and a measured amount of fortifier should be used per portion of food (see **Chapter 3** for recommended portion sizes of food). Care staff need to be informed about what food fortification has been used.

Some care homes will currently be using mainly energy-dense ingredients for food fortification (e.g., cream, butter, sugar). However, as per the reasons outlined above, starting to use nutrient dense food fortifiers instead is the preferred option as nutrient dense fortifiers will provide residents who are at risk of malnutrition with more of all the nutrients that they need.

Table 11 shows examples of nutrient-dense food fortification ingredients with suggested portion sizes [26].

Table 11: Nutrient dense ingredients for food fortification

Nutrient dense food fortifier	**Quantity that could be added to 1 portion of food** (grams unless otherwise stated)	**Approx protein content** (grams)	**Approx energy content** (kcal)	**Could be added to a portion of:**
Cheese, grated	10 (1 tablespoon)	3	40	Potatoes, vegetables
Egg, beaten*	½ - 1 egg	4 - 7	40 - 75	Custard, milk puddings, mashed potato
Dried, skimmed milk powder**	15 (1 tablespoon)	6	55	Custard, milk puddings, 'cream of' soups, porridge, mashed potato
Greek yoghurt	45 (1 generous tablespoon)	2	60	Porridge
Ground nuts e.g. peanuts or almonds	15 (1 tablespoon)	3	90	Vegetable soups, stews, casseroles, curries, porridge
Nut butter e.g. peanut butter	15 (1 tablespoon)	4	95	Porridge, vegetable soups, stews, casseroles, curries

Paneer, grated	10 (1 tablespoon)	3	35	Curries
Pea protein powder	17 (1 tablespoon)	11	60	Vegetable soups, stews, casseroles, curries
Soya protein powder	14 (1 tablespoon)	14	50	Vegetable soups, stews, casseroles, curries

* Providing the eggs used have British Lion mark – In 2017, the Food Standards Agency deemed raw or less-than-thoroughly cooked British Lion marked eggs and egg products as safe to consume by certain vulnerable groups including older adults
**Use skimmed milk powder that does not contain added vegetable fat

What is the nutritional aim/target?

For residents at risk of malnutrition a general starting point for catering and care teams is, in addition to what the resident is already eating, aiming to increase nutritional intake by about 500kcals a day using nutrient-dense fortification strategies, snacks and drinks. This is often very achievable and only usually requires making 3 or 4 small changes to what a resident is already eating and drinking each day.

It is important to recognise that not everything needs to be fortified and that a food-based approach should be personalised to each resident's preferences. This can make it more likely that residents eat and drink what is offered and benefit from it. Some examples of how to increase intake by 500kcals a day using nutrient-dense ingredients are:

- An extra 200ml glass of fortified milk (see recipe above under Nutrient Dense Drinks)
- 150g pot of yoghurt fortified with 1 heaped tablespoon (15grams) of skimmed milk powder**
- 1 portion of mashed potato fortified with 1 tablespoon (10grams) grated cheese

= Additional ~500kcals + protein + vitamins and minerals

- 1 Cheese scone
- Medium spread (15grams) of nut butter on 1 slice of bread
- 1 portion of mashed potato fortified with ½ beaten egg

= Additional ~500kcals + protein + vitamins and minerals + fibre.

Please note - Residents at low risk of malnutrition do not need and should not be provided with a nutrient-dense diet/food-based approach to managing malnutrition.

What is the role of prescribed oral nutritional supplements (ONS)?

Oral nutritional supplements (ONS) do not contain anything more than food can provide[27]. Food should be able to meet residents' needs and when a resident is at risk of malnutrition the food-based approach outlined above should be provided. It is important to ensure that a resident's intake is optimised with food and a food-based approach before either purchase or a prescription of ONS is even considered.

In addition, most areas have local NHS guidance in place, which includes appropriate prescribing of ONS and in some cases advises against the prescribing of ONS for care home residents. If prescribed ONS are issued, this should usually be as a short-term treatment option for disease-related malnutrition if someone is temporarily unable to meet their needs using food/drink only[27]. ONS are not intended for long-term use or as a replacement for providing food sufficient to meet residents' nutritional needs.

How do homemade supplements (see Appendix 4) compare to prescribed ONS?

- The homemade supplement recipes (Fortified Milkshake/Fortified Fruit Juice) in **Appendix 4** have a similar energy and protein content to similar prescribed ONS [28, 29].
- The fortified milkshake recipe in **Appendix 4** should be used in preference to the fortified fruit juice recipe as it is more nutrient dense.
- The fortified fruit juice recipe can be used when a resident does not like or cannot take milk. The recipe has a lower nutritional content than the fortified milkshake recipe,

however, it is a close equivalent to prescribed juice type ONS which are not nutritionally complete. The fortified fruit juice recipe is also not nutritionally complete, however the closest micronutrient content can be achieved by using a vitamin fortified fruit juice.

- It is helpful to note that because of its sugar content some caution may be needed when considering using the fortified fruit juice recipe for residents at risk of malnutrition who also have diabetes, if they struggle to manage their blood glucose control.

Dysphagia

Dysphagia is a medical term used for swallowing difficulties, which can affect resident's ability to eat and drink comfortably and safely [30]. Swallowing difficulties can be associated with a range of health conditions including dementia, stroke, other neurological disorders and head and neck cancers.

The incidence and severity of swallowing difficulties can increase with age and it is estimated that between 50 and 75% of care home residents have signs and symptoms of dysphagia [31, 32].

Signs and symptoms of swallowing difficulties may include one or more of the following and are outlined in Figure 6 below:

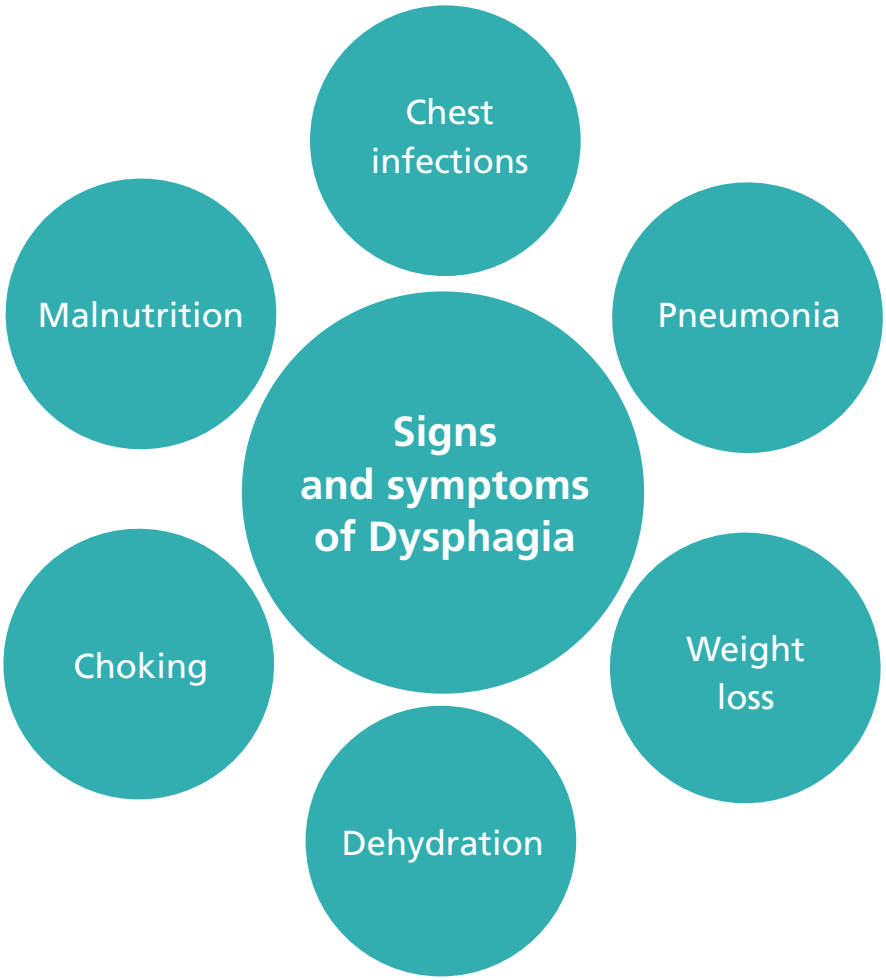
- Coughing after eating and/or drinking
- Choking
- Hoarseness
- Chest infections
- Aspiration pneumonia
- Weight loss
- Inability to control food or saliva (drooling)
- Dehydration
- Malnutrition.

Swallowing difficulties can increase the risk of aspiration (food or fluids entering the lungs) which may increase the risk of developing chest infections and aspiration pneumonia.

Swallowing requires a range of actions and number of stages for eating and drinking to take place safely and comfortably. Problems can occur in one or more stages of the swallowing process.

Identifying and managing swallowing difficulties early may help to reduce possible complications including pneumonia, malnutrition and dehydration[33, 34].

Figure 6: Signs and symptoms of dysphagia



Management of swallowing difficulties

If a resident has any signs and symptoms of swallowing difficulties, the local area NHS policy or protocol regarding management of swallowing difficulties should be followed within the care home. Speech and language therapists and other trained healthcare professionals (such as dysphagia practitioners) play a key role in the identification and management of swallowing difficulties [32, 34, 35].

For a resident experiencing difficulties swallowing, the process of eating or drinking may be slower, more difficult, and/or more tiring. Both difficulty swallowing and its management can negatively affect a resident's quality of life for example a fear of eating and drinking, embarrassment about swallowing difficulties, anxiety and depression.

Support & decision making

Managing swallowing difficulties requires a multidisciplinary approach to support both the resident and those involved in their care to try to manage the resident's safety and care experience [31, 32]. Management of swallowing difficulties can involve recommendations to modify food and fluid consistency as well as advice for the resident about swallowing techniques, positioning and exercises to help reduce possible risk of aspiration.

The Royal College of Speech and Language Therapists competency framework for eating, drinking, and swallowing supports care home managers to identify what level of skills and knowledge is needed by staff to support residents with eating, drinking and swallowing difficulties [38].

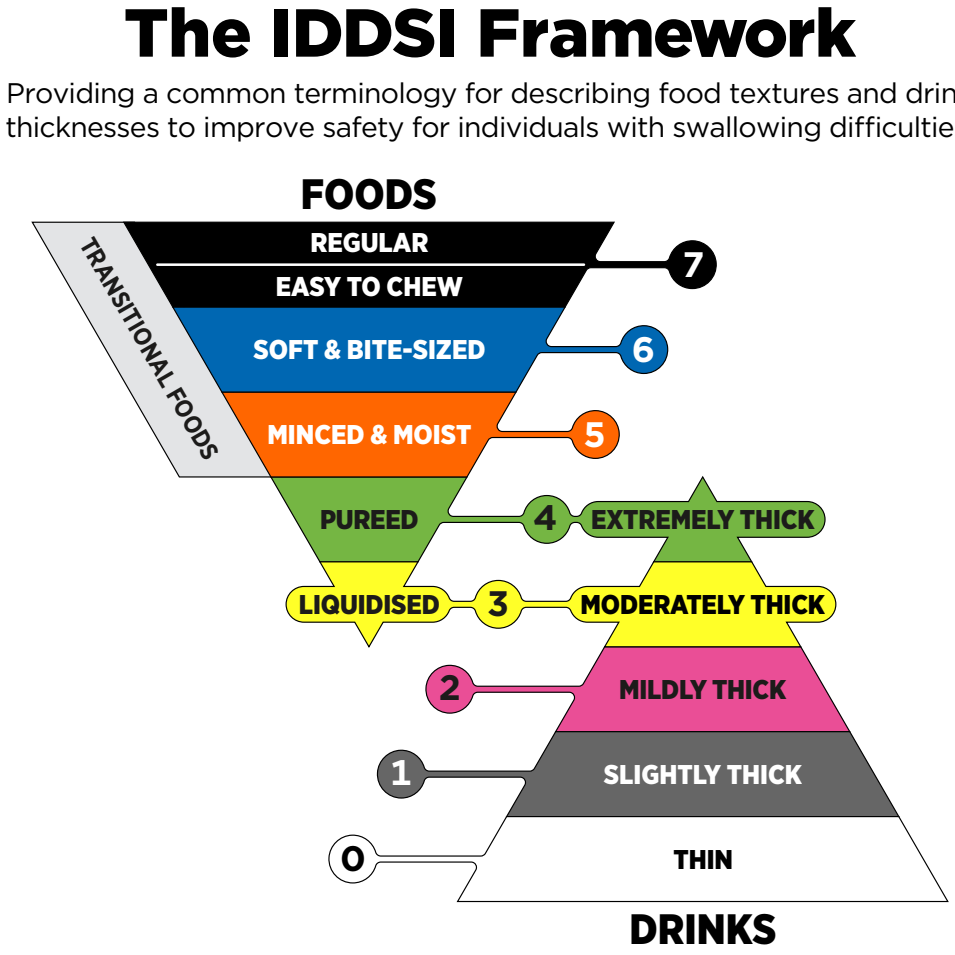
Some residents who have capacity to do so may choose not to follow all or some of the modified texture food and/or fluid recommendations that they have been given. Making a decision not to follow a recommendation about having modified texture food or fluid may be referred to as 'risk feeding' or 'eating and drinking with acknowledged risk' - where a resident weighs up the possible risks versus the possible benefits of following or not following the recommendations in relation to what matters to them [36, 37].

Malnutrition and dehydration can be a negative consequence of having modified texture food and fluid but may also be a risk of 'eating and drinking with acknowledged risk'.

IDDSI

The International Dysphagia Diet Standardisation Initiative (IDDSI) is a globally standardised approach to describing and defining the consistency of modified texture food and liquids which may be recommended to support people with swallowing difficulties and is shown in figure 7 below[39].

Figure 7: IDDSI Framework



The IDDSI framework consists of a continuum of 9 Levels which are numbered 0 – 7 (Please note there are 2 descriptors for Level 7).

Fluid consistency is numbered as Levels 0 – 4:
Level 0 – Thin
Level 1 – Slightly Thick
Level 2 – Mildly Thick
Level 3 – Moderately Thick
Level 4 – Extremely Thick

Food consistency is numbered as Levels 3 – 7:
Level 3 – Liquidised
Level 4 – Pureed
Level 5 – Minced & Moist
Level 6 – Soft & Bite-Sized
Level 7 – Easy to Chew
Level 7 – Regular

IDDSI testing methods and meal times

IDDSI provides guidance on testing methods which are intended to confirm the flow or texture characteristics of particular foods or drinks at the time they are tested. The food and drink provided should meet the testing method for the texture/consistency that is being offered.

When providing modified texture meals, the catering team need to ensure that the texture of the meal/snack is in line with the texture descriptor that the resident requires.

At each meal/snack/drink time the catering team should test food and fluid texture by following IDDSI guidance. Care staff should also check the texture/consistency of food and fluid provided by the catering team just before it is served to the resident, to ensure the consistency hasn't changed between preparation and meal service.

Care homes need to consider the modified texture meal options which can be prepared by the catering team, using available catering equipment. Care homes need appropriate catering equipment e.g., food processors to be able to prepare good quality, visually appealing meals that meet both nutritional and texture requirements for each resident who has a modified textured diet.

Depending on the ingredients used, meals and drinks that require modification can take significantly more time to prepare because each meal component needs to meet IDDSI testing methods and must also still meet the resident's nutritional needs. IDDSI audit tools may help catering teams to ensure the correct texture/consistency is achieved [40].

In some circumstances, care homes may choose to purchase pre-prepared modified texture meals from an external supplier. These products can help to ensure the provision of nutritionally adequate, visually appealing modified texture meal options for residents.

Mealtime planning

Just as for all other residents, communication, organisation, and preparation are key to supporting residents with swallowing difficulties. The catering team need to know:

- How many individual residents require modified texture meals and snacks
- Which IDDSI level/s are needed and by whom they are needed
- Which meal, dessert and snack options provided meet the desired IDDSI texture
- Which meals, desserts and snacks can be modified to achieve the IDDSI texture that the resident requires.

Hints and tips for food preparation

- Plan meals to ensure that personal tastes, cultural preferences and health needs (e.g., diabetes, coeliac disease) are met
- Where dishes on the standard menu can't be modified to Levels 3, 4, 5, 6 or 7 easy to chew, separate menus or choices should be offered to ensure residents receive an adequate choice.
- When adding fluid to food to achieve IDDSI Level 3 or 4, use nutrient dense fluids such as milk-based sauces. Gravy or cooking juices can also enhance the flavour of the dish but may not be nutrient dense. Avoid using water as it dilutes both flavour and the overall nutritional content of the food served
- Enhance flavours using ingredients like herbs, spices or cheese where appropriate
- Prescribed thickeners should not be used for thickening foods. Purchased food thickeners such as Brakes Instant Food Thickener, Nutrisis™, Ultratex™, and natural thickeners e.g., flour or cornflour/corn starch can be used to thicken food items
- Ensure that the presentation and appearance of modified texture meals look visually appealing and appetising. Present different meal items separately on the plate
- Ensure that food or drink is served at an appropriate temperature
- Be aware that the texture of modified food can change over time, especially if it changes temperature, so food should always be tested according to IDDSI testing methods before serving.

Choices

- Residents who require a modified texture meal should have more than one option to choose from at each mealtime, and different meal options that are similar to the offer from the main menu should be provided each day. Avoid providing the same meal options every day
- A choice and variety of suitable texture snacks and desserts should also be offered to residents who required a modified texture diet
- There may be some residents who prefer a meal, dessert or snack option which is in line with IDDSI Level 7 easy to chew or another IDDSI level. A preference like this should be respected and not restricted. However, a resident who prefers a different texture is not the same as a resident for whom modified texture food is appropriate because of difficulty swallowing
- Specialist meal providers who can provide foods which follow IDDSI texture descriptors can be explored where necessary.

Hydration

For residents who have thickened fluids:

- Offer the same number of fluid choices, serving sizes and vessels as for all other residents
- Follow manufacturer instructions on mixing techniques for prescribed thickeners
- Use IDDSI testing methods to check fluid consistency
- Prepare thickened drinks when the resident is ready to drink, not in advance
- Avoid leaving thickened drinks for long periods, as the texture of drinks may change over time
- Be aware that some nutrient dense drinks may take more time to thicken to the required consistency.

Thickeners for drinks are ACBS (Advisory Committee on Borderline Substances) listed and will be prescribed for individual residents. It is good practice to use the same brand of prescribed thickener throughout the home for all residents who are having thickening drinks.

Dementia

It is estimated that about 70% of care home residents have dementia or severe memory problems[41].

Residents living with dementia can experience eating and drinking difficulties which can include:

- Being unable to communicate their likes and dislikes
- Changes in food preferences and eating habits
- Changes in taste and smell
- Forgetting to eat, eating too much or forgetting they have eaten
- Loss of ability to eat and/or drink independently
- Refusing food or appearing to refuse food
- Decreased awareness of thirst
- Decreased appetite
- Swallowing difficulties (dysphagia).

Due to these and other challenges people living with dementia can be at higher risk of malnutrition and/or dehydration.

Changes in eating habits

Dementia can lead to changes in food and fluid intake and the choices that the resident makes compared to what might have been 'typical' or 'usual' for them. It is important to try to find out what the resident's current food and fluid preferences are, especially if the resident is unable to communicate their likes and dislikes. Carers who know the resident are likely to be able to help with this. Family and friends may also be able to advise, although they may be less aware of what the residents most recent preferences are, especially if the person who is living with dementia has been a resident for a long time.

Residents living with dementia should be fully supported with the following:

Choice of food and drink

- Managing/adapting to any changes to senses, tastes or textures such as:
  - Some residents living with dementia may prefer sweeter foods. Try adding small amounts of honey or sugar to savoury food or small amounts of syrup, jam or honey to puddings to increase the sweetness
  - Support and enable unusual food choices or combinations where these are preferred e.g., if main course is only eaten if sprinkled with sugar; if eating dessert before a main meal enables a resident to eat a main meal too rather than serving in the traditional order when only the dessert might be eaten
- If the resident has a poor appetite/food intake, seems to have difficulty recognising or telling carers that they are hungry or thirsty, encourage food and drinks at times when they seem to want to eat and drink the most.

Menu

- Instead of written menus use show plates, visual menus, picture cards with photos of the meals, desserts, snacks and drinks available to help residents living with dementia to make choices
- Use brief verbal descriptions of meals, snacks and drinks and give residents time to communicate their choice. Be aware that people living with dementia may forget or struggle to understand what has been said to them, so choices may need to be repeated or presented in a different way
- Encourage discussion about the upcoming meal or snack before and during meal and snack times.

Assistance

- Encourage independence by supporting residents living with dementia to help themselves, for example at breakfast serve toast in a toast rack, with butter and marmalade in small dishes
- Specialist feeding aids may help promote independence e.g., nonslip mats, adapted cutlery, deep lipped plates, large handled mugs, plain brightly coloured plates on a contrasting colour tablecloth
- Eating and enjoying a meal is the priority, not having good table manners. Don't worry if mealtimes become slightly messy and consider clothing protection for residents who might need this

- If a resident needs their food to be cut up or served in a different way to make it easier for them to eat it, try to do this in front of them
- If the resident has difficulty using their hands or has difficulty recognising food/ remembering how to eat, use gentle verbal prompts or 'hand over hand' support with or without cutlery ('hand over hand' means the carer supports the individual resident's hand, and guides the resident's hand to their mouth)
- Be aware of the resident's pace of eating (encourage eating one mouthful at a time) and eating preferences
- Ensure there is enough time available to support the resident to eat at their own pace
- If a resident eats quickly or tends to put large amounts of food into their mouth, encourage them to slow down by talking to them, cutting food into smaller pieces, providing smaller cutlery and supervising them at mealtimes.

Stimulation

Stimulation and activity can promote alertness and hunger cues prior to a mealtime. Ideas can include:

- Suitable physical exercise e.g., standing up and sitting down, armchair exercises, balloon tennis, parachute games [42]
- Cognitive stimulation before mealtimes e.g., food-based activities or other ideas such as arts and crafts, music, debates/ discussions [43].

Finger foods

Residents living with dementia may find it more difficult to remember how to eat with cutlery and may also find it more difficult to remain seated to eat a whole meal.

Finger foods may be helpful for residents who struggle to stay seated to complete a meal, who walk with purpose and/or those who have difficulty recognising or using cutlery.

Finger foods are foods that are easy to pick up and can be eaten with the hands. They can be any type of food and should not be limited to typical snack or 'buffet' style foods. Ensure that a finger food meal or snack is comparable to the regular menu options - finger food options should be as nutritious as other regular meals and snacks (see **Chapter 3**).

Tips for providing finger food options:

- Present finger foods in a way that is accessible to residents and may tempt them to eat
- Provide a variety of hot and cold options
- Residents who have swallowing difficulties or other special dietary needs will need further consideration as not all of the suggestions below may be suitable.

Finger food examples:

Breakfast

- Fresh fruit pieces or dried fruit
- Toast or bread fingers with spread, jam, marmalade, peanut butter or melted cheese
- Pieces of English muffin, Scotch/ American pancakes, teacakes, or crumpets with spread, jam, marmalade, peanut butter or grilled cheese
- Rolled pancakes with a filling
- Halved hard-boiled egg
- Black pudding slice
- Pieces of Spanish omelette
- Sausage
- Slice of bacon
- Pieces of eggy bread
- Cereal bar
- Flapjack squares
- Yoghurt tubes.

Main meal

- Pieces of cooked meat
- Pieces of boneless fish
- Breaded chicken/fish goujons
- Koftas
- Cooked tofu or Quorn™ pieces
- Slice of firm quiche
- Slice of nut roast
- Slice of frittata
- Roast or boiled potatoes, potato wedges, chunky chips, pieces of bread, slices of plantain, slices of cassava, cooked gnocchi, potato croquettes, polenta slices, large ravioli, slices of yam, Yorkshire pudding.

- Cooked broccoli or cauliflower florets, squash cut into large pieces, whole green beans, root vegetables e.g., carrot, parsnips, swede, sweet potato cut into large pieces
- Raw quartered tomatoes, chunks of cucumber, celery sticks, pieces of raw carrot.

Processed meats e.g., sausages and fish cakes are often popular menu items but do not provide as much protein per portion. They should therefore only be on the menu alongside dishes containing better quality sources of protein and/or appear on the menu with other sources of protein e.g., sausages with Yorkshire puddings (**See Chapter 3**).

Desserts

- Sliced fruit or sponge cake/pudding
- Gingerbread/shortbread
- Individual fruit tart
- Custard tart
- Small cake
- Pieces of fresh fruit.

Second/Simple meal

- Sandwiches or bread rolls with a protein based filling (cheese, ham, tuna, peanut butter) served with cherry tomatoes and pieces of cucumber, carrot, celery or pepper
- Selection of toastie quarters made with cooked meat or cheese
- Fajita/tortilla wrap with filling (chicken, beef or tofu with salad).

Snacks

- Pieces of cheese scone
- Pieces of hot cross bun
- Pieces of plain scone with jam/butter
- Cheese with crackers
- Yoghurt tubes
- Halved hard-boiled egg
- Flapjack square
- Slice of malt loaf or fruit bread
- Tofu cubes
- Falafel
- Dim sum
- Bread sticks with dip
- Pieces of fresh fruit
- Cereal bars
- Biscuits (made with nutrient dense ingredients where appropriate)
- Pieces of cake (made with nutrient dense ingredients where appropriate)
- Ice cream cone.

Remember also to offer and encourage drinks regularly throughout the day to avoid dehydration. More detailed and practical advice for minimising risk of dehydration can be found in **Chapter 1**.

Saying 'no' to food or drinks

Some residents living with dementia may say 'no' when food or drinks are offered or suggested to them. It is important to be aware that this may not actually mean 'I don't want that.' The resident may be saying 'no' because they cannot communicate their needs and preferences. The resident may be wanting to 'walk with purpose' or they may have reduced interest in or appetite for food. In very advanced (severe) dementia the resident may not be eating and drinking because they no longer recognise the food and drink anymore, or how to even eat. Care should be taken not to label this as 'refusal to eat' as they may likely lack the mental capacity to make decisions about eating and drinking. It may also indicate that the resident is approaching end of life, so MDT input may be required.

Not eating and drinking increases the risk of developing malnutrition and dehydration, so providing a person-centered approach to care planning becomes essential to support any residents who say 'no' to food or drink to still eat and drink enough.

Be aware that changes to food and fluid intake may be caused by things other than a dislike of food and drinks offered (see Table 12 below) and may require referral onto relevant services when appropriate:

Table 12: Services that can provide support for problems with food and fluid intake

Sore mouth Poor dentition/Poorly fitting dentures	Dentist/Oral health review
Difficulty chewing and/or swallowing	Speech & language therapist or dysphagia trained practitioner
Mood Poor mental health Behaviour that challenges	GP/Mental Health Team
Medical condition Medication changes	GP/Advanced nurse practitioner/ pharmacist

Ethical considerations

A resident who continually refuses food or drink despite being provided with support will be at high risk of developing dehydration and malnutrition. In this situation advice should be sought from the multi-disciplinary team (MDT) around whether it is appropriate to consider other nutrition support options.

We wish to acknowledge how helpful the Bournemouth University Ageing and Dementia Research Centre publications have been in writing this section (see table 3 for reference).

Diabetes

It is estimated that 25% of the care home population has diabetes[44]. The National Advisory Panel on Care Home Diabetes (NAPCHD) identified that across health and social care sectors there is little knowledge about the importance and principles of nutritional care of residents with diabetes[44].

In view of how common malnutrition, frailty, sarcopenia and other health conditions are for care home residents, NAPCHD recommends:

- A food and diet approach for healthcare professionals and carers supporting older adults with diabetes in care homes
- All residents with diabetes have a person-centred, individualised care plan that clearly outlines their:
  - nursing and nutritional needs
  - medication requirements
  - triggers for a hospital admission
  - frequency of blood glucose monitoring and equipment to be used
  - individual blood glucose targets.

It is advised that care homes liaise with dietitians and the wider MDT to determine the nutritional needs and priorities for residents with diabetes.

NAPCHD advises moving away from the standard healthy eating and weight loss advice that is usually recommended for the general population and instead nutritional recommendations include:

- Regular meals and snacks containing a source of starchy carbohydrate e.g., bread, potato, rice, pasta, breakfast cereals
- Encouraging slow-release carbohydrates if possible e.g., wholemeal bread, pasta, rice, noodles, potatoes with skins and breakfast cereals with no added sugar
- Considering portion size guidance especially regarding starchy carbohydrates
- Aiming for consistency wherever possible regarding meal and snack timings
- Not offering a sugar-free diet but encouraging avoidance of sugary drinks or sugar added to drinks or cereals
- Continuing to offer desserts and snacks. Encourage plainer varieties of cakes, biscuits or alternatives
- Avoiding use of foods labelled 'diabetic'
- Offering 2-3 portions of fruit a day but making up the '5 a day' using vegetables where possible.

It is important to note that where a resident may be at risk of malnutrition, advice is not to unnecessarily restrict food options, and optimising dietary intake using a food-based approach will usually be the priority. For example, if a resident with diabetes who is at risk of malnutrition has a sweet tooth, then restricting sugar may cause them more harm if it means that they do not eat as much and continue to lose weight. The benefits and risks of any dietary restrictions should be considered by the resident or in their best interests if they are unable to make this decision themselves.

Vegetarian and vegan diets

A resident may choose to eat a vegetarian or vegan diet for moral (e.g., animal welfare, environmental), religious, cultural or health reasons. Under the Human Rights Act 1998 and the Equality Act 2010 in England, Wales and Scotland, veganism is classified as a belief and a protected characteristic[46,47]. The Health and Social Care Act 2008 (Regulated Activities) Regulations state 'when a person has specific dietary requirements relating to moral or ethical beliefs, these requirements must be fully considered and met'[25].

It is important to ensure an individual resident's choice to follow a vegetarian or vegan diet is established on admission in order to support them to make choices and to ensure their beliefs and values are respected and upheld.

If a resident loses capacity to make decisions regarding their food and drink choices and there is any difficulty around what foods should be offered, healthcare professional advice should be sought and the resident's best interests explored to continue to ensure the residents beliefs and values are upheld.

A vegetarian diet

People who are vegetarian **do not** eat:

- Meat or poultry
- Fish, shellfish or crustaceans
- Insects
- Products that may be derived from dead animals e.g., suet, gelatine, stock made using any of the above.

A vegetarian diet can include:

- Vegetables and fruits
- Grains and pulses
- Nuts and seeds
- Eggs
- Milk and products made from milk such as cheese (if animal rennet free), yoghurt, butter
- Honey.

A vegan diet

People who are vegan do not eat any food or use any other products derived from animals and so **do not** eat any of the following:

- Meat or poultry
- Fish, shellfish or crustaceans
- Insects
- Products derived from dead animals e.g., suet, gelatine, stock made using any of the above
- Eggs
- Milk and products made from any animal milk e.g., cheese, yoghurt, butter
- Honey
- Products that contain any of the above e.g., cakes, biscuits etc.

A vegan diet can include:

- Vegetables and fruits
- Grains and pulses
- Nuts and seeds
- Products made from these such as plant-based milk alternatives (soya, oat, almond), plant based 'cheese', plant based 'yoghurt'.

Some alcoholic drinks may not be suitable for those who are vegetarian or vegan (check food labels to be sure).

Menu planning

It is essential that vegetarian and vegan residents' dietary needs and preferences are considered when menu planning.

The catering team should have the knowledge and skills to cook familiar and appropriate meals for all residents including those who choose a vegetarian or vegan diet. The same standard of food and drink offer should be provided for all residents, to avoid meal repetition as much as possible [48].

Where appropriate, including a variety of vegetarian or vegan options as part of the regular menu can provide more choice for all residents. A vegetarian or vegan diet should meet a resident's nutritional needs and including soya, tofu, calcium fortified soya milk, fortified breakfast cereals, nuts and beans can help to support residents to eat a nutritionally balanced diet (see **Chapter 3** for balanced meal planning guidance)[49, 50].

However, additional consideration may be required to ensure that nutritional balance can be achieved, as some vegetarian and vegan foods may be lower in protein and micronutrients including vitamin B12, folate, calcium, iron, zinc and iodine[51, 52].

As stated in **Chapter 3**, protein is needed to maintain muscle strength and reduce the risk of muscle loss and frailty. At each meal, vegetarian or vegan dishes must contain a source of protein to provide the minimum protein content for each meal (e.g., cheese, eggs or meat alternatives [including products such as soya and Quorn™], tofu, pulses such as beans [not green beans], chickpeas, lentils and nuts). The carbohydrate, vegetables and accompaniments should be similar to the main menu and appropriate for the dish with which they are served.

Suitable vegetarian or vegan gravy and sauces should be provided as appropriate to the dish. These should be encouraged as they can make food less dry and therefore easier to eat.

Residents who are vegetarian or vegan may have additional dietary needs (e.g., swallowing difficulties, diabetes), which may require further consideration and meal planning. These additional needs combined with taste preferences, poor appetite, and/or cultural preferences can increase the risk of malnutrition. Where there are longer term challenges with meeting residents' nutritional needs, professional advice from a dietitian is recommended.

See **Chapter 3** for quantity of each food group to provide per meal and refer to Table 13 below for a comparison of protein content of vegetarian/vegan foods:

Table 13: Energy and protein content of some vegetarian and vegan foods

Food type	**Portion size** (grams unless otherwise stated)	**Energy per portion** (kcal)	**Protein per portion** (grams)
Protein			
Kidney beans, dried	90	239	20
Lentils, dried	60	143	11
Quorn™	100	73	14
Nuts	60	369	13
Seitan	60	10	17
Tofu	100	73	8
Soya protein	100	447	37
Milk and milk alternatives			
Semi skimmed milk	100ml	46	4
Whole milk	100ml	61	3
Soya milk fortified with calcium	100ml	38	3
Alpro™ soya growing up dairy free drink	100ml	64	3
Oat milk	100ml	48	1
Almond milk (sweetened)	100ml	29	1
Greek yoghurt	150	198	9

Vegan Greek yoghurt alternative	150	78	9
Cheese	60	240	15
Vegan cheese alternative	60	204	0
Cooked breakfast items			
Egg, scrambled - 2 eggs	120	284	13
Vegan scrambled egg alternative	120	54	3
Food fortifiers			
Skimmed milk powder**	15	55	6
Pea protein powder	17	60	11
Soy protein powder	14g	50	14
Nut butter	15g	95	4
Ground almonds	15g	90	3
Grated cheese	10g	40	3
Greek yoghurt	45g	60	2
Beaten egg	1	75	7

**Use skimmed milk powder that does not contain added vegetable fat

Main meal ideas for a vegetarian diet

- Quorn™ or beans in a sauce e.g., sweet and sour, curry, casserole, tomato and herb served with rice or potatoes and seasonal vegetables
- Cottage pie made with lentils served with seasonal vegetables
- Pasta bolognese made with lentils or tofu and vegetables
- Tart or flan made with eggs and cheese, served with potatoes and vegetables.

Simple/second meal ideas for a vegetarian diet

- Scrambled egg and baked tomatoes served with toast
- Baked potato and grated vegetarian cheese served with salad
- Houmous and vegetarian halloumi served with pitta bread and raw vegetable strips
- Vegetarian cheese and broccoli quiche served with potato wedges and homemade coleslaw
- Omelette with spinach served with bread and salad or baked beans
- Cauliflower cheese made with vegetarian cheese served with baked potato and peas.

Dessert ideas for a vegetarian diet

Many dessert recipes can be adapted to be vegetarian by using plant-based alternatives to products like gelatine.

Main meal ideas for a vegan diet

- Spaghetti or pasta with lentils and roast vegetables served with salad
- Mixed beans in tomato, chilli or curry sauce served with rice
- Nut roast served with potatoes and vegetables
- Vegetable cottage pie made with butter beans and vegetables
- Tofu or vegan Quorn™ in a sauce served with rice and vegetables.

All of these dishes are also suitable for a vegetarian diet.

Simple/second meal ideas for a vegan diet

- Vegetable ravioli made with tofu and spinach
- Peanut butter and jam, or houmous and avocado sandwich
- Baked beans and vegan cheese on toast
- Avocado and houmous salad served with wholemeal bread
- Lentil & spinach quiche/omelette served with chips and mixed salad
- Vegan pizza made with vegetables and lentils served with side salad.

All of these dishes are also suitable for a vegetarian diet.

Dessert ideas for a vegan diet

Many dessert recipes can be adapted to be vegan by using plant-based alternatives to milk, egg and gelatine.

- Peach and mango compote served with custard (made with plant-based milk)
- Fruit loaf with vegan spread
- Vegan cheesecake
- Seasonal berries and soya yoghurt
- Rice pudding made with soya milk
- Vegan Eton mess (meringue made with aqua faba instead of egg white)
- Vegan apple and blackberry crumble/sponge with vegan ice cream/custard.

All of these dishes are also suitable for a vegetarian diet.

Religious and cultural diets

The UK is a multiracial and multicultural society which is constantly changing and both religion and culture impact on people's food choices. People also have personal beliefs and follow guidance on what is and is not appropriate to eat and drink for their faith to varying degrees. It is therefore important not to make assumptions about an individual resident's food choices and habits based on their ethnic origin or religious beliefs, as there is no 'one size fits all'.

It is essential to understand the individual resident, their background and their current religious and/or cultural dietary requirements, choices, and preferences to support a person-centred approach to meeting their needs and respecting and ensuring their values are understood and upheld. The Health and Social Care Act 2008 (regulated activities) Regulation 14 states that 'note any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background must be met'[8]. To avoid unacceptable cross-contamination, the same principles used to avoid cross contamination in management of food allergy should be practiced.

Religious dietary requirements are likely to be specific to the individual resident's own religious beliefs.

Food culture is different from religious dietary requirements and instead relates to behaviours, attitudes and traditions of people or societies that surround the production and consumption of food.

Neither religious nor cultural requirements restrict the ability to eat a healthy balanced diet.

It is important not to make assumptions about an individual resident's food choices and habits based on their ethnic origin or religious beliefs as there is no 'one size fits all'.

Religion

Seeking guidance of a local religious or cultural advisor is strongly recommended if advice about any cultural or religious diet is required.

Christianity

In general, there are few dietary restrictions except for certain foods that may not be eaten during Lent (the 40 days leading up to Easter Sunday). There are several feast days, for example Christmas, Easter and there are also times when people may choose to fast e.g., avoiding meat on Ash Wednesday, Good Friday and all Fridays in Lent.

African-Caribbean people may be Christians, but dietary customs are not uniform, and are often linked more to the persons culture which depends on where the person lives, lived or has links to.

There are two branches of Christianity where food choices may be more limited:

- Seventh Day Adventism

People will often follow a vegetarian diet but even if they do not, pork and fish without fins or scales are often avoided. Stimulants including tea, coffee and alcohol are also often avoided.

- Rastafarianism

The degree of dietary restriction depends on the persons individual beliefs however, many people who practice Rastafarianism are vegetarian or vegan, and processed or preserved foods and stimulants may also be avoided. People who practice Rastafarianism will also sometimes choose 'Ital' foods which means foods in a whole and natural state.

Islam

Islam is the name of the religion that Muslims follow.

Muslims tend to eat Halal ('permissible') foods which means that foods must be procured, processed and traded in compliance with Islamic Law. Any meat or meat products must

adhere to Islamic Law regarding animal slaughtering, otherwise eating them is considered unlawful or forbidden (Haram). Checking the label is the best way to determine if a product is certified Halal.

Some foods are not permissible and are forbidden. These include pork or pork containing products, crustaceans, blood, non-Halal animal-derived ingredients such as gelatine or suet, alcohol and any alcohol containing foods.

All of the following foods are naturally Halal:

- Fruit
- Vegetables
- Eggs
- Milk and foods made from milk such as cheese
- Fish with fins and scales.

During Ramadan (the ninth month of the Islamic calendar) fasting (avoiding food and drink between sunrise and sunset) is practised. Some people including older adults and those who are chronically or acutely ill may be considered exempt from fasting.

Hinduism and Buddhism

Hindu and Buddhist beliefs include non-violence to all forms of life so meat, fish, poultry and eggs (and foods containing these ingredients) may be avoided. In Hinduism beef is forbidden and people may be lacto-vegetarians (avoiding meat and eggs). Alcohol may be avoided by Hindus and Buddhists and there are also times when individuals may choose to fast. However as with all religious and cultural practices, following the above can be a matter of individual choice.

Sikhism

Sikhs are unlikely to eat pork and eating beef is forbidden. If meat is eaten it must be killed by the Jhatka method which is not common in the UK. People who practice Sikhism may be lacto-vegetarians like Hindus and Buddhists. Fasting is forbidden and alcohol is also prohibited. Personal preference can determine which dietary restrictions are followed.

Judaism

Jewish people usually follow what is stated in the Torah about what is acceptable (Kosher) and what is forbidden (Trief), and these define the selection, preparation and consumption of permitted foods. To be Kosher, food must meet the standards of Kashrut (Jewish laws from the Torah) and must adhere to Shechita methods of ritual slaughtering.

Forbidden foods include:

- Pork or products containing pork
- Vultures, ostriches, hawks
- Eggs that contain blood
- Shellfish.

Kosher foods include:

- Lamb/mutton, beef and goat*
- Chicken, turkey, goose, duck*
- Eggs from chickens, turkeys, geese or ducks
- Fish with scales and fins
- Other food or dairy products that contain ingredients derived from kosher animals
- Fruits and vegetables.

*from a certified Kosher supplier due to religious preparation requirements

Meat and milk products must not be eaten, prepared or cooked together. Preparing/cooking them requires use of separate utensils and crockery, and these must be stored, washed and dried separately from each other. A period of time between eating meat and dairy is also usually required, and depending on the individual the amount of time can vary between 3-6 hours.

Kosher products will be labelled/have a logo on them called a 'Hechsher' which demonstrates that they have approval from a Rabbi or Kosher agency. Checking the label is the best way to determine if a product is certified Kosher.

Fasting is common on the Day of Atonement (date varies), and during Passover (8 days during April) all foods which swell or rise during cooking such as ordinary (leavened) bread, pasta and grains are avoided.

Cultural

Cultural diets are related to personal preferences and often come from the person's country of origin. They are not necessarily strict dietary requirements or linked with someone's religion.

Culturally acceptable diets may relate to foods, cooking methods and flavour profiles that are different to those most commonly found in a traditional British diet.

Common cultural diets in the UK include West African, African-Caribbean, Chinese, Eastern European, Middle Eastern and South Asian.

Some older adults can be more traditional in terms of both their religious and cultural dietary choices, even when their younger relatives eat more traditional British foods or foods from other cultures.

In all cases it is vital to find out the individual resident's usual eating habits, preferences and foods avoided in order meet their needs. Understanding and adapting to the backgrounds, culture, and religion of all residents will allow for better menu planning and ensure that food provided is acceptable to all.

Ideas for menu planning

It is essential that religious and cultural needs and preferences are considered when planning a care home menu as follows:

- The catering team should be equipped with the relevant dietary knowledge and skills required to cook appropriate meals for all residents within their home
- Working with the resident and their family if appropriate can allow catering teams to explore whether it is possible to cook meals compliant with a resident's religious beliefs from scratch within the kitchen, or if it is preferable to provide ready-prepared, appropriately certified meals that are purchased from a specialist supplier
- The standard menu should be adapted to reflect residents' religious and cultural preferences to support better choice. Where for example, over 50% of residents within the home have similar religious or cultural preferences, the standard menu should include at least one appropriate option per day

- Whatever the solution for residents, it is crucial that all residents receive the same standard of food and beverage service as outlined in **Chapter 3**
- Providing a variety of culturally appropriate options as part of the regular menu, or on social occasions such as specific events can keep options interesting and exciting for all residents in the home
- It can also be beneficial to introduce culturally appropriate foods as snack items to determine resident preferences and support further menu planning
- It is important to consider an individual resident's written and spoken language in terms of how a menu is presented to residents to support them to make meal choices.

Healthier eating for residents who wish to lose weight

Supporting weight loss in older adults should be approached carefully. The National Institute for Health and Care Excellence (NICE) recommends to: 'Interpret BMI with caution in people aged 65 and over, taking into account comorbidities, conditions that may affect functional capacity and the possible protective effect of having a slightly higher BMI when older'[53].

It is important to identify whether there is a need for weight loss by considering whether it will support improved quality-of-life outcomes, for example, could weight loss improve pressure injury prevention, breathing difficulties, mobility or personal care. For any resident where losing weight is considered to be beneficial, care needs to be taken that a resident's energy intake is reduced without compromising their intake of other nutrients, including protein.

For many residents, a more appropriate goal may be to prevent further weight gain rather than to encourage weight loss. This can be supported by following the balanced diet/menu recommendations in **Chapter 3** and by also encouraging physical activity where possible.

Any decisions regarding attempting weight loss should be the resident's choice (or a decision made in their best interests if they lack the mental capacity to make their own decisions about their food and drink choices) and this must be discussed with the wider multi-disciplinary team who support with care planning[25].

A holistic approach should be taken to identify any underlying reasons for unwanted weight gain that may be contributing to increasing obesity. This may include certain mental health conditions, certain medications and behaviours that challenge.

It is important to recognise that residents have the right to choose not to follow healthy eating recommendations and their right to do this should be respected. For residents who lack the mental capacity to make their own decisions about their food and drink choices, a 'best interests' decision may be needed [25].

Please note: It is also important to ensure that nutrient dense diet principles (such as food fortification for residents at risk of malnutrition) is not applied to food and drinks for residents who have not been identified as at risk of malnutrition. This is to avoid weight gain in those who are not at risk of malnutrition.

Mental health conditions

Mental health conditions can be common for residents of care homes, and they can cause or contribute to unintentional weight loss or weight gain. Mental health conditions include anxiety, depression, psychosis, distress and behaviours that challenge[54].

It is important that any mental health issue is identified as soon as possible and managed by the care home multi-disciplinary team (in some cases this will need to be in partnership with specialist mental health services). Concerns about eating and drinking such as eating and drinking less than or more than usual, should be considered in relation to any mental health issues as these problems can be associated with many mental health conditions.

As for all other residents, nutrition screening should identify whether a resident with a mental health condition is at risk of malnutrition and would therefore benefit from a nutrient-dense diet.

As well as optimising a resident's intake with a nutrient-dense diet, other strategies may be helpful and these should be personalised to the resident's individual behaviours, for example:

- If the resident is depressed and refusing to eat and drink, they may respond to being supported to engage in activities that are enjoyable/meaningful to them, and which include eating and drinking

- If the resident has a delusional disorder (psychosis) and believes that food may cause them harm, they may be more likely to accept food and drink that is packaged and sealed and can be opened by them or in front of them
- If the resident appears distressed and declines to eat (behaviour that challenges), try to understand their unmet need and what might help meet those needs.

Palliative care/end of life care

High-quality palliative and end of life care is a key element of the Framework for Enhanced Health in Care Homes[55]. The need for palliative and end of life care can be variable and includes managing conditions such as dementia, cancer and frailty. The primary goal is usually optimising the best quality of life for the resident and their support network.

Malnutrition can be common with chronic diseases, particularly as disease progresses[56]. The overall goal of managing malnutrition needs to be considered in relation to wider medical management, and the needs and wishes of the resident (or decisions made in their best interests). As medical treatments are discontinued and ceilings of care are put in place, the overall goal of nutritional care is likely to move away from maintaining or improving nutritional and functional status and instead move to focus on providing comfort, pleasure and enjoyment.

A reduction in appetite, weight loss and deterioration in swallow are common as someone approaches the final weeks and days of their life. A resident may lose interest in eating and drinking and decline to eat. Relatives and carers are likely to need reassurance that nutrition support at this point is unlikely to change the resident's outcome and instead may lead to harm such as pain and feelings of discomfort. Prescription of oral nutritional supplements towards the end of life is also unlikely to be appropriate.

Food allergy

Food allergies can be life-threatening for some people and must be taken seriously by food service teams. UK legislation requires all food services, including those in care homes, to provide information about the presence of any of the 14 specified allergens (see list below) in any of the food they serve to residents, staff or visitors.

There are 14 major allergens that are governed by UK food laws[57] which are:

- Celery
- Cereals containing gluten
- Crustaceans
- Eggs
- Fish
- Lupin
- Milk
- Molluscs
- Nuts
- Peanuts
- Sesame
- Soya
- Sulphur dioxide (sulphites)
- Mustard.

Catering teams must be able to evidence the exact ingredients used, including the brand names and pack sizes where applicable and this must include any alternative ingredients used. Caterers must also take note of any precautionary 'may contain' labels on packaging. From 1 October 2021, the requirements for 'prepacked for direct sale' (PPDS) food labelling changed in Wales, England and Northern Ireland [58]. Also known as Natasha's Law, this labelling regulation helps to protect consumers by providing allergen information on the packaging of these products.

Any food business that produces PPDS food is required to label it with the name of the food and a full ingredients list. Allergens must be highlighted within the ingredients list.

In addition to this some residents may have allergies to other food items. Where this is the case, safe food needs to be provided for them.

Allergen management

It is vital that information related to resident's food allergies is collected and recorded as early as possible in the admission process and is communicated quickly and effectively to all catering and care teams. In addition, if any staff member or visitor who has a food allergy is eating within the home, details about their food allergies must be communicated appropriately to the catering and care team. It is recommended that all healthcare facilities have a food allergy policy or a wider food, nutrition and hydration policy that includes allergen management.

It is recommended that all healthcare facilities have a food allergy policy or a wider food, nutrition and hydration policy that includes allergen management.

Providing safe food

To help cater for people with food allergies, it is recommended that care homes have a clear approach within their food policy about how they manage food services for residents with a food allergy. This might include purchasing specialist meals that are free from all 14 allergens, or embedding kitchen practices such as:

- A recipe management system that identifies allergens within a dish
- Safe preparation through ingredient label checking
- Safe preparation and service to avoid cross contamination.

In all cases it is essential that catering and care teams receive training about the management of food allergies and how to safely provide food for anyone with a food allergy [59].

Residents with a food allergy should be free to choose from the standard menu, where possible and appropriate, and need to be provided with accurate allergen information to enable them to make a safe choice.

Ingredient suppliers must provide information on the 14 allergens in ingredient lists or product specifications for all products purchased, including cereals containing gluten. They must also follow Food Standards Agency guidance on communicating risk of contamination with allergens during manufacturing.

Gluten-free diet for the management of coeliac disease

A gluten-free diet is the only medical treatment for coeliac disease and a skin condition called dermatitis herpetiformis. Gluten is a type of protein found most commonly in wheat, rye, barley, some oats and other grains such as kamut.

Depending on the food service system there are different options for providing a gluten-free diet including:

Fresh cook meals

Most homes can and will prepare meals that contain no gluten-containing ingredients within their kitchen environment, using the same best practice as preparing any food for a resident with a food allergy.

Points to consider include:

- Understanding and applying residents' preferences to make sure that the dishes being prepared for them are likely to be eaten. Offer a choice of meals every day that are suitable for their needs
- Using allergen management and Hazard Analysis Critical Control Point (HACCP) systems which may include a manual allergen builder or recipe database system to understand whether recipes contain any cereals containing gluten
- Ensuring all food labels for all ingredients are checked to make sure they are gluten free. Staff must never guess or make assumptions that something is suitable and should look out for cereals containing gluten on the label which include wheat, rye, barley, oats, kamut etc as the label may not mention gluten specifically
- Preparing any gluten free meals and snacks in a clean space within the kitchen and taking appropriate steps to avoid cross contamination in the kitchen through use of equipment, utensils, boards, crockery and cutlery
- Making sure no ingredients that may be contaminated with gluten are used e.g., open packs of butter or large jars of pickle that may contain breadcrumbs
- Using a dedicated toaster, toaster bags or a clean grill for toasting gluten free bread to avoid any cross-contamination with gluten containing bread.

Coeliac UK produces guidance on preparing gluten free meals for catering teams in collaboration with the Food Standards Agency [60].

Pre-packaged gluten free meal solutions

Providing gluten free foods for residents may involve buying in a complete meal solution from a specialist dietary meals supplier or meals from regular suppliers that are labelled gluten free. The need for gluten free foods applies to all items on a menu, for example cereals, soups, yoghurts, desserts and biscuits.

Can items on menus be identified as having no gluten containing ingredients?

Identifying individual meals as including 'No Gluten Containing Ingredients' (NGCI) on menus or using the 'NGCI' coding is not permitted. However, it is acceptable to produce a separate menu which lists dishes that do not contain any gluten containing ingredients where controls are in place to avoid cross-contamination with gluten containing ingredients.

Kidney (renal) disease

If dietary modifications are needed for residents with kidney disease this should be recommended and guided by a specialist renal dietitian.

Dietary modifications for someone with kidney disease will often restrict intake of one or more of the following:

- Potassium
- Phosphorus
- Sodium (salt)
- Fluid.

As kidney disease progresses, the risk of developing malnutrition also increases. Menus need to be designed to enable residents to optimise their nutritional intake within the constraints of their recommended diet. Collaboration between catering teams and specialist renal dietitians is crucial to meet the needs of this population.

R

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Appendices

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Appendix 1: Summary dietary information sheet

The summary dietary information sheet is adapted from original provided by Harbour Healthcare.

Resident Name **RED if MUST score 2 or more, amber if MUST score 1**	**Food and drink allergy, intolerance** or special diet required	**IDDSI Level – food**	**IDDSI Level – fluid (incl soup)**	**Nutrient dense/ Fortification preference in line with MUST Score**	**Cultural/ religious diet including vegetarian/ vegan**	**Drink preferences** e.g strong tea, 1 sugar	**Portion size** small (S) medium (M) large (L)	**Adaptive Crockery – Cutlery** including cup/glass	**Assistance required with eating and drinking**

Appendix 2: Mealtime service checklist

Description	Yes	No	Partially	Comments	Actions
The dining room environment is suitably prepared.					
The dining area is tidy and tables are clean. Suitable seating and space is available to meet resident needs. The area is easily accessible to residents. Menus meet resident's needs (font size, typeface etc) and be appropriately displayed.					
The tables are set appropriately.					
Where possible, residents are encouraged to help set the tables and condiments e.g, salt, pepper, sauces are placed on each table. Napkins are available.					
The place settings are personalised.					
There is a range of placemats, cutlery and/ or cups, glasses, mugs are provided to meet individual residents' preferences and support needs.					

Description	Yes	No	Partially	Comments	Actions
Interest in mealtimes is encouraged.					
Where possible, residents are involved in food/menu related activities and discussions before mealtimes to help encourage and prepare them.					
Cues to mealtimes are encouraged.					
Where possible, cooking food smells and sounds are present to help stimulate resident appetites and interest in mealtimes. Hand washing is encouraged.					
There is a positive dining room ambience.					
There is a provision for relaxing background music and sounds for residents. Distractions are minimised e.g., TV is turned off. The area is well lit and ventilated.					
Mealtime service					
The meal service is planned and resident centred.					
A summary dietary information sheet (or equivalent) is available and actively used by staff at all meal and snack times.					

Description	Yes	No	Partially	Comments	Actions
Each meal is checked by a member of the care home team to ensure that it is in line with the residents summary dietary information sheet.					
Staff are briefed before the meal service.					
Staff are informed and familiar with the menu choices, portion sizes, alternative meals and snacks and how to serve the food. Staff understand the residents' individual food and fluid preferences and their support needs.					
Staff have defined roles and responsibilities at mealtimes.					
There is an agreed person in charge of the overall meal service (meal time coordinator). Staff are familiar with setting up and using the meal service equipment. There is a clear plan of who will be serving the food and who will sit and support residents with eating and drinking. Meal services to rooms are coordinated in conjunction with the dining room service.					

Description	Yes	No	Partially	Comments	Actions
Verbal and visual choice of meals and drinks are offered to residents.					
Where possible residents are encouraged to choose their meal at the point of service. There is a provision of ordering from a table menu, using 'show plates' (if the catering team is not available) and/or using pictorial menus.					
Staff are able to adapt the portion sizes to meet the resident's individual needs.					
Portion sizes are tailored to the residents needs and well presented on the plate. Second portions are available and offered to residents, where appropriate.					
During the mealtime					
The food and drinks presented look visually appealing and colourful.					
All meals (including special diets) are well presented on the plate. Sauces/gravy is offered separately at the table (where appropriate).					
Condiments are available for every mealtime.					
Condiments such as salt, pepper and mustard are in clean dispensers that are see through or very clearly labelled.					

Description	Yes	No	Partially	Comments	Actions
The time is suitable for eating and sociability.					
Residents are served their meals course by course. There is sufficient time provided for residents to enjoy, eat their meals and socialise. Mealtimes are not rushed or feel like a task.					
Mealtime etiquette.					
Residents are provided with positive support, irrespective of how they eat, such as eating with their hands.					
After the mealtime					
Recording of food and fluids					
When it is appropriate, residents' food and fluid intakes are accurately documented before plates are removed from the dining area.					

Please refer to Chapter 2 – 'Delivering a positive mealtime experience to enable residents to eat and drink well' for further information.

Appendix 3: Menu assessment checklist

Description	Yes	No	Partially	Comments	Actions
Standard Menu Planning and Design					
There is a team approach used for menu planning. Menus are informed by feedback from residents and carers about which dishes are most popular and what they would like to be included on the menu.					
The menu type reflects the needs of the resident group e.g. 4-week seasonal cycle.					
The menu structure describes breakfast, main meal, simple (second) meal and snacks provided for residents, as a minimum each day.					
The main meal of the day has a minimum of two courses (recommended main course and dessert) and two or three choices at each meal (Chapter 3, table 4).					

Description	Yes	No	Partially	Comments	Actions
If sandwiches are a menu option, a minimum of 3 sandwich fillings are offered (all including a good source of protein and a choice of white or wholemeal bread).					
A minimum of one hot and one cold dessert is available at every main meal (Chapter 3, table 4).					
Where required the menu provides nutrient dense options at every mealtime (Chapter 3, table 4).					
Alternative main meal options are available if a resident does not like what is on the menu.					
There is a structured snack time that is co-ordinated with the beverage service.					
A choice of snacks is available at any time of day or night to meet the resident preferences and their dietary needs (Chapter 3, table 8, 9).					
There is a process for capturing menu feedback from residents and carers about which dishes are most and least popular.					

Description	Yes	No	Partially	Comments	Actions
Potatoes, bread, rice, pasta and starchy carbohydrate					
The recommended carbohydrate portion sizes (where appropriate) are available at each meal for residents to receive, according to their needs (Chapter 3, table 4).					
A choice of both hot and cold breakfast cereals are available daily, with a range of fibre content.					
At least one source of carbohydrate based food is available at every meal.					
A choice of white, wholemeal sliced bread or rolls is available every day.					
The menu contains a good variety of appropriate carbohydrate-based sides that suit both the meals served and the resident group.					
Fruit and vegetables					
The total food offer including snacks, is capable of providing 5 portions of fruit and vegetables per day.					

Description	Yes	No	Partially	Comments	Actions
Two 80gram portions portions of different vegetables is available at each main meal.					
A salad or vegetable option is available with the second/simple meals.					
Fresh fruit is available throughout the day, at main meals and as a snack option.					
One of the dessert options at the main meal contains one portion of fruit (Chapter 3, table 4).					
A portion (150ml) of fruit juice is available every day.					
Beans, pulses, eggs, nuts, fish, meat and other proteins					
All meals contain a high-quality source of protein that is able to meet the recommended portion sizes (Chapter 3, tables 4, 6 and 7).					
Breakfast offers at least 20g protein using the foods suggested, including cooked breakfast options (Chapter 3, Tables 5 & 6).					

Description	Yes	No	Partially	Comments	Actions
Standard portions of main meals contain the recommended minimum of 30g protein over at least 2 courses (Chapter 3, table 4).					
Standard portions of simple (second) main meals contain the recommended minimum of 25g protein spread across at least 2 courses (Chapter 3, table 4).					
For every vegetarian dish there is an appropriate source of protein to meet the recommended minimum protein content (Chapter 3, table 4).					
Dairy and alternatives					
One dessert option at every meal is made from nutrient dense ingredients e.g. milk-based pudding, custard, yoghurt.					

Description	Yes	No	Partially	Comments	Actions
Alternative desserts are always available e.g. yoghurt, ice cream, cheese and biscuits.					
Spreads and accompaniments					
Appropriate spreads, sauces and condiments e.g. mint sauce, apple sauce, pickle, mustard, horseradish are available at every mealtime, where appropriate.					
Gravy and other sauces are served separately and offered to residents at every mealtime, where appropriate.					
Standard preserves are always available e.g. jams, marmalade and honey.					
Hydration					
A minimum of 1600ml of fluid is offered to residents throughout the day.					
There is a range of drinks available (hot and cold) that are accessible to residents at all times.					

Description	Yes	No	Partially	Comments	Actions
Suitable cups, mugs, glasses and adaptive equipment are available, where required.					
Nutrient dense fluids e.g. whole milk, fortified milk, milkshakes, malted drinks and smoothies are available for residents who are identified at risk of malnutrition.					
Catering for special diets					
Menu options are capable of meeting special and/ or cultural dietary needs of the residents such as modified texture, dementia, diabetes, Halal, Kosher and vegetarian (see relevant sections in chapter 4).					

Appendix 4: Homemade supplement recipes

Fortified Milkshake

Makes 1 portion
1 portion = 220ml
Serve 2 x 220ml portions per day
(or 4 x 110ml per day depending on the resident's preference)
300kcal and 17g protein per 220ml portion

Ingredients

1/3 pint/180ml whole milk

2 heaped tablespoons/30grams skimmed milk powder**

4 heaped teaspoons/20grams vitamin fortified milkshake powder (Aldi Cowbelle, Asda Milkshake Mix, Lidl Goody Cao, Nesquik®)

OR 5 heaped teaspoons (25grams) 'Ovaltine™ Original Add Milk' powder

OR 5 heaped teaspoons (25grams) 'Horlicks™ Original' Malted Drink powder

Directions

Mix milk powder and milkshake/ Ovaltine™/Horlicks™ powder together in a glass.

Gradually mix in milk and stir well.

**Use skimmed milk powder that does not contain added vegetable fat

Fortified Fruit Juice

Makes 1 portion
1 portion = 220ml
Serve 2 x 220ml portions per day
(or 4 x 110ml per day depending on the resident's preference)
180 – 250kcal and 8 – 9g protein per 220ml portion

Ingredients

180ml pure fruit juice (If possible, use fruit juice with added vitamins such as Kubus™ 100% Multivitamin Juice (Tesco), Naturis™ Multivitamin Juice (Lidl) or Tropicana™ Multivitamin Boost).

40ml undiluted premium cordial (not sugar free/diet/no added sugar) e.g., Belvoir™, Bottle green™, Ribena™, Rocks Organic™.

10grams (2 x 5gram sachets) egg white powder or 80gram liquid egg white (e.g.,Margarets™ liquid egg white) (these can be found in the home-baking section of most supermarkets or larger, better value packs can be purchased online).

Directions

Put egg white powder or liquid egg white in a glass.

Gradually stir in undiluted cordial or squash (do not whisk).

When mixed, gradually mix in fruit juice.

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Endorsements & acknowledgements

Endorsements

► NACC

The National Association of Care Catering (NACC) is proud to have been working in partnership for this Care Catering Digest. This document is a welcome and necessary publication to enable consistency across the care home sector. A multidisciplinary team bringing hospitality and nutrition together is the best solution for an all-encompassing approach to meeting residents' nutritional needs. This is a must-have document for all Catering teams in care homes, from induction through to ongoing reference and review. No care home for the elderly should operate without this.

This is also a guidance document useful for regulators and stakeholders who commission, guide and inspect services.

In the same way that the equivalent document, the 'Nutrition Digest' for the NHS is now a measured necessity for all hospital caterers, so this should also be in care homes.

Members of the working group

Name	Role	Organisation
Helen Ream – Working Group Chair	Healthcare and Food Service Dietitian/Vice-Chair of the Food Services Specialist Group	Compass Group UK & Ireland/British Dietetic Association
Alison Smith – Working Group Vice Chair	Prescribing Support Consultant Dietitian/ Committee member of BDA Older People Specialist Group and BDA Optimising Nutrition Prescribing Specialist Group	NHS Hertfordshire and West Essex Integrated Care Board/ British Dietetic Association
Elizabeth Armstrong	Registered Dietitian	Northern Ireland
Laura Barker	Clinical Lead – Dietetics/ Dysphagia Practitioner – Speech & Language Therapy	Rotherham Doncaster and South Humber NHS Trust (RDaSH)
Allan Brazier	National Treasurer	National Association of Care Catering
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Vittoria Romano	Chair of the Older People Specialist Group/Specialist Dietitian and Appropriate Prescribing Lead	British Dietetic Association/ Central London Community Healthcare NHS Trust
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Helen Ream

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All members of the working group completed conflicts of interest forms prior to the development of these guidelines. Signed copies are retained by the Chair of the working group.

Stakeholder groups and organisations

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- Older people Specialist Group (OPSG)
- Food Services Specialist Group (FSSG)
- National Association of Care Catering (NACC)

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