Adult Nutrition and Hydration Policy for Community Use

This policy aims to promote good nutrition and hydration for all adults cared for by staff in community settings across the Trust.

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Approved by:	Nutrition Steering Group	
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Type of Policy	Clinical √	Non-Clinical

Contents

1.0 QUICK LOOK SUMMARY

This policy aims to promote and improve nutrition and hydration of the adult patients we care for in their homes across Leicestershire and Rutland (including care homes). It explains how patients who are at nutritional risk can be identified, how nutritional status can be improved and what support there is from members of the multidisciplinary team (MDT).

Undernutrition increases morbidity and mortality and therefore good nutrition, good hydration and appropriate malnutrition screening is fundamental.

Good hydration is important for overall good health. Ensuring patients get enough water every day is an important step in maintaining their health. Staff need to be aware to signs of dehydration and asking about fluid intake within their assessments.

Nutritional risks are identified by nutritional screening tools. NICE Clinical Guideline – Nutrition Support in Adults (2006) states that screening for malnutrition should be carried out by healthcare professionals with appropriate skills and training.

Nutrition and hydration forms part of the MDT care planning process and is part of the National Quality Standard. A care plan should be clearly documented in the patient's clinical record.

Oral care needs should also be considered as part of the care plan. Poor oral hygiene can affect an individual's nutritional intake.

Food and drink provision is difficult to monitor if the patient lives in their own home, however, the importance should be discussed, and the monitoring encouraged when there is a concern.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

1.1 VERSION CONTROL AND SUMMARY OF CHANGES

Version number	Date	Comments
1	March 2012	Harmonised version of LCRCHS Adult Nutrition and Hydration Guideline for Community Use
2	December 2015	Updated references and key documents. Amended section 6 to reflect LMSG guidelines on screening, food first and dietetic referral
3	December 2017	Updated references and key documents and some small changes to different sections in policy
4	July 2023	Review due, Policy transferred to new template

1.2 KEY INDIVIDUALS INVOLVED IN DEVELOPING AND CONSULTING ON THE DOCUMENT

Name	**Designation**
Anne Scott	Director of Nursing, AHP & Quality
Jane Martin	Assistant Director Nursing & Quality
Implementation Lead	
Core policy reviewer group	
Wider consultation	Nutrition and Hydration Steering Group
	Heads and Deputy Heads of Nursing
	Policy Group Members

1.3 GOVERNANCE

Level 2 or 3 approving delivery group	**Level 1 Committee to ratify policy**
Nutrition Steering Group	Quality and Safety Meeting

1.4 EQUALITY STATEMENT

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It considers the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

1.5 DUE REGARD

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 DEFINTIONS THAT APPLY TO THIS POLICY

Body Mass Index (BMI)	Measurement of weight compared to height to provide a weight category (underweight, healthy weight, overweight or obese).
EPR	Electronic patient record
Hydration	Required to ensure normal bodily functions. This applies to any fluid consumed. Foods that have a high fluid content e.g. soup, jelly, ice cream will support good hydration
Malnutrition	A state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes a measurable adverse effect on body composition, function and/or clinical outcome
MUAC	Mid Upper Arm Circumference
MUST	Malnutrition Universals Screening Tool
Nutritional Screening	Agreed tool that will quickly identify a patient's nutritional risk. This can be completed by any health care professional with appropriate training.
Nutritional Assessment	A more thorough analysis of a patient's nutritional intake and requirements carried out by a dietitian
Nutritional support	Active measure put in place to help improve nutritional intake. This could be oral, enteral, or parental
Oral nutrition	Food taken orally and includes fortified food, additional snacks, and oral nutritional supplements
ONS	Oral nutritional supplements

2.0. PURPOSE AND INTRODUCTION

The policy extends to all adult patients cared for in their own homes and care homes across Leicester, Leicestershire and Rutland (except for eating disorders). By achieving the care in this policy, it will allow the Trust to meet the following requirements:

- Care Quality Commission – Fundamental Standards 2016 – Food and Nutrition
- 10 Key Characteristics of 'Good Nutrition and Hydration Care 2015
- NHS England – Guidance - Commissioning Excellent Nutrition and Hydration 2015-18 (2015)
- Meeting Nutritional and Hydration Needs NICE Clinical Guidance 32 – Nutrition Support in Adults (2006)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 14

Improving nutrition and hydration is supported by:

- Managing Adult Malnutrition in the Community (2021)
- British Association of Parenteral and Enteral Nutrition (BAPEN)
- Age UK: Eating and Drinking Well (2020)
- Water UK – Water for Healthy Aging: Hydration Best practice Toolkit for Care Homes (2005)
- Nutrition support in adults: Quality standard **[QS24]** (2012)
- Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline **[CG32]** (updated in 2017)
- The British Dietetic Association Digest (2023)
- Public Health England: Healthier and more sustainable catering A toolkit for serving food to older people in residential care.
- National standards for healthcare food and drink (2022)

3.0 POLICY REQUIREMENTS AND AIM

The policy is for staff working in Leicestershire Partnership Trust and aims to promote good nutrition and hydration for all adults who are cared for and visited by staff at home or in care homes across Leicester, Leicestershire and Rutland.

This policy aims to improve nutrition and hydration of the adult patients we care for in their homes across Leicestershire and Rutland (including care homes). It explains how patients who are at nutritional risk can be identified, how nutritional status can be improved and what support there is from members of the multidisciplinary team (MDT).

4.0 IMPORTANCE OF NUTRITION AND HYDRATION

Having enough to eat and drink is one of the most basic human needs and yet it is known from the Department of Health 'Dignity in Care' campaign, research, complaints and media reports that some vulnerable people are not having their needs met.

The Combating Malnutrition: Recommendations for Action by the British Association of Enteral and Parenteral Nutrition (BAPEN) estimates that 3 million people are malnourished in the UK. The report found 93% of this figure live in the community. This represents 5% of the population and the incidence of malnutrition increases to 14% for those over 65 years of age. The BAPEN Nutrition Screening Week surveys have shown that more than a third of adults admitted to care homes in the previous 6 months were malnourished.

4.1 UNDERNUTRITION

Undernutrition increases morbidity and mortality and therefore good nutrition, good hydration and appropriate malnutrition screening is fundamental. Symptoms and risk factors of malnutrition can include:

- Unintentional weight loss
- Low BMI
- Loss or changes in appetite
- Loss of interest in food
- Difficulties in access to food
- Difficulties with food preparation
- Disease status
- Poor wound healing and recurrent infections
- Inadequate care support in relation to food and hydration provision

4.2 HYDRATION

Good hydration is important for overall good health. Ensuring patients get enough water every day is an important step in maintaining their health.

Staff need to be aware to signs of dehydration and asking about fluid intake within their assessments. Staff need to take account of individuals at greater risk of dehydration:

- Pregnant or breastfeeding
- In a hot environment
- Physically active for long periods
- Ill or recovering from illness

Warning signs of dehydration can include:

- Urine is a darker yellow/amber colour
- Bad breath
- Decreased amount of urine
- Dry mouth and swollen tongue
- Sluggishness and fatigue
- Sugar cravings

If the patient is experiencing any of the following symptoms seek medical attention immediately:

- Confusion
- Dizziness
- Fainting
- Heart palpitations

5.0 NUTRITIONAL RISKS AND SCREENING

Nutritional risks are identified by nutritional screening tools. NICE Clinical Guideline – Nutrition Support in Adults (2006) states that screening for malnutrition should be carried out by healthcare professionals with appropriate skills and training.

Nutritional risk screening should be offered to:
- All people on registration at GP surgeries
- All people in care homes on admission
- All hospital inpatients on admission
-All outpatients at their first appointment

Nutritional risk screening should be repeated upon clinical concern (e.g. reduction in appetite). NICE guidance further stated that screening should be considered at other opportunities e.g. health checks, flu injections.

The Care Quality Commission requires residents in care homes to be nutritionally screened and repeated as per guidance. The local authority and ICS' require screening as part of their quality schedule for residents they fund in care homes.

It is good practice for visiting health care professionals to ask service users if there have been any changes to their weight and appetite upon each visit. If there are any concerns, nutritional screening should be repeated and the GP informed.

5.1 MALNUTRITION UNIVERSAL SCREENING TOOL (MUST) ASSESSMENT

Leicestershire Partnership Trust currently use the Malnutrition Universals Screening Tool (MUST). This is a nationally validated nutritional screening tool and is also used in some care homes in the city and county.

The MUST tool uses a step-by-step process to identify if an individual is at low, medium or high risk of malnutrition. The steps include calculation of Body Mass Index (BMI), a weight loss percentage in the last 3-6 months and the acute disease effect score. A score of 0 is classified as a low risk, a score of 1 is a medium risk and a score of 2 or above is a high risk of malnutrition. The action required will depend on the final score calculated. An online MUST calculator can be accessed through the BAPEN website

Step 1 of MUST is the BMI score. An objective weight (actual weight) should be obtained (unless deemed clinically inappropriate). If a weight is not obtained, the reason should be clearly documented in the patient's EPR.

Subjective criteria can be used if a weight cannot be obtained (i.e., mid upper arm circumference (MUAC)). A MUAC can be used to estimate BMI category. Information and guidance on weight/MUAC can be found on the BAPEN website.

In some situations, a weight estimation may be used. If an estimated weight is taken, then a

note should be added to the patients EPR to make this clear.

If there are any factors present that may influence body weight (e.g. oedema and amputations), this should be documented in the patient's EPR.

A competency for use of adult weighing scales is available on the LNDS website.

An attempt should be made to measure body height in all patients. If a height measure is not possible, a height recall or estimated height should be used and documented. Factors affecting accuracy of any height measure obtained, such as curvature of the spine, should be clearly documented. If a height check is not possible, an ulna length measurement is a recognised means of estimating height. Guidance on the method can be found on the BAPEN website.

The weight and height measures obtained, or estimated should be used to calculate the patient's Body Mass Index using an online calculator (found on BAPEN website) or via EPR.

Step 2 of MUST requires the calculation of weight loss in percentage over the last 3-6 months to provide a score (score 0 if <5%, score 1 of 5-10% and score 2 if 10% or more).

When using MUST in community settings, only step 1 and 2 should be used to calculate the nutrition risk score. Step 3 (the acute disease effect) is unlikely to apply outside hospital settings.

5.2 MUST SCORE AND ACTIONS

All patients who are at nutritional risk should have their nutritional score assessed when accepted onto the case load and repeated:

- Fortnightly if MUST score > 1
- MUST score 1 or less
- Sooner if concerns
- On discharge from community case load

NICE and BAPEN recommend monthly weight checks for individuals in care homes and repeated more frequently if there are concerns. Frequency of weighing and screening of patients in their own home will be subject to individual agreement from trust staff.

Patients with a MUST score of 1 or more should have a nutritional care plan developed to include first line actions. This should include:

- Frequent meals and snacks
- Encouragement of high protein/calorie options
- Fortifying food and drinks with additional sources of protein and/or energy
- Consideration of vitamin and mineral supplementation
- Providing nutritious drinks (e.g., hot milky drinks, milk shakes, over the counter nutritional supplements) and snacks.

Further information on the LNDS 'Food First' guidance can be requested from Leicestershire Nutrition and Dietetic Service. The care plan should include monitoring and review of food and drink intake and MUST. Further information on care planning is discussed in Section 6.

Hydration should be monitored and encouraged for service users to meet their fluid requirements. People in care homes should have a nutrition and hydration plan to monitor this and meet their needs. Information on the warning signs can be found above in 4.2.

A dietetic referral should be considered for a full nutritional assessment via the patients EPR

if they have scored as high risk on MUST **and** have implemented first line interventions with no improvement after 1 month. Information on the referral process to Nutrition and Dietetics can be found in section 8.3.

Staff should continue to follow the first line advice described above unless clinically inappropriate, e.g. if a patient is nil by mouth. For further information, please refer to the guideline on LLRAPC Managing Malnutrition in Adults in Primary Care

6.0 CARE PLANNING

Nutrition and hydration forms part of the MDT care planning process and is part of the National Quality Standard. A care plan should be clearly documented in the patient's clinical record.

Community staff will work with care providers, patients and/or family whom there are concerns regarding the adequacy of their nutritional intake for them to record the food and drink consumption over 3 complete days, or longer if appropriate. Community staff can use this as part of their assessment and ongoing advice/action, in addition to the MUST screening tool.

Patients with specific nutritional needs should have this clearly identified in their care plan. If the patient is in a care home, it may be advantageous to keep a list in the kitchen or on the drinks trolley. These may include patients:

- Following a therapeutic/special diet
- On a texture modified diet or thickened fluids
- Requiring extra drinks or snacks or food fortification
- Needing assistance with eating or drinking
- On a food intake and/or fluid balance chart
- Nil by mouth

Oral care needs should also be considered as part of the care plan. Poor oral hygiene can affect an individual's nutritional intake (e.g. cause pain or prevent an individual eating chewing foods). Teeth should be brushed correctly twice a day and any issues with poor fitting dentures, sore mouth or gum disease should be actioned.

7.0 FOOD AND DRINK PROVISION

Food and drink provision is difficult to monitor if the patient lives in their own home, however, the importance should be discussed, and the monitoring encouraged when there is a concern. Food charts by LNDS are available.

Monitoring may be easier for patients who reside in care homes. Information on food and drink provision, including menus and available snacks, can be made available for all patients and visitors, and kept updated by the catering/care home manager.

8.0 NUTRITIONAL SUPPORT

Nutritional support allows measures to be put in place that aim to improve the nutritional status of the patient.

Patients requiring nutritional support should be encouraged to choose high-energy options and be offered snacks and nutritious drinks, such as high energy/high protein shakes. Caution is needed regarding patients with diabetes or renal disease and seek advice from

dietetics for these cases.

A ‘food first’ approach that focuses on offering small, energy dense meals regularly throughout the day is recommended (see 5.2).

8.1 ORAL NUTRITIONAL SUPPLEMENTS

Healthcare staff should make regular checks on the ‘best before’ date of ONS stored in the patient’s home and ‘best before’ dates should be checked before giving patients nutritional supplements. ONS should be stored in a cool, dry place and should be offered chilled from the fridge, unless otherwise requested.

If the thickening of Nutritional supplements is being considered, discussion should take place with the GP/Pharmacist that may include signposting to specialist dysphagia products that can be prescribed.

8.2 HOME ENTERAL FEEDING

For some patients an enteral feed may be the required method of nutritional support. This will involve feeding by a naso-gastric or Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. These patients will need a referral to the Home Enteral Nutrition Service (HENS) by nursing staff and/or GP.

If a patient is already on an enteral feed in hospital and being discharged to their home/care home the patient needs to be referred to HENS by the hospital team. It is recommended one working week is given to ensure time for the HENS team to provide training for the family or carers regarding management of enteral feeds and to allow time for them to practice and gain confidence prior to discharge.

8.3 REFERRAL PROCESS AND SUPPORT FROM THE NUTRITION AND DIETETICS DEPARTMENT

Referrals for patients to be seen as outpatients or in their own homes can be made using the PRISM form on SystmOne. This form can only be completed by healthcare staff and should be completed and sent as a task to LNDS. Referrals should be marked as urgent if there are significant concerns and include a clearly stated reason.

Referrals to the Nutrition and Dietetic department can be made if a patient has a high MUST score (2 or above) and first line interventions have been tried with no improvement seen after 1 month. A referral can also be made if the patient requires specialist advice on a special or therapeutic diet, e.g., coeliac disease and poorly controlled diabetes.

All referrals must include a weight/MUAC, height, BMI and MUST score within the last 4 weeks. In addition, confirmation of the implementation of the LLR APC Malnutrition Guidance is required.

Outpatients’ will be sent a letter by the central booking team asking them to phone to arrange an appointment at a clinic that suits them best. Patients who require home visits will be contacted by the dietitian to arrange an appointment.

The dietitian will agree a care plan with the patient and communicate with the referring agent and other agencies involved about this plan, including who will review the care plan and follow up arrangements.

9.0 Dietetic Assessment

The dietitian will offer telephone appointment and if a face to face appointment is required/requested, this will be either as an outpatient, visit to their own home/care home, community ward or day centre.

The dietitian will undertake a nutritional assessment on all all appropriately referred patients. A nutritional assessment is a key role of the dietitian and includes assessment of anthropometrics, hydration, biochemistry, and the effect of disease on nutritional status.

Nutritional assessment can be used to assess nutritional status and plan aims and objectives of dietetic treatment. The dietitian will use the information obtained to calculate the individual's requirements for nutrition and fluids.

Nutritional assessment will include an assessment of the following factors:

- Weight
- Weight history
- Height
- BMI
- Diet history
- Additional factors that will affect nutritional intake e.g. oral health, medication side effects, bowel issues, mental health, cognition and other clinical conditions.

The dietitian will often estimate nutritional requirements for patients referred for nutritional support unless assessment has shown that nutritional intervention is not indicated, e.g. late palliative care as per LLR APC Managing Malnutrition in Primary Care.

Patients' will require ongoing involvement and review of their nutritional care plan and ongoing review of nutritional status will be required unless clinically inappropriate. Actions will be clearly documented in the patients' clinical record. The aim/goal will be agreed with the patient and with the carer and family if informed consent has been obtained. If a patient lacks capacity, the Mental Health Act will be adhered to.

The dietitian will review hydration needs, flag concerns about dehydration and discuss appropriate ways of ensuring fluid needs are met or optimised.

10.0 ADULT COMMUNITY HEALTH SERVICES

10.1 SUPPORT FROM SPEECH AND LANGUAGE THERAPY(SLT)

Patients suspected of having difficulties swallowing their food or drink should be screened using the Community Health Services or Adult Learning Disability SLT referral-screening tool.

If a SLT referral is felt to be appropriate, these patients should have a medical referral documented in their notes by their consultant/GP/registered health care professional and a referral will be made on the SLT referral-screening tool or by letter (signed by the GP/Consultant/Community Matron).

All referrals will be acted upon within 4 weeks. However, referrals will be screened when received by the SLT department and an urgency level will be assigned. Patients at high risk of choking/aspiration will be seen within 2 weeks (priority). Where there is a significantly high

risk of choking/aspiration, the SLT service will aim to see patients more urgently (within 5 working days), however there is not a funded ‘rapid response’ time within the service.

The SLT will see the patient in their local clinic or may visit in their own home/care home as appropriate to conduct a swallowing assessment and/or mealtime observation.

The SLT team will discuss and document a patient’s swallow assessment, the suggested recommendations and plans for follow up/onward referral. Documentation will be within the nursing notes/care plan/report to the GP or consultant and further advice given as appropriate.

10.2 ADULT LEARNING DISABILITY

If a person has difficulties with eating or drinking, they can be referred to their locality team who have an open referral system for those over 18 years with a learning disability.

Referrals will be seen according to the ‘Nutrition and Hydration Pathway', which provides guidelines for safe, enjoyable, and nutritious eating and drinking.

An initial screen comprising of an observation of a mealtime(s), nutritional screening and case history will be undertaken by a trained worker within two weeks at the most appropriate location.

Referrals triaged by the speech and language therapist as urgent may be seen sooner, but there is no funded ‘rapid response’ for urgent referrals currently. The trained worker will leave initial recommendations and refer on to the relevant professional(s) in the team within one week.

The relevant professional(s) work together with the person and their carer to assess and diagnose the difficulty, risk, and need. Together they will devise a plan to minimise risk of aspiration, maximise independence, dignity and support good nutrition and hydration according to best current practice. The plan can be made accessible for the person and can be provided in various formats. In particular, the SLT will assess the person’s swallow and communication skills and make recommendations to minimise the risk of aspiration or choking and facilitate best communication with the involvement of the person.

Training and support can be given to patients, staff and carers until they are confident with the plan. The person will be discharged when stable and risks are minimised but may be re-referred if needs change or more support is needed.

10.3 SUPPORT FROM OCCUPATIONAL THERAPY (OT)

The aim of the OT intervention is to enable an individual to regain independence or reach an optimum level of independence in feeding.

The OT assessment will be carried out at mealtimes to determine whether the patient is independent or having any difficulties with feeding. Cultural beliefs will be respected, e.g. finger feeding. Other considerations include the environment, crockery, and cutlery.

The environment will be considered, and the patient will be encouraged to take their meals seated (e.g., at the table in the care home dining room). This facilitates good positioning and promotes socialising with other people.

Specialise crockery and cutlery may be required. Patients will be encouraged to use standard household items wherever possible. If a patient has difficulties (e.g. upper limb

weakness, function in one hand only, poor co-ordination), the OT will assess them. The OT may ask the patient to practise with feeding aids such as adapted cutlery, large handed or angled cutlery, plate guard and a Dycem nonslip mat.

The OT team will work closely with other members of multi-disciplinary team to provide continuity of care to the patient.

10.4 SUPPORT FROM PHYSIOTHERAPY

The physiotherapist may be called on to support particular areas in the care plan. This could include good positioning for eating and drinking, good positioning during enteral feeding, and assessment and maintenance of good respiratory status. The physiotherapist or nurse may recommend and administer Yankeur suctioning of the airways and would provide training for the carers if appropriate and necessary.

11.0 DUTIES WITHIN THE ORGINASATION

Policy, Guideline or Procedure / Protocol Author

To ensure the policy is reviewed in accordance with identified timescales, the implementation, monitoring and effectiveness of the policy will be reviewed by the Directorates and appropriate governance group.

Lead Director

- To communicate, disseminate, and ensure Directorates commence implementation of the policy and provide assurance through the Trust's Quality Governance Framework into the Trust Board.

Directors, Heads of Service

- Divisional Directors and Heads of Service are responsible for delivering the nutrition and hydration agenda and act when patient's nutritional care is at risk.
- Ensuring all clinical staff are aware of the policy and have the appropriate equipment available as detailed in the policy.
- Ensuring that effective systems are in place to support appropriate risk assessment and care planning to manage those patients at risk as far as is reasonably practicable.

Senior Managers, Matrons and Team Leads

- Managers and Team leaders are responsible for supporting the implementation of this policy at community level.

Responsibility of Clinical Staff

- All health care staff have a responsibility to deliver good nutritional care. In a community environment this will mainly involve nurses, but will also include nutrition and dietetics, speech and language therapists and occupational therapists.

12.0 Consent

• Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

• If the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

13.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
	Completion of trust nutrition and hydration e-learning on u-learn every 3 years	Check training completed on u-learn	Line manager will receive workforce reports	Line manager

14. 0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.
- If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

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- National Association of Care Catering (2011). NACC Nutritional Standard
- National Patient Safety Agency (2011). Dysphagia Diet Food Texture Descriptors
- NHS England – Guidance - Commissioning Excellent Nutrition and Hydration 2015-18 (2015)
- NHS Institute for Innovation and Improvement (2010) High Impact Actions for Nursing and Midwifery – Keeping nourished, getting better.
- NICE (2006) Clinical Guideline 32 – Nutrition support in adults
- Patients Association – Managing adult malnutrition in the community (2015)
- Royal College of Nursing (2007) Hospital hydration best practice toolkit

Appendix 1 Training Requirements

Training Needs Analysis

Training topic:	
Type of training: (See study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ **Role specific** ☐ Personal development
Directorate to which the training is applicable:	☐ **Mental Health** ☐ **Community Health Services** ☐ Enabling Services ☐ **Families Young People Children / Learning Disability Services** ☐ Hosted Services
Staff groups who require the training:	All clinical community staff
Regularity of Update requirement:	3 yearly
Who is responsible for delivery of this training?	E learning team and nutrition and dietetics
Have resources been identified?	Nutrition and hydration e-learning available on u-learn
Has a training plan been agreed?	
Where will completion of this training be recorded?	☐ **ULearn** ☐ Other (please specify)
How is this training going to be monitored?	Via workforce training compliance reports

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	√
Respond to different needs of different sectors of the population	√
Work continuously to improve quality services and to minimise errors	√
Support and value its staff	√
Work together with others to ensure a seamless service for patients	√
Help keep people healthy and work to reduce health inequalities	√
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	√

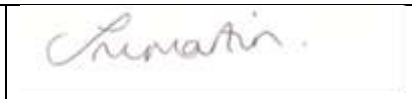
Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	Adult Nutrition and Hydration Policy for Community Use
Date Screening commenced	July 2023
Directorate / Service carrying out the assessment	Enabling
Name and role of person undertaking this Due Regard (Equality Analysis)	Jane Martin, Assistant Director nursing & Quality
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS:	
OBJECTIVES:	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	positive
Disability	positive
Gender reassignment	positive
Marriage & Civil Partnership	positive
Pregnancy & Maternity	positive
Race	positive
Religion and Belief	positive
Sex	positive
Sexual Orientation	positive
Other equality groups?	No discrimination

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No√
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk, please give evidence or justification for how you reached this decision:			
All patents will be treated equally – there is no discrimination			
Signed by reviewer/assessor		Date	04.07.23
Sign off that this proposal is low risk and does not require a full Equality Analysis			

Head of Service Signed		Date	04.07.23

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Adult Nutrition and Hydration Policy for Community Use	
Completed by:	Jane Martin	
Job title	Assistant Director Nursing & Quality	**Date** 04.07.23

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**N/A**
Date of approval	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust