NUTRITION AND **HYDRATION**

NUTRITION

OBSERVE

Look for

- Changes to usual eating habits
- Slower to eat
- Holding or pooling food in the mouth
- Refusing to eat
- Leaving food on the plate
- Difficulty chewing food
- Difficulty swallowing food

Signs of poor nutrition

- Lack of appetite or interest in food
- Tiredness and irritability
- Always feeling cold
- Loss of fat and muscle mass
- Higher risk of getting sick
- Longer healing of wounds
- Weight loss
- Constipation and/or diarrhoea

NUTRITION

IDENTIFY

Risk factors for poor nutrition

- Older age
- Prolonged hospital admission
- Dislike of eating and drinking
- Texture modification, for example, pureed, minced, moist, soft food
- Requiring assistance with food or fluids
- Cognitive impairment and/or confusion
- Impaired function and requiring increased assistance
- Decreased appetite
- Depression
- Multiple medicines
- Chronic pain
- Mouth hygiene issues
- Gastrointestinal issues, for example, nausea, vomiting, diarrhoea, abdominal discomfort

Assessment

- Check if resident is having the correct diet – normal, soft, pureed food
- Any coughing when swallowing food
- Food preferences, intolerances and/or allergies
- How much food is being eaten
- Are bowels regular
- Any weight loss or gain, for example, are clothes fitting, belt in a few notches
- Do dentures fit well, good mouth care
- Are glasses and/or hearing aids being used
- Any behaviour and/or mood changes
- Any change in level of function

NUTRITION

RECORD

Plan of care

- Check care plan and progress notes
- Follow dietitian and speech language care plans
- Ensure use of food and bowel charts
- Weigh regularly
- Provide assistance and support as needed
- Correct positioning
- Use of correct utensils
- Consider cultural needs

REPORT

Notify registered nurse of any changes

HYDRATION

OBSERVE

Observe for...

- Changes to usual drinking habits
- Very thirsty
- Refusing to drink
- Leaving drinks unfinished
- Unable to reach or hold cup or water jug
- Difficulty swallowing
- Coughing or choking when drinking

Signs of dehydration

- Dry mouth, lips, tongue
- Reduced sweating
- Sunken eyes
- Low blood pressure
- Confusion and irritability
- Fast heart rate
- Needing more help with care
- Drowsiness and/or fatigue
- Constipation
- Reduced urine and/or darker urine

IDENTIFY

Risk factors for dehydration

- Older adults often have decreased thirst
- Requiring assistance with food and fluids
- Incontinence
- Cognitive impairment and/or confusion
- Impaired function and requiring increased assistance
- Depression
- Multiple medicines, includes diuretics, for example, frusemide
- Poor swallowing
- Acute illness, diarrhoea, vomiting and/or nausea
- Fluid restriction
- Dislike of water, preference for tea or coffee
- Fluid restriction

Assessment

- Check lips, tongue, mouth
- Check vital signs
- Urine output and how much
- Urine concentration and what colour
- Level of fluid intake
- Any coughing when drinking
- Any behaviour or mood changes

HYDRATION

ACTION

Plan of care

- Check care plan and progress notes
- Follow the SLT plan – thickened/thin fluids
- Accurate fluid balance chart
- Monitor hydration – lips, tongue, mouth
- Regular vital recordings
- Regular mouth care
- Monitor urine output and bowels
- Offer fluids of choice 2 hourly
- Use the right cup for the resident's needs – sipper cup or straw
- Encourage and assist with fluid intake

REPORT

Notify registered nurse of any changes

RECORD

Document in progress notes/update care plan