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 or religious food practices and preferences. For example, consider karakia before eating, tapu and noa spaces

ACTION

Provide assistance and support as needed

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 and update care plan