Social care (Adults, England)

KNOWLEDGE SET FOR NUTRITION AND WELLBEING

CONTINUOUS TRAINING PROGRAMME

Candidate Name…….....

Jet Training, Care Plus1, Minehead Road, Norton Fitzwarren, Taunton, Somerset, TA2 6NS
Telephone 01823 270845 Mobile 07775643169
Email: info@jet-training.org.uk

KNOWLEDGE SET FOR NUTRITION AND WELL-BEING

1. PREPARATION/ PRESENTATION OF FOOD AND DRINK

1.1 Understand the common factors which affect dietary requirements:

AGE

Good nutrition for old age

The fastest growing segment of the population in most industrialized countries is the elderly; and too often this is also a group most susceptible to many health risks from a nutrient poor diet. Evidence from numerous sources indicate that a significant number of elderly fail to get the amounts and types of food necessary to meet essential energy and nutrient needs. There are a wide range of reasons why older individuals might not be eating the most nutritious diet which is all the more reason why health professionals and care providers need to be constantly aware of the necessity for maintaining an optimal nutritional health status in the elderly. Physiological, psychological and economical changes in the later years can all contribute to poor nutrition among the elderly, and accordingly establishment of healthy nutritional habits often requires a multifaceted intervention approach to address the wide range of factors contributing to suboptimal nutrient intakes.

After age fifty there are many metabolic and physiological changes which impact on the nutritional needs of an individual. The metabolic rate slows and can decline as much as thirty percent over a lifetime. This results in decreased caloric needs which can be complicated by changes in an older person's ability to balance food intake and energy needs. Even with a decreased caloric need, many older people have difficulty getting sufficient calories which can eventually lead to chronic fatigue, depression, and a weakened immune system. As we age our body composition changes with a decrease in lean tissue mass (as much as 25%) and an increase in body fat. Such changes can be accelerated because older adults utilize dietary protein less efficiently and may actually need a greater than recommended amount of high quality protein in their diet to maintain lean tissue mass. These changes in metabolism and physiology can be exaggerated due to complications from digestive difficulties, oral and dental problems, and medication-related eating and nutrient problems.

And while there are many physical and clinical factors that can contribute to undernutrition in the elderly, there are as many equally important social and economic factors that can further complicate the nutritional well-being of an older individual. Contributing factors include loneliness, lack of cooking skills, depression, economic concerns, weakness and fatigue, and, in too many cases, an unwarranted fear of many high quality, nutrient dense, affordable foods. All these factors can contribute to the fact that a significant number of older men and women consume less food than required to meet energy and nutrient requirements, and are at moderate to high nutritional risk.

The nutritional risk of the elderly is no doubt affected by the fact that the low-fat, low-cholesterol diet message has been heard loud and clear by this population. Many elderly readily accept the fear of fat and cholesterol message because of their heightened concern regarding their own health, and the knowledge that the risk for chronic diseases increases with age. And while dietary limits on fat and cholesterol consumption are widely assumed to be effective risk-

reduction interventions in young and middle-aged adults, the appropriateness of such dietary restrictions in older individuals has become an area of considerable debate.

There is evidence that good nutrition promotes vitality and independence whereas poor nutrition can prolong recovery from illness, increase the costs and incidence of institutionalisation, and lead to a poorer quality of life. Good nutrition is ageless and the message to older people must be that the quality of your nutrition is basic to the quality of your life.

CULTURE (also special events/occasions)

The pace of change in British eating seems to have increased at such a rate that you do not have to be very old to have experienced it. So think how much more dramatic is the contrast that older generations can remember from wartime rationing that did not finally end until 1954. Rationing was designed to ensure fair shares of the most wholesome diet possible for all, resulting in a period when it is claimed that the nutritional status of the British population was never better. Those who liked sugar in their tea had to go without, no bananas, 2 oz cheese per adult per week – but those enjoying brown bread remember 'national flour... sort of grainy'.

Haven't we lately become a country of fast food and takeaways? Aren't there unprecedented numbers of women going out to work, relieved they can rely on microwave ovens and convenience foods? Aren't we benefiting from being a newly multi-cultural society with people from elsewhere bringing their cooking styles and recipes with them?

This is the kind of question addressed by various 'knowledge producers'. Business consultants and market researchers working for industry clients interested in their markets, aim to provide them with details of commercial trends. Based in universities, social anthropologists and sociologists aim to understand the social and cultural contexts of food, and are beginning to show how questions such as these tie together.

Tying these together goes back to the long social and economic transformation that is industrialisation. Progressively more food processing, preparation and cooking takes place in factories rather than the home – going the way of spinning and weaving, making candles and lighting fires – all depending on continuing developments in, and sophisticated new applications of, several sciences and engineering. Socially, the invention of the factory meant the separation of the home from the place of manufacturing, which, in turn, gave a meaning to the expression for women 'going out to work' and the idea of a housewife who did not.

A period of full employment in the 1960s entailed a steady increase in married women employed outside the home, and, later, an increase in mothers of young children doing likewise. Household incomes have risen, yet women continue to be responsible for organising the shopping and doing the cooking. The double burden of work inside and outside the home made a readily defined mass market for the sale of electrically powered kitchen technologies, sold in the name of labour saving to 'busy wives and mothers' and for frozen dinners, ready-prepared vegetables, cook-in sauces and more. It also created a market in which manufactured foods could aptly be re-named 'convenience' foods.

Industrialisation has brought its own versions of social inequalities. Despite the increased prosperity associated with these changing patterns, poverty persists, constraining the freedom to

choose, and bringing disparities in diet between social groups. Long established debates continue to surface: are those on lowest incomes really too hard up to be able to afford a nutritionally well balanced diet, or are they simply bad at household budgeting and cooking? Fish'n'chips – a mainstay of nineteenth century working class diet – is a case in point, at the time attracting criticism on the grounds of questionable nutrition, dubious social acceptability and representing monotony in the diet. More enlightened medical and social appraisal of the period, however, led to approval of its economy in time and money, and its source of nutrients absent in, and providing relief from, the monotony of bread and dripping.

RELIGION/FAITH TRADITION

Food culture and religion

Food is an important part of religious observance and spiritual ritual for many different faiths, including Christianity, Judaism, Islam, Hinduism and Buddhism. The role of food in cultural practices and religious beliefs is complex and varies among individuals and communities. The following article is not all-encompassing. It is an introduction to a diverse and complex topic, and includes some of the ways in which various religious groups include food as a vital part of their faith.

Christianity

The various faiths of Christianity include Roman Catholic, Orthodox and Protestant. The regulations governing food differ from one to the next, including some faiths that don't advocate any restrictions. Selected facts include:

- The ritual of the transubstantiation (changing) of bread and wine into the body and blood of Jesus Christ is believed to occur at communion.
- Roman Catholics fast for at least one hour prior to communion.
- Fasting is sometimes considered to be 'praying with the body'. It is believed to improve spiritual discipline - by overcoming the sensations of the physical world and focussing on prayer and spiritual growth. It may serve as a way to respect those people around the world who regularly face starvation or malnutrition.
- Self-denial (of food) can help Christians to remember that having what you want is not always the path to happiness.
- Variations of fasting or abstinence are observed by some Roman Catholics on such occasions as Lent or Good Friday; for example, some may strictly avoid meat at this time.
- Most Protestants observe only Easter and Christmas as feast days, and don't follow ritualised fasting.
- Mormons avoid caffeinated and alcoholic beverages.
- The majority of Seventh Day Adventists don't eat meat or dairy products, and are likely to avoid many condiments including mustard. Those that do eat meat don't eat pork.

Judaism

Judaism can be Liberal or Orthodox, based on the degree of adherence to the Jewish laws. 'Kashrut' refers to the laws pertaining to food in the Jewish religion. 'Kosher' means that a food is permitted or 'clean', while anything 'unclean' (such as pork and shellfish) is strictly forbidden. The Jewish 'food laws' originated more than 2,000 years ago and contribute to a formal code of

behaviour that reinforces the identity of a Jewish community. Food forms an integral part of religion in life for a practising Jew. Other selected facts include:

- Foods must be prepared in the right way in order to be kosher; for example, animals that provide meat must be slaughtered correctly.
- The consumption of certain foods, including dairy products and fish, is subject to restrictions; for example, there are rules forbidding the mixing and consumption of dairy products with meats.
- Ritualised fasting is also included in Judaism. Yom Kippur - the Day of Atonement - for example, is a Jewish fast that lasts from, approximately, dusk till dusk.
- Jewish feast days include Rosh Hashanah and Passover.
- The Passover commemorates the birth of the Jewish nation. The food eaten helps to tell the story of the Exodus; for example, bitter herbs recall the suffering of the Israelites under Egyptian rule.

Islam

In Islam the concept of 'Halal', meaning 'lawful or permitted', is applied to all areas of a person's life including regulations surrounding food. Prohibited foods are called 'Haram'. It is thought that the Creator turns a deaf ear to a Muslim who eats Haram foods. Other selected facts include:

- The list of Haram foods includes pork, alcohol, foods that contain emulsifiers made from animal fats, frozen vegetables with sauce, particular margarines, and bread or bread products that contain dried yeast.
- Gelatine can be made from pig and, since pork is Haram, products containing gelatine are forbidden.
- Caffeinated drinks such as coffee are sometimes considered Haram.
- Certain religious dates demand fasting from dawn till dusk.
- Some Muslims choose to fast on Mondays or Thursdays or both.
- The month of Ramadan requires mandatory fasting during sunlight hours, as do particular dates of religious significance, such as the ninth day of Zul Hijjah.

Hinduism

People who practice the Hindu religion don't eat meat from animals. They also avoid foods that may have caused pain to animals during manufacture. 'Karma' is believed to be the spiritual load we accumulate or relieve ourselves of during our lifetime. Animals are believed to have spiritual awareness. If a Hindu consumes animal flesh, they accumulate the Karma of that act - which will need to be balanced through good actions and learning in this life or the next. Depending on the level of adherence to this belief, in many cases beef is forbidden, while pork is sometimes restricted or avoided. Selected facts include:

- 'Food is God (Brahman)' is a common Hindu saying. Food is thought to be an actual part of Brahman, rather than simply a Brahman symbol.
- Foods contain energies such as sound waves that can be absorbed by the person who eats them - the Hindu religion takes literally the maxim 'You are what you eat'.
- According to the Hindu religion, violence or pain inflicted on another living thing rebounds on you (Karma).
- In keeping with the aim to avoid violence or pain to any living thing, vegetarianism is advocated, but not compulsory.
- Prohibited animal products tend to vary from one country or region to the next; for example, duck and crab may be forbidden in one geographical location, but not in another.

- Foodstuffs such as alcohol, onions and garlic are thought to inhibit the Hindu's quest for spiritual enlightenment by exciting the body and leading to acts which may have Karmic impact, and are therefore avoided or restricted.
- While beef is forbidden, dairy products including milk, butter and yoghurt are considered to enhance spiritual purity.
- Fasting depends on the person's caste (or social standing) and the occasion; for example, rules regarding fasting depend on whether the day has religious or personal significance.

Buddhism

The dietary rules of Buddhism, which is more of a life philosophy than a religious doctrine, depend on which branch of Buddhism is practiced and in what country. Selected facts include:

- In his lives on Earth, Buddha cycled through various animal forms before he took on the form of a human being - this is why most Buddhists are vegetarian.
- Similarly to the Hindu concept of Karma, Buddhism proposes that violence or pain inflicted on others will rebound on you, further strengthening the need for a vegetarian lifestyle. Some Buddhists believe that the cause of human aggression is violence against animals.
- Some Buddhists avoid meat and dairy products, while others only shun beef.
- Religious dates vary from one region to the next. Mahayana Buddhism, for example, celebrates three festivals for the birth, enlightenment and death of Buddha, while Theravada Buddhists observe all three events on a single day.
- Buddhist monks tend to fast in the afternoon.
- Buddhist monks and nuns aren't allowed to cultivate, store or cook their own food; instead, they must rely on 'alms', which are donations from believers. This sometimes includes meats, as monks and nuns aren't allowed to ask for specific foods.

Traditionally, meat from bears, dogs, elephants, horses, hyenas, lions, panthers, snakes and tigers are strictly prohibited to Buddhist monks and nuns.

MEDICAL CONDITIONS AND ALLERGIES

- **dysphagia,**

Dysphagia is associated with a wide range of medical and surgical conditions. It frequently goes unrecognised and can occur as a result of damage to the central nervous system or muscles of the head and neck. Dysphagic patients are at high risk of developing serious complications such as undernutrition, dehydration and aspiration. The multi-disciplinary approach is crucial in appropriate patient care.

Dysphagia can be defined as having difficulty or discomfort in swallowing. Patients present with choking and coughing on swallowing, with food sticking and causing pain or discomfort. Because of this, dysphagia sufferers often have a loss of appetite or weight loss. Aspiration and pneumonia is a serious consequence of food passing into the pharynx uncoordinated, entering the airways, acting as a breading ground for infection. Malnutrition and dehydration are very common, resulting from the reduced oral intake due to the increased effort it takes to eat and drink sufficient amounts. Poor nutritional status is associated with serious health risks such as impaired wound healing, higher risk of infection and impaired mental and physical function.

- **diabetes,**

What should people with diabetes eat?

People with diabetes should try to maintain a healthy weight and eat a diet that is:

- low in fat (particularly saturated fat)
- low in sugar
- low in salt
- high in fruit and vegetables (at least five portions a day)
- high in starchy carbohydrate foods, such as bread, chapatti, rice, pasta and yams (these should form the base of meals) - choose wholegrain varieties when you can

There are no foods that people with diabetes should never eat. And there is no need to cut out all sugar. But, like everyone, people with diabetes should try to eat only small amounts of foods that are high in sugar or fat, or both. If you have diabetes you can eat cakes and biscuits sparingly, as part of a balanced diet.

Fruit juice is high in fructose (fruit sugar) so it can cause blood sugar levels to rise quickly. Because of this, it's best for people with diabetes to drink juice with a meal and avoid having more than one small glass a day.

If you are prone to low blood sugar (hypoglycaemia), you might sometimes need to increase your blood sugar level quickly. If you suffer from a hypoglycaemic episode, you should have some fast-acting carbohydrate, such as a sugary drink or some glucose tablets, and follow this up with a starchy snack, such as a sandwich.

- **coeliac disease,**

Coeliac disease is also called gluten intolerance or gluten sensitivity. It's an auto-immune disease, which means the body's immune system attacks itself. The type of reaction it causes is different to a food allergy - it doesn't cause anaphylaxis. Many people with coeliac disease don't realise they have it.

When people with coeliac disease eat foods containing gluten, it damages the lining of the small intestine, which stops the body from absorbing nutrients. This can lead to diarrhoea, weight loss and eventually malnutrition.

Foods to avoid

Gluten is a protein found in wheat and also in a number of other cereals including rye and barley. So, if you have coeliac disease you need to avoid foods made from these cereals, including most types of bread, pasta, pizza, pastry and cakes.

Wheat ingredients are used in many foods, such as some sausages and burgers, and many sauces. Foods in batter or breadcrumbs aren't suitable for people with coeliac disease either. If you have coeliac disease, always check the ingredients on the foods you buy. You will also need to avoid some alcoholic drinks made from barley, such as beer and lager.

Since November 2005, food labelling rules require pre-packed food sold in the UK, and the rest of the European Union, to show clearly on the label if it contains cereals containing gluten, including wheat, rye, barley and oats (or if one of its ingredients contains these). Bear in mind that there could still be foods on the shelves that were produced before this date.

Rice, potatoes and corn don't contain gluten, so these are OK to eat. You can also buy special products that are suitable for people with coeliac disease, such as gluten-free pasta and bread.

Oats contain a protein that is similar to gluten, but not exactly the same. It's also possible for small amounts of other cereals, such as wheat, to get into oat products when the crop is growing, or being harvested or transported. Research has shown that some people with coeliac disease can't tolerate oats or oat products. At the moment, medical experts don't have enough evidence to decide whether all people with coeliac disease should avoid oats.

If you have coeliac disease you will probably be advised to avoid oats, as well as wheat, rye and barley, especially when you are first diagnosed. You should discuss whether to start eating oats again with your health professional because oats may not be suitable for some people with coeliac disease.

It's important to understand that products labelled 'wheat free' aren't the same as those labelled 'gluten free'.

Wheat-free products may contain other cereals, such as rye or barley, so these might not be suitable for someone with coeliac disease (unless they are also labelled 'gluten free').

Gluten-free products won't contain gluten, but they may still contain other proteins found in wheat (albumins, globulins and starch granule proteins). So these might not be suitable for people who are intolerant or allergic to wheat.

Coeliac UK, a charity to support people with gluten intolerance, works with manufacturers to produce a regularly updated list of foods that don't contain gluten.

- **renal disease,**

Diet for renal failure

Patients with kidney disease, also called renal failure, can use diet to control the progress and many of the symptoms of their condition

Kidneys remove toxins from our blood and dispose of them through urine. Unless they're working properly, human bodies begin to retain fluid; when the bloodstream is at capacity, this fluid is held by the cells, and begins to build up in lungs, the heart cavity, and anywhere else it can find to deposit itself. Extremities swell, so rings and shoes fit tighter. Faces puff up, and maybe our waistbands feel a bit more snug. But the seriousness of fluid build-up can't be ignored when it begins to affect heart and lung function.

This is one condition that needs to be controlled in very large part by diet. In fact, strict compliance with dietary guidelines can delay the onset of dialysis for months or years by reducing the stress on the kidneys.

When the dialysis does begin, diet modifications are in order. Specifics will depend on each person's unique health situation, and on the type of dialysis — whether it's the kind done at home (peritoneal dialysis) or in a clinical setting (hemodialysis). What follows are general guidelines; these are in no way intended to replace a physician's or dietitian's recommendations. Consultation with a nutritional specialist is imperative; every patient's situation will be different!

SODIUM restrictions are paramount. It is literally impossible to take in NO sodium, because that's an element found in so many foods, but it is possible to limit the amount in a diet. First, obviously high sodium foods must be eliminated. These include cured meats (ham, sausage, bacon, corned beef, and the like), most cheeses, "fast" foods, pickles, bouillon cubes, soy sauce, and most Chinese or oriental foods.

Sodium hides in most commercially prepared foods, too; because salt is such a good preservative, it's used in packaging materials for cereal, bread, baking mixes, and most canned vegetables. This makes fresh food a wiser choice.

Some canned foods, such as vegetables, flaked fish or shellfish, poultry or meats, can be sodium-reduced by rinsing thoroughly. Place the food in a colander, rinse under running water for one full minute, and drain until all moisture is gone.

Even though it feels like a lot has been eliminated from diet choices (yes, pizza is tough to work into a low sodium eating plan) there are a myriad of ways to prepare delicious meals without high sodium content.

- Choose naturally low-sodium foods. As a rule, white cheeses are a safer bet than cheddar. Choose mozzarella, parmesan, ricotta, and look for low-salt varieties of your favourites. All unprocessed meats, poultry, and fish are acceptable. All fresh and frozen vegetables, all fruits and juices, and well-rinsed canned vegetables are suitable.

Homemade soups and noodles are healthier than the pre-made ones.

According to the specific limits of your own diet, it's okay to include moderately high sodium foods once in a while. Biscuits, a pancake, (homemade, to avoid the preservative salts of commercial mixes) cottage cheese, and sweet pickles or relish fall into this category.

- Look for no or low-salt versions of your favourite foods: tuna packed in water rather than oil, salt-free pretzels, unseasoned popcorn (dress up with chili powder, parmesan cheese, and a little garlic powder), no-salt butter are some examples.
- Collect a good selection of no-sodium seasonings; these can surprise people with spicy, robust taste independent of any salt.
- Keep an eye out for quick and easy low-sodium recepies for your favourite foods, and stock your pantry with the ingredients.

FLUIDS must be restricted. Your physician will set a limit for you, somewhere between four and eight cups maximum per day. Fluid is defined as anything that melts at room temperature, so in addition to water and juices, you must count ice cream, gelatine desserts, sherbet, and watermelon.

POTASSIUM counts, too, and it's harder to control for several reasons. You can't taste it, like you can salt, it's not a required item to be listed in the nutritional contents of packaged food, and it's in many foods.

The highest potassium amounts are found in nuts, avocados, potatoes, winter squash including pumpkin, oranges, kiwi, peaches, apricots, and anything dried — fruits, beans and lentils.

Low potassium foods, safest to include frequently in a renal patient's diet, include applesauce, black berries, grapes, tangerines, canned pears and plums; asparagus, green or waxed beans, corn, cauliflower, cucumbers, water chestnuts, and summer squash. Juices such as apple, cranberry, lemonade, grape, and fruit-flavoured drinks are okay; just remember to count them in your fluid total for the day.

PROTEIN plays an important role in the diet of any kidney patient. For those who are pre-dialysis, the amount must be limited to conserve kidney strength. After dialysis begins, however, protein needs to make up the major portion of the patient's menu, and the guideline will be set as a minimum, rather than a maximum amount per day — as much as 2 grams per kilogram of body weight. The physician will determine the recommended amount for each person, depending on their over all health and their specific needs.

PHOSPHOROUS begins to be a consideration once dialysis begins, also. Foods to avoid based upon phosphorous content are dairy products, whole grains, bran and barley, nuts, coconut, figs and dates, raisins, salmon, sardines, oysters, and organ meats.

Cola drinks are also high in phosphorous, but soft drinks that are light coloured (7-Up and Sprite, club soda) are fine.

Meat, poultry, fish and eggs are high in phosphorous, but are still an important part of the dialysis patient's diet because of the protein content; they should not be limited.

Because of the importance of limiting the amount of phosphorous in the blood stream, physicians will usually prescribe a "phosphate binder," — such as Tums—to be taken in prescribed doses with each meal.

While it seems like an inordinate amount of food has been eliminated from a wise menu plan for persons with renal failure, it is possible to have a healthy and delicious variety of food every day. A daily plan based on the amount of protein recommended for the individual patient, complemented by fresh, low-potassium fruits and vegetables and supplemented by low salt snacks, not only tastes wonderful, but is worth the effort in the life-saving health benefits achieved.

- **mental health,**

Mental health can be significantly improved by a simple change in diet, according to mental health charity Mind.

It has published a new guide to mood and food, highlighting how strong the relationship is between what people eat and how they feel.

While it is well established that diet can affect physical health, the guide points out that there is also a strong link between food and mental wellbeing.

In a survey to coincide with Mind Week, one-in-four people said that eating chocolate improved their mood - though for many this was short-lived.

However, one-in-five respondents said sweet and sugary foods had a negative effect on their mental health.

Symptoms made worse

Diet can aggravate the symptoms of a whole range of illnesses including autism, schizophrenia, depression, anxiety and panic attacks.

The Mind Guide to Food and Mood lists some of the foods which are most likely to affect people's moods including:

- artificial flavourings and preservatives
- chocolate
- coffee
- eggs
- milk products
- oranges
- sugar
- wheat products.

Foods required for good mental health include plenty of fruit and vegetables and those containing essential fatty acids, such as sardines, tuna, salmon, pumpkin and walnuts.

The book's author, nutritional therapist Amanda Geary, has developed a sample meal which is designed to produce a lift in mood.

It consists of oily fish such as sardines, tuna or salmon with a salad of lettuce, avocado and pumpkins seeds, followed by stewed fruit with dried apricots and bananas on an oatcake biscuit base, topped with walnuts.

The combination of foods releases sugars slowly, in contrast to caffeine and chocolate which give an immediate boost followed by a dip.

"A lot of people who I see with problems such as anxiety and panic attacks and PMS find a significant improvement in their mental health by changing their diet," she told BBC News Online.

"Obviously there are a large number of factors affecting mental health but food is proving to be one of them."

The booklet says some foods often considered healthy are eaten by most people most days.

"Unfortunately these can be the very foods that are having a disguised yet disabling influence upon your health," it says.

Food sensitivity

Food intolerance and sensitivity can affect mood but there are also other complex relationships between eating patterns and mental health.

And deficiency in certain vitamins, minerals or fatty acids can have dramatic effects, such as the link between vitamin B deficiency and schizophrenia symptoms.

Interactions between food and certain medicines can also have an effect.

A popular type of antidepressant, monoamine oxidase inhibitors, can interact with a substance called tyramine found in foods such as cheese, beans and yeast extract causing dangerously high blood pressure.

The guide suggests that the best way to make changes to eating habits to improve mental health is with the help of a nutritional therapist.

However, people can make changes themselves by gradually eliminating particular products one at a time.

- **physical disability**, etc)

Eating a healthy diet is a challenge for most individuals but for a person with a disability it may be a greater challenge. Their disability may be a physical disability, an intellectual disability (from childhood or after an accident or stroke), a mental illness. Any disability has the potential to impact on the person's ability to eat healthily.

People with disabilities have a higher incidence of diet related health problems than the general community. Health statistics tell us they are more likely to experience:

- Obesity
- Underwight
- Constpation
- Malnutrition
- Dehydration
- Heart Disease
- Diabetes.

The food we eat and the activities involved in planning, preparing and eating meals are important to our enjoyment of life. Certain foods and meals make up our cultural identity and give us a sense of belonging.

There may be many reasons why a person with a disability may be at risk of missing out on the social, emotional and physical benefits of a healthy diet.

- Physical abilities may limit access to shopping, involvement in cooking, independent eating or being able to chew and swallow lumpy foods.
- Sometimes healthy eating and balanced meals seem far less important than all the other challenges of daily life.
- Medications or certain disorders may alter metabolism and change appetite making it difficult to maintain a healthy weight.
- Financial constraints can reduce choice and options.
- Depression, boredom or emotional problems can make it difficult to keep motivated about self-care and healthy eating.
- Communal and institutional living or difficulties communicating may limit opportunities to be involved in meal planning and having access to preferred food choices.

Changing towards a healthier eating plan can result in health benefits and improved wellbeing for people with disabilities. The first step may be ensuring a regular adequate intake of fluids. A good level of hydration can reduce headaches and constipation. Being involved in meal planning, preparation and shared meals can also have social and emotional health benefits.

PERSONAL CHOICE

- **vegetarian/vegan;**

Fancy a sausage?

No thanks. A vegetarian is someone who doesn't eat meat. No chops, bacon, sausages. No chicken. No fish. About one in twenty adults in the UK is vegetarian.

A vegan is someone who doesn't eat meat. Or anything made by animals. No eggs, dairy (milk, cheese, butter) or honey. Most vegans also avoid animal products altogether. No leather shoes. Or feather filled pillows. About one in four hundred adults in the UK is vegan.

Why are people vegetarian?

These are common reasons:

We don't like meat. Yuck - it is gross. Have you seen how chicken nuggets are made? And just look at the oozing Doner in every kebab shop. Say no more.

We don't think animals should be used and slaughtered for human consumption. Animals are kept in terrible conditions. Treated cruelly. Just to be served with chips and sauce.

We feel better on a veggie diet: healthier and fitter. Vegetarians have lower cholesterol levels, are less likely to be overweight and may even live longer.

The food scares: CJD, E Coli, Bird Flu. It's enough to put anyone off their chipolata.

Our religious or spiritual beliefs. For example, the majority of the world's vegetarians are Hindhu.

Sounds good. So should I go veggie? Your diet and lifestyle is a personal choice.

But here's some stuff to think through first:

Family: Vegetarian food can be labour-intensive. Who does the cooking in your house? It's time to offer to help. Dig out that potato peeler.

Safety: Simply cutting out meat is definitely unhealthy. Our bodies will suffer. We must replace meat with other protein rich foods, like pulses, seeds and nuts. And consider taking a dietary supplement (vitamins) too. Some vitamins are designed 'specially for vegetarians.

Friends: We may feel strongly about being a vegetarian. They can still be our mates even if they guzzle flesh. Avoid the, "You do know you're eating a sheep's baby" remarks. But don't let them put you off, either. Stick to your guns. It may not be easy. Specially at parties and sleepovers. They'll get used to it. Why isn't everyone vegetarian?

- **menu;**

A menu can help nutrition by planning ahead a menu with the correct nutritional needs of the individual, and can also help with keeping costs down by not buying food that will not be eaten.

PHOTOGRAPHS OF FOOD AND DRINK

Dysphasia

Dysphasia is the impairment of the ability to speak or, sometimes, to understand language, as the result of brain injury, a brain tumour, etc.

Dysphasic clients cannot tell carers what they want to eat and drink, so photographs of food and drink can help clients choose what they wish to eat and drink

The same is true of those who do not speak English and those with behavioural disorders such as autism.

TIMING AND AVAILABILITY OF FOOD AND DRINK

Malnutrition and dehydration are serious and common problems among older people in nursing and residential care homes. The situation is exacerbated because staff may not be trained to recognise the signs and symptoms of malnutrition and dehydration and hence opportunities for early intervention are missed. A nutrition assessment should form part of the admission process to identify whether an individual has, or is at risk of developing, malnutrition and dehydration.

Whilst meals are generally at set times, the availability of microwaves means that people can eat at other times when it suits them. If malnutrition is an issue, the client should be offered food, little and often and should be weighed at leat weekly. Many people who may be at risk of dehydration should be offered drinks and have a fluid balance chart to help estimate whether the client is drinking enough, and shouls have a jug of water/juice by the bedside

1.2 Understand the importance of the appropriate preparation and presentation of food and drink:

FOOD HYGIENE

Food handling, preparation

Some carers already attend training courses around food safety to support their food management practices. Attendance on such training courses is considered best practice. There is alegal requirement for staff who prepare and cook food in the home to attend a formal training course or to obtain a qualification in food safety.

On a practical level, understanding and ensuring the basic principles of food and personal hygiene are observed during any class activity, including food preparation, should avoid food poisoning occurring.

The basic principles of safe food preparation can be summarised as the '4Cs':

- clean: wash your hands,

- surfaces and utensils properly and keep them clean
- cook: cook food properly
- chill: chill food properly
- cross contamination: avoid spreading food poisoning bacteria between foods by cross contamination

PERSONAL HYGIENE (WORKER AND INDIVIDUAL)

PERSONAL HYGIENE

Personal hygiene must play an essential part in the day to day running of any safe food operation.

Personal cleanliness is:

- Your moral duty.
- Your LEGAL duty.
- Something to be proud of.

Many types of food poisoning bacteria live on or in our bodies and it is therefore absolutely essential that certain basic rules are followed to try to prevent their transfer onto food.

REMEMBER that if you have bad habits like touching you nose, eyes, lips or hair, licking your fingers or biting your nails that you are in real danger of contaminating food with bacteria. You must become aware of any bad habits and stop them.

DAILY PERSONAL HYGIENE CHECK LIST

- Bathe or shower daily.
- Brush teeth several times a day.
- Wash hair regularly - including beards.
- Keep finger nails short, clean and do not wear nail varnish.
- Do not wear any jewellery as it may unfasten and fall into food or drink or could trap dirt.
- Do not wear strong perfume or aftershave as the smell may taint food.
- Have a clean change of clothing every day.
- Make sure that protective clothing provided for you is kept clean.

WHILST AT WORK

You have to work with your hands and to avoid contaminating food with food poisoning bacteria YOU must keep your hands clean.

Wash them frequently and in particular they must be washed AFTER:

- Going to the toilet.
- A break in the rest room.
- Touching your face or hair.
- Sneezing, coughing, or blowing your nose.
- Cleaning duties.
- Touching dirty surfaces or utensils.
- Handling raw food
- Handling rubbish

DO USE

- A wash hand basin provided for hand washing only. It must have:
- Hot water.
- Soap.
- Paper towels or other means of hand drying

DO MAKE SURE you wash

- Palms
- Back of hands
- Between fingers
- Under nails

DO NOT

Eat, drink, smoke or comb your hair in any food room.

DO WEAR

All protective clothing provided and change it regularly.

DO COVER

Minor cuts and abrasions with a suitable, brightly coloured waterproof dressing.

VISITORS TO KITCHENS

All visitors must comply with personal hygiene rules and this includes delivery staff

REMEMBER - CLEAN FOOD DESERVES CLEAN STAFF

If you require further advice, please contact the Environmental Health Department.

CONSISTENCY AND TEXTURE OF FOOD AND DRINK

Firstly. All food should be appropriate to the person receiving it, the quality and quantity should relate to their tastes, nutritional needs and in enough amounts that satisfy their needs. However, when clients are unwell, the nature, amount and texture may be part of a care plan.

Some foods are more easily chewed and swallowed than others. That is why changing food textures may make it easier for a patient to control food in the mouth and swallow.

When possible, the diet should be tailored to each patient's chewing and swallowing abilities. Some clients cannot tolerate certain foods (e.g., dry ground meat, rice, or corn), even though they can tolerate other foods of a similar consistency. In this case, the diet order should clearly state which foods are not allowed for a patient.

Dietary staff should be trained on the correct way to prepare pureed meals, with an emphasis on flavour and texture to make pureed foods as appealing as possible to patients. Both dietary and nursing staff should understand the reasons for texture modifications as well as the importance of modifications to the safety of the patient.

Patients with dysphagia often require thickened liquids. Fluids can be categorised as thin, nectar-thick, honey-thick, or spoon-thick (sometimes called pudding-thick). Most fluids are thin liquids (e.g., water, coffee, tea, soda, juice, broth milk, and liquid nutrition supplements that are juice-based). Gelatin, sherbet, and ice cream are considered thin liquids because they will liquefy in the mouth within a few seconds.

Nectar-thick liquids include peach or apricot nectar, vegetable juice, and thin milkshakes. Honey-thick liquids include thin liquids thickened to honey consistency using thickening agents. Spoon-thick liquids are thickened to pudding consistency. All thin liquids can be thickened to nectar, honey, or spoon thickness using thickening agents. It is critical for staff to know the proper fluid consistency for each client and provide only what is ordered.

Pre-thickened liquids can now be ordered from most food-service suppliers. These products assure that a patient receives the consistency that is ordered. Some medical facilities still use thickening packets that are mixed into glasses of fluids as the meal tray is delivered to the patient. In these facilities, staff should be trained on the correct use of the packets to assure that fluids are given as ordered.

TEMPERATURE OF FOOD AND DRINK

The Food Hygiene (England) Regulations 2006, Schedule 4, Paragraph 2 & 6 require (subject to certain exemptions) that food is not kept at a temperature above 8°C if that food is likely to support the growth of harmful bacteria or the formation of toxins, and that cooked food is kept at or above 63°C.

The common food poisoning bacteria cannot multiply easily at temperatures below 8°C and thus temperature control is the single most important factor in preventing food poisoning

Drink temperatures should be what the client approves of unless there are risks involved. At home, a client may drink scolding hot tea, but if in care, there are dangers of scolding themselves or other, so a hot drink must also be safe from harming clients whilst being pleasant and enjoyable to drink,

Cold drinks are preferably cold, especially in hot weather and not luke warm, however issues of teeth sensibility may cause the cold drink to be less cold, and of course preference is always an issue.

VARIETY

To obtain the nutrients and other substances needed for good health, vary the foods you eat

Foods contain combinations of nutrients and other healthful substances. No single food can supply all nutrients in the amounts you need. For example, oranges provide vitamin C but no vitamin B12; cheese provides vitamin B12 but no vitamin C. To make sure you get all of the nutrients and other substances needed for health, choose the recommended number of daily servings from each of the five major food groups displayed in the Food Guide Pyramid.

Use foods from the base of the Food Guide Pyramid as the foundation of your meals

People do choose a wide variety of foods. However, people often choose higher or lower amounts from some food groups than suggested in the Food Guide Pyramid. The Pyramid shows that foods from the grain products group, along with vegetables and fruits, are the basis of healthful diets. Enjoy meals that have rice, pasta, potatoes, or bread at the centre of the plate, accompanied by other vegetables and fruit, and lean and low-fat foods from the other groups. Limit fats and sugars added in food preparation and at the table.

Choose different foods within each food group

You can achieve a healthful, nutritious eating pattern with many combinations of foods from the five major food groups. Choosing a variety of foods within and across food groups improves dietary patterns because foods within the same group have different combinations of nutrients and other beneficial substances. For example, some vegetables and fruits are good sources of vitamin C or vitamin A, while others are high in folate; still others are good sources of calcium or iron. Choosing a variety of foods within each group also helps to make your meals more interesting from day to day.

What about vegetarian diets?

Some eat vegetarian diets for reasons of culture, belief, or health. Most vegetarians eat milk products and eggs, and as a group, these lacto-ovo-vegetarians enjoy excellent health.

You can get enough protein from a vegetarian diet as long as the variety and amounts of foods consumed are adequate. Meat, fish, and poultry are major contributors of iron, zinc, and B vitamins in most American diets, and vegetarians should pay special attention to these nutrients.

Vegans eat only food of plant origin. Because animal products are the only food sources of vitamin B12, vegans must supplement their diets with a source of this vitamin. In addition, vegan diets, particularly those of children, require care to ensure adequacy of vitamin D and calcium, which most obtain from milk products.

Foods vary in their amounts of calories and nutrients

Some foods such as grain products, vegetables, and fruits have many nutrients and other healthful substances but are relatively low in calories. Fat and alcohol are high in calories. Foods high in both sugars and fat contain many calories but often are low in vitamins, minerals, or fibre.

People who do not need many calories or who must restrict their food intake need to choose nutrient-rich foods from the five major food groups with special care. They should obtain most of their calories from foods that contain a high proportion of essential nutrients and fibre.

Growing children, teenage girls, and women have higher needs for some nutrients

Many women and adolescent girls need to eat more calcium-rich foods to get the calcium needed for healthy bones throughout life. By selecting lowfat or fat-free milk products and other low fat calcium sources, they can obtain adequate calcium and keep fat intake from being too high.

Young children, teenage girls, and women of childbearing age should also eat enough iron-rich foods, such as lean meats and whole-grain or enriched white bread, to keep the body's iron stores at adequate levels.

Enriched and fortified foods have essential nutrients added to them

National policy requires that specified amounts of nutrients be added to enrich some foods. For example, enriched flour and bread contain added thiamin, riboflavin, niacin, and iron; skim milk, lowfat milk, and margarine are usually enriched with vitamin A; and milk is usually enriched with vitamin D. Fortified foods may have one or several nutrients added in extra amounts. The number and quantity of nutrients added vary among products. Fortified foods may be useful for meeting special dietary needs. Read the ingredient list to know which nutrients are added to foods. How these foods fit into your total diet will depend on the amounts you eat and the other foods you consume.

Where do vitamin, mineral, and fibre supplements fit in?

Supplements of vitamins, minerals, or fibre also may help to meet special nutritional needs. However, supplements do not supply all of the nutrients and other substances present in foods that are important to health. Supplements of some nutrients taken regularly in large amounts are harmful. Daily vitamin and mineral supplements at or below the Recommended Dietary Allowances are considered safe, but are usually not needed by people who eat the variety of foods depicted in the Food Guide Pyramid.

Sometimes supplements are needed to meet specific nutrient requirements. For example, older people and others with little exposure to sunlight may need a vitamin D supplement. Women of childbearing age may reduce the risk of certain birth defects by consuming folate-rich foods or folic acid supplements. Iron supplements are recommended for pregnant women. However, because foods contain many nutrients and other substances that promote health, the use of supplements cannot substitute for proper food choices.

ATTRACTIVE APPEARANCE OF FOOD AND DRINK (COLOUR, LAYOUT)

"I want order and taste. A well displayed meal
is enhanced one hundred per cent in my eyes."
Marie-Antonin Careme (1783-1833) "the cook of kings and the king of cooks".

Appetising - appealing to or stimulating the appetite especially in appearance or aroma

My mother always said 'you eat with your eyes'. Food piled high and splodged haphazardly on a plate is a big turn-off, while meals that look as good as they taste satisfy on another level altogether.

Changing your attitude to the way you present food can positively change the way you eat, turning it into a more pleasurable and considered experience. We asked some of our favourite *Weight Watchers* food stylists how to take a more professional approach at home.

Expert tips

Like airbrushing models, some stylists use tricks to make food look good – a quick layer of gravy browning to make turkey breast look richly brown or cigarette smoke to mimic 'steam' coming off a stew – but here are some practical tricks you can try at home:

(1) Start with plates: white or cream set off food the best. The restaurant vogue for big white-rimmed soup-dish style dishes is for a reason – busy patterns just fight with the food, while white offers a blank canvas.

(2) Use a smaller plate than usual, so it looks like you have a larger portion, even if it is smaller than you're normally used to.

(3) Glass plates are in for tapas-style meals or antipasti, dips and crudites. Rustic-looking chopping boards are an attractive way to display prosciutto, olives and other nibblies

(4) When it comes to baking look past traditional cookware to other interesting (heatproof) containers you may have in the house. Try baking individual breads in small terracotta plant pots, puddings in teacups or setting jelly in egg cups.

(5) Try theming the meal and the table; for example, Japanese food is naturally healthy and lends itself to a dramatic table – sushi boards, individual dipping bowls and chopsticks.

(6) Paper runners are fashionable – you can buy them or make your own and, if feeding kids, give them crayons to keep them happy at the table.

(7) Think rainbow when it comes to choosing vegetables – serve lots of bright colours. If roasting cut vegetables into even-sized chunks, instead of boring old discs, slice carrots and zucchinis on a slight angle.

(8) Brown chicken before stir frying or adding to casseroles, otherwise it looks pale and uninteresting.

(9) Jewellery or accessories finish an outfit, just as garnishes add an attractive touch to dishes – keep plenty of pots of herbs for plucking off sprigs. Ditto lemons.

(10) Stacking food a mile high is no longer in vogue, but some height does look good, so serving meat or fish fillets on mash or couscous is still cool.

(11) When serving pasta, use a proper spaghetti fork to twirl mini-mountains of pasta attractively in the centre of a bowl-style plate.

(12) Drizzle and swirl like the TV chefs – soups benefit from a swirl of low-fat yoghurt or light cream. Thin it a little with water then swirl in circles.

(13) Salads need to look perky and fresh - no limp leaves, thank you!

(14) You don't need to spend a fortune on crockery - those martini glasses you never use for cocktails are not only retro and in, but are great for low calorie value jellies and fruit salads.

(15) Sort out your crockery and donate to charity anything past its use-by date.

(16) Use large metal serving spoons for dishing out food in sensible dollops - it gives a neater finish than using small spoons.

(17) If you want to serve rice in mounds, remember to lightly oil the ramekin or timbale before filling, then invert on to plates.

(18) When barbecuing, use long sprigs of rosemary with the leaves removed as substitute skewers.

PORTION SIZE

Measuring portion size

When it comes to getting a balanced diet, it's not easy understanding what a healthy portion looks like, after all it depends on what food you're eating for example, a cup of pasta a day is a recommended daily portion, but not a cup of butter! It may seem time consuming to begin with but one trick is to watch what you're eating throughout the day. Read food labels to check the serving size and nutritional value of each serving and if you've got time, use a food weighing scales to weigh out your portion size. Of course most of us haven't got the time or inclination to get too bogged down at this level, so we've made it easy with our quick-to-view portion size guide..

SUPPLEMENTARY/COMPLEMENTARY FOODS

Definition: Nutritional products providing all the nutrients usually present in a well balanced meal. An additional food or drink product which is given to make up for a deficiency identified during nutritional assessment.

PEG FEEDS

A PEG (percutaneous endoscopic gastrostomy) system is the most common. This allows nourishing liquid food to go directly through a tube into the stomach and can be a relief to those who have severe chewing or swallowing difficulties. People can often continue to eat a little by mouth, so they don't lose the chance to enjoy their favourite foods.

The PEG tube is usually fitted under local anaesthetic and the process is fully reversible if no longer needed. Even so, it can still be a daunting step for a person with MS and their carers. Some changes to a person's lifestyle are inevitable and carers will need to learn to care for the PEG tube. District nurses and community dietitians can help when considering PEG feeding, or if issues arise once a PEG system is fitted. Most manufacturers of PEG systems also have 24-hour helplines and employ specialist nurses to help PEG users and their carers.

RECONSTITUTION AND MOULDING OF FOOD

Reconstitution and moulding of food is used to make eating simpler and easier and is designed to help individuals who have eating disorders such as, difficulty in swallowing.

INDIVIDUALS ARE ENABLED TO PREPARE THEIR OWN FOOD AS APPROPRIATE

It's very important to prepare food safely, to help stop harmful bacteria from spreading and growing.

The client must hands can easily spread bacteria around the kitchen and onto food. This is why it's important to always wash hands thoroughly with soap and warm water at each of these times:

- before starting to prepare food
- after touching raw meat, including poultry
- after going to the toilet
- after touching the bin
- after touching pets

Don't forget to ensure that the client dry's their hands thoroughly, because if they are wet they will spread bacteria more easily.

Remind the client that raw meat contains harmful bacteria that can spread very easily to anything it touches, including other foods, worktops, chopping boards and knives.

It's especially important to keep raw meat away from ready-to-eat foods, such as salad, fruit and bread. This is because these foods won't be cooked before you eat them, so any bacteria that get onto the foods won't be killed.

To help stop bacteria from spreading, ask the client to remember these things:

- Don't let raw meat touch other foods.
- Never prepare ready-to-eat food using a chopping board or knife that they have used to prepare raw meat, unless they have been washed thoroughly first.
- Always wash their hands thoroughly after touching raw meat and before they touch anything else.
- Always cover raw meat and store it on the bottom shelf of the fridge where it can't touch or drip onto other foods.

Preparing poultry

Most poultry and farmed game birds sold in the UK have already been gutted before they are made available for purchase.

This means that the intestines and other internal organs (the innards) have been removed.

But, farmers who slaughter fewer than 10,000 birds a year are allowed to sell poultry and farmed game birds that have not had their innards removed.

Client's might find this type of poultry and farmed game birds on sale at the farm gate, or in local markets. Wild game birds, such as pheasants, that have not been gutted, may also be on sale.

Risks from gutting poultry and game birds at home

Removing the guts and other internal organs from poultry and game birds in the home carries the increased risk of contaminating kitchen worktops and equipment with harmful bacteria.

If a bird's stomach or intestine ruptures during removal, bacteria can spread from the contents of the guts. This could contaminate the meat - or other foods - and cause food poisoning.

General advice

It is always better to ask your supplier to gut the poultry or game bird for you, when you buy it.

If this is not possible we recommend that you take these precautions:

- use an insulated cool bag to transport the carcase home
- get the poultry or game into a fridge quickly - ideally within 1-2 hours
- store raw poultry or game away from cooked food
- put raw poultry or game at the bottom of the fridge to avoid it dripping on to other food
- always wash your hands, using warm water and soap, after handling raw meat, poultry or game, and before touching other food
- clean the preparation area thoroughly before and after you start gutting the bird

When gutting poultry or a game bird

- handle and remove the innards well away from other foods to avoid contamination of worktops and other foods
- use disposable cloths, paper towels and disposable gloves whenever possible
- the guts should be removed carefully from the rear of the bird and the heart from the neck
- avoid rupturing the intestines and spilling the contents of the gut
- keep work surfaces and equipment clean and dry during use

After gutting poultry or game

- don't wash poultry or game-bird meat because any splashing might spread bacteria around the kitchen
- wipe blood clots off the bird with paper kitchen roll
- dispose of removed innards and any other inedible material carefully in a waste bin - place it in a sealed container before disposing of it
- wash utensils and work surfaces thoroughly in warm soapy water after use and, if possible, disinfect them
- wash your hands thoroughly in warm soapy water after handling raw poultry and dry thoroughly

Also remember:

The food and drink provided meets the client's wishes and preferences and is in accordance with their plan of care and dietary requirements

Food is prepared, cooked and stored in ways which promote the food's appeal, maintains hygiene and minimises risks to health and safety

Food and drink is served with the appropriate utensils and in a hygienic manner

Food is presented attractively and in a way that meets the client's preferences in relation to quantity, temperature, consistency and appearance

Personal hygiene measures are implemented before, during and after handling food

Work surfaces, cooking utensils and equipment are thoroughly cleaned before and after use, and stored correctly. Stale or unusable left-over food is disposed of in a safe manner and place

Where it is necessary to record the client's intake, records completed by the worker are accurate, legible and complete

1.3 Understand the importance of creating an appropriate environment in which to eat and drink, including (where relevant to the working environment):

CHOICE OF EATING AREA AND COMPANIONS

Dining Issues. • Is the kitchen clean? • How is the food presented? • Are meals served at normal hours? • Are snacks available? • May the family bring in food? • Are special meals prepared for those on special diets? • Are substitutes offered if a patient does not like a food item? • Do patients who need assistance with eating receive help? • Is the dining room comfortable and cheerful? • Can wheelchairs fit under the tables?

Clients regard the food they are given as one of the most important factors in determining their quality of life. It is important in maintaining their health and wellbeing. Failure to eat – through physical inability, depression, or because the food is inadequate or unappetising – can lead to malnutrition with serious consequences for health. Care staff should monitor the individual client's food intake in as discreet and unregimented a way as possible.

Care and tact should always be used. The avail-ability, quality and style of presentation of food, along with the way in which staff assist clients at mealtimes, are crucial in ensuring clients receive a wholesome, appealing and nutritious diet. The social aspects of food – its preparation, presentation and consumption – are likely to have played a significant part in most people's lives, and it is important that homes make every effort to ensure this remains so for individuals once they move into care.

While it is recognised that many clients will no longer be able to play an active part in preparing food – even snacks and light refreshment – many still want to retain some capacity to do so. In

these situations, restriction on access to main kitchens because of health and safety considerations may present problems.

It is important that homes look at alternative ways of maintaining clients' involvement – for example, by providing kitchenettes, organising cooking as part of a range of daily activities – and enabling clients to be involved in laying up and clearing the dining rooms if they wish to, before and after mealtimes.

Individuals' food preferences, both personal and cultural / religious, are part of their individual identity and must always be observed. These should be ascertained at the point where an individual is considering moving into the home and the home must make it clear whether or not those preferences can be observed. Homes must not make false claims that they can properly provide kosher, halal, vegetarian and other diets if they cannot observe all the requirements associated with those diets in terms of purchase, storage, preparation and cooking of the food

- **dining room,**

Care should be taken by staff to enable residents to make their views known if another resident's messy eating habits cause distress to others;

Dining rooms should not have the appearance of institutional canteens.

Furniture and furnishings should be domestic in style. Chairs should be of a comfortable height with sturdy arms (but which can be pulled right up to the table) to assist those who have difficulty in getting up from sitting. Client's should be able to choose how mealtimes are organised and how dining tables are arranged.

Choice of sitting at tables alone or with one or two or several other people should be possible. Regimentation at mealtimes all people being required to sit down to the meal at the same time should be avoided unless it is the clear wish of residents to do so; dining rooms should be non-smoking although smoking areas may be designated elsewhere as long as this is in line with the home's overall smoking policy.

- **bedroom,**

Client's should have the opportunity, if they wish and if they are able, to prepare snacks and drinks for themselves. This might mean kettles in rooms (if this has been assessed as an acceptable risk) or small kitchen facilities near or in their own accommodation; they should have the opportunity to eat in their rooms if they wish to.

- **lounge,**

Eating in the lounge may be acceptable if a client wishes, although other clients may object, the client may have a disability need to eat where they sit, or may just want to watch their favourite T.V. show. Other issues regarding spillage of food and drink and other Health and Safety issues must be taken into consideration.

- **Outdoors**

Eating in the outdoors may be acceptable and positive, especially if family and friends are involved if a client wishes, although other clients may object, the client may have a disability need to eat where they sit, or may just want to enjoy a sunny afternoon as they would in their own home. Other issues regarding spillage of food and drink and other Health and Safety issues must be taken into consideration.

COMPANIONS

Client's find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.

The routines of daily living and activities made available are flexible and varied to suit service users' expectations, preferences and capacities.

Client's have the opportunity to exercise their choice in relation to:

- leisure and social activities and cultural interests;
- food, meals and mealtimes;
- routines of daily living;
- personal and social relationships;
- religious observance;

Client's interests are recorded and they are given opportunities for stimulation through leisure and recreational activities in and outside the home which suit their needs, preferences and capacities; particular consideration is given to people with dementia and other cognitive impairments, those with visual, hearing or dual sensory impairments, those with physical disabilities or learning disabilities.

Clients maintain contact with family / friends / representatives and the local community as they wish.

Clients are able to have visitors at any reasonable time and links with the local community are developed and/or maintained in accordance with clients' preferences. Clients are able to receive visitors in private. Clients are able to choose whom they see and do not see. The registered person does not impose restrictions on visits except when requested to do so by clients, whose wishes are recorded.

Relatives, friends and representatives of clients are given written information about the home's policy on maintaining relatives and friends' involvement with clients at the time of moving into the home. Involvement in the home by local community groups and/or volunteers accords with clients' preferences

POSITIONING AND SUPPORT OF INDIVIDUAL TO AID SWALLOWING, DIGESTION AND GENERAL COMFORT

In long-term care facilities, mealtime should be an important and exciting event that client's and staff look forward to three times a day. Providing client's with a homelike, pleasant dining atmosphere should promote socialization, enhance awareness, and increase appetities, thereby improving their quality of life.

The purpose of swallowing is to get food from the mouth, through the throat (pharynx), to the stomach, without allowing it to go down the nose or down the windpipe (trachea). Your throat is like a dual carriageway: food goes down to the stomach (and in some circumstances back up!) and air goes up and down it to the lungs.

The pharynx divides into two near the top: the tube at the front is the windpipe which goes to the lungs; and the tube at the back goes to the stomach (oesophagus). Before swallowing food is chewed and held in the mouth. There is nothing in the throat, the windpipe is open and breathing occurs. When you swallow, the food is pushed into the throat, and the windpipe closes off . Food then slips down the tube at the back leading to the stomach. Because the windpipe is closed, you momentarily stop breathing. Once the food has passed through the throat, the windpipe opens up again and breathing can resume.

If you have any food or drink in your throat when your windpipe is open and you are breathing, there is a chance it could fall into the windpipe. This is experienced as 'going down the wrong way' and coughing and spluttering usually ensues.

Difficulties in eating and/or swallowing can develop for a variety of reasons. The problem is best understood by looking at the three different stages involved in swallowing, and associated behaviours, separately.

1) Oral Preparation Stage

The lips, tongue, teeth and cheeks break up food, mix it with saliva and form a soft ball that can be swallowed. In the case of liquids, it is a question of control. The tongue forms a cupped shape around the liquid and holds it ready for swallowing.

2) Pharyngeal Stage and the Swallow Reflex

The tongue squeezes the food or liquid to the back of the mouth and the swallow reflex is triggered: the windpipe is closed off and food/liquid is passed through the back of the throat, down to the stomach, and then the windpipe opens again. Muscles in the wall of the throat assist movement of food/drink downwards by wave like movements called peristalsis.

If you touch the front of your throat and swallow you can feel the Adam's Apple (larynx) move up and down. This is the mechanism which closes the windpipe and is part of the swallowing reflex. You need to have something in your mouth to swallow: try swallowing repeatedly; after three or four swallows it becomes difficult as your mouth becomes empty of saliva.

3) Oesophageal Stage

This is the movement of food from the lower part of the throat, through the gullet (oesophagus) to the stomach, assisted by a continuation of the peristaltic wave.

Cough

A cough is the body's response to 'foreign bodies' entering the airway or windpipe. It is our way of protecting our lungs from getting clogged up and interfering with breathing. It is under neurological control and can therefore be affected in dementia. The important thing to understand is that if someone can cough when you ask them to, it doesn't necessarily mean they will cough to clear their windpipe. Likewise, if someone is unable to cough on request, it may be that they will have an adequate 'protective' cough.

Aspiration

Aspiration is when liquids or food do go down the wrong way and are not removed by coughing.

Gag Reflex

Contrary to popular belief the presence or absence of a gag reflex has no relationship to someone's ability or inability to swallow safely.

SWALLOWING PROBLEMS (DYSPHAGIA)

Problems with swallowing in dementia can arise at any of the stages, either in isolation or in combination. Muscle movements may become slow or uncoordinated; the swallow reflex can become delayed or incomplete; or the coordination of all three stages can become unbalanced. Whilst most problems can be diagnosed on examination sometimes it is necessary to confirm this by 'videofluoroscopy'. This is a video X-ray to show exactly what is happening when food and drink of different consistencies is swallowed.

Below are listed some common problems and strategies used to facilitate swallowing. It is, however, recommended that the advice of a speech and language therapist is sought, as strategies recommended will vary according to the stages of the swallow affected and the client. You can obtain a referral through your GP, or if necessary contact your local hospital or the Royal College of Speech and language Therapists for information on services locally. Other professionals, such as a dietician, occupational therapist, physiotherapist, or district nurse, may need to be involved.

Common problems that you may notice

- being unaware of food when it arrives
- failing to do anything with food in the mouth, just holding it there
- difficulty chewing and/or difficulty moving food to the back of the mouth
- spitting lumps of food out
- eating very fast or putting too much into the mouth
- eating insufficient amounts or refusing food and/or drink
- talking with food or drink in the mouth and forgetting to swallow causing coughing
- coughing/choking on food and /or liquids
- complaints of food not going down or getting stuck in their throat
- a 'wet' or 'gurgly' voice after swallowing
- difficulty swallowing tablets
- dribbling
- chronic chestiness or recurring chest infections

Ways to promote safe eating that may be suggested by a speech and language therapist

1. **<u>Strategies</u>**

- Sitting upright, keeping the chin down. If you put your head back to drink, you are opening up the airway more, therefore if the swallow reflex is slow, it is easier for food and drink to go down the wrong way.
- Take small sips of drink, perhaps from a teaspoon. Avoid the use of drinking vessels that encourage the head to tip back (eg feeder beakers)
- Take small mouthfuls of food.
- Alternate food and drink to help clear the mouth of food: this should be discussed with a speech and language therapist.
- Try encouraging the swallowing of each mouthful twice to clear any food or drink that may remain in the mouth or in the throat after the first swallow.
- If the person has not swallowed what is in their mouth, sometimes it helps to present an empty teaspoon rather than more food. This can encourage the second swallow mentioned above.
- Frequent swallows to counteract dribbling.
- Check mouth after finishing eating to ensure no food or fluid remains.
- You may have to sit with the person to remind them to use these strategies, and you may find that mealtimes take much longer.

2. **<u>Changes to diet</u>**

Special diets (soft or puree), merely avoiding certain foods, or preparing them differently can make a big difference. Foods that may present difficulty for someone with a swallowing problem include:

a. mixed textures eg food in a lot of fluids like ministrone soup, or cornflakes and milk;
b. stringy textures eg bacon, cabbage, runner beans
c. floppy textures eg lettuce, cucumber
d. small, hard textures such as peanuts, peas, sweet corn and broad beans

Cooking food longer so it becomes softer; mashing food with the back of a fork; or liquidising it in a blender can help.
Thickening fluids to yoghurt or sometimes porridge onsistencies may help as they are easier to control. There are a number of thickening agents available through your GP or from a dietician. It is important to speak to a speech and language therapist about this, and it can also be helpful to have guidance in using thickeners as the fluids may become lumpy which does not look appealing and may be off putting!

The use of nutritional supplements if necessary.

Crushing tablets or using a syrup form may be easier for someone with a swallowing problem but seek advice from your GP as some tablets need to be taken whole.

Equipment

Specially designed cups which allow drinking whilst keeping the chin down; cutlery, plates and non slip mats are available. An occupational therapist can advise you on this.

Sometimes these strategies may be insufficient to ensure an adequate dietary intake. After discussion with your doctor it is may be decided to feed via a tube directly into the stomach.

This is called a gastrostomy, and it can be used in conjunction with eating small amounts orally, or can be used alone.

Food and eating is central to living in terms of pleasure and socialising as well as survival, therefore eating and swallowing problems have a major impact both on the person directly affected and those caring for them. It is possible to compensate for many difficulties, and support and guidance from a speech and language therapist can make the difference.

AN ATTRACTIVE AND CLEAN ENVIRONMENT

Ever wondered why red is such a popular colour for restaurants and dining rooms? It's because it stimulates the appetite. It's also an energising colour and therefore a good backdrop for social situations - thus its status as a classic dining room colour. However, choose the shade carefully - you want to create warmth rather than an oppressive, angry atmosphere.

If your room is small or dark, use it subtly. It might be more effective to paint or paper one wall red, or hang a red-based painting.

Other colours to get your mouth watering are orange and yellow. And neutrals always work well. Avoid pinks and purples as they have a sedative effect - not ideal for eating or entertaining. Blue doesn't affect the appetite but is considered good for encouraging communication. It also gives a clean, classic look to a table, particularly when teamed with white - be inspired by Delft ware and Cornish blue crockery.

Create a flattering light

For daytime use, dining rooms should be light and airy and make the most of natural light. If the room is naturally dark, have pale or neutral blinds rather than curtains on the windows, which will only block the light even more.

In the evening, try to create a warm, mellow ambiance, so avoid harsh lighting from above.

- For a gentle glow, if you have a picture rail, consider having hidden strip-lighting along this (in a low wattage) to uplight the cornicing and ceiling.
- Use lamps and uplighters dotted around the room at different levels to vary the light in the room.
- Candlelight is the softest light and creates an intimate atmosphere, perfect for dinner parties.

Have enough storage

If you don't already have a cupboard in your dining room, there's no better time to invest in a sideboard as they're seeing a revival since their heyday. As such, they are widely available both new and second-hand. Once you have somewhere to store tableware, glasses and table linen, you'll wonder how you managed without it.

The other benefit of a free-standing unit, such as a sideboard, is that it creates a focal point in the room and provides an extra surface for drinks and nibbles.

Laying a formal dinner table

- Whether or not you use a tablecloth depends on the state of your table. Nina left the mahogany dining table bare, as she considered it too attractive to cover with a cloth. The reflection of flickering candlelight and crystal glasses in the wood adds glamour and sparkle. For a less formal, more modern look, a runner is a good idea. This is a long strip

of material, which is placed down the centre of the table.

- If your table isn't in the best condition, use a clean, crisp tablecloth. White is the classic option (though easily stained). Otherwise use a coloured or patterned cloth that complements the room.
- Placemats: advice is 'always'.
- A charger plate is optional. This decorative plate is the same size or slightly larger than a main course plate. Apart from looking pretty, its only purpose is to stop a hot plate from marking the table.
- Another optional extra is a starter plate. Placed on top of the charger plate (if you have one) in advance of food being served, it's ideal for 'sharing' starters, such as antipasti.
- Napkins should be folded neatly and placed in the centre of each setting. A squirt of starch when ironing them will ensure a more professional, crisp look.
- Cutlery: depending on the number of courses, arrange cutlery so that guests start from the outside and work inwards. Polish with a clean, dry cloth before laying the table to remove fingerprints and tarnish.
- Glasses: use large glasses for red wine and smaller ones for white. Save coloured glasses for white wine or water as wine buffs don't like to be served red wine in anything other than clear ones.
- Nina doesn't like to drink water out of a tumbler and so always serves it in a stemmed glass. However, this is a matter of personal choice, so whatever style you choose, keep it consistent at each setting.
- Fresh flowers should be either long-stemmed in a tall vase or cut short in a bowl or short vase so that people can talk over or under them. Heads of peonies or roses in a pretty cut-glass bowl work well.
- Food can be brought in a tray, and the tray stays at the table, some trays and cutlery are specialise to deal with disability.
- Salt, pepper and other accompaniments should be available for personal choice and preferment.
- Protective clothing, such as aprons may be used to keep the client clean and dignified

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AIDS TO FACILITATE EATING AND DRINKING

- **special crockery and cutlery,**

Dishwasher proof crockery that makes eating and drinking easier for people with impaired strength or mobility in hands and arms.

Feed cutlery is ergonomically designed for and adults who need help eating and drinking. Soft and rounded shapes make feeding easier and more comfortable.

- **plate guard,**

A **Plate Guard** prevents food from being pushed off the plate by making scooping food onto utensils easier. Internal grove attaches to the rim of the plate. The 1 1/4 inch plastic rail is dishwasher safe. Large size fits onto plates with a diameter of 9 to 11 inches.

- **cup with spout,**

This white plastic feeding cup with two handles has a partially covered lid to prevent spills.

- **dentures,**

Teeth are necessary for cutting and chewing food, so someone with dentures has the ability to cut and chew, if a client has got dentures and they are not available then this is an unacceptable eating situation.

The elderly are more likely to suffer from dental problems. Ill-fitting dentures, jaw pain, mouth sores and missing teeth can make chewing painful. All of these factors make it increasingly difficult for the elderly to eat healthy foods.

- **spectacles,**

If a client can see the food on offer, they can make a decision on the presentation, quantity and quality of it and this should ensure a good eating experience, dirty or no spectacles are not acceptable where they are in use.

- **hearing aids**

Eating and being social are 2 normal events, so if a client has hearing issues and their hearing aid is not supplied, they are less likely to hear others so they will be less likely to join in a conversation.

IN RESIDENTIAL SETTING – RESTAURANT STYLE LAYOUT AND SERVE ONE TABLE AT A TIME

See An Attractive And Clean Environment above

POSITION OF WORKER IF ASSISTING AN INDIVIDUAL WITH EATING AND DRINKING

Feeding Skills for Carers of Frail Elderly

Elders with chronic illness and impaired mobility may suffer from various degrees of feeding problems. It is therefore important for carers of these elders to provide appropriate assistance according to the elders' individual needs.

Objectives:

- To maintain a healthy diet and balanced nutrition.
- To prevent complications such as aspiration pneumonia induced by choking.
- To encourage and assist elders with eating problems so as to maximize their independence and self care ability.
- To make eating an enjoyable experience to improve their quality of life.

Preparation before Feeding

Environment

- Ensure that the eating area is well-ventilated, with adequate lighting and free from distractions so as to enhance the elders' concentration and to prevent choking.

Feeding Utensils

- Ensure the utensils are clean. Use non-slip mat to fix utensils on the table for easier feeding. Replace any broken utensils.
- Choose appropriate feeding utensils. e.g. fork or spoon instead of chopsticks.
- Use smaller spoons to control feeding amount and minimize the risk of choking.
- Use straws or specially designed cups to control the amount and flow of fluids during drinking.
- Consult occupational therapist if necessary for advice on the choice of feeding devices, e.g. spoon and fork with enlarged handles, adapted chopsticks, a bowl with a raised curved lip which enhances scooping of the food. (Fig. 1)

The carer

- A warm and caring attitude is always important. Explain to the elder what you are doing and try to gain their cooperation.
- Good personal hygiene should be observed, wash hands thoroughly with water and soap.
- Assist the elder in hand washing before every meal. If needed, perform oral care such as rinsing the mouth before meals to stimulate appetite.
- Assess the elder's chewing and swallowing abilities. Give appropriate assistance if required.
- Communicate with the elders before feeding, e.g. discuss the menu with demented elders to enhance their cognition and stimulate their interest. For elders with visual impairment, guide them along by informing them the food types and position of the food and utensils. Ensure all the food and necessary feeding aids are within their reach.

Choice of food

- Individual's food preference, religion and health status should be taken into consideration during preparation of meals. e.g. Diabetic, low salt and vegetarian diet etc.
- Choose nutritious food which are easy and safe to swallow. Change menus regularly to stimulate appetite.
- Prepare food according to individual's chewing and swallowing abilities. e.g. pur?e, porridge or fluid diet. Remove the bones and skin of meat to decrease the risk of choking. Chop up the food into smaller pieces for easy chewing.
- Avoid foods which are sticky and difficult to chew and swallow so as to prevent choking, e.g. glutinous dumplings.

The elder

- Assist the elder in wearing dentures if required.
- Ensure the elder is sitting comfortably in an upright position to facilitate safe swallowing. The seat should be adjusted to a suitable height.

Safety Tips on Feeding

- Ensure that the elder is fully alert during feeding.
- Ensure proper positioning of the elder. Sitting with head slightly flexed and chin down which reduces the risk of choking.
- Serve food at the right temperature, e.g. not too hot.
- Do not rush, allow plenty of time for feeding. If the elder refuses to eat, try to find out the reason and provide assistance accordingly.
- Observe for any signs of swallowing difficulties, e.g. cough, dribbling, aspiration of food back into the nose, etc. In case of choking or aspiration, keep calm and call for help at hospital.
- Signs and symptoms of aspiration are:
    - Breathing difficulty
    - Engorged face and neck veins
    - Face turning blue, loss of consciousness in severe cases.
- Ensure adequate fluid intake for elders who cannot feed themselves so as to prevent dehydration.

After Care

- After feeding, check the mouth for any food debris and apply oral care and wipe the mouth with wet towel and maintain good personal hygiene. Cleanse the dentures.
- Remove the utensils, apron and serviettes. Let the elder rest comfortably.
- Avoid lying down right after feeding. Remain sitting in an upright position for at least 20 to 30 minutes to prevent aspiration.

For those elders who are particularly frail, observe their mental state after feeding and monitor for signs of aspiration and choking

ENSURE INDIVIDUALS ARE NOT RUSHED THROUGH THEIR MEALS

- Routine nutritional screening should be carried out on admission to hospital or residential care. The dietary needs and preferences of service users, and any assistance needed at mealtimes, should be assessed, recorded and referred to by all frontline staff.
- A speech and language therapist should assess anyone exhibiting swallowing difficulties, to ensure the correct textures of foods and liquids are provided.
- Where necessary, record food and fluid intake daily.
- Food should be made available and accessible between mealtimes.
- Give people time to eat; they should not be rushed.
- Avoid interruptions to mealtimes by other routine tasks, such as administering medication.
- Where necessary, provide assistance discreetly. Use serviettes, not bibs, to protect clothing. Offer finger food to those who have difficulty using cutlery, and provide adapted crockery and cutlery to enable people to feed themselves where appropriate.
- While socialising during mealtimes should be encouraged, offer privacy to those who have difficulties with eating, if they wish, to avoid embarrassment or loss of dignity.
- Managers should ensure that mealtimes are sufficiently staffed to provide assistance to those who need it.
- Don't make assumptions about people's preferences on the basis of their cultural background - people should be asked what their preferences are.
- Staff should receive training to equip them with the skills to communicate with people

with dementia and communication difficulties. Visual aids (such as pictorial menus) and non-verbal communication skills may help people to make choices. Gather information on people's needs and preferences from people who know the person well.

- All care staff, including caterers, should have access to quality training to raise awareness of the risk of malnutrition and the importance of providing good nutritional care for all service users.
- Commissioners and providers should ensure that home care staff have sufficient allocated time and the skills to prepare a meal of choice for the service user, including freshly cooked meals.
- Food should be made to look appetising. Where food needs to be puréed, use moulds to keep foods separate and indicate what they are - for instance a fish-shaped mould for fish.
- Carry out regular consultation with service users on menus.
- Wherever possible, involve service users in meal preparation.
- In residential settings, where access to industrial kitchens is denied, provide facilities for people to make drinks and snacks.
- Ensure that fresh water is on offer at all mealtimes and freely available throughout the day.

2. ROLES AND BOUNDARIES

2.1 Understand the role, and responsibilities and boundaries of the worker with regard to following the policies and procedures of the care setting on assessment of dietary requirements:

- Person-centred approach

PERSON-CENTRED APPROACH

We believe that all individuals have the following characteristics

UNIQUENESS

Regardless Of Illness, All Individuals Are Unique And This Must Be Acknowledged By Everyone

COMPLEXITY

Individuals Are Complex Beings And A Myriad Of Factors Influence The Way We See And Respond To The World Around Us.

ENABLING

We Need To Recognise The Strengths And Abilities Of Individuals With a Mental Health illness And Ensure Opportunities Exist For Them To Be Utilised.

INDIVIDUALITY

The Recognition Of A Sense Of Self, Who We Are And What Place We Hold In The World Around Us.

It Places An Emphasis On The Positive Effects Of Daily Interaction

VALUE OF OTHERS

ICS recognises the individuality of all people. the roles of direct care staff, the formulation of policies and procedures and staff and managers supporting each other…

NUTRITIONAL SCREENING (RECOGNISING MALNUTRITION)

Undernutrition in the Elderly

By James Collier BSc (Hons) - Consultant in Nutrition and Moderator of Dietetics.co.uk

Undernutrition is becoming increasingly prevalent in the ever-growing elderly population. Is poor nutrition just an inevitable consequence of ageing, or are there reasons which health professionals can address to deal with this problem?

The elderly population is growing, and over the next 50 years the number of people over 75 years is likely to double (Thomas 1998). As a population sub-group, older people are the major users of health and Social Services resources, yet are an economically disadvantaged group. Many elderly people lead healthy and independent lives, but the incidence of frailty, disability and illness increases as they get older. Among independent older people 3% of men and 6% of women are underweight, and in nursing and residential care, these figures rise to 16% and 15% respectively (Finch et al 1998).

A national survey of older people in private household (DoH 1992) found the following:

- Over half reported long standing illness or disability
- One in five had difficulty seeing, even with glasses
- One in ten were unable to walk down the road or manage stairs
- One in five had been seen by a hospital doctor in the preceding three months
- Half of the women and a quarter of the men aged 85 years and over were not able to cook a main meal alone
- Only one in ten received 'meals on wheels'

Not only do older people have practical disadvantages but they also have different nutritional requirements to that of the normal adult population, and health professionals working with this client group must be aware of these fundamental needs. With increased age, people become more vulnerable to malnutrition for many reasons including those listed below:

Factors Affecting Malnutrition in the Elderly

1. Oral
    - swallowing problems from a stroke, Parkinson's disease or other neurological disorder
    - Worsening dentition and periodontal disease, ill fitting dentures
    - Candida
2. Manual dexterity
    - frail skin on hands
    - peripheral vascular disease
    - osteo- and rheumatoid arthritis
    - loss of use of hands from a stroke, Parkinson's disease or other neurological disorder

3. Socio-economic
    - Isolation - limited access to shops
    - bereavement
    - poverty
    - institutionalisation
4. Malabsorption
    - more prone to infection and thus bacterial overgrowth
    - after previous surgery
    - achlorhydria
5. Diminished sensory ability
    - Taste changes
    - Less smell perception
    - hard of hearing
    - reduced appetite
6. General Health
    - Drugs and alcohol
    - Chronic disease and disability

All these above risk factors may affect intake, digestion, absorption, utilisation and metabolism of food and nutrients. It becomes increasingly important for improved quality of the diet, as the total amount of food falls with age.

Oral and pharyngeal health

In the Western World dental health is improving in all ages including the elderly who are more likely to retain their teeth. However, tooth decay still often goes unrecognised in some individuals. Also with malnutrition this can lead to a change in mouth shape, so a person with dentures may find they are not fitting properly.

Oral candida is frequently missed on nutritional assessments if the individual does not present with the typical white plaques. Thrush can lead to significant taste changes and reduced enjoyment, therefore, enthusiasm for food.

Many neurological problems may cause dysphagia, the most common being cerebrovascular accident, and if the individual isn't provided with appropriate textures and advice, food intake is likely to be compromised.

Gut function

Changes in the gut microflora can affect digestion and absorption of nutrients. With a reduced immune system there may be bacterial overgrowth in the gut, or conversely, the use of antibiotics may reduce the beneficial gut flora, leading to diarrhoea or constipation. With the ageing process there is also reduced efficiency of motility of gut muscle.

Isolation

With increasing age there is greater chance of being alone (death of spouse and adult children), and housebound individuals are more vulnerable of nutritional inadequacy. They may depend on 'meals on wheels' and store cupboard foods. It is particularly a problem in the winter months as it is harder to get to shops. Upon retirement there is also a considerably reduced income for the elderly who are forced to shop locally where food items are generally more expensive and there is reduced selection. As more supermarkets are relocating out of towns it makes it harder for the elderly to access them.

Drug use
Drugs can affect the absorption and metabolism of some nutrients. As a population older people use a large percentage of prescribed medication, and many are often using more than one drug, as well as some over-the-counter medicines. Clinical effects of these drugs on an already less efficient metabolism can be loss of appetite and taste changes from chemotherapy and analgesics, or specific nutrient interactions, for example hypokalaemia with loop diuretics and hypocalcaemia from corticosteroids (Thomas 1998).

Illness
Incidence and prevalence of undernutrition in the elderly with acute or chronic illness is greater. Nutritional status may be further compromised by other problems in conjunction with the illness, such as trauma, surgery, infection drug therapy which alter nutrient requirements. This makes recovery even more difficult. Merely being in hospital puts patients at increased risk of malnutrition unfortunately (Webb & Coperman 1996, Wood & Creamer 1996). The elderly are particularly prone to fractures of the large bones due to frailty, instability and osteoporosis (Lehmann et al 1991), which puts huge stress on nutritional requirements.

Assessment of Nutritional Inadequacy in the Elderly

There are a number of methods of assessing nutritional status in elderly subjects, a few of which are briefly discussed below. Unfortunately, not always are any of these assessments performed routinely.

Assessment of nutrient intake

Recommendations for intakes for the population are known as Dietary Reference Values (DRVs) (DoH 1991). These are the 'gold standard' of intakes or energy and each nutrient in the UK. If there is concern of inadequacy of an elderly person's diet a State Registered Dietitian will check the composition of an individual's diet by dietary analysis of food diaries against DRVs.

Laboratory Tests

Laboratory Tests are also indicators of inadequacy, which measure the concentration of a particular nutrient or variable affected by a particular nutrient in a tissue. For example serum haemoglobin, albumin, or individual micronutrients can be measured.

Anthropometry

This includes weight, height and Body Mass Index (BMI). All are simple and useful measurements for a quick assessment. BMI can be calculated form the following equation:

$$\text{BMI} = \frac{\text{weight in kilograms}}{\text{height in metres}^2}$$

There are reference ranges to see if an individual in under- or overweight.

In some cases, skinfold thickness, arm circumference and grip strength measurements may be taken. These generally need an experienced assessor.

Nutritional Screening

It could be argued that all patients admitted to an acute hospital bed should be screened for nutritional status by qualified nursing staff. Nutritional screening tools with emphasis on use for the elderly population have been devised for the assessing nurse to use his/her professional judgement and consider factors like BMI, recent weight loss, skin condition, respiratory function, dementia, nausea, and many more. Furthermore, it is also argued that nutritional screening should be done routinely in nursing homes or even in elderly patients living at home (Holmes 2000). Tools for these situations are available.

The Role of the Health Professional

Using information gained from assessments there should be action plans in place on how to address the nutritional problems. Nutritional support provided will vary between clinical cases, but could include the use of oral nutritional supplements and input from a dietitian.

As can be seen, there is a complex web of factors affecting nutritional status in the elderly involving the ageing process itself, illness, drug treatment and socio-economic factors. Elderly are as risk if they are in an acute hospital, nursing or residential care or in their own homes. It is the health professional's responsibility to highlight nutritional problems and act upon them appropriately.

CARE PLANNING

The client's health, personal and social care needs are set out in an individual plan of care.

A care plan of care generated from a comprehensive is drawn up with each client and provides the basis for the care to be delivered.

The care plan sets out in detail the action which needs to be taken by care staff to ensure that all aspects of the health, personal and social care needs of the client are met.

The care plan meets relevant clinical guidelines produced by the relevant professional bodies concerned with the care of older people, and includes a risk assessment, with particular attention to prevention of falls.

The care plan is reviewed by care staff in the home at least once a month, updated to reflect changing needs and current objectives for health and personal care, and actioned.

Where the client is on the Care Programme Approach or subject to requirements under the Mental Health Act 1983, the client's plan takesthis fully into account.

The plan is drawn up with the involvement of the client, recorded in astyle accessible to the client; agreed and signed by the client whenever capable and/or representative (if any).

RISK ASSESSMENT

Risk assessment is nothing new in the sense that we all assess risks every day, e.g. when deciding to overtake a lorry or when ordering a strange sounding meal at your local Indian restaurant! However, risk assessment in the workplace has more of a formality to it. As we have already seen, the assessment of risk is now a general requirement in the Management of Health & Safety at Work Regulations 1999. These require an employer to make suitable and sufficient assessments of all the risks to Health & Safety of employees and others (residents, visitors) affected by the employer's undertaking.

The purpose of a risk assessment is to help the employer determine what measures should be taken to avoid injury at work - its as simple as that.

Try not to look upon risk assessments as yet more paperwork. Use it as a tool to identify the hazards present and then evaluate the extent of the risks involved, taking into account whatever controls are already in place.

Begin by making a simple list of all the operations in your place of work. You will very quickly have a comprehensive list, but don't forget the less obvious (cleaning, maintenance, medicines control, etc)

Then systematically work your way through the list. There are no fixed rules as to how a risk assessment should be undertaken, although it should:

i) Identify the hazard;
ii) Assess the risk from the hazards;
iii) Identify the existing control measures and the extent to which they control the risks;

iv) Put in place any further measures that may be necessary;

v) Record, if necessary;
vi) Review, if circumstances change.

Risk is both the **probability** that harm will occur and its **severity**. Use a scoring system to quantify the risk. This will help to prioritise where work is needed to control the risk. The following is a simplified example:

Severity:		***Probability***
3 Death	*3*	*certain to happen*
2 3 day injury	*2*	*quite likely to happen*
1 minor injury	*1*	*very unlikely*

REMEMBER! The risk assessment is a means to the end, not the end itself. Measures to be taken as a result of it will inevitably follow. Using such a scoring system as the above helps prioritise these measures, and guides the employer in fulfilling his or her statutory Health & Safety obligations.

For small organisations with few or simple hazards, the risk assessment can be a very straightforward process requiring no specialist skills. However, the risk assessor must be competent and be able to recognise where expert opinion is needed. For example, where the work to be done is complicated or presents an especially high risk to workers and/or members of the public.

In the case of Registered Care Homes there is of course the added concern for the Health & Safety of the residents themselves. Special consideration needs to be given here when conducting risk assessments.

By far the biggest risk to the Health & Safety of Residential Care Home workers is that of injuries resulting from manual handling - in particular the movement of the residents themselves. This is dealt with in a separate module entitled "Lifting and Handling Risk Assessment".

For now however, we will concentrate on general risk assessments.

There are no fixed rules for doing a risk assessment. However, in general terms you will need to do one or more of the following:

i) Observe the workplace environment, the layout, the standard of cleanliness(e.g. floor and work surfaces), lighting, temperature, fire precautions, etc;

ii) Inspect the work equipment to ensure that it is safe to use and adequately guarded;

iii) Observe the activity itself, the tasks people perform individually or as teams;

iv) Inspect any personal protective equipment that has been provided and is used;

v) Observe maintenance and cleaning activities;

vi) Observe manual handling methods used, particularly when handling residents;
vii) Consider the fact that residential care is a 24-hour operation. How do risks differ in the middle of the night? Is help always going to be available to move a resident?

ASK! If you are not totally familiar with the work you are risk assessing, speak to the operative. Ask them about the problems they encounter. They may be aware of elements of the job that you might not normally see. In this way you can be sure that you have correctly interpreted what you have seen.

It is important to think of people who may be present in the work area at times other than when you are conducting your risk assessment. For example, visitors (especially relatives). Is their presence and/or offered assistance going to put the employee to undue risk?

Who may be at risk?

- ☞ Employees engaged in normal duties around the Home;

- ☞ Ancillary workers: cleaners, maintenance, temporary workers (e.g. agency nurses);
- ☞ Delivery personnel;
- ☞ Students, trainees;
- ☞ Visitors ☞ Staff with disabilities;
- ☞ Young / old workers;
- ☞ Pregnant women;
- ☞ Untrained or inexperienced staff;
- ☞ People with pre-existing ill -health (e.g. bronchitis);
- ☞ Employees on medication which might increase their vulnerability to harm;
- ☞ Lone, isolated workers (e.g. night shift)

Evaluate

- Is the risk adequately controlled?
- What precautions are in place? Do they:
  - Meet legal requirements?
  - Comply with recognised standard?
  - Represent good practice?
  - Reduce risk as far as reasonably practicable?
- What more needs to be done?
- Apply the principles of prevention and protection

Record findings

Like the Safety Policy statement, this is only required for those employers with five or more employees.

- "Significant findings" means:
  - the more serious hazards, and
  - the most important conclusions
- No need to show how the assessment was done if you can demonstrate:
  - A proper check was made
  - Precautions are reasonable
- Assessments need only to be suitable and sufficient - i.e. don't go OTT!

You don't have to be perfect!

ORAL HEALTH

The advances in dental technology are providing the means for more people to keep a healthy set of teeth well into later life than ever before. Improved dental care for OAPs now means that pulling a tooth at the slightest sign of infection is thankfully a thing of the past. At present, dental care for the elderly focuses more on restoration than the prevention of oral disease and there are a few rules that should be followed to ensure good dental health.

Dental Problems and the Elderly

More people than ever have healthy teeth well into later life but the aging process does bring about its own set of medical problems. Elderly people are more susceptible to oral disease and this can bring about further medical complications and complaints. Many people are unaware that oral disease is closely related to their overall health and if oral disease is discovered it may well be that there are also other underlying medical problems.

Common Oral Problems for OAPs

Dry Mouth

Among the more common dental complaints for OAPs is a condition called dry mouth that occurs due to a reduction in the amount of saliva produced. Dry mouth can happen for a number or reasons with the most common being the amount and type of medication taken, it can also occur as the result of cancer treatments using radiation.

Root Decay

Root decay occurs as the gums recede from the teeth, the roots of the teeth are then more exposed to bacteria and more susceptible to decay.

Darkened Teeth

After a lifetime of consuming food, drinking coffee, tea and other stain inducing liquids, OAPs will find that darkened teeth may be a problem. Darkened teeth can also be caused by changes to dentin, this is the tissue that lies beneath the tooth enamel.

Gum Disease

Gum disease caused by plaque is a major factor in tooth loss and can occur due to a variety of reasons. Poorly fitted dentures, the use of tobacco, an unhealthy diet and food left between teeth will all enhance the risk of plaque. Diseases such as diabetes and cancer will also be common sources of gum disease. If gum disease is left untreated then it can cause other medical complaints such as heart and respiratory problems.

Good dental care for OAPs will take all of these problems into consideration and restorative measures by a dentist can be taken to ensure that the problems are treated and minimised.

Dental Examinations for the Elderly

Regular dental examinations for the elderly are vital in order to ensure that any oral diseases are caught in the early stages. When you visit your dentist for an examination he will take into consideration health complications that the elderly are susceptible to. If it has been a while since

your last examination then the dentist should conduct a thorough oral examination and he will also ask questions on your medical history. The dentist will ask questions regarding your general oral health particularly if there has been any recent bleeding to your gums or swellings in your mouth.

During the examination the dentist will check your face, neck, lymph nodes and salivary glands; this is quite normal as he will be looking for any swellings, lumps or discolouration to the skin. The dentist will then conduct a full oral examination of your mouth, gums and teeth, looking closely for any signs of gum disease or decaying or cracked teeth. If you wear dentures the dentist will also examine these for any signs of breakage or wear.

Daily Dental Care for OAPs

Daily dental care for OAPs should consist of a regular brushing and flossing routine. This should occur twice daily, once in the morning and before bed. Partial or full dentures should be cleaned thoroughly to ensure that no food is left on the dentures that can contribute to gum disease. If you have a problem with mobility and find it hard to visit the dentist then there are now mobile dentists who will make visits, either in your home or to your nearest residential home. The aging process does not mean that teeth should be neglected and regular dental care means many senior citizens can have a full set of healthy teeth for the duration of their lives.

2.2 Understand the role, responsibilities and boundaries of the worker in relation to monitoring the condition and therapies of the individual:

DOCUMENTATION AND RECORD-KEEPING

It is generally accepted that written documentation is significant not only as a communication medium in care homes, but also in the fulfilment of a number of other professional and legal obligations

Records kept would be of the following:

Fluid balance Chart
Record of Food eaten
Weight Chart
Care Plan notes
Staff Handover notes

OBSERVING AND REPORTING CONCERNS

I would observe and report concerns on:

Skin

Dehydration can be seen in the skin, by pinching the skin, the elasticity may be poor and the skin takes time to go back to its original position.

The colour of the skin may show a pale or pallor skin, which may signal anaemia.

Eyes

May well be dry and deep, showing dehydration, or have a yellow tinge, depicting jaundice

Temperature

High temperature can cause dehydration, and the need for increased fluids and food intake

Weight

Can go up when diet is improved or down when malnutrition and dehydration is suspected

Urinalysis

All samples should be midstream and collected in a clean sterile container. Suprapubic aspiration or fresh catheter samples are ideal, but not always practical.

Physical examination

Colour The colour of the urine can vary greatly. Normal urine varies from colourless to dark yellow. Various factors can affect urine colour.[1]

Turbidity Cloudy urine may be due to excess phosphate crystals precipitating in alkaline urine, which is of no significance. It can however also be seen in pyuria secondary to infection.

Odour The normal odour is described as urinoid. In concentrated specimens this can be strong but does not imply infection which has a more pungent smell. Alkaline fermentation causes an ammoniacal smell, and patients with diabetic ketoacidosis produce a urine that may have a sweet or fruity odour. Other causes of abnormal odours are cystine decomposition (a sulphuric smell), gastrointestinal-bladder fistulae (a faecal smell), medications (e.g.vitamin B6), and diet (e.g. asparagus).

Dipstick Analysis Immerse the dipstick completely in fresh urine and withdraw immediately, drawing the edge along rim of container to remove excess. Hold the dipstick horizontally before reading.

Specific Gravity SG <1.008 is dilute and >1.020 is concentrated.

Increased specific gravity is seen in conditions causing dehydration, glycosuria, renal artery stenosis, heart failure (secondary to decreased blood flow to the kidneys), inappropriate antidiuretic hormone secretion and protenuria. Some dipsticks give falsely high readings in the presence of dextran solutions and IV radiopaque dyes, but this varies, so check the manufacturer's leaflet.

Faeces

What are faeces?

Faeces are made of water, bits of food that could not be digested, dead cells from the lining of the intestines and dead bacteria - all the solids that the body doesn't need or want any more. They are brown in colour because of bile from the liver, but are darkened by iron and pigments in foods and red wine.

Black faeces

If the bowel has a lot of iron-rich material in it, the faeces tend to be dark brown or black. This can happen if you are taking iron tablets, or have eaten a lot of red meat or black pudding. It can also happen if the upper part of your intestine is losing blood -this blood is digested further down the intestines in the same way as food. Such bleeding can be due to an ulcer, irritation of the stomach from taking drugs like aspirin and ibuprofen, or tumours. If a lot of blood is being lost into the intestines, the faeces become black and sticky, like tar. These symptoms should be reported to your doctor urgently so that you can be treated before the blood loss becomes too severe. The reason for the bleeding can also be investigated.

Red blood on the faeces

A common cause of seeing red blood streaked over the faeces after opening your bowels is piles (see Piles). These are swellings round the anus that contain blood, and are common in women who have had a baby or in people who tend to be constipated. They can be painful or itchy. The skin over the surface of the piles is thin, so they bleed quite easily, although this is rarely more than a drop or two. Occasionally, blood on faeces can indicate bleeding in the bottom part of the bowel, which may be due to a tumour. If you have this type of bleeding, it is wise to see your doctor, particularly if you are over 50. Piles can be treated. They can be injected with a chemical to make the blood inside them clot or removed surgically. However, they do tend to come back. The best way to combat this problem is to eat a high-fibre diet, ideally with five portions of fresh fruit and vegetables a day, to keep the faeces soft.

Smelly Faeces

Normally, when we eat, food is digested by enzymes in the intestines. There are different enzymes for different types of food, and those that digest fatty foods are helped by bile made by the liver. Sometimes the bile or enzymes are not made or can't get into the intestines because of a blockage. This means fat in the intestine can't be digested, and so it passes through the bowel where bacteria feed on it. The high levels of fat and the waste products from the bacteria will make the faeces smelly, pale and frothy, and difficult to flush away easily.

Why does this happen? It can be due to a number of reasons. Coeliac disease, a condition in which you cannot tolerate protein found in wheat, can affect the intestines so they can't absorb fat in the diet. In gall bladder disease, bile, which is normally stored in the gall bladder, can't get into the intestine to help absorb fat. If your pancreas, which makes enzymes and insulin, isn't working properly, fat won't be digested. This can happen if you have chronic pancreatitis or a tumour in the pancreas. If you develop any of these symptoms, visit your doctor to see what is causing the problem. You may need to reduce the amount of fat in your diet or take tablets to replace the missing enzymes.

Pale Faeces

Pale faeces following an attack of diarrhoea soon return to normal. They can also occur in jaundice - because bile can't get into the intestines, the yellow colour builds up in the blood instead. Gall stones are often the culprit and are often associated with bad abdominal pains. However, the tube that feeds bile into the intestines may be blocked - this is not usually painful - or the liver may be inflamed (hepatitis). If your faeces become pale and your skin or the whites of your eyes turn yellow, consult your doctor.

Vomiting

It's easy to spot the symptoms of nausea: you experience that queasy sensation, or feel as if you might be sick. Sometimes it can often lead to you physically being sick or vomiting. It's certainly not a pleasant experience, but we've all been through it at some point.

Nausea and vomiting can be caused by a multitude of triggers that are explained below. You might think that vomiting is caused by what's happening in your stomach, but you'll be surprised to learn that it's actually your brain that controls whether you will actually be sick or not! What triggers vomiting will depend on where the brain is getting its information:

- the inner ear (eg: motion sickness, dizziness)
- another part of the brain (eg: head injury, migraine)
- digestive system(eg: stomach bug, stomach not processing food as it should, and even overindulging!)
- bloodstream (eg. too much alcohol)

Diarrhoea

Diarrhoea is the passing of increased amounts (more than 300g in 24 hours) of loose stools.

It is often caused by a virus and bacteria and can be acute (short term) or chronic (long term) - lasting more than two to three weeks.

Most people are affected by diarrhoea at some time in their lives. It is often accompanied by stomach pains, feeling sick and vomiting. It is usually due to consumption of drinking water contaminated with bacteria, undercooked meat and eggs or inadequate kitchen hygiene - in other words, an infection.

What causes diarrhoea?

- Diarrhoea is mainly caused by bacterial and viral infections and food poisoning.

Diarrhoea can also be caused by bacteria or viruses that have been transmitted from person to person. For this reason, it is important to wash your hands with soap and water after using the toilet.

Diarrhoea normally only lasts for a few days, but it can be very stressful when it occurs.

Food poisoning

Certain bacteria (usually staphylococci) irritate the digestive tract by producing toxins. These toxins affect the mucous membrane much sooner, a few hours after consumption, compared with bacterial infection. For this reason, people with inflammation or sores on their hands should not prepare food for others.

Other causes

When taking antibiotics, many people suffer diarrhoea, which may continue after the antibiotic course has finished. The diarrhoea occurs because the antibiotic alters the intestinal bacterial environment. It is not an allergic reaction. In rare cases it requires medical treatment.

Chronic diarrhoea

Chronic diarrhoea can be a symptom of many disorders:

- irritable bowel syndrome
- acute, recurrent or chronic intestinal infections
- chronic intestinal inflammation (ulcerative colitis and Crohn's disease)
- chronic pancreatitis, which produces fatty stools
- laxatives
- lactose intolerance
- improper diet (consumption of too much alcohol, coffee or sweets)
- metabolic disorders such as diabetes and thyrotoxicosis
- intolerance to gluten (wheat protein).

What are the symptoms of diarrhoea?

- Frequent, watery motions.
- Loss of appetite.
- Nausea, vomiting.
- Stomach pains.
- Fever.
- Dehydration.

If the diarrhoea lasts more than three weeks, it is considered chronic.

SEEKING ADVICE AND GUIDANCE

In all situations, where the situation is beyond the carers knowledge, ability and skills, the carer must seek advice and guidance from an individual who has the knowledge, ability and skills

EDUCATION OF INDIVIDUALS AND THEIR SIGNIFICANT OTHERS

Example - Diabetes

Living with type 2 diabetes

If you've been diagnosed with type 2 diabetes, you'll already know that certain aspects of your lifestyle may need to change.

Life with type 2 diabetes can be active, healthy and full, but only if you manage the condition effectively. Having diabetes means that in order to stay well, you have to pay special attention to certain areas.

When you were diagnosed, you should have been assigned a diabetes care team who explained the most important aspects of managing your condition. These are:

- Maintain a healthy weight.
- Eat a healthy and balanced diet.
- Exercise for 30 minutes a day, five times a week.
- Learn about your prescribed medication and take the recommended dose.
- If you smoke, stop.
- Check your feet every day for signs of damage.
- Keep appointments with your diabetes care team.
- Make sure you know who to contact for help or advice, and contact them if you need to.

In addition, you may also have learned to monitor your blood glucose (sugar) level regularly, to understand how it's affected by food and exercise. You may have been prescribed diabetes medication or insulin to inject if you need this to keep your blood glucose level stable.

But learning to manage your diabetes takes time, patience and effort. You may also be coping with difficult emotions after diagnosis, such as anger, confusion or depression.

That's why it's recommended that all people with type 2 diabetes attend a programme of structured education. You'll learn more about the condition, the effect it has on your body and your mind, and how to manage this.

The DESMOND programme

Your GP or diabetes care team can refer you to a programme of structured education. There are several. Look out for your local one.

One such programme is DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed), which specialises in helping people with type 2 diabetes to become effective self-managers of the condition (see External links).

The DESMOND course is a six-hour programme, usually lasting one or two days. Up to 10 people with type 2 diabetes meet with two trained DESMOND healthcare professionals.

"People come to DESMOND with a lot of misconceptions about diabetes," says Marian Carey, national director of the programme. "Some think they'll never be able to eat a piece of cake again. Others don't appreciate the seriousness of the condition. They wrongly think that type 2 diabetes is a 'mild form' of the condition.

"We discuss the serious health problems that can result from poorly managed diabetes. And we give people the skills they need to avoid this."

DESMOND focuses on helping you change your lifestyle in order to manage your diabetes. This means having a good understanding of how diet and exercise affect your body.

"We talk about the amount of glucose in different foods, and explain portion sizes and food labels," says Carey. "We don't impose a diet on people. We try to inform them so that they can make their own choices."

At DESMOND courses you also meet other people with type 2 diabetes. It gives you the chance to talk about the feelings you might have about your diagnosis, such as anger and depression.

"DESMOND helps people see how they can manage their condition in a way that fits with the life they want to lead," says Carey. "Our randomised trials show improvement in people stopping smoking, losing weight and keeping it off, and in feelings of depression."

Talk to your diabetes care team or GP about DESMOND and other courses of structured education.

2.3 Understand the role, responsibilities and boundaries of the worker in relation to food handling and serving:

PERSONAL HYGIENE

Personal hygiene - food handlers

One of the most common causes of food poisoning is poor hygiene on the part of food handlers.

All food handlers should:

- Regularly wash their hands with hot water and antibacterial soap, especially after going to the toilet, in between handling raw and cooked food, after breaks for eating, drinking or smoking as well as after coughing, sneezing or blowing the nose, after touching hair, handling waste food or refuse and after using cleaning chemicals
- Clean cuts, burns and sores and cover with an appropriate waterproof dressing
- Keep fingernails clean and short. Nail varnish should not be worn
- Wear clean protective clothing and a head covering. Outdoor clothing must not be brought into food rooms
- Remove jewellery, hair grips and watches
- Not wear strong-smelling perfume
- Not smoke in food rooms or whilst handling open food
- Report any illness/disease which may be transmitted through food

FOOD HYGIENE

Follow our guide to food hygiene to avoid food poisoning.

Millions of people in the UK suffer from food poisoning every year. But many cases of food poisoning could be prevented by following a few simple food hygiene tips.

Preparing food

Bacteria spreading from one food to another is a major cause of food poisoning. This can happen when raw food touches or drips onto ready-to-eat food, or when chopping boards, utensils and people's hands have touched raw food. To prevent bacteria from spreading, remember to do the following:

- always wash your hands before preparing food and after touching raw food, especially raw meat
- prepare raw and ready-to-eat food separately
- if you have used a knife or chopping board with raw meat, do not use them with ready-to-eat food (such as fruit, salad and cooked food) unless you have cleaned them thoroughly first
- keep cloths, tea towels and hand towels clean and change them frequently

Cooking food

Cooking food properly kills harmful bacteria. It's important to do the following:

- thaw meat and poultry fully before cooking
- always check that food is piping hot all the way through before you eat it, even if you have followed a recipe or cooking instructions on packaging
- don't reheat food more than once and always check that it is piping hot all the way through before you eat it

Chilling food

Some foods need to be kept chilled to keep them safe, for example food with a 'use by' date, food that you have cooked and will not serve immediately, or other ready-to-eat food such as prepared salads.

Always remember to:

- put food that needs to be chilled in the fridge straight away
- cool cooked food as quickly as possible and then put it in the fridge
- store raw meat and poultry in a sealed container at the bottom of the fridge to stop it touching or dripping onto ready-to-eat food
- don't overload the fridge. This can stop cold air from circulating, which could allow foods to get too warm

Take extra care

If you are preparing food for elderly people, babies, toddlers, pregnant women or someone who is ill, avoid giving them eggs with runny yolks, or foods that contain eggs that won't be cooked, for example homemade mayonnaise and some types of ice cream, icing or mousse. This is because eggs can contain harmful bacteria. When preparing eggs for these people, cook them until the white and yolk are solid.

PROMOTING INDEPENDENCE

Promoting independence can be categorised as:

- **Fair -** equally available to all regardless of circumstances – and making best use of resources
- **Personalised -** personalised to the needs and wants of each individual, especially the most vulnerable; providing access to the health services most suited to every individual at the time and place of their choice; and with clinicians and individuals working closely together in partnership to improve health as well as treat illness.
- **Effective -** focused on delivering outcomes for patients that are among the best in the world – saving more lives and improving the quality of life
- **Safe -** as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive
- **Locally accountable** – empowering staff locally to lead change and innovate, ensuring that change is based on the best clinical evidence and meets local needs; and where patients and the public are consulted to ensure they shape and champion their own local services

Each client should be enabled to be as independent as possible within the constraints of their ability and needs and the organisations ability to ensure its viability

ASSISTED FEEDING

Eating skills tend to be taken for granted from childhood. By the time we reach adulthood we have forgotten what a complex set of skills they were to learn. They are psychomotor and social skills that are vital to our survival as an individual and in society. It is important therefore to distinguish between changes that may need to be made to adapt to normal ageing while maintaining healthy nutrition, and the development of pathological changes.
Little seems to have been written about the effect of natural ageing processes on eating skills but there has been an increasing interest in eating problems in diseases such as dementia (Watson and Deary, 1997), and stroke (Carr and Mitchell, 1991; McLaren, 1996; 1997). There is also a considerable amount of occupational therapy literature which may be of help.

DEFINITIONS OF EATING AND FEEDING

The 'Eating-feeding continuum' (Eberhardie, 2000), consists of four major stages: independent eating, assisted eating, assisted feeding and dependent feeding. In the literature 'independent eating' and 'self-feeding' are terms that are loosely defined and often used indiscriminately to include truly independent eating and assisted independent eating. A patient can remain independent and self-feed even if he or she cannot cook, shop or clear away. A good example of this would be the individual who needs a Meals-on- Wheels service.
Independent eating skills can be defined as a series of independent activities which include:

- The desire for food and fluid
- The ability to recognise food
- The motivation to seek out, select and bring home food
- The ability to prepare food and drinks by cutting, chopping, mixing, cooking and serving a meal or snack

- The ability to move food from a serving receptacle such as a plate, fork, spoon or cup to the mouth
- The ability to maintain body posture
- The ability to open the mouth, close the lips, bite, chew and form a bolus
- The ability to swallow safely
- The ability to clear away the waste and maintain hygiene by washing up.

Assisted eating is the maintenance of independent eating by modifying any of the elements identified above if they are weak or absent, for example by taking a person to the shops by car so that they do not have to carry heavy bags, cutting up the food, providing eating aids or modifying the texture of the diet to assist swallowing.

It is in this stage that much can be done to promote independence, quality of life and a healthy individual.

The biology of eating

In order to assess eating, the skill needs to be broken down into its component parts to identify the physical and mental processes involved. How do we recognise food? How do we choose what to eat and when? What are the psychomotor skills involved in shopping? What drives us to eat? How do we prepare food? How do we know that it is safe? How do we transfer food from plate to mouth? How do we prepare food for swallowing?
A brief answer to these questions is given in Table 2, which shows the gross anatomical structures that are involved as well as the major physiological processes required to eat independently. It also shows how, at each stage, the natural ageing process can affect the healthy individual's desire and ability to eat.

In assessing patients and planning good nutritional support, it is essential to understand the detail of the process in order to identify any problems at an early stage. Early assistance can include advice on how to maintain a nutritious diet by adapting lifestyle, or on equipment to assist independent eating. For example, an older person or carer could prepare and freeze meals for microwaving in order to have a nutritious diet within a limited budget. In this way nurses can play a significant part in the prevention of malnutrition and its consequences, which are depression, tissue breakdown, poor healing and increased risk of infection.

Prevention of malnutrition will help to protect the older person if he or she develops one or several of the many diseases or disorders associated with old age such as dementia, cardiovascular disorders, arthritis or continence difficulties (Van Nes et al, 2001). Good nutrition promotes a sense of well-being, diminishes the risk of infection and mental disorder and plays a role in the prevention of specific disorders such as osteoporosis, cancer, diabetes mellitus and cardiovascular disease.

Assessment

Eating aids

There is a tendency to be sparing in the number of eating aids readily available for use by patients. This results in three possible outcomes. The individual may alter the diet and exclude some foods, lose some independence and have to be fed by a nurse or carer or may refuse to eat.

Many hospitals accept that, in the past, eating aids such as padded spoons or plate guards have been locked up in cupboards or their use subjected to unnecessary bureaucracy. Allowing patients to use such eating aids, which can help maintain their independence, can only improve the situation.
There is ample evidence that the patient who refuses to eat or has an inadequate diet is at risk of malnutrition with all its costly sequelae (King's Fund, 1992; Edington et al, 1996). The provision of common eating aids is likely to be a less expensive option than paying the salaries of nurses to feed a patient or the treatment of the consequences of poor nutrition such as pressure ulcers and repeated or multiple infections.

Useful eating aids should include padded cutlery, two-handled beakers, uni-valvular straws, rubber placemats, eggcups with a suction base, plate guards and tilting teapots. The Disabled Living Foundation website contains a number of factsheets on this area (www.dlf.org.uk/factsheets). Other useful pieces of equipment, including shopping trolleys and high-back chairs with head supports, are available.

Radical change: a call to senior CARERS

There needs to be a radical change in the way nutritional status in older people is assessed. It has taken a long time to reach a minimum standard of routine nutritional screening but still patients in primary, secondary and tertiary settings are malnourished. It is totally unacceptable that, in a land of plenty, patients should be starving due to a lack of proper assessment and the waste of scarce resources.
Senior nurses in clinical, educational and managerial roles need to be more active in promoting health by making sure that patients have appropriate and quality nutrition. They can achieve this by ensuring that the assessment is holistic and the solutions to clinical and social problems are addressed.
Thorough assessment and clinical management is more cost efficient than employing unqualified staff to feed patients or dealing with the consequences of malnutrition. It costs more to treat a pressure ulcer than to prevent it. Nurses and support workers are not alone. They need to enlist the support of the community in the form of families, friends and voluntary organisations to promote independent eating skills wherever possible. Healthy older people are a good source of help in solving such problems. A multi-professional approach needs to be adopted.

The cost of medication, hospital stays, waiting times and wound-care products could all be reduced if only senior nurses focused attention on ensuring that patients receive adequate nutrition.

Conclusion

In order to reduce the risk of malnutrition health-care professionals need to consider the whole process of eating in order to assess adequately the patient's nutritional intake and all the factors that may affect it. Helping an individual to maintain independent eating is not only a complex nursing skill but one that can influence the patient's quality of life and reduce the risk of a variety of health problems from constipation and depression to pressure ulcers and vitamin deficiencies.

2.4 Understand the roles, responsibilities and boundaries of personnel in relation to nutrition and well-being:

SOCIAL CARE WORKER

Social care is a rewarding and challenging career. For all sorts of reasons and at all stages in their lives people need help coping with the day-to-day business of living. Social care workers provide this support.

Clients regard the food they are given as one of the most important factors in deter-mining their quality of life. It is important in maintaining their health
and wellbeing. Failure to eat – through physical inability, depression, or
because the food is inadequate or unappetising – can lead to malnutrition wth serious consequences for health.

Care staff should monitor the individual resident's food intake in as discreet and unregimented a way as possible. Care and tact should always be used. The avail-ability, quality and style of presentation of food, along with the way in which staff assist residents at mealtimes, are crucial in ensuring residents receive a wholesome, appealing and nutritious diet.

The social aspects of food – its preparation, presentation and consumption – are likely to have played a significant part in most people's lives, and it is important that homes make every effort to ensure this remains so for individuals once they move into care. While it is recognised that many residents will no longer be able to play an active part in preparing food – even snacks and light refreshment – many still want to retain some capacity to do so. In these situations, restriction on access to main kitchens because of health and safety considerations may present problems. It is important that homes
look at alternative ways of maintaining residents' involvement – for example,
by providing kitchenettes, organising cooking as part of a range of daily activities – and enabling residents to be involved in laying up and clearing the dining rooms if they wish to, before and after mealtimes.

Individuals' food preferences, both personal and cultural/religious, are part of their individual identity and must always be observed. These should be ascertained at the point where an individual is considering moving into the home and the home must make it clear whether or not those preferences can be observed. Homes must not make false claims that they can properly provide kosher, halal, vegetarian and other diets if they cannot observe all the requirements associated with those diets in terms of purchase, storage, preparation and cooking of the food. Staff are ready to offer assistance in eating where necessary, discreetly, sensitively and individually, while independent eating is encouraged for as long as possible

WORKERS NOT INVOLVED IN DIRECT CARE

- ***COOK***

Can influence dietary uptake by cooking meals to nutritional and personal choice requirements, preventing malnutrition and encouraging well-being.

- ***ADMINISTRATOR,***

Manages Budgets, so food budget can influence the types of food bought, should set the budget for food to ensure nutrition and well-being

- ***ANCILLARY WORKER***

May include gardener who grows their own fruit and vegetables, which affects the budget costs and can give organic foods that may add to the clients nutrition and well being, may even allow certain clients to use their skills in the garden

MANAGERS (REGISTERED, SENIOR)

Clients receive a wholesome appealing balanced diet in pleasing surroundings at times convenient to them.

The registered person ensures that clients receive a varied, appealing, wholesome and nutritious diet, which is suited to individual assessed and recorded requirements, and that meals are taken in a congenial setting and at flexible times.

Each client is offered three full meals each day (at least one of which must be cooked) at intervals of not more than five hours.

Hot and cold drinks and snacks are available at all times and offered regularly. A snack meal should be offered in the evening and the interval between this and breakfast the following morning should be no more than 12 hours.

Food, including liquified meals, is presented in a manner which is attractive and appealing in terms of texture, flavour, and appearance, in order to maintain appetite and nutrition.

Special therapeutic diets / feeds are provided when advised by health care and dietetic staff, including adequate provision of calcium and vitamin D.

Religious or cultural dietary needs are catered for as agreed at admission and recorded in the care plan and food for special occasions is available.

The registered person ensures that there is a menu (changed regularly), offering a choice of meals in written or other formats to suit the capacities of all clients, which is given, read or explained to clients.

The registered person ensures that mealtimes are unhurried with clients being given sufficient time to eat.

SPECIALIST personnel

- ***MEDICAL PERSONNEL,***

Can prescribe vitamins etc, or food compounds that supplement the diet such as complan. Peg feeds may also be prescribed

- ***DIETICIAN,***

Can give advice on:

Examples of other areas of diet therapy also covered:

- Nutrition related skin problems eg Urticaria / Eczema
- Cholesterol Lowering
- Diabetes
- Polycystic ovary syndrome (PCOS)
- Vegetarianism - including vegan
- Anaemia
- Weight management over weight / under weight
- Anorexia, bulimia, compulsive eating
- Preconception diets
- Children's diets
- Food allergy / intolerance testing via diet
- Probiotics and gut health / gastrointestinal disease
- Nutrition and cancer
- Nutrition and the brain
- GI diets
- Nutritional support for pre-operation/ post-operation
- Autoimmune diseases e.g. Arthritis

- ***SPEECH AND LANGUAGE THERAPIST,***

Speech and Language Therapy Services

Communication disorders can affect all aspects of everyday life. Speech and Language Therapy Service staff work with anyone who has a communication difficulty or swallowing problem.

Problems could relate to any of the following:

- Stroke
- Dementia
- Neurological intervention
- Progressive neurological disorders such as Parkinson Disease and Multiple Sclerosis

- Traumatic brain injury
- Autism
- Cleft lip/palate
- Developmental speech and language delay or disorder
- Fluency disorders
- Cancer of the head or neck
- Hearing impairment
- Learning disabilities
- Physical disabilities
- Voice Disorders

The Speech and Language Therapy Service can be used as an input withi a multi-Disciplinary Team. Most therapists are employed by the Health Service, but close links are maintained with Local Education Authorities and Social Services Departments.

Aims of the service:

- to meet the changing needs of adults and children who have a communication impairment and/or related eating and swallowing problems.
- to improve people's quality of life,
- to help carers to understand and respond to the clients' needs.

Types of Communication Difficulty

- Speech
  - Failure to appreciate differences between sounds resulting in the wrong use within words
  - Physical inability to make sounds resulting from physical abnormality or after oral or facial surgery.
  - Disturbance of neuromuscular control.
- Language
  - Delay or failure to develop comprehension of language and/or the failure to use it to convey appropriate information
  - Acquired loss of perception, recognition, comprehension and/or expression of language. This may affect spoken and/or written forms.
- Voice
  - When the quality, pitch, volume or flexibility differ significantly from the voices of those of similar age, sex and cultural group.
- Fluency
  - For example, problems caused by blocking sounds or words.
- Eating and Swallowing Disorders
  - Difficulty in preparing food in the mouth to swallow, or in swallowing the food from the mouth into the stomach, due to neurological or structural damage
  - Sucking or chewing.

- ***OCCUPATIONAL THERAPIST,***

The Role of the Occupational Therapist

Occupational Therapy strives to develop the optimum level of independent function for life within the family and community. Parents and carers are encouraged to be partners in the

treatment process. The Occupational Therapist has a special interest in promoting function in the following areas:

- **Fine motor skills** e.g. handwriting, dexterity, eye/hand co-ordination.
- **Perceptual motor and sensory motor skills** - the goal of therapy is to improve the child's ability to organise sensations in order to learn a new skill or activity.
- **Visual perception** - this relates to the ability to make sense of visual information in the environment.
- **Social skills and personal self help**, e.g. dressing, hygiene, eating and drinking.

The Occupational Therapist is also able to advise on specialised equipment / aids related to the above.
The Occupational Therapist works as part of a multi-disciplinary team, with teaching and education also being fundamental to the role. Occupational Therapy is a well-established and recognised health profession Various Therapy techniques and activities are used to help individuals cope with everyday life. The objective is to promote optimum independence at home, work or in school.

Assessment

Occupational Therapists use a range of evaluation procedures. These may include standardised tests, which are used in conjunction with clinical observations. The assessments are used to ascertain underlying difficulties / dysfunction in the following areas.

Motor Co-ordination

This looks at basic motor ability which serves as a foundation for the fine motor skills and learning.

Sensory and Perceptual Motor Function

This looks at the ability to process, organise and interpret different sensory information for motor organisation and academic learning. This would encompass information received through touch, vision, body position, awareness of position of body in space (proprioception), awareness of body
parts, and the ability to interact with the environment.

Visual Perception

This looks at the ability of the individual to make sense of visual information in the environment.

Handwriting

This skill involves motor control, visual motor control and visual perception, i.e. the ability to interpret what the individual sees and express it in a motor way.

Activities of Daily Living

Here we consider independence in basic self care. For example, using a knife and fork, dressing, personal hygiene, toileting, and community skills.

Behaviour and Emotion

Those with motor co-ordination difficulties experience many difficulties in every day life and this can often lead to frustration or distress. The Occupational Therapist strives to reduce these feelings and instil a sense of success and achievement.

INTERVENTION

Treatment

Prior to treatment, the Occupational Therapist analyses and interprets the results of the assessment. A treatment plan is then drawn up with specific aims in order to facilitate and improve functional performance.

Therapy may be given in a variety of ways:

- Individual
- Group
- Home Programme

Activities can also be integrated into classroom and P.E. activities. Throughout the treatment period, the Occupational Therapist documents and evaluates the individual's progress and modifies the treatment plan accordingly.

Approaches used by the Occupational **Therapist**:

The Occupational Therapist may adopt many different treatment approaches in order to meet the individual's specific needs. The most common approaches used are:

- Sensory Integration
- Sensory Motor Approach
- Perceptual Motor Training

Direct Therapy for some individuals is not always appropriate. The therapist may therefore choose to promote skills using of the following approaches

Functional

This approach focuses on facilitating mastery of tasks that are part of various areas of occupational performance, i.e. splinter skills for tasks such as dressing or writing.

Compensatory

This approach focuses on minimising the effects of defects in functional performance, e.g. using colour coding to help organisational skills.

Adaptive

This approach focuses on changing a task or aspects of the environment to minimise deficits in performance, e.g. worksheets to minimise writing.

Management

This aspect focuses on minimising distressing or disruptive feelings and behaviours so that the individual is more able to deal with primary problems, e.g. psychological support, counselling etc.

Intervention by an Occupational Therapist generally encompasses one or more of these approaches.

Each programme is specifically designed to meet individual needs and incorporates biological, psychological and social aspects. Service provision may be through direct therapy monitoring, or consultation.

- ***PHYSIOTHERAPIST***

The Role of The Physiotherapist

The physiotherapist's (PT) role in the management of client's needs is to work in partnership with the client to enable them to achieve and maintain optimal function and independence. For many clients this will involve taking an active role in family, work and social lives.

Physiotherapists will carry out detailed client assessments to:

- identify how a client's condition affects them physically and to what degree an individuals function is affected including mobility, posture etc
- examine the musculoskeletal system to get a baseline of a client's current status
- consider other body systems i.e. neurology, cardiovascular
- an special equipment requirements such as walking aids, modified footwear, splint requirements, food equipment
- the client's current self management and coping strategies
- the need for physiotherapeutic interventions

The PT discusses assessment findings with the client and, in conjunction with them, devises a goal orientated treatment plan. This may include pain management with the use of ice, heat, electrotherapy and hydrotherapy. The client can then progress on to other treatment approaches including: range of movement and muscle strengthening exercises, improving mobility, and posture re-education.

The PT may provide education on their condition for the client and guides them on self-management of their condition long term. This then enables the client to modify their exercise programme according to their disease activity. Education of family and carers is also an important part of the PTs role. Clients' ability to perform functional activities, such as transfers on and off the toilet, and climb stairs, are also assessed.

Liaison with other members of the multidisciplinary team is often an important part of ensuring the best outcome for the client. By setting realistic goals and working together with the client, the PT aims to promote independence and enable the client to reach their optimum potential at home, work and in social activities.

3. DIET AND WELL-BEING

3.1 Understand what constitutes a well balanced diet:

WATER

It's very important to make sure we are drinking enough. Our bodies need water or other fluids to work properly.

Water makes up about two-thirds of our body weight. And it's important for this to be maintained because most of the chemical reactions that happen in our cells need water. We also need water for our blood to be able to carry nutrients around the body.

In climates such as the UK, we should drink approximately 1.2 litres (6 to 8 glasses) of fluid every day to stop us getting dehydrated. In hotter climates the body needs more than this. We also get some fluid from the food we eat.

Drinks that contain caffeine, such as tea, coffee and cola, can act as mild diuretics, which means they make the body produce more urine.

This affects some people more than others, but it also depends on how much caffeine you drink and how often.

It's fine to drink these sorts of drinks, but we should also drink some fluids each day that don't contain caffeine.

CARBOHYDRATES

Starchy foods such as bread, cereals, rice, pasta and potatoes are a really important part of a healthy diet. Try to choose wholegrain varieties whenever you can.

Starchy foods should make up about a third of the food we eat. Most people should be eating more starchy foods. So if you want to eat healthily try to think about the proportions of the different foods you eat in a day.

Starchy foods are a good source of energy and the main source of a range of nutrients in our diet. As well as starch, these foods contain fibre, calcium, iron and B vitamins.

Some people think starchy foods are fattening, but they contain less than half the calories of fat. You just need to watch out for the added fats used for cooking and serving, because this is what increases the calorie content. If you're concerned about your weight, wholegrain varieties are an especially good choice.

Low-carbohydrate diets

'Low-carbohydrate' diets have had a lot of publicity recently. These diets usually involve cutting out most starchy foods.

Cutting out starchy foods, or any food group, can be bad for your health because you could be missing out on a range of nutrients. Low-carbohydrate diets tend to be high in fat, and eating a diet that is high in fat (especially saturated fat from foods such as meat, cheese, butter and cakes) could increase your chances of developing coronary heart disease.

These diets may also restrict the amount of fruit, veg and fibre you eat, all of which are vital for good health.

So, rather than avoiding starchy foods, it's better to try and base your meals on them, so they make up about a third of your diet.

PROTEINS

The body needs protein to grow and repair itself. Most adults in the UK get more than enough protein for their needs. Protein-rich foods include meat, fish, milk and dairy foods, eggs, beans, lentils and nuts.

FATS

Many food labels give figures for the product's fat content. Some food labels also break the figures down into these different types of fat: saturates, monounsaturates and polyunsaturates.

Saturated fat can raise blood cholesterol levels, which increases the chance of developing heart disease.

Monounsaturates and polyunsaturates are both types of unsaturated fat. These don't raise blood cholesterol in the same way as saturated fats and provide us with the essential fatty acids that the body needs.

Most people know that we should be cutting down on fat. But it's even more important to try to replace the saturated fat we eat with unsaturated fat.

MINERALS

What are minerals?

Minerals are essential nutrients that your body needs in small amounts to work properly. We need them in the form they are found in food.

Minerals can be found in varying amounts in a variety of foods such as meat, cereals (including cereal products such as bread), fish, milk and dairy foods, vegetables, fruit (especially dried fruit) and nuts.

Minerals are necessary for three main reasons:

- building strong bones and teeth
- controlling body fluids inside and outside cells
- turning the food we eat into energy

These are all essential minerals:

- calcium
- iron
- magnesium
- phosphorus
- potassium
- sodium
- sulphur

VITAMINS

What are vitamins?

Vitamins are essential nutrients that your body needs in small amounts to work properly. There are two types of vitamins: fat-soluble and water-soluble.

Fat-soluble vitamins

Fat-soluble vitamins are found mainly in fatty foods such as animal fats (including butter and lard), vegetable oils, dairy foods, liver and oily fish.

Your body needs these vitamins every day to work properly. However, you don't need to eat foods containing them every day.

This is because, if your body doesn't need these vitamins immediately, it stores them in your liver and fatty tissues for future use. This means the stores can build up so they are there when you need them. But, if you have much more than you need, fat-soluble vitamins can be harmful.

These are all fat-soluble vitamins:

- vitamin A
- vitamin D
- vitamin E
- vitamin K

Water-soluble vitamins

Water-soluble vitamins are not stored in the body, so you need to have them more frequently.

If you have more than you need, your body gets rid of the extra vitamins when you urinate. Because the body doesn't store water-soluble vitamins, generally these vitamins aren't harmful.

Water-soluble vitamins are found in fruit, vegetables and grains. But unlike fat-soluble vitamins, they can be destroyed by heat or by being exposed to the air. They can also be lost in the water used for cooking.

This means that by cooking food, especially boiling, we lose lots of these vitamins from the food we eat. The best way to keep as much of the water-soluble vitamins as possible is to steam or grill, rather than boil.

These are all water-soluble vitamins:

- vitamin B_6
- vitamin B_{12}
- vitamin C
- biotin
- folic acid
- niacin
- pantothenic acid
- riboflavin
- thiamin

FIBRE

Fibre helps prevent constipation, piles and bowel problems. Good sources of fibre include some breakfast cereals, kidney beans, mixed unsalted nuts, wholemeal bread, baked beans, fruit and vegetables.

N.B. Regular water and fluid intake is vital to ensure people remain well hydrated. It can help stimulate the appetite, assist in nutrients being absorbed by the body, and can help with many conditions including: ulcers, constipation, urinary infection, and incontinence. It is, however, necessary to be aware that with PEG feeding (see key words) there may be a risk of volume overload (www.caredirections.co.uk/frame_comment_50.htm)

3.2 Understand the factors to consider when purchasing food and drink:

FRESH FOOD (AVAILABILITY)

Eating seasonally has dramatic and far-reaching implications. For a start, the food is less likely to have travelled as far to meet demand. Think of apples - in season for a very short time, September and October - yet they appear on our supermarket shelves day in, day out. These apples have been flown over from the USA, South America, New Zealand... By only eating food when it is in season in our own country, we are helping to contribute to a greener environment by saving food miles.

Eating seasonal food also means that we begin to understand our food better, and appreciate the fruits of each season. It is, if you think about it, completely natural to enjoy sweet and fruity tomatoes and strawberries in August; and the more dense and earthy root vegetables such as turnips and squash in January. To eat seasonally is to eat the food we should crave naturally!

It is really tough to get used to eating seasonally, as we have all become used to eating what we want, when we want it, irrespective of seasonality.

Why Eat With the Seasons?

Eating with the seasons doesn't have to be a chore. It's more than a fashionable practice – it makes sense for your body and your budget. If you're not convinced yet, here are some more reasons:

- It saves you money: it stands to reason that British produce, grown nearby and readily available, is cheaper than air-freighted produce from overseas.
- It supports your local economy: buy buying British-grown food you are directly supporting local farmers and distributors, and keeping the money in our country boosts our economy and buying power.
- It's how our ancestors did it: naturally, our bodies demand different foods for different seasons. In winter humans have traditionally built up energy and fat reserves for the colder weather; nature provides root vegetables for nutritional, substantial meals. In summer we need cool food, fast energy and less of the slow-release stuff.
- It's a good way to vary your diet: in the UK, our climate enables us to grow different things at different times of the year. That's a good thing – it means you will be getting different vitamins every month of the year.
- It's better for the environment: because your food has not travelled a long way, and because it's grown using natural resources, rather than heated glass-houses and artificial conditions.
- It means you're eating a wide range of foods: which makes a balanced diet easier to achieve.

What Should You Eat By Season?

Here's what you have to work with – and some child-friendly ideas for using new vegetables each season.

- Spring: Broad beans, radishes, lettuces, asparagus, wet garlic, celery, artichokes, beetroot, purple sprouting broccoli.

  TRY: stir-frying PSB and spring onions, adding cooked noodles and dressing with fresh ginger, coconut milk and soy sauce.

  TRY: foraging for wild garlic in a local woodland: at home, turn it into a spring risotto using vegetable stock, Arborio rice and lots of parmesan.

- Autumn: Tomatoes, courgettes, peppers, pumpkins, squashes, fennel, then leeks, greens, and carrots.

  TRY: roasting discarded chunks of your Halloween pumpkin, and tossing them with double cream and parmesan, before serving over tagliatelle.

  TRY: using leeks instead of onions to make a tomato pasta sauce, or whizzing up a creamy leek and potato soup.

- Winter: Swede, parsnips, celeriac, leeks, cabbage, chestnuts, stored apples and pears.

  TRY: mashing swede or celeriac with your potatoes (use a 50:50 mix), adding butter and milk to appeal to fussy eaters.

TRY: making a wicked toffee apple crumble: soften chunks of apple in brown sugar and butter, then top with oats and nuts and bake in small portions.

- Summer: Runner beans, courgettes, shallots, sweetcorn, spinach, tomatoes, peppers, herbs, aubergine and chard.

  TRY: dicing courgettes, peppers and tomatoes very small, and stewing to make a thick tomato sauce – then mixing with cooked pasta, topping with cheese and grilling for a nice, melty topping.

  TRY: getting the children to help you make 'kebabs' – alternate marinated chicken chunks with halloumi cheese, cherry tomatoes and pieces of coloured pepper, before brushing with flavoured oil and barbecuing.

FROZEN FOODS

Cool benefits of frozen food

- Freezing is a natural process and does not usually require the use of any preservatives.
- Frozen food seals in freshness. Frozen vegetables, for example, are picked and frozen within hours of harvest, therefore locking in the vitamins and minerals, as well as the taste and texture.
- Thanks to freezing technology, people can enjoy all types of food throughout the year, regardless of the season at affordable prices.
- Freezing food could kill or reduce many potentially harmful microbes, which cause food poisoning.
- Frozen food tends to cost less than fresh, can be stored for much longer and offers brilliant flexibility for meal planning, thereby reducing wastage.
- Manufacturers are able to freeze food within minutes, which, compared to home freezing, gives a superior texture, taste and appearance, as well as retaining the nutritional value.
- Frozen food is easy to keep and easy to use, and there is little waste, whereas two thirds of the population ditch anything up to 20 items of fresh and chilled food a month.
- Frozen food gives consumers a quick and convenient way of fitting in a nutritious meal

PROCESSED FOOD (CANNED, READY MEALS)

Food processing dates back to the prehistoric ages when crude processing incorporated slaughtering, fermenting, sun drying, preserving with salt, and various types of (such as roasting, smoking, steaming, and oven baking). Salt-preservation was especially common for foods that constituted warrior and sailors' diets, up until the introduction of canning methods. Evidence for

the existence of these methods exists in the writings of the ancient Greek , Chaldean, and Roman civilisations as well as archaeological evidence from Europe, North and South America and Asia. These tried and tested processing techniques remained essentially the same until the advent of the . Examples of ready-meals also exist from pre industrial revolution times such as the Cornish pasty and the Haggis

How food is canned

Canning is a totally natural process and is also one of the most popular ways of preserving food. During canning, washed and prepared ingredients are
put into a can; the lid is then sealed on and the container is heated to cook the food inside.

Once inside the cooker, it is heated for a short time at a very high temperature – like pressure-cooking at home. Cooking the food in this way locks in the
nutrients, vitamins and minerals and destroys the natural bacteria that cause food to 'go off'.

Almost any type of food can be canned and the process can be relied on to keep the food inside fresh, safe and ready to eat.

It's nutritious

Most canning factories are situated close to where the food is grown. The food is often picked, prepared and canned in a matter of hours. Compare this to
'fresh food', which can be transported many miles and stored in a warehouse or shop for days.

Food begins to lose some nutritional value from the very moment it's harvested. Light, heat, air and water all affect the quality of food. Canning helps to preserve the goodness in food, locking it in and giving little time for valuable nutrients to be destroyed.

Canned food can be just as nutritious as fresh and frozen. A can of carrots, for example, contains more Vitamin C and Iron than either fresh or frozen carrots.

Canned food has already been cooked and is ready to eat straight away, or can be gently heated. Fresh food can be over cooked, which destroys nutrients.

How long can you keep it?

One of the many benefits of canned food is its long shelf life. All unopened canned food will keep for at least two years with many varieties remaining in a perfect condition for up to five years.
In 1992 it became law that all food cans must carry a best before date-mark stating the date by which food should be eaten.

Any opened canned food which is not going to be used straight away, should be transferred to a clean, covered container, preferably airtight and refrigerated. It should then be treated like fresh and eaten within two days. Don't leave food in the can once it has been opened.

Ready Meals

Pre-prepared meals have taken off because they're so convenient. You can pop them in the microwave and they'll be ready in minutes - without the washing up. Also, as more family members eat at different times, there's less food and time wasted preparing separate dishes. It's an easy way to get variety if you're cooking for one. They work out more expensive than food made at home - but many people think that's balanced out by the time they save.

Are they healthy?

"The problem with ready meals is that you're much less in control of what goes into them.

Two similar ready meals, for example, can look virtually the same on the packet but have very different nutritional composition."

That's not to say ready meals are bad for you. Many manufacturers have taken on board the healthy eating message to produce more nutritious ranges. But not all ready meals labeled 'healthy', 'low fat' or 'diet' are actually better for you than ordinary ready meals, so it's a question of making the right choice.

The key principles to watch out for in choosing more healthy ready meals are:

1. Low salt content - because salt may be associated with hypertension
2. Low saturated fat content - because saturated fat is linked to high LDL cholesterol, which can result in circulatory diseases, as well as problems associated with obesity, such as diabetes
3. Low sugar content - for healthy teeth
4. High vitamin and mineral content - for healthy bones, skin, hair and digestion

Choosing from a wide range of healthy foods you can enjoy

Read the label

Taking a close look at the label should give you a good idea, even though the terms used by manufacturers aren't always clear. For example, sugar can be listed as glucose, maltose, dextrose and sucrose. And salt can appear as 'sodium'. The ingredient list is given in decreasing order by weight. Nutritional information, usually shown in a table, gives information about specific ingredients such as carbohydrate, protein, fat and sodium.

A good tip from health watchdogs is to use the '100g' column to compare different brands of similar types of foods and to choose the lower fat, sugar and salt varieties.

The government has issued guidelines to try and regulate claims made on food packaging. 'Low fat', for example, should contain no more than 3g of fat for solids or 100ml for liquids. Don't confuse it with 'reduced fat' or 'light'. Be aware that although a 'sugar-free' dish contains no added sugar, it may contain naturally-occurring sugar or artificial sweeteners. Vague claims like 'all natural' are meaningless from a health point of view.

Getting the balance right

Ready meals are popular with dieters because their calories are listed on the label. Portion sizes also tend to be smaller, without the opportunity to go back for seconds.

Nutritionists stress how important it is to add your own vegetables or salad to a ready-prepared meal. Salad, vegetables, bread, rice or pitta bread take little time to prepare but they can add vital balance - as well as fill you up if you find the portions small. Make sure to use healthy salad dressings and use butter and other fat spreads sparingly.

Don't think your veg has to be fresh to be healthy. "Frozen vegetables are probably going to do you more good than something that's been lying forgotten for a week in the fridge," says the BNF's Sarah Stanner.

Also, don't forget desserts. Fresh fruit, low fat yoghurt or low fat fromage frais are quick and healthy ways to round off a meal.

There's some confusion over whether chilled or frozen ready meals are better for us. Sarah says there's no difference as long as you follow the instructions. Always make sure you follow the heating instructions on ready meals.

Eating Out

It is important to ensure if you are eating out, that these meals are also healthy. Packed lunches account for some of those meals, but takeaways and restaurants are also very popular. Worries about meals out being fattening can lead to people skipping lunch when they're eating out in the evening. The problem with this is that you can end up being so hungry that you don't make sensible menu choices.

While you can't easily compare the calories of each dish on the menu you can follow some simple guidelines to get the best nutritional value from the meal. Stack up the vegetable portions, pick dishes that come without cream and high fat sauces, choose grilled or baked dishes rather than fried ones, don't fill in time between courses by eating bread and butter and try having either a starter or a dessert but not both.

Look out for cafes and restaurants displaying the Heartbeat Award sign in England and Wales, or the Healthy Eating Circle sign in Northern Ireland. This means healthier eating practices are followed and healthier food choices are offered.

Tips for eating out more healthily

Fastfoods

- ask for your baked potato without butter. Low-fat fillings such as baked beans, cottage cheese, tuna and mushrooms are delicious.
- mayonnaise heaps calories onto burgers. Ask for it to be left off if you can. Add zing with plenty of grilled onions, pickled gherkins, or a tomato chutney,barbecue or sweet and sour sauce. Try to choose grilled rather than fried burgers.

- go for sandwiches with low fat fillings, such as chicken, and ask for plenty of mixed salad and wholemeal bread, which is higher in fibre.
- fruit juices or spring water are more refreshing than sweet fizzy drinks and contain more vitamins and minerals.
- fast fried fish can be highly nutritious, but the batter has little nutritional value and is bursting with fat. Remove the batter before you eat the fish and choose a chip-shop that serves chunky chips (or preferably jacketed wedges) as the fat content is generally lower. Don't forget the mushy peas! They're a great source of fibre.

Italian food

Experts talk of the health benefits of a Mediterranean diet, which includes smaller portions of red meat, high consumption of vegetables and herbs, particularly tomatoes, onions and garlic, and the use of olive oil. You can make these benefits part of your ready meal experience too:

- starters like garlic bread pile on the pounds - try a salad instead, but go easy on the sauce
- choose pasta and chicken dishes with a tomato sauce rather than creamy ones like carbonnara)
- pick up a pizza with lots of vegetable toppings to fill you up and ask for less cheese avoid fatty toppings like quattro formaggio (four cheeses), salami, sausage and pepperoni

Chinese food

The benefits of Chinese meals are that they are often steamed or stir-fried, which tends to keep the goodness in the food and limit the added fat. For a more healthy Chinese meal:

- steer clear of anything fried such as pork or prawn balls, which can be mostly batter
- go for plain rice or noodles rather than the fried versions. You'll get lots of fibre and carbohydrates without the fat
- make at least one dish a vegetable dish
- don't eat prawn crackers
- try eating with chopsticks. It will take you longer to eat and you'll feel you've eaten more

Indian food

Indian food is now the UK's favourite cuisine and it can also be highly nutritious if you choose your dishes with a little care:

- beware the breads! Parathas are deep-fried and Keema naans often contain processed meats, which can be fattening
- baked dishes such as plain tikkas (without sauce) and tandooris are better for you than korma, masala and biryani because they're 'dry' cooked, whereas the others can be crammed with cream or oil
- as with Chinese food, tempting side orders like onion bhajees are often deep fried and best avoided
- have plain boiled rice rather than pilau and have a vegetable dish try and avoid too many dishes that are high in added colouring

NUTRITIONAL VALUES

For every physical activity, the body requires energy and the amount depends on the duration and type of activity. Energy is measured in Calories and is obtained from the body stores or the food we eat. Glycogen is the main source of fuel used by the muscles to enable you to undertake both aerobic and anaerobic exercise. If you train with low glycogen stores, you will feel constantly tired, training performance will be lower and you will be more prone to injury and illness.

A calorie (cal) is the amount of heat energy required to raise the temperature of 1g of water 1°C from 14° to 15°C. A kilocalorie (kcal) is the amount of heat required to raise the temperature of 1000g of water 1°C.

Nutrient Balance

Carefully planned nutrition must provide an energy balance and a nutrient balance.

The nutrients are:

- **Proteins** - essential to growth and repair of muscle and other body tissues
- **Fats** - one source of energy and important in relation to fat soluble vitamins
- **Carbohydrates** - our main source of energy
- **Minerals** - those inorganic elements occurring in the body and which are critical to its normal functions
- **Vitamins** - water and fat soluble vitamins play important roles in many chemical processes in the body
- **Water** - essential to normal body function - as a vehicle for carrying other nutrients and because 60% of the human body is water
- **Roughage** - the fibrous indigestible portion of our diet essential to health of the digestive system

What are the daily energy requirements?

Personal energy requirement = basic energy requirements + extra energy requirements

Basic energy requirements (BER) includes your basal metabolic rate (BMR) and general daily activities

- For every Kg of body weight 1.3 Calories is required every hour. (An athlete weighing 50Kg would require 1.3 × 24hrs × 50Kg = 1560 Calories/day)

Extra energy requirements (EER)

- For each hours training you require an additional 8.5 Calories for each Kg of body weight. (For a two hour training session our 50Kg athlete would require 8.5 × 2hrs × 50Kg = 850 Calories)

An athlete weighing 50Kg who trains for two hours would require an intake of approximately 2410 Calories (BER + EER = 1560 + 850)

Energy Fuel

Like fuel for a car, the energy we need has to be blended. The blend that we require is as follows:

- 57% Carbohydrates (sugar, sweets, bread, cakes)
- 30% Fats (dairy products, oil)
- 13% Protein (eggs, milk, meat, poultry, fish)

The energy yield per gram is as follows: Carbohydrate - 4 Calories, Fats - 9 Calories and Protein - 4 Calories.

What does a 50 kg athlete require in terms of carbohydrates, fats and protein?

- Carbohydrates - 57% of 2410 = 1374 Calories - at 4 Calories/gram = 1374 ÷ 4 = 343 grams
- Fats - 30% of 2410 = 723 Calories - at 9 Calories/gram = 723 ÷ 9 = 80 grams
- Protein - 13% of 2410 = 313 Calories - at 4 Calories/gram = 313 ÷ 4 = 78 grams

Our 50kg athlete requires 343 grams of Carbohydrates, 80 grams of Fat and 78 grams of Protein

What types of fat are there?

The nature of the fat depends on the type of fatty acids that make up the triglycerides. All fats contain both saturated and unsaturated fatty acids but are usually described as 'saturated' or 'unsaturated' according to the proportion of fatty acids present. Saturated fats are generally solid at room temperature and tend to be animal fats. Unsaturated fats are liquid at room temperature and are usually vegetable fats - there are exceptions e.g. palm oil, a vegetable oil that contains a high percentage of saturated fatty acids.

Unsaturated	Saturated
Sunflower oil	Beef
Olive Oil	Bacon
Rice Oil	Cheese
Nuts	Butter
Rapeseed Oil	Biscuits
Oily fish - Sardines	Crisps

What types of carbohydrates are there?

There are two types of carbohydrates - **starchy (complex) carbohydrates** and **simple sugars**. The **simple sugar's** are found in confectionery, muesli bars, cakes and biscuits, cereals, puddings, soft drinks and juices and jam and honey but they also contain fat. Starchy carbohydrates are found in potatoes, rice, bread, wholegrain cereals, semi skimmed milk, yoghurt, fruit, vegetables, beans and pulses. Both types effectively replace muscle glycogen. The **starchy carbohydrates** are the ones that have all the vitamins and minerals in them as well as protein. They are also low in fat as long as you do not slap on loads of butter and fatty sauces. The starchy foods are much more bulky so there can be a problem in actually eating that amount of food so supplementing with simple sugar alternatives is necessary.

Your digestive system converts the carbohydrates in food into glucose, a form of sugar carried in the blood and transported to cells for energy. The glucose, in turn, is broken down into carbon dioxide and water. Any glucose not used by the cells is converted into glycogen - another form

of carbohydrate that is stored in the muscles and liver. However, the body's glycogen capacity is limited to about 350 grams; once this maximum has been reached, any excess glucose is quickly converted into fat. Base your main meal with the bulk on your plate filled with carbohydrates and small amounts of protein such as meat, poultry and fish. The extra protein & vitamins you may require will be in the starchy carbohydrates.

Lactose Intolerance

Lactose intolerance results when the mucosal cells of the small intestine fail to produce lactase that is essential for the digestion of lactose. Symptoms include diarrhea, bloating, and abdominal cramps following consumption of milk or dairy products.

Carbohydrates for Performance

To support a training session or competition athletes need to eat at an appropriate time so that all the food has been absorbed and their glycogen stores are fully replenished.

Following training & competition, an athlete's glycogen stores are depleted. In order to replenish them the athlete needs to consider the speed at which carbohydrate is converted into blood glucose and transported to the muscles. The rapid replenishment of glycogen stores is important for the track athlete who has a number of races in a meeting.

Eating 5-6 meals or snacks a day, will help maximise glycogen stores and energy levels, minimise fat storage and stabilise blood glucose and insulin levels.

COST AND VALUE FOR MONEY

Step1

Determine your budget. Instead of complaining about your lack of cash, establish how much money you actually have available to spend on healthy food. Make a budget regularly since other financial obligations in your life may fluctuate. Knowing your baseline will help you form realistic meal expectations.

Step2

Shop around for bargains. Prices vary between store chains as well as the same stores within different neighbourhoods. You may find that is more beneficial to purchase certain varieties or brands of food across several stores to find the best value. Thoroughly search ad circulars to make note of upcoming sales. Take advantage of store initiated savings including double coupon days or early-bird specials. Search online to find added deals and coupons. Find deals on produce, meat and bread nearing its expiration date.

Step3

Plan your meals. Spontaneous expenditures can expand your waistline as well as your budget. Map out what meals and snacks you will eat to help you save the money you do have. Write down your meal proposals to ensure each food group is accurately represented. Calculate your nutritional needs by assessing your current disease state, age and overall activity level. Consult your doctor or dietitian for individualized recommendations.

Step4

Visit your local farmers' market. Since the products are grown locally, you won't pay costs associated with shipping or out-of-season growing. Choose from a wide variety of meat and produce to add to your diet. Sacrifice a Saturday morning to bring home health foods for minimal cost. Make a list of the products and current pricing for future reference.

Step5

Prepare your meals at home. Although food made at your favourite restaurant may be healthy, you incur extra costs to pay for the convenience of not having to prepare it. Dust off your utensils and grab a cookbook to save money. Invest in healthy cooking aides such as books and instructional videos to beef up your cooking skills. Experiment with fresh ingredients to create your own healthy favourites.

SUPPORTING INDIVIDUALS TO WORK WITHIN BUDGETS

Have you ever attempted to budget and given up in frustration or discouragement? If you can figure out the reason your budgeting attempt failed, you'll be able to institute a rewarding, successful budget and stick to it. Think about it. What really determines whether budgeting works for you?

One of the top reasons, if not THE top reason, so many people fail at budgeting is attitude. If you think of it as a penny-pinching sacrifice instead of a means for achieving your financial goals and dreams, how long are you likely to stick with it? It's like the difference between going on a diet and eating healthily. One is negative and restrictive; the other is positive and allows you to indulge now and then and still achieve your goals.

To increase your chances of success, work on your attitude first. Many people refuse to budget because of budgeting's negative connotation. If you're one of them, try thinking of it as a "spending plan" instead of a "budget." Once you've attempted to budget and failed, the bad feelings associated with any type of failure can keep you from trying again. Don't give up!

Why does budgeting matter? Money is a tool that enables you to reach your goals in life, but until you know where your money goes, you can't make conscious decisions about how to use this tool effectively. A budget shows you exactly where your money goes and provides a spending plan that lets you save for the things that are important to you: a new house, a new car, a comfortable retirement, a college education, travel, or whatever your particular goals and dreams happen to be.

There are several universal budgeting concepts that every successful budget will include, but one of the most important features of a successful budget is customization to your needs. Don't try to force your lifestyle and personal situation into a generic, one-size-fits-all budget. If a simpler approach makes it easier to stay committed, then go for simplicity. If you stick with a realistic, effective budget long enough, the rewards will keep you motivated; in the meantime, do whatever it takes to keep yourself going.

One important aspect of a successful, long-term relationship is working towards common goals, and a budget is a means of achieving them. Couples who can't come to an agreement about

savings towards common goals should sit down and talk calmly and rationally and come to a compromise to resolve this disconnect in their relationship.

It's okay to have individual goals that the other person doesn't share, and to provide for a way for those goals to be met, but it's critical to have basic common financial goals that both people in the relationship agree to and are motivated to work towards. If you can't agree about saving towards those goals, you're going to be at cross-purposes that are going to be a cause of ongoing conflict. A budget centered around conflict and resentment is a budget doomed for failure.

If you still can't figure out why your budget isn't working, consider the psychological factors at work. What does money mean to you? Do you use it for reasons other than its obvious purpose? Do you use it as a self-esteem booster, to make yourself feel worthwhile? Do you enjoy the heady rush of making a new purchase? Do you use it as a sign of power or control in a relationship?

There are a number of good books about the psychological aspects of money that can help you spot these factors and help you work with them.

If you jump into budgeting without a positive attitude about it, chances are high that you'll give up before you've seen the difference a budget or spending plan can make in your life. The secret is to work on your attitude first.

3.3 Understand the importance of appropriate storage of food and drink, including for carriage and delivery, and incorporating stock rotation:

REFRIGERATOR (TEMPERATURE, HYGIENE)

Fridge Temperature Records
Why take temperature readings?

There are a number of reasons why taking temperature readings are important

They show food is being stored at temperatures which limit the growth of bacteria capable of causing food spoilage and/or food poisoning.

They provide a check that refrigerated equipment is working correctly.

The **Food Safety (Temperature Control) Regulations 1995** require that certain foods are kept at or below 8°C. It is recommended that they operate at between 2°C and 5°C. In order for you to know whether you are complying with this requirement checks must be made

The **Food Safety (General Food Hygiene) Regulations 1995** require proprietors of food businesses to identify potential food hazards, decide which of these hazards need to be controlled to ensure food safety and then put into place effective control and monitoring procedures to prevent the hazards causing harm to consumers.

Proper temperature control is the single most important measure in preventing food poisoning and therefore must be strictly controlled.

Why record temperature readings?

It is an offence to sell food which is unfit, substandard or which may cause harm to the person consuming it.

The principal defence available to a person accused of selling such food is one of **due diligence.** This requires them to prove they **"took all reasonable precautions and exercised all due diligence to avoid committing the offence"**. Written records are considered essential when trying to establish a defence in cases where temperature control is an issue.

It clearly demonstrates that measures are in place to control a major food safety hazard even though written records are not necessarily a legal requirement.

What type of thermometer should I use?

You must be able to rely on the readings it gives and therefore accuracy is most important. Digital thermometers are recommended. Not only are they very accurate but different probes can be used which enable hot and cold food as well as airtemperatures to be tested. Alternatively, relatively cheap freezer thermometers can be used

Energy ratings

After central heating, refrigeration appliances are the biggest domestic users of energy, because they're on all the time. New models of fridge are now labelled A++, A+, A, B or C, based on their energy consumption. An A++ rating indicates the most efficient category.

If your last fridge was bought before September 1999, it could be anything up to a G rating, with no limit on how much energy it uses.

FREEZER (TEMPERATURE, STAR-RATED [★] COMPARTMENTS)

There are no defined temperatures for freezers although we would recommend they operate at -18°C or below.

Icebox stars

The star-rating system for iceboxes tells you what they can freeze and for how long.

Ice boxes in fridges

Star rating	Icebox temperature	Food storage
4 stars	-18° C or colder	Freeze fresh food, and store food for up to three to 12 months
3 stars	-18° C	Store pre-frozen food for up to three to 12 months
2 stars	-12° C	Store pre-frozen food for up to a month
1 star	-6° C	Store pre-frozen food for up to a week
No stars	n/a	Suitable only for making ice

DRY CUPBOARD

- Store root vegetables in a dark place away from other fruit and vegetables.
- Check that safety seals are intact when first opening food packaging.
- After opening packets of dried foods (e.g. flour, rice and breakfast cereals) reseal them tightly or transfer the contents to storage jars.

- Remember to label them the name of the food and the date.
- Select storage jars and containers with tight lids and always wash and allow them to dry thoroughly after use.
- Store cooking, eating and drinking utensils in cupboards and drawers and clean and tidy these storage spaces regularly.
- Store pet foods separately from human foods.

LARDER

A place, such as a pantry or cellar, where food is stored, a supply of food.

3.4 Understand the importance of using the most appropriate method of cooking and re-heating food (steaming, roasting, baking, microwaving, frying) according to:

CARE SETTING (COMMUNITY, RESIDENTIAL)/THE NEEDS OF THE INDIVIDUAL

COOKING

Making sure food is hot enough

To test if food has been properly cooked, check that it is 'piping hot' all the way through. This means that it is hot enough for steam to come out.

Cut open the food with a small knife so that you can check that it is piping hot in the middle. Generally, if food is piping hot in the middle, then it will be piping hot all the way through. But if you're cooking a very large dish, you might need to check it in more than one place, because some parts of the dish may be less hot than others.

Some foods change colour when they are cooked. Looking at colour is especially useful for checking meat.

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Checking if meat has been properly cooked

It's very important to make sure poultry, pork, burgers, sausages and kebabs are properly cooked all the way through.

If you are checking a burger, sausage, or a portion of chicken or pork, cut into the middle and check there is no pink meat left. The meat should also be piping hot in the middle.

If you're checking a whole chicken or other bird, pierce the thickest part of the leg (between drumstick and thigh) with a clean knife or skewer until the juices run out. The juices shouldn't have any pink or red in them.

Kidneys, liver and other types of offal should be cooked thoroughly until they are piping hot all the way through.

Rare meat

It's fine to eat steaks and other whole cuts of beef and lamb rare, as long as they have been properly 'sealed'. Steaks are usually sealed in a frying pan over a high heat.

It's important to seal meat to kill any bacteria that might be on the outside. You can tell that a piece of meat has been properly sealed because all the outside will have changed colour.

It's OK to serve beef and lamb joints rare too, as long as the joint is a single piece of meat, not a rolled joint (made from different pieces of meat rolled together).

But pork joints and rolled joints shouldn't be served rare. To check these types of joint are properly cooked, put a skewer into the centre of the joint. The juices shouldn't have any pink or red in them.

Remember, you shouldn't eat these types of meat rare:

* poultry
* pork
* burgers, sausages, chicken nuggets
* rolled joints
* kebabs

This is because these types of meat can have bacteria all the way through them. So if they aren't properly cooked then any bacteria in the meat might not be killed.
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Leftovers

If you have cooked food that you aren't going to eat straight away, cool it as quickly as possible (ideally within one to two hours) and then store it in the fridge. Don't keep leftovers for longer than two days.

When you reheat food, make sure that it's piping hot all the way through. If the food is only warm it might not be safe to eat. Don't reheat food more than once.

About a third of the food we buy ends up being thrown away and most of this could have been eaten. One of the main reasons for throwing food away is because people cook and prepare too much. Using leftovers is a good way to reduce the amount of food you waste and save money.

Aluminium pans

It's best not to use aluminium pans, baking trays and foil, or other cookware made of aluminium, to cook foods that are highly acidic, such as:

* tomatoes/ * rhubarb/ * cabbage/ * many soft fruits

This is because aluminium can affect the taste of these sorts of food.

REHEATING

Microwave ovens can play an important role at mealtime, but special care must be taken when cooking or reheating meat, poultry, fish, and eggs to make sure they are prepared safely. Micro wave ovens can cook unevenly and leave "cold spots," where harmful bacteria can survive. For this reason, it is important to use the following safe microwaving tips to prevent foodborne illness.

- follow the microwave manufacturers instructions
- follow instructions on food packaging
- keep the inside of the microwave oven clean

Microwave Oven Cooking

- Arrange food items evenly in a covered dish and add some liquid if needed. Cover the dish with a lid or plastic wrap; loosen or vent the lid or wrap to let steam escape. The moist heat that is created will help destroy harmful bacteria and ensure uniform cooking. Cooking bags also provide safe, even cooking.
- Do not cook large cuts of meat on high power. Large cuts of meat should be cooked on medium power for longer periods. This allows heat to reach the center without overcooking outer areas.
- Stir or rotate food midway through the microwaving time to eliminate cold spots where harmful bacteria can survive, and for more even cooking.
- When partially cooking food in the microwave oven to finish cooking on the grill or in a conventional oven, it is important to transfer the microwaved food to the other heat source immediately. Never partially cook food and store it for later use.
- Use a food thermometer to verify the food has reached a safe temperature. Place the thermometer in the thickest area of the meat or poultry not near fat or bone and in the innermost part of the thigh of whole poultry. Cooking times may vary because ovens vary in power and efficiency. Check in several places to be sure meat is above 75°C. Fish should flake with a fork. Always allow standing time, which completes the cooking, before checking the internal temperature with a food thermometer.
- Cooking whole, stuffed poultry in a microwave oven is not recommended. The stuffing might not reach the temperature needed to destroy harmful bacteria.

Microwave Defrosting

- Remove food from packaging before defrosting. Do not use foam trays and plastic wraps because they are not heat stable at high temperatures. Melting or warping may cause harmful chemicals to migrate into food.
- Cook meat, poultry, egg, casseroles, and fish immediately after defrosting in the microwave oven because some areas of the frozen food may begin to cook during the defrosting time. Do not keep partially cooked food to use later.

Reheating in the Microwave Oven

- Cover foods with a lid or a microwave-safe plastic wrap to hold in moisture and provide safe, even heating.
- Heat ready-to-eat foods and leftovers until steaming hot.
- After reheating foods in the microwave oven, allow standing time.

Containers

- Only use cookware that is specially manufactured for use in the microwave oven. Glass, ceramic containers, and all plastics should be labeled for microwave oven use.

- Plastic storage containers such as margarine tubs should not be used in microwave ovens. These containers can warp or melt, possibly causing harmful chemicals to migrate into the food.
- Never use aluminum foil or metal plates in the microwave oven.

STEAMING

Definition

Steaming is the cooking of prepared foods by steam (moist heat) under varying degrees of pressure.

M**ethods**

There are two methods of steaming: atmospheric or low pressure and high pressure.

- In *low pressure* steaming food may be cooked by direct or indirect contact with the steam.
    - direct, in a steamer or in a pan of boiling water, e.g. steak and kidney pudding;
    - indirect, between two plates over a pan of boiling water.

- *High pressure* steaming takes place in purpose-built equipment, which does not allow the steam to escape, therefore enabling steam pressure to build up, increasing the temperature and reducing cooking time.

Advantages

- Retention of nutritional value
- Makes some foods lighter and easier to digest
- Low pressure steaming reduces risk of overcooking
- High pressure steaming enables food to be cooked or reheated quickly because steam is forced through the food cooking it rapidly
- Labour-saving and suitable for large-scale cookery
- High speed steamers used for 'batch' cooking enable the frequent cooking of small quantities of vegetables throughout the service. Vegetables are freshly cooked, retaining colour, flavour and nutritive value
- With steamed fish, the natural juices can be retained by serving with the fish or in making an accompanying sauce
- Steaming is economical on fuel as a low heat is needed and a multi-tiered steamer can be used

Disadvantages

- Foods can look unattractive
- It can be a slow method

Examples of foods which you might choose to cook by steaming:

Fish e.g. sole; Meat, e.g. tongue, ham and bacon Vegetables, e.g. almost all vegetables are suitable Sweet puddings, e.g. suet, sponge

ROASTING

Roasting is a way of cooking. Something gets roasted if it is put it over a fire (and let it burn) some. The same effect can also be attained with a grill at a barbecue.

Meat

In different countries people like to roast different things. People usually roast pork, beef, chicken, lamb, and duck. The roasted meat is called roast.

Most meat being roasted has to cook for a long time. In Britain, a piece of roast meat is called a "joint". For health reasons, a piece of pork or chicken is never roasted.

Roasting is a dry heat method of cooking, where prepared food is cooked with the presence of fat, in an oven or a spit.

Reasons for roasting

- It makes food tender, by breaking down and softening protien, starrch, cellulose an fibre
- It makes food more palatable and digestable
- It makes food safer to eat by destroying bacteria which causes food poisoning
- It produces a particular quality in food, colour, flavour and texture
- Potatoes have less fat than chips

BAKING

Baking is the technique of prolonged cooking of food by dry heat acting by conduction, and not by radiation, normally in an oven, but also in hot ashes, or on hot stones. It is primarily used for the preparation of bread, cakes, pastries and pies, tarts, quiches, and cookies. Such items are sometimes referred to as "baked goods," and are sold at a bakery. A person who prepares baked goods as a profession is called a . It is also used for the preparation of baked potatoes; baked apples; baked beans; some pasta dishes, such as lasagne; and various other foods, such as the pretzel.

Many domestic ovens are provided with two heating elements: one for baking, using convection and conduction to heat the food; and one for broiling or grilling, heating mainly by radiation. Meat may be baked, but is more often roasted, a similar process, using higher temperatures and shorter cooking times.

The baking process does not add any fat to the product, and producers of snack products such as potato chips are also beginning to replace the process of with baking in order to reduce the fat content of their products.

The dry heat of baking changes the structures of starches in the food and causes its outer surfaces to brown, giving it an attractive appearance and taste, while partially sealing in the food's moisture. The browning is caused by of sugars and the Maillard reaction. Moisture is never really entirely "sealed in", however; over time, an item being baked will become dry. This is often an advantage, especially in situations where drying is the desired outcome, for example in drying herbs or in roasting certain types of vegetables.

The most common baked item is bread. Variations in the ovens, ingredients and recipes used in the baking of bread result in the wide variety of breads produced around the world.

Some foods are surrounded with moisture during baking by placing a small amount of liquid (such as water or broth) in the bottom of a closed pan, and letting it steam up around the food, a method commonly known as .

Over time breads become hard in a process known as going stale. This is not primarily due to moisture being lost from the baked products, but more a reorganization of the way in which the water and starch are associated over time. This process is similar to recrystallization, and is promoted by storage at cool temperatures, such as those of a domestic refrigerator.

FRYING

Frying is the cooking of food in oil or fat, a technique that originated in ancient Egypt around 2500BC.[1] Chemically, oils and fats are the same, differing only in melting point, but the distinction is only made when needed. In commerce, many fats are called oils by custom, e.g. palm oil and coconut oil, which are solid at room temperature.

Fats can reach much higher temperatures than water at normal atmospheric pressure. Through frying, one can sear or even carbonize the surface of foods while caramelizing sugars. The food is cooked much more quickly and has a characteristic crispness and texture. Depending on the food, the fat will penetrate it to varying degrees, contributing richness, lubricity, and its own flavour.

Frying techniques vary in the amount of fat required, the cooking time, the type of cooking vessel required, and the manipulation of the food. Sautéing, stir frying, pan frying, shallow frying, and deep frying are all standard frying techniques.

Sautéing and stir-frying involve cooking foods in a thin layer of fat on a hot surface, such as a frying pan, griddle, wok, or sauteuse. Stir frying involves frying quickly at very high temperatures, requiring that the food be stirred continuously to prevent it from adhering to the cooking surface and burning.

Shallow frying is a type of pan frying using only enough fat to immerse approximately one-third to one-half of each piece of food; fat used in this technique is typically only used once. Deep-frying, on the other hand, involves totally immersing the food in hot oil, which is normally topped up and used several times before being disposed. Deep-frying is typically a much more involved process, and may require specialized oils for optimal results.

Deep frying is now the basis of a very large and expanding world-wide industry. Fried products have consumer appeal in all age groups, and the process is quick, can easily be made continuous for mass production, and the food emerges sterile and dry, with a relatively long shelf life. The end products can then be easily packaged for storage and distribution. Examples are potato chips, french fries, nuts, doughnuts, instant noodles, etc.

Fried foods for their low nutritional value, especially by deep frying, which imbues the food with fat from the oil, lowering their nutrient density.

LEGISLATION AND GUIDANCE RELATED TO FOOD AND DRINK

4.1 Understand the legislation, regulations and guidance that govern nutrition and food preparation and handling:

THE HEALTH & SAFETY AT WORK ACT (HSWA) 1974

This Act covers all people at work, including those working in Registered Care Homes. The only exception being domestic workers in private employment. The Act extends to the prevention of risks to the health and safety of the general public.

The HSWA includes the following general objectives:

- To secure the health, safety and welfare of all persons at work;
- To protect others from the risks arising from workplace activities;

Some duties are qualified by so far as is reasonably practicable which, at its simplest is striking a reasonable balance between an existing risk and the cost involved with reducing it to an acceptable level.

Employer's duties (HSWA)

There is a general duty under Sections 2 and 3 to ensure the health, safety and welfare of all employees at work.

Specific duties include:

- The provision and maintenance of plant and systems of work that are safe and without risks to health.
- Making arrangements for ensuring safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances.
- The provision of information, instruction, training and supervision to ensure health and safety.
- The maintenance of a safe workplace, with safe access to and egress from it.
- The provision and maintenance of a safe working environment and adequate arrangements for welfare at work.

Employers have a duty to prepare and revise as necessary a Statement of Health and Safety Policy and to consult with safety representatives. They have a duty not to charge employees in respect of anything done or provided to ensure legal compliance.

Duties of employers towards people other than their own employees include the following:

- Non-employees not to be exposed to risks so far as is reasonably practicable;

- Non-employees to be provided with prescribed information which might affect their health and safety.

In a Registered Care Home it should be especially noted that particular care must be exercised because so many aspects of the work involve the Health & Safety, not only of the employees, but also of the residents and the visiting public as well.

Employees' duties (HSWA)

All employees have a duty under Section 7 to look after the health and safety of themselves and others.

THE MANAGEMENT OF HEALTH AND SAFETY AT WORK REGULATIONS 1999.

These Regulations have no civil liability. They impose only criminal liability. A breach of these Regulations may lead to prosecution in the Magistrate's Court or the Crown Court.

Their main purpose is to provide a broad framework within which the remaining Regulations are set by creating General Duties on employers, employees and the self-employed.

Duties on employers:

The core of these Regulations is RISK ASSESSMENT so that is where they start:

- To make a suitable and sufficient assessment of the **risks to his own employees and other persons affected by his activities** in order to identify the measures he needs to take to comply with the requirements and prohibitions imposed on him by or under relevant Health & Safety regulations.

- To **review and revise** risk assessments, and implement changes where necessary.

They then go on,

- To ensure the effective **planning, organisation, control, monitoring and review** of the preventive and protective measures.

- To provide appropriate **health surveillance**.

- To appoint one or more **competent persons** to assist him in complying with the relevant statutory provisions.

- To establish procedures to be followed in the event of **serious or imminent danger**, and nominate **competent persons** to implement these procedures.

- To provide employees with **comprehensible and relevant information** on:
  1. The risks identified by the assessment;
  2. The preventive and protective measures;

3. The emergency procedures;
4. The competent persons to implement the emergency procedures; and
5. The risks associated with shared workplaces, where appropriate.

- Where a workplace is shared:
  1. To **co-operate** with other employers;
  2. To take all reasonable steps to **co-ordinate** safety procedures; and
  3. To **inform** other employees concerned of the risks arising out of or in connection with his own undertaking.

- To provide **comprehensible information** to employers from an **outside undertaking** on the risks arising from his own undertaking and the measures he has taken to comply with the relevant statutory provisions.
- To take into account **health and safety capabilities** of individuals when entrusting tasks to them.
- To ensure **health and safety training of employees:**
  i. At the **recruitment** stage;
  ii. On being exposed to **new or increased risks** due to transfer, change of responsibility, introduction of new work equipment, change respecting existing work equipment, introduction of new technology, introduction of a new system of work or change respecting an existing system;

  iii. **Training** to be repeated periodically, adapted to take account of new or changed risks, and to be undertaken during working hours.

There is a duty on employers to provide **temporary workers** with comprehensible information on:

- Occupational qualifications or skills required for safe working.
- Any health surveillance required under the relevant statutory provisions.
- **Women of child-bearing age** who give notice of pregnancy, must be specifically risk assessed under for any hazards that may affect them or their babies. If necessary working conditions should be altered or, if not reasonable, temporary suspension may be necessary (especially for night work if a doctor's certificate advises)**.**
- Young persons must be separately risk assessed and must be protected against certain special hazards, which may arise owing to lack of experience, awareness of risks or maturity.

It is the employer's duty to consult with **Safety Representatives** specified as follows:
- Concerning the introduction of any measure which may **substantially** affect the health and safety of employees that the representative represents;
- About arrangements for nominating **competent persons**;
- In relation to **information** he is required to provide under the relevant statutory provisions;
- On the planning and organisation of any **health and safety training**;
- With regard to the consequences of the introduction of **new technology**.
- The employer is to provide **facilities and assistance** to enable Safety Representatives to carry

out their functions.

It should be noted that employees are entitled to Safety Representation, irrespective of whether or not the organisation has a recognised trade union.

Duties on employees:

- Using all work items provided by the Company in the correct and safe manner, in accordance with their training.

- Adhering to safe working practices and observe Company Safety Rules.
- Telling the supervisor about any shortcomings in training or instruction when asked to undertake a task, for which they do not consider themselves competent.
- Taking personal care and responsibility for Personal Protective Equipment where it has been issued ensuring that it is correctly worn.
- Immediately stopping working in a situation that might present a serious and imminent danger to themselves or to others.
- Notifying his/her supervisor any shortcomings in the Health & Safety arrangements even when no immediate danger exists.
- Supporting and assisting the development of the Safety Management System.

6 April 2006

Amendment to the management of health and safety at work regulations

The Health and Safety Commission (HSC) has announced an amendment to the Management of Health and Safety at Work Regulations 1999, which comes into force today.

The amendment changes the civil liability provisions in the Regulations so as to exclude the right of third parties to take legal action against employees for contraventions of their duties under these Regulations. This extends to employees the same protection against third party action as that provided for employers.

The amendment neither creates any new duties, nor does it remove any. The practical effect will be to reduce the likelihood of claims against employees by third parties. Therefore, it is expected that there will be no additional burdens on businesses.

FOOD SAFETY ACT 1990

Wide ranging legislation designed to ensure all food produced and offered for sale is safe to eat and is not advertised or presented in a misleading manner. The 1990 Act provides the enforcement authorities, i.e. the Environmental Health Officers of the Local Authority, with powers to order improvements or even closure in appropriate circumstances.

The Food Safety (General Food Hygiene) Regulations 1995

These regulations apply to all food retailers, caterers, processors, manufacturers and distributors. The regulations place two general requirements on the owners of food businesses.

- To ensure that all food handling operations are carried out hygienically and according to 'Rules of Hygiene'
- To systematically identify and control all potential food safety hazards
- There is an obligation on any food handler who may suffer from a disease which could be transmitted through food to report this to the employer, who may be obliged to prevent the person concerned from handling food

The Food Safety (Temperature Regulations) 1995

- These govern the temperature at which food can be kept safely and for how long. There are 2 important temperatures for food safety: 8 degrees centigrade and 63 degrees centigrade.
- Foods which degrade must be held at no more than 8 degrees centigrade and below to minimise micro-biological multiplication, and food heated to 63 degrees centigrade and above which kill off micro-organisms
- An exception to this rule is food on display that can be kept for four hours, low risk food and preserved foods. There may be exceptions where there is scientific evidence

HUMAN RIGHTS ACT 1998

The Human Rights Act 1998 gives legal effect in the UK to the fundamental rights and freedoms contained in the European Convention on Human Rights (ECHR). These rights not only affect matters of life and death like freedom from torture and killing but also affect your rights in everyday life: what you can say and do, your beliefs, your right to a fair trial and many other similar basic entitlements.

The rights are not absolute – governments have the power to limit or control them in times of severe need or emergency. You also have the responsibility to respect the rights of other people – and not exercise yours in a way which is likely to stop them from being able to exercise theirs.

Your human rights are:

- the right to life
- freedom from torture and degraded treatment
- freedom from slavery and forced labour
- the right to liberty
- the right to a fair trial
- the right not to be punished for something that wasn't a crime when you did it
- the right to respect for private and family life
- freedom of thought, conscience and religion
- freedom of expression
- freedom of assembly and association
- the right to marry or form a civil partnership and start a family
- the right not to be discriminated against in respect of these rights and freedoms
- the right to own property
- the right to an education
- the right to participate in free elections

If any of these rights and freedoms are abused you have a right to an effective solution in law, even if the abuse was by someone in authority, for example, a policeman.

CARE STANDARDS ACT 2000

The Care standards Act reforms the regulatory system for care services in England and Wales. It replaces the Registered Homes Act 1984, and associated regulations.

The Care Standards Act sets out a broad range of regulation making powers covering, amongst other matters, the management, staff, premises and conduct of social care and independent healthcare establishments and agencies.

Section 23 gives powers to the Secretary of State to publish statements of national minimum standards which the Commission for Social Care Inspection must take into account when making its decisions.

National Minimum Standards

The National Minimum Standards for registered care services are issued by the Department of Health as part of the implementation of the Care Standards Act 2000. These standards include requirements about the competence of the work force including their suitability, experience and qualifications. Each registered care service has a registered manager who is responsible for service and the many resources including staff that are required.

Registered managers should have a copy of the relevant National Minimum Standards for the service they manage. These are available from the Commission for Social Care Inspection, the website is www.csci.org.uk (see the link on the right).

The requirements of the Care Standards Act 2000 are currently being implemented. The overall intention is to improve the quality of care provided and to ensure that services are what users want.

HEALTH ACT 1999

Health Act 1999 Partnership Arrangements

Under the **Health Act 1999**, money can be pooled between health bodies and health-related local authority services, and resources and management structures can be integrated. The arrangements, which have been in use since April 2000, allow the joining-up of existing services and the development of new, co-ordinated services.

COMMUNITY CARE ACT 1990

The Aim of the NHS Community Care Act 1990 is to help people live safely in the community. Social Services assess the needs of people and arrange for the provision of social care services to meet these needs. Other responsibilities include: procedures for receiving comments and complaints, registration and inspection procedures, the individual's ability to contribute.

MENTAL HEALTH ACT 1983

1. The Mental Health Act 1983 makes provision for the compulsory detention and treatment in hospital of those with mental disorder. The Act is in ten parts:

I Application of the Act (the scope)
II Compulsory admission to hospital and Guardianship
III Patients concerned in criminal proceedings or under sentence
IV Consent to treatment
V Mental Health Review Tribunals
VI Removal and Return of Patients within UK etc
VII Management of property and affairs of patients
VIII Miscellaneous functions of local authorities and the Secretary of State
IX Offences
X Miscellaneous and Supplementary

2. Individuals may be detained under a number of different sections of the Act on the basis of the presence of mental disorder as described in the Act and which requires hospital treatment. Admission to hospital under the civil sections of the Act (Part II) may only be made where there is a formal application by either an Approved Social Worker (ASW) or the nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies.

3. Patients may apply to Mental Health Review Tribunals within each period of detention who consider whether the conditions for continued detention are still present. The Tribunal may order a conditional or absolute discharge. Patients can also apply to the hospital managers to review their case. The patient's own responsible medical officer must also continue to review the appropriateness of detention. Patients may also be received into guardianship under the Act.

4. Patients may contact the Mental Health Act Commission which has responsibility to protect the interests of detained patients. It does this by visiting hospitals and registered mental nursing homes and talking to patients about their care and treatment. It also has the responsibility to investigate complaints and operates the "Second Opinion Appointed Doctor" service for second opinions required under Part IV of the Act. The Commission is required to produce a report on their activities every two years.

5. Part III of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order (on the basis of two medical recommendations) for the detention in hospital of a person convicted of an offence who requires treatment and care. The Court may also make a Guardianship order. A Restriction Order may be imposed at the same time which places restrictions on movement and discharge of a patient detained under section 37; all movement is then subject to the Home Secretary's agreement. This part of the Act also contains powers to transfer prisoners to hospital for treatment of a mental disorder.

6. The Act is supplemented by the Memorandum on Parts I to VII, VIII and X.

7. Section 118 of the 1983 Act places a duty on the Secretary of State to prepare and, from time to time, revise a Code of Practice for the guidance of those concerned with admission of patients under the Mental Health Act and the treatment of patients suffering from mental disorder. The most recent Code was published in March 1999

DATA PROTECTION ACT 1998

The Data Protection Act contains 8 Principles. These state that all data must be:

- Processed fairly and lawfully
- Obtained & used only for specified and lawful purposes
- Adequate, relevant and not excessive
- Accurate, and where necessary, kept up to date
- Kept for no longer than necessary
- Processed in accordance with the individuals rights (as defined)
- Kept secure
- Transferred only to countries that offer adequate data protection

The legislation underpinning these principles is complex and not really suitable for direct devolution to all the staff who may have responsibility for personal data. Nor does it provide a measure of compliance. Hence the need for supporting products and information

DISABILITY DISCRIMINATION ACT 1995 and updates

The Disability Discrimination Act (DDA) 1995 aims to end the discrimination that many disabled people face. This Act has been significantly extended, including by the Disability Discrimination Act 2005. It now gives disabled people rights in the areas of:

- employment
- education
- access to goods, facilities and services, including larger private clubs and transport services
- buying or renting land or property, including making it easier for disabled people to rent property and for tenants to make disability-related adaptations
- functions of public bodies, for example issuing of licences

The Act requires public bodies to promote equality of opportunity for disabled people. It also allows the government to set minimum standards so that disabled people can use public transport easily.

The Department for Work and Pensions (DWP) website offers further information, including details on the changes made by the Disability Discrimination Act 2005.

NATIONAL SERVICE FRAMEWORK FOR OLDER PEOPLE

The National Service Framework for Older People, developed in 2001, is the first ever-comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people. It is a 10 year programme of action linking services to support independence and promote good health, specialised services for key conditions, and culture change so that all older people and their carers are always treated with respect, dignity and fairness.

The National Service Framework contains a number of standards:

Standard One - Rooting out age discrimination

NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Aim - To ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age.

Standard Two - Person-centred care

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Aim - To ensure that older people are treated as individuals and they receive appropriate and timely package of care, which meet their needs as individuals, regardless of health and social services boundaries.

Standard Three - Intermediate Care

Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Aim - To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

Standard Four - General hospital care

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to met their needs.

Aim - To ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

Standard Five - Stroke

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Aim - To reduce the incidence of stroke in the population and ensure that those who have a stroke have prompt access to integrated stroke care services.

Standard Six - Falls

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.

Older people who have fallen receive effective treatment and rehabilitation and with their carers, receive advice on prevention through a specialised falls service.
Aim - To reduce the number of falls, which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

Standard Seven - Mental health in older people

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.

Aim - To promote good mental health in older people and to treat and support those older people with dementia and depression.

Standard Eight - The promotion of health and active life in older age

The health and well being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

Aim - To extend the healthy life expectancy of older people.

RCN GUIDELINES – CLINICAL STUDY 17 'RECIPE FOR CHANGE'

No information available

4.2 Understand the organisation's policies and procedures with regard to nutrition and well-being, food and drink preparation and presentation

FOOD AND DRINK POLICY AND PROCEDURE

HELP CLIENTS TO GET READY FOR EATING AND DRINKING

Clients are encouraged to speak up about their nutritional needs. They have a right to express their wishes and preferences. We will always try to meet the request if deemed reasonable and within budget.

In line with the care plan and the immediate or future requirements of the client, support will be given appropriate to their needs. The support will help the client to be as self-managing as possible, whether this means full management or the provision of utensils to enable self-management.

There is a monthly menu and clients are encouraged in advance to make reasonable requests for alternatives where the food and drink is not to their taste.

We will endeavour to listen to comments, research the issues (i.e. dietician) and respond in an appropriate manner, speak and respond with clarity and in a way that is consistent with the clients comprehension, understanding, abilities and needs.

Whether at client meetings, in agreed meetings, adhoc meetings, in writing, by letter or through intermediaries, we will endeavour to meet the dietary needs of our clients to the best of our ability.

Any appropriate specialised container or implement should be provided if a disability is present. Where there is a need to have special aprons or other protective clothing, then this should be provided. The seating should be appropriate to the clients' needs, and any cushions, trays and body alignment supports in situ. T.V. music and / or radio (especially if they are eating in their own room) should be available for the comfort of the clients if they so wish.

Professional specialists as in:

Dieticians, Occupational Therapists and Speech Therapists may be involved if the client has special needs.

Clients, for hygiene reasons are required to wash their hands prior to a meal, and if they cannot get to a wash hand basin, then a bowl of water, soap and towel is offered to them where they are.

Hygiene and toiletry needs. They can have a serviette, wet wipe or paper towel during the meal.

They are offered means to wash their hands again and / or a clean paper towel following the meal.

The environment for eating must be a clean area with appropriate implements, glasses or cups, serviettes and table cloths where appropriate. There should be an ambience to the room that is conducive to a feel good factor that should encourage clients to eat and drink. There should be no unwarranted odours, and the smell of food should be enticing to the palate. The room, food, ambience and aroma should be such that it creates a happy environment that enables maximum interaction of clients, visitors where appropriate and carers.

HELP CLIENTS TO CONSUME FOOD AND DRINK

Clients are encouraged to speak up about their nutritional needs. They have a right to express their wishes and preferences. We will always try to meet the request if deemed reasonable and within budget.

Clients should be as self-managing as possible, where any deficits are present, a care plan should indicate in agreement with the client, how much input the carer should provide.

All food handlers must adhere to the strict hygiene code of the Food Safety Act, including washing of hands at each appropriate juncture. Hair should be tied back and covered, aprons and / or other protective clothing may be used.

The correct utensils are used for preparing, serving and eating the meals and are washed in an industrial class dishwasher. Crockery and cutlery are appropriate for the client's use. Special and / or adapted utensils may be required.

The food is served to the client in the correct quantity (quantities varying from client to client) and with an attractive presentation. Any special diet should be incorporated, with food being cut into manageable portions, minced or blended where required. Some food may need to be given via a tube, such as a nasal gastric tube or a tube feed into the stomach. They should be able to eat at their own pace. Food in the Home is provided in a nutritious and attractive format and is offered to the client in the appropriate hot or cold format. The client's dietary requirements are taken into account as well as their preferences. This is linked to their plan of care. They may have food allergies and this would need to be known to prevent them eating those foods. Recording of intake and output may be important to prevent physical and / or mental deterioration.

A Fluid Balance chart with accurate intake and output levels, plus a chart stating what food intake has been. It may be important to weigh the client daily, weekly or monthly to maintain knowledge of their physical state, check for dehydration or pressure sores. Any food or fluid balance form or chart must be accurate, complete, legible and current.

During and after a meal, clients can have the use of a serviette, wet wipe or paper towel. They are offered the means to wash their hands again, and can use a wet wipe and / or a clean paper towel following the meal. Where disagreements about dietary needs are discussed, we would seek an agreed solution. Where no resolution is possible, we would ask alternative appropriate professional/s for an opinion and act on their advice.

ENABLE CLIENTS TO CHOOSE FOOD AND DRINK

Clients are encouraged to speak up about their nutritional needs. They have a right to express their wishes and preferences. We will always try to meet the request if deemed reasonable and within budget. Where a request exceeds the budget, arrangements can be made by contract to include a more sophisticated or expensive diet

There is a monthly menu and clients are encouraged in advance to make reasonable requests for alternatives where the food and drink is not to their taste.

Whether at client meetings, in agreed meetings, adhoc meetings, in writing, by letter or through intermediaries, we will endeavour to meet the dietary needs of our clients to the best of our ability.

The Home will endeavour to listen to comments, research the issues and respond in an appropriate manner and speak and respond with clarity and in a way that is consistent with the clients comprehension, understanding, abilities and needs. The clients and carers should where practicable, ask appropriate questions regarding dietary needs.

There may be leaflets or books that give appropriate advice. Where a carer cannot give necessary advice, the appropriate professional should be consulted.
Where the client indicates that they are unhappy about the food and / or drink, appropriate discussions are made in order to find a suitable alternative within the budget. Any dietary requirement outside normal fee standard will be on a separate contract agreed with the client.

Food and drink should be appropriate to the client's choice, needs and preferences, taking into consideration their ethical, religious, moral, physical and psychological needs. Any specific diets must conform to quality, quantity and nutrition requirements of a normal diet, with involvement of their G.P or dietician where appropriate.

Where disagreements about dietary needs are discussed, we would seek an agreed solution. It may be the food choice is inappropriate (e.g. for diabetes).

Where no resolution is possible, we would ask alternative appropriate professional/s for an opinion and act on their advice.

Where continual disagreements are linked with choice of food or drink (e.g. alcohol for a client with Liver Disease), the issue should be referred to the appropriate person or authority. Where there is no solution the client and the Home must take a view of the compatibility of the client to the Home and if required request a move to another Home.

PREPARE AND SERVE FOODAND DRINK TO CLIENTS

Clients are encouraged to speak up about their nutritional needs. They have a right to express their wishes and preferences. We will always try to meet the request if deemed reasonable, within the care plan and within budget. Where a request exceeds the budget, arrangements can be made
by contract to include a more sophisticated or expensive diet
The Home prepares and serves food according to the rules of the Food Safety Act 1990 as amended.
Food in the Home is provided in a nutritious and attractive format and is offered to the client in the
appropriate hot or cold format. The client's dietary requirements are taken into account as well as
their preferences. This is linked to their plan of care. The correct utensils are used for preparing, serving and eating the meals and are washed in an industrial class dishwasher.

The food is served to the client in the correct quantity (quantities varying from client to client) and
with an attractive presentation. Any special diet should be incorporated, with food being cut into manageable portions, minced or blended where required. Some food may need to be given via a tube, such as a nasal gastric tube or a tube feed into the stomach.

All food handlers must adhere to the strict hygiene code of the Food Safety Act, including washing of hands at each appropriate juncture. Hair should be tied back and covered, aprons and / or other protective clothing may be used.

All surfaces are cleaned after the meal, being made ready for the next meal.
All utensils and equipment are put away to store when washed and clean. Products are put back into store.

Stale and left over food is removed from the kitchen and taken and disposed of in the waste disposal facility promptly after the meal.

Recording of intake and output may be important to prevent physical and / or mental deterioration.

A Fluid Balance chart with an accurate intake and output levels, plus a chart stating what food intake has been. It may be important to weigh the client daily, weekly or monthly to maintain knowledge of their physical state, check for dehydration or pressure sores. Any food or fluid balance form or chart must be accurate, complete, legible and current.