Leicestershire Partnership NHS Trust

Community Nutrition and Hydration Policy

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

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Summary and aim

The aim of this policy is to ensure all patients, service users receiving care from community services have their nutrition and hydration needs assessed, met, and monitored.

Target audience

All staff providing support to patients in the community

Training

Nutrition and hydration eLearning

Food hygiene level 1

Key requirements

Nutrition and hydration needs must be assessed, documented and acted upon

A food-first approach should be prioritised and implemented as a first line intervention.

Patients at risk must have a documented care plan and appropriate referrals

Care must be person-centred, respecting cultural and individual needs and preferences

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

Introduction and Purpose

To ensure all patients receiving care from community services have their nutrition and hydration needs assessed, met, and monitored, to:

- Maintain health and wellbeing
- Prevent malnutrition and dehydration
- Support recovery and independence
- Reduce avoidable hospital admissions

Policy Requirements and Objectives

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

It explains how patients who are at nutritional risk can be identified; how nutritional status can be improved and what support there is from members of the multidisciplinary team (MDT).

Reference should be made to the following LPT Policies

- Individual service standard operating procedures
- Enteral Nutrition Policy
- Joint infant feeding policy for LPT and UHL
- Healthy Growth Guidelines Birth to School Leaving Age
- Refeeding Policy
- Blended diet policy
- Food and fluid refusal policy
- LPT Mouthcare Policy.
- Group Nutrition and Hydration Strategy (LPT &NHFT) 2025 – 2028

Improving nutrition and hydration is supported by the documents identified in the reference list for this policy.

Process

1.0 Nutrition and Hydration

1.1 Importance of nutrition and hydration

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

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

Anyone, of any weight and BMI can experience malnutrition and therefore it is essential malnutrition screening is completed accurately and appropriately.

1.2 Under nutrition

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

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

In children:

- A static weight/height
- A reduction in weight/height centiles
- Feeding aversion
- Restrictive eating

1.3 Over nutrition

Excess nutrition (overnutrition) happens when energy or nutrient intake consistently

exceeds the body's demands. It fundamentally disrupts cellular and metabolic function.

Chronic overconsumption can lead to excess weight, systemic inflammation, insulin resistance, and a significantly elevated risk of chronic diseases like type 2 diabetes and cardiovascular disease.

Body Mass Index (BMI) categories are standard worldwide with the following ranges:

- Overweight 25 – 29.9kg/m2 (23-27.4kg/m2 for Asian, Black African, African-Caribbean or Middle Eastern ethnic background BMI *)
- Obese 30kg/m2 and above (27.5kg/m2 and over for Asian, Black African, African-Caribbean or Middle Eastern ethnic background BMI *)

*Individuals from an Asian, Black African, African-Caribbean, or Middle Eastern ethnic background have a higher risk of developing health problems at a lower BMI, therefore there are different cut-off points for certain ethnic descents.

BMI is a simple guide, and it does not account for muscle mass, body composition, or distribution of fat. In addition, patients with oedema, ascites, or amputations will impact the accuracy of the BMI.

For patients in the community with a BMI of over 25 kg/m2 (or 23.5kg/m2 in specific ethnic backgrounds), the role of professionals is to offer behavioural and healthy lifestyle advice to the patients and their support network, where appropriate and to be signposted to Tier 2 weight management services.

1.4 Hydration

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

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

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

Additionally, children are at risk if they:

- Are under 1 year of age, especially infants under 6 months.
- Have vomiting and/or diarrhoea (gastroenteritis).

- Have a high temperature

Warning signs of dehydration can include:

- Urine is a darker yellow/amber colour
- Reduced urine output
- Bad breath
- Decreased amount of urine
- Dry mouth and swollen tongue
- Sluggishness and fatigue
- Sugar cravings
- Reduced tears when crying
- Sunken eyes

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

- Confusion
- Dizziness
- Fainting
- Heart palpitations
- Age-appropriate signs, e.g. infants Sunken fontanelle, reduced nappies

Children should be urgently assessed if they have:

- Persistent vomiting and cannot keep fluids down.
- Signs of moderate or severe dehydration.
- Reduced consciousness or unusual drowsiness.
- Rapid breathing, poor circulation, or signs of shock

2.0 Nutritional risks and screening

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

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

-All outpatients at their first appointment

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

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

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

Texture modified foods and thickened fluids should be prescribed and communicated using the International Dysphagia Diet Standardisation Initiative (IDDSI) Framework.

2.1 Malnutrition Universal Screening Tool (MUST) assessment

Leicestershire Partnership Trust currently use the Malnutrition Universals Screening Tool (MUST) for adults. This is a nationally validated nutritional screening tool and is also used in some care homes in the city and county. IN CHS Community Nursing there is some use of the LNDS assessment that is being replaced by MUST

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

Step 1 of MUST is the BMI score. An objective weight (actual weight) should be obtained (unless deemed clinically inappropriate). LPT staff can obtain accessible scales which are available across the Trust for use for patients who are non-weight bearing, for further details contact dietetic service. If a weight is not obtained, the reason should be clearly documented in the patient's electronic patient record (EPR).

Subjective criteria can be used if a weight cannot be obtained i.e., mid upper arm circumference (MUAC). A MUAC does not calculate an actual BMI, but it can indicate whether BMI is likely to fall within certain ranges. MUAC can also be monitored over time to identify changes that may indicate nutritional deterioration.

Information and guidance on weight/MUAC can be found on the BAPEN website and

presented in appendix 3.

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

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

An attempt should be made to measure body height in all patients. If a height measure is not possible, a height recall or estimated height should be used and documented. Factors affecting accuracy of any height measure obtained, such as curvature of the spine, should be clearly documented. If a height check is not possible, an ulna length measurement is a recognised means of estimating height. Guidance on the method can be found on the BAPEN website and presented in appendix 3.

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

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

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

2.3 MUST score and actions

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

MUST Score	Classification	Action
0	Low risk of malnutrition	**Routine care:** • Check MUST upon referral and then repeat annually. • Review MUST sooner if there is a clinical concern.
1	Medium risk of malnutrition	**Observe:** • Inform GP/MDT with concerns. • Develop a care plan on EPR to support improvement in nutritional status. • Review MUST 2-3 monthly*

		• Repeat sooner if there is a clinical concern, e.g. consider treating if approaching high risk or if rapid clinical deterioration anticipated.
2 or more	High risk of malnutrition	**Treat:** • Inform GP/MDT with concerns. • Develop a care plan. • Repeat MUST monthly*
***Leicestershire Partnership Trust Clinicians will only repeat MUST during scheduled appointments and will not visit exclusively for a MUST review.** **Review frequency reflects community caseload arrangements and should occur at the next planned contact or sooner if clinical concerns arise.** **For individuals in care or nursing homes, the care provider should follow monitoring guidelines in line with the BAPEN MUST score.**		

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

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

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

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

Hydration should be monitored and encouraged for service users to meet their fluid requirements. People in care homes should have a nutrition and hydration plan to monitor this and meet their needs.

A dietetic referral should be considered for a full nutritional assessment via the patients EPR if they have scored as high risk on MUST **and** have implemented first line interventions with no improvement after 1 month.

Staff should continue to follow the first line advice described above unless clinically inappropriate, e.g. if a patient is nil by mouth.

2.4 Children/young person assessments

MUST is not validated for children and young people, nutritional screening tools for children in the community are not used.

Growth should be assessed using RCPCH UK-WHO Growth Charts and managed in accordance with NICE NG75 Faltering Growth and local Healthy Growth Guidelines.

Concerns include:

- Crossing two centile spaces downward
- Weight faltering
- Faltering height growth
- BMI concerns

NICE NG75 Faltering Growth guidance should be followed

3.0 Care planning

The community team will support the care planning/advice offered to the patient and/or who supports them in the community. Community staff will support the development of a care plan for patients with MUST ≥1 which is person centred, this aligns with NICE Quality Standard QS24

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

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

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

Oral care needs should also be considered as part of the care plan. Current best

practice links oral health directly to nutrition, hydration, aspiration pneumonia risk and dysphagia management. (e.g. cause pain or prevent an individual eating chewing foods). Teeth should be brushed correctly twice a day and any issues with poor fitting dentures, sore mouth or gum disease should be actioned.
Refer to LPT Mouthcare Policy.

Nutrition screening outcomes, care plans and review arrangements should be documented and communicated at transfer, discharge and handover.

Children with eating, drinking and swallowing needs will be provided with an Eating and Drinking Plan for use in different settings. Training on eating, drinking and swallowing needs will be provided by Speech and Language Therapy (SLT) to enable parents, carers and/ or staff to understand associated risks and follow the plan appropriately

4.0 Food and fluid provision

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

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

4.1 Nutritional support

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

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

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

Poor nutrition and hydration may be indicators of self-neglect. Where concerns are identified, staff should consider safeguarding procedures and refer in line with the Trust Safeguarding Policy.

Please refer to Healthy Growth Guidelines Birth to School Leaving Age for nutritional support in paediatrics

4.1.1 Oral nutritional supplements (ONS)

LLR Area Prescribing Committee (APC) Managing Malnutrition in Adults in Primary Care is the Leicester, Leicestershire and Rutland Area Prescribing Committee guideline that supports the identification and management of adults at risk of malnutrition in primary care. It is intended for adults who are nutritionally at risk and are not already under the care of a dietitian

If the patient is a care home or nursing home resident, staff should refer to the ONS Replacement in Care Home Pathway

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

Thickening of ONS is not recommended. If the thickening of Nutritional supplements is being considered, discussion should take place with the GP/Pharmacist that may include signposting to specialist dysphagia products that can be prescribed.

4.1.2 Home Enteral Feeding

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

If a patient is already on an enteral feed in hospital and being discharged to their home/care home the patient needs to be referred to HENS by the hospital team. It is recommended one working week is given to ensure time for the HENS team to provide training for the family or carers regarding management of enteral feeds and to allow time for them to practice and gain confidence prior to discharge. HENS contact details are hens.team@nhs.net or 01162227161. Please see LPT's Enteral feeding Policy for further information on enteral feeding.

5.0 Referral process and support from the Nutrition and Dietetics department

Referrals for patients to be seen as outpatients or in their own homes can be made

using the PRISM form on the EPR. This form can only be completed by a registered healthcare professional and should be completed and sent as a task to Leicestershire Nutrition Dietetics Service (LNDS). Referrals should be marked as urgent if there are significant concerns and include a clearly stated reason.

Where the referral criteria have been met, nursing/care homes can refer directly to the service via their specific referral form which is outlined in the Oral Nutritional Supplement Care Home Pathway.

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

All referrals must include a weight/MUAC, height, BMI and MUST score within the last 4 weeks. In addition, confirmation of the implementation of the LLR APC Malnutrition Guidance is required that can be found on the LLR APC Blood and Nutrition Guidelines page or through the Leicestershire Medicines Formulary.

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

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

5.1 Dietetic Assessment

All referrals to primary care dietetics are triaged. If accepted, appointments will be offered within the 18 weeks Key Performance Indicator (KPI) however if clinically indicated, urgent referrals may be offered earlier appointments. If referrals are not accepted, this will be communicated with the refer with a justification for the decision and where possible signposting to relevant useful information or services.

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

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

nutritional status.

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

Nutritional assessment will include an assessment of the following factors:

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

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

Patients' will be offered ongoing involvement and review of their nutritional care plan and ongoing review of nutritional status unless clinically inappropriate. Actions will be clearly documented in the patients' clinical record. The aim/goal will be agreed with the patient and with the carer and family if informed consent has been obtained. If a patient is suspected to lack capacity, a mental capacity assessment will be completed as per the Mental Capacity Act 2005 and associated Code of Practice should be followed will be adhered to.

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

6.0 Specialist/specific services

6.1 Babies, Children and Young People

Please refer to Joint infant feeding policy for LPT and UHL
Please refer to Healthy Growth Guidelines Birth to School Leaving Age

6.1.1 Children with a neurodisability and or neurodiversity:

Physiotherapy and Occupational Therapy assessments and reviews should include

verbal basic background screening for (changes in/to) ability to eat and drink, eating or drinking habits and diet, weight gain or loss and current presentation plus screening for concerns of the digestive system and its functioning.

Assessments should include observations of current status and/or changes to growth, bodyweight gains or loss.

Presentations or changes that give rise to concerns should be raised in supervision and/or referrals to the appropriate professional need to be completed - this would include safeguarding considerations and procedures to be followed if required.

6.2 CAMHS Community

Community CAMHS should assess nutrition and hydration as part of comprehensive mental health assessment and ongoing review.

Consideration should be given to:

- Restrictive eating behaviours.
- Sensory-related food avoidance.
- Weight loss or faltering growth.
- Body image concerns.
- Neurodevelopmental conditions that may impact nutrition.
- Emerging eating disorders.

Concerns should be discussed with parents/carers where appropriate and referrals made via local eating disorder, paediatric or dietetic pathways in line with clinical need.

6.3 Eating Disorders

The Adult Disorder Service supports patients with anorexia, bulimia, binge eating disorder and Other Specified Feeding or Eating Disorder (OSFED). Referrals to the service will be prioritised based on risk presentation of the patient.

At the point of assessment, a comprehensive history taking is completed with an experienced clinician and the patient, this includes dietary intake and nutrition. Some patients also require full physical health assessment as well; a full Medical Emergencies in Eating Disorders (MEED) risk assessment is completed for any patients who are under BMI 15.

Specific Nutritional Screening Tools such as MUST are not used in the service as patients who present are already identified as at risk of malnutrition or obesity.

A Specialist eating disorder dietician is employed within the eating disorder team, internal referrals from therapists and assessors to the dietician can take place as required and a further dietetic assessment and intervention can take place when clinically indicated

6.4 Adult learning disability

Patients with a learning disability requiring dietetic support should be referred to the dietetics team as outlined in 5.0.

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

Referrals will be triaged and assigned to the appropriate profession(s), and nutrition and hydration concerns will be considered as part of the intervention. Refer to the Learning Disability Pathway for further information on the service offer.

6.5 Community mental health services

Community Mental Health Services should assess nutrition and hydration as part of a holistic biopsychosocial assessment. Consideration should be given to individuals experiencing severe mental illness, depression, psychosis, dementia, self-neglect, substance misuse, eating difficulties, cognitive impairment or social isolation.
Mental health services should ensure that nutritional status is considered alongside physical health monitoring requirements, including weight, BMI and metabolic health assessments for patients prescribed antipsychotic medication

Staff should be alert to:

- Significant unintended weight loss or gain.
- Reduced appetite or fluid intake.
- Self-neglect affecting food access, preparation or intake.
- Medication-related metabolic effects, including weight gain associated with antipsychotic medication and side effects of prescribed medication.
- Physical health conditions impacting nutritional status.
- Risks associated with dehydration, particularly in older adults and those with cognitive impairment.

MUST screening should be undertaken whenever there is concern regarding nutritional intake, weight loss or malnutrition risk.

Identified concerns should be documented within care plans and escalated through appropriate medical, dietetic, or safeguarding pathways

6.6 Speech and Language Therapy (SLT)

6.6.1 Adults

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

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

All referrals will be acted upon within 4 weeks. However, referrals will be screened when received by the SLT department and an urgency level will be assigned. Patients at high risk of choking/aspiration will be seen within 2 weeks (priority). Where there is a significantly high risk of choking/aspiration, the SLT service will aim to see patients more urgently (within 5 working days), however there is not a funded 'rapid response' time within the service.

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

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

6.6.2 Children

If there is a concern about an infant, child or young person's feeding /eating, drinking and swallowing, a SLT referral should be made in line with Children's SLT referral guidelines.

The referral will be screened and offered a first telephone appointment for case history taking. This will be followed by an episode of care for clinical assessment and intervention, according to level of clinical need.

A written report and / or Eating and Drinking Plan will be provided.

Liaison with Multi-Disciplinary Team (MDT) including Dietitian, Physiotherapist, OT, healthy together practitioner and members of the medical team etc will take place as

indicated in order to meet the child's needs.

7.0 Equality, diversity and inclusion

Community staff should ensure that nutrition and hydration support is inclusive, accessible, culturally sensitive, and person-centred. By recognising and responding to individual differences and reducing barriers to good nutrition and hydration, staff can help improve health outcomes and reduce inequalities within the community.

Roles and Responsibilities

Roles and responsibilities including duties of relevant individuals and groups.

Lead Executive Director

- The Lead Executive Director is the Group Chief Nurse/Executive Director of Nursing, AHPs and Quality
- To communicate, disseminate, and ensure Directorates implement the policy and provide assurance through the Trust's Quality Governance Framework into the Trust Board

Policy Authors

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

Directors, heads of Service, heads of Nursing, Lead APHs

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

Operational & clinical leads

- Deputy heads of nursing, managers, team leader, matrons are responsible for supporting the implementation of this policy at community level.
- Ensure staff training and compliance
- Monitor audit outcomes

Clinical Staff

- Arrange the monitoring of dietary/fluid intake
- Escalate concerns appropriately
- Implement care plans

Registered Nurses / AHPs

- Undertake screening (MUST)
- Develop and review care plans
- Refer to dietetics/SALT as needed

Dietitians

- Provide expert nutritional assessment and treatment
- Lead on complex cases

Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered.

If the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed, recorded and best interests process is initiated where appropriate.

Staff should ensure patients are involved in decisions regarding nutritional care and support wherever possible. Where nutritional interventions are declined, discussions, risks, capacity assessments and agreed management plans should be documented clearly within the clinical record.

Consideration should be given to patients whose mental illness, cognitive impairment or self-neglect may impact their ability to make informed decisions regarding nutrition and hydration.

Appendix One: Definitions

Body Mass Index (BMI)	Measurement of weight compared to height to provide a weight category (underweight, healthy weight, overweight or obese).
Dehydration	Insufficient fluid intake leading to physiological impairment
Dysphagia	Difficulty or discomfort when swallowing foods, liquids, or saliva
EPR	Electronic patient record
Hydration	Required to ensure normal bodily functions. This applies to any fluid consumed. Foods that have a high fluid content e.g. soup, jelly, ice cream will support good hydration
LNDS	Leicestershire Nutrition and Dietetic Service.
Malnutrition	A state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes a measurable adverse effect on body composition, function and/or clinical outcome
MEED	Medical Emergencies in Eating Disorders
MUAC	Mid Upper Arm Circumference
MUST	Malnutrition Universals Screening Tool
Nutritional Screening	Agreed tool that will quickly identify a patient's nutritional risk. This can be completed by any health care professional with appropriate training.
Nutritional Assessment	A more thorough analysis of a patient's nutritional intake and requirements carried out by a dietitian
Nutritional support	Active measure put in place to help improve nutritional intake. This could be oral, enteral, or parental
ONS	Oral nutritional supplements
Oral nutrition	Food taken orally and includes fortified food, additional snacks, and oral nutritional supplements
OSFED	Other Specified Feeding or Eating Disorder
WHO Growth Charts	Are growth monitoring charts developed by the World Health Organization to assess whether a child's growth is within the expected range for healthy children under optimal conditions. They are commonly used to plot and monitor a child's growth over time

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Appendix Two: Governance

Version control and summary of changes

Version number	Date	Description of key change
1	March 2012	Harmonised version of LCRCHS Adult Nutrition and Hydration Guideline for Community Use
2	December 2015	Updated references and key documents. Amended section 6 to reflect LMSG guidelines on screening, food first and dietetic referral
3	December 2017	Updated references and key documents and some small changes to different sections in policy
4	July 2023	Review due, Policy transferred to new template
5	Sept 2025	Clarity on action and review of MUST added in a table to 5.2
6	June 2026	Review due, transferred to new template. Policy amended from adult only to all-age Addition of excess nutrition Identification of other documents that could be relevant added Addition of excess nutrition

Responsibilities

Responsibility	Title
Executive Lead	Group Chief Nurse/Executive Director of Nursing, AHP and Quality
Policy Author	Assistant Director of Nursing & Quality

Advisors	Heads of Nursing Deputy Heads of Nursing Lead AHPs Community Matrons Dietetics
Policy Expert Group	
Nutrition and Hydration Steering Group	

Governance

Governance Level	Name
Level 1 Assurance Oversight	Quality and Safety Committee
Level 2 Delivery Group for policy approval and compliance monitoring	Quality Forum

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Community incidents Community patient safety investigation recommendations/actions related to nutrition and hydration in the community	To Quality forum via directorate highlight reports

Training Requirements

All community staff to complete Level 1 Food training

Nutrition and hydration eLearning is also available

References

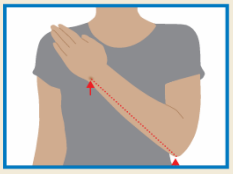
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Appendix Three: Alternative measurements (BAPEN)

If height cannot be obtained, use length of forearm (ulna) to calculate height using tables below.
(See The 'MUST' Explanatory Booklet for details of other alternative measurements (knee height and demispan) that can also be used to estimate height).

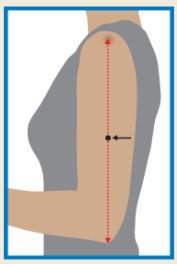
Estimating height from ulna length



Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

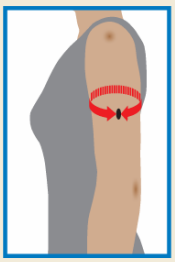
Height (m)	men (<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
	men (≥65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
	Ulna length (cm)	32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
Height (m)	Women (<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
	Women (≥65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
Height (m)	men (<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
	men (≥65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
	Ulna length (cm)	25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
Height (m)	Women (<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
	Women (≥65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

Estimating BMI category from mid upper arm circumference (MUAC)



The subject's left arm should be bent at the elbow at a 90 degree angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.

Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug but not tight.



If MUAC is <23.5 cm, BMI is likely to be <20 kg/m^2.
If MUAC is >32.0 cm, BMI is likely to be >30 kg/m^2.

The use of MUAC provides a general indication of BMI and is not designed to generate an actual score for use with 'MUST'. For further information on use of MUAC please refer to *The 'MUST' Explanatory Booklet.*

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