MENTAL HEALTH GROUP

Eating Disorders Learning Disability Mental Illness

THE BRITISH DIETETIC ASSOCIATION

PROFESSIONAL CONSENSUS STATEMENT

The Nutritional Care of Adults with a Learning Disability in Care Settings

adapted from QIS Food, Fluid and Nutritional Care Standards (September 2003)

produced by:

Dietitians working with Adults with a Learning Disability and members of the Scottish Dietetic Learning Disability Clinical Network supported by The British Dietetic Association Specialist Mental Health Group

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Introduction

With the move towards community resettlement and the closure of the large learning disability institutions, it was recognised by the Scottish Dietetic Learning Disability Development Forum that there was a growing need to support carers in the provision of nutrition for adults with a learning disability.

In 2000 a sub group of Scottish dietitians working with adults with a learning disability worked towards producing nutritional care standards. This was adapted from CRAG report into nutrition of elderly people and nutritional aspects of their care in long-term settings. (Reference: 1) During the development of the standards the Scottish Commission for the Regulation of Care and NHS QIS (Quality Improvement Scotland) were established (Reference: 2) and through these organisations a number of relevant documents have been published:

- National Care Standards, care homes for people with learning disabilities;
- NHS QIS – Food, Fluid and Nutritional Care in Hospitals;
- NHS QIS – NMPDU – Nutrition for physically frail older people – best practice statement;
- NHS QIS – NMPDU – Nutrition assessment in referral in the care of adults in hospital.

Dietitians have recognised the variety of skills, knowledge and expertise of staff employed in care settings. To date there has been a lack of nutritional information or guidance specifically aimed at adults with a learning disability and to this end we have undertaken a systematic review of published work to develop clear and concise best practice guidelines in this field. Each paper was classified for evidence levels based on the SIGN Classification Levels (Appendix 3)

The original document was reviewed and updated in April 2008

The best practice guidelines are reflective of the previously mentioned documents and also take account of the recently published Health Needs Assessment Report References: 3 and NHS QIS – Quality Indicators - Learning Disabilities Reference 4. They aim to support and enable care staff in the provision of nutritionally adequate meals (including fluid) and empower clients to make an informed choice.

There are 5 best practice guidelines:

1. Assessment, screening and care planning
2. Education and training
3. Menu design, food preparation and presentation
4. Communication and Empowerment
5. Facilities available for eating and drinking

In developing these best practice guidelines consultation has been sought through the Scottish Dietetic Learning Disability Clinical Network and the Mental Health Specialist Interest Group of the British Dietetic Association.

1. Assessment, Screening and Care Planning (all evidence level IV, grade C)

BEST PRACTICE GUIDELINE	RATIONALE	ACTION
On moving to a new care home and on an ongoing basis it is recommended that the nutritional status of every client be assessed by the care provider.	• Malnutrition is an important public health problem. People with learning disabilities have a high risk of being nutritionally compromised. References: 2, 6 • Clients' energy intake below their nutritional needs may put them at risk of undernutrition. References:1, 4, 6 • The screening and assessment process help to identify undernutrition and factors that may prevent clients from eating and drinking adequately. References: 1, 4, 6 • People with learning disabilities have greater health needs compared to the general population. Reference: 6	• Using a recommended screening tool, clients should be assessed for undernutrition within 1 week of moving into a new home. If there are concerns the screening should be repeated at monthly intervals. • Routine screening should take place at 6 monthly intervals Reference: 4, 9 **Helpful hints**: • Weigh on accurate and appropriate scales. • Weigh monthly and record on annual weight monitoring chart (Appendix 1 and 2). • Screening outcome and action filed in client record. • Should assessment highlight concerns. refer to specialist learning disability health services Reference: 6

2. Education and Training (all evidence level IV, grade C)

BEST PRACTICE GUIDELINE	RATIONALE	ACTION
All staff should use ‘ The Balance of Good Health’, or equivalent 5 food group model for planning nutritionally balanced, adequate meals Reference: 3, 9	• Good nutritional care improves disease outcomes and clients’ quality of life. Providing balanced, adequate meals is central to good nutritional care. • ‘ The Balance of Good Health’, is a pictorial model that has been evaluated as likely to be understood by the general public, and is therefore an appropriate resource to guide carers. Reference: 2, 3, 8 • Undernutrition has a major effect on both physiological and biochemical systems leading to impaired immune response and respiratory function, delayed wound healing and significantly impacts on quality of life. Reference: 1, 4 • Many adults with a learning disability rely totally on their carers to meet their nutritional and fluid needs.	• Specific nutrition education training for adults with learning disabilities should be available for staff, (seek advice from local dietitian working with adults with a learning disability). • Content of training should include ‘ The Balance of Good Health’/ Five Food Group model, menu design and compilation. • Care providers should be able to evidence knowledge and understanding in the provision of nutritionally adequate meals for their own clients.

3. Menu Design, Food Preparation and Presentation (all evidence level IV, grade C)

BEST PRACTICE GUIDELINE	RATIONALE	ACTION
Meals should be varied and nutritious, reflecting food preferences, seasonal variation, cultural, religious considerations and any special dietary needs. They should be prepared safely and attractively presented. Reference: 5, 8	• Client's food and fluid intake, eating and drinking pattern, specific likes and dislikes are recognised and accounted for. Reference: 2, 8, 9 • Provision of suitable, nutritious food will ensure that clients nutritional requirements are met, and will help minimise food and fluid waste Reference: 2, 8 • Food that is prepared safely, presented attractively and served without delay is more likely to be eaten, thus optimising nutritional content, temperature control and quality Reference: 2, 8	• A member of staff to oversee nutritional care within care setting should be identified. This will include: • Identification and recording of individual dietary recommendations / preferences, eating and drinking patterns. • Ensuring that systems are established to achieve appropriate menu planning to suit clients needs. • Communication with other staff and clients about the provision of nutritional care. • Referring to specialist learning disability health services as necessary. • All staff require training in accordance with food hygiene regulations, as per care procedures.

4. Communication and Empowerment (all evidence level IV, grade C)

BEST PRACTICE GUIDELINE	RATIONALE	ACTION
Client's views should be sought to inform decisions are made about their nutritional care, food and fluid provision. Reference: 8, 9	• Information and communication helps clients make informed choices. Reference: 8, 9 • Poor staff / client communication about food and nutritional care can result in clients' nutritional needs not being met. Reference: 2, 8	• Staff should communicate regularly with clients about nutritional care, food and fluid provision, using pictorial information where necessary, in order to support informed choice. • Menu plans are designed taking into account, not only therapeutic requirements, but also informed food choices, ethnic, cultural, religious or other preferences that clients may have.

5. Facilities Available for Eating and Drinking (all evidence level IV, grade C)

BEST PRACTICE GUIDELINE	RATIONALE	ACTION
The eating environment must be conducive to the clients needs. Clients should never feel rushed or uncomfortable whilst eating or drinking. Reference: 2,8,9	• The environment in which the client's eat, is as important as the food provided, as it can have a major impact on nutritional intake.	• Dining areas should be available with adequate and appropriate furniture. • Tables should be laid appropriately and consideration given to tablecloths, mats and napkins. • Appropriate condiments, crockery and cutlery and special equipment for eating and drinking should be available. • Dining areas must be conducive to good communication e.g. appropriate background music, suitable temperature and ventilation. • Assistance should be available for eating and drinking if required. • Sufficient time must be allowed to eat meals and drink fluids whilst encouraging the social aspects of eating and drinking. • Unnecessary interruptions should be avoided.

Appendix 1: Weight Monitoring Chart

see next page

WEIGHT MONITORING CHART

Name:					
Address: **Telephone:**					
Dob:					
Ht		**Wt**		**BMI**	
GP Name: **Telephone:**					
Aims:					
Wheelchair information					
Wheelchair weight		Date weight			
Special Clothes List:					

DATE	Wt in Kgs	Date	Wt in Kgs

Weight kgs

Date:

MONTHLY MEASUREMENTS (*please plot on the black vertical line)*

- If you are concerned about continuous weight loss/gain, please contact your GP

Appendix 2: Guidelines for Using Weight Monitoring Chart

The weight monitoring chart has been developed to allow care staff to monitor the client's weight.

To complete the chart::

1. Detail client's name, address, telephone number and date of birth in box provided
2. Detail height in metres and present weight in box provided
3. Work out Body Mass Index (BMI) using the following calculation

$$\frac{\text{Weight (kg)}}{(\text{Height (m)} \times \text{Height (m)})}$$

Example

Weight = 75 kg Height = 1.75 m

1.75 x 1.75 = 3.06

$\frac{75}{3.06} = 24.5$

4. Aims
   .. BMI less than 18 gain weight or maintain if advised by dietitian.
   .. BMI between 18.5 and 25 maintain weight.
   .. BMI greater than 25 lose weight following '' The Balance of Good Health'/ Five Food Group Guidelines .
5. Wheelchair information – detail wheel chair weight including if pummel, footplates and tray included and date weight taken. Remember to have the wheel chair set up in the same way each time.
6. Special clothing List:- to identify at the outset clothing/aids as worn daily i.e. callipers, body brace, splints, modified shoes, helmets
7. Record date of weight taken and actual weight in kg.
8. Complete left hand side of graph by filling in appropriate scale for weight in kg.
9. Each month fill in date and mark weight with a cross on the graph, join up subsequent recordings with a line to give pictorial representation.

Appendix 3: Grading Scheme

The classification of recommendations and the levels of evidence for intervention studies used in this guideline are from the Scottish Intercollegiate Guidelines Network (*SIGN 50: a guideline developers' handbook*), and summarised in the tables below

Level	Type of Evidence
Ia	Evidence obtained from meta –analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one other type of well- designed quasi-based experimental study
III	Evidence obtained from well-designed non- experimental descriptive studies, such as comparative studies, correlation studies and case studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities

Grade	Recommendation
A **(Evidence levels Ia, Ib)**	Required – at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing specific recommendation
B **(Evidence Levels Iia, IIb, III)**	Required – availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation
C **(Evidence level IV)**	Required – evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities Indicates absence of directly applicable clinical studies of good quality

Appendix 4: Authors' Curriculum Vitae

Fredrica Di Mascio

Qualified in 1986 with a BSc Human Nutrition and Dietetics at Queen's College in Glasgow and subsequently registered with the Health Profession Council. Working in the field of Adults with Learning Disabilities since 1990 and involved in the community resettlement of clients from Lennox Castle Hospital (1999). Currently Head of Service for Dietetics within the Glasgow Learning Disability Partnership.

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Qualified in 1979 with a Diploma in Dietetics and Catering at Queen Margaret College in Edinburgh and subsequently registered with the Health Profession Council. Working in the field of Adults with Learning Disabilities since 1991 and involved in the community resettlement of clients from Lynebank Hospital, Fife moving to Lothian to join the Community Learning Disabilty Teams in 1999.

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We are all active members of the Scottish Dietetic Learning Disability Clinical Network, which to date have completed the following pieces of work :
Dysphagia Standard, SNDRI Pictorial Diet Sheets- on 'Are You Constipated?', Do you want to stay fat, healthy eating and gentle exercise, screening tool and weight graph.
Work currently on-going includes Dysphagia Cookbook, Scotland wide priority system for dietietic referrals, to name but a few. Group members have contributed to The Caroline Walker Trust 'Eating well: children and adults with learning disabilities' publication and are currently involved with the SIGN guideline obesity review.

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