Nutrition guidelines and menu checklist for care homes

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> *"...nutritious meals are far more than just food - they are a cornerstone of dignity, health and quality of life"*
>
> **Care home executive chef**

Foreword

Good nutrition is essential to health, wellbeing, and quality of life. It supports strength, independence, healing and resilience, particularly in care home settings where residents may have complex and evolving needs.

Achieving good nutritional care in care homes is a shared responsibility. From chefs and kitchen teams, to nurses, carers and support staff, everyone has a role to play in helping residents eat well and stay well hydrated. Whether it's preparing appetising meals, noticing changes in appetite, encouraging regular drinks or creating a warm and sociable mealtime environment, these daily actions make a significant difference.

These guidelines are underpinned by a 'food first' approach, placing food and drink at the centre of holistic, person-centred care. This means offering nourishing meals, drinks and snacks throughout the day, adapting menus to reflect individual needs and preferences and ensuring that mealtimes are enjoyable, dignified and tailored to each resident.

This guidance has been developed to support care homes across Northern Ireland by providing practical, evidence-based recommendations that can be implemented by all members of the care team. The aim of the guidance is to help ensure high-quality nutritional care, improve health outcomes and prevent malnutrition.

We encourage all care homes to adopt and embed these guidelines into everyday practice. By doing so, we can collectively raise the standard of nutritional care, support better health outcomes and enhance the quality of life for residents.

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Introduction to nutrition in care homes

Introduction to nutrition in care homes

Eating the right food to keep healthy and well is important throughout life. It is important to get a variety of foods as well as the right proportions of foods*.

You don't have to achieve this balance at every meal but you should aim for this over the course of the weekly menu cycle.

Five main food groups

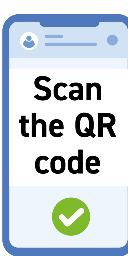
Serving size refers to the amount of food that you are recommended to eat. Portion size refers to the amount of food you choose to eat in one sitting (fruit and vegetables, however, are always referred to as portions).

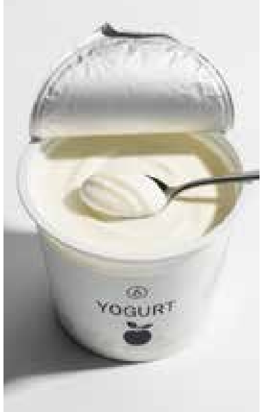
Food group	Function	Dietary sources and additional notes	Daily servings required
Carbohydrates (starchy)	Sources of energy, B vitamins, fibre and some calcium.	Bread, rice, potatoes, pasta, rice, oats, quinoa. Offer wholegrain varieties to help increase fibre intake, which will help prevent constipation.	Offer at least one serving from this group at each meal. Try to provide 6 servings from this group per day to ensure adequate energy. See table of serving sizes in Appendix 3.
Fruit and vegetables	Sources of vitamins and minerals as well as fibre.	Offer a variety of all fruit and vegetables including fresh, frozen, canned and dried fruits, fruit juices and smoothies. As fruit juice and smoothies contain free sugars, this should be limited to a maximum 150ml portion per day.	Offer a minimum of 5 portions per day. See table of portion sizes in Appendix 3.
Beans, pulses, fish, eggs, meat and other proteins	Sources of protein, vitamins and minerals.	Pulses, such as beans, peas and lentils. Meat, fish, eggs and poultry. Try to use leaner cuts of meat and chicken in your menus and offer less processed meat (sausages, ham, deli meats and bacon). Offer fish at least 2 servings per week, one serving of which should be oily (mackerel, salmon). Offer tinned, frozen or fresh options.	Offer 3 servings per day. See table of serving sizes in Appendix 3.

Food group	Function	Dietary sources and additional notes	Daily servings required
Dairy and alternatives	Sources of calcium, protein and B12	Milk and dairy products, for example yogurt and cheese For residents following a plant-based diet ensure that the plant-based drinks you offer are fortified with calcium (120mg per 100ml).	Offer 3 servings per day, a serving at each main meal.
Oils and spreads	Contain fats, some fat intake is required to obtain fat soluble vitamins (A, D, E and K) and essential fatty acids.	Butter, spreads and oils. Choose unsaturated fats, oils and spreading fats, for example olive oil, rapeseed oil, sunflower oil and their spreads. Avoid saturated fats such as butter, lard and coconut oil.	Too much fat in our diet can increase the risk of heart disease.

* Scan the QR code or follow the link to see www.gov.uk/government/publications/the-eatwell-guide[1]

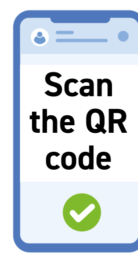
Foods that are high in fat, sugar and salt such as butter, crisps, chocolate, biscuits, sweets and sugary drinks tend to be high in calories but are low in other essential vitamins and minerals. Offer these foods less often and in smaller amounts.





Specific nutritional considerations for older adults in care homes

The British Dietetic Association's Eating, Drinking and Ageing Well resource outlines the balance of food groups and drinks that older adults need to achieve a nutrient rich diet.[2] Scan the QR code or follow the link: www.bda.uk.com/resource/eating-drinking-and-ageing-well-a-new-bda-resource-for-older-people.html



Nutrient	Function	Dietary sources and additional notes
Protein	Older people have higher protein requirements. Protein helps preserve lean body mass and strength. Higher intakes of protein reduce risk of frailty, fractures and disability and improves cognition.	Meat, poultry, fish, and eggs Beans, pulses and lentils Milk and dairy foods Protein requirements are higher in residents with inflammation, infections and wounds.
Vitamin B12	Vitamin B12 can help improve energy levels and health.	Meat, fish, poultry, and eggs Milk and dairy products Foods that are fortified with vitamin B12, such as breakfast cereals and yeast extract. Vegan diets will require to be supplemented with vitamin B12.
Folate	Folate is required to make healthy red blood cells. Folate deficiency is more common in an unbalanced diet or in people who misuse alcohol.	Broccoli, Brussels sprouts, asparagus, peas, and chickpeas Brown rice
Iron	Iron deficiency in older adults is associated with poorer cognitive function, increased risk of dementia and reduced mobility.	Liver and red meat Beans, chickpeas, and soya bean flour Dried fruit, nuts, green leafy veg, and fortified breakfast cereals Plant-based sources of iron should ideally be taken alongside food and drinks rich in vitamin C to aid absorption of iron.

Nutrient	Function	Dietary sources and additional notes
Zinc	Adequate zinc intake is required to support the immune system.	Red meat and poultry Beans, wholemeal bread, and lentils
Calcium	Calcium is required to help maintain bone and teeth health, it regulates muscle contractions and blood clotting. Inadequate calcium intake can increase bone loss especially in older women increasing the risk of osteoporosis and fractures.	Milk and dairy products Green leafy vegetables Fortified plant-based drinks, nuts and seeds
Vitamin D	Vitamin D supports bones, muscles and teeth. It helps preserve muscle strength, preventing falls, and reducing the risk of fractures.	Vitamin D is made from sunlight on our skin during summer months (between late March and early April to the end of September). However, this is limited in winter months, in patients with darker skin and those living with obesity. As care home residents may have limited outdoor exposure, a daily 10 microgram (mcg) vitamin D supplement is recommended all year round. Vitamin D3 is the best choice; however, people following a vegan diet can opt for vitamin D2.

Nutrient	Function	Dietary sources and additional notes
Fibre	An adequate fibre intake improves gut function, reducing constipation and improving good gut bacteria. It can help improve mental health.	Wholegrain, wheaten or granary breads Brown rice and whole wheat pasta Fruit and vegetables Beans pulses and lentils
Salt	Too much salt can increase blood pressure, risk of stroke and heart disease.	A large amount of salt in our diet is added to food during the manufacturing process for example foods like bacon, ham, meat pies and ready-made meals are high in salt. To reduce the amount of salt, prepare meals using fresh, whole ingredients instead of relying on pre-packaged or processed foods. Avoid adding salt during cooking. Salt enhances the palatability of food, so it is important when reducing salt intake to enhance the flavour of the meals that you offer with other flavourings such as pepper, herbs, mustard, spices or vinegar. Salt may be added sparingly to food on request by residents. Avoid using lower salt and sodium substitutes such as Lo-salt due to their potassium content.

Healthy eating for those who wish to lose weight

The National Institute for Health and Care Excellence (NICE) recommends to: 'Interpret BMI with caution in people aged 65 and over, taking into account comorbidities, conditions that may affect functional capacity and the possible protective effect of having a slightly higher BMI when older'.[3] Therefore, weight loss in older adults should be considered with caution. Any decisions regarding attempting weight loss should be the resident's choice (or a decision made in their best interests if they lack mental capacity to make their own decisions about food and drink choices). Decisions to commence a weight loss diet should be discussed and supported by the wider multi-disciplinary team involved in care planning. It may be more appropriate to prevent further weight gain than focus on weight loss. This can be supported by following a balanced, nutrient rich diet (as outlined above). Nutrient dense diet principles (such as food fortification for residents at risk of malnutrition) should not be applied to these residents to avoid weight gain (BDA 2024).[2]

Fluid and adequate hydration

Fluid and adequate hydration

Good hydration is essential for good health. Ensuring that residents are adequately hydrated should be a priority for all care home staff.

The main functions of fluids are:		
Blood flow	Regulate body temperature	Help control blood glucose levels
Healthy digestion	Healthy skin and joints	Keep mouth moist
Improved gut health	Maintain cognition	Reduce constipation

Dehydration can be life threatening and is a frequent cause of hospital admissions but is often preventable.

Possible causes of dehydration:		
Reduced sense of thirst	Concerns about continence	Diarrhoea and vomiting
Dysphagia	Reduced co-ordination or ability to drink	High environmental temperature (hot weather or warm room)
Taste changes	Infection, high body temperature (fever)	Certain medications
Reduced access to fluid/ preferred drinks	Reduced kidney function	Dependent on others for drinks

Risks associated with dehydration:		
Urinary tract infections, acute kidney injury and kidney stones	Hospitalisation	Low blood pressure
Confusion or delirium	Drug interactions, side effects and toxicity	Seizures
Dry or sore mouth	Constipation	Falls
Poor temperature regulation	Dry skin, poor wound healing, pressure sores or ulcers	Death

Signs and symptoms of dehydration

Mild to moderate dehydration
Irritability
Dry or sticky mouth and tongue
Tongue coating or furrowing
Less frequent urination and dark-coloured urine
Increased thirst or decreased saliva
Dry skin
Decrease in tears
Mildly sunken eyes
Headache
Fatigue, sleepiness or confusion
Constipation

Severe dehydration
Very dry mouth, skin and mucous membranes
Lack of urine or dark – coloured urine
Extreme sense of thirst
Dry skin that lacks elasticity (doesn't bounce back)
Lack of tears
Sunken eyes
Weight loss
Lack of sweating

Fluid requirements

Fluid requirements differ from person to person. It is recommended that you offer 7-8 glasses of fluid (approximately 1.6L for women and 2L for men). This can be challenging to achieve. However, every sip counts and a range of fluids should be encouraged (ESPN 2022). [4]

What counts as a fluid?

The following foods or drinks will contribute to fluid intake and can be included when monitoring a resident's intake:

Water (tap, still or sparkling)	Tea or coffee (up to 5 cups a day)	Milk or non-dairy alternatives, milkshakes
Malted milk drinks or hot chocolate	Sugar-free squash, fruit juice or smoothies.	Fruit juice or smoothies (max serving per day 150ml)
Fizzy drinks (preferably sugar-free versions)	Alcohol (within recommended limits)	Prescribed oral nutritional supplements
Ice lollies, ice cream	Yogurt, custard, soups, milky puddings or jelly	Gravy or sauces

Foods cooked in a fluid should not be included on a fluid record chart, for example water used to cook pasta, rice and vegetables.

What if a resident is on fluid restriction?

Fluid intake may need to be restricted in some residents with, for example, heart failure, renal disease. This warrants discussion with the resident's GP or consultant and fluid restriction should be documented in resident's individual care plan.

Thickened fluids

Residents with eating, drinking and swallowing difficulties (dysphagia) may be advised to drink thickened fluids (See additional information in Dysphagia section). This will be outlined by the Speech and Language Therapist (SLT) in their Recommendations for Eating, Drinking and Swallowing (REDS). If thickened fluids are required, this includes all fluids that a resident consumes, including milk on cereal, gravy and sauces.

Decaffeinated drinks

A report by Care England (2024) outlines the findings of a 6-month trial offering decaffeinated drinks to care home residents that resulted in a 35% reduction in falls compared to caffeinated drinks. Therefore, consider offering residents decaffeinated drinks such as decaffeinated tea and coffee.[5]

Alcoholic drinks

Older residents can experience the effects of alcohol more quickly. If consumed, alcohol should be included on the residents' fluid intake chart. Alcohol can be taken in moderation (up to 14 units a week) and include alcohol-free days.

1 unit = 25ml measure of spirit/76ml glass of wine/½ pint beer.

When to offer more fluids

Warm weather or environment	Wound exudate (fluid loss from wounds)	Vomiting and diarrhoea
Increased physical activity, such as physiotherapy, dance, chair exercises	Large stoma output	Pyrexia, high temperature or increased sweating

Tips to achieve hydration goals

Please consider residents' individual requirements before implementing the following advice.

Challenge	Practical tips to overcome
Not feeling thirsty or forgetting to drink	Offer fluids regularly as part of the resident's daily routine, for instance with medications, after visiting the toilet, after activities and with every meal and snack. Build activities around fluids, like: Mocktail Monday, Teatime Tuesday, Watery Wednesday, Thirsty Thursday, Fruity Friday. Remember – it is often more effective to offer a drink rather than ask the resident if they would like one.
Access to drinks This may not be appropriate within all settings and a risk assessment may be required.	Ensure drinks are within reach and within line of sight. Consider a 'hydration friendly environment', for example hydration station with a water dispenser or a jug. Provide help if required and encourage loved ones to help.
Taste preferences	Consider adding flavours to water, such as a slice of lemon, mint, ginger, squash or cordial, in line with REDS. This can help stimulate a more effective swallowing reflex. Find out the resident's favourite drinks and how they are taken (hot or cold).
Not wanting to drink as needs the toilet	Provide reassurance and emphasise that concentrated urine from poor hydration irritates the bladder, making incontinence and frequency worse.
Overnight urination	Offer fluids gradually throughout the day instead of in large volumes in one sitting.
Best drinking vessel	Specialised cups can be recommended by SLT or Occupational Therapist (OT) for specific needs. Consider resident's preferences, such as a china cup, mug, beaker or straw. Consider the weight and size. A bigger handle might make it easier for the resident to independently drink. Some residents find it more appealing if the vessel is clear whilst colour can be used to offer contrast.

Challenge	Practical tips to overcome
Keeping drinks warm	Consider a thermos mug or flask, especially if the resident takes longer to finish their drink or wanders. For those requiring thickened fluids this can help maintain the temperature whilst waiting for the drink to thicken.
Thickening drinks **Thickening drinks for people with Swallowing Difficulties on Vimeo** **https://vimeo.com/912568189/85aab0f3da** Scan the QR code	Use water from fridge or cold tap, opt for stronger flavours like fruit juice or cordial if water is not tolerated. Avoid lumps by stirring with a fork. Don't make drinks thicker than recommended, measure fluids and read preparation instructions.

Oral health

Oral health

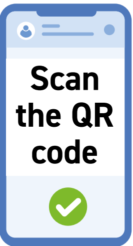
Good oral health is essential for maintaining comfort, dignity and the ability to eat and drink well. In care homes, promoting oral hygiene directly supports better nutrition, reduces the risk of infection and helps residents enjoy mealtimes safely and confidently.

Strategies to maintain or improve oral care

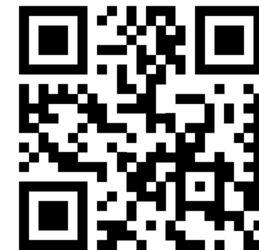
- **Encourage independence with oral care**
  Support residents to carry out their own mouth care whenever possible to maintain dignity, confidence, and daily routine. Use prompts, mirrors or hand-over-hand guidance to promote independence.
- **Help when needed**
  Some residents may be unable to manage their oral hygiene due to physical or cognitive limitations. In these cases, staff should step in to provide thorough and respectful mouth care.
- **Daily oral health checks**
  Look in the mouth daily for signs of pain, swelling, bleeding, dry mouth or poorly fitting dentures. Document and report any concerns.
- **Assist when required and support twice-daily brushing and denture care**
  Toothbrushing with fluoride toothpaste and denture cleaning should be done at least twice daily. Remove dentures and clean overnight. Check fit regularly.
- **Promote hydration**
  Encourage regular fluid intake to help prevent dry mouth, which can affect comfort, taste and swallowing.
- **Monitor nutritional intake for oral-related problem**
  If a resident is avoiding certain foods or eating less, investigate whether pain, infection or mouth dryness may be affecting their ability to eat comfortably.
- **Report concerns promptly**
  Report any signs of dental pain, sores, bleeding gums or mouth infections to a senior member of staff or a dental professional without delay.
- **Include oral health in care and nutrition plans**
  Oral hygiene must be part of individual care plans, particularly for residents at risk of malnutrition, dehydration or swallowing difficulties.
- **Maintain dignity and comfort during oral care**
  Oral care should always be provided in a way that respects the resident's privacy and preferences. A clean and healthy mouth helps residents eat, speak and engage with others more confidently.

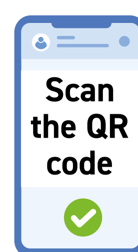
Useful resources for providing oral care for people with dysphagia

- **PHA mouth care awareness video for people with dysphagia**
  A short training video highlighting the importance of good mouth care for adults with swallowing difficulties, with practical guidance for carers. **www.publichealth.hscni.net/publications/mouth-care-awareness-video-people-who-care-adults-dysphagia**



- **PHA poster: How to help people with swallowing difficulties keep their mouths clean**
  An easy-to-follow poster for staff, showing step-by-step guidance for providing effective mouth care to people with dysphagia.
  www.pha.site/Dysphagia





Malnutrition and nutritional screening

Malnutrition

Malnutrition is a state of nutrition in which a deficiency, excess or imbalance of energy, protein, and other nutrients, causes measurable adverse effects on tissue or body form, function or clinical outcome (BAPEN, 2024).[6]

Incidence

Malnutrition is a common problem - 48% of adults screened across health and care settings in the UK and Republic of Ireland are at risk of malnutrition (BAPEN's Malnutrition and Nutritional Care Survey 2023). The findings indicated that risk is highest for those in their own homes (49%) and those in care homes (42%).[7]

Malnutrition is estimated to cost £23.5 billion annually within the UK (BAPEN, 2018).[7]

Causes

There are many social, physical, and medical factors which can contribute to malnutrition. These should be considered during the pre-admission assessment and nutritional screening process.

Social factors

- Living in isolation
- Limited knowledge of nutrition
- Limited cooking skills
- Alcohol or drug dependency
- Poverty
- Limited mobility or lack of transport resulting in difficulty accessing food

Physical factors

- Poor dentition
- Loss of appetite due to loss of smell or taste
- Physical inability which reduces ability to cook, eat or shop for themselves
- Inability to get food into the mouth or requiring assistance with feeding
- Increased physical activity or movement like tremors or pacing

Medical factors

- Conditions causing a lack of appetite (such as cancer or liver disease)
- Mental health conditions such as depression
- Wounds with high exudate levels
- Any condition that reduces the body's ability to absorb or use nutrients
- Eating, drinking or swallowing difficulties (dysphagia)
- Vomiting or diarrhoea
- Symptoms of illness or disease, such as nausea or constipation
- Eating disorders
- Taking multiple medications and medication side effects
- Pain
- Impaired metabolism
- Cognitive impairment, including learning disability and dementia

Consequences

Frailty and malnutrition are strongly linked. Residents who are malnourished are almost four times more likely to become frail (BDA Care Homes Digest, 2024).[2]

If left untreated, this can result in a wide range of consequences, including:

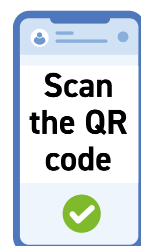
- Reduced muscle strength and fatigue (sarcopenia), increasing the risk of falls and decreasing mobility;
- Increased risk of infection or complications;
- Increased risk of hospital admission and longer stay in hospital;
- Impaired or delayed wound healing;
- Reduced fat and lean body mass, increasing pressure sore risk;
- Reduced respiratory muscle function, resulting in increased difficulties breathing, increased risk of chest infection and respiratory failure;
- Altered drug metabolism, which can increase side effects, for example dry mouth, loss of taste, constipation, diarrhoea, drowsiness;
- Reduced gastrointestinal secretions impairing digestion;
- Increased risk of depression, confusion, irritability and apathy;
- Reduced quality of life.

Identification of malnutrition

Nutritional screening should be carried out with a resident's consent, on admission to a care home and repeated monthly, or more frequently depending on the individual assessed need. Use a validated screening tool and include management guidelines to develop a care plan; for example records of food and drink intake and records of referrals to health professionals, if relevant.

With consent, nutritional screening should be completed on all residents, regardless of weight or Body Mass Index (BMI) unless otherwise indicated. Decisions not to complete nutritional screening should be recorded in the nutritional care plan.

The Northern Ireland Promoting Good Nutrition strategy identified the Malnutrition Universal Screening Tool (MUST) as the tool of choice to identify those adults who are at risk of malnourishment or are malnourished in nursing homes.[9]
www.bapen.org.uk/must-and-self-screening/must-toolkit/

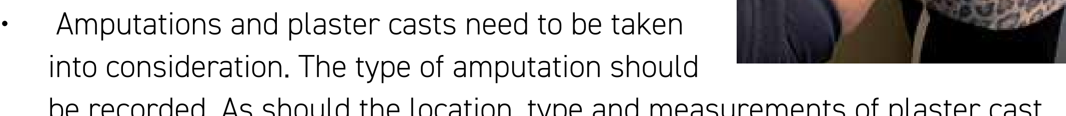


In residential homes and other care settings, the Patient Association Nutrition Checklist is a validated tool for staff who are not trained to complete MUST. See **www.patients-association.org.uk/patients-association-nutrition-checklist-toolkit**

Measuring weight

- Residents should be weighed at least monthly, ideally in light clothes without shoes, on the same set of scales if possible, and at a similar time of day.
- Hoist scales are required for residents who cannot stand or sit unaided.

- Scales must be accurate and in a good state of repair. They should be calibrated at least annually or as per manufacturers' instructions.
- Fluid retention (oedema or ascites) should be taken into consideration to establish a dry weight, as well as any fluid in catheter or stoma bags. The presence of oedema should be recorded, as should when it has resolved.
- For residents who are unable to be weighed due to clinical condition or physical ability, or residents with fluid retention, measurement of Mid Upper Arm Circumference (MUAC) should be considered (see MUST guidelines). A change in MUAC suggests a change in weight (a 10% reduction in MUAC suggests a 10% weight loss). If MUAC is not appropriate, consider the use of the Patient Association Nutrition Checklist.



- Amputations and plaster casts need to be taken into consideration. The type of amputation should be recorded. As should the location, type and measurements of plaster cast.
- For new residents, a weight history should be established if possible from the resident, loved ones, GP notes or discharging hospital or care home.
- Significant changes in weight, over 5% of body weight, should be checked to ensure accuracy.

Measuring height

- Use a height stick (stadiometer) where possible.
- Measure the height without shoes, with the resident standing upright with feet flat together, and heels touching the stadiometer.

- If height cannot be measured, use recently documented or self-reported height (if reliable and realistic). This may be obtained from the resident, loved ones, GP notes or if recently discharged; previous hospital or care home.
- If an accurate height cannot be obtained, estimated height can be used. Alternative measurements such as ULNA are described in MUST guidelines.
- Staff should record whether the height is actual, reported, or if an alternative measurement has been used to estimate it.
- It is good practice to review the recorded height annually as heights may reduce with increasing age.

Guidelines to improve nutritional intake for residents who are at risk of malnutrition

After nutritional screening, all residents should have a written care plan in place and nutritional care implemented. Residents should be referred to the local dietetic department as per agreed dietetic referral criteria (see Appendix 6: Nutrient dense diet checklist).

Residents who are at risk of malnutrition should have a food-based individualised care plan in place to improve nutritional intake. These residents are identified by:

- MUST score of 1 or above, or
- The Patient Association Nutrition Checklist at “increased risk of undernutrition”, or
- pre-admission assessment, or
- those currently prescribed Oral Nutritional Supplements (ONS).

Nutritional care planning

Residents identified as at risk of malnutrition continue to need a varied diet:

- Encourage a small and often intake, including:
  - breakfast
  - lunch or dinner
  - evening meal
  - snacks offered mid-morning, mid-afternoon and at supper time.
- Large portions can often put residents with poor appetites off their meals. Consider offering small portions and then second helpings. Consider the size of plate used as some residents may eat more depending on the size of plate.
- Large portions of fruit and vegetables may fill residents up, so consider offering fruit and vegetables alongside nutrient dense food, for example rice pudding and tinned fruit, carrots and hummus.
- Offer two puddings per day. If a resident declines a meal or eats less than half of their meal, offer an additional pudding, for example offer one milk-based and one fruit-based pudding.

Residents may not be able to obtain all the nutrients from the standard menu alone (see Appendix 6 Nutrient dense diet checklist). Therefore, nutrient dense snacks, drinks and foods should be encouraged (see Appendix 6: Nutrient dense diet checklist):

- Nutrient dense snacks rather than plain biscuits or cakes. Snacks should be readily available throughout the day and night especially for those who wake during the night. If a resident prefers to have a biscuit or cake, a nutrient dense drink can be offered alongside to help optimise intake (see Appendix 5: Snacks).
- Nutrient dense drinks should be offered between meals rather than just before so as to not fill residents up. They can be thickened in line with REDS as appropriate and may include:
  - full cream milk to drink (whole milk) rather than squash, water, tea or coffee
  - nourishing hot and cold drinks such as milky coffee, smoothies, multivitamin fruit juices, malted milk drinks, hot chocolate, homemade milkshakes
  - fortified milk can also be used in place of full cream milk in tea, coffee, cereal, porridge or milky puddings.

- Nutrient dense menu options will depend on the ingredients used and should be highlighted by the chef and/or catering team. Ideas can include:
  - meals with creamy sauces
  - milk-based products or desserts
  - foods that are fortified
  - foods, drinks or meals made with fortified milk.
- Food fortification means adding ingredients to food to increase the nutritional value. This can be done via catering or at the table prior to service in line with REDS and resident preferences.

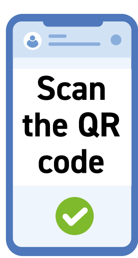
  Some examples of food fortification include:
  - add milk powder to puddings, yogurts, porridge or milk-based sauces
  - add extra butter or spread to foods, eg spread thickly on bread or crackers, mash into potatoes
  - add mayonnaise, salad cream and dressings generously to sandwiches, salads etc.
  - add jam, honey or syrup to breakfast cereals, porridge, cakes, scones, toast, puddings etc.
  - add double cream, Greek yogurt or dairy-free alternatives to sauces, yogurts, desserts or porridge
  - add beaten egg to mashed potatoes
  - add "toppers" to porridge or cereals such as ground almonds, fruit puree, dried fruit, chocolate spread
  - add ground nuts into soups, porridge, casseroles or stews.

Other tips to improve nutritional intake include:

- Avoid low-fat and low-sugar products. Fats and sugars provide energy and can help foods taste better.
- Offer a thick and creamy yogurt with breakfast.

Fortified milk

- Fortified milk has higher protein and calories.
- It is made by adding skimmed milk powder to whole milk (full fat). Milk powders derived from animal sources are preferred as they are higher in protein than those containing vegetable fat.
- Whisk four heaped tablespoons (60g/2oz) of skimmed milk powder into one pint (568ml) of whole milk (full fat). If possible, make a paste or roux with the milk powder and a small amount of milk, before gradually whisking in warm milk to achieve the desired consistency. Scan the QR code or visit https://youtu.be/mExRhghQKTE?si=4YGyVh4Ru1bQFwNY to watch a video on how to make fortified milk.



- This milk can then be used to make:
  - milky drinks such as hot chocolate and coffee;
  - malted drinks such as Ovaltine, Horlicks and cocoa;
  - porridge or poured over cereal;
  - sauces, such as white or cheese sauce;
  - milkshakes (try adding fresh fruit and ice cream for a 'thick shake');
  - desserts, such as custard, semolina, rice pudding;

  - instant soup in a cup or powdered soup;
  - thickened drinks – please be aware that thickener can take up to 15 minutes to activate correctly in milk-based liquids. Drinks should be tested to ensure they have reached the correct IDDSI level before serving (see IDDSI testing on page 48).

- Further recipes available in Appendix 7.
- Fortified milk should be stored in the refrigerator and used within 24 hours.

Oral Nutritional Supplements (ONS)

Prescribed oral nutritional supplements (ONS) are not the first line treatment options for malnutrition and should only be started when all food-based options have been trialled and in conjunction with a dietetic assessment.

Enteral tube feeding

If applicable and as per resident's needs, nursing staff should have up-to-date training on the knowledge and skills for provision of enteral tube feeding.

Any residents receiving nutrition via enteral routes should be under the care of a dietitian.

Religious and cultural diets

Religious and cultural diets

Religion and culture can have a major influence on an individual's food choice. People also have personal beliefs and follow guidance to varying degrees, on what is and is not appropriate to eat and drink for their faith or culture. It is therefore important not to make assumptions about a resident's food choice and habits based on their ethnic origin, religious beliefs and culture.

It is essential to seek to understand the residents background, their current religious or cultural dietary requirements, choices, and preferences. This helps to support a person-centred approach, which can meet their needs, whilst respecting and ensuring their values are understood and upheld. The Health and Social Care Act 2008 (regulated activities) Regulation 14 states that any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background must be met'.[10] This is reinforced in the Equality Act (2010) and NICE guideline [NG189] "Safeguarding adults in care homes" (2021).[3,11]

Understanding and adapting to the background, culture, and religion of all residents will allow for better menu planning and ensure that food provided is acceptable to all. It is important to avoid unacceptable cross-contamination: practise the same principles used to avoid cross contamination in the management of food allergy.

Tips for menu planning

- The catering team should be equipped with the relevant dietary knowledge and skills required to cook appropriate meals for all residents within their care home.
- Working with the resident and their loved ones can allow catering teams to determine whether it is possible to cook meals compliant with a resident's religious or cultural beliefs from scratch within the kitchen. If this is not possible, ready prepared, appropriately certified meals can be bought from specialist suppliers.
- It is important that all residents receive the same standard of food and beverage service.
- Providing a variety of culturally appropriate options as part of the regular menu, snack menu or on social occasions such as specific events can provide variety for all residents in the care home.
- Consider a resident's written and spoken language in terms of how a menu is presented to residents to support them to make meal choices.

Dietary customs

<table>
<tr><th>Religion or cultural identity</th><th>Dietary customs</th></tr>
<tr><td>Christianity</td><td>Main diet: Few dietary restrictions. Some may choose a vegetarian or vegan diet.

Notes: Some foods may be avoided during Lent (40 days leading up to Easter)

Some refrain from eating meat on Ash Wednesday, Good Friday and Fridays during Lent. Some residents may prefer to opt to eat fish on a Friday all year around.</td></tr>
<tr><td>Hinduism and Buddhist</td><td>Main diet: Usually vegetarian or vegan diet.
May avoid:
• beef, fish, poultry, dairy, eggs and foods containing these products
• garlic and onion
• alcohol, tea and coffee.

Notes: There are times where some residents may choose to fast (varies depending on individual beliefs)</td></tr>
<tr><td>Islam</td><td>Main diet: Halal “permissible” foods. Foods must be procured, slaughtered, processed and traded in compliance with Islamic law. Halal foods: fruits, vegetables, eggs, milk and dairy foods, fish with fins and scales.

Foods to avoid:
• pork and pork containing products
• blood, crustaceans
• non-halal meats and non-halal animal derived ingredients, for example gelatine, suet
• alcohol.

Notes: During Ramadan many avoid food and drink between sunrise and sunset. There are exemptions for older adults and those who are chronically or acutely ill.
Residents with diabetes, who have their diabetes controlled either by diet or tablets, may fast. However, they may need some modifications in the type, dose and timing of their tablets. Residents injecting insulin are usually asked not to fast.</td></tr>
</table>

Religion or cultural identity	Dietary customs
Judaism	**Main diet:** consists of fruits, vegetables, grains, herbs and Kosher meats. **Foods to check:** • check meat products are Kosher - beef, lamb, venison, goat, chicken, turkey, goose, duck • eggs (should not have blood spots) • fish must have scales and fins, for instance cod, haddock, mackerel, salmon, trout and whitefish **Usually exclude:** pork and pork products, non-Kosher meats and shellfish (crab, clams, prawns). **Notes:** Meat and dairy products must not be prepared, cooked or eaten together (3-6 hours apart). Preparing or cooking them requires use of separate utensils and crockery, and these must be stored, washed and dried separately from each other. Day of Atonement (date varies), and during Passover (8 days during April) all foods which swell or rise during cooking are avoided (bread, pasta and grains).
Rastafarian	**Main diet:** Usually vegetarian or vegan diet. **Foods to check:** Sometimes choose "Ital foods" (foods in a whole and natural state). May avoid: • non-organic foods • processed foods, canned foods • tea, coffee and alcohol • fish without scales and fins (acceptable fish that have scales and fins, such as cod, haddock, mackerel, salmon, trout and whitefish)
Seventh Day Adventists	**Main diet:** Usually vegetarian diet, some are vegan. **Foods to check:** meat, poultry, eggs, fish must have scales and fins (cod, haddock, mackerel, salmon, trout, white fish). **Foods to avoid:** Pork and foods containing pork. **May also avoid:** tea, coffee, alcohol, and foods containing these.
Sikhism	**Main diet**: Usually lacto-vegetarian (avoiding meat and eggs) **Foods to check:** meat if killed by Jhatka method is allowed (difficult to source in UK). **Foods to avoid:** pork, beef, alcohol and foods containing these.

Vegetarian, vegan and plant-based diets

Vegetarian, vegan and plant-based diets

A resident may choose to eat a plant-based diet including a vegetarian or a vegan diet for moral, religious, cultural or health reasons.

The Health and Social Care Act 2008 (Regulated Activities) Regulations state 'when a person has specific dietary requirements relating to moral or ethical beliefs, these requirements must be fully considered and met. This is reinforced in the Equality Act (2010) and NICE guideline [NG189] "Safeguarding adults in care homes" (2021[AF1]).[3, 10, 11]

A plant-based diet contains foods that come from plants with few or no ingredients that come from animals. This includes vegetables, wholegrains, beans, pulses, nuts, seeds and fruits.

Vegetarian diet

A vegetarian diet usually includes:

- vegetables and fruits
- grains, beans and pulses
- nuts and seeds
- wholegrains

Some vegetarian diets also include:

- eggs
- milk and products made from milk such as cheese (if animal rennet-free), yogurt, butter
- fish, shell fish, crustaceans
- fortified plant-based drinks (soy, oat or almond)

Vegan diet

A vegan diet does not include food derived from animals so excludes the following:

- meat or poultry
- fish, shellfish or crustaceans
- products derived from animals, including suet, gelatine, stock made from any of the above
- eggs
- milk and products from any animal milk, such as cheese, yogurt, butter
- honey
- products containing any of the above, such as cakes or biscuits
- insects, which may be used in some food colourings

Menu planning

It is important to establish with each resident what they eat or avoid eating and document this on their care plan. The catering team need to be advised of special dietary requirements.
Aim to provide a variety of plant-based choices on the menu to ensure the nutritional needs of the residents are catered for. Including soya, tofu, calcium fortified plant-based drink, fortified breakfast cereals, nuts and beans can help to support residents to eat a nutritionally balanced diet.

Residents following a vegetarian or vegan diet may have additional dietary needs (for example, swallowing difficulties, diabetes). These additional needs combined with taste preferences, poor appetite can increase the risk of malnutrition. Liaise with a dietitian for further advice.

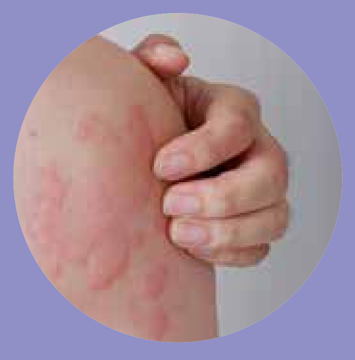
Some vegetarian and vegan foods may be lower in protein and micronutrients (like vitamin B12 and iron), therefore careful planning of the menu is required to offer a balanced diet. The following table may assist in menu planning nutrients that you need to consider.

Nutrient	Required for	Plant sources	Non-plant sources
Protein	• immune system • muscles • bones	• lentils, beans, chickpeas • seeds, nuts and nut butters • tofu and tempeh (fermented soya) • meat substitutes like soya, mycoprotein (Quorn, seitan)	• eggs • fish • dairy
Omega-3	• heart • lungs • immune • hormones	• walnuts • flax, chia and hemp seeds • rapeseed, hemp and flaxseed oils	• oily fish, eg pilchards, salmon, mackerel
Vitamin D All residents need a daily supplement of vitamin D3. A supplement containing D2 is suitable for residents following a vegan diet.	• bones • teeth	• fortified fat spreads • fortified breakfast cereals • fortified plant-based drinks (check food labels if fortified with vitamin D)	• eggs • oily fish

Nutrient	Required for	Plant sources	Non-plant sources
Vitamin B12	Nervous system	• fortified breakfast cereals • yeast extract • fortified soya drinks and yogurt Check food label as not all are fortified. Residents who exclude all animal derived foods are at risk of deficiency and vegan diets may need to be supplemented with B12.	• eggs • milk and dairy foods
Iodine	Thyroid hormones	Residents who exclude all animal derived foods are at risk of deficiency, and vegan diets may need to be supplemented with iodine.	• milk and dairy products • fish
Iron	Prevention of anaemia	• dried fruits • wholegrains • nuts and seeds • green leafy vegetables • peas, beans and lentils Offer foods rich in vitamin C to increase absorption of iron from plant sources for example oranges, orange juice (150ml), broccoli, berries. Avoid drinking tea and coffee at meal times as these contain tannins which reduce absorption of iron.	• eggs • oily fish
Zinc	Immune system	• nuts and seeds • wheat germ • beans • mushrooms • fermented soya (tempeh and miso)	• eggs • milk and dairy foods • shellfish

Nutrient	Required for	Plant sources	Non-plant sources
Calcium	Bones Teeth	• fortified plant-based drinks, yogurts and cheese alternatives • bread • green leafy vegetables, for example spinach, kale and broccoli • dried fruit, for example raisins, prunes, figs • calcium set tofu • soya beans Some residents may be prescribed calcium supplements.	• milk and dairy foods

Allergies and intolerances including coeliac disease



Food allergies and intolerances

Food allergies occur due to the immune system's reaction to the proteins in certain foods. Symptoms can range from mild to life-threatening; it is therefore important for care and catering staff to understand any allergies among the people they care for and support.

Food intolerances do *not* involve the body's immune system but occur when the body has difficulty digesting certain foods or ingredients. Symptoms can be uncomfortable but are not life threatening.

Some of the foods that cause intolerances overlap with food allergens; it is therefore essential that catering staff and care teams are aware if a resident has a food intolerance or allergy.

Food allergies

Symptoms can occur straight away after eating the food containing the allergen, or it can have a delayed effect of hours up to days.

Skin reactions	• Hives, itching, rashes, redness, eczema and flushing
Swelling	• Lips, tongue, face and throat
Breathing issues	• Sneezing, runny nose, cough, tight chest and breathlessness
Digestive issues	• Diarrhoea, cramps, bloating, nausea and vomiting
Cardiac issues	• Increased pulse, dizziness and fainting
Anaphylaxis	• Involves multiple reactions including swelling of throat and tongue, difficulty breathing and swallowing and loss of consciousness. **This requires urgent medical attention! Call 999 immediately.**

Diet and allergies

UK legislation requires all food services, including those in care homes, to provide information if they use any of the 14 regulated allergens as ingredients on any of the food and drink they serve to residents, staff or visitors. This includes the brand names and pack sizes where applicable and any alternative ingredients used. Caterers must also take note of any precautionary 'may contain' labels on packaging this includes any purchasing of allergen-free specialist meals.

Staff should ensure safe preparation and service to avoid cross contamination and complete training to manage allergens effectively.

Food Standards Agency, 2024[12]

There are 14 major allergens that are governed by UK food laws (57), which are:

1. Celery (seeds, stalks, leaves and roots)
2. Cereals containing gluten (such as wheat, rye, barley and oats)
3. Crustaceans (prawns, scampi, crabs, lobsters, shrimp paste)
4. Eggs (mayonnaise, cakes, mousses, pasta, sauces, food brushed or glazed in egg)
5. Fish (including anchovies in Worcester sauce, salad dressing, relish, stock cubes)
6. Lupin (flour and seeds for pizza bases, bread, pastries and pasta)
7. Milk
8. Molluscs (oysters, squid, octopus, cockles, mussels, scallops and snails).
9. Tree nuts (almonds, hazelnuts, walnuts, cashews, pecans, brazil, macadamia, pistachios)
10. Peanuts
11. Sesame seeds (bread, breadsticks, sesame paste, tahini and hummus)
12. Soya (soybeans, tofu, miso paste, desserts, ice cream, veggie burgers)
13. Sulphur dioxide (sulphites) (used to help foods retain colour or as a preservative in dried fruit, wine, beer, soft drinks)
14. Mustard (plant, seeds, powder, oil, flour and table)

To prevent reactions complete avoidance of an allergen is required. It is recommended that all care homes have a food allergy policy or a wider food and nutrition policy that includes allergen management. It is essential prior to or on admission that information regarding residents' allergies are collected and recorded, and a process is in place to communicate this to catering and care staff.

In addition, staff members or visitors who have a food allergy and are eating within the home, must also communicate appropriately with the catering and care staff about their food allergies.

For residents with allergies it is important that all food groups are included in their diet with inclusion of suitable alternative allergen-free options.

Coeliac disease

Coeliac disease affects around 1 in every 100 people worldwide which equates to around 500,000 people in UK and 10,000 people in Northern Ireland (Coeliac UK, 2024).[13]

Coeliac disease is not an allergy or intolerance but an autoimmune condition where the body attacks its own tissues due to ingestion of gluten, a protein that is found in wheat, barley, rye and oats leading to damage to the intestine.

The only treatment for coeliac disease is to follow a strict, lifelong gluten-free diet.

Gluten is found in food or drink that contains wheat, barley and rye eg flour, bread, pasta, cereals, cakes, biscuits, sauces, ready meals, barley water and beer or ale. Some people are also sensitive to oats.

Symptoms of exposure to gluten due to undiagnosed coeliac disease, poor compliance or cross contamination, are:

- Gastrointestinal issues such as constipation, diarrhoea, reflux or heartburn
- Skin issues such as dermatitis herpetiformis
- Abnormal blood results due to malabsorption of nutrients
- Headaches
- Depression.

Long-term exposure to gluten and non-compliance to gluten-free diet can lead to serious health conditions such as osteoporosis, respiratory problems, neurological problems and lymphoma or small bowel cancer.

Any resident with coeliac disease who has ongoing or recurring symptoms or requires further dietary education on a gluten-free diet should be referred to a dietitian.

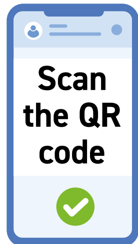
What is a gluten-free diet?

Residents with a diagnosis of coeliac disease must have access to gluten-free meal and snack options. When preparing gluten-free options it is important for staff to be aware of:

- Foods that are naturally gluten free - including plain meat, fish, chicken (no breadcrumbs or batter), pulses, fruit, vegetables, rice and potatoes.
- Available gluten-free substitutes and the importance of checking:
  - Food labels and ensuring packaged foods are 'gluten free' – avoid labels that say 'may contain wheat' or 'made in a factory handling wheat'
  - Ingredient lists for potential allergens like wheat, rye, barley and oats
- Sources of cross contamination, such as cooking utensils, crumbs from toasters or on cooking trays, crumbs on butter or jam or marmalade.

A gluten-free diet should include an extra portion of calcium rich foods daily due to reduced absorption of calcium in the gut.

Scan the QR code or follow the link to resources from Coeliac UK www.coeliac.org.uk



Gluten-free prescription products

Currently in Northern Ireland, there is a prescription allowance for gluten-free 'staple' products for anyone with a confirmed diagnosis of coeliac disease. For further guidance discuss with GP, dietitian or pharmacist. Further guidance is also available on www.coeliac.org.uk.

Practical dietary guidance when catering for residents with coeliac disease:

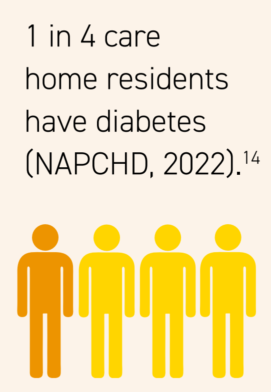
To avoid cross-contamination, residents require separate utensils and cooking equipment for the preparation of gluten-free options.

Food preparation	• Ensure appropriate hand hygiene • Wipe down surfaces and clean cooking equipment with hot soapy water • Avoid touching gluten containing foods until gluten-free options are prepared
Storage	• Store gluten-free foods separately, eg dedicated shelves and containers • Store gluten-free foods above gluten-containing foods • Using separate, colour coded bread boards for gluten and gluten-free breads
Cooking	• Have separate butter or spreads, jams and marmalades that are clearly labeled as 'gluten free' • Use a separate toaster or consider using toaster bags • Use a separate fryer for gluten-free foods • Use separate cutlery and utensils for gluten containing and gluten-free foods • Use separate dishes for condiments or opt for squeezable bottles • Consider cooking gluten-free options on upper oven shelves

Diabetes

Diabetes

1 in 4 care home residents have diabetes (NAPCHD, 2022).[14]



More than 90% of these residents have Type 2 Diabetes Mellitus (T2DM), with the remainder predominantly Type 1 Diabetes Mellitus (T1DM).

T1DM residents will have insulin injections. T2DM residents may be managed by diet alone, diet and oral medication and/or injectable medication (which is not insulin) and/or insulin injections.

Main principles for best practice in diabetes management in care homes

- To maintain the highest degree of quality of life and wellbeing without subjecting residents to unnecessary and inappropriate medical and therapeutic interventions.
- To provide sufficient support and opportunity to enable residents to self-manage their own diabetes.
- To provide an individualised care plan which considers the holistic needs of the resident.
- For residents on insulin, complex cases with significant multi-morbidity and/or frailty/dementia, or those with T1DM, care homes should liaise with dietitians and/or the Diabetes MDT to seek advice in developing individualised care plans (NAPCHD, 2022).[14]

Residents with diabetes should be encouraged to eat a variety of foods from the five main food groups and follow the nutritional considerations for older adults in care homes.

Special considerations for residents with diabetes

Consideration	Reason or advice
Meals or snacks should be regularly spaced over the day	This will help control blood glucose levels throughout the day.
Supper or snacks	This is required for those residents treated with mixed insulin; for example, Novomix 30, to prevent overnight hypoglycaemia. For example, slice of toast or yogurt.
High fibre choices should be encouraged as these help with maintaining blood glucose levels	• granary, multigrain or wheaten bread • new and sweet potatoes with skins • basmati or brown rice • wholemeal pasta • porridge oats • high fibre cereals such as Weetabix or Shredded Wheat
Consistent portion sizes day to day with consistent meal/snack timings	Particularly important for starchy carbohydrates to help maintain blood glucose levels (see Appendix 3).

Consideration	Reason or advice
Drinks	• Using sugar-free, no added sugar or diet/zero drinks or squashes is recommended. • Avoid adding sugar to meals/drinks. • Tea or coffee should be offered without sugar (use an artificial sweetener if necessary). • Pure unsweetened fruit juice should only be taken with a meal and maximum of 150ml once per day. It is better to take fresh whole fruit instead. • Fruit smoothies should be discouraged as these can cause high blood glucose levels. • Alcohol can cause both high and low blood glucose levels. If included, encourage taking with a meal. If on medication which can cause hypoglycaemia a supper snack is advised after taking alcohol. Avoid high sugar options such as alcopops, liqueurs and cider.
Snacks	• Fruit can range between 3 to 5 portions per day and spread evenly throughout the day due to the impact on glucose control. • Pancakes, cheese and crackers, wheaten bread, plain cakes or buns. • 1-2 plain biscuits such as Rich Tea, Marie biscuits or ginger biscuits x1.
Desserts	• Tinned fruit in natural juice, fresh fruit, stewed fruit without sugar (could substitute with artificial sweetener). • Diet/light/ no added sugar yogurt or fromage frais. • No added sugar milk pudding or sugar-free jelly. • Sugar-free ice lollies.
'Diabetic' foods and drinks	These are **not** recommended. They offer no benefit to people with diabetes. These can still affect blood glucose levels, can have a laxative effect and are expensive.
Medications	Administration and timing of diabetes medications, including insulin, need to take into account the timing of meals and snacks.

Weight management in diabetes

Decisions regarding weight management should be the residents' choice or a decision made in their best interests and in discussion with the wider MDT who support with care planning.

Nutrition support in diabetes

The advice below should be implemented for those residents with diabetes who are at risk of malnutrition.

- Whilst energy/protein/fat intake may increase, take care not to increase the sugar intake significantly for residents with diabetes. Fortifying with jam, chocolate spread and biscuit spreads may lead to higher blood glucose levels, which can further weight loss. Instead, consider fortifying with butter, cream, nut butter, sour cream or hummus.

- Offer additional nutrient dense snacks and drinks between meals, adopting a small and frequent meal or snack approach (Appendix 5 Snacks).
- Close monitoring of food intake and blood glucose levels is required, particularly for residents with diabetes on certain medications, due to potential risk of hypoglycaemia where oral intake has reduced.
- Oral nutritional supplements (ONS) may be required for some residents; these can cause blood glucose levels to rise. Consideration should be given to the type of ONS used and timing of ONS administration to help with the impact on blood glucose levels. Therefore, it is important to monitor blood glucose levels closely and liaise with GP/diabetes specialist nurse and dietitian to adjust medication as required.

Preventing hypoglycaemia (blood glucose less than 4mmol/L)

- Causes of hypoglycaemia can include
  - recent weight loss
  - poor appetite
  - reduced oral intake
  - delayed or missed meals
  - reduced carbohydrate intake
  - alcohol intake
  - increased physical activity
  - taking too much diabetes medication (gliclazide or insulin)
- Residents at risk of hypoglycaemia will require individualised care management plans and staff should follow local hypoglycaemia policies.
- Note not all hypoglycaemia treatment options will be appropriate for residents with dysphagia. Residents who have dysphagia and diabetes, who are at risk of hypoglycaemia, will require referral to Diabetes Specialist Team.

Eating, drinking and swallowing difficulties (dysphagia)

Eating, Drinking and Swallowing Difficulties (Dysphagia)

The medical term "dysphagia" is used to describe a difficulty eating, drinking or swallowing.

The incidence and severity of eating, drinking and swallowing (EDS) difficulties can increase with age and it is estimated that between 50 and 75% of care home residents have signs and symptoms of dysphagia. Risks associated with dysphagia include choking, aspiration, malnutrition, dehydration, social isolation and reduced quality of life.

Resources to help you identify and support people with swallowing difficulties
Swallowing Difficulties Observational Checklist will help you identify swallowing difficulties and provide guidance regarding referral. **www.publichealth.hscni.net/sites/default/files/2022-11/A4%20Swallowing%20Difficulties%20ID%20checklist%20Poster_Nov%2022.pdf**

If you notice that a resident is showing signs of swallowing difficulties, then you must record it, report it and refer them to SLT. Follow your local referral process (see Eating, Drinking and The Swallowing guide – "when and how to refer")
https://hscni.pagetiger.com/eds-guide-pha-editable/eds-guide-pha

Whilst awaiting SLT assessment, there is further guidance here - Fundamentals of Care for Eating, Drinking and Swallowing.

https://view.pagetiger.com/interim-plan-guidance-pdf-version/1

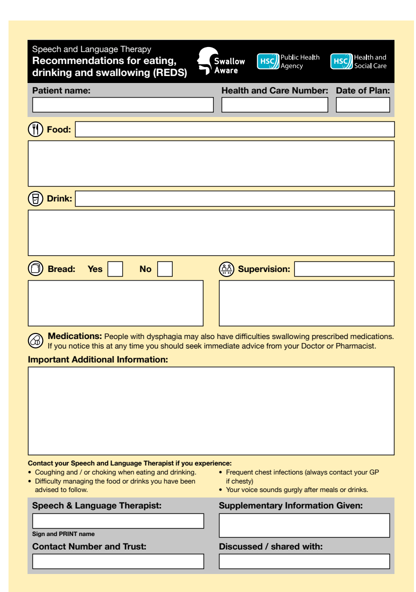
Recommendations for Eating, Drinking and Swallowing (REDS)

Following a specialist assessment, the SLT may provide Recommendations for Eating, Drinking and Swallowing (REDS). This document is used regionally and across all care settings.

This document includes:

- recommendations for the IDDSI level of foods
- recommendations for the IDDSI level of fluids
- recommendations for supervision
- recommendations about bread
- additional information, for example positioning, volumes and equipment

The REDS should be recorded in the resident's notes or electronic record and should be visible within the person's environment and clearly communicated with all those involved in the resident's care.



Speech and Language Therapy
Recommendations for eating, drinking and swallowing (REDS)
Swallow Aware | HSC Public Health Agency | HSC Health and Social Care

Patient name: | **Health and Care Number:** | **Date of Plan:**

Food:

Drink:

Bread: Yes ☐ No ☐ | **Supervision:**

Medications: People with dysphagia may also have difficulties swallowing prescribed medications. If you notice this at any time you should seek immediate advice from your Doctor or Pharmacist.

Important Additional Information:

Contact your Speech and Language Therapist if you experience:
- Coughing and / or choking when eating and drinking.
- Difficulty managing the food or drinks you have been advised to follow.
- Frequent chest infections (always contact your GP if chesty)
- Your voice sounds gurgly after meals or drinks.

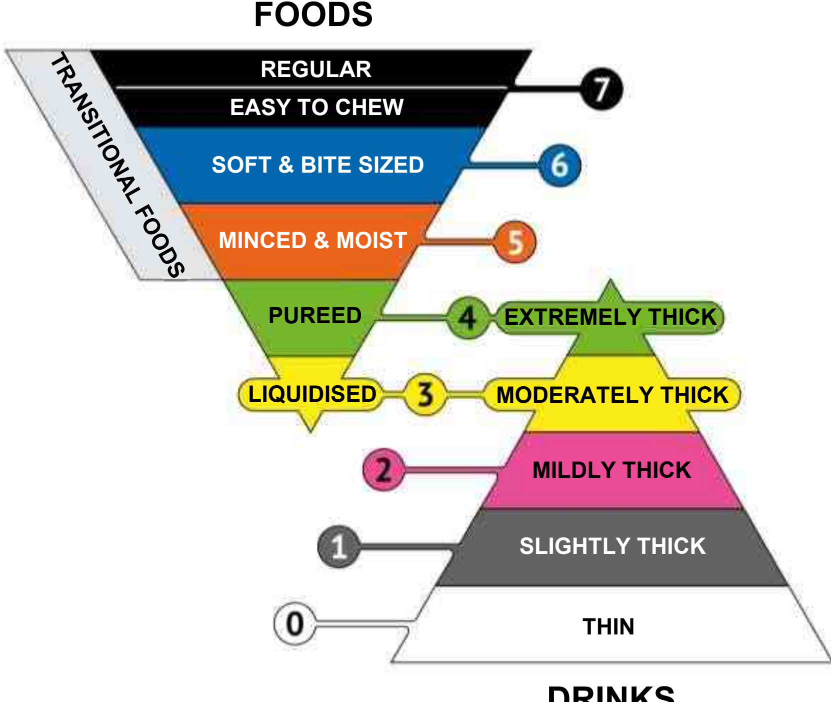
Speech & Language Therapist:
Sign and PRINT name
Contact Number and Trust:
Supplementary Information Given:
Discussed / shared with:

International Dysphagia Standardisation Initiative (IDDSI)

The SLT will use the International Dysphagia Standardisation Initiative (IDDSI) terminology on the REDS document to recommend the level of food and drink advised.

All staff involved in food or drink preparation and service have a responsibility to ensure that the meal, snack or drink is in line with the IDDSI descriptor that the resident requires.

IDDSI provides guidance on testing methods (scan the QR code below)that are intended to confirm the flow or texture characteristics of foods or drinks at the time they are tested. The food and drink provided should meet the testing method for the texture/ consistency that is being offered.[15] You can speak to your SLT or dietitian for support with IDDSI.



The IDDSI audit tools are a useful resource when developing a new menu item and when auditing texture modified food and drink: www.iddsi.org/resources/audit-tools

IDDSI flow test for liquids

IDDSI recommends the use of a specific 10ml syringe or the IDDSI funnel as objective methods to test the IDDSI level of a liquid.

Amount left in the syringe or funnel after 10 seconds

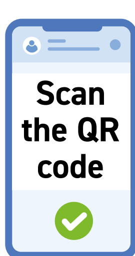
- Level 1 1-4ml
- Level 2 4-8ml
- Level 3 8-10ml
- Level 3 can also use the fork drip test
- Level 4 use the fork drip or spoon tilt test

IDDSI testing of foods

	Properties	Fork drip test	Spoon tilt test	Fork pressure Test	Syringe/ funnel test (10 sec flow)
3 LIQUIDISED	Smooth; no bits	Food drips slowly in droplets	---	Fork does not leave pattern, even briefly	>8ml remains; then fork drip
4 PUREED	No lumps	Mound; slight tail; no drip	Holds shape; slides; may spread slowly	Fork leaves clear pattern; food briefly retains indention	---
5 MINCED & MOIST	Fork Tine Size Test: 4mm x 15mm; no separate thin liquid	---	Holds shape; slides; may spread slowly	Easily squashed with fork; pressure without nail turning white; easily separates	---
6 SOFT & BITE SIZED	15mm x 15mm (0.5 inch); no separate thin liquid	---	---	Squashed without returning to original shape; pressure turns nail white; food can be broken up with fork or side of spoon	---
7 EASY TO CHEW	May be any size	---	---	Squashed without returning to original shape; pressure turns nail white; food can be broken up with fork or side of spoon	---

High risk foods

For a resident who has eating, drinking and swallowing difficulties, there are certain foods that are more likely to result in choking due to their texture and shape. Follow the link or scan the QR code to watch this short video to find out more.
See pha.site/HighRiskFoods



Nutrition and hydration for dysphagia

Residents with dysphagia are at higher risk of malnutrition and dehydration. Some reasons for this include:

Malnutrition	Dehydration	Both malnutrition and dehydration
• Liquid is added to food to modify the texture – this decreases the nutritional content • Those receiving modified texture diets often eat less because the texture has been modified • Thickening powder can cause a feeling of fullness, further reducing appetite • Lack of variety of foods offered at meal and snack times	• Thickened drinks may be less palatable • If thickened drinks are not prepared correctly, for example contain lumps of undissolved powder or are over-thickened - these are unlikely to be consumed • Recommendations to take small sips or fluids from a teaspoon may result in less being consumed • Thickened drinks may not be offered as frequently	• Residents with EDS difficulties may tire easily. • Residents with dysphagia may have anxiety around eating and drinking • Residents may no longer be able to eat or drink their favourite foods and fluids or may not recognise them. • Reduced self esteem - people with dysphagia may avoid eating and drinking around others (due to coughing, oral leakage, discomfort)

See section on Malnutrition and nutritional screening for more information on how to maximise nutritional intake and fluid intake.

Dysphagia and oral nutritional supplements

Prescribed oral nutritional supplements (ONS) are not the first line treatment options and should only be started when all food-based options have been trialled and in conjunction with a dietetic assessment. For residents with dysphagia, ensure the ONS product is compliant with the resident's IDDSI levels recorded on REDS.

It is important to note that if the resident's REDS changes, and their supplement does not match their new IDDSI recommendation, you should consult their GP, or their dietitian if they are still under dietetic care.

Safety tips

When a resident has a difficulty eating, drinking and swallowing, there are some extra important points to note when taking nutritional supplements:

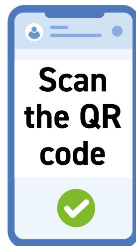
- Thickening powder should never be added to oral nutritional supplements. They do not thicken well due to their high fat and protein content.
- Most nutritional supplements taste best when taken cold but some IDDSI labelled ONS come with specific instructions to take them at room temperature – the dietitian or GP will advise.
- Never freeze or heat nutritional supplements prescribed for a resident with dysphagia. This may change the thickness (IDDSI level) which might make the supplement less safe for them to swallow.
- Powdered supplements should be made up according to the instructions on the packet – this will ensure they are the correct thickness (IDDSI level).

Hints and tips for modified texture meal preparation

- When adding fluid to food to achieve IDDSI Level 3 or 4, use nutrient dense fluids such as milk-based sauces. Gravy or cooking juices can also enhance the flavour of the dish but may not be nutrient dense. Avoid using water as it dilutes both flavour and the overall nutritional content of the food served.
- Enhance flavours using ingredients like herbs, spices or cheese where appropriate.
- The British Dietetic Association, within their "Care Home Digest" (2024), recommend the use of purchased food thickeners such as Brakes Instant Food Thickener, Nutrisis, UltraTex, or natural thickeners, for example flour or cornflour/corn starch, to thicken food items.[2] For residents who are already prescribed thickening powders for fluids, these can be used to thicken foods, for example to prepare soaking solutions. However, it is important to note that they can only be used for the individual resident for whom they are prescribed.
- Ensure that the presentation and appearance of modified texture meals look visually appealing and appetising (use moulds or piping for example). Present different meal items separately on the plate.
- Ensure that food or drink is served at an appropriate temperature.
- Be aware that the texture of modified food can change over time, especially if it changes temperature, so food should always be tested according to IDDSI testing methods before serving.

Good practice guidance for thickening drinks

Key information in relation to the use of prescribed thickeners:



- Thickeners are powders that are added to drinks to make them thicker. Thickeners must be prescribed for individual use.
- Adding thickener can sometimes make swallowing drinks easier because it causes drinks to move more slowly in the mouth and throat, giving more time to co-ordinate a swallow.
- Thickened fluids have risks as well as benefits, these should be considered for every resident. Do not thicken a resident's drink unless an SLT has advised this within the REDS.
- **Thickeners must be stored securely as they can pose a choking risk if ingested dry.**

Practical steps for thickening drinks

1. Follow the specific manufacturer's mixing instructions
2. Use only the scoop provided in the tin and add the correct number of level scoops
3. ALWAYS measure the fluid
4. Add measured fluid to powder and mix with a fork until powder is dissolved
5. Wait for the drink to reach the correct consistency and ensure there are no lumps before serving
6. Test drinks before serving to ensure they are the correct IDDSI level (see IDDSI flow test for liquids on page 48)

Other practical tips for thickening drinks

- For fizzy drinks, stir for 15 seconds to release some of the bubbles before mixing with the powder.
- Milk-based drinks take longer to mix, and may require up to 15 minutes standing time to reach the desired consistency.
- Pure apple or orange juice may take longer to reach the desired consistency.
- If thickening tea or coffee, always add the milk and sugar to the drink before mixing with the powder.
- Remember to test drinks before serving to ensure they are the correct IDDSI level (see IDDSI flow test for liquids on page 48).

Sensory enhancement strategies

Modifying taste and temperature has been found to improve swallowing for some people.

- Increasing the intensity of taste (for example, with spices) can stimulate a more effective swallowing reflex.
- Temperature alters the perception of textures in the mouth. Some people swallow more effectively when a hot meal is alternated with a very cold drink and vice versa.
- Carbonation (making drinks fizzy) may help prevent aspiration and improve residue management for some patients with dysphagia. Literature suggests that carbonation enhances the swallowing process by exciting multiple sensory pathways.

Eating and Drinking with Acknowledged Risks (EDAR)

Some residents and families may have questions or concerns about the advice they have received from their SLT. They may decide not to follow some or all of the recommendations.

"Eating and drinking with acknowledged risks" refers to the decision to continue eating and drinking despite the associated risks from having dysphagia.

This is a complex discussion and decision which requires input from various members of the MDT.

There are a range of factors to consider including:

- risk of respiratory complications (like chest infections or choking) if they ate or drank something that was outside of SLT recommendations
- individual preferences
- quality of life
- nutritional risks such as dehydration and malnutrition if minimal intake continues for a prolonged period of time
- capacity and best interests of resident

For more information on EDAR, speak to your SLT.

Training on dysphagia awareness

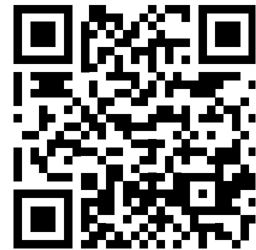
All staff should access mandatory Swallow Awareness (dysphagia) training – accessible on Learn HSCNI.

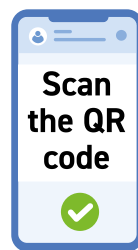
Signposting

Swallowing information for end of life care

Eating, Drinking and Swallowing – A guide for carers of people living with a dementia

For more information for healthcare professionals on dysphagia, follow the link or scan the QR code.
http://pha.site/dysphagia-professionals





Dementia

Dementia

According to Alzheimer's Society (2022), 69% of older people in care homes are living with dementia.[16]

Residents with dementia can experience many features contributing to reduced appetite and weight loss. They may eat less food or may be physically unable to eat, have greater nutritional requirements, or have neurological imbalances making mealtimes difficult.

Tips for meal and snack times:

- offer small portions and second helpings
- serve each course separately, allowing sufficient time for the resident to finish eating
- offer as much choice as possible, taking into account the resident's preferences*
- offer reassurance and choice
- consider unmet needs, for example pain, thirst, hunger, company, temperature, comfort
- consider colour of plate used to provide contrast, for example white bowl for tomato soup
- offer hand under hand assistance if needed and/or appropriate
- ensure mealtimes are calm and limit distractions, for example TV, patterned plates, noise, unnecessary items on the table
- liaise with occupational therapy (OT) for advice regarding suitable crockery or feeding aids

*A person with dementia may develop a preference for sweeter foods. Continue to offer a variety of food groups however consider adding sweet tastes to encourage intake, eg fresh fruit to savoury dishes, sweet pastry on pies or casseroles, sweeter sauces with a meal such as honey, BBQ or sweet and sour.

Finger foods

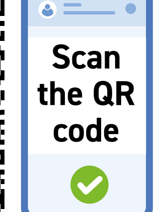
Finger foods are useful for residents who are not following an eating pattern of three regular meals, for those who walk about at mealtimes or who find it difficult to sit for an entire meal. They are ideal for residents who have difficulty recognising or using cutlery.

Finger foods can be suitable as main meals or snacks. They support people to choose the food they want to eat, and to feed themselves. Finger foods should be prepared so they are easy to pick up and eat with the hands.

For residents who walk about, a pouch bag or lunch box containing finger food may be useful. Ensure containers are cleaned regularly and is safe for the resident to use. A beaker with a lid can be used for drinks to avoid spillage.

Finger foods may not always be suitable for residents who require a modified texture diet (REDS) and you should consider a risk assessment, which takes into account the needs of all residents within the home.

www.publichealth.hscni.net/publications/eating-drinking-and-swallowing-guide-carers-people-living-dementia-english-and-translat



Finger food meal and snack ideas

Mealtime	Ideas (please consider residents REDS as appropriate)
Breakfast	Toast fingers, boiled eggs halved, fresh fruit, dried fruit, cereal bars, eggy bread, yogurt tubes or pouches, omelette squares
Main meal	Goujons, burgers, mini quiches or pies, mini pizzas, sliced or cubed meats, meatballs, drumsticks, vegetable batons, slices or sticks of fruit or vegetables, salad, chips, wedges, small potatoes, waffles
Light meals	Sandwiches, garlic bread, soup in a mug, scotch eggs, paninis, rolled up ham
Puddings	Individual cakes, pies or tarts, profiteroles, scones, sliced cake, ice cream cones, fruit kebabs, ice lollies
Snacks	Tea loaf, malt loaf, cheese and crackers, biscuits, crisps, fresh fruit, dried fruit, cheese cubes, cake bars, iced buns, cereal bars

Palliative care

Palliative care

The goal of palliative care is the achievement of the best quality of life for patients and their families (NICE, 2025).[17] Palliative care will enhance quality of life, and may also positively influence the course of illness.

The nutritional care required by palliative care patients depends on the stage of their illness and changes in the phase of illness can occur at any stage.

The below recommendations have been adapted with kind permission from Public Health Agency Guidance for appropriate prescribing of Oral Nutritional Supplements (ONS) in palliative care.

Proactive nutritional care

In the early phase of palliative care the resident may have months or even years of life remaining, and quality of life may be good. The aim of nutritional care is to maintain good nutritional status as tolerated by the resident to promote comfort and wellbeing:

- Identify those who are malnourished, or at risk of malnutrition, by nutritional screening.
- Proactive dietary management can reduce malnutrition when identified.
- Encourage a nutrient dense; high calorie, high protein diet if appropriate – refer to 'Malnutrition and nutritional screening' section.
- Minimize food related distress; encourage intake alongside resident wishes and preferences.
- Identify and manage symptoms, for example nausea, dry mouth, constipation, diarrhoea.
- Discuss future management of nutrition as appropriate including advanced care planning and escalation of care.

Conservative nutritional care

The resident experiences a general deterioration in their condition where they enter the last few months or weeks of life. Their appetite decreases and they become more fatigued. The aims of nutritional care are enjoyment of food and relief from food-related discomfort:

- Nutritional screening and weighing residents may not be appropriate at this stage however an individualised approach should be taken.
- Explain, as appropriate, that gradual loss of appetite and weight loss is normal and may not be reversible.
- Symptoms may persist despite treatment, for example nausea, diarrhoea, constipation, dry mouth.
- Continue to promote good mouth care.
- Focus on the enjoyment of food and drink, including resident preferences, rather than the need to maintain a normal diet.
- A nutrient dense, high calorie, high protein diet may be appropriate for some residents; however, it may prove too stressful for others.
- Oral nutritional supplements may be psychologically beneficial; however, appropriateness of prescription should be regularly reviewed as part of the care plan.

Comfort nutritional care

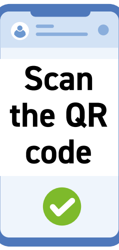
The resident is likely to be bed-bound, very weak and sleepy, with little interest in food or drinks. As the body slows down, systems within the body slow down. Withdrawing from eating and drinking is a natural part of the dying process. This should be explained to residents and those who are important to them.

The aim of care is to provide comfort:

- Small amounts of oral intake may decrease anxiety surrounding food. It may also provide comfort and taste for pleasure.
- At this point, Advance Care planning (ACP) and Escalation of Care documentation should be used along with the resident's wishes to make a decision regarding nutritional care.
- Provide good mouth care for comfort.
- Dietetic referral and MUST screening (see page 23) is not appropriate.

For more information for healthcare professionals on dysphagia, follow the link or scan the QR code:

http://pha.site/Dysphagia



Menu considerations

Menu considerations

Dietary needs, preferences or requirements

- Residents should be provided with a nutritious and varied diet which meets their individual dietary needs, preferences and religious or cultural requirements.
- At pre-admission or admission residents' dietary needs, preferences and religious or cultural requirements should be discussed and recorded. This may include input from the resident, their family, friends or loved ones and any recommendations from healthcare professionals. This information should be reviewed and updated as part of their nutritional care planning.
- A summary of residents' dietary needs, preferences and requirements should be available and actively used by staff at all meal and snack times.

Engagement with residents, families and loved ones

- Residents, families and loved ones should be involved in menu planning, including available choices for foods, drinks and snacks.
- Residents, families and loved ones should have an opportunity to provide feedback on issues such as choice, quality and quantity of foods, drinks and snacks.

Menu structure

- Menus should be rotated over a three-week cycle and revised at least six-monthly, taking into account feedback, as well as seasonal availability and sustainability to promote cost effectiveness.
- Display the daily menu in a suitable format (including pictorial where necessary) and in an appropriate location.
- Alternative options should be available on request.
- Communicate and record any variations to the menu.
- Keep records of menus and any variations for inspection purposes.
- Three regular meals and some snacks should be served every day at regular intervals; no more than five hours between each meal.
- Portion sizes should be adjusted in line with individual circumstances and extra servings should be available.
- The interval between the evening snack and breakfast being available should not be more than 12 hours.
- Food and drinks should be available 24 hours per day to allow for flexibility and individual circumstances.
- If appropriate, and following risk assessment, food and drink should be visible and accessible to residents (and visitors) so they are able to help themselves.

Menu choice

- Menus should offer a minimum of two choices at each meal including a hot meal choice.
- The two main meals of the day should have a minimum of two courses; ideally, this should include a main course and dessert. If offering two desserts, one should be a fruit-based option.
- Provide menus for special occasions such as celebrations or birthdays.
- Make residents aware of the next mealtime choices in sufficient time to allow for an alternative to be prepared if necessary.
- Structure snack times so that they are coordinated with the drink service and with activities.
- Offer snacks a minimum of twice per day with varied and rotated options.
- A range of hot and cold drink options should be available including bedtime drinks made with whole milk (full fat) or non-dairy alternatives.

"A nice tasty, healthy meal lifts the resident's spirits"
Care home staff, Southern HSCT area

Mealtime experience

Mealtime experience

Mealtimes are recognised and promoted as opportunities for social interaction. Evidence shows that eating with others in a calm and relaxed environment can increase appetite, oral intake and promote a positive mealtime experience (BDA Care Home Digest, 2024).[2]

- Ensure there is a clearly identified area available for dining.
- Give residents the opportunity to indicate their preferred choices of where to eat and whom to eat with.
- Where possible, residents should be actively involved in tasks such as setting the table.
- Colour contrast can help the resident see their food clearly - for example, put white foods like potatoes on a coloured plate (red and blue are commonly used), and coloured foods like tomato soup in a white bowl.
- Ensure tables are free from any unnecessary items.
- Protect mealtimes to ensure residents are given sufficient time to finish their meal without unnecessary interruptions or distractions.
- Offer residents appropriate clothing protectors, including napkins, which respect their dignity and protect their clothing.
- Residents should be offered use of toilet and handwashing facilities before and after meals.
- Residents should have all necessary aids in place for mealtimes as required, including dentures, glasses, hearing aids and aids for eating or drinking, such as specialist slip maps, drinks holders, straws, coloured crockery or adapted cutlery.

Mealtime service

- There should be a safety pause before serving foods, drinks and snacks. This will ensure everyone is aware of the needs of residents.
- Organise mealtimes to enable residents to receive adequate supervision and/or assistance which is specific to their needs.
- Foods, drinks and snacks should be appealing in terms of flavour, texture, smell and appearance.
- Serve foods, drinks and snacks at the correct temperature, taking into account resident preference including those residents who eat slowly.
- Maintain high standards of food hygiene and train staff appropriately to their level of food preparation and service.

Assistance with meals

Note that practical support or assistance should be provided to enable a successful eating and drinking experience. For instance, "help with cutting up food or opening packaging" is not the same as SLT EDS supervision.

- Residents should be facilitated to eat and drink independently where possible.
- Only offer assistance if necessary and if you have obtained consent.

- There should be adequate numbers of trained staff present at mealtimes to ensure appropriate supervision and assistance is available if needed.
- Position residents correctly and safely to avoid the risk of choking and to promote enhanced enjoyment of meals.

Additional practical advice for assisting a resident

- The same person should stay with the resident throughout the meal.
- The person should sit at eye level or slightly below, and either immediately in front of, or slightly to one side of, the resident who needs assistance.
- Offer small mouthfuls, but enough for the resident to feel the food in their mouth.
- Allow adequate time for the resident to chew and swallow each mouthful before continuing.
- Offer sips of drinks during mealtime as required.
- Assist gently, but never force. Consider hand-under-hand assistance.
- Maintain eye contact with the resident who needs help. Do not talk to someone else while offering food.
- Use verbal prompts. Talk clearly about the food you are offering (especially if it is texture modified or if the person has a visual impairment) and use a gentle but firm tone.
- Discourage the resident from talking with food in their mouth.
- Offer foods according to the resident’s preferences, such as whether they prefer foods combined or separate.

Appendices

Appendix 1: Menu checklist

Menu choices – daily targets	Yes	No	Comments and recommendations*
Menu planning and design			
3 regular meals daily			
The 2 main meals of the day should include a main course and dessert. If offering 2 desserts, one should be a fruit-based option			
A minimum of one main course cooked choice is offered at lunch or evening meal			
No more than 5 hours between each meal being offered during the day			
Offer snacks a minimum of twice per day with varied and rotated options			
The interval between evening snack and breakfast being available is less than 12 hours			
Food and drink should be available 24 hours a day			

* Consider photocopying or printing off these pages in order to write any comments or recommendations and retain this original to reuse.

Menu choices – daily targets	Yes	No	Comments/ Recommendations
Menu planning and design			
There is a process for capturing menu feedback from residents and families or loved ones			
Menus are informed by feedback from residents and families or loved ones			
Menu options meet the residents' dietary needs and preferences			
Beans, pulses, fish, eggs, meat and other proteins			
Minimum of one protein rich source is offered at each meal including breakfast			
Fish is offered 2-3 times per week including an oily fish option			
Milk, dairy and alternatives*			
Whole milk (full fat) is the first choice for all residents unless otherwise indicated			
3 servings of milk or milk products are offered daily			
Milk is offered to drink at each main meal			
One dessert option at every meal is made from milk-based ingredients eg yogurt, custard, milk-based pudding			
Plant-based drinks are fortified with calcium (120mg /100ml)			

Menu choices – daily targets	Yes	No	Comments/ Recommendations
Bread, rice, potatoes, pasta and other starchy foods*			
Offer at least one starchy food at each meal (including wholemeal varieties)			
A minimum of 6 servings are offered daily			
Offer at least 3 varieties of fortified breakfast cereals, including wholemeal options			
Both hot and cold breakfast cereals are available, including porridge			
Tea breads or scones or pancakes (including wholemeal varieties) are available as snacks			
Fruit and vegetables*			
A variety of fruit and vegetables should be offered with a minimum of 5 portions per day			
Vegetables, including salad, are offered at each main meal (fresh, frozen or tinned)			
Folate rich vegetables (such as broccoli, Brussels sprouts, asparagus, peas) are offered 3 times per week			
2-3 portions of fruit are offered daily (fresh, dried, tinned or frozen)			
One dessert option at the main meal contains 1 portion of fruit			
Fruit juice or smoothies are limited to 150ml/day			

Menu choices – daily targets	Yes	No	Comments/ Recommendations
Oils, spreads and accompaniments			
Appropriate sauces and condiments (eg pepper, ketchup, mint sauce) are available at every mealtime, where appropriate			
Gravy and other sauces are served separately and offered to residents at every mealtime, where appropriate			
Unsaturated oils are used for cooking eg rapeseed, olive or sunflower			
Unsaturated spreads are the first choice for all residents unless otherwise indicated			
Foods high in fat, sugar and/or salt			
Jam, honey, marmalade are available alongside toast, scones etc.			
Alternative snacks to sweet biscuits, cakes and pastries are available eg cheese and crackers, scones, pancakes, fruit, yogurt			
Salt is not on the table but available on request			
Lower salt and sodium substitutes are not used			

*see Appendix 3

Menu choices – daily targets	Yes	No	Comments/ Recommendations
Drinks and hydration			
7-8 glasses of fluid are offered daily (1.6 - 2.0L)			
A range of hot and cold drinks is offered			
Decaffeinated tea or coffee is available			
Sugar-free options are available			

Appendix 2: Mealtime experience checklist

	Yes	No	Comments/ Recommendations
Mealtime experience			
Dining area is clearly identified			
Opportunity is given for residents to choose where to eat and who to eat with			
Mealtimes are protected and free from interruptions and distractions			
All necessary aids are in place for mealtimes as required			
Mealtime service			
Mealtimes are organised to enable residents to receive adequate supervision and/or assistance which is specific to their needs			
Food, drinks and snacks are appealing in terms of flavour, texture, smell and appearance			
Foods, drinks and snacks are served at the correct temperature, taking into account resident preference including those residents who eat slowly			
High standards of food hygiene are evident and catering staff trained appropriate to their level of food preparation and service			

	Yes	No	Comments/ Recommendations
Assistance with meals			
Residents are supported to eat and drink independently where possible			
Assistance is offered only when necessary and consent has been obtained or in best interest of the resident			
Adequate numbers of trained staff are present at mealtimes to ensure appropriate supervision and assistance			
Residents are positioned correctly and safely to avoid the risk of choking and to promote enhanced enjoyment of meals			

Appendix 3: Serving sizes

Food group	Daily servings required	Examples of one serving
Bread, rice, potatoes, pasta and other starchy foods	Aim for at least 6 servings per day	• 90g boiled/ baked/ roast potato • 4 baby potatoes • ½ medium baked potato • 100g of mashed potato/sweet potato • 60g cooked rice • 60g cooked pasta or noodles • 60g couscous bulgar wheat, buckwheat, cornmeal, maize, wheat, barley, rye • 60g cassava, yams or plantain • 1 slice of bread • 1 slice potato bread • 1 slice wheaten bread • 30g breakfast cereal/porridge oats • 1 Weetabix/Shredded Wheat®
Fruit and vegetables	Aim for 5 or more portions per day	• 1 medium piece of fruit, eg apple, small banana, pear, orange or similar sized fruit • 2 small fruits, eg 2 plums, 2 apricots, 2 kiwis • Half a grapefruit or avocado • 1 slice of large fruit, eg melon or pineapple • 80g (3 tablespoons) of fruit salad • 1 small handful of grapes, cherries or berries • 150ml (1/4 pint or medium glass) of pure, unsweetened fruit juice (will not contain as much fibre as fresh fruit) • 20g (1 tablespoon) of dried fruit • 80g (3 heaped tablespoons) of cooked fruit or vegetables • dessert bowl of mixed salad
Meat, fish, eggs, beans and other non-dairy sources of protein	Aim for 3 servings per day	• 100g (raw weight) meat and poultry /60–90g cooked • 120–150g cooked fish • 2 eggs (size 3)/120g • 90-120g pulses, baked beans, dhal • 60g lentils/chickpeas uncooked • 60g of unsalted nuts or 30g of peanut butter
Milk and dairy foods	Aim for 3 servings per day	• 200ml (1/3 pint) of milk • 30g of cheese • 150g (medium pot) of yogurt • 200g (large pot/half a can) of milky pudding, eg custard, rice pudding, semolina or tapioca

Residents should be able to select the portion size that is appropriate for them.

Appendix 4: Nutritional content of typical menu options

Table 1: Average nutritional content of breakfast items

	Serving size (in grams unless otherwise stated)	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
Bran Flakes	30	100	3	22
Cornflakes	30	113	2	27
Rice Krispies	30	112	2	26
Wheat type (2 biscuits)	37.5	125	4	28
Porridge made with whole milk	160	180	8	20
Semi-skimmed milk	150ml	69	6	7
Whole milk	150ml	90	6	7
Greek yogurt	150	200	8	7
White bread	36	104	1	16
Wholemeal bread	36	96	1	14
Wheaten bread (1 slice)	38	84	4	15
Soda farl (1/2 farl)	75	180	6	31
Potato bread (1 slice)	70	136	3	27
Pancake	40	95	3	17
Crumpet	45	86	3	17
Banana, small without skin	63	51	1	13
Tinned pears, in own juice	115	38	0	10
Prunes, stewed without stones	30	24	0	12
Orange juice	150ml	50	0	12
Unsaturated spread (1 teaspoon)	5	27	0	0
Butter (1 teaspoon)	5	37	0	0
Jam (1 tablespoon)	20	52	0	14
Marmalade (1 tablespoon)	20	52	0	14

Table 2: Average nutritional content of cooked breakfast items

	Serving size (in grams unless otherwise stated)	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
Egg, scrambled (1 egg)	60	90	9	0
Egg, boiled (1 egg)	60	75	6	0
Eggy bread/ French toast (1 slice)	100	188	10	17
Sausages (2 sausages)	110	324	16	10
Bacon, back (1 slice)	18	52	4	0
Black pudding (1 slice)	58	172	6	10
Mackerel (1 fillet)	75	226	16	0
Kipper	100	245	22	0
Baked beans (regular tomato sauce)	135	109	7	20
Tomatoes, grilled	80	11	0	2
Mushrooms, fried (Rapeseed oil)	40	85	1	0

Table 3: Energy and protein content of some commonly used foods

Main meal	Average serving per resident (uncooked, in grams unless otherwise stated)	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
Protein				
Beef mince	100	225	20	0
Beef, roast	100	145	21	0
Beef burger	100	291	17	0
Chicken, roast	100	201	19	0
Lamb mince	100	196	19	0
Kidney beans, cooked	150	150	13	24
Quorn	100	73	14	2
Tofu	100	73	8	2
Whole milk	150ml	90	6	7
Cheddar cheese	60	250	15	0
Eggs (2), boiled	120	150	12	0

Main meal	Average serving per resident (uncooked, in grams unless otherwise stated)	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
Carbohydrate				
Jacket potato	180	175	5	39
Potatoes, roast	200	322	5	53
Potatoes, mashed with butter	120	122	2	21
White rice, cooked	120	175	4	38
White pasta, cooked	120	175	6	41
Couscous, cooked	120	213	9	33
White bread (1 slice)	36	79	3	17
Bagel (½)	43	117.5	4.5	25
English muffin (½)	34	76	3.5	15
Teacake (½)	42.5	119.5	3.5	21.5
Tortilla wrap (½) (white)	32.5	92.5	2.5	17.5
Tortilla wrap (½) (wholemeal)	32.5	88.5	3	14.5
Pitta (½) (white)	35	90	3	19.5
Pitta (½) (wholemeal)	30	73.5	3.5	13.5
Fruit scone (½)	35	101	3	16
Plain scone (½)	35	107	2	16

Main meal	Average serving per resident (uncooked, in grams unless otherwise stated)	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
Vegetables				
Broccoli	80	4	3	2
Cabbage	80	14	1	2
Carrots	80	22	1	5
Cauliflower	80	22	1	4
Cauliflower cheese side dish, whole milk	90	91	5	5
Parsnip	80	49	1	10
Sweetcorn	80	62	2	11
Peas	80	56	5	8
Sauces				
Gravy, instant (made up with water)	50	15	0	2
Bread sauce (made with whole milk)	45	49	2	6
White sauce	62	65	1	7

Table 4. Vegetarian diet

Main meal	Average serving size uncooked portion per resident (grams) unless otherwise stated	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
Protein				
Kidney beans, dried	90	239	20	14
Lentils, dried	60	143	11	10
Quorn	100	73	14	2
Nuts	60	369	13	0
Seitan	60	10	17	4
Tofu	100	73	8	2
Soya protein	100	447	37	1
Milk and milk alternatives				
Semi-skimmed milk	200ml	92	8	10
Whole milk	200ml	122	6	10
Soya milk fortified with calcium	200ml	76	6	6
Oat milk	200ml	96	2	14
Almond milk (sweetened)	200ml	58	2	4
Greek yogurt	150	198	9	7
Vegan Greek yogurt alternative	150	78	9	4
Cheese	30	120	7.5	0
Vegan cheese alternative	30	102	0	7
Cooked breakfast items				
Vegan scrambled egg alternative	120	54	3	3

Table 5: Examples of snack options with nutrient dense options*

Snack	Serving size (grams), unless otherwise stated	Average energy content (kcal)	Average protein content (grams)	Average carbohydrate content (grams)
*Cheddar cheese and crackers	30 (cheese) 16 (2 crackers)	303	10	11
*Cereal with whole milk	2 Weetabix 150ml whole milk	215	7	33
*Breakfast cereal with fortified milk	30g 150ml fortified milk	250	15	36
*Greek yogurt	100	133	6	5
*Smooth and creamy yogurt (fruit)	115	122	5	16
*Custard	150	147	4	24
*Rice pudding	150	140	5	24
Vanilla ice cream	60	101	2	13
Toasted currant bun	55	171	5	31
Crumpet with butter	50	157	3	19
Fruit scone half with butter and jam		180	2	29
Cheese scone half		120	6	15
Toast with butter	1 toast 5 (butter)	130	3	15
Pancake, sweet 1	30	76	2	13
Madeira loaf cake	40	129	1	23
Crisps	30	148	2	17
Hard-boiled egg	1	75	7	0
Nuts, small handful	40g	245	9	0
Tinned mixed fruit in juice	115	52	0	13
Tinned mixed fruit in juice with double cream	115 (fruit) 30 (cream)	110	1	13
Digestive biscuit	13	60	1	9
Pink wafer	8	38	0	5

Table 6. Examples of food fortification ingredients with suggested portion sizes and nutrient dense options*

Food fortifier	Quantity that could be added to 1 serving of food	Approx protein content (grams)	Approx energy content (kcal)	Approx CHO content (grams)	Could be added to
Dried, skimmed milk powder*	1 tablespoon (15g)	6	55	8	Custard, milk puddings, soups, porridge, mashed potato
Cheese, grated*	1 tablespoon (10g)	3	40	0	Potatoes, vegetables, eggs, soup, pasta
Egg, beaten*	½ - 1 egg	4 - 7	40 - 75	0	Custard, milk puddings, mashed potato, pasta
Greek yogurt*	1 generous tablespoon (45g)	2	60	2	Porridge, desserts, on top of fruit
Ground nuts eg peanuts or almonds*	1 tablespoon (15g)	3	90	0	Soups, stews, casseroles, curries, porridge
Nut butter eg peanut butter*	1 tablespoon (15g)	4	95	0	Porridge, soups, stews, casseroles, curries
Double cream	1 tablespoon	0	70	0	Porridge, soups, desserts, potatoes, pasta
Unsaturated spread	1 teaspoon (5g)	0	27	0	Potatoes, vegetables, thickly spread on crackers, pasta
Full fat mayonnaise	1 tablespoon (15ml)	0	102	0	Potatoes, sandwiches, eggs
Salad cream	1 tablespoon (15ml)	0	45	3	Sandwiches, eggs, salad
Jam/honey/syrup	20g	0	52	14	Porridge, yogurt, desserts, fruit

Information adapted from BDA Care Home Digest 1st Edition 2024[2]
www.bda.uk.com/practice-and-education/care-home-digest.html

Appendix 5: Snacks

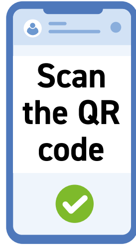
Snacks provide energy throughout the day and can contribute valuable nutrients such as vitamins, minerals, protein and fibre. Two to three snacks should be offered at regular intervals throughout the day. If appropriate, offer snacks with nourishing drinks to increase energy and fluid intakes for those who require them.

Normal consistency snack ideas

- A muffin, crumpet, croissant, bagel, scone, pancake or slice of toast with appropriate toppings such as spread, jam and cream, cheese spread, marmite, hummus, nut butter, chocolate or biscuit spread or boiled egg
- 1-2 plain biscuits, crackers or oatcakes with appropriate spread, eg nut butter, jam, cheese, chocolate or biscuit spread
- Handful of nuts
- Small bar of chocolate, flapjack, muesli or cereal bar
- Slice of fruit cake or malt loaf with spread
- Portion of fruit, eg apple, melon, banana, orange, kiwi or handful of dried fruit
- Portion of vegetable sticks, eg carrot, peppers, cucumber, celery with hummus, sour cream, yogurt or nut butter
- Pot of rice pudding, custard, mousse, trifle, tapioca, semolina, full fat or thick and creamy yogurt
- Small bowl of Angel Delight or supermarket own brand instant whip made with full fat milk and double cream
- Small bowl of jelly made with evaporated milk or yogurt (no added sugar or sugar-free jelly for those residents with diabetes)
- Corn snacks, eg bag of Quavers, Skips or Wotsits
- Small bowl of breakfast cereal, eg Weetabix, Ready Brek

Snack ideas for adults with eating, drinking and swallowing difficulties

The following tables give ideas only. Food and drinks vary in consistency depending on brand, temperature, moisture, freshness/ripeness and method of cooking. The best and recommended way to ensure a food is appropriate for any particular IDDSI level is to use the IDDSI testing methods. Scan the QR code for more information www.iddsi.org/images/Publications-Resources/DetailedDefnTestMethods/English/V2DetailedDefnEnglish31july2019.pdf



<table>
<tr>
<td>IDDSI Level Liquidised

Thickening powder may need to be added to achieve IDDSI Level 3.

If on Level 4 fluids, Level 3 snacks are not suitable.</td>
<td>Sweet
• Smooth thin yogurt or fromage frais
• Thin custard
• Level 3 tested milkshakes
• Liquidise the below with cream, yogurt, custard or milk to achieve a thin puree consistency. Remove any excess fluid. Smooth jams, lemon curd or honey can be added for flavour:
- Instant whip, Angel Delight
- Mousse
- Smooth cheesecake topping (no base)
- Blended trifle
- Liquidised soft tinned fruit
- Liquidised stewed apples
- Liquidised cake
- Rice pudding</td>
<td>Savoury
• Bowl of soup
• Liquidise the below with milk, pouring cream, cream cheese, yogurt, mayonnaise or crème fraiche to achieve a thin puree consistency:
- Smooth hummus
- Avocado
- Smooth dips
- Mousses eg salmon, taramasalata
- Smooth fish or meat pâté</td>
</tr>
</table>

<table>
<tr>
<td>IDDSI Level Pureed

Some may need sieved prior to serving

Can also enjoy Level 3 snacks if in line with their fluid recommendations

Thickening powder may need to be added to achieve IDDSI Level 4</td>
<td>Sweet
• Smooth dessert pots eg Rolo or Milkybar
• Panna cotta
• Lemon posset
• Thick custard
• Smooth semolina
• Blancmange
• Crème caramel
• Add whipped cream, thick custard, smooth yogurt or fromage frais to the below to help reach a puree consistency.
- Pureed fruit
- Blended cake
• The below can be taken alone or added to puree puddings to enhance their flavour.
- Lemon curd
- Lemon, lime or orange juice and zest
- Smooth jams or marmalades
- Smooth chocolate or hazelnut spreads
- Chocolate or fruit flavoured syrups</td>
<td>Savoury
• Smooth moist Weetabix, porridge or Ready Brek
• Smooth cheese spreads
• Cream cheese triangles
• Soft cream cheese, can add meat, fish or bean paste for extra flavour
• Smooth dips eg smooth guacamole, smooth hummus, sour cream and chive
• Avocado pureed with yogurt or mayonnaise
• Smooth peanut butter with thick yogurt, cream or milk</td>
</tr>
</table>

IDDSI Level Minced and Moist	Sweet	Savoury
IDDSI Level Minced and Moist Can also enjoy snacks from Level 3 and 4 lists- check fluid Level recommended.	**Sweet** • Creamed rice, tapioca or semolina • Soaked and drained corn flaked or puffed rice cereals • Well mashed banana • Ripe avocado mashed with banana. Can add chocolate spread or flavouring or cocoa powder • Small pieces of soft, smooth chocolate eg chocolate buttons • Stewed fruit • Add pouring cream, whipped cream, custard, smooth yogurt or fromage frais to the below to help reach a minced and moist consistency: - Mashed sponge or cake - Mashed trifle - Melt in the middle puddings - Mashed and moist biscuit	**Savoury** • Mashed egg or tuna (with mayonnaise/ butter, yogurt or crème fraiche) • Ripe avocado mashed with Greek yogurt or cream cheese If Speech and Language Therapy have recommended transition foods (foods that start as one texture and change to another in the mouth) the below could be considered: • Soft corn snacks which melt in the mouth, eg Skips, Quavers, Wotsits or supermarket own brand • Wafers

IDDSI Level 6 Soft and Bite-sized	Sweet	Savoury
IDDSI Level 6 Soft and Bite-sized Can also enjoy snacks from Level 3, 4 and 5 lists- check fluid Level recommended.	**Sweet** Soft and bite-sized pieces (no bigger than 1½ cm) of the following: • Soft cake or cake bars • Soft muffins (no raisins) • Chocolate rolls broken into bite sized pieces • Plain biscuits – dunked in hot drinks eg ginger biscuits, Rich Tea, digestives • Soft chocolate, with no fruit or nuts eg Milkyway • Soft ripe fruit, skin removed (tinned or fresh) eg banana, plums, peach, pear, mango, strawberry, raspberries	**Savoury** Soft and bite-sized pieces (no bigger than 1½ cm) of the following: • Smooth cheese eg goats' cheese, brie or camembert with rind removed • Ripe avocado • Chopped egg

IDDSI Level 7 Easy to Chew	**Sweet**	**Savoury**
 Can also enjoy snacks from Level 3, 4, 5 and 6 lists- check fluid Level recommended	• Soft biscuits • Sponge fingers • Soft plain or cheese scones • Soft fudge	• Boiled eggs • Crustless quiche • Egg

Appendix 6: Nutrient dense diet checklist

Daily targets	Yes	No	Comments/ Recommendations
Fortified diet			
Are fortified meals prepared?			
Are these options highlighted on the menu? (examples in Malnutrition and nutritional screening section)			
Minimum of two puddings offered per day?			
Nutrient dense snacks			
Is there a range of nutrient dense snacks available? (See Appendix 4, Table 5)			
Are these options highlighted on the menu?			
Are they offered 2-3 times a day?			
Fortified milk			
Is fortified milk available?			
Is it prepared correctly? (as per instructions in Malnutrition and nutritional screening section)			
Is it offered in hot drinks, breakfast cereals or porridge?			
Is it offered as a drink with main meals?			
Nutrient dense drinks			
Are homemade fortified drinks offered between meals and at supper time? (see Appendix 7: Nourishing drink recipe ideas)			

Appendix 7: Nourishing drink recipe ideas

This recipe sheet contains simple ideas for delicious, nourishing drinks.

- Anyone recommended by a Speech and Language Therapist (SLT) to have thicker fluids (IDDSI Level 1 – 4) can still have nourishing drinks. Just make sure the drink is the correct thickness (IDDSI level).
- Drinks should be completely smooth (no lumps) and may need thickening powder added to ensure it is the correct IDDSI level. Milky drinks can take longer to thicken (up to 15 minutes). **Remember to test drinks before serving to ensure they are the correct IDDSI level (see IDDSI flow test for liquids on page 48).**
- Some nourishing drinks may be naturally thick (may not need thickening powder added).
- Additional high-calorie, high-protein drinks should not replace meals. They can be taken between meals. Always choose full fat products.
- You do not need any special equipment to make the high-calorie drinks. You can use a hand blender or liquidiser to whizz together the ingredients. If you do not have a liquidiser, try using a sieve to push all of the ingredients through before serving, to remove any lumps.

How to make fortified milk

Using the recipe below, you can make up a pint of fortified milk. You can then use this in drinks and foods throughout the day to boost nourishment.

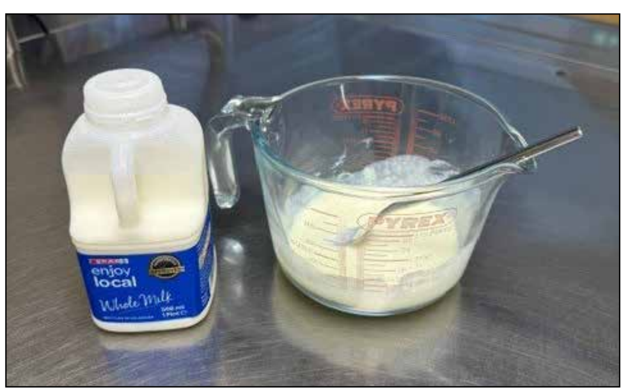
You will need:

- Skimmed milk powder*
- 1 pint of whole milk
- Measuring jug
- Tablespoon
- Fork

* Use skimmed milk powder that does not contain non-milk or vegetable fat.
Keep refrigerated and use within 24 hours.

1. Add 4 heaped tablespoons (60g) of skimmed milk powder to a jug.

2. Add a small amount of milk and mix with a fork to make a smooth paste.



3. Add in the remainder of the milk and stir well.

4. Aim to use the pint of nourishing milk throughout the day.

Add it to drinks, to soup or to cereal/porridge.

Make milky drinks or milk puddings with this milk.

Use to make a milkshake, milky coffee or hot milky drinks (hot chocolate, Ovaltine and Horlicks).

Delicious nourishing drinks

Nourishing drinks and every day foods can provide similar nutrition to prescribed nutritional supplements. The following recipes are included to help increase calories and protein intake.

Simple nourishing shake

- 200ml (1/3 of a pint) of fortified milk
- 1 (125g) pot full fat strawberry yogurt
- 1 heaped tablespoon of milkshake powder

Whisk milk and yogurt together. Add the milkshake flavouring.

Experiment with different flavours of yogurt and milkshake powder to increase variety.

Provides 350kcal and 18g protein

Fruit Smoothie

- 115g plain full fat Greek yogurt
- 45g fruit cocktail or other tinned fruit of choice
- 40ml condensed milk

In a blender, puree the fruit until smooth.
Once smooth add Greek yogurt and condensed milk into blender. Blend all ingredients until there is a smooth consistency. Serve chilled.

Provides 256kcal and 6g protein

Nourishing hot chocolate

- 200ml fortified milk
- 1 tablespoon of drinking chocolate
- Sugar to taste

Warm the milk and add the chocolate power. Add sugar to taste. For additional flavour, try adding a teaspoon of coffee or a pinch of cinnamon.

Provides 240kcal and 16g protein

Fortified fruit juice

This is a great option if you cannot take or dislike dairy.

- 180ml pure fruit juice
- 40ml diluted cordial (not sugar free/diet/no added sugar)
- 80g liquid egg white

Put liquid egg white into a glass; gradually stir in undiluted cordial. When mixed, gradually add in fruit juice.

Provides 200kcal and 8g protein

Super soup

- 200ml fortified milk
- 1 packet of powdered soup (single serving)
- 2 tablespoons of full fat cream

Warm the milk. Add the powdered soup and stir well.

Provides 330 to 480kcal and 10 to 15g protein, depending on soup used.

Non-dairy high calorie drinks

Tropical smoothie
This is a great option if you cannot take or dislike dairy.

- 150ml carton of orange juice
- 1 mashed banana
- 3-4 tablespoons of tinned peaches (in syrup)
- 2 teaspoons of honey

Blend all ingredients.

Provides 264kcal and 3g protein

Banana-licious

Choose higher calorie and protein dairy-free alternatives to make this recipe

- 100g vanilla yogurt
- 130ml sweetened dairy-free milk
- 30ml of dairy-free cream
- 1 whole banana, chopped
- 1 teaspoon of honey

Blend all ingredients.
Top tip: for a thicker smoothie, freeze the banana chunks before blending.

Provides 305kcal and 7g protein

Thanks to Prescribing Support Team Dietitians in NHSCT.

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"food... is as important as medicine, it's a memory, a comfort, a connection to life's joy."
Care home operations manager

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