NUTRITION
for physically frail older people

best practice statement

nmpdu
Nursing & Midwifery Practice
Development Unit

The Nursing and Midwifery Practice Development Unit

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The Nursing and Midwifery Practice Development Unit

Introduction

The Nursing and Midwifery Practice Development Unit (NMPDU) was established in January 2000 to support the identification, dissemination and implementation of best practice across Scotland.

The NMPDU has a responsibility for "ensuring that role and practice development in Nursing, Midwifery and Health Visiting is taken forward across Scotland in a planned and cohesive manner; that benefits gained from excellent practice in any area – clinical or geographical - might be extended systematically across Scotland to the benefit of patients, staff and the NHS as a whole" (Scottish Office 1997).

One of the key aims of the NMPDU is to identify areas of nursing and midwifery practice amenable to the development of 'best practice statements'.

Background to best practice statements

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing and midwifery practice. The development of best practice statements reflects the current emphasis on delivering care that is patient centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

What is a best practice statement?

A best practice statement is a statement to describe best and achievable practice in a specific area of care. The term 'best practice' reflects the NMPDU's commitment to sharing local excellence at national level. Best practice statements are underpinned by a number of shared principles (p.2).

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Key principles of best practice statements

- best practice statements are intended to guide practice and promote a consistent and cohesive approach to care
- best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may contribute to multidisciplinary working and other members of the health care team may find them helpful
- statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary
- information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus
- statements are targeted at practitioners, using language that is accessible and meaningful
- consultation with relevant organisations and individuals is undertaken
- statements will be reviewed and updated every 3 years
- responsibility for implementation of statements will rest at local level
- key sources of evidence and available resources are provided

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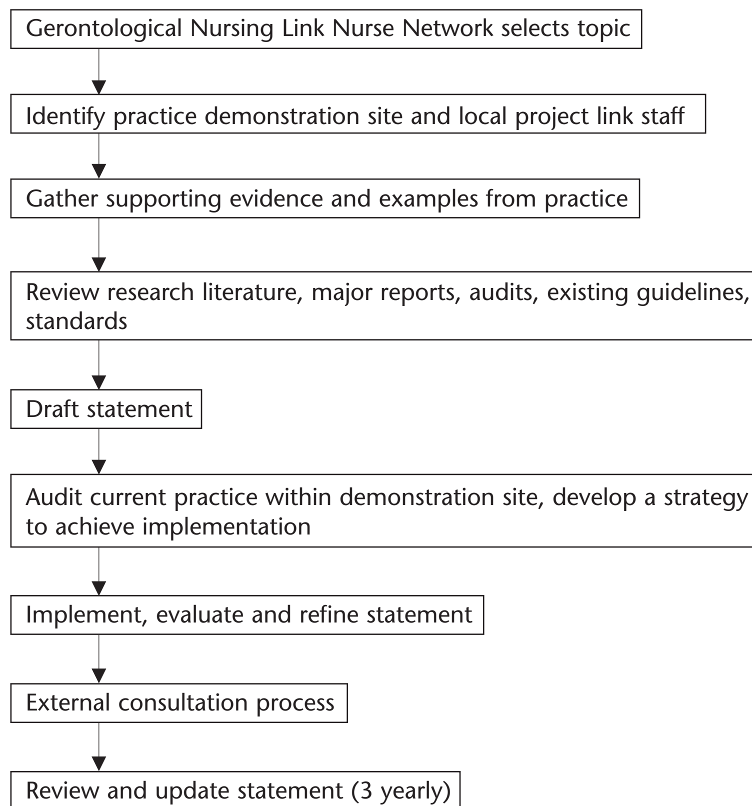
Key stages in the development of best practice statements:

A unique feature of the Gerontological Nursing Demonstration Project practice statements is that they are refined through evaluative research to enhance practice utility.



The Nursing and Midwifery Practice Development Unit

Who was involved in developing the statement?

Steering Group

Debbie Tolson	Professor of Gerontological Nursing, Glasgow Caledonian University
Irene Schofield	Gerontological Nursing Research Fellow, Glasgow Caledonian University
Ruth Ramsay	Dietician, Forth Valley Primary Care NHS Trust Expert Advisor
Morag MacKellar	Head of Nutrition and Dietetic Services, Forth Valley Primary Care NHS Trust
Linda Campbell	Gerontological Link Nurse Network
Sandra Cameron	Gerontological Link Nurse Network
Sue Gardiner	Gerontological Link Nurse Network

Demonstration Site Staff

Dr Joanne Booth	Nurse Consultant, Forth Valley Primary Care NHS Trust
Christine O'Donnell	Senior Clinical Nurse, Bo'ness Community Hospital. Forth Valley Primary Care NHS Trust
Avril Magill	Senior Clinical Nurse Manager, Forth Valley Primary Care NHS Trust
Ailsa Black	Head Housekeeper, Bo'ness Community Hospital. Forth Valley Primary Care NHS Trust
Morag MacKellar	Head of Nutrition and Dietetic Services, Forth Valley Primary Care NHS Trust
The Quality of Life User Group.	Bo'ness Community Hospital. Forth Valley Primary Care NHS Trust

Nurse Reference Group

Scottish Gerontological Link Nurse Network (see Appendix 1)

How can the statement be used?

The recommended best practice statement can be used in a variety of ways, although primarily it is intended to promote evidence based practice. The statement is intended to be realistic but stretching and can be used:-

- as a basis for developing and improving the care that nurses give to older people
- to stimulate learning amongst teams of nurses
- to promote effective interdisciplinary team working
- to determine whether a quality service is being provided
- to stimulate ideas and priorities for nursing research

The Nursing and Midwifery Practice Development Unit

Best practice statement on nutrition for physically frail older people

This best practice statement has been produced by the Nursing and Midwifery Practice Development Unit to offer guidance on meeting the nutritional needs of physically frail older people within continuing care facilities such as community hospitals, nursing homes/care homes. It was developed and demonstrated within a community hospital and has the potential to inform the care of dependent older people who are experiencing delayed hospital discharge or who reside within the community. The statement has been developed collaboratively by the Gerontological Nursing Demonstration Project research team (Glasgow Caledonian University), the Scottish Gerontological Link Nurse Network (Appendix 1), staff at the Demonstration Site at Bo'ness Community Hospital and NMPDU. It is for the use of nurses and care teams and provides information for older people and their families.

The Gerontological Nursing Demonstration Project

This practice innovation research project involves the development of best practice statements, which are informed by a review of existing evidence and refined through testing and user involvement in a demonstration site. The presentation of the statement reflects the emerging definition of gerontological nursing, and an agreed set of values developed by the Scottish Gerontological Link Nurse Network. The statement reflects the beliefs of nurses and may be applied within a variety of care settings. To see the definition and list of values refer to Appendix 2, alternatively you may wish to find out more about the project by visiting the web-site at www.geronurse.com.

The Nursing and Midwifery Practice Development Unit

How was the Best Practice Statement on Nutrition for Physically Frail Older People developed?

Evidence from major research studies, audit reports, existing standards, guidelines and committee reports has been reviewed by an Expert Advisor guided by a team of expert practitioners and researchers. Members of the Scottish Gerontological Link Nurse Network have assisted in the identification of the nursing contribution and in ensuring that the statement reflects their beliefs about the nursing care of older people. Groups representing the interests of older people and older people themselves have contributed to the process. The statement has already been tested and revised within a Scottish Community Hospital.

Further information about the development process and evidence base is located at the website www.geronurse.com

What is the evidence base?

All recommendations are evidence based. The level and type of evidence which informs the statements, is denoted using SIGN criteria. In the majority of cases the type of evidence used to support the recommended best practice statements is that obtained from expert committee reports. This is designated as level 4 type evidence (SIGN, 2001). The evidence is given an overall grade recommendation of 'D' which suggests that more research is needed to strengthen the evidence base for this aspect of nursing care. You can see the other levels of evidence and grading criteria in Appendix 3.

Who is the statement for?

The recommended best practice statement is primarily for the use of registered nurses. However, other members of the professional health care team may find them helpful in understanding the nurse's contribution to overall care, and in particular understanding the contribution which skilled nurses can make to the health of dependent older people. The statements have been written in accessible language so that care staff, older people, and their families or carers can understand them and contribute to evaluation.

Further information

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Section 1. Assessment and Care Planning

Key Points:

1. An initial screening of nutritional needs and preferences should be undertaken within 48 hours of admission.
2. Appropriate referral for specialist dietetic assessment is essential.
3. A healthy mouth is crucial for eating and drinking, and is influenced by oral hygiene (mouth care) as well as nutrition and hydration status.
4. Weighing scales and height equivalent measurement instruments are available and staff are competent to use them.
5. The older person and their carer(s) contribute to care planning and evaluation whenever possible.

Statement	Reason for Statement	How to demonstrate statement is being achieved
A registered nurse completes an initial screening of nutritional needs and preferences on administration.	To identify older people at risk of malnutrition (under and over nutrition), eating problems and to establish food and drink preferences.	Screening includes use of an appropriate tool[1]. Body mass is calculated using a recognised method of height equivalent (eg.demispan). Weight is recorded monthly and percentage weight loss calculated six monthly and appropriate action taken[2].
	To facilitate appropriate referral for specialist dietetic assessment.	Agreed criteria for referral to dietetic services is available, which draws on the NMPDU Best Practice Statement 'Nutrition Assessment and Referral in the Care of Adults in Hospital'.

[1] The Demonstration Site developed an original tool based on CRAG (2000) and Dickinson E, Brocklehurst J (1999) Clinical Audit of long-term care of older people. 2nd Edition. Royal College of Physicians. London. This tool requires further refinement.

[2] 5% weight loss over 6 months indicates significant risk of malnutrition, 10% indicates high risk

Section 1. Assessment and Care Planning (continued)

Statement	Reason for Statement	How to demonstrate statement is being achieved
Initial assessment of swallowing function and the condition of the mouth is made by a suitably competent registered nurse.	To ensure safety and identify and plan appropriate care for people with complex needs.	Referral criteria for specialist swallowing assessment by a Speech & Language Therapist exists. Referral criteria for specialist dental care exists. An evidence based mouth care policy exists[3].
Following screening the registered nurse develops a care plan with the older person, which is implemented and evaluated. Repeat screening is undertaken as indicated by changes in a person's condition or at predetermined intervals.	Care is more likely to be effective when the older person is involved in planning their own care. Needs change with health status and activity levels. Gradual changes are easy to miss.	Findings from the initial screening are documented and inform subsequent collaborative care planning. An individual's care plan includes agreement on repeat screening intervals.

Key Challenges:

1. Capturing a person-centred assessment.
2. Adopting risk assessment strategies to enable the older person to maintain some control in this aspect of their life.
3. Development of a validated screening tool for frail older people (no validated tool exists for physically frail older people3)
4. Reducing error in the measurement of body mass index and percentage weight change.
5. Provision and maintenance of weighing scales appropriate to the needs of older people.

[3] An NMPDU Best Practice Statement on mouth care for older people is in preparation

Section 2. Promoting a Nutritious Diet to maximise health

Key Points:

1. The constituents of a healthy diet for a physically frail older person, are specific to their overall condition, underlying pathologies, treatments, activity level and preferences.
2. Older people benefit from advice on nutritious eating, suited to their individual situation. Information enables informed decisions.
3. By promoting a nutritious diet nurses have the potential to enhance the health and wellbeing of frail older people.

Statement	Reason for Statement	How to demonstrate statement is being achieved
Registered nurses are knowledgeable about the constituents of a nutritious diet and apply this knowledge to maximise the health of frail older people.	Older people in hospitals and care homes are at risk of under nourishment. Provision of an energy and nutrient rich diet has the potential to improve the health and wellbeing of frail older people.	Older people and their carers receive information on the benefits of a nutritious diet. Appropriate printed/other material is used when discussing food and drink with the individual and families/visitors. Factors that affect an individual's dietary intake should be documented within the care plan, highlighting issues that are important to the person[1]. The multi-disciplinary team find creative ways of promoting a nutritious diet for individuals at risk of malnutrition and monitor progress. There is an adequate supply of nutritious food and drink available outside of standard mealtimes. Full fat milk is offered in preference to reduced fat milk.

[1] The intake chart used within the Demonstration Site is shown in Appendix 4

Key Challenges:

1. Finding ways to make culturally appropriate information accessible and relevant to dependent older people and their families / friends. Identifying barriers to change and negotiating solutions acceptable to the older person.
2. Accepting that the older person may not wish to follow a therapeutic diet.
3. Problem-solving to achieve the best care solutions for individuals. For example, considering the merits of exposure to sunlight in relation to the need to boost Vitamin D levels.
4. Responding to changes in needs during episodes of acute illness/ infection.
5. Working within Health & Safety Regulations in the provision of snack foods.

Section 3. The Environment of Care

Key Points:

1. Mealtime and snack time environments influence food and drink consumption.
2. It is the responsibility of registered nurses to enhance the mealtime care environment.
3. Staffing ratios will influence the quality of the mealtime care environment and capacity to provide assistance.

Statement	Reason for Statement	How to demonstrate statement is being achieved
Registered nurses ensure that the environment where a person eats is conducive to the enjoyment of meals.	Mealtimes are an important part of an older person's day. A relaxed, comfortable, friendly atmosphere, free from distractions is likely to promote increased intake of food and drink.	A registered nurse supervises mealtimes. There is opportunity to take meals, in company or alone, away from bed and treatment areas. Furniture, napkins, cutlery and crockery that promote dignity, choice and independence are available and used appropriately. Levels of background noise and other distractions are kept to a minimum during meals. Individuals are encouraged to eat and drink at their own pace and there is no time limit placed upon mealtimes. Family, friends and volunteers are welcomed at mealtimes to encourage and assist their relative if this is the wish of the individual.

Key Challenges:

1. Locating and creating or adapting a space separate from the bedside to take meals.
2. Controlling levels of background noise.
3. Having adequate numbers of staff to assist individuals to eat without rushing meals.
4. Ensuring that individuals are comfortable and that dignity and independence are promoted throughout mealtimes.
5. Making it possible for an older person to enjoy fresh air and sunshine, if that is their preference, to stimulate appetite.

Section 4. The Managerial Role of the Nurse

Key Points:

1. Mealtime care is recognised as a complex activity which is crucial to the health and wellbeing of frail older people.
2. Registered nurses have an important managerial role to play in promoting good nutritional care.
3. Fulfilment of the nurse's managerial role is dependent upon collaborative working with all staff and departments involved in the provision and preparation of food, in particular dietetic and catering personnel.
4. Involvement of older people, informal carers and nursing staff in menu planning is recommended.

Statement	Reason for Statement	How to demonstrate statement is being achieved
Registered Nurses manage the provision of food and drink as a vital part of the provision of the older person's total care. Registered nurses forge links between management, dietetic, catering and portering staff, to enhance the nutritional care older people receive.	The quality of nutritional care is influenced by: • Policies concerning food and drink provision • The methods used to transport food to specific facilities and to individuals • The physical, organisational and social emotional environment in which food and drink are consumed	There is an up to date local food and health policy on which practice is based; the policy is influenced by the views of nursing staff and the wider multi-disciplinary team. The policy specifies frequency of meetings and review/audit. Older people, their carers and nursing staff have input into menu planning and review on a regular basis. Choices are provided from a minimum of 2 main dishes at each meal, including choices for those with culturally specific needs, chewing/swallowing difficulties and reflect individual preferences. A minimum three week menu cycle is provided and reviewed at regular intervals. Menus are provided in a range of formats, for example large print and should include accurate descriptions and photographs of dishes.

Section 4. The Managerial Role of the Nurse (continued)

Statement	Reason for Statement	How to demonstrate statement is being achieved
		Meals are selected as close to mealtimes as possible. The presentation, portion size and temperature of meals is monitored. Feedback is provided to caterers on suitability of food, wastage and menu choice. Reviews of the success of food and drink provision are carried out and incorporate the views of nursing staff, patients and carers.

Key Challenges:

1. Making services constrained by budgets responsive to the nutritional needs of frail older people.
2. Describing meals in language or pictures that accurately and appetisingly represent the dish.
3. Providing a range of textures and food / drink choices.
4. Avoiding menu fatigue.
5. Finding ways of serving food promptly to maintain nutritional quality, temperature and appearance.

Section 5. Education and Training

Key Points:

1. Evidence based practice cannot be achieved without investment in education and training.
2. Partnerships in Active Continuous Education (PACE) packs offer the minimum acceptable level of training.
3. Investment in training enables staff to plan care that satisfies needs for food and fluids.
4. Delivering care for individuals with complex needs requires practical know how, interpersonal skills, problem solving skills and flexibility.

Statement	Reason for Statement	How to demonstrate statement is being achieved
Registered nurses and care assistants are provided with education and training on the importance of food and fluids to the health and well-being of older people.	Registered nurses must be able to assess older people's needs in relation to food and drink using recognised assessment tools.	The PACE packs (or equivalent) for registered nurses and care assistants are used as the minimum level of training offered to staff.
Education/training programmes include training on strategies for translating knowledge into practice.	To ensure that individuals receive food and fluids in a manner that promotes dignity and choice.	Documentation demonstrates assessment and planning for nutrition care at an individual level.
Nursing staff involved in nutrition care have a minimum of 2 hours training in assisting people with food and drinks; this training is updated every 2 years	Food Safety Legislation requires that staff are aware of good practice in food safety/hygiene	In-house training and education programmes incorporate ongoing updates for staff.
	Nurses are skilled at recognising and responding to the specific challenges commonly found within this patient group.	Staff are given time to attend updates
	Staff are aware of different types and consistencies of food appropriate for people at different stages with swallowing difficulties.	
Registered nurses receive training in screening of the individual's ability to swallow	Registered nurses are competent in planning interventions to assist people with complex needs to eat and drink	Screening of swallowing function is made by a suitably competent registered nurse.
Registered nurses receive education on the effect of dysphagia-swallowing difficulties on nutrition		Referral criteria for specialist swallowing assessment by a Dietician and Speech & Language Therapist exists.

Key Challenges:

1. Providing time for registered nurses to achieve essential skills to teach others to develop new ways of working.
2. Becoming skilled in recognising and dealing with, the specific nutritional problems of dependent frail older people.
3. Taking account of an older person's values, beliefs and experience when inquiring about food and drink habits and preferences.
4. Changing attitudes to meal-time care so that it is seen as an important therapeutic and social event.
5. Accessing training to facilitate simple and preliminary screening of a person's ability to swallow.

Appendix 1

Sources of evidence:

Section 1. Assessment and Care planning

Bond, S. (1997) *Eating Matters*. Centre for Health Services Research and the Institute for Health of the Elderly, University of Newcastle. (4)

Clinical Resource and Audit Group (CRAG). In Association with Centre for Health and Social Research (2000) The Nutrition of Elderly People and Nutritional Aspects of their Care in Long-term Care Settings. Edinburgh: The Scottish Executive. (3)

Copeman, J. (1999) *Nutritional Care for Older People. A Guide to Good Practice.* Care Professional Handbook Series. London: Age Concern. (4)

National Nursing, Midwifery and Health Visiting Advisory Committee (2002) *Promoting Nutrition for Older Adult In-Patients in NHS Hospitals Scotland.* Edinburgh: The Scottish Executive.

Royal College of Nursing (1993) *Nutrition Standards and the Older Adult. Dynamic Quality Improvement Programme*. London: RCN. (4)

Scottish Executive Health Department (1999) NHS MEL 54. Nursing Homes Scotland Core Standards-Nutritional Care. Edinburgh. (4)

Scottish Health Advisory Service (SHAS) (2000) *Older Peoples Quality Indicators.* Edinburgh:SHAS. (4)

Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+ . These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.

Sources of evidence:

Section 2. Promoting a Nutritious Diet to maximise health

Bond, S. (1997) *Eating Matters*. Centre for Health Services Research and the Institute for Health of the Elderly, University of Newcastle. (4)

Clinical Resource and Audit Group (CRAG). In Association with Centre for Health and Social Research (2000) The Nutrition of Elderly People and Nutritional Aspects of their Care in Long-term Care Settings. Edinburgh: The Scottish Executive. (3)

Scottish Executive Health Department (1999) NHS MEL 54. Nursing Homes Scotland Core Standards-Nutritional Care, Edinburgh. (4)

Scottish Health Advisory Service (SHAS) (2000) *Older Peoples Quality Indicators.* Edinburgh:SHAS. (4)

Caroline Walker Trust (1995) *Eating Well for Older People*. Report of an Expert Working Group. London: Caroline Walker Trust. (4)

Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+ . These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.

Sources of evidence:

Section 3. The Environment of Care

Bond, S. (1997) *Eating Matters.* Centre for Health Services Research and the Institute for Health of the Elderly, University of Newcastle. (4)

Clinical Resource and Audit Group (CRAG). In Association with Centre for Health and Social Research (2000) The Nutrition of Elderly People and Nutritional Aspects of their Care in Long-term Care Settings. Edinburgh: The Scottish Executive. (3)

Scottish Executive Health Department (1999) NHS MEL 54. Nursing Homes Scotland Core Standards-Nutritional Care, Edinburgh. (4)

Scottish Health Advisory Service (SHAS) (2000) *Older Peoples Quality Indicators.* Edinburgh:SHAS. (4)

Caroline Walker Trust (1995) *Eating Well for Older People*. Report of an Expert Working Group. London: Caroline Walker Trust. (4)

Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+ . These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.

Sources of evidence:

Section 4. The Managerial Role of the Nurse

Audit Commission (2001) *Acute Hospital Portfolio, 2001. Review of national Findings-Catering.* London:Audit Commission for England and Wales. (4)

Bond, S. (1997) *Eating Matters.* Centre for Health Services Research and the Institute for Health of the Elderly, University of Newcastle. (4)

Department of Health (1995) *The Health of the Nation. Nutrition Guidelines for Hospital Catering.* London: HMSO. (4)

Maryon-Davis, A. Bristow, A. (1999) *Managing Nutrition in Hospital: A recipe for Quality.* London:Nuffield Trust. (4)

National Nursing, Midwifery and Health Visiting Advisory Committee (2002) *Promoting Nutrition for Older Adult In-Patients in NHS Hospitals Scotland.* Edinburgh:The Scottish Executive.

Scottish Health Advisory Service (SHAS) (2000) *Older Peoples Quality Indicators.* Edinburgh:SHAS. (4)

Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+ . These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.

Sources of evidence:

Section 5. Education and Training

British Association for Parenteral and Enteral Nutrition (1999) *Hospital Food as Treatment,* Maidenhead: BAPEN. (4)

Clinical Resource and Audit Group (CRAG). In Association with Centre for Health and Social Research (2000) The Nutrition of Elderly People and Nutritional Aspects of their Care in Long-term Care Settings. Edinburgh: The Scottish Executive. (3)

Department of Health (1994) *Health of the Nation. Core Curriculum for Nutrition in the Education of Health professionals.* London: Department of Health. (4)

Maryon-Davis, A. Bristow, A. (1999) *Managing Nutrition in Hospital: A recipe for Quality.* London:Nuffield Trust. (4)

National Nursing, Midwifery and Health Visiting Advisory Committee (2002) *Promoting Nutrition for Older Adult In-Patients in NHS Hospitals Scotland.* Edinburgh:The Scottish Executive.

Scottish Executive Health Department (1999) NHS MEL 54. Nursing Homes Scotland Core Standards-Nutritional Care, Edinburgh. (4)

Evidence:

Grade D - evidence level 3 or 4; or extrapolated evidence from studies rated as 2+ . These are well conducted case control or cohort studies with a very low risk of confounding bias, or chance and a moderate probability that the relationship is causal.

Recommended Resources

Partnerships in Continuous Education (2001) Fundamental Nutritional Care of the Hospitalised Patient (Trained Staff), PACE, Queen Margaret University College, Edinburgh.

Partnerships in Continuous Education (2001) Nutrition an Issue for Quality Caring (Trained Staff), PACE, Queen Margaret University College, Edinburgh.

Partnerships in Continuous Education (2000) Evaluation of Education Needs-Nutrition, PACE, Queen Margaret University College, Edinburgh.

Appendix 2

Membership of the Scottish Gerontological Nurse Link Network

Anderson	Margaret	Specialist Nurse Practitioner	Mansion House Unit	Glasgow
Bastianiello	Linda	Ward Leader	Ashludie Hospital,	Monifieth
Brown	Andrea	Charge Nurse	Cameron Hospital	Leven
Cameron	Sandra	Senior Nurse	St Johns Hospital	Livingston
Campbell	Janet	Clinical Manager	Eastwood Court Nursing Home	Glasgow
Campbell	Linda	Clinical Ward Manager	Raigmore House	Inverness
Clarkson	Duncan	Director of Nursing	Whim Hall Nursing Home	West Linton
Douglas	Muriel	Senior Sister	Borders General Hospital	Melrose
Findlay	Michelle	Staff Nurse	Balfour Hospital	Orkney
Gardiner	Sue	Clinical Nurse Practitioner	Royal Victoria Hospital	Edinburgh
Glendye	Morag	Charge Nurse	Kirkcudbright Community Hospital	Kirkcudbright
Hagan	Stephen	Nursing Home Manager	Rowantree Nursing Home	Rutherglen
Howieson	Jean	Ward Sister	Kirklands Hospital	Bothwell
Lawson	Barbara	Senior Sister	Eastwood Court Nursing Home	Glasgow
Macgee	Mary	Senior General Manager & Divisional Nurse	Ashbourne Homes	Glasgow
Mann	Fiona	Matron/Manager Tamaris	Buchanan Lodge	Bearsden
McAloon	Mairi	Lecturer/Practitioner in Gerontology	Southern General Hospital	Glasgow
McCrimmon	Matilda	Deputy Sister	Vale of Leven Hospital	Alexandria
McFadyen	Ann Marie	Deputy Ward Manager	Lightburn Hospital	Glasgow
McLeish	Margaret	Sister	Lightburn Hospital	Glasgow
Mulholland	Marea	Staff Nurse	Southern General Hospital	Glasgow
Ness	Lauri	Sister	Dundee General Hospital	Dundee
Provan	Valerie	Quality & Effectiveness Co-ordinator	Ailsa Hospital	Ayr
Reid	Helen	Sister	Mearnskirk Hospital	Glasgow
Reid	Nancy	Practice Development Nurse	Ravenscraig Hospital	Greenock
Ross	Lindsay	Specialist Practitioner	Royal Victoria Hospital	Dundee
Stones	Lorna	Charge Nurse	Queen Margaret Hospital	Dunfermline
Tocher	Ria	Clinical Development Nurse	Corstorphine Hospital	Edinburgh
Tonge	Christine	Health Visitor for the Elderly	Health Centre	Shetland
Turnbull	Anne	Sister	Dumfries & Galloway Royal Infirmary	Dumfries
Warden	Mandy	Team Leader	Community Mental Health Team	Forfar

Appendix 3

Definition and Principles of Gerontological Nursing

'Gerontological nursing contributes to and often leads the interdisciplinary and multi-agency care of older people. It may be practiced in a variety of settings, although it is most likely to be developed within services dedicated to the care of older people.

It is a person-centred approach to promoting healthy ageing and the achievement of well being, enabling the person and her/his carers to adapt to health and life changes and to face ongoing health challenges.'

To achieve this, in-depth gerontological nursing knowledge and skills are required alongside a commitment to an explicit value base. The virtual practice development community of link nurses has developed a set of principles, which reflects its beliefs about gerontological nursing:

1. **Commitment to person-centred care**
   Understanding and acknowledging the needs and wishes of the older person and ensuring that these underpin the planning and delivery of care. Promoting continuity of care that values the older person's unique past, present and future individuality and recognising and respecting the person's role and contribution to family and wider society.

2. **Commitment to an enabling model of care**
   Recognising the uniqueness of each older person, and building on positive lifelong coping skills and strategies. Negotiating and reviewing care goals in partnership with the older person and family, according to the individual's needs and wishes.

3. **Promotion of an enabling environment**
   Promoting positive staff attitudes together with a supportive physical and organisational environment in order to create an enabling living, or care environment that conveys a sense of hope and achievement for the older person.

4. **Respect for a person's rights and choice**
   Respecting and promoting the rights of each older person as a consenting adult to make independent choices and care decisions, according to the person's wishes, and recognising when it is necessary to draw on patient advocacy services.

5. **Promoting Dignity**
   Promoting dignity in day to day care to include consideration for the older person's privacy and confidentiality.

6. **Establishing equity of access**
   Acting as champion and striving to secure on behalf of all older people the same access to services as other age groups.

7. **Maximising therapeutic interventions**
   Developing attitudes, knowledge, and skills in order to return a caring event into a therapeutic opportunity for the older person and where appropriate her/his family.

8. **Commitment to developing innovative practice**
   Adopting strategies to promote evidence based gerontological nursing practice and advancing knowledge, skills and competencies of staff through continued education and research.

9. **Commitment to an explicit and shared set of values**
   Developing an agreed care philosophy that seeks to maintain the uniqueness of the older person, reflecting her/his needs and identifying the standards of care, which she/he can expect.

10. **Commitment to interdisciplinary working and partnership**
    Working as part of a team of experts who recognise, seek out and respect each other's contribution to the care of the older person. Directing the collective effort towards the realisation of goals negotiated with the older person and her/his family, according to her/his needs and wishes.

Appendix 4

SIGN grading system

Levels of evidence

1++ High quality meta analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+ Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1 - Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++ High quality systematic reviews of case-control or cohort or studies
High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal
2+ Well conducted case control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
2 - Case control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

3 Non-analytic studies, e.g. case reports, case series

4 Expert opinion

Grades of recommendation

A At least one meta analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 1++ or 1+
C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 2++
D Evidence level 3 or 4; or
Extrapolated evidence from studies rated as 2+

Appendix 5

Intake Tool used within the Demonstration Site
Forth Valley Primary Care NHS Trust Older Peoples Services

Name: Ward: Date of Birth:
Please record all food and fluid intake below.
Record: N = none eaten/refused, A = all eaten or drunk, ¾, ½, ¼ eaten or drunk

Date:	Food Intake	Fluid Intake
Breakfast	A ¾ ½ ¼ N	
Fruit Juice	A ¾ ½ ¼ N	
Cereal/porridge	A ¾ ½ ¼ N	
Bread/toast	A ¾ ½ ¼ N	
Cream/milk	A ¾ ½ ¼ N	
Supplement	A ¾ ½ ¼ N	
Mid-Morning	A ¾ ½ ¼ N	
Biscuit/cake	A ¾ ½ ¼ N	
Supplement	A ¾ ½ ¼ N	
Other.............	A ¾ ½ ¼ N	
Soup	A ¾ ½ ¼ N	
Fruit Juice	A ¾ ½ ¼ N	
Main Course	A ¾ ½ ¼ N	
Potato	A ¾ ½ ¼ N	
Vegetable	A ¾ ½ ¼ N	
Salad	A ¾ ½ ¼ N	
Sandwich	A ¾ ½ ¼ N	
Pudding	A ¾ ½ ¼ N	
Fruit	A ¾ ½ ¼ N	
Supplement	A ¾ ½ ¼ N	
Mid-Afternoon	A ¾ ½ ¼ N	
Biscuit/cake	A ¾ ½ ¼ N	
Supplement	A ¾ ½ ¼ N	
Other	A ¾ ½ ¼ N	
Soup	A ¾ ½ ¼ N	
Main Course	A ¾ ½ ¼ N	
Potato	A ¾ ½ ¼ N	
Vegetable	A ¾ ½ ¼ N	
Salad	A ¾ ½ ¼ N	
Sandwich	A ¾ ½ ¼ N	
Pudding	A ¾ ½ ¼ N	
Supplement	A ¾ ½ ¼ N	
Before Bed	A ¾ ½ ¼ N	
Toast/Sandwich	A ¾ ½ ¼ N	
Supplement	A ¾ ½ ¼ N	

NHS
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