NUTRITION, FOOD SERVICE & DINING IN LTC

The best practices within this document are recommendations to support regulatory compliance to Ontario LTC legislation, promote optimal nutrition and hydration care and support person centered care. It is important to note, however, that residents' rights and preferences are paramount and should be respected regardless of legislation or best practice. The best practice document is based on resources and expertise from industry professionals and where applicable, are evidence-based. This is a living document that will transition with the evolution of the industry over time.

SUBJECT: NUTRITION ASSESSMENT & PLAN OF CARE	**Revised: 2023-03-06**
ONTARIO REGULATION 246/22 made under the FIXING LONG-TERM CARE ACT, 2021	
Nutritional Care and Hydration Programs	

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1. Purpose & Scope

- Comprehensive nutrition assessment is required for all residents living in long term care (LTC).
- This is needed to assess each resident's nutrition and hydration status, identify nutrition related concerns, and recommend interventions to help support improved outcomes, meet goals of care and /or maximize quality of life.
- From this assessment, a nutrition plan of care is created and regularly reviewed to monitor the acceptance and effectiveness of these interventions.

- This process also identifies and supports each resident's right to choose their preferences and their goals – a balance that can support/improve clinical outcomes, goals of care and quality of life.

2. Key Concepts

- There are many processes to complete a nutrition assessment, plan of care and monitor effectiveness. One of these ways is the standard nutrition care process. This is a systematic approach for registered dietitians (RD) to consistently address practice-related nutrition problems and uses a resident-centered framework that clarifies the RD's role. Read more about this process here.

- The nutrition care process is one standardized way of completing a nutritional assessment, however there are 4 general components of completing a comprehensive assessment and these include: nutrition assessment, identification of nutrition related concerns, nutrition interventions and monitoring & evaluation.

- Nutrition care goals balance nutrition and hydration needs with quality of life and person-centered care.

3. Practice Recommendations

a. Initial & Ongoing Assessment Process

- Processes are established for initial and ongoing nutrition assessments and screening, to identify nutrition risk issues that require RD intervention.

- Upon admission or move in, the following criteria and steps should be followed:

    - Interdisciplinary care team collects information within 24 hours of admission and on that allows safe and appropriate meal service. This includes but is not limited to diet orders including food texture and fluid consistency, assistive devices, food restrictions including allergies or cultural/religious practices.
    - Referral to be sent to RD immediately for any high-risk nutrition issues that include, but not limited to, dysphagia concerns, wounds, significant weight loss prior to admission, poor intake.
    - Communication with other care providers (i.e. power of attorney (POA)/substitute decision maker (SDM), primary health care, homecare, acute care, retirement home) to determine history and previous nutrition interventions.

- Nutrition manager (NM) or designate collects nutrition and hydration information for each resident during the first week of admission. This may include mealtime observation and review of food preferences and dislikes.

- The interdisciplinary care team completes the resident assessment instrument – minimum data set (RAI-MDS) or equivalent assessment of resident. Sections within the RAI-MDS assessment pertain to the resident's nutrition and hydration status.

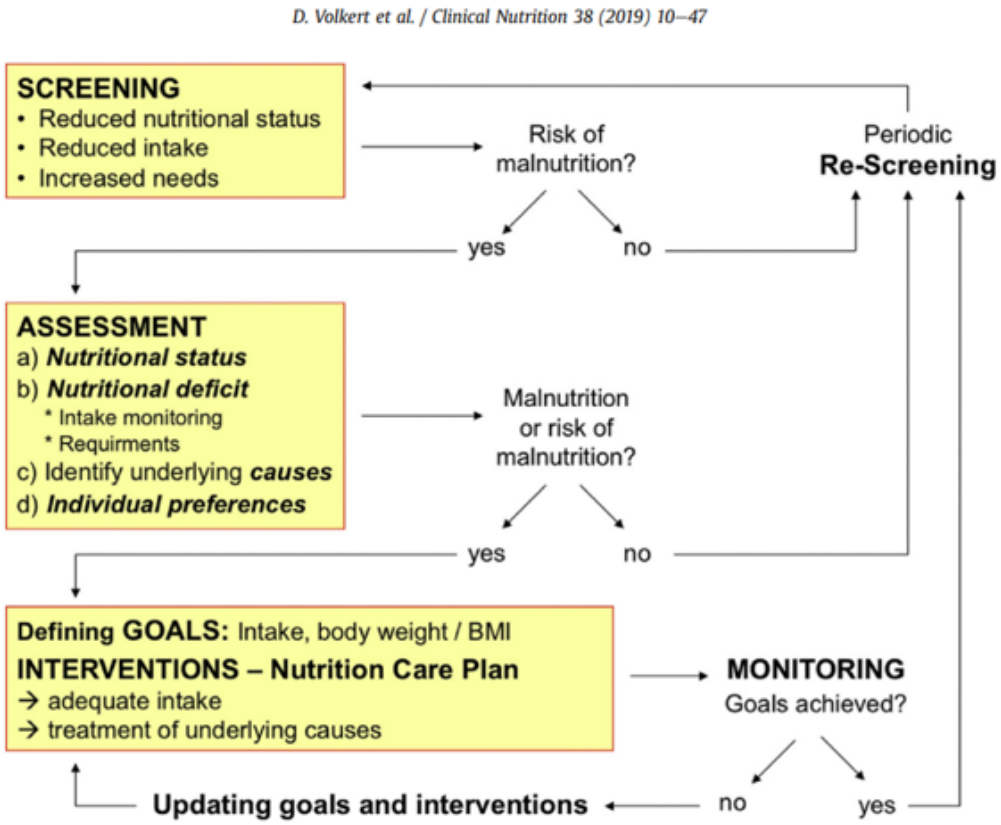
- RD completes a nutrition assessment that identifies each resident's nutrition, hydration and dining needs and nutrition and hydration risk issues. Time frames may be based on home policy or RAI-MDS requirements.

- The RD completes an assessment for all residents upon admission, annually and when there is a significant change in status. Also, the RD completes an assessment for all residents that are at high nutrition risk each quarter or more frequently as needed. Some RDs also complete assessments on residents at low or moderate risk based on home specific policy.

- Once the initial nutrition assessment is complete, ongoing monitoring and evaluation continues at minimum quarterly. Nursing and Healthcare staff continue to monitor for any concerns related to nutrition and hydration and refer to the RD for reassessment as required and based on home policy.

b. Aspects of Nutrition Assessment

- The process of nutritional care for seniors consists of several steps based on systematic screening for malnutrition. If there are any indicators of nutritional risk, a detailed assessment should follow, including individual treatment goals and a comprehensive nutritional plan of care with ongoing monitoring and evaluation. Refer to the process of nutritional care from ESPEN to follow.



- Screening for malnutrition in seniors upon admission or as early as possible is important. The Mini nutrition assessment (MNA) for older adults is one of the validated tools to identify malnutrition in older adults. (MNA, 2021)

- A comprehensive nutrition assessment uses biochemical & physical measurements and clinical analysis including, but not limited to:

○ Height and weight status and historical weight data if available ○ Current diet, food texture, fluid consistency ○ Hydration status ○ Dietary history and current documented food and fluid intake ○ Dentition, chewing or swallowing concerns ○ Use of assistive devices ○ Allergies and/or food intolerances ○ Preferences and food practices related to culture and/or religion ○ Vitamin or mineral supplements ○ Use of herbal supplements or other complementary and alternative medicine ○ Need for and use of oral nutritional supplements	○ Relevant conditions and diagnoses, including those known to be of particular risk to this population ○ Physical functioning ○ Cognitive functioning ○ Falls history and risk (sarcopenia risk) ○ Self-feeding ability and need for assistance ○ Skin integrity concerns ○ Gastrointestinal / bowel function / continence issues ○ Significant lab values ○ Medications and potential food-drug interactions ○ Estimated daily nutrition requirements which may include calories, protein, fluids, and other macro/micronutrients as deemed necessary

- Each assessment begins with the collection of data through review of the health record and consultation with the resident and power of attorney (POA) / substitute decision maker (SDM) as applicable.

- An observation of the resident during a meal or snack service is vital to assess and identify any chewing or swallowing concerns or other physical or positioning requirements to support the eating process. This may include positional aids, assistive devices, or assistance requirements.

- BMI is one measure of nutritional status but should not stand alone in the assessment for weight.

- RAI-MDS outcome scales to support assessment.

- Physical observations include a focused physical examination which may also identify signs of dehydration, nutrient deficiencies, and overall nutritional health. This may include noting muscle or fat loss, assessing fluid status by monitoring for edema or signs of dehydration and examining a resident's hair, eyes, mouth, skin, or fingernails for signs of malnutrition or nutrient deficiencies. Refer to https://thegeriatricdietitian.com/nutrition-focused-physical-exam for more details on performing a focused physical exam.

c. Interventions & Plan of Care

- Interventions are recommended based on the nutrition-related concerns identified in the assessment. This could include, but is not limited to, high energy/high protein items or commercial supplements for weight loss or wound healing, fiber interventions for constipation or bowel concerns, high fluid items for dehydration risks, assistive devices to promote independence, enteral nutrition due to a medical concern, or reduced potassium foods for renal concerns. Food first interventions are preferred to promote enjoyment of food over supplements as part of supporting quality of life.

- The RD consults with the interdisciplinary care team, the broader allied health team (e.g., speech language pathologist, acute care RD) and resident (or POA/SDM as appropriate), to develop interventions and an individualized nutrition plan of care, to maintain/restore/optimize nutrition health and hydration status.

- The nutrition plan of care:
  - Indicates problem/focus, goals/expected outcomes, interventions.
  - Identifies the interdisciplinary care team member(s) responsible for providing the interventions.
  - Indicates the expected reassessment date and resident's (POA/SDM if appropriate) response to the plan, as necessary.

- The interventions outlined in the nutrition plan of care should provide clear direction to the staff providing direct care to the resident.

- Interdisciplinary care team implements the nutrition plan of care.

- Therapeutic diets, textures, and fluid consistencies, as ordered by the RD and/or physician / nurse practitioner, are recorded in the residents' chart and communicated to the interdisciplinary care team, as per the home's policies.

- Early conversations and advanced care planning with residents/POAs/SDMs about realistic expectations, goals of care and preferences is encouraged to promote quality of life. (Advanced Care Planning Ontario)

- The documentation of a nutrition plan of care should be completed as per the home's policies.

d. Nutrition Monitoring & Evaluation

- Reassessment of the outcomes of each resident's nutrition plan of care, is completed quarterly, at minimum, and whenever there is a significant change in status and/or a referral for reassessment by a member of the interdisciplinary care team.

- Mechanisms are in place for the interdisciplinary care team to monitor and document each resident's response to the nutrition plan of care and interventions that includes the following:
    - Observe and document each resident's daily food and fluid intake, including meals, snacks, medication passes and social activities.
    - Take and record each resident's weight, monthly at minimum, and more often as ordered
    - Referral to the dietitian for refusal of interventions or whenever concerns are noted regarding changes in nutrition and hydration risk.

- Interventions need to be implemented, checked for their effectiveness and acceptance, and adjusted, if necessary, based on individual nutrition risk issues, nutrition care needs and change in health status until treatment goals are achieved.

- Residents are monitored by the RD and interdisciplinary care team to determine the level of support, supervision, encouragement, and assistance required with intake of food and beverages at meals and snacks:
    - Determine appropriate seating and positioning.
    - Determine those residents who would benefit from assistive devices, and types and amount of assistance required to support and maintain self-feeding skills.
    - Determine the need for a restorative dining program, with individual goals established for each resident participating in such a program.
    - Adapt the mealtimes and dining environment as deemed appropriate.

- The nutrition plan of care should be reviewed minimum quarterly. This should be documented as part of the residents' health record and the plan of care should be updated accordingly.

4. Home Specific Policies, Roles & Responsibilities

- Utilize these Best Practices to guide your home specific policies, roles, and responsibilities. Home specific polices take precedence over this document.

4. Resources & Tools

- **Sample Tools:**

- OSNAC Data Collection Tool
- OSNAC Dietary Referral form
- OSNAC High Nutrition Risk Monitoring Tool
- OSNAC Initial Visit Interview Tool
- OSNAC Nutrition Risk Identification Tool
- OSNAC Assessment Documentation Tool
- OSNAC Assistive Devices Tool

- **Additional Resources:**

- Fingertip Files for Dietitians (2018): The RD's Quick Reference Guide for Nutrition in Long Term Care Written and published by Leslie Whittington-Carter, MHS, RD. Fingertip Files.

- Advanced Care Planning Ontario. (n.d.) *Educational Videos.* https://advancecareplanningontario.ca/resources-educational-support/educational-videos

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5. Evidence & References

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