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The inspiration behind this document belonged to Naomi Hunter, Senior Dietitian who worked as the dietitian for the Learning Disabilities Service between 1996 and 2001. Naomi produced these guidelines in 1998. Despite support from the Learning Disabilities Service the funding to print and implement the document was never forthcoming.

Naomi was diagnosed with a life threatening condition and resigned from her post in 2001. Sadly she died in August 2003 aged 36 years after a long struggle with her illness and much medical intervention. Naomi was committed to her work with her clients within the Learning Disability Service and was passionate about improving their well-being and nutritional care. She was frustrated about the lack of commitment to improve and develop the nutrition and dietetic service to clients with Learning Disability. Naomi put a lot of effort into producing these practical guidelines and consulted widely with care home staff across Leicestershire. It has now been decided by Leicestershire Nutrition and Dietetic Service to launch and use the document so that the good work Naomi did can be shared and utilised.

The guidelines have been updated to include some new figures and references but the document is still essentially all Naomi’s work. It supports the spirit of ‘Valuing People - a new strategy for Learning Disabilities for the 21st Century’ and aims to work with carers to improve the health of adults with learning disability. It is hoped that staff working in care homes and day units across Leicestershire and Rutland will find this practical document useful to improve the health and nutritional well-being of their clients.

The Leicestershire Nutrition and Dietetic Service can be contacted for help in supporting the use of the information in this document.

Alison Scott  
Dietetic Manager – Primary Care  
Leicestershire Nutrition and Dietetic Service  

June 2004
Introduction

In 1999 the Government published its White Paper “Our Healthier Nation”. Within it, proposals for a concerted action to improve people’s living conditions and health are set out.

It proposes a ‘contract for health’ specifying what the Government must do in partnership with local organisations, and what the “individual” can do.

It puts forward specific targets for tackling some of the major killer diseases. These being:-

HEART DISEASE AND STROKE

ACCIDENTS

CANCER

MENTAL HEALTH

It recognises that ill health is the result of many complex issues. Some of these issues are beyond our control i.e. fixed (genetic make-up being one example) and some issues are hard for us as individuals to change, for example our environment or financial situation. However, some factors are within our control and these include diet, physical activity, smoking and alcohol.

“A good diet is an important way of protecting health. The amount of fruit and vegetables people eat is an important influence on health. Unhealthy diets, which tend to include too much sugar, salt and fatty foods are linked to cancer, heart disease and stroke as well as tooth decay. Research suggests that a third of all cancers are the result of a poor diet”. (Ref. 1)

For those adults with a learning disability who do not have control of their diet the responsibility of healthier eating lies in the hands of their immediate carers.

However, the value of food goes beyond healthy eating for a healthy body. It contributes hugely to our “quality” of life and mental well being. We eat because we enjoy eating! We gain immense pleasure from food and it is important we never lose sight of this when addressing the issue of diet and nutrition.
Summary of Contents

“Most people with learning disabilities have greater health needs than the rest of the population” (Ref.2)

Some of these extra health needs, which can be related to food and nutrition will be considered in this document. Practical advice will be offered on how to adapt the diet in order to help improve the health of the individual concerned.

“The nature of the health problems of people with learning disabilities has not changed over time, but the way that their needs are met has changed. Mental handicap hospitals were the main source of health care in the past but most of these are now closed. Most people with learning disabilities live in the community in their family homes, in residential care or in supported living arrangements”. (Ref.3)

Trained chefs and cooks prepared the meals within the old large mental handicap hospitals. These cook’s followed tried and tested recipes, were trained in the preparation of special diets, and served out meals according to set portion sizes.

There was not much freedom of choice, and no doubt residents had little to do with menu planning or food preparation. However, the food provided would have conformed to set standards, with recipes and menus planned and rotated.

Thankfully, we now face a completely different situation. For clients in hospital or living in a community residential setting, there is much more freedom. Clients likes and dislikes for particular foods can be better catered for, and those that can go shopping with staff do so. There is more opportunity to eat outside the home, and many residents can prepare their own food and drinks.

However, staff within these residential homes have been forced to take on the role of chef, diet cook, menu planner, healthy eating adviser, etc. without receiving adequate training. Many have coped admirably using their own recipe books and resourcefulness, and by drawing on their own experiences and knowledge as to what constitutes a healthy, balanced meal. But this must not cloud the issue of staff training needs. Managers can not avoid this issue of staff training when tackling the dietary needs of people living under their care.

This document will therefore set out guidance on providing a healthy balanced diet and how to plan a menu that meets nutritional needs, but DOES NOT aim to replace the need for suitable training in this area.

“People with learning disabilities and their carers may not recognise health needs and ensure that appropriate help is obtained. There is evidence that they do not use primary care services as much as would be expected from their needs”. (Ref. 3)

Staff and carers of people with learning disabilities are responsible for their clients nutritional well-being. They are expected to identify when their clients nutritional status becomes a cause for concern.

By monitoring body weight and food intake, it is hoped staff are able to identify nutritional problems as soon as they occur.
This document encourages basic minimum standards which residential homes can aim to meet. Some of these standards are already well established, for example, the recording of daily food intake.

The issue of staff training in this area of nutritional monitoring will also need addressing.

Finally, this document will outline how to go about accessing the services of a Registered Dietitian.

**In brief summary, this document will concentrate on the following key areas:-**

1. Special health needs of people with learning disabilities in relation to diet, food and nutrition.

2. What constitutes a healthy balanced diet.

3. Monitoring nutritional status and how to go about accessing dietetic services when a dietary/nutritional problem arises.
Section 1:-
Special health needs of adults with learning disabilities in relation to nutrition

OVERWEIGHT

It is generally acknowledged that the incidence of obesity among adults with learning disability is significantly higher than in the general population. The incidence of overweight and obesity in the general population has risen steadily over the last 20 years and the National Audit Office Report in 2001 (Ref 4) reported that in 1998 21% of women and 17% of men were obese (BMI > 30) and more than half of women and two thirds of men were overweight or obese (BMI > 25).

In contrast, a study of adults with learning disabilities found that 28% of men and 59% of women were obese. (Ref.5). Looking more closely at the evidence, it has also been found that prevalence is higher in persons with a mild to moderate learning disability in comparison to those individuals with a severe to profound learning disability. (Ref.5 and Ref.6)

Concentrating on the special needs of people with learning disabilities, there are several syndromes associated with excessive weight gain, such as Pradi-willi, Downs, Carpenter, Lawrence Moon and Cohen syndromes. Even so, putting clients with these syndromes aside, there is still a high prevalence of obesity (Ref.7) suggesting that other forces are at work, i.e. environmental factors and behaviour. Unfortunately, this is the case as people with learning disabilities are more likely to lead sedentary lives, eat through boredom (“comfort eat”) and lack of nutritional knowledge.

This is certainly a cause for concern.

Obesity is a serious health problem. It is associated with increased risk of coronary heart disease, elevated cholesterol in the blood, diabetes, high blood pressure, breathing difficulties, reduced mobility and decreased life expectancy. Not only does health suffer but so does self-esteem. Obese persons with a learning disability are more likely to be the object of social prejudice because of the social stigma associated with having both mental retardation and obesity. (Ref.7)

CLASSIFICATION OF OBESITY

The Body Mass Index (BMI) is a useful way of classifying weight in relation to height and body fat content.

\[
\text{BMI} = \frac{\text{Weight (kilograms)}}{\text{Height (metres)}^2}
\]

<table>
<thead>
<tr>
<th>BMI</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 or below</td>
<td>underweight</td>
</tr>
<tr>
<td>20 - 24.9</td>
<td>normal healthy weight for height</td>
</tr>
<tr>
<td>25 - 29.9</td>
<td>overweight</td>
</tr>
<tr>
<td>30 - 39.9</td>
<td>obese</td>
</tr>
<tr>
<td>40 and above</td>
<td>morbid obesity</td>
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</tbody>
</table>

A useful way of quickly checking a person’s BMI is by referring to a BMI chart (see Appendix A)
WHEN TO CONCERN YOURSELF ABOUT A CLIENT’S WEIGHT

An individual may look overweight because of poor muscle tone, poor posture of fluid retention. It is important to use your “professional judgement”.

However, a good guide is to re-look at past weights. If your client has been steadily gaining weight over time and is now approaching the “obese” (BMI over 30) category, then it may be wise to try and limit further weight gain.

If your client has a BMI of above 30 then it would be considered beneficial to their health to try and help the client to reduce his or her weight.

HELPING YOUR CLIENT TO LOSE WEIGHT

It is not easy to lose weight! Your client will need lots of support and encouragement. Be aware of quality of life and try not to approach the issue in terms of a “strict diet”.

POINTS TO CONSIDER:

- Is it really necessary for your client to lose weight?

  If health and mobility are not affected by your clients present weight and weight is stable, it may not be such a cause for concern.

- How old is your client?

  You may not actually be achieving a great deal in terms of health benefit by reducing your clients weight

- Is your client’s weight increasing?

  As mentioned before, a BMI between 25 and 30 is not necessarily a health issue. However, if your client’s weight is steadily increasing (look back at old weight records) then it may by wise to try and stabilise weight and aim to prevent it increasing further rather that weight reduction.

- Is activity the issue rather than diet?

  If your client does little or no exercise, perhaps approach weight reduction through physical activity and an exercise programme. Exercise is important for a number of reasons, e.g. cardiac function, circulation, respiration and muscle tone, as well as improving overall sense of well-being.

- Be realistic

As mentioned previously, losing weight can be hard. However, keeping the weight off is even harder! Think carefully about what is realistic and achievable. Not everyone will manage to bring their weight down to the “ideal” for their height. Look through old record charts and perhaps set a target based on a weight which your client once was. This may still be too heavy, but it is a lot more achievable than a weight they have never been in adult life!
PRACTICAL TIPS:

- Base meals around general healthy eating (see section 2)
- Aim for 3 regular meals every day
- Use “diet” or sugar-free/low calorie drinks
- Switch to semi-skimmed or skimmed milk
- Switch to low fat spreads instead of butter or margarine
- Avoid seconds (or offer mainly vegetables and fruit if need be)
- Try to avoid too many pastries, pies, fried food and rich puddings (instead of the latter, offer fruit, sugar free jelly or diet yogurts)
- Reduce snacks between meals
- Weigh your client on a regular basis (e.g. once a month) and give as much praise and encouragement as possible

UNDERWEIGHT

The flip-side of obesity! Again, people with a learning disability are more prone to becoming seriously underweight, and incidence is higher than in the general population. Looking more closely at the degree of learning disability, seriously underweight individuals are more likely to have a severe or profound learning disability and often when associated with a physical disability. (Ref.8)

Other compounding factors include inability to ask for food if hungry, swallowing difficulties and slow feeding, ataxia (uncontrollable muscle spasms), hyperactivity, constipation and an inability to self feed.

There a definite health risks of being underweight.

Individuals who are seriously underweight are more prone to infection, pressure sores, muscle loss (including muscle loss form the heart and digestive tract), weakness, confusion, and general lethargy. Quality of life is affected, and individuals are more likely to become depressed.

IDENTIFYING THE UNDERWEIGHT

BMI is one way of identifying if an individual is underweight (i.e. if BMI is below 20).

Again use your professional judgement. Does the individual look underweight? Can you see their ribs? Are their clothes hanging off them?
WHEN TO CONCERN YOURSELF ABOUT YOUR CLIENT’S WEIGHT

Re-look over past weights. What has been your client’s lowest weight? What has been your clients highest weight? If your client’s current weight is now below any prior weights recorded and his/her BMI is below 20, then concern yourself. It is important to prevent further weight loss. (See section below on Practical Tips).

If low weight/weight loss is also compounded by such factors as poor appetite, pressure sores, refusal to eat or drink and/or swallowing problems, then refer to a Dietitian (see Section 3 on accessing dietetic services).

HELPING YOUR CLIENT TO GAIN WEIGHT

Keeping an accurate record of food and fluid intake will help give an idea of how much your client is managing. This can be analysed by a dietitian to check for nutritional adequacy.

PRACTICAL TIPS

- Encourage “small and often”. Give food every 2 hours - whether it is asked for or not.
- Consider fortifying food. This can be done quite simply using ordinary foods and cooking methods. For example:
  - Frying food
  - Adding margarine to meals (avoid using low fat spreads)
  - Adding jam, cream or honey to puddings
  - Using full-cream milk to make coffee, hot chocolate, porridge, custard, milk jellies, etc
  - Make good use of high calorie foods such as biscuits, cheese, cakes, pastries, crisps, etc
  - Monitor your client’s weight. If the situation fails to improve consider referring to the dietitian (see section 3).

SWALLOWING PROBLEMS

This problem is more inclined to affect those individuals with a severe or profound learning disability plus a severe physical disability, for example as in Cerebral Palsy (Ref.9). However, even clients with a mild learning disability may be prone to choking or aspirating on food, especially if they tend to “bolt” food and not chew it thoroughly first.

Alerting the doctor is essential if there is any suspicion (i.e. food or fluid “going down the wrong way” and entering the lungs). This may present itself as frequent coughing or choking, recurrent chest infections, excessive drooling, clear stringy mucous from the mouth and an unwillingness to swallow.

A team approach may be necessary with nursing staff, Speech and Language Therapists, Physiotherapists, Occupational Therapists and Dietitians all needing to be involved. It is good practice to identify clients most at risk of swallowing difficulties and ensure a care plan or mealtime programme is produced for the client. This care plan, or programme should be renewed regularly with all the health professionals involved.
**PRACTICAL TIPS**

- Ideally, to keep food in its most “natural” state is better than altering it beyond all recognition! This is because it looks more appetising for the client, and it retains more nutrients. If necessary opt for soft meals (e.g. macaroni cheese, shepherds pie and rice pudding) or chop food up. Add extra gravy, sauces, butter, custard, ice-cream etc, to make it easier to swallow.

- Avoid liquidising food unless absolutely necessary. However, if a Speech and Language Therapist recommends pureeing food then puree using nourishing liquids such as milk sauces, custard, soup, gravy, rather than plain water.

- It may also be necessary to thicken pureed food using a thickening agent. This comes in the form of a powder, which is stirred/liquidised into the food. This prevents the liquid “separating out” from the solid matter. The Speech and Language Therapist or Dietitian can advise on how much to use and organise for your client to receive it on prescription.

- If your client is struggling to manage an adequate food intake, and/or is failing to maintain weight then nutritious drinks such as Complan and Build-Up can be offered. Oral Nutritional Supplements such as Fortisip, Ensure Plus, Forticreme, Provide Xtra are available on prescription and a Dietitian can advise on the most suitable one for your client. (See section 3 on accessing the services of a Dietitian).

**CONSTIPATION**

This is still unfortunately, commonly seen among those with physical and learning disabilities. Constipation is caused by a variety of factors including inadequate fluid intake (e.g. through drooling/swallowing problems and mild dehydration (Ref.10) not eating enough fibre, certain forms of medication (including over use of stimulant laxatives, such as senna, bisacodyl and sodium picosulphate) and lack of exercise.

A number of factors may predispose those with learning disabilities to constipation e.g. attention deficit disorders, neurological, neuromuscular and physiological defecits. (Ref.11)

Constipation itself may not be considered a particularly worrying health issue, but it has a knock-on effect where other issues are concerned e.g. challenging behaviour, abdominal pain, appetite, and lack of general well-being. Constipation in the long term increases the likelihood of clients developing such conditions as piles, diverticular disease, and possibly even bowel cancer.

**PRACTICAL TIPS**

- Firstly, aim to ensure your clients fluid intake is adequate. Ideally aim for at least 10 cups of liquid per day e.g. tea, fruit juice, squash, pop, water

- Once this is achieved try and improve your clients fibre intake step-by-step rather than all at once e.g. by offering more fruit (fresh, tinned, or dried) more vegetables, wholemeal bread, high fibre breakfast cereals, more beans and
pulses e.g. baked beans.

- At the same time as addressing the problem through diet, think about the possibility of increasing physical activity and exercise

## REGURGITATION, VOMITING AND RUMINATION

Regurgitation occurs when stomach contents return to the mouth. Vomiting is the projection of stomach contents out of the mouth, and rumination is the regurgitation of previously swallowed food back into the mouth where it is then re-swallowed or ejected.

It can be difficult to find out what triggers these symptoms because they often occur in those with a severe learning disability who possibly cannot communicate verbally. However, before assuming that behaviour is the cause, it is important to rule out possible physical/clinical causes such as Hiatus Hernia. Look for pain or nausea. Is the abdomen distended? Is the individual constipated or experiencing diarrhoea? Does the person eat inedible items (i.e. pica).

If the condition does appear to be behavioural, other members of the Multidisciplinary team, such as a psychologist, should become involved. (Ref.12 and Ref.13).

## PRACTICAL TIPS

- Avoiding drinks at meal-times can help those with reflux. Aim to keep meals as dry as possible, and offer drinks half an hour before and after meals.

- Thickening fluids with a thickening agent may also help prevent liquid from seeping back into the mouth.

- Offering small, frequent meals and snacks may also be of benefit as:
  
  (i) the stomach is not forced to try and contain large volumes of food. Spreading a meal out may also help (leave a gap between main course and pudding).

  (ii) the client is hungry and needs food regularly

- Position during eating is also vital. This can be hard to address in those who have severe physical disabilities and it is a good idea to seek the advice of a Physiotherapist, Occupational Therapist and Speech and Language Therapist
Section 2:–  
What constitutes a Balanced Diet?

THE BALANCE OF GOOD HEALTH

In August 1994, the Department of Health published the first National Food Guide ‘The Balance of Good Health’. It looks at the importance of food variety and gives an idea of how much we should aim to eat from the five different food groups rather than concentrating on specific nutrients (e.g. how much fruit and vegetables we should try and eat rather than how many grammes of fibre).

It helps translate theoretical guidelines into a visual guide of how much of different foods we should eat each day.

The Balance of Good Health

Reproduced with kind permission of the Food Standards Agency

The Balance of Good Health will apply to most adults with learning disabilities. However, it does not apply to those who are underweight or ill. For many people, following the principles behind the Balance of Good Health, will help keep their weight stable. Obviously, if underweight, it may be necessary to eat more of the fatty and sugary foods, milk and dairy foods, that are shown in the diagram.

The following information is taken directly from the leaflet ‘Healthy Eating for a Healthy Leicestershire’ which has been produced by the Leicestershire Nutrition and Dietetic Service and which is based around the Balance of Good Health.
FRUIT AND VEGETABLES
Choose a wide variety.
Aim for at least 5 servings per day.
e.g. an apple, a banana, 2 portions of vegetables, a glass of fruit juice.

BREAD AND OTHER CEREALS AND POTATOES
Eat all types and choose high fibre types whenever you can.
Aim for 4 or more servings per day (according to appetite and activity).
Include starchy foods at every meal.

MEAT, FISH AND ALTERNATIVES
Choose lower fat alternatives whenever you can
Aim for 2 servings per day.
e.g. baked beans on toast at lunch, meat with evening meal.

BREAD AND OTHER CEREALS AND POTATOES
Eat all types and choose high fibre types whenever you can.
Aim for 4 or more servings per day (according to appetite and activity).
Include starchy foods at every meal.

MILK AND DAIRY FOODS
Aim for 3 servings per day.
e.g. 600mls (1 pint) low fat milk OR 200mls (1/3 pint) milk plus 1 yogurt and 25g (1oz) cheese

FAT AND SUGARY FOODS
Try not to eat these too often, and when you do, have small amounts.

The Balance of Good Health can be used to plan healthy balanced meals. The meals should be based around a large proportion of vegetables, fruit and some form of starchy foods (e.g. pasta, rice or bread) or potato. The “protein” food (i.e. meat, fish egg or alternative) should make up a smaller proportion on the plate. Meat should be trimmed and cooked without fat. Dairy foods can be high in fat so choose low fat or fat-reduced varieties.

Fish is a healthy option but avoid battered or fried. Choose tinned fish in brine rather than oil.

Go easy with creamy sauces and watch salad dressings and mayonnaise. Perhaps try oil free dressings, natural yogurt, lemon juice and low calorie salad creams.

MENU PLANNING
Wherever possible, clients should be involved in the menu planning process. Ideally a 2 to 3 week cycle should be planned, but a well-thought out one week cycle is better than a badly thought out 3 week cycle.

Consider your clients. What are their likes and dislikes? Do you need to cater for special diets? (e.g. diabetic, vegetarian, soft diets etc.).

What is your food budget? Can you make use of a large supermarket or do you need to rely on local shops?

Can your members of staff prepare the food on the menu? Have you standard recipes to follow?

No menu cycle should be set for life. It is vital that it is reviewed on a regular basis and updated.
PRACTICAL TIPS

- Variety - this helps prevent menu monotony. The greater the variety of food and meals offered, the more likely it is you will be providing a balanced health diet.

- Offer fresh fruit daily (adjust accordingly to what is in season).

- Grill, bake, boil or steam instead of frying.

- Protein foods (see Balance of Good Health) should be offered twice a day. Beans and pulses are a cheap healthier alternative to meat and fish.

- Soup can make a nutritious light meal. Try adding beans, pasta, diced potato or grated cheese to make an interesting change.

- Try to buy in wholemeal/high fibre breakfast cereals, brown rice, and wholemeal bread.

- Consider sugar-free squashes and diet fizzy drinks for those clients watching their weight.

- Semi-skimmed milk should be the milk of choice for the majority of your clients, however, buy in full-cream milk for any resident who is underweight.

- Think about appearance, texture and colour of food when putting together a meal, e.g. mashed potato, swede and chicken in a white sauce may not stimulate a hearty appetite.

- Avoid high fat foods (such as pies, quiches, battered fish, and chips) on a regular basis.

Be flexible, not every one will appreciate the same food that you like. You may think it is healthy, nutritious and good for your client, but they may have a different opinion. If possible, work with your clients likes and dislikes, e.g. if your client will only eat chips and refuses to eat potato in any other form, try fat-reduced oven chips or chips cut thick with excess oil damped off with kitchen roll. Consider how you can make other aspects of the diet healthier, e.g. avoid pastries and other high fat foods on a regular basis. Include more vegetables and fruit.
Section 3:-
Monitoring Clients Nutritional Status

How do we know if someone is getting all the nutrients they need? When do we know if someone is becoming overweight or underweight?

These are questions carers may ask when they are responsible for another person’s diet, food intake and nutritional well being (Ref 14).

The following are guidelines which can be incorporated into care plans or “in house” policies.

GENERAL OBSERVATION

Think about your client’s appearance. Does your client look too thin? Can you see their ribs or backbone? Have you had to buy new clothes for your client in a different size recently?

FOOD INTAKE

Keeping a Food Record is standard practice in Residential Homes but the value of the information obtained depends on the skill of the member of staff recording. If your client is starting to leave food, perhaps consider keeping a more accurate food record with actual amounts of food left on the plate. Also keep a close eye on fluids, both quantity and type drunk.

MONTHLY WEIGHTS (See Appendix C)

Again, this is standard practice in Residential Homes but it is important to act on significant weight changes, e.g. 7lb (3kg) or more. Ideal weight range for height should be stated on care plans (See Appendix B) to give members of staff an idea of what their client should weigh.

Scales should be accurate (standard bathroom scales are not the most suitable choice) and should be calibrated on a regular basis - ideally twice a year.

Access to hoist or chair scales should be made available to those who cannot stand (local hospitals and health centres may have these).

It can be difficult to gain an accurate idea of height but one VERY crude method is to measure individual parts of the body (tip of heel to knee, knee to hip and so on, ending with the back of the neck to the top of the head). This will give you a very rough idea of height.

SKIN CONDITION

Another good sign of nutritional well being is the state of your client’s skin. This should look healthy and intact and not dry or flaky. Obviously, any sign of sores, ulcers or red pressure areas can be an indication of poor nutrition.
Appendix D contains a Nutritional Screening Tool for adults with learning disabilities. This tool can be used as a means of “scoring” your clients nutritional well being. It can be repeated on a regular basis, e.g. monthly, in order to highlight any changes in nutritional status. Any score above 15 warrants a referral to a dietitian.

ACCESSING THE SERVICES OF A DIETITIAN

A dietitian will become involved with an individual when they receive a medical referral from a doctor. However, other people can make a referral as long as the dietitian is made aware of which GP to contact.

The following are possible reasons for a dietetic referral:

- Low body weight, especially if associated with a swallowing difficulty, vomiting, poor food intake, disinterest in food, behavioural problems.
- Clients with special dietary needs, e.g. diabetes, high cholesterol.
- Possible food allergies or restricted diets, e.g. milk free.
- Unplanned weight changes, especially if over a short period of time.

If you identify a client needs referral to a dietitian, it is best to contact the client’s GP who can write a referral. This will be sent to the nearest dietetic department (or there may be a dietitian who holds regular clinics at the practice or nearby health centre). If your client is able to attend an outpatient department, an appointment will be sent to your Residential Home. If your clients needs a home visit, this needs to be specified on the referral.

The dietitian can also offer support and training for staff in homes and day centres on nutritional issues. Please contact your dietitian if you would like training on dietetic or nutritional issues to be arranged.
APPENDIX A  is BMI CHART

See separate document – BMI Chart
**APPENDIX B**

**TABLE ON ACCEPTABLE WEIGHTS FOR HEIGHT** *(Based on Body Mass Index (BMI) in the range of 20-25).*

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<thead>
<tr>
<th>HEIGHT</th>
<th>BODY WEIGHT</th>
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</tr>
<tr>
<td>174</td>
<td>5'8.5&quot;</td>
</tr>
<tr>
<td>176</td>
<td>5'9&quot;</td>
</tr>
<tr>
<td>178</td>
<td>5'10&quot;</td>
</tr>
<tr>
<td>180</td>
<td>5'11&quot;</td>
</tr>
<tr>
<td>182</td>
<td>5'11.5&quot;</td>
</tr>
<tr>
<td>184</td>
<td>6'0.5&quot;</td>
</tr>
<tr>
<td>186</td>
<td>6'1&quot;</td>
</tr>
<tr>
<td>188</td>
<td>6'2&quot;</td>
</tr>
<tr>
<td>190</td>
<td>6'3&quot;</td>
</tr>
<tr>
<td>192</td>
<td>6'3.5&quot;</td>
</tr>
<tr>
<td>194</td>
<td>6'4&quot;</td>
</tr>
<tr>
<td>196</td>
<td>6'5&quot;</td>
</tr>
<tr>
<td>198</td>
<td>6'6&quot;</td>
</tr>
<tr>
<td>200</td>
<td>6'7&quot;</td>
</tr>
</tbody>
</table>

* Adapted by the Commonwealth Department of Health from Garrow - Classification of Obesity.

Suitable for both men and women over 18 years.
APPENDIX C WEIGHT MONITORING CHART

Leicestershire Nutrition and Dietetic Service

<table>
<thead>
<tr>
<th>Name</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.O.B.</td>
<td>Height</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight (kg)</th>
<th>Wt Change</th>
<th>BMI</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

LDWeightMonitoringChart
**APPENDIX D - LNDS NUTRITIONAL SCREENING TOOL FOR ADULTS WITH LEARNING DISABILITIES**

Affix addressograph here

Date:

Weight (kg) $\text{BMI} = \frac{\text{kg}}{\text{m}^2}$

Height if measurable (m) =

Ideal weight range for height =

**Guidelines for use:**
* Recheck monthly
* Score more than one criteria per section if applicable

<table>
<thead>
<tr>
<th><strong>BODYWEIGHT FOR HEIGHT</strong></th>
<th><strong>DEGREE OF LEARNING DISABILITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Looks underweight (BMI below 19)</td>
<td>4</td>
</tr>
<tr>
<td>Looks overweight (BMI above 25)</td>
<td>2</td>
</tr>
<tr>
<td>An acceptable weight (BMI 19-25)</td>
<td>5</td>
</tr>
<tr>
<td>*Looks severely undernourished</td>
<td>0</td>
</tr>
<tr>
<td>Has recently lost more than 3kg</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>APPETITE AND DIETARY INTAKE</strong></th>
<th><strong>FEEDING ABILITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal intake</td>
<td>0</td>
</tr>
<tr>
<td>Reduced intake</td>
<td>3</td>
</tr>
<tr>
<td>*Very poor intake most days</td>
<td>5</td>
</tr>
<tr>
<td>Goes through phases - refusing food</td>
<td>2</td>
</tr>
<tr>
<td>Special diets eg: Puree, Diabetic</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PSYCHOLOGICAL STATE</strong></th>
<th><strong>SYMPTOMS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoys mealtimes</td>
<td>0</td>
</tr>
<tr>
<td>Disruptive behaviour at mealtimes</td>
<td>3</td>
</tr>
<tr>
<td>Regurgitates/self induces</td>
<td>3</td>
</tr>
<tr>
<td>Eats inedible matter</td>
<td>2</td>
</tr>
<tr>
<td>Will only eat limited range of foods</td>
<td>3</td>
</tr>
<tr>
<td>Hyperactive/Athetosis</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SKIN TYPE</strong></th>
<th><strong>AGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>0</td>
</tr>
<tr>
<td>Dry and Flaky</td>
<td>3</td>
</tr>
<tr>
<td>Oedematosus</td>
<td>3</td>
</tr>
<tr>
<td>*Leg ulcer/pressure sore (all grades)</td>
<td>5</td>
</tr>
<tr>
<td>If over 65 years add 2 to score</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TOTAL</strong></th>
</tr>
</thead>
</table>

* **AUTOMATIC REFERRAL TO DIETITIAN**
There are three instances which trigger an automatic referral to a Dietitian. These have been marked with an ASTERISK.

REFER OVERLEAF FOR ACTION AND DOCUMENTATION
ACTION

**Nutritional Score 0-9** ⇒ Encourage a well balanced varied diet.

**Nutritional Score 10 - 15** ⇒ At risk of malnutrition. Try the following action points:-

- Keep an accurate record of food intake for a few days eg: 4-5 days. This may highlight problems area in the diet.
- To improve nutritional intake try the following:
  - encourage milky drinks/milky puddings
  - encourage small snacks between meals
- Consider the need for dietary supplements.
- If in any doubt, discuss with the Dietitian.

Reassess monthly and if no improvement in nutritional score, refer to Dietitian.

**Nutritional Score >15** ⇒ REFER CLIENT TO DIETITIAN

Remember this is only a screening tool, therefore if in any doubt about the score, look at your client and use your professional judgement.

<table>
<thead>
<tr>
<th>DATE</th>
<th>NUTRITIONAL SCORE</th>
<th>WEIGHT (kg)</th>
<th>DIETETIC REFERRAL</th>
<th>NURSE SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>SCORE</td>
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<td>DATE</td>
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**REFERRAL PROCEDURE:**
GORSE HILL TREATMENT UNIT, THE LAURELS, BALDWIN UNIT. Tel: (0116) 225 5279
ASK FOR GILLIAN BAVERSTOCK (SENIOR DIETITIAN)

**COMMUNITY GROUP HOMES:**
INDIVIDUAL CLIENT REFERRALS SHOULD BE MADE BY A G.P. OR ANOTHER MEMBER OF THE PRIMARY HEALTH CARE TEAM TO THE PRIMARY CARE NUTRITION AND DIETETIC SERVICE ON OUR SAFE HAVEN FAX NUMBER 0116 2727228. (If you client requires a home visit the reason needs to be specified in the referral, otherwise your client will be sent an outpatient appointment).

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The help of various sources has been valued in the development of this screening tool, in particular Judy Waterlow; in addition Derby City Hospital NHS Trust, Plymouth Nutrition and Dietetic Service and Netheridge Hospital multi-disciplinary team.
REFERENCES


Leicestershire Nutrition and Dietetic Service

- who to contact for dietetic referrals and queries.

i) For Gorse Hill Hospital - Senior Dietitian, Learning Disabilities, Mansion House, Leicester Frith Hospital. Telephone 0116 2255278.

ii) For Charnwood and North West Leicestershire PCT – Primary Care Dietitian, Loughborough Community Hospital. Telephone 01509 564204

iii) For Hinckley and Bosworth PCT- Primary Care Dietitian, Hinckley Health Centre. Telephone 01455 441849

iv) For South Leicestershire PCT – Primary Care Dietitian, Mansion House, Leicester Frith Hospital. Telephone 0116 2255278

v) For Market Harborough – Primary Care Dietitian, Market Harborough and District Hospital. Telephone 01858 438132

vi) For Melton and Rutland – Primary Care Dietitian, St. Marys Hospital, Melton. Telephone 01664 854802

vii) For Leicester City West PCT – Primary Care Dietitian, Caldicote School, Braunstone, Leicester. Telephone 0116 2630861

viii) For Eastern Leicester PCT – Primary Care Dietitian, Mansion House, Leicester Frith Hospital, Telephone 0116 225 5278
USEFUL ADDRESSES

- Action Against Allergy  www.actionagainstallergy.co.uk
- British Heart Foundation  www.bhf.org.uk
- British Nutrition Foundation  www.nutrition.org.uk
- Coeliac UK  www.coeliac.co.uk
- Diabetes UK  www.diabetes.org.uk
- Digestive Disorders Foundation  www.digestivedisorders.org.uk
- Food Standards Agency  www.foodstandards.gov.uk
- Health Development Agency  www.hda.nhs.uk
- Vegetarian Society of the United Kingdom  www.vegsoc.org
- Weight wise  www.bdaweightwise.com