

PART IV

OVERHEAD TRANSPARENCIES OUTLINES

SECTION 1

OPENING REMARKS

- OHT 1.1 Seminar Aims
- OHT 1.2 Australian Nutrition Screening Initiative (ANSI)
- OHT 1.3 Definitions
- OHT 1.4 HACCC Target Group for Nutritional Risk Screening
- OHT 1.5 Nutrition Screening and Intervention by an Interdisciplinary Team
- OHT 1.6 Poor Nutrition in Vulnerable Adults. Does it Matter?
- OHT 1.7 Summary of Background Factors for Poor Nutrition

OHT 1.0

Seminar aims

- 1) To demonstrate nutritional risk screening and monitoring, including:
 - a) Nutrition and health issues
 - b) Nutritional Risk Screening and Monitoring Tool
 - b) Food and nutrition issues and dietary principles
 - c) Identified problems and simple intervention strategies
- 2) To demonstrate the Resource Manual and Case Studies
- 3) To provide information on ways of accessing external support and expertise
- 4) To provide opportunities for staff development and networking
- 5) To promote and advocate for good quality community services

Australian Nutrition Screening Initiative (ANSI)

- 1) Review of United Kingdom (1979) and USA initiatives (1990)
- 2) Literature review of the prevalence of nutrition related problems
- 3) Screening should begin with older people and those who care for them
- 4) Aims of the ANSI *Determine Your Nutritional Health Checklist* (1994):
 - Raise awareness of problems in the elderly
 - Overcome barriers to good nutrition in the elderly
 - Encourage a multidisciplinary approach
 - Identify appropriate interventions
 - Demonstrate cost-effective outcomes
 - Encourage further screening by health workers to identify persons at risk

Definitions

Nutritional Risk

“The risk factors of poor nutritional status are characteristics that are associated with an increased likelihood of poor nutritional status”

(Nutrition Screening Initiative, 1992)

Nutritional Risk Screening

“The process of discovering characteristics known to be associated with dietary or nutritional problems”

(Nutrition Screening Initiative, 1992)

The purpose of Nutritional Risk Screening:

- 1) To identify individuals at high risk of food and nutrition problems

or

- 2) To identify individual who already have poor nutritional status

Screening then facilitates intervention and monitoring.

OHT 1.3

HACC Target Group for Nutritional Risk Screening

Vulnerable people

- Frail Older People
- Adults With a Disability
- Financially Disadvantaged People Living in Alternative Accommodation

**“Nutrition screening and
intervention are best accomplished
by an interdisciplinary team ...
(that) uses existing programs
and fosters collaboration amongst
professionals.”**

(Nutrition Screening Initiative, 1992)

Poor Nutrition in Vulnerable Adults:

Does it Matter?

- More likely to fall
- Need more assistance
- Need more complex support and care
- More complications eg. infections, pressure sores
- Less likely to be able to live independently
- Need more frequent and longer stays in hospital

Poor nutrition makes people feel awful, affects their quality of life, and starts deterioration in a downward cycle.

Poor nutrition is associated with increased morbidity and mortality.

Poor nutrition is much harder and more expensive to treat than to prevent.

OHT 1.6

Summary of Background Factors for Poor Nutrition

- Inappropriate, inadequate food intake
- Poor appetite
- Poverty
- Social isolation
- Dependency
- Disability
- Feeding problems
- Acute conditions
- Chronic disease
- Chronic, multiple medication
- Advanced age (80+)

SECTION 2

NUTRITION AND HEALTH ISSUES

- OHT 2.1 Summary of Nutritional Risks
- OHT 2.2a-b Obvious Underweight-Frailty?
- OHT 2.3 Healthy Weight Range for Vulnerable People
- OHT 2.4 Unintentional Weight Loss?
- OHT 2.5 Severity of Unintentional Weight Loss
- OHT 2.6 Simple Interventions for Underweight-Frailty or Unintentional Weight Loss
- OHT 2.7 Reduced Appetite or Reduced Food and Fluid Intake?
- OHT 2.8 Mouth or Teeth or Swallowing Problem?
- OHT 2.9 Follows a Special Diet?
- OHT 2.10 Unable to Shop for Food? Unable to Prepare Food?
- OHT 2.11 Unable to Feed Self?
- OHT 2.12a-c Feeding Problems in High dependency Adults
- OHT 2.13 Nutrition Decision Tree: Referring High Dependency Adults to a Specialist
- OHT 2.14 Obvious Overweight Affecting Life Quality?
- OHT 2.15 Unintentional Weight Gain?
- OHT 2.16 Simple Interventions for Obvious Overweight Affecting Life Quality in the Older Person
- OHT 2.17 Simple Interventions for Obvious Overweight Affecting Life Quality in Vulnerable Adults 16-64 years
- OHT 2.18 Six Areas of Intervention to Improve Nutritional Health and Well-Being

RM 3.0; OHT 2.0

Summary of Nutritional Risks*

Obvious underweight - frailty?

(RM 3.1)

Unintentional weight loss?

(RM 3.2)

Reduced appetite or food and fluid intake?

(RM 3.3)

Mouth or teeth or swallowing problem?

(RM 3.4)

Follows a special diet?

(RM 3.5)

Unable to shop for food?

(RM 3.6)

Unable to prepare food?

(RM 3.7)

Unable to feed self?

(RM 3.8)

Obvious overweight affecting life quality?

(RM 3.9)

Unintentional weight gain?

(RM 3.10)

RM Section 3; OHT 2.1

Obvious underweight-frailty?

- Is the client obviously underweight - wasted?
- What is the duration of time at this current weight?
- Are there any signs of:
 - fluid retention (pushing weight up)?
 - dehydration (pushing weight down)?

Obvious Underweight-frailty? (continued)

- More critical to health if underweight is not usual
- Low energy body reserves of energy and nutrients for use in emergency
- A bout of poor food intake or increased needs can cause severe weight loss
- Unlikely that life can be sustained at a body weight less than 60 per cent of reference body weight
- It is difficult for a vulnerable person to regain weight
- Prevention of underweight is highly desirable

This is a client safety issue

RM 3.1; OHT 2.2b

Healthy Weight Range for Vulnerable People

Adults over 65 years of age

This range is higher than that for other adults
(Body Mass Index of 22-27)

Adults 16-64 years of age

Active adults
(Body Mass Index of 20-25)

Adults 16-64 years of age

Vulnerable, and highly dependent people with a disability

(Body Mass Index of 20-25 highly desirable)
Often an arbitrary choice on the low side (say, no less than a Body Mass Index of 18)

Unintentional Weight Loss?

- **Weight loss of 5 kg over six months or less is a serious sign of decline into poor nutrition**
- **More important if the person was under- weight in the first place**
- **Loss of weight can occur because of:**
 - Reduced food intake
 - Mouth or teeth or swallowing problem
 - Nausea, vomiting, diarrhoea, constipation
 - Increased need for energy
- **Severe weight loss is associated with higher rates of morbidity and mortality**

This is a client safety issue and is not to be ignored

RM 3.2; OHT 2.4

Severity of Unintentional Weight Loss?

NOTE: Severity of weight loss may be masked by fluid retention

Time	Significant %	Severe %
Over one month	5	More than 5
Over one-three months	7.5	More than 7.5
Over three-six months	10	More than 10

Simple Interventions for Underweight-Frailty or Unintentional Weight Loss

- Always review medications and update food preferences
- Provide optimal dining environment
- Allow adequate time for meals and snacks
- Give most food when most alert (anytime)
- Small meals and small snacks (3 + 3)
- Provide substitutes for items refused
- Motivational counselling-Eating better will help you feel better
- Suggest increased food energy (extra sugar, milk, margarine, thick soups, cream)
- Suggest fortified drinks between meals, particularly at night, eg. *Milo, Actavite*, milkshake

Monitor weekly until the client feels better and weight is stable

Check outcomes: obvious underweight, frailty, or weight loss?

Always consider referral for specialist advice: doctor, dietitian

RM 3.1-3.2; OHT 2.6

Reduced Appetite or Reduced Food And Fluid Intake?

- Many vulnerable people miss meals
- Meals on Wheels may be divided into two meals, without extras
- More than 1-2 two days of reduced food intake can lead to severe weight loss
- Illness may even increase the need for food
- Inappropriate special diets may be followed
- Loss of appetite can be related to change in medication

**Any sudden unexplained change in appetite:
refer doctor, dietitian**

RM 3.3; OHT 2.7

Mouth or Teeth or Swallowing Problem?

- Missing teeth, ill-fitting dentures
- Chewing and swallowing difficulties
- Cracked or sore lips, dry mouth, sore tongue, and pain or sensitivity to hot or cold
- Deficiencies of specific micro-nutrients (riboflavin, iron, vitamin C) cause mouth problems
- All of these problems may affect food and fluid intake, and socialisation
- Meat is the most common food avoided
- Specific medical problems can occur (dysphagia, cancer)

Consider referral: dentist, doctor, dietitian, speech pathologist

RM 3.4; OHT 2.8

Follows a Special Diet?

- Special diets are not always required for life
- Special diets can be a nuisance and may cost more
- The need for a special diet should be assessed at frequent intervals
- Uninformed alteration in usual food intake can cause more health problems
- If a special diet is required for a specific therapeutic reason, then it will improve the client's quality of life and health
- A coordinated approach is required for the client care plan (to avoid mixed messages)
- Any client rejection of a special diet may be best accepted

Always refer for advice: dietitian, doctor

RM 3.5; OHT 2.9

Unable to Shop for Food? Unable to Prepare Food?

A client who is unable to shop or prepare food may not eat enough due to:

- Less food choice (no ideas, no prompts)
- Reduced independence
- Possible dislike of foods offered
- Type of foods and fluids
- Methods of preparation
- Reduced life quality

These factors can affect the enjoyment of food and reduce intake

RM 3.6-3.7; OHT 2.10

Unable to Feed Self?

A client who requires feeding may not eat enough due to:

- Embarrassment
- Loss of independence
- Possible lack of care and attention by the Carer
- Dislike of the food and fluids offered
- Type of food and fluids
- Method of preparation
- Presentation
- Not enough time to eat and drink

These factors can affect food enjoyment and reduce intake, and may be a client safety issue

Always consider referral: dietitian, occupational therapist, social worker

RM 3.8; OHT 2.11

Feeding Problems in High Dependency Adults

- Long term and consistent management is required
- Low palatability
- Low nourishment value
- Inappropriate posture while feeding
- Inappropriate timing and duration of meals
- Misconception about the value of low client body weight
- High energy and nourishment needs
- Embarrassment, discomfort, possibly pain, fear
- Chewing and swallowing problems
- Constipation
- Dependency, inability to ask for more

Remember: complex feeding problems often improve with increased body weight and muscle strength

RM 3.8.1; OHT 2.12a

Feeding Problems in High Dependency Adults (continued)

- Feeding dependency
- Food refusal, drink refusal
- Drooling
- Coughing while feeding or immediately afterwards
- Swallowing air while feeding
- Choking episodes (choking risk)
- Gurgly 'wet' voice during or after meals (can be silent)- aspiration risk from entry of food or fluid into the lungs
- Vomiting
- Regurgitation of food
- Rumination of food

THERE MAY BE RISK OF FOOD AND FLUID LUNG ASPIRATION SO:

- **DO NO HARM**
- **DO NOT FORCE FEED**
- **DO NOT CHANGE CLIENT'S FEEDING ROUTINE IN ANY WAY**
- **ALWAYS REFER TO SPECIALIST (DOCTOR, DIETITIAN)**

RM 3.8.1; OHT 2.12b

Feeding Problems With High Dependency Adults

Simple and safe interventions:

- Sitting up support and chin support
- Peaceful mealtimes, good hygiene, no distractions
- Enough time to eat and drink
- Attention to food and fluid preferences
- Taste, smell, appearance and temperature of food
- The name of the food and drink is important

Client safety issues:

- Food and fluid aspiration into the lungs
- Safety is an even more critical in frail underweight people with aspiration problems and risk of pneumonia
- DO NO HARM
- DO NOT CHANGE the texture and thickness of foods and fluids without specialist advice

The client MUST be referred immediately to a specialist: doctor, dietitian

RM 3.8.1; OHT 2.12c

Nutrition Decision Tree: Referring High Dependency Adults to a Specialist

Feeding problem	Referral
Consistent refusal of food or fluids	Dietitian, doctor, pharmacist, social worker, psychologist
Gum or tooth disease	Visiting nurse, dentist
Can't reach meal and feed self	Carer
Can't sit in chair comfortably to feed	Occupational therapist, physiotherapist
A feeding program may be required	Dietitian, speech pathologist
Food or fluid dribbles out of mouth	Speech pathologist
Coughs, gags or chokes while feeding or afterwards	Speech pathologist, dietitian
A meal takes more than 40 minutes to eat	Doctor, dietitian, speech pathologist, physiotherapist
A problem with swallowing or silent aspiration Gurgly 'wet' voice during or after meals	Speech pathologist, doctor
Gut not functioning	Doctor
Will texture modification be sufficient to make feeding safe	Doctor, dietitian, speech pathologist

**Continue to monitor at regular intervals by
nutritional risk screening and monitoring**

RM 3.8.2; OHT 2.13

* Modified from the Nutrition Decision Tree (Dear and Webb, 1996).

Obvious Overweight Affecting Life Quality?

- A good body weight is a protective factor
- Body fat is a readily available energy store in times of stress and low food intake
- An overweight vulnerable and inactive person has to follow a very strict diet to achieve weight loss
- A very strict diet is likely to reduce life quality and health
- Weight maintenance may be the best choice

Refer to a dietitian for expert assistance

RM 3.9; OHT 2.14

Unintentional Weight Gain?

Possible reasons:

- Change in medication
- Constipation
- Increased food intake
- Change in food behaviour or feeding situation
- Decreased activity
- Fluid retention

Simple interventions:

- Safe avoidance of sugars, fats and alcohol
- Suggest a nourishing diet:
- 1 3 3 4 5+ food plan (older people)
- 1 2 3 4 5+ food plan (younger adults) without any extra foods
- A low dose vitamin and mineral supplement (3-4 times a week)

Check outcomes: Support weight maintenance or slow weight loss (no more than 0.5 kg/month)

Referral: doctor, dietitian (if weight loss is required)

RM 3.10; OHT 2.15

Simple Interventions for Obvious Overweight Affecting Life Quality in Older People

- Sugars, fats and alcohol can be safely avoided
- **Suggest the 1 3 3 4 5 daily food plan***

1 small serve	Lean meat, fish, poultry or eggs
3 serves	Dairy foods (reduced fat)
3 serves	Fruit (fresh, canned or stewed)
4 serves	Vegetables (fresh, canned, dried, frozen)
5 serves	Bread or cereals (high fibre)
6-8 cups	Fluid (low energy)
- Suggest a low dose vitamin and mineral supplement (three or four times a week)
- If high energy, nutrient poor foods (such as cake, wine, icecream) replace essential foods, then health will slowly deteriorate

Monitoring: monthly, about well-being and life quality

RM 3.9-3.10; OHT 2.16

* Modified from the 1 2 3 4 5+ food plan (Baghurst and Hertzler et al. *Journal of Nutrition Education*, 1992, vol 24, pp.65-72).

Simple Interventions for Obvious Overweight Affecting Life Quality in Vulnerable Adults 16-64 years

- Sugars, fats and alcohol can be safely avoided
- **Suggest the 1 2 3 4 5 daily food plan***

1 small serve	Lean meat, fish, poultry or eggs
2 serves	Dairy foods (reduced fat)
3 serves	Fruit (fresh, canned or stewed)
4 serves	Vegetables (fresh, canned, dried, frozen)
5 serves	Bread or cereals (high fibre)
6-8 cups	Fluid (low energy)
- Suggest a low dose vitamin and mineral supplement (three or four times a week)
- If high energy, nutrient poor foods (such as cake, wine, icecream) replace essential foods, then health will slowly deteriorate

Monitoring: Monthly, about wellbeing and life quality

RM 3.9-10; OHT 2.17

* Modified from the 1 2 3 4 5+ food plan (Baghurst and Hertzler et al. *Journal of Nutrition Education*, 1992, vol 24, pp. 65-72).

Summary of Six Areas of Intervention to Improve Nutritional Health and Well-Being

- Social support
 - Oral health
 - Mental health
- Medical problems
 - Medications
- Food and nutrition support

“Nutrition screening and intervention are best accomplished by an interdisciplinary team ... (that) uses existing programs and fosters collaboration amongst professionals.”*

* Nutrition Screening Initiative (1992)