

# SECTION 3

## NUTRITION AND HEALTH ISSUES

*In this Manual, vulnerable people include frail elderly people, adults with disability, and financially disadvantaged adults living in alternative accommodation*

## 3.1 OBVIOUS UNDERWEIGHT – FRAILITY?

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This factor is important because the underweight adult has so little body energy and nutrient reserves for use in times of emergency such as illness or reduced food and fluid intake. This is even more critical to health, if underweight is not the normal situation for the particular person.

A stable body weight at a low level (say 80-90%) over a period of years can be consistent with apparent health, but a bout of poor food intake or increased needs can precipitate severe weight loss. As far as we know, it is unlikely that life can be sustained when body weight drops below, say 60% of the reference weight.

The vulnerable adult is in a difficult position, because to regain weight more energy must be taken in daily food and drink than the body requires on a daily basis. This is difficult for a vulnerable person to maintain on a consistent basis for weeks and perhaps months.

Prevention of underweight is highly desirable in the vulnerable person. Those who are moderately overweight will have more protection from any stress which reduces food intake (over a day or two). Even temporary reduction in food and fluid intake will have an effect.

### Relevant comments:

- *I am always this weight*
- *I am very tired*
- *I can't go to the letterbox at the moment*
- *I like to be thin, it is natural to be thin when you are old or disabled*

### Observations:

- Is the person obviously underweight or wasted?
- Are there any signs of fluid retention (swollen feet, hands) pushing weight up?
- Are there any signs of dehydration (decreased back of hand skin elasticity) pushing weight down?
- Try to identify possible reasons for underweight-frailty.

### Further questions:

- *Do you think that you are losing weight?*
- *How long have you been at your present weight?*

### Assessment of body weight status (a global indicator of nutritional status)

If you have the person's weight and height, look up their best weight range in Section 3.1.1 (adults over 65 years), 3.1.2 (adults 16 to 64 years).

## Simple interventions:

- Address any identified problems
- Increase the awareness of the person and carer
- Statement you can make to the person:  
*You can help yourself by starting to eat little and often*
- Review medications
- Update food preferences
- Suggest three small meals and three small snacks every day
- Give most food when the person is most alert
- Allow adequate time for meals and snacks
- Provide substitutes for meals refused
- Recommend use of extra milk (to ensure tolerance to milk, increase milk gradually)
- Increase energy intake with extra sugar, milk, margarine, thick soups, cream
- Suggest fortified drinks between meals (particularly at night), for example-milk with skim milk powder and topping for a high energy milk shake, milo (refer Section 5.3.3.1)
- Ask a dietitian about nourishing snacks for the person to take between meals
- A multi-vitamin and mineral supplement may be recommended two to three times weekly (Refer Section 5.7)
- Encourage slight increase in activity
- Monitor weight

## Monitoring:

Low body weight may be a client safety issue

Weekly support and check of food and fluid intake and weight is important

**Check outcome:** Obvious underweight-frailty?

**Consider referral:** doctor dietitian, if no improvement in two weeks (less time if severe weight loss as well)

### 3.1.1 Healthy Weight Range for People Over 65 Years

Height		Ideal weight range	
centimetres	feet and inches	kilograms	stone (st) and pounds (lb)
142	4' 8"	44.4 to 54.4	6 st 13 lb to 8 st 5 lb
145	4' 9"	46.3 to 56.8	7 st 3 lb to 8 st 12 lb
147	4' 10"	47.5 to 58.3	7 st 6 lb to 9 st 1 lb
150	4' 11"	49.5 to 60.8	7 st 10 lb to 9 st 7 lb
152	5' 0"	50.8 to 62.4	7 st 13 lb to 9 st 10 lb
155	5' 1"	52.9 to 64.9	8 st 4 lb to 10 st 2 lb
158	5' 2"	54.9 to 67.4	8 st 8 lb to 10 st 8 lb
160	5' 3"	56.3 to 69.1	8 st 11 lb to 10 st 11 lb
163	5' 4"	58.5 to 71.7	9 st 2 lb to 11 st 2 lb
165	5' 5"	59.9 to 73.5	9 st 5 lb to 11 st 7 lb
168	5' 6"	62.1 to 76.2	9 st 10 lb to 11 st 13 lb
170	5' 7"	63.6 to 78.0	9 st 13 lb to 12 st 5 lb
173	5' 8"	65.8 to 80.8	10 st 4 lb to 12 st 9 lb
175	5' 9"	67.4 to 82.7	10 st 7 lb to 12 st 13 lb
178	5' 10"	69.7 to 85.5	10 st 12 lb to 13 st 5 lb
180	5' 11"	71.3 to 87.5	11 st 2 lb to 13 st 9 lb
183	6' 0"	73.7 to 90.4	11 st 7 lb to 14 st 2 lb
185	6' 1"	75.3 to 92.4	11 st 11 lb to 14 st 6 lb
188	6' 2"	77.8 to 95.4	12 st 2 lb to 14 st 12 lb

This table shows the best and most protective weight range for height, in older people over 65 years. This range is higher than that for other people, and approximates a body mass index of 22-27.

## **3.1.2 Healthy Weight Range for Adults 16 to 64 Years**

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It is difficult to provide one simple healthy weight range for younger adults. These clients range from those who are active and ambulant and independently living-to those who are vulnerable, perhaps non-ambulant and highly dependent.

Significant recent weight change particularly unintentional weight loss (refer Section 3.2) is more important for morbidity and mortality than actual body weight.

### **Active adults 16 to 64 years**

The healthy weight range for active younger adults 16 to 64 years is shown on the next page, and is always applied with common sense.

### **Vulnerable, and highly dependent people**

It is difficult to set body weight standards for these people as a group. For the individual, difficulties may include retarded growth and development, immobility, distorted body shape, limb contractures, spinal deformity, and skeleton abnormalities.

In most cases, low body weight is NOT due to the particular disability, but due to low food intake and perhaps a higher need for nourishment.

An arbitrary choice of body weight standard can be made and considerable care needs to be taken in deciding what is the person's best weight. For practical reasons this may be on the low side (say no more than 5 kg less than that for more ambulant clients).

In essence, the choice of an appropriate body weight is usually a practical decision, based on the body weight when the person has the best health and life quality. It may come back to maintenance of the client's usual weight.

## Healthy Weight Range for Adults 16 to 64 Years

Height		Ideal weight range	
centimetres	feet and inches	kilograms	stone (st) and pounds (lb)
142	4' 8"	40.3 to 50.4 kg	6 st 5 lb to 7 st 13 lb
145	4' 9"	42.1 to 52.6 kg	6 st 9 lb to 8 st 4 lb
147	4' 10"	43.2 to 54.0 kg	6 st 11 lb to 8 st 7 lb
150	4' 11"	45.0 to 56.3 kg	7 st 1 lb to 8 st 12 lb
152	5' 0"	46.2 to 57.8 kg	7 st 4 lb to 9 st 1 lb
155	5' 1"	48.1 to 60.1 kg	7 st 8 lb to 9 st 6 lb
158	5' 2"	49.9 to 62.4 kg	7 st 12 lb to 9 st 11 lb
160	5' 3"	51.2 to 64.0 kg	8 st 0 lb to 10 st 1 lb
163	5' 4"	53.1 to 66.4 kg	8 st 5 lb to 10 st 6 lb
165	5' 5"	54.5 to 68.1 kg	8 st 8 lb to 10 st 10 lb
168	5' 6"	56.4 to 70.6 kg	8 st 12 lb to 11 st 1 lb
170	5' 7"	57.8 to 72.3 kg	9 st 1 lb to 11 st 5 lb
173	5' 8"	59.9 to 74.8 kg	9 st 6 lb to 11 st 11 lb
175	5' 9"	61.3 to 76.6 kg	9 st 9 lb to 12 st 0 lb
178	5' 10"	63.4 to 79.3 kg	9 st 14 lb to 12 st 6 lb
180	5' 11"	64.8 to 81.0 kg	10 st 3 lb to 12 st 10 lb
83	6' 0"	67.0 to 83.7 kg	10 st 7 lb to 13 st 2 lb
185	6' 1"	68.5 to 85.6 kg	10 st 11 lb to 13 st 6 lb
188	6' 2"	70.7 to 88.4 kg	11 st 2 lb to 13 st 12 lb

This table shows the best and most protective weight range for height, in adults 16 to 64 years. This range approximates a body mass index of 20 to 25.

## 3.2 UNINTENTIONAL WEIGHT LOSS?

When a vulnerable person loses a lot of weight without trying (say 5 kg over six months or less), it is a serious sign of decline into a poor nutritional state and perhaps malnutrition. This decline is more rapid and worse if the person was underweight before the weight loss began.

Of all the signs and symptoms of malnutrition, severe weight loss is the factor most clearly associated with relatively higher rates of morbidity and mortality. It is not a sign to be ignored. Ask the visiting nurse to check that dehydration has not contributed to this weight loss.

Loss of weight can occur for the following reasons:

- Reduced food intake (refer Section 3.3)
- Mouth or teeth or swallowing problem (refer Section 3.4)
- Feeding problems (refer Section 3.8)
- Nausea and vomiting (refer Section 4.7)
- Diarrhoea or constipation (refer Sections 4.8 and 4.9)
- Increased need for energy (such as illness and/ or increased activity) (Refer Section 5.3.3)

Clients who have lost weight unintentionally may not be getting enough food for their needs. Less food may be eaten or there may be an increased need for food due to disease. If medication is taken, this may require review.

### Relevant comments:

- *I think that I am losing weight*
- *My clothes don't fit me*
- *My dentures are loose*
- *I feel weak*

### Observations:

Try to identify possible reasons for unintentional weight loss

#### Severity of body weight loss (note that it may be masked by fluid retention)

Time	Significant weight loss	From 70 kg	From 60 kg	From 50 kg	From 40 kg
Over 1-month	5	3.5 kg	3 kg	2.5 kg	2 kg
Over 1-3 months	7.5	5.3 kg	4.5 kg	3.8 kg	3 kg
Over 3-6 months	10	7 kg	6 kg	5 kg	4 kg

Time	Severe weight loss	From 70 kg	From 60 kg	From 50 kg	From 40 kg
Over 1month	More than 5 %	More than 3.5 kg	More than 3 kg	More than 2.5 kg	More than 2 kg
Over 1-3 months	More than 7.5 %	More than 5.3 kg	More than 4.5 kg	More than 3.8 kg	More than 3 kg
Over 3-6 months	More than 10 %	More than 7 kg	More than 6 kg	More than 5 kg	More than 4 kg

### **Further questions:**

- *How much weight have you lost overall?*
- *How long did it take to lose that weight?*
- *What is your usual weight?*
- *How has this weight loss affected you?*

### **Simple interventions:**

- Address any identified problems
- Always review medications
- Provide motivational counselling through statements such as:  
*You will feel much better when you eat much better*  
*Your leg ulcer will heal up when you are back to your best weight*  
*You will feel better when you eat food to give you energy*
- Suggest three small meals and three small snacks every day (3+3)
- Increase energy intake with extra sugar, milk, margarine, thick soups, cream
- Suggest fortified drinks between meals (particularly at night), for example-milk with skim milk powder and topping for a high energy milk shake, *Actavite, Milo*. Improve tolerance by not giving large amounts at first (refer Section 5.3.3.1)
- Ask a dietitian about nourishing snacks to take between meals
- A multi-vitamin and mineral supplement may be recommended two to three times weekly (Refer Section 5.7)

### **Monitoring:**

- Unintentional weight loss is a client safety issue
- Monitor weekly until weight loss has ceased, and improvement begun

**Check outcome:** Unintentional weight loss?

**Always refer for specialist advice:** doctor, dietitian, if weight loss continues for one or two weeks (depending on severity and time)

## 3.3 REDUCED APPETITE OR REDUCED FOOD AND FLUID INTAKE?

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In the underweight person, a short period (more than one or two days) of reduced appetite and reduced food and fluid intake can rapidly lead to severe weight loss.

Many vulnerable people miss meals and so don't get enough energy and nutrients from their food. Some reasons for skipping meals include loss of appetite, poor memory, loneliness, difficulties in preparing food, access to food, and lack of money.

Adults who receive Meals on Wheels may divide the one delivered meal into lunch and tea, and not eat any other food that day.

Some people follow special diets that were prescribed many years ago that may no longer be appropriate or needed (refer Section 3.5).

Illness can cause poor appetite, and treatment may even include 'diets' which limit the foods which can be eaten and reduce enjoyment of food. Loss of appetite can sometimes be related to a change in medication. Taste and smell sensations are reduced in vulnerable people, and these can be further reduced by some medications (refer Section 4.6).

Illness can also increase the need for food. Common diseases such as Alzheimer's, dementia, Parkinson's disease, infections, fractures and hyperactivity all increase the need for additional energy from food (Section 4.5). Adults who are not taking 6 to 8 cups of fluid every day are probably missing out on nourishment as well as fluid intake (refer Section 5.4)

### Relevant comments:

- *I only eat two meals a day*
- *I have (or have had) an illness or condition that made me change the kind and/or amount of food I eat*
- *I never eat a proper meal*

### Observations:

- If not eating because of a 'diet' (refer to Section 3.5)
- Is the problem due to social isolation, poverty, or a functional dependency or disability?
- If an adult spends less than \$ 30 on food each week, it is unlikely that s/he can buy enough food to supply them with adequate nutrients (refer Section 4.2)
- Does the person live alone or have limited social support? Is the person housebound?
- Does s/he need assistance to walk, travel, shop, prepare and cook food, etc?
- Does s/he have access and use of a secure, clean food storage and preparation area?
- Is there any evidence of mental problems?

### Further questions:

- Try and identify the reason for reduced appetite or reduced food and fluid intake
- *Do you miss meals because they are difficult to prepare or cost too much?*
- *Do you keep some of your Meals on Wheels for later?*
- If appetite is poor: *How long have you had a poor appetite?*

## Simple interventions:

- Address reasons for reduced food intake
- Review medications such as digoxin toxicity
- Suggest small frequent meals or snacks (3+3)
- The person should eat most when their appetite is best-even if not at a usual mealtime
- Consider a special nutritional supplement if food intake is very small
- Suggest home care services assist with meal preparation or assistance with shopping
- Check if assistance is required with finances
- Can Meals on Wheels provide an evening meal?
- For people who forget meals:
  - Can someone visit around meal times to remind them?
  - Can they attend group meals where they will be encouraged to eat with others?

## What to do when people say they just don't want to eat:

- Emphasise that improved eating will make them feel better; they could feel stronger, have less constipation or have their wounds heal more quickly
- Avoid setting goals related to weight; the desired outcome is eating and feeling better
- Better nutrition helps to maintain independence
- Set small (or even smaller) goals and gradually build on them
- Even a small glass of milk, a banana, sandwiches, a couple of biscuits with cheese, or sugar in cups of tea can make a difference if repeated day after day
- Be patient: their food intake may be low but each improvement brings them closer to their goal
- Encourage social contact at mealtimes with family or neighbours, or arrange transport to group meals or distant friends; look to include them in other social activities which include some food

## Monitoring:

- At least monthly

**Check outcome:** Reduced appetite or reduced food and fluid intake?

**Consider referral:** doctor (for any sudden change in appetite), dietitian (for problems with a 'diet' or when supplements might be needed to make up for a poor intake); bereavement counsellor, Aged Care Packages Team, Aged Care Recreation Officer

Others may be relevant-Social worker, Local Government Community Services (including Meals on Wheels), day care, occupational therapy, physiotherapy.

## 3.4 MOUTH OR TEETH OR SWALLOWING PROBLEM?

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It is very difficult for people to ingest enough nourishing food (with variety) if their teeth or dentures are loose, broken or missing, or if they have a sore tongue and gums, or any swallowing difficulties. Oral health involves teeth, gums, dentures, swallowing and dryness or pain in the mouth.

Problems include missing teeth, ill-fitting dentures, teeth grinding, chewing and swallowing difficulties, cracked or sore lips, dry mouth, sore tongue, gingivitis, and pain or sensitivity to hot or cold.

As a result of mouth or teeth problems, many people may omit some foods or an entire food group from their diet. These problems may affect food and fluid intake, nutritional quality of the diet and socialisation.

Severe deficiencies of micro-nutrients (iron, folate, riboflavin, ascorbic acid) can actually cause mouth problems.

Meat (a valuable source of protein, iron, zinc and energy, and other micro-nutrients) is the most common food which will be avoided because of mouth, teeth or swallowing problems.

Poor oral health leading to weight loss is an important risk factor for malnutrition, and intervention in this area of health may be very important for some clients. Specific medical problems can also occur (dysphagia, cancer) which cause even more complex problems.

A swallowing problem is a physical symptom of an underlying disorder.

### Relevant comments:

- *I have a teeth, mouth, or swallowing problem that makes it hard for me to eat*
- *This medicine makes my mouth dry*

### Further questions:

- Try to investigate the reasons for mouth, teeth or swallowing problems
- Does the person have one or more of the following:
  - Loose teeth or ill-fitting dentures? Teeth grinding?
  - Dry mouth? Pain, soreness in tongue?
  - Soreness/cracks in corner of mouth?
  - Mouth sores that don't heal?
  - Bleeding, swollen gums?
  - Toothache or sensitivity to hot and cold?
  - Pain, clicking in jaw?
- How long is it since your client visited the dentist?
  - If the person has visited the dentist recently, what was the reason for this visit (checkup, dentures fitted)?

- Are there any other causes of the swallowing problem?
  - Is food consistency and texture an issue?
  - Is the temperature of food and fluids an issue?
  - Is food quantity an issue?
  - Is there a problem swallowing liquids or solids or both?
  - Is gagging and/or choking a problem?
  - Is the throat sore?
  - Is the person drowsy at the mealtime?
  - Is food found in the mouth some time after a meal?

### **Simple interventions:**

- Plan intervention to correct or limit signs and symptoms, and if possible the causative factors
- Ill fitting dentures should be adjusted or replaced
- Suggest use of lip balm to keep the lips moist
- Use soft and minced meats
- Use soft and wet foods instead of liquid and dry foods
- Avoid irritants such as peppers and spices
- Encourage small frequent meals and snacks (say 3+3)
- Encourage concentrated high energy items such as sugars, and perhaps fats
- If chewing meat is a problem suggest casseroles and minced meat dishes. If the client is on Meals on Wheels, arrange for the meat to be *soft* (not always minced)
- Include concentrated high energy items such as sugars, and perhaps fats
- Increased presence of mucus or phlegm is **NOT** improved by avoiding milk; if this is a problem (in the absence of disease), then encourage extra fluid of any kind, including milk
- For a dry mouth and/or cracked lips-encourage adequate fluid intake and sipping of water to keep the mouth moist, and suggest gravies and sauces with meals to make the food moist
- Review the effect of medication over the mealtime

### **Monitoring:**

- Weekly review of mouth, teeth and swallowing difficulties, body weight

**Check outcome:** Mouth, teeth or swallowing problem?

**Consider referral:** visiting nurse, dentist, chemist, doctor, dietitian, speech pathologist (Difficulty in swallowing should always be investigated by a doctor, with possible referral to a speech pathologist and dietitian)

## 3.5 FOLLOWS A SPECIAL DIET?

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Vulnerable people are put at nutritional risk by any acute or chronic illness which causes change in their usual diet.

Modified and special diets can affect quality of life, be a nuisance and may cost clients more. Modified/special diets are not always required for a lifetime and client's nutritional needs will change over time.

Individuals often get mixed messages about food and diet from doctors, dietitians, and well meaning relatives and friends; a coordinated approach is always required in the client care plan.

Clients can develop other health problems if the usual amounts and types of foods that they take are restricted or altered to follow a modified or special diet; careful supervision is required.

No person should be on a modified or special diet unless the aim and benefit of the diet is clearly known to them. Always assess the relevance of following a special diet at frequent intervals (at least 6 to 12 months).

If a special diet is required for a specific therapeutic reason then it is important to follow it properly. This will ensure that the client's health and well being improves, which makes it worth the effort.

### Relevant comments:

- *I am sick of this diet*
- *I only follow it when I am sick*
- *My doctor says that I shouldn't eat any food beginning with "p"*

### Observations:

Try to find out why the special diet is required and if the aim and benefit of the diet is clearly known to the person

### Further questions:

#### 1) Why are you following this diet?

- *What is your diet doing for you?*
- *Is it working for you? Do you still need it?*

#### 2) What do you think about this diet?

- *Does your diet suit you?*

#### 3) When did you start this diet?

- *How long have you been following this diet?*

#### 4) Who suggested/recommended/asked you to follow this diet?

- *Who gave you the details about this diet?*
- *When did you last get your diet reviewed by a doctor and a dietitian?*

## **Simple interventions:**

- Address the identified problem
- Avoid adding to the mixed messages about the diet
- Try to achieve a co-ordinated approach in the client care plan
- If the modified or special diet appears to conflict with the health goals most appropriate for the person now or if the person/carer does not know the reason why a modified diet is being followed, or if the aim of the diet is not clear, always refer the person to the doctor and/or dietitian
- After firm encouragement and a trial period with a modified or special diet, consider cessation after discussion with the person and carer, doctor and/or dietitian if compliance is poor

## **Monitoring:**

- Preferably monthly
- Regular monitoring is essential if an adult is following a modified or special diet, in order to make sure that the (treatment) goals of the diet are being achieved
- Approach your local dietitian for assistance if required

**Check outcome:** Follows a special diet?

**Always refer for specialist advice:** doctor, dietitian.

## 3.6 UNABLE TO SHOP FOR FOOD?

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Vulnerable people may only buy foods which are easy to carry or easy to prepare and cook. Difficulty with shopping may be due to a decreased mobility or physical disability, or (if they have not been shopping for some time) people may not know or remember what foods are available. A person who is unable to shop may not eat enough because of reduced food choice (no ideas, no prompts), a reduced level of independence, or reduced life quality.

### Relevant comments:

- *I don't know what to eat when I don't go shopping; I like other people helping me*
- *I am not always able to go shopping*

### Observations:

- Try to identify possible reasons for inability to shop
- Does your client have any other resources available to help them (family, neighbours)?

### Further questions:

- *What is the main problem when you go shopping?*

### Simple interventions:

- Address causes of the problem if possible
- Assess food skills
- Support maintenance of independence as long as possible
- Arrange assistance from family and neighbours if possible
- Help the person with shopping lists (basic items and extras)
- Provide the client with information about food delivery from local shops and markets
- Help to arrange food orders by telephone
- Contact family or neighbour support for assistance with shopping
- If you provide a shopping service, take the person with you when you can

### Monitoring:

- As often as possible

<b>Check outcome:</b> Unable to shop for food?
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**Consider referral:** local government services, occupational therapist (for assessment and aids), dietitian (for assessment and information), social worker (such as finance for utensils)

## 3.7 UNABLE TO PREPARE FOOD?

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Vulnerable clients may not be physically or mentally capable of preparing and cooking food. This lack of independence can have serious effects on their enjoyment of it, and their intake of food and fluids. There may also be problems organising their food into nourishing meals and snacks.

Adults who are unable to prepare food for themselves may not eat enough because of lack of choice (no ideas, no prompts), a reduced level of independence, possible dislike of the foods offered, or reduced life quality.

### Relevant comments:

- *I am not always able to cook for myself*
- *I don't like the way she cooks the food*
- *I don't like Meals on Wheels*
- *My daughter cooks with too many spices*

### Observations:

- Try to identify possible reasons for inability to prepare food
- Does the person have any other resources available to help them (family, neighbours, friends)?
- Would the person be helped by special utensils or Meals on Wheels?
- Could the person assemble meals if the preparation was already done?

### Simple interventions:

- Address causes of the problem if possible
- Assess food skills
- Support maintenance of independence as long as possible
- Contact family or neighbour or friend for assistance with food preparation
- Check if more prepared foods can be purchased
- Check if prepared foods can be assembled and heated by the client
- Check if packages can be opened, divided and stored cleanly and safely by the client
- Would the person be helped by special utensils and devices, or by Meals on Wheels?
- Provide simpler recipes

### Monitoring:

- As often as possible

<b>Check outcome:</b> Unable to prepare food?
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**Consider referral:** occupational therapist (for assessment and aids), dietitian (for assessment and information), social worker (such as finance for utensils), local government services.

## 3.8 UNABLE TO FEED SELF?

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A person with a physical, mental or intellectual problem may require feeding. Then a number of reasons may give rise to reduced food and fluid intake such as embarrassment, loss of independence, possible lack of time and care and attention by the carer, possible dislike of the food and fluids offered.

Quality of life can be reduced by poor social and eating skills which reduce socialisation and limit outings away from home.

### **Relevant comments:**

- *I don't like the way she cooks the food*
- *I don't like Meals on Wheels*
- *The food hurts me*
- *The food is cold*
- *I am hungry*
- *I want more*

### **Observations:**

- Try to identify possible reasons for inability to feed self
- Does the person have any other resources available to help them (family, neighbours, friends)
- Would the person be helped by special utensils or Meals on Wheels?

### **Simple interventions:**

- Address causes of the problem if possible
- Support maintenance of independence as long as possible
- Arrange assistance from family, neighbours and friends if possible
- Provide special utensils and devices, or Meals on Wheels
- Provide simpler recipes
- Avoid actually feeding a person unless this is absolutely necessary

### **Monitoring:**

- As often as possible

<b>Check outcome:</b> Unable to feed self?
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**Always consider referral:** dietitian (for assessment and information), occupational therapist (for assessment and aids), social worker (finance for utensils etc.), Local Government Services.

## 3.8.1 Feeding Problems in High Dependency Adults

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Feeding high dependency adults is often time consuming and difficult. If it isn't done with sufficient time, care and attention then the person often does not get enough food and fluid. In this situation, clients often experience increased feeding problems as their health deteriorates.

Complex feeding and swallowing problems most often improve as the person's nutritional health improves towards the best weight for their best health.

Factors which need to be considered to reduce feeding problems and poor nutrition in high dependency adults can include the following:

- Low palatability of diet (appearance, smell, taste, texture)
- Low nourishment value of foods and fluids offered
- Inappropriate posture while feeding (sagging body when sitting up, unsupported chin)
- Inappropriate timing of meals, insufficient time allowed to the client for meals
- Low body weight, which is incorrectly perceived to be acceptable by client and/or carer
- High energy and nourishment needs, hyper-activity, hyper-flexion of muscles
- Embarrassment, discomfort and possibly pain and fear of eating and drinking
- Chewing and swallowing problems, constipation
- Dependency, inability to ask for more food or fluid, chronic underfeeding

### Types of physical feeding problems:

- Feeding dependency, drinking dependency
- Food refusal, drink refusal
- Drooling
- Coughing while eating or drinking, or immediately afterwards
- Swallowing air while feeding
- Choking episodes (choking risk)
- Gurgly 'wet' voice during or after meals (aspiration risk from entry of food or fluid into the lungs); food aspiration may also occur without any noise, when the person with silent aspiration does not cough or blink
- Vomiting
- Regurgitation of food (unpleasant and unexpected return of previously swallowed food to the mouth)
- Rumination of food (previously swallowed food is deliberately returned to the mouth for re-chewing, and then is re-swallowed)

**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 FOR SPECIALIST ADVICE (DOCTOR, DIETITIAN)**

## **Simple and safe interventions:**

- Sitting up support and chin support
- Peaceful calm mealtimes, good hygiene displayed, no distractions
- Appropriate time spacing of fluids and foods, and enough time to eat and drink
- Attention to individual's food and fluid preferences
- Consider taste, smell and appearance of the plated food, and the temperature of the food and drink
- Does the person know the name of the food and drink that they are having?
- *Refer Section 5.9.3 for advice about high dependency adults with feeding problems who require foods and fluids which are modified in texture (thinned or thickened)*

## **Adult safety issues:**

- Food and fluid aspiration into the lungs is a safety issue for all vulnerable persons with feeding problems
- Safety is an even more critical issue for frail adults who have lost a lot of weight and are underweight and who aspirate into their lungs and are at risk of pneumonia
- Concern is expressed that for individuals with aspiration swallowing problems the carer must DO NO HARM and make no changes whatsoever to the persons feeding routine without expert assistance and advice
- DO NOT CHANGE the texture and thickness of foods and fluids without specialist advice
- The person MUST be referred immediately to a specialist

## 3.8.2 Nutrition Decision Tree for Adult Referral to a Specialist

<b>Feeding problem</b>	<b>Referral</b>
Consistent refusal of food and/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
Is a feeding program required?	Dietitian, speech pathologist
Food or fluid dribbles out of mouth?	Speech pathologist
Coughs, gags or chokes while feeding or immediately afterwards?	Speech pathologist, dietitian
A meal takes more than 40 minutes to eat?	Doctor, dietitian, speech pathologist, physiotherapist
A physiological 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
<b>Continue to monitor at regular intervals by Nutritional Risk Screening and Monitoring</b>	

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

## 3.9 OBVIOUS OVERWEIGHT AFFECTING LIFE QUALITY?

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Normal to moderate overweight is a protective factor in the vulnerable person. Body fat provides a readily available energy store and is a safeguard in times of stress (infections, trauma) or reduced appetite and reduced food or fluid intake or unintentional weight loss.

To lose even small amounts of weight (say 0.5 kg a month), an overweight inactive person has to follow a very strict diet which cannot provide enough nourishment for them to maintain their physical activity and life quality. An overweight person who goes on a very restricted diet is at risk of muscle wasting, infections and associated morbidity and mortality.

In making a decision about whether a weight loss program should be commenced in a vulnerable overweight person, life quality should be considered. The answer lies in the balance between any expected improvement in life quality with a small slow weight loss, versus any expected deterioration in life quality due to a very restricted diet, muscle wasting and associated health risks.

A better option for older adults may be omission of high energy refined foods and a goal of weight maintenance. This is also the best option for people with a disability who have disorders which are associated with obesity (Prader Willi syndrome, Down syndrome).

### Relevant comments:

- *It doesn't hurt me to go without food; I am too fat anyway*
- *I am having difficulty walking; I have always been tubby*
- *The doctor says I have to lose weight*
- *I haven't eaten anything since yesterday because I am trying to lose weight*

### Observations:

- Try to identify the possible effects on the person of overweight and obesity or of 'dieting'

### Further questions:

- *Do your legs feel weak?*
- *Why are you trying to lose weight?*

### Simple interventions:

- Adults who are concerned about their weight can safely avoid sugars, fats and alcohol
- If the person is determined to follow a diet to lose weight, suggest a nourishing diet of the
- 1 3 3 4 5+ food plan for older people (refer Section 5.3.1) or the 1 2 3 4 5+ food plan for younger adults (refer Section 5.3.2), without any extra foods
- Also suggest a low dose vitamin and mineral supplement (three or four times a week)
- Always consider referral to a dietitian if weight loss is essential

**Monitoring:**

- As frequently as possible, for food intake, well being and weight

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

**Consider referral:** doctor, dietitian if weight loss is definitely needed.

## 3.10 UNINTENTIONAL WEIGHT GAIN?

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Unintentional weight gain can occur for the following reasons:

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

### **In vulnerable adults, unintentional weight gain is not usually as important as weight loss (refer Section 3.2), however-**

- If unintentional weight gain occurs due to fluid retention, the adult may need medical care and a medical check-up may be required
- If weight gain occurs due to constipation, this is usually small and temporary and only accounts for 1-2 kg; it can be corrected over time by change in food and bowel habits (refer Section 4.9)
- In overweight vulnerable people with severe heart disease (or lung disease, diabetes, or problems with mobility), unintentional weight gain may be disadvantageous; in this case it may be important to try to assist the person to prevent further weight gain (refer Section 3.9)

### **Relevant comments:**

- *I am having difficulty walking*
- *Can you get me some clothes that fit me?*
- *I can't stop eating*
- *I want fried foods, sweets, chocolates*

### **Further questions:**

- Are you hungry?
- Have you had any activity today?
- Are you lonely?

### **Simple interventions:**

- Who are concerned about their weight can safely avoid sugars and fats and alcohol
- If the person is determined to follow a diet to lose weight, suggest they follow a nourishing diet of the 1 3 3 4 5+ food plan (for older people) or the 1 2 3 4 5+ food plan (for younger adults), without any extra foods (refer Section 3.9)
- Also suggest a low dose vitamin and mineral supplement (three or four times a week)
- Always consider referral to a dietitian if weight loss is essential

## **Monitoring:**

- As frequently as possible, for food intake, well-being and weight

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

**Consider referral:** doctor, dietitian if weight loss is definitely needed