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Nutrition Matters

March 2009

Hello and welcome to the inaugural edition of **Nutrition Matters**, a quarterly newsletter produced by Melbourne Dietetic Centre for hospitals to support optimal nutrition practices.

The professional dietitians at Melbourne Dietetic Centre compile the dietetic insights offered in this newsletter. In this issue, we look at malnutrition in hospitals and what we can do to prevent it.

Malnutrition in the hospitalised elderly

Malnutrition is considered a major risk factor for nutritional deficiencies, infections, reduced physical and cognitive functional status, delayed recovery and mortality in the hospitalised elderly¹. According to a study undertaken by Sullivan et al², up to 61% of older hospital in-patients have poor nutritional intake and are undernourished. A common assumption is that a decline in nutritional intake is an inevitable consequence of ageing and disease and that intervention is only minimally successful. Nutritional assessment and treatment have however, been shown to be effective in maximising patient health status and should be a routine aspect of care for all elderly persons².

In some instances even patients with good appetites do not receive adequate nutrition during their hospital stay due to insufficient feeding assistance³. A high proportion of elderly patients present with eating difficulties ranging from dysphagia to cognitive or physical impairments, which affect their ability to self-feed. Currently in most hospital settings it is the nursing staff's responsibility to feed patients requiring assistance, however often they struggle to meet this demand on top of other nursing duties.

A study by Tsang⁴ identified the reasons for high food wastage in the elderly hospitalised to include: inappropriate time of meal serv-

ice (ie too close to previous meal or snack); too large a quantity served at one time and therefore overwhelming; Registered Nurses administration of medications at the same time as meal service therefore unable to assist patients; patient asleep at meal time; and patient refusal of the meal secondary to poor appetite, physical illness or tiredness⁴.



A proportion of patients with dementia exhibit the 'sundowning' phenomenon, becoming more restless, agitated and confused in the late afternoon to evening, which can affect their eating behaviours. In more cognitively aware patients, many do not eat or drink at supper if they had already prepared

for bed or do not want to have to use the toilet during the night⁴. Therefore, nutritional interventions implemented earlier in the day are ordinarily more effective in the elderly patient group.

The 'Malnutrition Universal Screening Tool' ('MUST') has been developed for nutrition screening purposes and can be used even if weight and/or height cannot be obtained, enabling more complete information on malnutrition prevalence and its impact on clinical outcome to be obtained. A study by Stratton et al⁵ using the 'MUST', found that 58 % of elderly patients were at malnutrition risk and that these individuals had greater mortality (in-hospital and post-discharge) and longer hospital stays than those assessed to be of low malnutrition risk. The results support the importance of routine screening with a tool, such as the 'MUST', and the effectiveness of the resultant early malnutrition detection⁵.

Once patients at risk of poor nutritional intake or malnutrition have been identified, a number of interventions can be implemented to improve their nutritional intake and health status⁶. Using nutrition supplements has been proven to be an effective way of preventing or reversing malnutrition in the elderly age group. A study by Gazzotti et al⁶ prescribed 200 ml of nutrition



Malnutrition in the hospitalised elderly Cont...

supplement drinks twice daily (500 kcal, 21 g protein per day) throughout hospitalisation and convalescence. Compliance with oral supplementation was good and on day 60, significant weight loss from admission weight was observed in the control group, but not in the supplemented group. Patients typically consume significantly more calories and refuse foods and fluids less often in the morning as there is a longer period since the previous meal (dinner) therefore provision of nutritionally dense foods or supplements are usually most effective at breakfast⁴.

The following strategies may aid in reducing the risk of malnutrition in the hospitalised elderly:

- Routine use of nutrition screening tools (such as the 'MUST') or inclusion of simple checklists in the nursing assessments to identify patients at risk of inadequate nutrition intake or malnutrition and referral to a dietitian where appropriate.
- Ensure adequate staff are available for feeding assistance at meals. Ideally 1 nurse to 1 totally feeding dependent and 1 nurse to 3-4 partially feeding dependent patients.
- Arrangement of staff breaks and medication rounds so as maximum numbers of nursing staff are available on the ward during meal times.

- Nursing staff to first target feeding assistance with those who eat less than 50% of most meals as they are at the highest risk of malnutrition.
- Provision of supplement drinks throughout the day, particularly at breakfast when intake is highest, and avoid administration at supper when compliance is low.
- Provision of small-medium (ie avoid large) yet energy and nutritionally dense meals with at least 2.5 hours between meal service.

Providing feeding assistance to elderly patients is an important but often neglected part of hospital care. Feeding needs are often complex and feeding patients requires training, experience and medical knowledge of the danger signs for aspiration, impaired swallow or choking⁴. All hospitals are encouraged to regularly review and revise their provision of feeding assistance and malnutrition detection systems. Some facilities may benefit from staff education on how to identify and prevent malnutrition. A dietitian can provide education and also assist in tailoring a malnutrition minimising strategy to a facility's individual situation, to help better their elderly patients' health outcomes.

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4. Tsang MF. Is there adequate feeding assistance for the hospitalised elderly who are unable to feed themselves. *J Nut & Diet* 2008; 65: 222-8.
5. Stratton RJ, King CL, Stroud MA, Jackson AA, Elia M. 'Malnutrition Universal Screening Tool' predicts mortality and length of hospital stay in acutely ill elderly. *Br J Nutr*. 2006 Feb;95(2):325-30
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7. Adams N, Bowie A, Simmance N, Murray M, Crowe T. Recognition by medical and nursing professionals of malnutrition and risk of malnutrition in elderly hospitalised patients *J Nut & Diet* June 2008;144-150



Hospitals in the News

“Nearly one-third of elderly hospital patients are malnourished, and a further 61 per cent are at risk of malnutrition” – a recent study conducted by St. Vincents hospital has found⁷. The study also suggests doctors and nurses do a poor job of spotting the problem and even when they do, few of the patients affected are referred to a dietitian for help.

Melbourne Dietetic Centre, as Victoria's largest and leading group of private practice dietitians, has many tools and strategies to help your hospital reduce and prevent malnutrition. To enquire about our services, call 9817 1544 or visit our website www.dietitiancentre.com.au.

About MDC

Melbourne Dietetic Centre is the largest private practice of professional dietitians in Victoria. MDC has provided professional and accredited Dietetic Services to hospitals, individuals, aged care facilities, government, community and corporate groups since 1982, and are leaders in the area of Nutrition and Dietetics

Our team of 14 professional dietitians share a strong commitment to providing dietetic services that are of an exceptionally high professional standard. Our commitment to customers is to ensure Best Current Practice for patients, and to provide leadership for continuous quality improvement.

Why Choose an MDC Dietitian?

- Although acting as a sole dietitian in your hospital, your dietitian will have the ongoing support of a large, expert team who are leaders in dietetics & nutrition
- We take care of all dietitian HR and provide cover dietitians during leave
- We take care of Continuous Professional Development and Quality Assurance to ensure Best Practice and better patient outcomes
- We ensure our dietitians are qualified with the DAA and APD program and have the level of expertise to provide an outstanding service
- All MDC dietitians are fully insured and have work cover

What MDC Can Provide For Your Hospital

- Regular or on-call clinical services for patients
- Group services / education
- Nutrition screening for malnutrition risk
- Locum or leave cover for your regular dietitians
- Menu reviews
- Food service education
- Individual consultations for out-patients

Additional MDC Services

- Individual consulting
- Aged care services
- Presentations and workshops
- Nutrition auditing
- Nutrition and hydration policy development
- Corporate programs and services



Meet The Team

Julie has over 10 years experience as a dietitian working in clinical nutrition, aged care consulting, 1:1 counselling, group education and nutritional health promotion.

Julie has practised in a range of settings including: public hospitals, community health, nursing homes and provided public health education via seminars, radio sessions, group programs and displays. Julie has a passion for improving the quality of life for her patients and her experience through working across many fields in Melbourne has helped countless individuals to make significant improvements to their health.

Julie enjoys working with institutions to help improve overall nutrition and hydration systems and has recently been involved in developing and conducting nutrition and swallowing audits throughout the Peninsula region.

When not working, Julie loves to spend time with her husband and two young daughters. Julie enjoys being involved in her daughters' school, eating out, visiting family and friends and walking.



Julie Orr

BSc, Grad Dip Nutrition and Diet, APD



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