# Section 4: Well for life – Promoting better nutrition

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About this nutrition training program

Background
This educational package has been developed to assist dietitians (as facilitators) to conduct a workshop with primary health and community service staff (as participants) to raise awareness of nutrition issues and the benefits of good nutrition for older people and their carers. The package is designed to be used by people without a background in education or training, but who do have specialist knowledge in nutrition for frail older people in the community.

The following Well for life – Promoting better nutrition package provides an introduction to nutritional needs of frail older people, identifying nutritional risk, implementing simple interventions and monitoring.

This educational package is drawn from materials from the documents:
Identifying and planning assistance for home-based adults who are nutritionally at risk: a training manual (Department of Human Services, 2001). This is referred to as Nutrition training manual in this section.
Identifying and planning assistance for home-based adults who are nutritionally at risk: a resource manual (Department of Human Services, 2001). This is referred to as Nutrition resource manual in this section.

These manuals provide comprehensive information and training resources on nutrition issues for frail older people. They were developed by members of the Dietitians Association of Australia (DAA), Victorian Branch, with Home and Community Care (HACC) Program funding from the Department of Human Services. To access these manuals, visit the website http://www.health.vic.gov.au/hacc/publications/nutrisk-tm.htm

How to use the package
This package is intended to be delivered as a seminar or workshop, usually over three hours.

This seminar is for primary health and community services staff who care for older people in the community. The seminar can be easily adapted to also suit the needs of direct service deliverers, such as home care and personal care workers.

Aim
This seminar aims to enhance opportunities for frail older people in the community for appropriate and timely nutrition care, by providing primary health and community service staff with information to raise awareness of the importance of nutrition for frail older people. Staff will also be able to identify nutrition risks and implement strategies to manage nutrition-related health issues and refer clients to appropriately qualified health professionals.
Participants
Participants in the seminar could include:

- community/district nurses
- home care and personal care workers
- planned activity group coordinators and assistants
- social support workers
- any staff member who works in a direct care role.

Participants in the seminar may range from very experienced to inexperienced and/or from highly qualified to having minimal formal education. Try to obtain information about the background of the group before the seminar. Consider if it may be better to run separate seminars for staff from different backgrounds in terms of their training and experience.

It is also important to have some idea about the participants’ prior knowledge of the topic. Include some questions of the whole group at the beginning of the seminar to get some feel for the group’s understanding of the topic. The Nutrition training manual, Part 2, has some further tips and resources for planning the training.

Learning objectives
At the end of the seminar, participants should be able to:

- **discuss** nutrition-related health issues for frail older people
- **apply** this knowledge to case examples of frail older people
- **discuss** food and nutrition needs of frail older people
- **propose** opportunities to manage nutrition risk and improve nutrition for frail older people in the community.

Preparing for the seminar
Prior to conducting the seminar, ensure that:

- there is support from management to run the seminar
- all staff who will be attending are able to take time off from their regular duties
- management will be interested in and supportive of ideas generated by participants
- the content and audiovisual material and props required for the seminar are reviewed. Suggestions are given for additional materials for illustrating the presentation and creating an interactive seminar.
The best training programs are those:
• that have been developed in response to an identified need
• where program participants feel they have some ownership over the program (for example, they have been involved in deciding that the program was needed)
• where program participants have been consulted about how the program could be run
• that are interactive and involve participants
• that have some tangible outcomes (such as an action plan; lists of ideas to be implemented; practical strategies for working with real case examples).

For further tips and resources, see section titled ‘Orientation and training needs assessment’ in Part 2 of the Nutrition training manual.

**Equipment/environmental requirements**

• Laptop and data projector (or if one is not available, sufficient photocopies of the PowerPoint slides to be used as handouts)
• A room large enough to hold the group seated in a circular arrangement and sufficient space to allow for small group work, if needed
• Tea/coffee making facilities (morning or afternoon tea)
• Butchers paper or whiteboards and marker pens (for each small group).

**Additional resources**

• Help sheets 2, 3, 4, 5, 6, 7 and 14 in Section 2 of this Resource Kit
• Help sheets from the Nutrition resource manual (see Table 1 below listing Help sheet titles required for this training)
• Healthy eating healthy ageing (DAA) and Making every mouthful count, (DAA ). Purchase from DAA Tel (02) 6282 9798 or Fax (02) 6282 9888 or email nationaloffice@daa.asn.au Dietitians can view on screen the contents of both these brochures through their member login to DAA website under the DINER link.
• Food and nutritional health for adults – risk screening and monitoring outline. This resource includes instructions and copies of the nutritional risk screen and can be obtained from the website http://www.health.vic.gov.au/hacc/downloads/pdf/riskscreening&monitoring.pdf
• Nutrition seminar feedback form (see page 31 in this package).

**For more information**

Contact your local HACC or community health service dietitian for more information on how to organise this training or you can contact DAA (Victoria) for contact details of dietitians in your area. DAA (Victoria) email: vic@daa.asn.au
Table 1: Identifying and planning assistance for home-based adults who are nutritionally at risk: a resource manual – help sheets (Department of Human Services, 2001)

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## Suggested seminar format

### Module 1: Introduction to nutrition and health issues in frail older people

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<th>Content (what will be taught)</th>
<th>Method (how it will be taught)</th>
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<tbody>
<tr>
<td><strong>Module 1: Part 1</strong></td>
<td>Overview of seminar, its aims and learning objectives, why this is an important topic and why the seminar is being offered.</td>
<td>Use brief explanatory comments. Ensure introductions (participants) if everyone does not know each other. Question participants on what they hope to get out of the seminar. Use prepared PowerPoint slides.</td>
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<tr>
<td>Introduction (5 minutes)</td>
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</table>
| Presentation (10 minutes) | Overview of:  
- definitions of nutritional risk  
- definitions of nutritional risk screening and monitoring  
- why nutrition matters in frail older people  
- background factors for poor nutrition. | Use prepared **PowerPoint slides to illustrate key points.**  
Ask each participant to spend three minutes listing as many reasons for what might cause poor nutrition in older people. Ask them to think of clients who may have had these problems.  
Record reasons offered by the participants on the whiteboard. See if these match up with factors listed in the prepared PowerPoint slide, *Background factors for poor nutrition.* |
| Case example for discussion (5 minutes) | Demonstrate positive effects of nutrition risk screening, intervention and monitoring. Stress that nutritional risk screening and monitoring is best accomplished by an interdisciplinary team. | Use short case example, taken from your own experience, to illustrate benefits clients have experienced through improved nutrition. |
| **Module 1: Part 2** | Overview of key nutrition risk factors for frail older people.  
This presentation should provide the opportunity for discussion on the background and meaning of each nutrition risk factor. | Use prepared **PowerPoint slides.** Slides could be supplemented with photos and/or slides of people to illustrate underweight and frailty. |
| Presentation (allow 15 minutes) | | |
| Application of seminar information to determine simple interventions (allow 30 minutes) | This section of the module should provide an opportunity for:  
- application of theoretical information from earlier presentation  
- use of case studies to develop simple interventions for improved nutrition for the frail older person. | Organise participants into two groups. Split the risk factor list into two lists. Provide one group with one list and the second group with the remaining list of factors. Ask participants in each group to discuss what simple interventions might address each of the risk factors they have on their list.  
After 15 minutes, ask groups to consider whether the interventions presented in the *handouts* (Help sheets 3.1 – 3.10 in the Nutrition resource manual) match suggestions from participants? What additional suggestions did the group have?  
Ask a representative from each group to present interventions for the list of risk factors for their group. (15 minutes) |

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<th>Content (what will be taught)</th>
<th>Method (how it will be taught)</th>
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<td>Tea/coffee break</td>
<td>A short break should be included.</td>
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<tr>
<td>Module 1: Part 3 Presentation (allow 20 minutes)</td>
<td>Overview of general assessment issues that affect the nutritional health of frail older people, including financial; social; personal hygiene; food hygiene; mental health; poly-drugs; gastro-intestinal problems; incontinence; breathing problems and medical problems.</td>
<td>Use prepared <strong>PowerPoint slides</strong>.</td>
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Module 2: Nutritional risk screening and monitoring

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<tr>
<td>Presentation (10 minutes)</td>
<td>This module presents the ten trigger questions that are part of the Nutritional Risk Screening and Monitoring Tool. This tool is included in the Service Coordination Tool Templates (Health Behaviours Profile). In the following session case studies are used to illustrate how this tool is used to identify interventions in the process of initial needs identification, assessment and care planning.</td>
<td>Use prepared PowerPoint slides.</td>
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<tr>
<td>Application of the seminar information (40 minutes)</td>
<td>This section of the module should provide an opportunity for: • application of theoretical information from earlier presentation • use of case studies to demonstrate application of the process of nutrition risk screening and development of possible interventions for improved nutrition for the older person.</td>
<td>Organise small groups and provide one case study to each group (allow 20 minutes for discussion). Ask a representative of each group to summarise their outcomes (allow 20 minutes although time will vary depending on the number of small groups). If time is limited, ensure each case study is presented once and ask for comments from the group to add to information presented.</td>
</tr>
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Handouts
• Case studies 1 and 2 included in this package
• Help sheets 2.5, 2.6, 2.7 and 2.8 in the Nutrition resource manual.

Facilitator to guide the activity using the Facilitator’s guide to completing case studies included in this package. See if the outcomes presented by participants match up with those listed in the Facilitators guide. This could be provided as a handout to participants on completion of the exercise.

Tea/coffee break A short break should be included.
## Module 3: Food and nutritional needs of frail older people

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| Presentation (20 minutes) | This module should raise awareness amongst participants of the food and nutrition needs of frail older people. The topics covered include:  
  • food habits and patterns, including simple interventions  
  • good nutrition for older people  
  • the 13345+ Food Plan  
  • who needs extra foods and drinks?  
  • being well nourished on delivered meals  
  • enhancing nutritional intake in group settings  
  • simple interventions for underweight-frailty or unintentional weight loss.  
  The group setting has great potential to enhance the food and nutrition intake of at risk frail older people. Promote discussion of quality provision of food in group settings. | Use prepared PowerPoint slides.                                                                                                                                 |

**Handouts**

- Healthy eating healthy ageing and/or Making every mouthful count, (DAA).
- Good food and health advice for older people who want to help themselves – information booklet for older people, families and carers (Department of Human Services, 2001).

(See page 3 in this package for details on how to obtain these resources.)

In relation to group activities for frail older people, use Help sheets 2, 3, 4, 5 and 6 in Section 2 of this Resource Kit as **handouts** for discussion on quality provision of food in group settings.
## Module 4: Obtaining support if nutritional risks are identified

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<td>Presentation</td>
<td>This module should provide the opportunity for discussion on how to obtain support if nutritional risks are identified. Key points to be covered include: • referral to health professionals for a multidisciplinary approach • roles and functions of dietitians in home-based care • client safety issues that indicate need for urgent referral.</td>
<td>Use prepared PowerPoint slides.</td>
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<td>Describe possible actions that could be taken to ensure timely professional assistance in managing the frail older person with food and nutrition issues.</td>
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<tr>
<td>Summary</td>
<td>Encourage participants to use the information and skills gained to apply to their care of frail older people. Ask them to consider looking at a range of options where their attention to nutrition risk screening or interventions in group settings might be applied.</td>
<td>Conclude the seminar by revisiting the learning objectives.</td>
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<td>Assist group in planning for further learning sessions/activities, including directing them to other relevant resource people.</td>
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<tr>
<td>Evaluate</td>
<td>Evaluate the seminar and determine further learning opportunities from the group.</td>
<td>Hand out the feedback form to each participant and collect at the end of the seminar.</td>
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### Handouts
- Hand out Help sheets 6 and 14 in Section 2 of this Resource Kit.
Module 1: Introduction to nutrition and health issues in frail older people

Definition of nutritional risk

This section provides some definitions of nutritional risk and nutritional risk screening and explains why it is important to screen frail older people for nutritional risk.

Nutritional risk is defined as:

The risk factors of poor nutritional status are characteristics that are associated with an increased likelihood of poor nutritional status. (Nutrition Screening Initiative, 1992)

Nutrition risk is generally higher in older age groups because of many factors, including the ageing process and co-morbidities, use of medications, financial, geographical and social factors (Stewart A, and Bryce A, 2000).

Screening using the Australian Nutrition Risk Screening Initiative (ANSI) Tool showed that 30 per cent of independently living older people (over 70 years) were at high nutritional risk (Cobiac L and Syrette A, 1995). The nutritional status of older people has the potential to be improved through nutritional risk screening and monitoring.

Definition of nutritional risk screening and monitoring

Nutritional risk screening and monitoring is defined as:

The process of discovering characteristics known to be associated with dietary or nutritional problems. (Nutrition Screening Initiative, 1992)

Screening for nutritional risk can serve a number of purposes. It assists in targeting intervention; helps define appropriate interventions for those at high and low risk; establishes monitoring procedures to measure success of interventions; and can be used for benchmarking of standards of care (Stewart A and Bryce A, 2000).

Good nutrition is integral to maintaining good health, muscle and bone strength and, therefore, the ability to be physically active.

(Refer to Help sheet 1 in Section 2 of this Resource Kit.)

Why nutrition matters in frail older people

Poor nutrition is one of the major reasons why people become frail and dependent. Nutrition matters because frail older people:

- are more likely to fall
- need more assistance
- need more complex support and care
- have more complications, for example, infections, pressure sores
- are less likely to be able to live independently
- need more frequent and longer stays in hospital.

If decline occurs, this leads to the need for extraordinary means (more supplements, more health services, professional time) to improve nutritional status. Also, poor nutritional status is likely to lead to premature, costly hospital admission or other health problems requiring special management (for example, dressings for wound healing; antibiotic therapy for infections).
Reasons for poor nutrition may include:
- inappropriate or inadequate food intake
- poor appetite
- social isolation
- dependency
- disability
- feeding problems
- acute conditions
- chronic disease
- chronic, multiple medication
- advanced age, that is, 80 years and over.

Nutritional risk factors

The factors used to identify nutritional risk are explained below. These risk factors are used in the Nutritional Risk Screening and Monitoring Tool (see Module 2, Trigger questions, in this education package).

Development of the Nutritional Risk Screening and Monitoring Tool

A list of 12 scored risk factors was developed through the Australian Nutrition Risk Screening Initiative (ANSI) to be used as an awareness raising tool (Lipski, 1996) based on knowledge of other examples of nutrition risk screening in the United Kingdom and the United States (Davies L, 1984, Nutrition Screening Initiative, 1993 and 1995).

Experience of Australian health care workers using the ANSI Tool (Stewart and Butler, 1996; McLaren and Bacon, 1995), highlighted a number of areas where this ANSI Tool did not meet the needs of health and community service workers for risk screening and intervention for their clients. From this, the Home and Community Care (HACC) Risk Screening Tool (Wood, 1996) was developed for use by community services staff. The tool and the resource and training packages go beyond an awareness raising initiative. They aim to assist community service workers to detect and manage nutritional risk at an early stage, including utilising expertise of relevant health professionals, where required.

Obvious underweight – frailty?

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 frail older person. Prevention of underweight is very important in frail older people.

People who are moderately overweight will have more protection from any stress that reduces food intake (over a day or two). Even temporary reduction in food and fluid intake will have an effect. A bout of poor food intake or increased needs required, for example, for wound healing, can cause severe weight loss in older people.
Ask the following questions:

- Is the client obviously underweight or looks wasted/thin?
- How long has the client been at this current weight?
- Are there any signs of fluid retention (pushing weight up) or dehydration (pushing weight down)?

**When any of the above relate to frail older people using services, suggest to participants they consider referral to:**

- a **general practitioner (GP)** to investigate and treat underlying cause
- a **dietitian** for advice on specific dietary strategies to treat symptoms and prevent decline.

**Unintentional weight loss?**

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. This is a client safety issue and is not to be ignored. Weight loss of 5 kg over six months or less is a serious sign of decline into poor nutrition and is more important if the person was underweight 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.

Simple interventions are listed in the PowerPoint slide, *Simple interventions for underweight frailty or unintentional weight loss* and also in Help sheets 3.1 and 3.2 in the Nutrition resource manual.

**When any of the above relate to frail older people using services, suggest to participants that they consider referral to:**

- a **GP** to investigate and treat underlying cause
- a **dietitian** for advice on specific dietary strategies to treat symptoms and prevent decline.

**Reduced appetite or reduced food and fluid intake?**

Reasons for reduced appetite or reduced food and fluid intake can include the following:

- many vulnerable people miss meals because of loss of appetite, poor memory, loneliness, difficulties in preparing food, access to food and lack of money
- delivered meals may be divided into two meals, without extras and, therefore, the older person will not eat enough energy or nutrients for that day
- increased needs for food due to illness may not be met
- inappropriate special diets may be followed
- a change in medication may lead to a loss of appetite.

More than one to two days of reduced food intake can lead to severe weight loss in older people. Simple interventions to assist with reduced food and fluid intake are listed in Help sheet 3.3 in the Nutrition resource manual.
When any of the above relate to frail older people using services, suggest to participants that they consider referral to:
• a GP to investigate and treat underlying cause
• a dietitian for advice on specific dietary strategies to treat symptoms and prevent decline.

Mouth, teeth or swallowing problems?
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.
Severe deficiencies of specific micro-nutrients (riboflavin, folate, iron, Vitamin C) cause mouth problems.
As a result of mouth or teeth problems, many people may omit some foods or an entire food group from their diet (for example, meat). These problems may affect food and fluid intake, nutritional quality of the diet and socialisation.
Specific medical problems can occur, which cause poor oral health and/or swallowing problems, for example, dysphagia, due to stroke or other causes or loss of teeth due to poor oral hygiene.
Simple interventions to assist with mouth, teeth or swallowing problems are listed in Help sheet 3.4 in the Nutrition resource manual.

When any of the above relate to frail older people using services, suggest to participants that they consider referral to:
• a dentist for management of oral health
• a GP to investigate and treat underlying cause
• a dietitian for advice on specific dietary strategies to treat symptoms and prevent decline
• a speech pathologist for a swallowing assessment and advice on safe swallowing strategies.

Follows a special 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 a 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 6–12 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 wellbeing improve, which makes it worth the effort.

Simple interventions to assist people who are following a special diet are listed in Help sheet 3.5 in the Nutrition resource manual.

When any of the above relate to frail older people using services, suggest to participants that they consider referral to:
- a GP to confirm or otherwise the need for the special diet
- a dietitian for advice on specific dietary strategies to manage current dietary needs.

Unable to shop for and/or prepare food?
Some older people may only buy foods that are easy to carry or easy to prepare and cook. Difficulty with shopping may be due to decreased mobility or physical disability or (if the older person has 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.

Older people may not be physically or mentally capable of preparing and cooking food. There may also be problems organising their food into nourishing meals and snacks. Older people 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.

These factors can affect the enjoyment of food and reduce food intake.

Simple interventions to assist people who are unable to shop for and/or prepare food are listed in Help sheets 3.6 and 3.7 in the Nutrition resource manual.

When any of the above relate to frail older people using services, suggest to participants that they consider referral to:
- a dietitian for advice on specific dietary strategies and food ideas in order to manage issues and prevent decline
- an occupational therapist for advice on modified food preparation and aids
- a social worker for advice on financial matters in relation to sufficient money and budgeting to purchase food.

Unable to feed self?
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, and 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.
These factors can affect food enjoyment and reduce intake and may be a safety issue for the older person. Simple interventions to assist people who are unable to feed themselves are listed in Help sheet 3.8 in the Nutrition resource manual.

**When any of the above relate to frail older people using services, suggest to participants that they consider referral to:**

- an **occupational therapist** to advise on modified food preparation and aids and ways to increase socialisation at meal times
- a **dietitian** for advice on specific dietary strategies and food ideas in order to manage issues and prevent decline.

**Obvious overweight affecting life quality?**

Normal to moderate overweight is a protective factor in the older person. Body fat provides a readily available energy store and is a safeguard in times of stress (infections, trauma) or reduced appetite, 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 an older 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 people may be omission of higher energy foods and a goal of weight maintenance. Physical activity is a critical part of weight control for older people.

Simple interventions to assist people whose quality of life is affected by being overweight are listed in Help sheet 3.9 in the Nutrition resource manual.

**When any of the above relate to frail older people using services, suggest to participants that they consider referral to:**

- a **dietitian** for advice on specific dietary strategies to manage overweight or unintentional weight gain
- a **physiotherapist** or **exercise physiologist** to advise on and organise a specific exercise program for the older person who is overweight or at risk of unintentional weight gain.
Unintentional weight gain?

Unintentional weight gain in frail older people can occur for a number of reasons, such as:
• change in medication
• constipation
• increased food intake
• change in food behaviour or feeding situation
• decreased activity
• fluid retention.

In frail older people, unintentional weight gain is not usually as important as weight loss. However, if unintentional weight gain occurs due to fluid retention, seek medical advice and refer to a GP. 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 a change in food and bowel habits.

In overweight frail older 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.

Encouraging and promoting opportunities for physical activity is very important in weight management in frail older people.

Refer to Help sheets 8–19 in Section 2 and Section 3 in this Resource Kit for more strategies on promoting physical activity in older people. Refer to Help sheet 14 in section 2 of this Resource Kit for details of health professionals who can advise and assist older people on increasing their physical activity.

Simple dietary interventions might include:
• safe avoidance of sugars, fats and alcohol
• suggest a nourishing diet, such as the 1 3 4 5+ food plan
• a low dose vitamin and mineral supplement (3–4 times a week)
• support weight maintenance or slow weight loss (no more than 0.5 kg/month).

Simple interventions to assist people who have had unintentional weight gain are listed in Help sheet 3.10 in the Nutrition resource manual.

When any of the above relate to frail older people using services, suggest to participants that they consider referral to:
• a GP for specific advice regarding health issues that may be causing weight gain and for appropriate medical support for the older person who is trying to control their body weight
• a dietitian for advice on specific dietary strategies to manage overweight or unintentional weight gain
• a physiotherapist or exercise physiologist to advise on and organise a specific exercise program for the older person who is overweight or at risk of unintentional weight gain.
General assessment issues that can affect food and nutrition

This module should include a brief overview of general assessment issues that impact on the nutritional health of frail older people. These issues are listed below.

1. Social problems
   - Bereavement, depression, social isolation (reduced food intake common)
   - Reduced motivation to eat or drink for known or unknown reasons
   - Unable to access or use secure, clean food storage and preparation area
   - Rummaging, foraging, begging or stealing food.

2. Financial difficulties
   - Has food run out in the past week with no money to buy more?
   - Less than $30 (Nutrition resource manual, Department of Human Services, 2001) for food for each adult person every week? (this amount was provided as an average in 2001, so would be more today).

3. Personal hygiene and food hygiene problems causing possible food contamination and food poisoning symptoms of diarrhoea or vomiting.

4. Food and dietary problems
   - Irregular meals or less than three meals a day?
   - Does not take 1 2 3 4 5+ food plan most days?
   - Did not have one or more of the food groups yesterday?
   - Excessive use of sweet or savoury foods?
   - More than two alcoholic drinks daily?
   - Housebound? No direct skin exposure to sunlight for important production of Vitamin D?
   - Eats inedible objects such as dirt, soap (pica)?
   - Inappropriate and challenging behaviours which involve food?

5. Mental health problems
   Poor mental health (sadness, grief, confusion, depression, memory loss, anxiety or nervousness) affects motivation to eat, the ability to meet nutritional needs and general health.

6. Polypharmacy (more than three types of medications daily)
   The more medications taken, the more likely these medications will interact to produce side effects such as loss of appetite, taste change, nausea, diarrhoea, constipation, fatigue and drowsiness (causing reduced food intake).

7. Gastro-intestinal problems, such as nausea and vomiting, diarrhoea, constipation and regurgitation.

8. Incontinence, which can lead to reduced fluid and food intake.
9. Breathing problems
Conditions such as asthma, chest infection and emphysema cause the body to work much harder. People with breathing problems require one and a half times more energy in their diet due to the extra effort required for breathing.

10. Other medical problems
Other problems, such as cancer, may reduce an older person’s ability to access enough food and fluids, increasing the need for nourishment. An older person’s nutrition can also be affected by medical problems that require specific modified/special diets, for example, diabetes, some kidney and liver disorders and osteoporosis.

**Interventions to improve nutritional health and wellbeing**

Nutrition risk screening is a method to determine nutrition risk and lead to planning and implementation of appropriate interventions and monitoring to prevent decline in nutritional status and health.

The following are key areas where interventions may be required to improve nutritional health and wellbeing:

- social support
- oral health
- mental health
- medical problems
- medications
- food and nutrition support.

Nutrition screening and intervention are best accomplished by an interdisciplinary team, where health professionals and programs work together to achieve timely and effective health outcomes for the frail older person.

(Refer to Help sheets 4.1–4.12 in the Nutrition resource manual for simple interventions which address the general assessment issues that can affect food and nutrition.)
Module 2: Nutritional risk screening and monitoring

Nutritional risk screening and monitoring

Nutritional risk screening, monitoring and intervention processes link all aspects of care, including screening and monitoring, care planning, identification and use of resources, and identification and implementation of simple interventions.

Community development is also an important part of caring for the food and nutrition needs of older people. Primary health and community service staff who care for older people might consider ways to improve, advocate for equitable access to, or provide information on safe quality food, public transport, shop locations, user friendly shops, local cafes and markets.

The nutritional risk screening and monitoring tool – 10 trigger questions

This module presents the ten trigger questions that are part of the Nutritional Risk Screening and Monitoring Tool. This tool is included in the Service Coordination Tool Templates (Health Behaviours Profile). Case studies (included in the ‘Handouts’ section in this package) are used to illustrate how this tool is used to identify interventions in the process of initial needs identification, assessment and care planning. The trigger questions include:

1. Obvious underweight – frailty?
2. Unintentional weight loss?
3. Reduced appetite or food and fluid intake?
4. Mouth or teeth or swallowing problem?
5. Follows a special diet?
6. Unable to shop for food?
7. Unable to prepare food?
8. Unable to feed self?
9. Obvious overweight affecting life quality?
10. Unintentional weight gain?

Case studies

The learning objectives are based on practical application of the seminar content. Therefore, the program uses case studies as prompts for discussion and problem-solving. It is suggested that groups should work on two case studies during the small group exercise. Two case studies to choose from are included in the ‘Handouts’ section.

It is suggested that the facilitator present the case studies and ask participants to consider the following instructions:

• Using the risk screening and monitoring tool, complete a screening of the person in the case study (refer Help sheets 2.6, 2.7, 2.8 in the Nutrition resource manual).
• Note the general needs assessment issues that are present which might contribute to the nutrition risk (refer Help sheet 2.5 in the Nutrition resource manual).
• Consider if the person would benefit from referral to another health care professional.

A facilitator’s guide to completing case studies is included in this package. See if the outcomes presented by participants match those listed in the facilitators guide. This could be provided as a handout to participants on completion of the exercise.
Food habits and patterns

Adults have a lifetime of eating and drinking experiences, and they often have established a fairly set daily food pattern which suits them. This pattern takes into account their food preferences and dislikes and meets their ethnic, social and cultural needs. Such food patterns are often central to the existence of an older person, providing structure for the day and giving them control over ‘something’ in their difficult lives. Their food behaviour is probably linked to preservation of their identity and personality. The nurturing and comforting aspects of food are often very important to them.

Disturbance of a person’s preferred food habits should be minimal. Always consider the food life experiences of the client and respect their food habits and patterns. Only when there is substantial and known benefit to a person, should consideration be given to changing their basic food habits and pattern of eating. On these occasions, modifying their usual pattern of eating is the best approach for them.

It is important not to stereotype clients as they are likely to have been raised and lived in a wide range of cultural and environmental settings, all of which affect food and health. Gender may influence attitudes, knowledge and roles for many matters relating to food, for example, shopping, food preparation, awareness of health and body needs and expectations of their carers.

Ethnic, cultural and religious groups have different attitudes, knowledge and roles for food and its relationship to health issues.

Refer to Help sheets 2, 4, 5 and 7 in Section 2 of this Resource Kit and Help sheet 5.2 in the Nutrition resource manual.

If food habits are complex, encourage participants to refer clients to a dietitian who can assess and advise on the individual needs of the older person.

Food habits and patterns – principles and simple interventions

The following principles are suggested for addressing any problems in an older person’s food habits and patterns:

- minimal disturbance of food habits and patterns
- always provide choice in foods and drinks
- respect client food life experiences, food taboos and beliefs
- respect client food habits and patterns
- only suggest change in basic food habits and patterns of eating if there will be a known benefit to the client.

Some simple interventions that could be tried include:

- introducing small modifications of basic patterns, if necessary
- offering fresh or plain foods to which familiar sauces and condiments can be added.
Good nutrition for older people

In the healthy older person, energy requirements decrease with ageing and a lower activity level. Although the basic energy requirement is less in an older person than for younger adults, the requirement for protein, vitamins and minerals remains the same. Requirements for some nutrients may even increase (such as calcium). Hence, the nutrient density of the older person’s diet must be greater in order to maintain nourishment and optimal nutritional health. It is therefore more difficult for older people to meet their nutrient requirements, as they require the same amount of nutrients from a smaller amount of food.

In addition, in the presence of disease or trauma, both energy and nutrient requirements in older people may increase, thus increasing their need for food at a time when their appetite may be reduced.

Vitamin D is important for both bone and muscle strength and is necessary for calcium absorption (NHMRC, 1999). Vitamin D is mostly gained through the action of sunlight on skin and in lesser amounts through the diet from Northern Hemisphere fatty fish, such as herring and mackerel, and Vitamin D fortified margarine and milk. People who remain indoors are at high risk of deficiency of this vitamin, making them more prone to bone fractures. Note that glass and sunscreens block the important rays from the sun which make Vitamin D.

To maintain good Vitamin D levels, it is recommended that hands, face and arms without sunscreen are exposed directly to sunlight for short periods on most days in southern states. Note that it is still important to avoid extended sunlight exposure between 10 am and 2 pm in the summer months (or 11 am and 3 pm daylight saving time) because of the risk of skin damage. Easy access to shade and use of sunscreen during extended exposure periods are essential and drinks are important for prevention of dehydration. If a client is unlikely to receive adequate sunlight exposure, it is recommended that they seek advice from their GP (refer to Help sheet 4 in Section 2 of this Resource Kit and Help sheet 5.6 in the Nutrition resource manual).

Salt and salty foods can be used sparingly, and according to taste, except when a special low salt diet is required for medical reasons (high blood pressure, fluid retention).

People should eat at least three times a day.

Older people must eat better ... not less!
The 1 3 3 4 5+ food plan

The following will provide sufficient nutrients for older people who are not underweight and/or do not have any special nutritional problems.

 Include daily:
  1 small serve meat, fish, poultry or eggs
  3 serves dairy foods (+/- fat)
  3 serves fruit (fresh, canned, dried, stewed)
  4 serves vegetables (fresh, canned, dried, stewed)
  5+ serves bread or cereals (preferably high fibre)

 6–8 cups of fluid are needed each day, and may include water, tea, coffee, milk and juice. Soft drink and cordial can also be taken.

  Unless weight reduction is essential, one or two extras, such as a piece of cake, a scone, a few lollies, ice cream or a glass of wine, can be enjoyed.

  A small appetite means that taking the most nourishing foods first is the best thing to do, followed by the less nourishing foods (foods with higher energy content, but with less essential protein, vitamins and mineral).

  Note: For some frail older people, more than the above is required to maintain their body weight.

Who needs extra foods and drinks?

Frail older people often have a higher need for energy and nutrients over long periods. Below are important notes about the need for even more food by some frail older people.

More food than is outlined in the 1 3 3 4 5+ food plan is required by some frail older people to maintain their body weight at a reasonable level. More energy and nutrients are required to:

  • correct underweight
  • reverse weight loss
  • fight an infection
  • heal a wound
  • recover from recent surgery
  • rebuild a fracture.

Being well nourished on delivered meals

Delivered meals supply only part of the daily diet for any vulnerable person. Delivered meals (eg Meals on Wheels [MOW]) are designed for the frail older person who is nutritionally at risk and supply for them approximately:

- 1/3 daily need for energy
- 1/2 daily need for protein, thiamin, riboflavin, niacin, Vitamin A, calcium, iron and zinc
- 2/3 daily need for Vitamin C.

To achieve an adequate daily diet, two other meals need to be added, so it looks something like this:

<table>
<thead>
<tr>
<th>Morning</th>
<th>Afternoon</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cereal, milk, sugar, toast, margarine, jam, Tea</td>
<td>Main course (MOW) Dessert (MOW) Coffee</td>
<td>Soup (MOW) Sandwiches Fruit, yoghurt, custard, or other dairy dessert. Tea/ coffee</td>
</tr>
<tr>
<td>Fruit juice (MOW)</td>
<td>Tea and cake</td>
<td>Milk and biscuits</td>
</tr>
</tbody>
</table>

Good snacks to have between meals include milk drinks, cereal foods, breads and fruits.

If a frail older person does not take such extra foods (particularly more of the milk group, cereals and breads), they will not be getting sufficient energy and nourishment. Good snacks for people to take between meals are the ones that they know and like best. These include fruits, cake, biscuits, milk drinks, desserts, cereals with milk, bread and butter, ice cream, fruit juice, yoghurt, lollies, chocolates, chips (crisps), cheese, dried fruits, and so on. As most vulnerable people like tasty food, they may refuse food that is not cooked with some salt.

Delivered meals are only part of the daily diet for any person.

At least three meals every day are recommended for all frail older people.

(Refer to Help sheets 5.2–5.8 in the Nutrition resource manual [see Table 1, page 4, for full list of Help sheets] and Help sheets 2, 4, 5 and 7 in Section 2 of this Resource Kit.)
Enhancing nutritional intake in group settings

Eating is usually a social activity and meals eaten with others are often more enjoyable. Eating alone can lead to reduced interest in food. Reliance may also be placed on ready prepared or snack food rather than on maintenance of cooking skills. Reduced food intake is common when people are experiencing social isolation, bereavement or depression. Vulnerable people may have even less motivation to eat or drink, for known or unknown reasons (Nutrition resource manual, Department of Human Services, 2001).

The group setting has great potential to enhance the food and nutrition intake of the at risk frail older person. For older people attending group sessions, for example, planned activity groups, the meal and snack times are opportunities for social enjoyment of food and provision of food in support of the nutritional needs of participants. Also, at these sessions an older person’s nutritional risk can be monitored and relevant nutrition information offered. Refer to Help sheets 2, 3, 4, 5 and 6 in Section 2 of this Resource Kit for more information on quality provision of food in social settings.

Simple interventions for underweight-frailty or unintentional weight loss

- Always review medications
- Find out the food preferences of the older person
- Provide optimal dining environment in group settings or wherever possible in the older person’s home environment
- Allow adequate time for meals and snacks
- Give most food when most alert (that is, this can be anytime
- Small meals and small snacks (3 + 3)
- Provide substitutes for items refused
- Motivational counseling – promote that ‘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, for example, Milo, Actavite, milkshake.
Module 4: Obtaining support if nutritional risks are identified

Referral to health professionals for assessment and intervention

By way of introduction to this module, briefly discuss what circumstances might indicate referral to some or all of the health professionals listed on the PowerPoint Slide, Health professionals for clients referral for assessment and intervention.

Roles and functions of dietitians

Dietitians can be involved in a variety of roles to support the food and nutrition needs of older people in the community. The roles and functions are given in Section 6.1 of the Nutrition resource manual. These are summarised as follows:

- Policy development to support food and nutrition needs of older people in the community, including community food supply and food services.
- Development of community resources to support home care, including client information, shopping and transport services, community and commercial food services and volunteers.
- Training and provision of resources to service providers, including aged care workers, volunteers, personal carers, food services and regional aged care services; for example, training and resources on food and nutrition issues, nutrition risk screening, early assessment, intervention and monitoring and managing community resources and food services.
- Direct client services including:
  - assessment of dietary patterns and intake
  - assessment of nutritional status
  - intervention strategies
  - counselling and information
  - client support and monitoring
  - liaison with other service providers.

(Refer to Help sheet 6.1 in the Nutrition resource manual and Help sheet 14 in Section 2 of this Resource Kit.)

Reasons for referring clients to a dietitian

Dietitians can assess the older person, advise on specific diet, nutrition or food issues and increased nutritional risk and monitor progress of the person who requires assistance. They can also act as a resource person for other health care professionals. A referral to a dietitian should be made when the frail older person:

- has gained or lost 5 kg (10 lb) or more without trying in the last six months
- has one or more of the following problems:
  - poor appetite and the food does not taste good
  - trouble chewing and swallowing
  - finds pills are upsetting so cannot eat
  - treats illness with vitamin supplements
– has many nutrition questions or needs advice about what to eat
– spends less than $30 (Nutrition training manual, 2001) a week on food
  (this amount was provided as an average in 2001, so would be more today)
– usually needs help shopping for food
  • has an illness that the doctor said needs a special diet
  • has trouble following a special diet.

Often occupational therapists, physiotherapists and dietitians work together and will refer people to each other as appropriate.

Refer to Help sheet 14 in Section 2 of this Resource Kit and Help sheet 6.1 in the Nutrition training manual.

Client safety issues

The following issues indicate the need for urgent referral to a health professional or range of health professionals or organisations:
• alcohol withdrawal – this requires urgent referral to a doctor
• low body weight
• unintentional weight loss
• unable to feed self
• rumination
• regurgitation
• choking
• unable to recognise food
• rummaging for food
• food contamination.

Also refer to Help sheet 6 in Section 2 of this Resource Kit.

Conclusion

This session focused on nutrition-related health issues, ways to screen and monitor frail older people for risk factors, and food and nutrition needs of frail older people. Urge participants to apply what they have learned and to ensure they pay early attention to nutrition issues for frail older people. For more in-depth information on simple interventions, consider arranging additional seminars.

Evaluation

Hand out the feedback form to each participant and collect at the end of the seminar.

Assist the group in planning for further learning seminars/activities, including directing them to other relevant resource people.
References


National Health and Medical Research Council (NHMRC) (1999), Dietary guidelines for older Australians, Canberra.


Nutrition seminar: feedback form

1. Was this seminar relevant to your work? (tick one only)
   - highly relevant
   - relevant
   - limited relevance
   - no relevance

2. Was this seminar relevant to you? (tick one only)
   - highly relevant
   - relevant
   - limited relevance
   - no relevance

3. How much do you feel you learnt from this seminar about nutrition, risk screening and monitoring for frail older people? (tick one only)
   - learnt a great deal
   - learnt some new information
   - not much was new
   - learnt nothing new

4. Has your view of food and nutrition issues in frail older people living at home changed?
   - YES
   - NO

   If YES, how has your view changed? If NO, why not?

   ____________________________________________________________

   ____________________________________________________________

5. Is this a useful way to access information? If YES – why? If NO – why not and what other ways would be more useful?

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

6. Have you (or will you) use any of the information from this seminar in your work? Please describe.

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

7. How could the seminar be improved?

   ____________________________________________________________

   ____________________________________________________________
8. Would you recommend this as a useful seminar for others?
   □ recommend highly
   □ recommend
   □ not recommend

9. Do you believe that your workplace could change its practice to improve nutrition opportunities for clients? If yes, in what ways?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

10. Please describe any difficulties or barriers to making these changes.

    ______________________________________________________
    ______________________________________________________
    ______________________________________________________

11. Any other comments?

    ______________________________________________________
    ______________________________________________________
    ______________________________________________________
    ______________________________________________________
    ______________________________________________________
PowerPoint slides: 
Well for life: promoting better nutrition

1 Title: Well for life: promoting better nutrition
2 Seminar aims
3 Overview of seminar
4 Module 1: Introduction to nutrition and health issues in frail older people
5 Module 1, Part 1: Definitions of nutritional risk and screening
6 & 7 Poor nutrition in frail older people
8 Background factors for poor nutrition
9 Module 1: Part 2: Summary of nutritional risks
10 & 11 Obvious underweight-frailty?
12 & 13 Unintentional weight loss?
14 & 15 Reduced appetite or reduced food and fluid intake?
16 & 17 Mouth, teeth or swallowing problems?
18 & 19 Follows a special diet?
20 & 21 Unable to shop for and/or prepare food?
22 & 23 Unable to feed self?
24 & 25 Obvious overweight affecting life quality?
26 & 27 Unintentional weight gain?
28 Module 1: Part 3: General assessment issues that can affect food and nutrition
29 Key areas to intervene to improve nutritional health and wellbeing
30 Module 2: Nutritional risk screening and monitoring
31 Nutritional risk screening and monitoring in the assessment and intervention process
32 Nutritional Risk Screening Tool
33 Module 3: Food and nutritional needs of frail older people
34 Food habits and patterns
35 Food habits and patterns – simple interventions
36 Good nutrition for older people
37 The 1 3 3 4 5+ food plan
38 Who needs extra foods and drinks?
39 & 40 How to be well nourished on delivered meals
41 Enhancing nutritional intake in group settings
42 Simple interventions for underweight-frailty or unintentional weight loss
43 Module 4: Obtaining support if nutritional risks are identified
44 Health professionals for client referral for assessment and intervention
45 Roles and functions of dietitians in home-based care
46 Reasons for direct client referral to a dietitian
47 Signs for urgent referral – issues of client safety
Well for life
Promoting better nutrition

Seminar aims
Enhance opportunities for frail older people in the community to receive timely nutrition care by providing information to service staff to:
• Raise awareness of the importance of nutrition for frail older people
• Assist in early identification of nutrition risks and implementation of strategies to manage nutrition-related health issues and referring clients to appropriately qualified health professionals.

Overview of seminar
• To demonstrate nutritional risk screening and monitoring, including:
  – Discuss nutrition-related health issues
  – Introduce and demonstrate the Nutritional Risk Screening and Monitoring Tool
  – Use case studies to identify problems
  – Discuss food and nutrition issues and dietary principles
• Learn ways to access external support and expertise
• Have knowledge to promote and advocate for good quality community services

Module 1
Introduction to nutrition and health issues in frail older people

Module 1, Part 1:
Definitions of nutritional risk and screening
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
• To identify individuals at high risk of food and nutrition problems
• To identify individuals who already have poor nutritional status

Poor nutrition in frail older people
Does it matter?
• More likely to fall
• Need more assistance
• Need more complex support and care
• More complications, such as infections, pressure sores
• Less likely to be able to live independently
• Need more frequent and longer stays in hospital
Module 1, Part 2: Summary of nutritional risks

- Obvious underweight – frailty?
  - Unintentional weight loss?
  - Reduced appetite or food and fluid intake?
  - Mouth or teeth or swallowing problem?
  - Follows a special diet?

- 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

Obvious underweight – frailty? (cont’d)

- Low body reserves of energy and nutrients for use in emergency
- A bout of poor food intake or increased needs can cause severe 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

Unintentional weight loss?

- Inappropriate, inadequate food intake
- Poor appetite
- Poverty
- Social isolation
- Dependency
- Disability
- Feeding problems
- Acute conditions
- Chronic disease
- Chronic, polypharmacy
- Advanced age (80+)
### Unintentional weight loss? (cont’d)

- Severe weight loss is associated with higher rates of morbidity and mortality.
- Unintentional weight loss is a client safety issue and is not to be ignored.
- When any of the above relate to older people attending your service, consider referral to:
  - GP to investigate and treat underlying cause
  - Dietitian for advice on specific dietary strategies to treat symptoms and prevent decline

### Reduced appetite or reduced food and fluid intake? (cont’d)

Any sudden unexplained change in appetite, refer to:
- GP to investigate and treat underlying cause
- Dietitian for advice on specific dietary strategies to treat symptoms and prevent decline.

### Mouth, teeth or swallowing problems? (cont’d)

When any of the above relate to older people attending your service, consider referral to:
- Dentist for management of oral health
- GP to investigate and treat underlying cause
- Dietitian for advice on dietary strategies to treat symptoms and prevent decline.
- Speech pathologist for swallowing assessment and advice on strategies.

### 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 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

### Mouth, teeth or swallowing problems?

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

### 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 frequently
- Uninformed alteration in usual food intake can cause more health problems
- If a special diet is required for a specific therapeutic reason, 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
**Follows a special diet? (cont’d)**

When any of the above relate to older people
Attending your service, consider referral to:
  - GP to confirm or otherwise the need for the special diet
  - dietitian for advice on specific strategies to manage current dietary needs

**Unable to shop for and/or 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

**Unable to shop for and/or prepare food? (cont’d)**

These factors can affect the enjoyment of food and reduce intake. When any of the above relate to older people attending your service, consider referral to:
  - dietitian for advice on specific dietary strategies, food ideas to manage issues and prevent decline
  - occupational therapist to advise on modified food preparation and aids
  - social worker to advise on financial matters in relation to sufficient money and budgeting to purchase food.

**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

**Unable to feed self? (cont’d)**

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

When any of the above relate to older people attending your service, consider referral to:
  - occupational therapist to advise on modified food preparation and aids and ways to increase socialisation at meal times
  - dietitian for advice on specific dietary strategies, food ideas in order to manage issues and prevent decline.

**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
Obvious overweight affecting life quality? (cont’d)

When any of the above relate to older people attending your service, consider referral to:
- dietician for advice on specific dietary strategies to manage overweight or unintentional weight gain
- physiotherapist or exercise physiologist to advise on and organise a specific exercise program for the older person who is overweight or at risk of unintentional weight gain.

Unintentional weight gain? (contd)

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

When any of the above relate to older people attending your service, consider referral to:
- GP: for advice regarding health issues that may be causing weight gain and for medical support for the older person who is trying to control their body weight
- dietician: for advice on dietary strategies to manage overweight or unintentional weight gain
- physiotherapist or exercise physiologist: to advise on and organise an exercise program for the older person who is overweight or at risk of unintentional weight gain.

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 4 5 = food plan (older people)
- a low dose vitamin and mineral supplement (3-4 times a week)

Module 1, Part 3: General assessment issues that can affect food and nutrition

- Social problems
- Financial difficulties
- Personal hygiene and food hygiene problems
- Food and dietary problems
- Mental health problems
- Medical problems
- Polypharmacy (more than three types of medication daily)
- Gastro-intestinal problems
  - nausea and vomiting
  - diarrhoea
  - constipation
- Incontinence
- Breathing problems

Key areas to intervene to improve nutritional health and wellbeing

- 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.’

Module 2

Nutritional risk screening and monitoring
Nutritional risk screening and monitoring in the assessment and intervention process

| Initial Contact |
| Initial Needs Identification (Nutritional risk screening) |
| Specialist Assessment |
| Service Specific Assessment |
| Comprehensive Assessment |
| Case Planning |

Nutritional Risk Screening Tool

Module 3

Food and nutritional needs of frail older people

Food habits and patterns
- Adults have a lifetime of eating and drinking
- They often have a fairly set daily food pattern
- Such food patterns may be central to their existence
- Food behaviour may be linked to identity and personality
- Nurturing and comforting aspects of food are very important
- Gender issues are important
- Ethnic, cultural and religious issues are usually important

If food habits are complex, consider referral to a dietitian.

Food habits and patterns – simple interventions
- Minimal disturbance of food habits and patterns
- Always provide choice in foods and drinks
- Respect client food life experiences, food taboos and beliefs
- Respect client food habits and patterns
- Only suggest change in basic food habits and patterns of eating if there will be a known benefit to the client
- Try small modifications of basic patterns, if necessary
- Offer fresh or plain foods to which familiar sauces and condiments can be added

Good nutrition for older people
- Energy needs:
  - decrease with age
  - increase with illness, stress, infection, surgery
- Protein, mineral and vitamin needs:
  - remain the same or increase with age
  - increase with illness, stress, infection, surgery
- Sufficient fluid and fibre intake is always important
- Vitamin D is required by housebound people
- Sparing use of salt
- At least three meals a day are recommended
  Older people must eat better ... not less!
The 1 3 3 4 5 + food plan

- 1 small serve meat, fish, poultry or eggs
- 3 serves dairy foods (+/- fat)
- 3 serves fruit (fresh, canned, dried, stewed)
- 4 serves vegetables (fresh, canned, dried, stewed)
- 5+ serves bread or cereals (preferably high fibre)
- 6-8 cups fluid
- 2+ serves indulgences (cake, wine, ice cream)

Note: More than this is required by some older/ill people to maintain their body weight

Modified from the 1 3 3 4 5 + food plan. (Bingham and Herbstel et al. Journal of Nutrition Education, 1982, vol 24, pp. 60-72)

Who needs extra foods and drinks?

Vulnerable people often have a high need for energy and nutrients over long periods:
- to correct underweight
- to reverse weight loss
- to fight an infection
- to heal a wound
- to recover from recent surgery
- to rebuild a fracture
- to meet increased needs due to a head injury
- to promote recovery after illness

How to be well nourished on delivered meals

- Meals on Wheels supplies only part of the daily diet for any vulnerable person
- Meals on Wheels are designed for the older person and supply for them approximately:
  - 1/3 daily need for energy
  - 1/2 daily need for protein, thiamin, riboflavin, niacin, vitamin A, calcium, iron and zinc
  - 2/3 daily need for vitamin C
- Good snacks to have between meals include: milk, drinks, cereal foods and breads, fruits

How to be well nourished on delivered meals (cont’d)

<table>
<thead>
<tr>
<th>Time</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cereal, milk, sugar, toast, margarine, jam, tea</td>
<td>Main course (MOW), Dessert (MOW), Coffee</td>
<td>Soup (MOW), Sandwiches, fruit, yoghurt, custard or other dairy dessert, Tea/coffee</td>
</tr>
<tr>
<td></td>
<td>Fruit juice (MOW)</td>
<td>Tea and cake</td>
<td>Milk &amp; biscuits</td>
</tr>
</tbody>
</table>

Enhancing nutritional intake in group settings

(if eat alone most of the time)

- Eating is usually a social activity
- Reduced food intake is common in social isolation, bereavement and depression
- The vulnerable person may be less motivated to eat and drink
- Eating alone can lead to reduced interest in food and eating
- Increased use of ready prepared snack foods rather than maintaining one’s cooking skills, may result from eating alone

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, such as Milo, Actimel, milkshake
Module 4

Obtaining support if nutritional risks are identified

Health professionals for client referral for assessment and intervention

- Visiting nurse
- GP
- Dietitian
- Occupational therapist
- Speech pathologist
- Social worker
- Physiotherapist
- Dentist
- Psychologist
- Delivered meals
- Diabetes educator
- Other

Roles and functions of dietitians in home-based care

- Consultancy, training and provision of resources to service providers
- Provision of resources in food, nutrition and dietetics to colleagues
- Development of community resources to support home care
- Policy development
- Direct client services

Reasons for direct client referral to a dietitian

When your client:
- Has gained or lost 5 kg (10 lb) or more without trying in the last six months
- Has one or more of the following problems:
  - poor appetite and the food does not taste good
  - trouble chewing and swallowing
  - finds pills are upsetting so cannot eat
  - treats illness with vitamin supplements
  - has many nutrition questions or needs advice about what to eat
  - spends less than $10 a week on food (Nutrition Training Manual, 2001)
  - usually needs help shopping for food
- Has an illness that the doctor said needs a special diet
- Is supposed to be on a special diet but has trouble following it

Signs for urgent referral – issues of client safety

- Alcohol withdrawal – urgent referral to doctor
- Low body weight
- Unintentional weight loss
- Unable to feed self
- Ruminating
- Regurgitation
- Choking
- Unable to recognise food
- Rummaging for food
- Food contamination
Handouts

Case studies 1 and 2
Facilitator’s guide to completing case studies
### Case Study 1: Woman, 75 years, severe emphysema, weight loss, referred by daughter

A 75 year old woman has severe emphysema and uses a Ventolin pump daily. She lives in a one bedroom flat, is on a pension, and does not have a telephone at home because of the cost. She manages to go shopping in an electric wheelchair but is unable to cook as a rule. Her daughter cooks a meal for her on most weekends, otherwise she buys a take-away chicken dinner, and she has a meal delivered by Meals on Wheels (MOW) during the week.

She has lost a lot of weight over the past few years, and states she was normally around 10 stone or 63 kg. She is now 45 kg. She has a small appetite and often goes without breakfast (otherwise a bowl of porridge), especially if she is not up before 9 am, because she says she couldn't manage to eat her lunch if she ate breakfast after 9 am.

She feels she must be getting enough to eat since she has a good meal at lunchtime. She saves the soup from her delivered meal for dinner, and usually has nothing else to eat. Black tea is her usual drink, about four cups a day.

### Case Study 2: Man, 74 years, recent stroke, referred by doctor

A 74 year old man has had a recent stroke, which has left him with right sided paralysis. He also has trouble swallowing, often choking on some foods. His dentures are loose, so he tends to leave them out. He has lost 3 kg in one month.

Most of the time his wife has to feed him; recently this is taking longer as he is very drowsy. He is also constipated and has problems with his bladder (often needing to go to the toilet every one or two hours). His wife has osteoarthritis, so cannot shower him—the visiting nurse comes in to do this.

His diet history is shown below:

- **Breakfast:** Cereal and milk, 1/2 glass orange juice
- **Lunch:** Pumpkin soup or a mornay dish
- **Tea:** Mince meat and vegetables
- **Drinks:** 1/2 cup tea (morning and afternoon) 1 brandy, lime and soda before dinner

His wife says that she tries to avoid high fat foods to avoid the risk of her husband having another stroke.
Facilitator’s guide to completing case studies

This guide is designed to assist facilitators to conduct the small group activity (Module 1: Part 2) to identify nutritional risk factors, general assessment issues and simple interventions in respect of case studies 1 and 2. Participants work in small groups and practise application of the nutritional risk screening tool on the case study provided.

Case study 1: Woman, 75 years, severe emphysema, weight loss, referred by daughter

‘YES’ to the following risk factors:
• Obvious underweight-frailty
• Unintentional weight loss
• Reduced appetite or reduced food or fluid intake
• Unable to prepare food

General needs assessment factors which are relevant
• Reduced mobility
• Shortness of breath
• Severe weight loss (30%)
• At risk (no phone)
• Social isolation
• Depression
• Finances
• Personal care decreasing
• Poor knowledge of food needs
• Misses breakfast
• Small evening meal
• No sugar

Suggested actions
• Refer for case management
• Home care daily
• Day care, such as social support and/or planned activity group
• Refer to GP for shortness of breath
• Refer to visiting nurse for medication and personal care
• Occupational therapist (kitchen safety)
• Financial counselling
• Talk with daughter
• Encourage small frequent meals, milk and increased sugar intake
• Refer to dietitian
• Monitor nutritional risk
• Monitoring might be a two-week trial of simple intervention strategies (less time if severe weight); if no response refer to specialist. Monitoring at monthly intervals (or more frequently by a team member) is recommended to ensure that nutritional risk has been decreased through the most effective intervention.
Case study 2: Man, 74 years, recent stroke, referred by doctor

“YES” to the following Risk Factors:
- Obvious underweight-frailty
- Unintentional weight loss
- Reduced appetite or reduced food and fluid intake
- Mouth or teeth or swallowing problem
- Follows a special diet
- Unable to shop for food
- Unable to prepare food
- Unable to feed self

General needs assessment factors which are relevant
- Recent stroke, drowsy
- Psychological issues (concerned about wife)
- Reduced mobility
- Bladder problems
- Constipation
- Severe weight loss (3 kg in one month)
- Decreased fluid intake (500 ml per day)
- Fear of choking
- Dentures not used
- Wife feeds him
- Wife inappropriately avoids preparing high fat foods for him
- Low bread and milk intake

Suggested actions
- Refer to GP (prostate, constipation, medication, drowsiness)
- Visiting nurse support
- Refer to speech pathologist
- Refer to dentist
- Carer support
- Refer to dietitian for client/carer education
- Small frequent meals; information to client and wife re food and fluid needs, use of sugar, milk and bread
- Visiting nurse daily supervision of rehydration and intervention, then weekly, then two weekly
- Wife to monitor food intake
- Dietitian to monitor food intake
- Monitoring might be a two-week trial of simple intervention strategies (less time if severe weight loss); if no response refer to specialist
- Monitoring at monthly intervals (or more frequently) by a team member is recommended to ensure that nutritional risk has been decreased through effective intervention