Choose a client who is at risk of malnutrition

The purpose of this assignment is to choose a client who is at risk of malnutrition, by identifying why the client was at risk and how this risk was identified clinically. The nutritional tool used to assess the client will be identified, discussed, and explored in-depth. Reasons why the client became at risk will be explained, as well as how the risk was dealt with, managed, and the actions taken to control the risk. An explanation of how this was documented will be explained, and the reasons why it is important to have good nutrition in healthcare will also be discussed.

The five step model of the Health and Safety Executive 1998 will be included throughout this assignment. Mrs Watson is 69 years old, when she came to the nursing home to live, the following had to be identified and recorded in the first twenty four hours of arrival as part of the nursing assessment. On admission the nutritional assessment form has to be completed, the form asks for the clients weight which was 43kg her height was 5ft on the BMI scoring sheet Mrs Watson scored 19 given 1 on the Malnutrition Universal Screening Tool chart putting her in the at risk of malnutrition group.

Appendix 2, p. 10 (Malnutrition Advisory Group 2007). Over the first month it was identified by staff through routine checks and observation that Mrs Watson was not eating, this was reported to the nurse in charge, who decided to have her put on a daily food chart which documents everything she eats and drinks. Over the first four weeks this chart proved she had not been eating or drinking much.

On admission the clients weight showed she was already undernourished and at risk of malnutrition but over the next four weeks she had lost another

3kgs putting her weight down to just 40kgs putting her at a very high risk putting her BMI score to 17 on the 'MUST' Tool and her weight loss score on the 'Must' Tool for management guidelines a scoring of 2 which is treated as a high risk, the guidelines for treating this risk is to get in touch with the dietician and to try and improve on nutrition food, monitor and review care plan on a weekly basis.

Explains that the body mass index is a single number that adjusts weight for height. It indicates whether a person is underweight, normal weight, overweight or obese. The body mass index can be worked out by using a formula BMI= body weight in kilograms over (height in metres). The BMI classifications give the following results: for a BMI less than 20 means the person is underweight, 20 to 25 is overweight and 30+ obese. Naszarko L. (2002) continues to say that oedema can hide weight loss, so if a clients BMI seems normal it could hide the fact the client is actually undernourished.

Mrs Watson has a lot of factors that put her " at risk"; she has a learning disability, bipolar disorder and has diabetic insipidus. Her current weight is a cause for concern as it continues to decrease, due to her state of mania, coupled with a reduced food intake, she is often throwing food offered to her away and will not accept care staff assisting her, she strips off her clothes and is destructive when she is like this, she often refuses medication and spits it out.

She has difficulty getting food on the fork and into her mouth, can appear confused and unaware of what to do with objects that she holds in her hand, so needs hand over hand prompting, due to agitation; she has high energy

expenditure. The client is also on a lot of medication, some of these can cause a reduced food intake and have side effects such as anorexia, nausea, vomiting, food aversions, and a disinterest in food (Nazarko L. 2002).

Diabetes can cause weight loss frequent urination and a severe thirst which can make the client feel full at meal times. Learning disabilities and bipolar disorder medications can reduce the ability to chew and swallow food, this can cause the client to have a poor appetite and lead to digestive problems so increases the need for nutritional help. Clients with learning disabilities have greater health needs and are dependent on the carer to maintain their nutritional and fluid needs (Rodwell, S. et al. , 2006).

Appendix 1 shows the nutritional assessment form which was filled in during the assessment of the client, the form says that if the client responds yes to any of the questions on the form then the Malnutrition Universal Screening Tool (Must) needs to be included. 'Must' is a screening tool with five steps which identify malnourished adults or adults at risk of malnutrition; it contains guidelines to be used for the development of a care plan. 'Must' tool is a reliable practical way for assessing clients at risk as it is quick to identify clients at risk of being malnourished or a risk to malnutrition.

It gathers nutritional measurements such as height, weight, and recent weight loss. It determines which group the patient is at risk and so forms an appropriate care plan. The 5 steps of the 'Must' tool Appendix 2, p. 8; begins with steps 1-3 which take 3 measurements and score them against the scale provided. Body mass index, weight loss, acute disease effect. Step 4 is when

the scores are added up to see if the client is at risk of being malnourished. Step 5 shows guidelines in which the risk can be managed.

On the must flow chart it shows three scores so whatever risk group the client is in this chart gives a plan of action. Because the client scored 2 on the management guidelines Appendix 2, p. 10 she is considered a high risk. The guidelines recommend for an energy dense menu choice. Nutritional drinks to be given twice a day, food charts should be recorded daily, weight to be checked regularly. Snacks and drinks to be made with full fat milk. Assessment should be made within seven days, since the client has lost 3kg since admission her case was referred to the dietician.

The risk was managed by continuing with, and assessing care plans, weekly weights and BMI scores and daily food and fluid charts. Staff assisted client in eating when necessary, given a soft diet as the client finds it hard to chew and swallow. Staff took the time to help the client without rushing her. Care plans will continue to be assessed, planned, and implemented. The dietician prescribed the client two cartons of . ensure plus per day along with a fat supplement Calogen 2 x 30mls on a daily basis. The dietician requires the client to be encouraged to have a high fat sugar diet.

The client's poor appetite was assessed; medication was checked as this can affect appetite. The client's mouth was checked for mouth sores and ulcers, but seemed fine Dentures fit well. The community learning disability nurse monitors her weight on a regular basis. To try and improve the client's appetite, her favourite foods were offered. Her mood was monitored daily to see if this could be a cause for her disinterest in food. The client was moved

to a table of her own, she seemed to get very agitated and upset sitting at a table with other clients who could be quite noisy.

As I reflect back on the importance of adequate nutrition for my client during placement I realise it is important for keeping the body functioning normally, maintaining a healthy weight and for preventing disease. Wardlaw, et al. , (2004) explains that if disease develops, good nutrition helps to minimise the effects. Good nutrition involves consuming foods in appropriate amounts.

No one food provides the body with all the nutrients it needs, for good health the body needs protein, carbohydrates, fats, vitamins, minerals and fibre. I found that older people are less active and so use less energy. Dimasco, et al. (2006) explains that as people age, body fat increases and muscle tends to decrease. Muscle tissue burns more calories than fat. With my client, certain disorders and drugs can change the body's nutritional needs.

They can decrease appetite and interfere with the absorption of nutrients. Dorner, D. , (1997) tells us that malnutrition increases the risk of chest infection and immobility increases the risk of constipation, which can lead to a poor appetite, urinary retention and an increased chance of getting a urine infection. Malnutrition inhibits mobility and delays recovery; muscle loss can lead to reduced respiratory function.

Malnutrition can cause exhaustion, poor mobility, poor appetite, and depression. Providing a nutritious diet will help the client have improved health. Dzik-jurasz. , (2007) p21 explains that " as long ago as 1860, Florence Nightingale identified the importance of good food for people's recovery from illness. " In conclusion it seems all modern research supports,

and highlights the fact that people who don't get the right food and hydration tend to stay in hospital longer, and experience more complications such as hospital acquired infections and pressure sores.

Nurses do not have the time to help clients at mealtimes, although nutrition should be treated as a priority it is not always possible to be in two places at once, usually more than one client needs help to be fed, but sometimes there is not enough staff . It is important for the client to feel comfortable in there environment, they should never feel rushed. Assistance should be available when needed, and it is important that the staff communicate well, and have training in nutrition.