

Malnutrition in the elderly: causes and intervention strategies



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1. INTRODUCTION

Malnutrition is an age related challenge facing the elderly globally. Achieving good nutrition can be especially difficult for the elderly. The prevalence of malnutrition is considerably higher (25-49%) of elderly people in the world (Kucuk et al, 2017). Possible causes of malnutrition in elderly is hidden. However, many factors such as physiological changes, changes in nutritional needs, illness and physical limitation, food-medication interaction, depression and loneliness, and food insecurity are common causes of malnutrition. In this regard, this research will elaborate the causes or factors that contributes to elderly malnutrition, resources or ways to support these elderly get their nutritional needs.

2. Malnutrition and contributing factors in elderly

Globally, current demographic change relating to ageing population has led to rise in absolute number and proportion of elderly. This increase in elderly population has posed the need to look into the meaning of malnutrition, possible causes and programs in an effort to support the elderly overcome malnutrition. In a study by Kucuk et al; (2017), the prevalence of malnutrition risk was 28-53. 6% and malnutrition frequency was 8- 15. 9% among elderly people in Turkey. Malnutrition in the elderly is inevitable, and usually goes unnoticed especially with the elderly issues and living at home. It is a problem experienced by all elderly living in their own house or staying in a care-giving institution such as a nursing home or hospital that is significant, common, and often late diagnosed. Elderly face a higher risk of malnutrition because of physical and physiological changes associated with aging. Kucuk et al; (2017), points out that the most fundamental cause of <https://assignbuster.com/malnutrition-in-the-eldery-causes-and-intervention-strategies/>

malnutrition is insufficient nutrient consumption. The second is the increase in the need for nutrients due to fever, infection, or catabolic disorders.

Insufficient nutrition consumption

The most fundamental cause of malnutrition is insufficient nutrient consumption (Kucuk et al; 2017). Malnutrition in the elderly occurs when there is a lack of stability between nutritional intake and nutritional needs. Protein-energy malnutrition in older Europeans is an increasing health problem, mainly due to changes in demographics (Visser et al; 2017). Malnutrition is referred to lack of nutrients such as energy, protein and minerals which lead to malfunction of the body. Minimal dietary intake has adverse effect on wound healing and the protein-energy malnutrition has connection with the entire body protein and inadequate micronutrient alters the nutritional status. the variation in the nutritional status affect the healing process and strength of the wound, synthesis of collagen, skin tend to be inelastic, and unable to produce antibodies that fight and prevent infection. The fragile body is prone to pressure ulcer which has relation with immobility, weight loss and the impairment of immune system (Kucuk et al; 2017). Assessment and follow up of the nutritional status reduces the malnutrition and assist in the prevention of pressure ulcers. Previous studies have shown that there is a connection between malnutrition and pressure ulcer so in order to detect and prevent pressure ulcer, the nutrition screening and examination has be set as guideline for admission of patient with pressure ulcer.

Physical changes

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Malnutrition mostly occur in the elderly as result of physical changes related to ageing. The consequence of malnutrition in elderly living at home differs from institutionalized elderly. Failure to examine and analysis the cause of malnutrition result to huge problems. Elderly living at home experience challenges such as not be able to perform daily life activities and their functionality deteriorate and they also experience falls and fractures while institutionalized elderly are faced with problems such as pressure ulcers, cognitive decline, infections, and anemia and extend the duration in the hospital.

Disease

Gastrointestinal problems can be seen among elderly just like any other age group, and they bear special importance because of their relationship with nutrition (Kucuk et al; 2017). In a study by Kucuk et al; (2017) participants who had a gastrointestinal problem had a lower mean MNA score than those who did not have one. Participants who suffered from a gastrointestinal problem such as loss of appetite, dysphagia, vomiting, and difficulty chewing had a lower mean nutritional score than those who did not. Many studies indicate a strong relationship between mouth health and malnutrition.

Participants who had a mouth health problem associated with lack of teeth, dry mouth, or dentures had a lower mean nutrition score than those who did not. According to the study, among elderly individuals, those who were female, those who had an acute and chronic illness, those who were on medication, those who were suffering from sensory loss, those who had gastrointestinal problems, and those who had a mouth health issue had a

higher incidence of malnutrition. It is necessary that the elderly individuals
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be scanned for their nutritional status and associated risk factors when they are first admitted to care-giving institutions. Individuals suffering from a nutritional problem should be given proper dietary support.

The existence of one or coexisting of disease such as arthritis, cancer, diabetes, Parkinson's disease, Alzheimer's disease and depression are causative factor to malnutrition in elderly. Furthermore, the study into the connection between pressure ulcer and nutrition status has been entangled because there is no standardized definition for malnutrition, lack of unified screening tools, and finally inadequate information as regards the role of malnutrition in pressure ulcer. In particular, elderly with multi-morbidity, malnutrition is a common result of diseases.

Environmental situations

The prevalence of malnutrition varies widely across different population subgroups of older persons but is generally acknowledged to be higher in older persons with deteriorating health and functional status, and increasing dependency and disability. In the community, malnutrition affects less than 10% of independently living older persons; however, the prevalence of malnutrition has been reported to be 50% and higher in nursing home residents, geriatric patients in acute care hospitals and patients in geriatric rehabilitation (Visser et al; 2017). Recent Australian studies have indicated that the prevalence of malnutrition is likely to be up to 50% in the rehabilitation setting (Markovski et al; 2018). Markovski et al; (2018) in their study supports the contention that an environment can increase food intake, increase patients' opportunities to enjoy the social aspect of meal times, and

potentially lead to weight gain and reduced malnutrition risk in the rehabilitation setting. The authors conducted an observational study in the subacute setting across two sites of Western Health Care Service (Footscray and Williamstown campuses). The data pertaining to food intake and patient satisfaction with the dining environment were collected with verbal consent over a three-month period (July–October 2012) on the consumption of the midday meal over two consecutive days, day 1 in the dining room, and day 2 at the bedside. Elderly patients in two rehabilitation wards were observed consuming the midday meal on two consecutive days: day 1 in the dining room and day 2 at the bedside. The patients' intake was recorded by a visual 5-point assessment scale and analyses for protein and energy content using the hospital food services nutrient analysis of the menu. Patients were also surveyed on preference of eating environment through a written survey.

Results: This study found that patients consumed 20% more energy and protein when dining in a communal environment ($P = 0.006$ and 0.01 , respectively). Patients with a body mass index of less than 22 ($P = 0.01$ and 0.01 , respectively) and those with significant cognitive impairment ($P = 0.001$ and 0.007 , respectively) ate 30% more protein and energy in the dining room, and those identified at risk of malnutrition (Malnutrition Screening Tool (MST) ≥ 2) ate 42% more energy and 27% more protein in the dining room, although this was not statistically significant ($P = 0.05$ and 0.16). A total of 86% of surveyed patients favored eating their midday meal in the dining room

Physiological changes

They can be referred to as the unpreventable changes because they are age related. As stage progresses, most elderly experience the following:

Deficiency in the recommended daily allowance for multivitamins and minerals when the energy consumption is inadequate; inadequate food consumption as result of loss appetite because the taste bud is not adequately functioning that is elderly cannot differentiate between sweet and sour, absorption and nutrients usage problems, reduced lean body mass as result of changes in body compositions. Change in body composition is experienced due to the aging progress. Common physiological problems that affect the nutritional status of elderly are sensory loss, poor mouth and dental health, decreased appetite, chewing problems and dependency on help for eating. Malnutrition is accompanied by loss of body weight, muscle mass and strength and is regarded as etiologic factor in the development of sarcopenia and frailty (Kieleswetter ET AL; 2018). Muscle mass depletion is common phenomenon of aging, and the presence of undernutrition exacerbates this condition and may cause progression to frailty and/or functional disability. The loss of physical capacity goes along with reduced mobility and difficulties in daily activities like shopping, cooking and eating and may therefore conversely threaten nutritional status. Sarcopenia occurs when there is a reduction in the lean body mass. The lean body mass is about 45% at age 30 and gradually reduces to approximately 27% at age 70. The reduction in the lean body mass is coupled with an increase in the fat mass. Increment that occur is from 14% to 30% from age 30 to 70 respectively. Naseer et al; (2015), study showed that nutrition is important to preserve immunity and muscle mass in elderly. According to Bell et al;

(2014) studies in hip fracture demonstrates that BMI only identifies a proportion of malnourished patients.

3. EFFECTS OF MALNUTRITION ON THE elderly

Malnutrition has negative effects on many functions of the body. These include cardiovascular, renal, respiratory, gastrointestinal, immunity-related, and mental effects. Because of all these effects, untreated malnutrition leads to a higher rate of morbidity and mortality among the elderly (Kucuk et al; 2017). Visser et al;(2017) points out that, malnutrition has emerged as an important etiological factor in the development of sarcopenia and frailty, two major geriatric health threats, which, in turn, provoke nutritional problems and may further aggravate malnutrition. Determining malnutrition and malnutrition risk at early stages enables taking precautions and initiating appropriate nutritional support on time. By this way the rate of complications of malnutrition can be reduced.

4. PROGRAMS TO HELP SUPPORT NUTRITION OF THE ELDERLY

According to Visser et al; (2017), in 2010, the Joint Programming Initiative (JPI) A Healthy Diet for a Healthy Life (HDHL) was launched to achieve the vision that by 2030 all citizens will have the motivation, ability and opportunity to consume a healthy diet from a variety of foods and have healthy levels of physical activity, and that the incidence of diet-related diseases will have decreased significantly (JPI 2015). Within this initiative, in 2015 a call for a Joint Action ' Malnutrition in the Elderly.

In Europe, Policies and education regarding screening and intervention for malnutrition policies and practices for screening and treatment of

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malnutrition in older persons vary widely across Europe. For example best practice examples exist and serve as models for other countries for healthcare professionals receive to receive education on nutrition knowledge about malnutrition in older persons(Visser et al; 2017).

Specifically in 2010, Western Health introduced the ' Dining With Friends' programme, a supportive communal dining environment in the aged care, subacute setting as part of a broader initiative focusing on patient-centered care (Best Care for Older People Everywhere, BCOP). 8 The ' Dining with Friends' programme commenced in a subacute ward at Williamstown Hospital three days/week and was later initiated in 2011 in a subacute ward at the Footscray Hospital (Markovski et al; 2018).

Screening for malnutrition is an essential measure in the prevention of nutritional problems. Detection of malnutrition can be facilitated by the use of a simple and reliable nutritional screening tool (Ulger, Z et al; 2018) . The Mini nutritional assessment- short Form (Mna-sF) is an easily administered, validated and widely used clinical tool which can be performed in 5 minutes without the The MNA (Mini Nutritional Assessment) has been an extensively used method to identify risk of malnutrition in the elderly and in those that may benefit from early intervention. The MNA is a simple, low cost and non-invasive method that can be done at bedside. Added MNA scores allow one to screen the elderly who have an adequate nutritional status, those who are at risk of malnutrition and those who are malnourished. The MNA consists of anthropometric and global indicators, including information on eating patterns and self-perception of health, such as: reduced food intake; weight loss of > 3 kg body weight; mobility, bed- or chair-bound; psychological <https://assignbuster.com/malnutrition-in-the-elderly-causes-and-intervention-strategies/>

stress; neuropsychological problems; body mass index; inability to live independently; taking > 3 prescription drugs; having pressure sores or skin ulcers; number of full meals eaten per day; consumption of high-protein foods; consumption of fruits and vegetables; amount of liquids consumed per day; inability to feed self; difficulty in self-feeding; self-view of nutritional status; self-view of health status; mid-arm circumference receive home care services or are 50 Indian Journal of Gerontology institutionalized, and of patients who are chronically ill, frail, have Alzheimer's disease or cognitive impairment. It has been demonstrated that the sensitivity of this scale is of 96 per cent, the specificity is of 98 per cent and the prognostic value for malnutrition is of 97 per cent. This method has been broadly used among the geriatric population and a higher prevalence of malnutrition has been associated with the elderly most in need of care (Sunthlia et al; 2016).

CONCLUSION.

As healthcare professionals working within the community setting, it is important to appreciate the physiological changes older adults experience and support them to identify the effect that they are having on their nutritional intake and status. Community nurses can offer and encourage small changes to diet, which will prevent weight loss and the significant impact that this can have on overall health and wellbeing. It is also vital to ensure that older patients are regularly screened to identify any risk of malnutrition and take appropriate action (McGinley, et al; 2017). According to McGinley, et al; (2017) for many older people within NHS community services, they should be recommended to relax their healthy eating habits and restrictions and adapt an energy dense, small and often approach to <https://assignbuster.com/malnutrition-in-the-elderly-causes-and-intervention-strategies/>

eating, especially for those experiencing a lack of appetite. These older people should be advised to eat several small, nutrient rich meals, choose foods that are easy to chew, consider, for example, meals-on-wheels if available, or putting patients in touch with organisations such as Wiltshire Farm Foods or Everdine and Oakhouse Foods. Frozen or fresh ready meals can also help.

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