Nutrition in the elderly: a basic standard of care and dignity for older people

With an ageing UK population people are living longer and enjoying longer periods of retirement. The number of people over the age of 65 years in the UK is projected rise to 20% by 2051 (Office of National Statistics, 2004). The fastest growing section of the population is those aged over 85 years – this sector is projected to reach 3.2 million in the UK by 2033. These figures also reflect trends seen across European countries. The 2008-based national population projections, EuroPop2008, predicted an increase to 30% of people aged 65 years and over by 2060 (Eurostat, 2008). Similarly the number of people aged 80 years or over is projected to treble.

These demographic trends have consequences for developments in public policy and care of the elderly and also add new challenges to delivery of older people's care. Forster and Gariballa (2005) and Elia et al (2008) have highlighted the risk of malnutrition rising with age with a higher prevalence in those in receipt of care and those living in institutions. Low awareness of malnutrition among health- and social-care professionals has been addressed by publications and campaigns by several key parties. Age Concern England (2006) described the growing risk of older people being malnourished or their nutritional status getting worse while admitted to hospital. *Caring for Dignity*, a report by the Commission for Healthcare Audit and Inspection (2007), underlined the need for commitment to nutrition throughout health-care organizations.

The World Health Organization (1971) defined malnutrition as 'the cellular imbalance between the supply of nutrients and energy and the body's demand for them to ensure growth, maintenance and specific functions'. Malnutrition is consistently under-diagnosed and under-treated in both primary and secondary care. The causes of malnutrition are multifactorial. Inadequate diet quality, micro-nutrient deficiencies, chronic conditions, psychological, social and even environmental factors all contribute to under-nutrition. Older people following a major physical illness such as stroke, with other co-morbidities, those from black and minority ethnic communities and those with mental illness have a greater risk of poor nutritional status, which may be under-recognized and associated with worse outcomes. In stroke especially, poor nutrition is widely prevalent and under-recognized (Singh et al, 2004). It is a marker for increased mortality, hospital stay, morbidity and residential placement. Under-nutrition compromises the immune system, resulting in impaired wound healing and increased susceptibility to infection along with impaired physical performance.

Assessment of nutrition

Apart from nutritional screening, which is an initial rapid evaluation method to detect significant risk of malnutrition, nutritional assessment (a more in-depth evaluation) is an integral part of comprehensive assessment and care for older people. Several screening tools exist in clinical practice with MUST (Malnutrition Universal Screening Tool) the most widely used (Malnutrition Advisory Group, 2008).

This tool is suitable for use by a range of health-care workers. It has been validated across a range of health-care settings and assesses weight status, change in weight and the presence of an acute disease likely to result in no dietary intake for more than 5 days. It categorizes subjects into low, medium or high risk of malnutrition and provides guidance on developing individualized dietary care plans. Regular nutritional assessment in stroke and regular reviews are best performed through multidisciplinary evaluation at multiple levels with patients' and relatives' involvement being an integral part of clinical practice.

Recommendations

Despite major improvements in the care of older people and general improvements in attitudes towards care of the elderly, under-recognition and management of under-nutrition remains a major challenge. To address these issues it is important that health-care organizations involved in delivering and commissioning health care are aware of the issues around under-nutrition and provide adequate training and education to all health-care staff.

All acute trusts, primary care trusts and community hospitals should include nutrition as a part of their regular clinical governance framework. There needs to be a commitment to nutrition throughout health-care organizations with a specified lead, and this should be communicated to all staff and patients. Feeding and nutrition is an integral part of dignity in older people's care. It is important to follow National Institute for Health and Clinical Excellence (National Collaborating Centre for Acute Care, 2006) guidelines in relation to nutrition and to implement a recommendation that all patients, on admission to hospital or at their first clinic appointment, should be screened for nutritional status.

As part of a comprehensive assessment, patients should undergo nutritional screening at the time of admission to care homes. Nutritional support should be considered in people who are malnourished and those who are at high risk, and especially in those following a major illness such as stroke. There are many different strategies to improve nutrition – making meals more appetising and more widely available, use of multivitamin or multi-mineral supplements, or oral liquid nutrition. Nutritional support should also be considered in those identified as being at risk or in a state of malnutrition and oral dietary supplements or intravenous nutritional support should be considered and provided when necessary (Mucci and Jackson, 2008).

People admitted to hospital following a stroke must have a swallow assessment so that their nutritional needs can be met. In addition to oral and intravenous support,

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access to the gut directly in stroke patients with dysphagia may be achieved by a nasogastric or percutaneous gastric tubes. Nasogastric tubes have a risk of extubation and aspiration, and aspiration pneumonia and oral complications of enteral feeding including diarrhoea, hyperglycaemia, hypercapnia, electrolyte imbalance and rebound feeding should be addressed by appropriate therapy.

Conclusions

Malnutrition in older people is multifactorial, under-recognized and often undetected by health-care professionals. Addressing nutritional needs improves recovery from illness and general wellbeing of older people. Education and training and multi-agency partnership working between commissioners, providers and regulators of health and social care is key to reduction of malnutrition risks. BJHM

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KEY POINTS

- Malnutrition of older people should have no place in a modern society, yet three million people are living at risk of malnutrition in the UK.
- Older people being admitted to hospital or nursing homes should be screened and assessed for nutritional status.
- The Care Quality Commission and the General Medical Council should ensure that professionals recognize that food and help with eating is a key issue in maintaining the health and dignity of older people.
- Adequate nutritional support, both oral and parenteral, should be provided when necessary.

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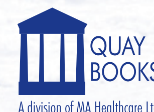

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