Helping your older patients to keep eating

Weight loss is often overlooked in older patients until it is too late. Being aware of the early signs and offering practical advice can help you maintain the health of your older patients.

SALLY JAMES

BSc, DipNutDiet, GradDipCounselling, APD

Ms James was Senior Dietitian, specialising in aged care, at Concord Repatriation General Hospital, Concord, NSW. She now works in private practice as a nutrition consultant in West Ryde, NSW.

Helping older patients maintain their nutritional status is one of the challenges of caring for this group, and eating well and exercising regularly are the most important self-help activities you can encourage. Younger patients and the well elderly can benefit from advice about reducing saturated fat intake, but the most important nutrition message for older, more frail patients is to maintain weight and to eat enough – of anything.

Declining nutritional status is common among older people, and associated with increased mortality and morbidity. It also affects quality of life. Weigh older patients regularly, and intervene at the first sign of progressive weight loss. Any weight loss over 5% should be investigated (see Table 1).

Factors contributing to weight loss

A simple nutrition screening tool may help to identify causes of declining nutritional status in older patients, allowing appropriate management to be commenced.

Frailty

Declining strength or changed abilities (such as a result of stroke) can result in reduced dietary intake caused by difficulty with shopping, cooking, opening containers or using cutlery. An occupational therapy review can help people to minimise their limitations and make the most of their abilities.

In addition, remember that the increasing size of supermarkets often means that grocery shopping is difficult for frail patients.

Lack of skills

In this age group, men have traditionally not assumed responsibility for household duties such as shopping and cooking. For men who are caring for a spouse or living alone, these can be bewildering experiences.

Limited finances

It can be expensive to shop for one. A welfare worker or community credit adviser can help patients with budgeting, and a dietitian can advise

IN SUMMARY

- **Weigh older patients regularly. Any weight loss over 5% should be investigated.**
- **Use a nonconfrontational approach to understand why patients find it hard to keep eating. Ask about appetite, not intake. The factors contributing to weight loss in older patients should be identified before starting treatment.**
- **Review medication. If significant weight loss has occurred, the dosages of all medications need to be reviewed.**
- **Encourage small, regular, energy dense meals and snacks. For the frail aged patient, increasing overall energy intake is more important than reducing salt and saturated fat.**
- **Suggest familiar foods before commercial supplements. High protein liquid supplements have a place; however, they are expensive and need to be used in adequate amounts to be effective. Remember that vitamin supplementation alone will not improve nutritional status.**
- **Consider referral to a dietitian with experience in aged care.**

Table 1. Significant and severe weight loss in elderly patients*

Time interval (months)	Significant weight loss	Severe weight loss
1	5%	>5%
3	7.5%	>7.5%
6	10%	>10%

* Weight loss is lost weight expressed as a percentage of usual weight. Adapted from Blackburn GL, Bristian BR, Maini BS, et al. Nutritional and metabolic assessment of the hospitalised patient. J Parenter Enteral Nutr 1977; 1: 11-22.

patients about cheap, nutritious foods. Good choices include bread, rice, barley, rolled oats, baked beans, powdered milk, and fruit and vegetables in season.

Dental problems

Do the patient's dentures fit? Are any teeth decaying? Sometimes a dental review is all that is needed to help people chew and eat better.

Constipation

Maintaining fibre and fluid intake may be overlooked, especially in winter or when physical limitations make independent toileting difficult. High fibre cereals alone do not prevent constipation – encourage your patients to drink regularly and to keep up their intake of fruit and vegetables. Bananas and dried fruit are always easy to eat if apples and oranges are too hard or messy.

Chronic disease

Chronic disease can affect nutritional status, either directly or indirectly. Neurological disorders such as Parkinson's disease and motor neurone disease are frequently associated with weight loss. Early advice about soft, moist meals that are high in protein and energy should be part of treatment, along with timely referrals to a speech pathologist for assessment of swallowing, and a dietitian for more specialised dietary advice.

Chronic lung disease with its additional nutrient requirements and associated fatigue can make it difficult not only to shop and prepare meals, but to eat. Diabetes and heart disease may affect nutritional status, often as a result of medication or diet used in management.

Table 2. Declining nutritional status: some solutions to contributing problems

Problem	Possible solutions
Difficulty with shopping	Home delivery of foods, community assistance with shopping (can be arranged by an aged care assessment team or a community nurse)
Inability to cook	Frozen supermarket meals, home delivered meals, club meals, takeaway meals Occupational therapy review
Poor appetite	Small, frequent meals and snacks Extra margarine, glucose or skim milk powder Commercial supplements can be considered
Dry mouth	Extra sauces and gravy
Teeth problems	Dental review
Constipation	Fresh fruit, fluids, cereals, dry or tinned fruit
Chronic disease	Anticipating symptoms that affect nutritional status
Loneliness	Community outings or an exercise group
Depression	Treatment for depression (e.g. medication or counselling)

Medication

Many medications commonly prescribed for older patients have side effects that can result in poor appetite. Regular medication review is essential. Consider:

- Is the patient taking unnecessary medications?
- Do medications cause a dry mouth, a change in taste perception or malabsorption of nutrients?
- Is the patient experiencing electrolyte disturbances from diuretics?
- Is constipation, urinary retention or a dry mouth a result of anticholinergic agents?

If significant weight loss has occurred, the dosages of all medications need to be reviewed.

Loneliness

Loneliness often leads to decreased food intake. Interaction such as joining a seniors' exercise class or attending a day centre may provide a new social network. Lunchtime 'friendship clubs' serve the dual purposes of providing companionship and a hot meal.

Depression

Depression can be overlooked and should always be considered when appetites flag. Both doctor and patient may be reluctant to use antidepressant medication, but the results can be powerful. Encouraging the depressed patient to eat without treating the depression is a lose–lose situation.

Dementia

Dementia can be a cause of undernutrition. The patient with a dementing illness

usually has increased energy needs (often associated with pacing or agitation) that can be coupled with forgetting to eat, failure to recognise familiar foods, changes in taste, and difficulties with cutting food, chewing and swallowing.

Denial

Most frail patients know they should be eating better; others believe their intake is better than it actually is. Before you suggest changes, understand why it is hard to keep eating. Use a nonconfrontational approach – for example, asking patients about changes in appetite is less threatening than asking them how much they eat.

What advice do I give?

Identifying the reasons why your patient is not eating well is relatively easy when you start looking; providing practical advice that the patient is willing and able to follow is much harder (see Table 2).

Recommending Meals on Wheels and a high protein liquid supplement may be part of the answer, but more is needed. Some useful resources are listed at the end of this article.

Start with simple advice

Suggesting three meals a day or small, frequent meals and snacks is a good start. A 'meal' may be a good soup and toast followed by a piece of fruit, or a cheese and tomato sandwich followed by tinned fruit and ice cream.

Encourage convenience foods

Many 'heat and serve' meals are a valuable source of nutrition, either alone or with added vegetables or bread, as appropriate. Older people may be reluctant to use frozen vegetables, although these are often cheaper, available in more suitable quantities for people who live alone, and can be easier to carry and prepare.

Suggest a shopping list

A shopping list can help. Include prepared desserts (such as custards or yoghurt), frozen vegetables, tinned soup, convenience meals and 'cook-in' sauces. A shopping list could include:

- ready-made desserts
- frozen meals
- individual frozen pies or quiche
- frozen vegetables
- cheese
- raisin bread
- breakfast cereal
- baked beans
- dried and canned fruit
- tinned soup
- powdered milk.

Suggest variety

Meals on Wheels are a great help when the meals are eaten, but often patients are reluctant to accept the meals, or eat the dessert only. More variety can be provided by a combination of Meals on Wheels or other home-delivered meal schemes, and frozen supermarket meals or takeaway foods such as barbecued chicken or Chinese meals.

Many local community groups offer lunches which provide a social outing as well as a meal; licensed clubs often have cheap midday meals.

Recommend energy dense foods

Recommend energy dense foods rather than bigger meals. For the frail aged patient, increasing overall energy intake is usually more important than reducing salt and saturated fat intake.

Energy dense foods that can be recommended for your patients are listed in the box on this page.

Energy dense foods for frail elderly patients

Fortified milk

Milk can be fortified with milk powder: sprinkle powdered whole milk (half a cup) on 600 mL of cold milk (not low fat milk), and mix (with flavour if desired). Milk that is fortified in this way can be used on cereals, to make up tinned soups, and in drinks. It is cheaper than commercial supplements and more flexible.

Butter and margarine

Butter or margarine can be added to vegetables (including vegetables from Meals on Wheels), and can be spread thickly on sandwiches. Glucose polymers are a cheap, easy way to increase carbohydrate intake, but may not be suitable for patients with poorly controlled diabetes.

Supplements

High protein liquid supplements have a place; however, they are expensive and need to be used in adequate amounts to be effective. Recommend a multivitamin supplement if you think it may be necessary, but remember that vitamin supplementation alone will not improve nutritional status.

Sweet foods

Tastes change, and sweet foods are usually better accepted than savoury foods, especially in patients with a dementing illness. Easy nutritious desserts include tinned fruit with custard, cream or ice cream, individual apple pies or frozen cheesecake. Individual chocolate desserts, creamed rice and crème caramel are easily available in the refrigerator section of the supermarket.

continued

Consultant's comment

The fact that most doctors pay little attention to the nutritional status of elderly patients is a paradox, given that undernutrition may lead to catastrophic outcomes but is potentially reversible.

In elderly patients, undernutrition is associated with impaired immunity, recurrent sepsis and poor wound healing, as well as increased morbidity and mortality, longer and more complicated hospital stays, and significantly increased treatment costs. People at particular risk include those with brain disease (stroke, dementia or Parkinson's disease), a fractured hip, chronic obstructive pulmonary disease, or chewing and swallowing problems. Disabled housebound people are also at risk.

Common but under-recognised risk factors include dyspraxia of swallowing, silent aspiration and very slow eating. Institutional food services need to target people at risk and provide foods that have appropriate consistencies, with sufficient time to consume meals and (if necessary) feeding assistance.

Screening for undernutrition and early interventions are essential. Simple high calorie protein drink supplements are one way to reduce the complications of protein energy undernutrition. All institutions looking after elderly people should fund catering services and nutritional support as a high priority, and promote a multidisciplinary team approach to nutritional support.

Dr Peter S. Lipski
Staff Specialist Geriatrician
Department of Geriatric Medicine
Gosford Hospital, Gosford, NSW

Consider community supports

A home-care worker who will cook an appropriate meal and share a cup of tea can be more cost effective than a regular delivery of meals that are not eaten. Many frail older people can maintain weight well with this type of support.

Concluding comments

Helping your older patients maintain their nutritional status is vital to their quality of life. Weigh patients regularly to be alert for early signs of weight loss, and encourage them to maintain their independence by suggesting practical, ordinary foods, backed up by community supports when needed. MT

Useful resources

1. Reduce the risk. A common sense guide to preventing poor nutrition in older people (1996). Copies can be obtained from The Nutrition Department, Central Coast Area Health Service, PO Box 361, Gosford NSW 2250.
2. Eat well for life: dietary guidelines for older Australians. Consumer pamphlets, booklets and posters can be ordered free of charge by phone (1800 020 103) or the NHMRC website (http://www.nhmrc.health.gov.au). A supporting scientific report can be purchased through government bookshops or by mail order from Ausinfo, GPO Box 84, Canberra ACT 2601.
3. Dietitians Association of Australia, 1/8 Phipps Close, Deakin ACT 2600. Telephone (02) 6282 9555 or email (daacanb@hcn.net.au). The association has a website (www.daa.asn.au) and branches in all States and Territories.
4. Identifying and assisting home based vulnerable people who are nutritionally at risk. A resource manual, checklist for nutritional risk screening and monitoring (available in pads of 50), booklet for patients, family and carers, and training manual can be purchased from the Victorian branch of the Dietitians Association of Australia (Home and Community Care Project), PO Box 1264, Carlton, Vic 3053.