

## “The role of the dietitian in the Geriatric team”

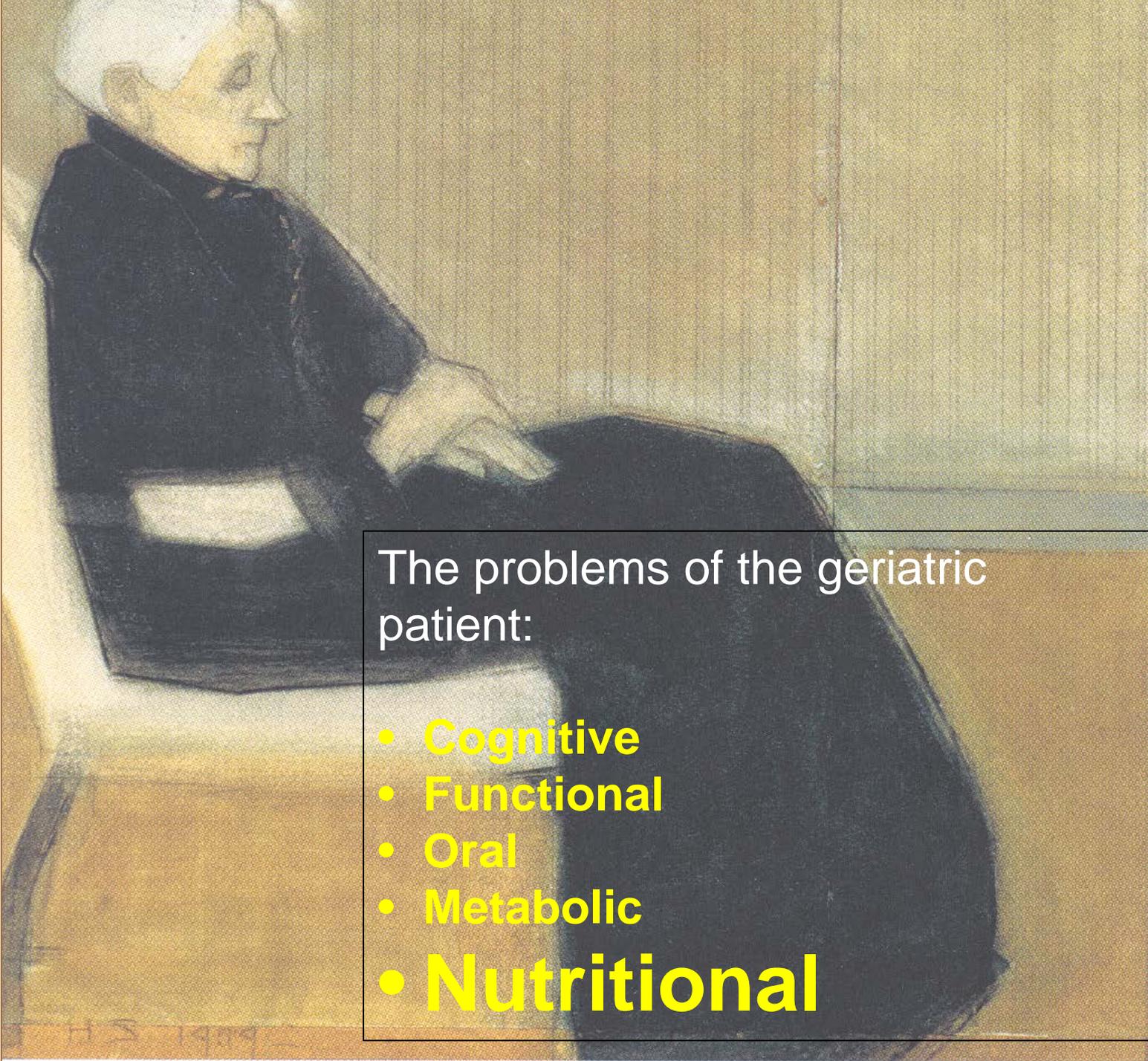
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**Högskolan Kristianstad**

# Healthy→Frail→Sick

- Retired at 59 yrs (mean in Eu)
- Many reach their 100s
- Older adults cover more than a generation
- More healthy and sick individuals
  - The trajectory from health to sickness is individual
- *Nutrition part of both prevention and treatment.*





The problems of the geriatric patient:

- **Cognitive**
- **Functional**
- **Oral**
- **Metabolic**
- **Nutritional**



# ESPEN

*The European Society for Clinical Nutrition and Metabolism*

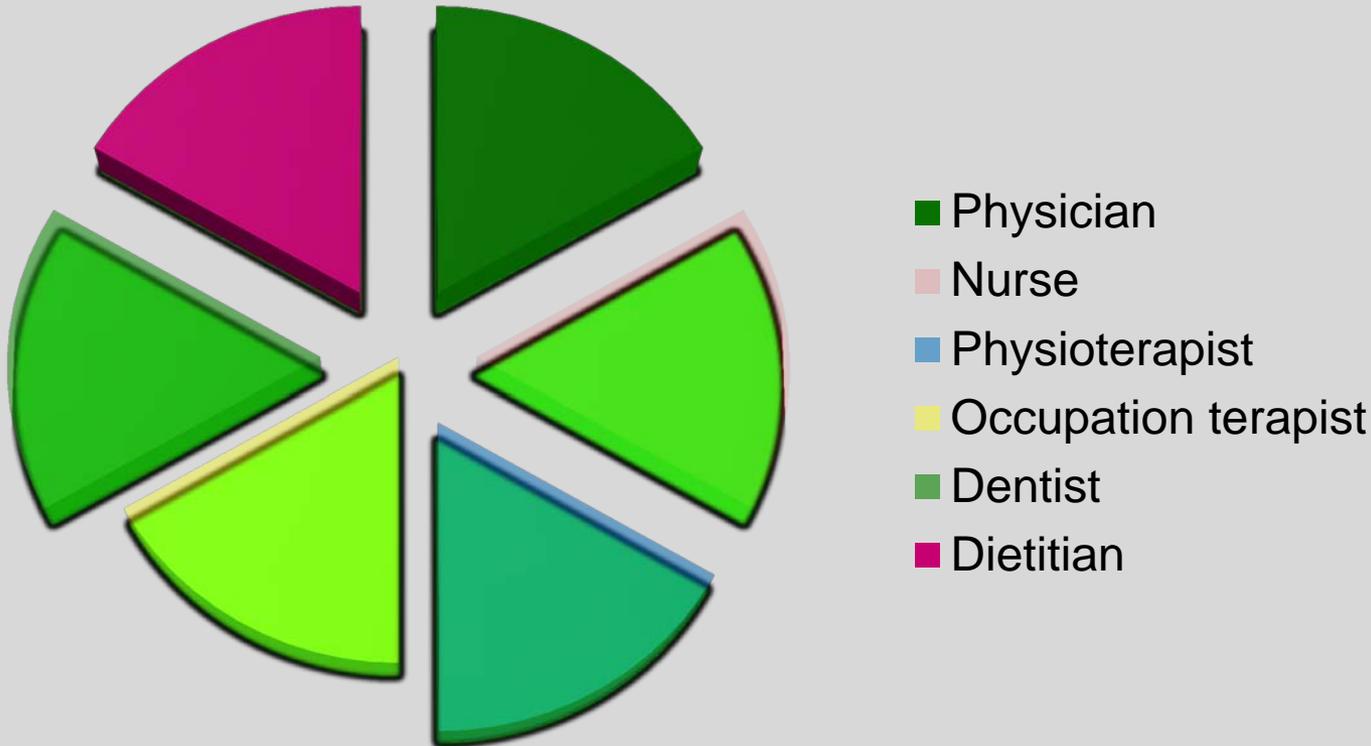
## How many?

Malnutrition is reported present in

- 5% of the entire population
- 10% in those over 65 years
- 15% in ages 75-80 living at home
- 35-40% of all hospital admissions
- up to 60% in care homes
- 20 million in EU

# What is the added value of the dietitian?

**Geriatric team**



# The role of the dietitian



## **Briefing Paper on the Role of the Dietitian in the Prevention and Management of Nutrition-related Disorders in Older Adults**

Dietitians play a key role in the prevention and management of nutrition-related disorders in older adults (i.e. in this paper referred to as individuals aged over 65 years). Dietitians, as members of integrated multidisciplinary teams, are uniquely qualified to apply scientific evidence to the promotion of healthy eating, individualised nutritional therapy and counselling to individuals and groups (Arvantitakis et al., 2009).



# *Dietetic core competences working with older adults*

- Knowledge, skills and attitudes which underpin gerontology and geriatric nutrition.
- Understanding of basic principles of gerontology and geriatrics, age-related changes in physiology and metabolism



# *Dietetic core competences working with older adults*

A 'person-centred' approach that requires an understanding of food habits for this age group.



What are the nutritional problems?



# Nutritional problems in relation to age

- Appetite regulation
  - Anorexia of ageing : An unintentional decline in food intake, and, as a result, loss of body weight, that begins near the end of life; it represents a sign of failure to preserve steady levels of body weight and energy stores.\*
- Inflammation
  - Loss of fat free mass and weight
  - ↓ appetite
- Sensory properties impaired

\* Donini et al. International Psychogeriatrics, Vol 15 No 1, 2003, pp 73-78



# Nutritional problems in relation to age

- Dysphagia
- Alterations in metabolism and body comp
  - ↑ insulin resistance
  - ↓ muscle protein syntesis
  - ↑ body fat ↓ muscle mass
- Cognitive impairment
  - eating disabilities



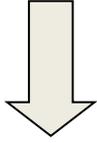
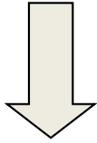
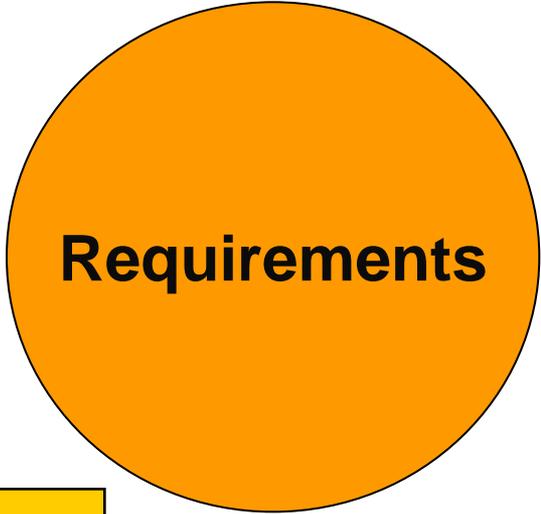
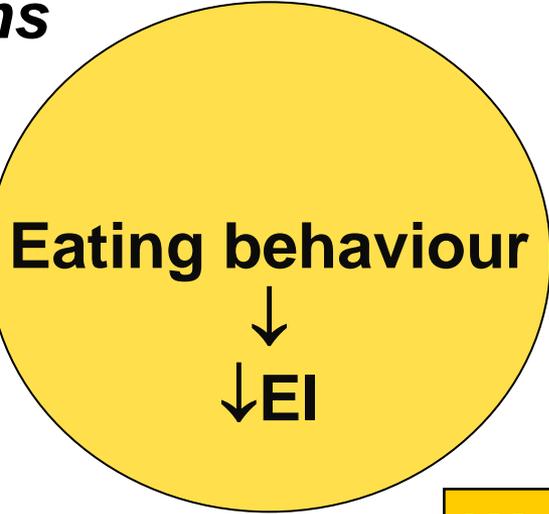
Negative energy balance



*Etiology*

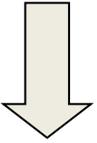
**Disease** - physical or mental  
**Disability**  
**Treatment** - mainly drugs

*Symptoms*



*Signs*

**Weight loss**



*Diagnosis*

**Disease Related Malnutrition**



# What does the dietitian do?



# The nutritional care process

- Malnutrition risk screening
- Nutritional assessment
- Diagnostic procedure
- Nutritional care plan
- Nutritional care
  - Nutrition therapy
- Monitoring and evaluating
- Documentation

# Screening is the entry to a structured process

- **MNA** (Minimal Nutrition Assessment)
- **NRS 2002** (Nutrition Risk Screening)
- **MUST** (Malnutrition Universal Screening Tool)
- **SGA** (Subjective Global Assessment)

# Nutrition Assessment

- Client History
  - Social situation
- Biochemical Data e.g.
  - Glucose, D-vit status, Albumin
- Anthropometric Measurements
  - BW, BMI, body composition, HGS



# Nutrition Assessment

- Nutrition-Focused Physical Findings
  - Weight loss, dysphagia, food and nutrition intake, GI, cognition, eating behaviour etc
- Food/Nutrition-related history e.g.
  - Food habits
  - Food preferences
- Calculation of energy and protein needs



# Eating behaviour causing malnutrition

- Eating all meals *but too little*
- Limited food choice
- Eating only one or few meals
- *Can't eat* without assistance
- Eating behaviour differs from day to day

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# Nutrition diagnosis statement

## **Inadequate oral intake (NI-2.1)**

*related to*

reduced appetite, altered taste, pain,  
and sore mucosa due to medication;

*as evidenced by*

- 4% weight loss in 2 weeks
- Energy intake covering 40% of estimated energy needs



# Nutrition diagnosis

## **Unintended Weight Loss (NC 3.2)**

*related to*

inappropriate food choices

*as evidenced by*

- 10% weight loss in 4 weeks
- Energy intake covering 65 % of estimated energy needs



# Intervention- Nutrition Prescription



- Unik med 2 kcal/ml
- 400 kcal per flaska (200 ml)
- Høgt proteinnehåll, 18 g (18E%) per flaska (200 ml)
- Låg laktoshalt, (< 0,1g/100 ml)
- Två goda smaker: aprikos och vanilj

- 1800 kcal high energy, high protein diet with-modified texture
- Oral nutrition supplements high energy/high protein (2 kcal/ml)
  - 50 ml x 4 times per day



# Nutrition therapy

Oral nutrition

Medical Nutrition

Diet

ONS

Tube feed

Parenteral  
nutrition

Food choice  
Meal pattern  
Cooking methods

Special diets  
Food modification:  
Food fortification  
Texture modification

Enteral nutrition

Feeding assistance



# Meal pattern

Meal	Time	Distribution of energy	
		(%)	kcal
Breakfast	07.00-08.30	15-20	320-430
In between	09.30-10.30	10-15	210-320
Lunch	11.00-13.00	20-25	430-540
In between	14.00-15.00	10-15	210-320
Dinner	17.00-18.30	20-25	430-540
Evening	20.00-21.00	10-20	210-430



# Prescription defined by:

- Indication
- Goal
- Ethical considerations
- Type of therapy
  - Timing
  - Amount
- Evaluation
  - Outcome



# Ethical considerations

”While reducing morbidity and mortality is a priority in younger patients, in geriatric patients maintenance of function and QoL is often the most important aims”

# In the inter-professional care of older adults, dietitians should:

operate at all levels:

prevention,  
diagnosis,  
intervention,  
monitoring

to maintain or improve nutritional health and promote active and healthy ageing and quality of life in older people.





Thank you