

Assessment of Risk Factors for Malnutrition, such as Food, Budgetary Restrictions, Social Isolation, Chronic Disease, and Physiologic Changes, as well as the Nutritional Requirements for Elderly Patients

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Abstract

The nutritional condition of adults over 65 has changed as a result of physiologic and psychological changes. Actually, this group is more at danger from malnutrition than from fat. This article looks at the nutritional needs for seniors as well as the risk factors for malnutrition, including food, financial constraints, social isolation, chronic disease, and physiologic changes. Assessment and nursing interventions are also presented.

Keywords: Nutritional status; Physiologic; Malnutrition; Nutrition; Older patients

Introduction

In a manner, this was a distinguished gathering of older folks. Its members could relocate since they have relatives who can take care of them. But if one were to conduct interviews with every member of the group, a variety of food problems would definitely come out. Chronic diseases and poor oral hygiene are immediately distinguishable. More investigation may reveal a career who has been caring for an ill spouse for months, as well as at least one individual who spends the majority of mealtimes alone, looking out a window and hardly picking at meals [1,2]. In the elderly population, nutrition plays a crucial role in maintaining health and slowing the ageing process. In this population, malnutrition is more common and is linked to declines in functional status, impaired muscle function, decreased bone mass, immune dysfunction, anaemia, reduced cognitive function, poor wound healing, delayed post-operative recovery, higher hospital readmission rates, and mortality. Age-related changes in cytokine and hormone levels, changes in fluid electrolyte control, decreased lean body mass, decreased appetite, and decreased energy expenditure all contribute to slower stomach emptying and diminished sensations of taste and smell. The complicated aetiology of malnutrition in older persons is also influenced by pathologic changes associated with ageing, including chronic illnesses and psychiatric disorders. The Malnutrition Universal Screening Tool is often used in clinical practise, and nutritional screening is crucial to identifying and treating individuals at risk. A holistic approach to management is necessary, and underlying issues such chronic sickness, depression, medication, and social isolation must be addressed. Patients who are physically or mentally impaired require particular care and consideration. In patients at high risk or in patients unable to satisfy daily needs, oral supplements or enteral feeding should be taken into consideration. Age-related physiologic and psychological changes make poor nutrition conceivable. In fact, even in America, where obesity is on the rise, undernutrition and malnutrition remain frequent among elderly people (age of 65 and older). The American Society for Parenteral and Enteral Nutrition defines malnutrition as "any disturbance of nutrition status, including difficulties stemming from a lack of nutrient intake, impaired nutrient metabolism, or over-nutrition." There are a lot of factors that might cause it, including (1) inadequate intake (2) poor absorption, (3) nutrient loss via diarrhoea, excessive sweating, bleeding, or renal failure, (4) drug addiction, and (5) infection [3].

40% to 60% of older adults admitted to hospitals are either

malnourished or at risk for it, according to the Nutrition Screening Initiative (NSI), a multidisciplinary coalition led by the American Dietetic Association and the American Academy of Family Physicians. Malnutrition affects patients receiving home care at a rate of 20% to 60%. This is important information for those in charge of these patients' care because malnutrition is associated with more expensive and prolonged hospital stays. A person who is malnourished is also more prone to have weaker muscles and slower healing wounds. Additionally, pressure ulcers, infections, and surgical complications are more likely to affect them. These figures clearly show that nurses today in all healthcare settings must be vigilant to detect undernutrition and utilise the appropriate therapies. This article will focus on the macronutrients (carbohydrates, proteins, and fats) as well as the physiologic and psychological changes that make undernutrition a severe danger for older people in order to address this issue.

Types of poor nutrition

The type of undernutrition that most commonly affects elderly people is the protein-energy form. It might be brought on by either a decrease in intake or the hyper metabolism linked to specific disorders (such as trauma, fever, and surgery). According to the Institute of Medicine, "clinical and biochemical evidence of insufficient consumption" is required for a diagnosis of protein energy undernutrition (IOM). Lethargy, a low body mass index (BMI), and biochemical evidence such decreased serum albumin or other serum amounts of protein. Marasmus and kwashiorkor are two forms of undernutrition in protein and calories. Although obesity is a major public health problem in the US and throughout the world, it is uncertain what damage it poses to older people. Obesity is a dietary problem that affects elderly persons rather commonly. It has not been demonstrated that a high BMI in older people predicts death, and there is some evidence to suggest that

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being overweight as one ages may serve as a protective factor against some conditions like hip fractures. Also poorly defined and lacking in evidence-based support are the alternatives for treating obesity in the elderly. The IOM contends that while assessing the benefits and risks of weight loss in obese older people, each unique situation must be taken into account. Lean body mass (body tissues not containing fat or fat-free mass), which is already declining with age, may not necessarily be appropriate in older persons since the loss of fat-free mass is associated with considerable morbidity and death. Older folks may actually have greater optimum body weights than younger adults, according to a theory [4]. The body's requirements for calories, grammes of protein, and water fluctuate as we age due to physiologic changes. The IOM states that as people age, their lean body mass steadily decreases and their body fat levels increase. Reduced basal metabolic rate brought on by lean body mass reduction decreases elderly people's energy needs, or essential calories. However, owing to illness, injury, stress, and level of activity, a person's overall daily needs may increase.

A lack of nutrition is more likely to occur in older people as a result of dietary, economic, psychological, and physiological factors. Risk factors for poor nutrition in older people include lack of appetite, swallowing or eating issues, inadequate hot meals, eating less than two meals per day, and having little or no hunger. Some elderly people have begun eating fewer meals per day out of need, giving up bread and juice in favour of healthier alternatives, and grocery shopping on a tight budget. Additionally, those on fixed incomes could change their buying habits depending on the day of the month since they typically only receive money once each month. Fresh veggies can be purchased when the monthly check comes in, but beyond 30 days, purchases could only be of inexpensive nonperishables like cold cereal [5]. Older people who live alone may lose their desire to cook due to loneliness. Shahar and colleagues found that widows are more likely to lose weight since their appetites and pleasure of food tend to deteriorate with time. Others who are elderly may find it difficult to cook meals for themselves due to physical restrictions or a lack of culinary skills. Finally, if older persons lack access to transportation to stores, they may be at a greater risk for undernutrition, especially those who live in remote regions.

Elderly people are more likely to have chronic conditions that restrict their ability to consume. For instance, a disability may make it challenging to prepare or eat meals, and dejection may cause one to lose their appetite.

Poor dental health, which includes having cavities, gum disease, missing teeth, and xerostomia, or dry mouth, which makes it challenging to "lubricate, masticate, and swallow food," is another risk factor. Antidepressants, antihypertensive, and bronchodilators can all make xerostomia worse. Older people are more susceptible to malnutrition due to two physiological changes: a decline in lean body mass and re-distribution of fat around internal organs. These changes lend some support to the idea that older people require fewer calories. Because lean body mass contains metabolically active tissues, it burns and consumes more calories. When lean body mass decreases, calorie needs rise. Additionally, anthropometric measures may be impacted by changes in spine shortening, skin turgor, elasticity, compressibility, and thickness. Changes in taste, which can be brought on by medications, dietary restrictions, or taste bud atrophy, are the final element that can impact nutrient intake.

Diagnosis and testing

Given how important nutrition is to protecting older people's health and avoiding disease, nutritional assessments should be

performed often while caring for this demographic. A few of the many existing typical test components include calculating weight, height, weight history, and functional limits. To determine status, however, a more complete assessment is necessary. "Clinical, nutritional, and social histories; anthropometric and biochemical data; as well as drug nutrient interactions" are taken into consideration in this. Assessment of food intake is essential in any therapeutic setting. If a patient has lost weight, is hypermetabolic, has low blood protein levels, or has wounds that aren't healing properly, nurses or nursing assistants may be required to record intake using a calorie count (also known as a nutritional intake analysis) for a preset time period [6,7]. This is especially important if it's not clear whether a patient's diet is meeting his needs. An outpatient may seek a nutritionist to provide a food-frequency or dietary-recall questionnaire, in which the patient notes everything he has ingested over a set period of time (often 24 hours), in response to similar concerns. A person's height, weight, and body mass index (BMI) are measured through anthropometry in order to assess their nutritional status and spot obesity and underweight. Given the importance of these two metrics, nurses should exercise discretion when assigning this work to nursing assistants. Inter rater reliability can be established by rechecking the patient's measures and comparing them with the nursing assistant's findings, if they want to do so. It is suggested that you do this frequently. A referral to a nutritionist should be made as soon as undernutrition is identified or suspected. In addition to consulting a multidisciplinary team with nutrition knowledge, a pharmacist may review a patient's prescriptions to check for drug-nutrient interactions (many medications can cause anorexia or change taste or appetite). The following techniques can help your patients' nutritional status [8-12]. People with dry mouth are recommended to stay away from things like coffee, alcohol, smoking, dry, clunky, spicy, salty, and meals that are very acidic.

Other measures that the patient might take include applying petroleum jelly to their lips and dentures, sipping water often, and chewing sugarless hard candy or gum to increase salivation (not recommended for people with dementia or dysphagia).

Improving diet

- You might employ a variety of strategies to encourage midday eating in the hospital setting.
- Take a stroll after meals to gauge how much food is being consumed and whether help is needed.
- Take your breaks before or after meals whenever feasible to ensure there is adequate staff available to help patients with meals.
- Encourage relatives to stop by for meals. Ask them to bring favourite home goods as long as they follow the patient's diet. Learn what the patient likes to eat [13-15].
- Suggest modest, regular meals that are high in nutrients to assist patients recover or maintain their weight. Ask the nutritionists to provide healthful snacks.
- Bedpans, urinals, and emesis basins should be removed from rooms before meals.
- To reduce the chance of discomfort or nausea during mealtimes, use analgesics and antiemetics as prescribed.
- Serve patients food in a chair if they can readily get out of bed and stay seated.
- To encourage a calmer atmosphere when feeding the patient,

sit at her eye level and make eye contact with her.

- Order a late food tray or keep food warm if patients aren't in their rooms for meals. Avoid interrupting patients for rounds and less urgent operations during mealtimes.
- Before a meal is provided, help patients with their dental hygiene and denture placement.

Discussion

If elderly people aren't eating enough, they should start getting nutrition-specific treatment if the benefits of increased nutrition exceed the risks. Risks associated with parenteral nourishment include infections due to catheters, hyperglycemia, metabolic bone disease, aberrant fluid and electrolyte balances, and high liver enzyme levels. Some risks of enteral tube feeding include aspiration pneumonia, fluid and electrolyte imbalances, feeding intolerance, and gastrointestinal issues.

Conclusion

Older patients receiving parenteral nourishment at home may not receive the same degree of professional care as older patients receiving tube feedings, who are frequently monitored at home. In a recent study of elderly people receiving home enteral feeding, challenges led to unplanned physician visits and readmissions, indicating the clear need for a multidisciplinary approach to monitoring these patients at home.

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Conflict of Interest

Author declares no conflict of interest.

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