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Nutrition management in seniors with malnutrition

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Aim

The aim of the study was to find out the incidence rates of risk of malnutrition and malnutrition in seniors living at home and in an elderly care facility, separately for both genders. We also aimed to determine the variability of BMI value in different nutritional statuses of seniors.

Theoretical framework

The ageing processes can also be significantly influenced by nutritional factors. Nutritional disorders are frequent in the elderly. Adverse nutritional status negatively affects the overall health, physical and mental status, and quality of life of the elderly. Malnutrition is more common in this age group. According to the European Society for Clinical Nutrition and Metabolism (ESPEN), malnutrition ("mal" – "poor" nutrition) is a condition resulting from a lack of nutrient absorption or a lack of nutrient intake that leads to an altered body composition

(both weight and muscle mass reduction), which leads to reduced physical and mental performance, impaired function and even the development of diseases. The term malnutrition includes undernutrition, undernourishment – nutrient deficiency, but also overnutrition – intake of more nutrients than needed. Malnutrition affects up to 39% of seniors hospitalized or living in a social service facility, and 1 in 3 seniors suffers from malnutrition in the home environment.

Methods

To achieve the objectives, we chose a standardized nutrition questionnaire – the Mini Nutritional Assessment, which was complemented with our own questions. The research sample consisted of 196 seniors. One of the inclusion criteria for the study was age 65 years and older. The methods of descriptive statistics, Pearson's $\chi 2$-test and Kruskal-Wallis test, were used for statistical analysis of the data.

Results

The incidence of risk of malnutrition was noted in 73.47% of seniors, normal findings in 26.53%. The presence of significant differences in the incidence rate of risk of malnutrition according to the type of housing of seniors ($\chi 2$= 0.03; df = 1; p-value = 0.861) was not confirmed. The incidence in both groups was approximately 33%. There were no statistically significant differences in the incidence of risk of malnutrition by gender of seniors ($\chi 2$ = 0.272; df = 1; p-value = 0.601). The incidence in both groups is approximately 38%. Pearson's $\chi 2$ test also did not confirm the presence of significant differences in the incidence rate of malnutrition between genders ($\chi 2$= 0.027; df = 1; p-value = 0.869). The incidence in both groups is approximately 38%. Statistically significant differences exist in the incidence of risk of malnutrition by patient age groups ($\chi 2$= 14.150; df = 2; p-value < 0.001). The risk of malnutrition decreased significantly with each age group. Statistically significant differences in the incidence of malnutrition were observed in individual age groups ($\chi 2$= 13.163; df = 2; p-value = 0.001), with the presence of malnutrition increasing with the age of seniors. The median BMI was significantly different for each nutritional group despite some overlaps (Kruskal-Wallis $\chi 2$ = 34.958, df = 2, 50 p-value < 0.001). The highest value was found in patients in normal condition (median = 26.72; min-max = 21.48-53.57), lower in patients at risk of malnutrition (median = 24.34; min-max = 17.09-30.59), and the lowest in patients suffering from malnutrition (median = 20.90; min-max = 16.14-28.39).

Theoretical and practical relevance of the work

Early prevention and treatment of malnutrition in the elderly must be comprehensive and properly indicated under the supervision of a physician. It is necessary to individually identify the causes of malnutrition and try to eliminate or alleviate them. We recommend that nurses regularly assess the nutritional status of seniors and provide timely nutritional intervention when needed. Nutritional intervention includes optimizing the diet consumed as well as adding complex enteral preparations that are easily digestible. In justified cases, appetite-enhancing preparations may also be administered. The patient's psychological aspect, motivation and the social dimension of eating are also crucial. Simple interventions by nurses (adapting eating patterns to the mental and physical abilities of the senior), the use of appropriate compensatory aids (e.g. the use of straws or special cups), assistance with eating, etc. can also be helpful. We also recommend that emphasis should be placed on communication with the senior, to find out the senior's perspective on his/her health, to assess and meet his/her nutritional and other needs.