Week 11: Geriatric Bootcamp Dysphagia and Malnutrition

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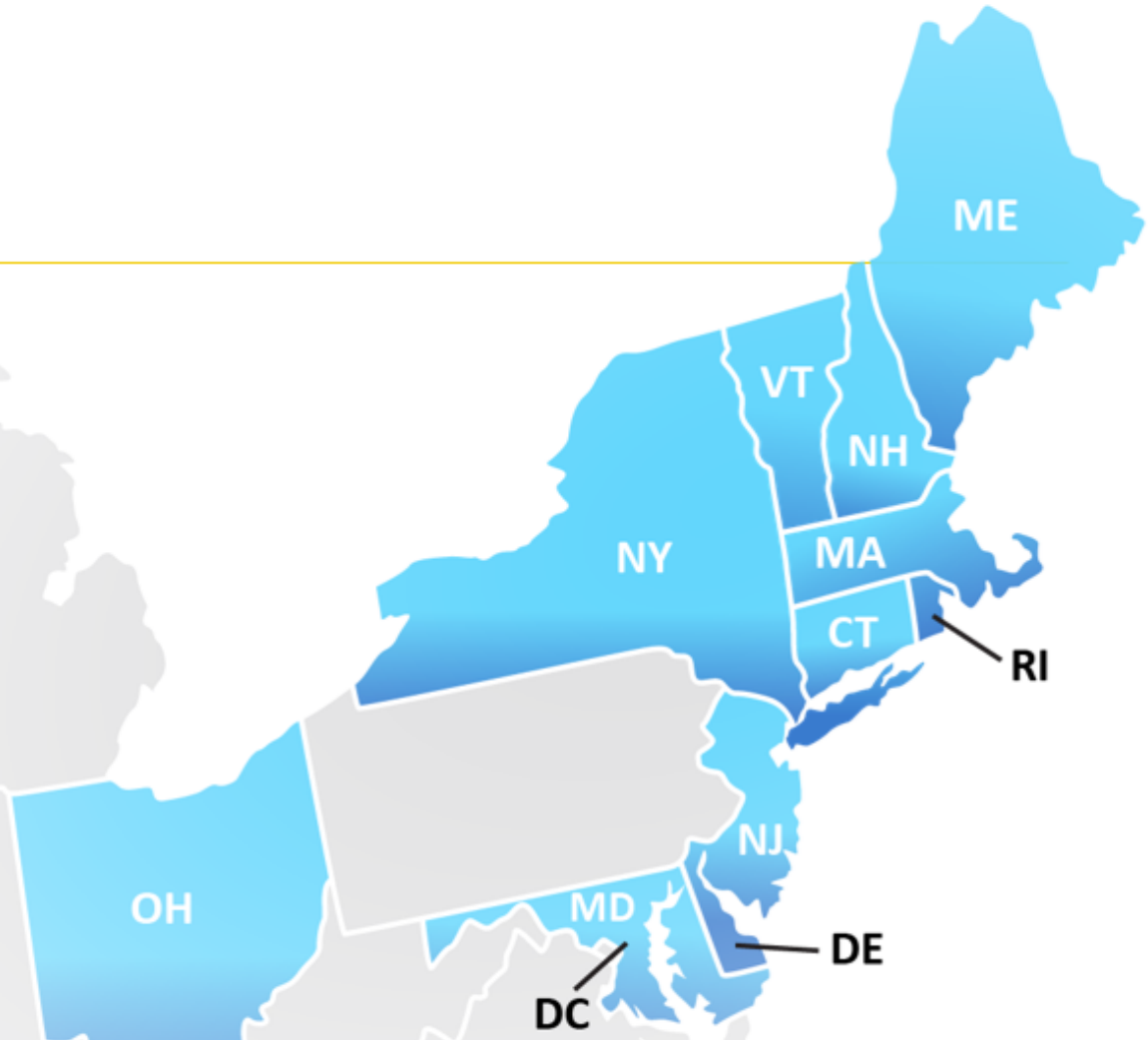

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Malnutrition and Dysphagia in Long-term Care

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Objectives

1. Define malnutrition and dysphagia in LTC residents.
2. Describe a strategy for evaluation and prevention of malnutrition and dysphagia.
3. Describe the approach of comfort feeding with end-stage dementia.

Definition of Malnutrition

Academy of Nutrition and Dietetics:

Inadequate intake of protein and/or energy over prolonged periods of time resulting in loss of fat stores and/or muscle stores, including starvation-related malnutrition, chronic disease or condition-related malnutrition and acute disease or injury-related malnutrition.

As many as 50-60% of LTC residents are at risk for unintended weight loss and malnutrition.

Malnutrition: Contributing Factors

Factors associated with aging

- Impairments
- Psychosocial factors
- Physical changes of aging
- Chronic disease
- Polypharmacy

Factors potentially associated with institutionalization

- Staffing challenges
- Limitations of food delivery systems
- Timing of menu selection vs service
- Challenges of bulk meal preparation, overly restrictive therapeutic diets, limited menus

Consequences of Malnutrition

- Loss of strength and function/increased risk of falls
- Depression
- Lethargy
- Immune dysfunction/increased risk of infection
- Delayed recovery from illness
- Pressure injuries/poor wound healing
- Increased chance of hospital admission and readmission
- Increased treatment costs
- Increased mortality

Evaluating Malnutrition

Most important criteria to identify and evaluate:

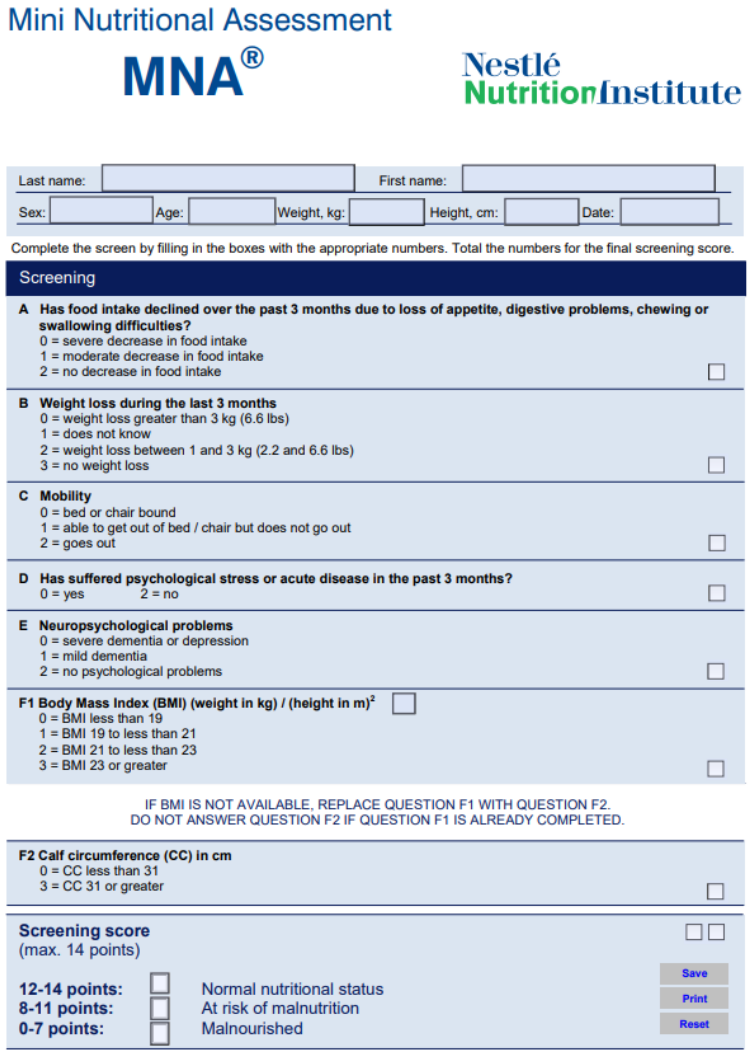
1. Insufficient energy intake
2. Weight loss/low body weight
3. Loss of muscle mass
4. Loss of subcutaneous fat
5. Localized or generalized fluid accumulation that may sometimes mask weight loss
6. Diminished functional status as measured by hand grip strength

Evaluating Malnutrition: Screening & Assessment

Screening Tool:

MNA-SF

(Mini Nutritional Assessment – Short Form)



Mini Nutritional Assessment

MNA®

Nestlé NutritionInstitute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F1 Body Mass Index (BMI) (weight in kg) / (height in m)²
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater

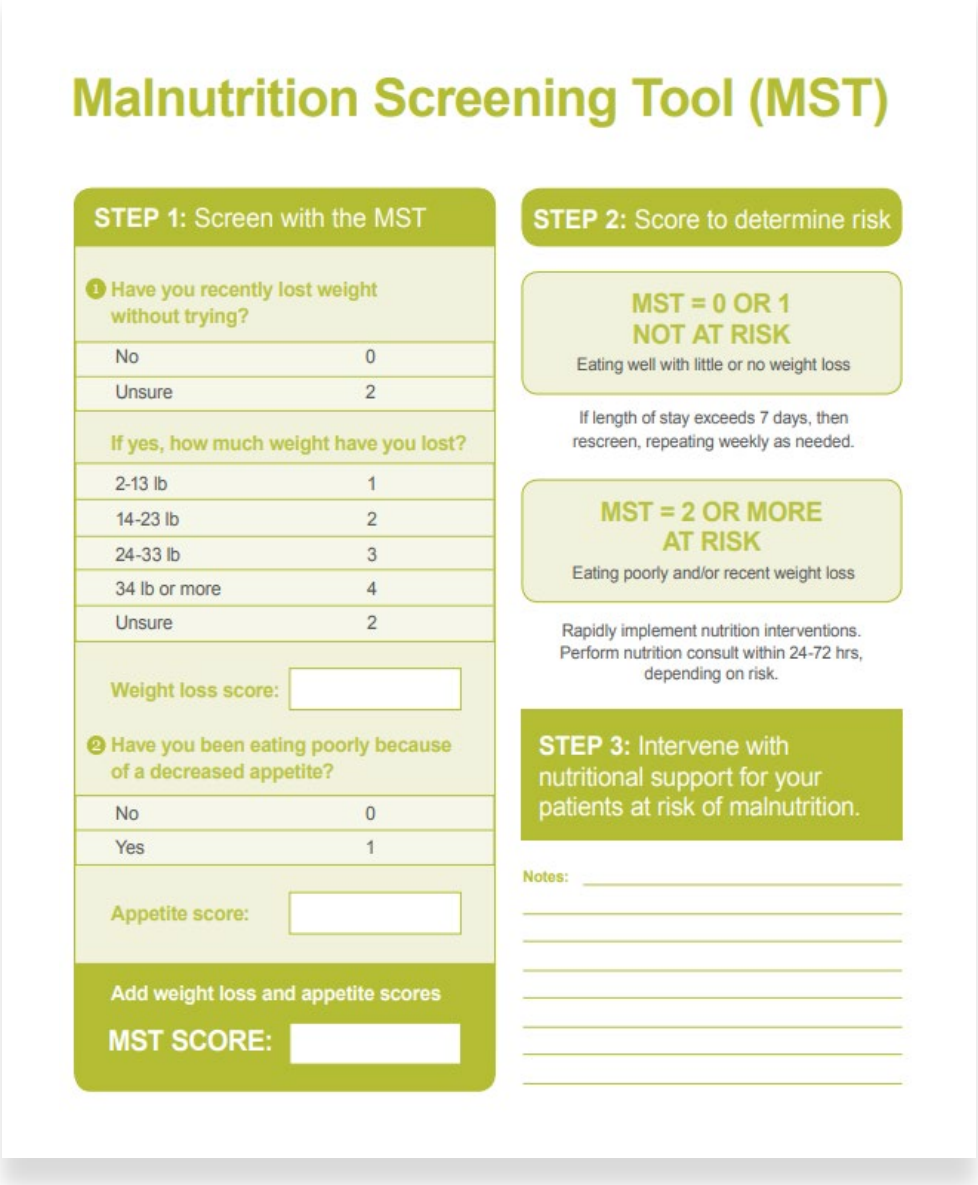
Screening score
(max. 14 points)

12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished

Save Print Reset

Evaluating Malnutrition: Screening & Assessment

Screening Tool:
Malnutrition Screening Tool (MST)



Malnutrition Screening Tool (MST)

STEP 1: Screen with the MST

1. Have you recently lost weight without trying?

No	0
Unsure	2

If yes, how much weight have you lost?

2-13 lb	1
14-23 lb	2
24-33 lb	3
34 lb or more	4
Unsure	2

Weight loss score: ____

2. Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score: ____

Add weight loss and appetite scores

MST SCORE: ____

STEP 2: Score to determine risk

MST = 0 OR 1
NOT AT RISK
Eating well with little or no weight loss

If length of stay exceeds 7 days, then rescreen, repeating weekly as needed.

MST = 2 OR MORE
AT RISK
Eating poorly and/or recent weight loss

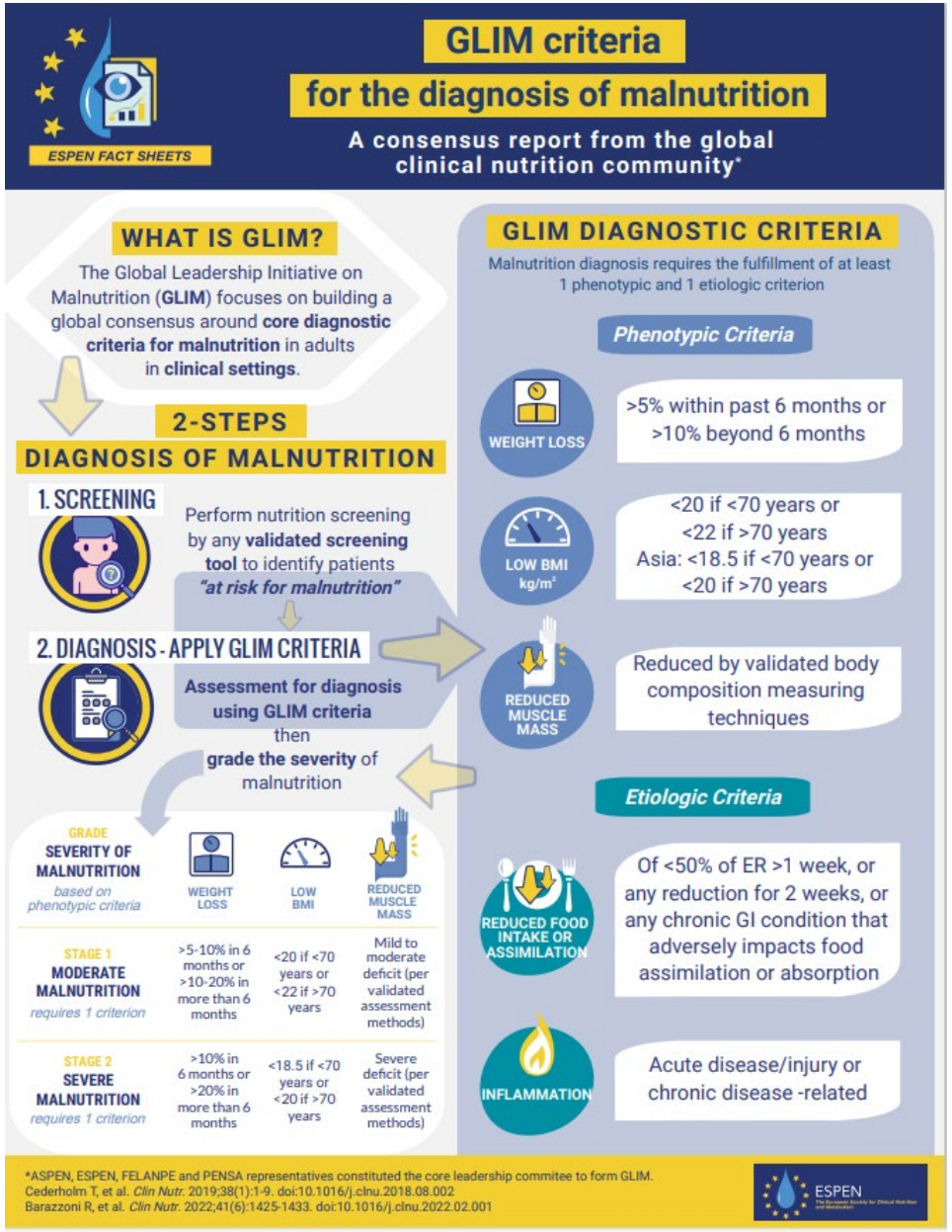
Rapidly implement nutrition interventions. Perform nutrition consult within 24-72 hrs, depending on risk.

STEP 3: Intervene with nutritional support for your patients at risk of malnutrition.

Notes: _____

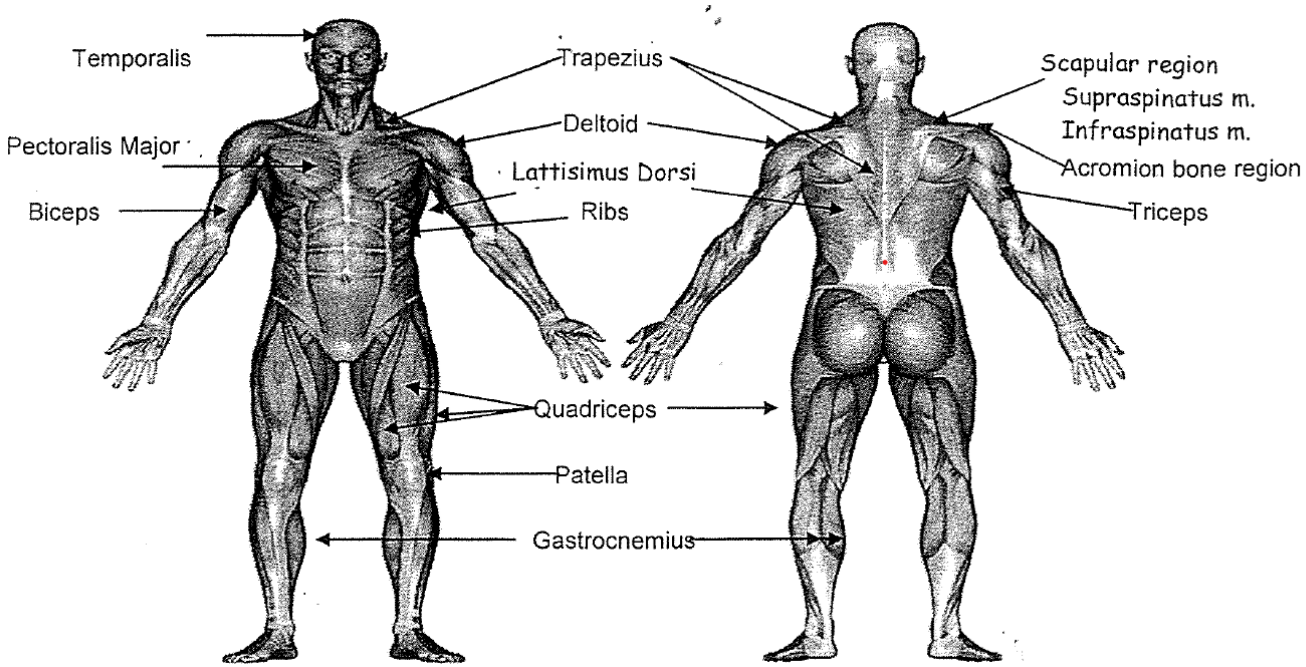
Evaluating Malnutrition: Screening & Assessment

Assessment Tool:
Global Leadership Initiative on Malnutrition (GLIM)



Evaluating Malnutrition: Screening & Assessment

Assessment Tool: Comprehensive RD Assessment including **Nutrition Focused Physical Exam (NFPE)**



Preventing Malnutrition

- Snack program
- Fortified food and beverage program
- Med pass with a 2 kcal/ml oral nutrition supplement
- Weights!
- Timely assessment of any unintended weight loss
- Oral care
- Meal times: “all hands on deck”
- CNAs in care plan meetings and skin/weight committee meetings
- Examine dining program
- Liberalized/individualized diets (Pioneer Network)

Dysphagia and Aspiration - Definitions

Dysphagia – a swallowing disorder that can range in etiology and severity

Aspiration – when food, liquid, saliva, gastric contents, or foreign object enters the airway and progresses below the level of the vocal folds

Silent Aspiration – aspiration which occurs without coughing, choking, etc.

Aspiration Pneumonia (PNA) – a pulmonary infection that results from foreign substances entering the lung

Dysphagia affects 12-53% LTC residents.
Aspiration PNA is the 5th leading cause of death in patients 65 yrs or older,
3rd leading cause of death in patients 85 years or older.

Dysphagia and Aspiration: Evaluation and Prevention

Understanding Signs and Symptoms of Dysphagia

- Extra effort or time needed to chew or swallow
- Food or liquid leaking from the mouth or getting stuck in the mouth
- Weight loss or dehydration from not being able to eat or drink enough

Understanding Signs and Symptoms of Aspiration

- Poor secretion management
- Coughing during or after eating or drinking
- Clearing throat during or after eating or drinking
- Wet or gurgly sounding voice during or after eating or drinking
- Recurring pneumonia or chest congestion after eating or drinking
- Watery eyes or reddening of face during or after eating or drinking

Dysphagia and Aspiration: Evaluation and Prevention

- Dysphagia training for all frontline staff
- Dining program
- RDs are not SLPs!
- **Dementia training for all staff**

Dementia in Long-Term Care

- Highest risk population for malnutrition and dysphagia/aspiration
- According to one study, 86% of people with advanced dementia develop a feeding problem, and the onset was associated with 39% mortality at 6 months

Dementia and Dysphagia: Behaviors

- Difficulty recognizing food items
- Difficulty using utensils
- Food falling from mouth
- Plays with food
- Pushes food away
- Holds food in mouth
- Spits out food
- Chews without swallowing
- Eats only desserts
- Easily distracted by other items or residents
- Eats paper goods or other objects
- Hides food
- Decreased attention span/difficulty sitting for meals

Dementia and Dysphagia: Strategies

- Simplify
- Avoid distractions
- Relaxing music
- Lighting
- Extra time
- Adaptive equipment
- Physical assistance
- Hand feeding if necessary
- Always maintain dignity!

End-Stage Dementia and Nutrition

- There is no way to prevent recurrent aspiration in end-stage dementia
- Placement of feeding tubes is not uncommon in this population
  - One study showed that approximately one-third of nursing home residents with advanced cognitive impairment have feeding tubes
- Very emotional time for families and other caregivers: “Food Fight”
- **How can we as healthcare professionals reframe this discussion?**

End-Stage Dementia and Nutrition

- Compassion
- Early education
- Early clarification of healthcare wishes
- Objective explanation of feeding tubes as well as the dying process

➢ Introduce the concept of palliative care through these conversations:

COMFORT FEEDING

“Comfort Feeding Only” (CFO)

The New Dining Practice Standards and The American Geriatrics Society support careful hand feeding as a more compassionate alternative to tube feeding.

A CFO order can help residents and proxies make decisions regarding oral feeding versus enteral feeding rather than what can be seen as a decision to provide care versus withhold care.

A CFO order can help staff develop an individualized care plan.

“Comfort Feeding Only” Care Plan

- Resident focused
- Outline specific behaviors that would lead to the decision to discontinue hand feeding, focusing on the resident’s level of distress
- Outline specific interventions the staff will use to continue to keep resident comfortable once hand feeding discontinues

Conclusions

- ✓Interdisciplinary Teamwork
- ✓Training and Education
- ✓Systems

Thank you!

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- Addressing Staffing Challenges
- QAPI: Stump the SME
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Moving Needles: Improving Adult Immunization Rates in Post-Acute and Long-Term Care Settings

Heather Rooney
Project Manager, AMDA,
The Society for Post-Acute and Long-Term Care Medicine

Substance Use Disorders: What You Need to Know

Justin Alves, RN, MSN, FNP-C, ACRN, CARN, CNE

Kristin Wason, MSN, AGPCNP-BC, CARN
Project Manager, AMDA, Boston Medical Center
Grayken Center for Addiction
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