Supporting Nutrition Care in Older Adults: An Essential Component of 'Best Practice' Nursing

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Abstract

Evidence-based guidelines, recommendations and standards are considered the cornerstone of 'best practice' in nursing care. However, what optimal nutrition care of older adults actually looks like in real-world settings is also dependent on age, disease and care contexts and, perhaps most importantly, what matters to the older adult.

This chapter is a component of Part I: Nutritional Care in Old Age.
For an explanation of the grouping of chapters in this book, please see Chap. 1: 'Overview of Nutrition Care in Geriatrics and Orthogeriatrics'.

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Keywords

Nurses · Nursing staff · Malnutrition · Nutritional support · Older adults · Professional role

Learning Outcomes
At the end of the chapter, the reader will be able to:

- Describe why 'best practice' nursing care should consider individualised nutrition care actions across age, disease and care setting spectra.
- List key opportunities for nurses to coordinate, lead, deliver and evaluate supportive nutrition care processes.

Aunty Esther lived on a small island in the Torres Strait. Aunty was fit and healthy across her early adult years, living a traditional lifestyle including growing and harvesting local fruits and vegetables, fishing and collecting shellfish. However, over the years, as the island became progressively 'westernised', Aunty's diet changed, she reduced her exercise, and she consequently gained weight. By the time she had reached her early 50s, Aunty had developed obesity (class 3), type 2 diabetes, chronic kidney disease and heart disease. Aunty did not want to leave the island for any medical care and instead chose to entrust her healthcare to Mia, the community nurse. Over the next decade, Aunty and Mia worked together to manage her multiple conditions with a 'diet-only' approach, in line with Aunty's treatment preferences. In her mid-60s, Aunty essentially stopped eating for several months after her two sons were lost at sea. With support and care from nurse Mia, Aunty eventually recovered some of her lost muscle stores and enjoyed living with her granddaughter and extended family until her early 70s. Following a severe stroke, Aunty was cared for by her family and nurse Mia for a short time before she passed away, sitting outside on her woven coconut mat, surrounded by those she loved. Aunty Esther was proud to have never left her island home, and the only healthcare she ever consented to was provided by Mia, the community nurse.

6.1 What Is 'Best Practice' Nursing Nutrition Care?

Best practice is characterised as 'directive, evidence-based and quality-focused' care [1]; surrogate terms and related concepts include optimal care, evidence-based guidelines and practice, practice development and standards of care [1, 2]. To achieve best practice in nutrition care in older adults, evidence-based guidelines, recommendations and standards of care should underpin patient-focused care that is implemented into daily nursing practice [1]. Across global settings, evidence-based

guidelines and care standards that are relevant and appropriate to direct care in multimorbid older adults may be absent, competing or even contradictory. What is 'optimal care' will also need to consider the value of healthcare, which is defined primarily by care that matters to the older adult, with consideration given to the resources required to provide that care, in addition to diverse other barriers and enablers to care [3, 4]. As highlighted in Chap. 1, best practice should also support transitioning towards transdisciplinary care approaches, where [1] traditional professional boundaries are transcended; [2] knowledge, skills and accountabilities are integrated and shared; and [3] the focus is on solving real-world, complex nutrition problems, in partnership with the older adult and those who care for them [5].

How does this apply to nursing best practice in nutrition care? In many settings, nutrition specialists, for example, dietitians, medical nutrition specialists and nutrition support nurse practitioners, have been considered best *qualified* to deliver nutrition care processes [6, 7]. A recent systematic review has demonstrated that nurses can safely provide oral nutritional supplements, food or fluid fortification or enrichment, give education and dietary counselling to geriatric patients and patients' carers and administer nutrition care across professions; as such nurses are well placed to support essential processes of nutrition care to older adults [8]. As highlighted in our case study above, nurses are often best *positioned* to lead, coordinate and/or deliver 'best practice' nutrition care processes (Chap. 1) [9]. However, we also suggest that nurses should not be required to do this in isolation; for our case study above, in all but the most under-resourced settings, it would be important for nurse Mia to be embedded in a broader interdisciplinary team including medical and nutrition specialists.

Our case example builds on previous chapters highlighting that the spectrum and progression of nutrition care is evolving and can range from dietary management of lifestyle diseases to preventing, screening, identifying and managing malnutrition or other nutrition-related conditions and, ultimately, caring for those in the last stages of life by supporting food and fluids for comfort. It highlights that what should be defined as 'best practice' changes over the course of life and disease processes and fundamentally should be measured by delivering care that matters to the patient [10]. This emphasises a key point; in older, multimorbid adults, the actual individual care provided will at times be different to nutrient or disease-specific treatment recommendations endorsed by individual professions, societies or nations particularly where these have not been co-designed with culturally diverse, multimorbid, older adults.

Globally, nurses support coordination of patient-centric care processes across aging, disease and care setting spectra that require tailoring of care to the individual patient [11]. Nurses are highly attuned to individual patient's care needs and preferences; have highly developed skills in working across disciplines, systems and healthcare settings; and routinely translate evidence-based guidelines and recommendations into best practice, patient-centred care. A pivotal role for nursing is also to manage care conflicts and unrealistic expectations, whether these are directed from older adults and carers or individuals and teams caring for them [12]. Nurses actively support shared decision-making and goal setting and are well placed to

observe where previous goals or care recommendations require review and recognise and encourage specialist care [re]referral where this is appropriate [13]. Finally, in many settings globally, nurses are firmly established in clinical, policy, education and research leadership, governance and advocacy roles [14].

We consequently propose that nurses are well connected, brokering interdisciplinary team members, who are particularly well placed to coordinate, lead and deliver 'best practice' nutrition care processes and improvements.

6.2 Leading Supportive Nutrition Care for Older Adults with or at Risk of Malnutrition: An Example of Best Practice in Nursing Care

Nutrition care screening pathways exist that support triaging malnutrition care according to nutrition risk screening outcomes [15–17]. One example is the Systematised, Interdisciplinary Malnutrition Program for impLementation and Evaluation (SIMPLE) [15]. This approach triages screening three risk categories: standard, supportive or specialised nutrition care. What 'supportive' nutrition care processes look like should ultimately be determined by local teams with consideration to patient- and context-specific factors; this should consider different stages of nutrition care process models applied internationally (Fig. 6.1) [15–19]. Across settings, enabling systematised, interdisciplinary 'supportive' nutrition care processes

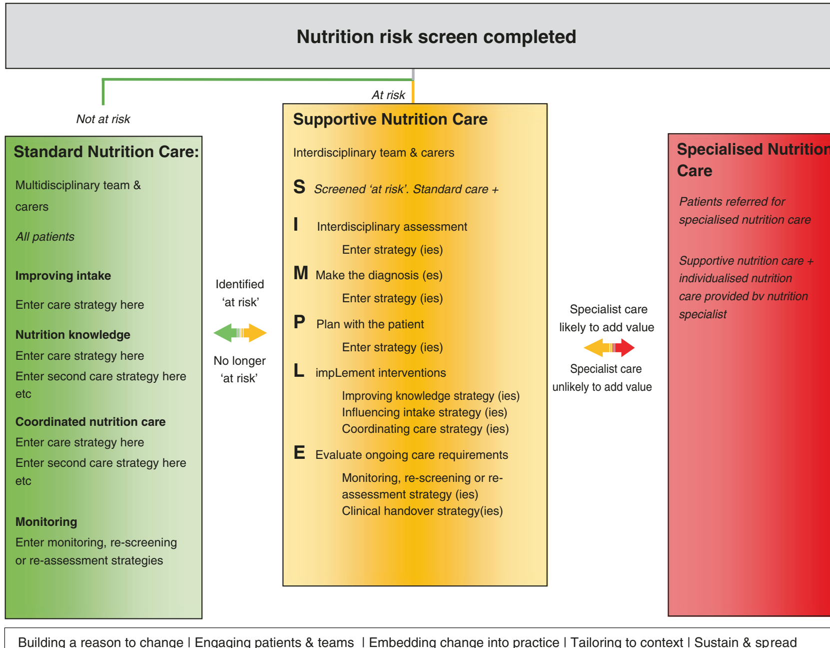

Fig. 6.1 A SIMPLE approach to supportive nutrition care [9]

where appropriate, rather than relying on specialist care delivery, has demonstrated improved and sustained patient-reported nutrition experience measures and health-care outcomes, whilst simultaneously directing specialist resources to where they are most urgently required [20–22].

Take-Home Checklist

- Table 6.1 provides a supportive nutrition care checklist for older adults with or at risk of malnutrition [15, 18, 19, 23]. We note that each and every one of these will not necessarily provide a useful grounding point for nurses aspiring to lead, coordinate and model best practice supportive nutrition care in older adults.

Table 6.1 Supportive nutrition care checklist for older adults with or at risk of malnutrition [9, 15, 18, 19, 23]

Service and setting level
• Evidence-based guidelines, care standards, accreditation processes, policies and operating procedures guide interdisciplinary nutrition and hydration care for older adults
• Interdisciplinary nutrition care committees meet regularly with regularly reviewed terms of reference and supporting governance processes
• Nutrition support teams or specialists are accessible to refer for specialist nutrition care
• On presentation and repeat nutrition screening, processes are embedded applying validated instruments; these should be audited and reported at least annually
• Social care and facility foodservices systems support timely access to safe, high-quality, nutrient-dense food choices in line with older adult requirements, individual and sociocultural preferences and preferred eating times
• Fortified food and additional snacks or finger food are available to support adequate dietary intake
• In longer-stay healthcare and home care facility settings, food intake shall be supported by a home-like, pleasant dining environment to support adequate dietary intake and maintain quality of life
• High-quality, aesthetically pleasing texture-modified, enriched foods are available for those with chewing problems or signs of oropharyngeal dysphagia
• Processes are established and audited that avoid or minimise nil by mouth and restrictive diets associated with surgery, procedures or tests
• Patient-reported nutrition experience measures (nPREMS) and outcomes measures (PROMs) guide provision of care and care improvements
• Processes are enacted to identify, document and benchmark nutrition-related complications (e.g. hospital-acquired malnutrition, falls, pressure injuries, skin tears and wound dehiscence)
• Nutrition education and curriculum are embedded in interdisciplinary healthcare professional training, orientation and re-entry processes
Individual-level audits, documentation and/or patient-reported experience measures demonstrate:
• Interdisciplinary team members deliver multicomponent supportive nutrition care processes
• Older adults or carers of those screened at risk report awareness of risk status when audited
• Specific supportive nutrition care processes actioned at point of screening
• ABCDEF approach to nutrition assessment (anthropometric, biochemistry, clinical, dietary, environmental and psychosocial and functional variables)
• Key nutrition assessment metrics (e.g. height, weight, BMI) recorded within specified timeframes
• Nutrition diagnoses (e.g. malnutrition) recorded within specified timeframes

(continued)

Table 6.1 (continued)

• Malnutrition-related hospital-acquired complications identification and intervention (e.g. malnutrition, pressure injury, skin tear, fall, delirium)
• All at-risk or malnourished older adults, or their caregivers where appropriate, report receiving individualised nutritional information and education
• Shared nutrition goal setting and multimodal interventions
• Medicine and supplement (prescribed or self-prescribed) review to support nutrition care and limit adverse drug-nutrient and food-drug interactions
• Pre-meal toileting, mealtime positioning and eating environment support enjoyment of meals
• Adequate time to eat, encouragement and assistance with meals where required
• Mealtime assistance, encouragement and support provided by interdisciplinary healthcare providers, volunteers, family, friends and carers
• High levels of older adult satisfaction with meals and mealtimes
• Low levels of food waste
• Oral nutritional supplements (ONS) or enteral or parenteral nutrition is offered where food fortification and dietary counselling are not sufficient to meet nutrition requirements, and these align with shared goals and treatment intent
• Prescribed diets and nutritional supplements reviewed and deprescribed where appropriate
• Clinical handover and integration of nutrition care across care settings

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Recommended Reading

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