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L'assistenza nutrizionale per un invecchiamento attivo di successo

SOCIETÀ ITALIANA
DI GERONTOLOGIA
E GERIATRIA

Roma, 30 novembre - 3 dicembre 2022
UNIVERSITÀ CATTOLICA DEL SACRO CUORE

"Se fossimo in grado di fornire a ciascuno la giusta dose di nutrimento e di esercizio fisico, né in eccesso né in difetto, avremmo trovato la strada per la salute".

Ippocrate, (460-377 a.C.)

Malnutrizione e disidratazione nell'anziano

- Prevalenza del 10% nelle persone anziane indipendenti, che cresce negli anziani istituzionalizzati.

- Aumento anche dell'obesità nell'anziano, che oscilla tra il 18 e il 30% nella popolazione mondiale sopra i 65 anni.

- La malnutrizione, per difetto o per eccesso è perciò un problema globale di salute rilevante e spesso sottostimato, che può influenzare un invecchiamento in salute.

Volkert et al., (2022) ESPEN practical guideline: Clinical nutrition and hydration in Geriatrics. Clinical Nutrition, 41, 958-989

Global Leadership Initiative on Malnutrition (GLIM): consensus conference per determinare criteri condivisi con cui definire lo stato di malnutrizione

Malnutrizione definita da:

1. Criteri fenotipici: (perdita di peso, basso indice di massa corporea (BMI) e massa muscolare ridotta)

2. Criteri eziologici: (ridotta assunzione di cibo o assimilazione e infiammazione)

Figura tratta da: Cederholm et al. (2019) GLIM criteria for the diagnosis of malnutrition- A consesus report from the global clinical nutrition community. Clinical Nutrition, 38, 1-9)

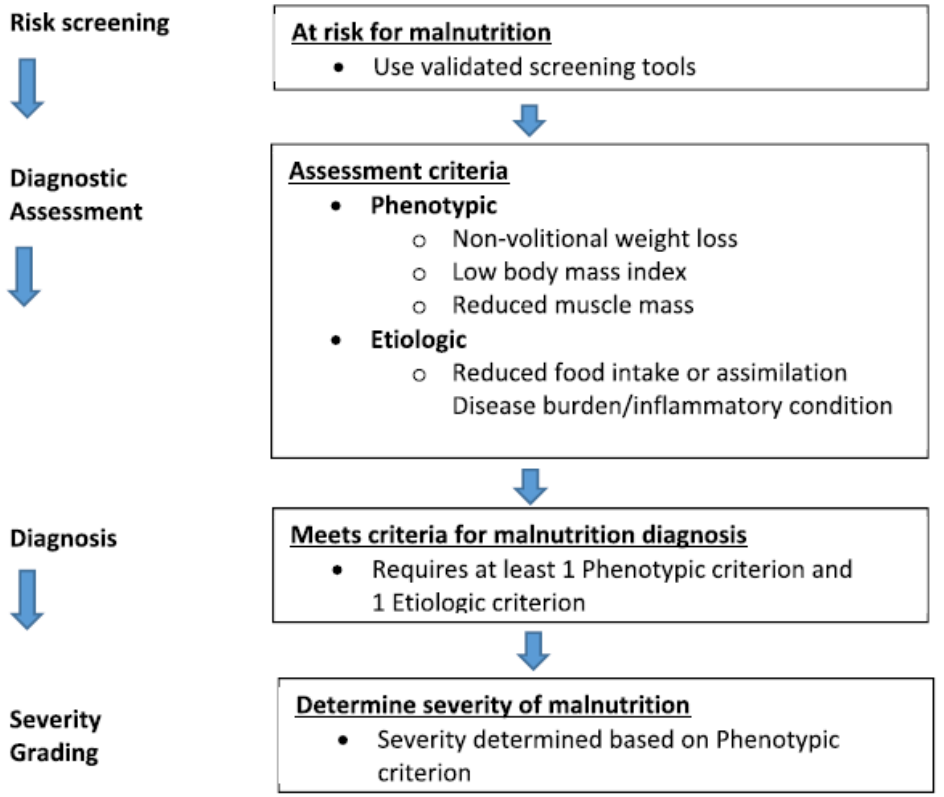


Fig. 1. GLIM diagnostic scheme for screening, assessment, diagnosis and grading of malnutrition.

Assistenza nutrizionale

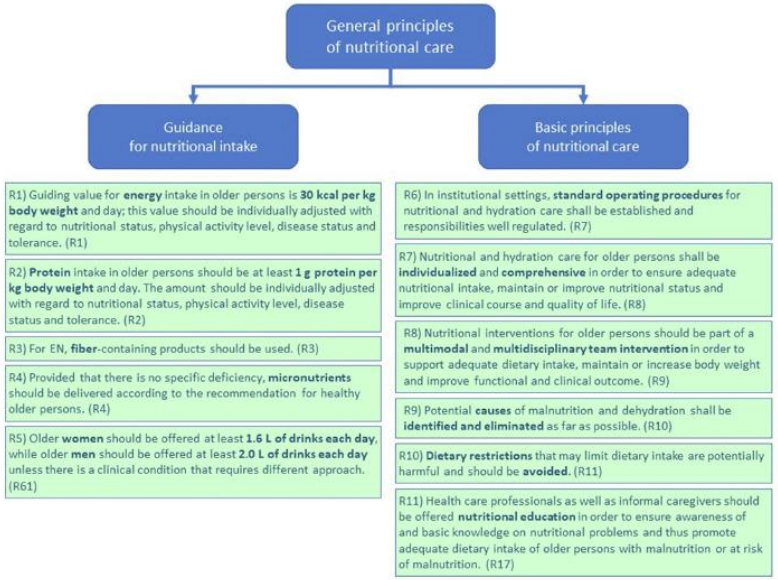


Fig. 2. General principles of nutrition care. EN, enteral nutrition.

Tratto da:Volkert et al., (2022) ESPEN practical guideline: Clinical nutrition and hydration in Geriatrics. Clinical Nutrition, 41, 958-989

Guidance for nutritional intake

R1) Guiding value for **energy** intake in older persons is **30 kcal per kg body weight** and day; this value should be individually adjusted with regard to nutritional status, physical activity level, disease status and tolerance. (R1)

R2) **Protein** intake in older persons should be at least **1 g protein per kg body weight** and day. The amount should be individually adjusted with regard to nutritional status, physical activity level, disease status and tolerance. (R2)

R3) For EN, **fiber**-containing products should be used. (R3)

R4) Provided that there is no specific deficiency, **micronutrients** should be delivered according to the recommendation for healthy older persons. (R4)

R5) Older **women** should be offered at least **1.6 L of drinks each day**, while older **men** should be offered at least **2.0 L of drinks each day** unless there is a clinical condition that requires different approach. (R61)

Principi generali assistenza nutrizionale

1. **R7:** standard operating procedure
2. **R8:** individualization of care
3. **R9:** multimodal and multidisciplinary intervention
4. **R10:** identification of potential cause of malnutrition or dehydration
5. **R11:** dietary restriction should be avoided
6. **R17:** the importance of nutritional education

Basic principles of nutritional care

R6) In institutional settings, **standard operating procedures** for nutritional and hydration care shall be established and responsibilities well regulated. (R7)

R7) Nutritional and hydration care for older persons shall be **individualized** and **comprehensive** in order to ensure adequate nutritional intake, maintain or improve nutritional status and improve clinical course and quality of life. (R8)

R8) Nutritional interventions for older persons should be part of a **multimodal** and **multidisciplinary team intervention** in order to support adequate dietary intake, maintain or increase body weight and improve functional and clinical outcome. (R9)

R9) Potential **causes** of malnutrition and dehydration shall be **identified and eliminated** as far as possible. (R10)

R10) **Dietary restrictions** that may limit dietary intake are potentially harmful and should be **avoided**. (R11)

R11) Health care professionals as well as informal caregivers should be offered **nutritional education** in order to ensure awareness of and basic knowledge on nutritional problems and thus promote adequate dietary intake of older persons with malnutrition or at risk of malnutrition. (R17)

Tratto da:Volkert et al., (2022) ESPEN practical guideline: Clinical nutrition and hydration in Geriatrics. Clinical Nutrition, 41, 958-989

R7 Standard procedure, R10 identification of potential cause of malnutrition or dehydration

- Importanza di avere procedure standard nelle persone anziane istituzionalizzate per ciò che concerne l'assistenza nutrizionale
- Assessment stato nutrizionale (screening, come Mini Nutritional Assessment)
- Piano nutrizionale individualizzato
- Definizione delle responsabilità all'interno del team
- Incontri regolari del Team
- Valutazione dell'intake
- Precoce individuazione persone a rischio di malnutrizione o già malnutrite

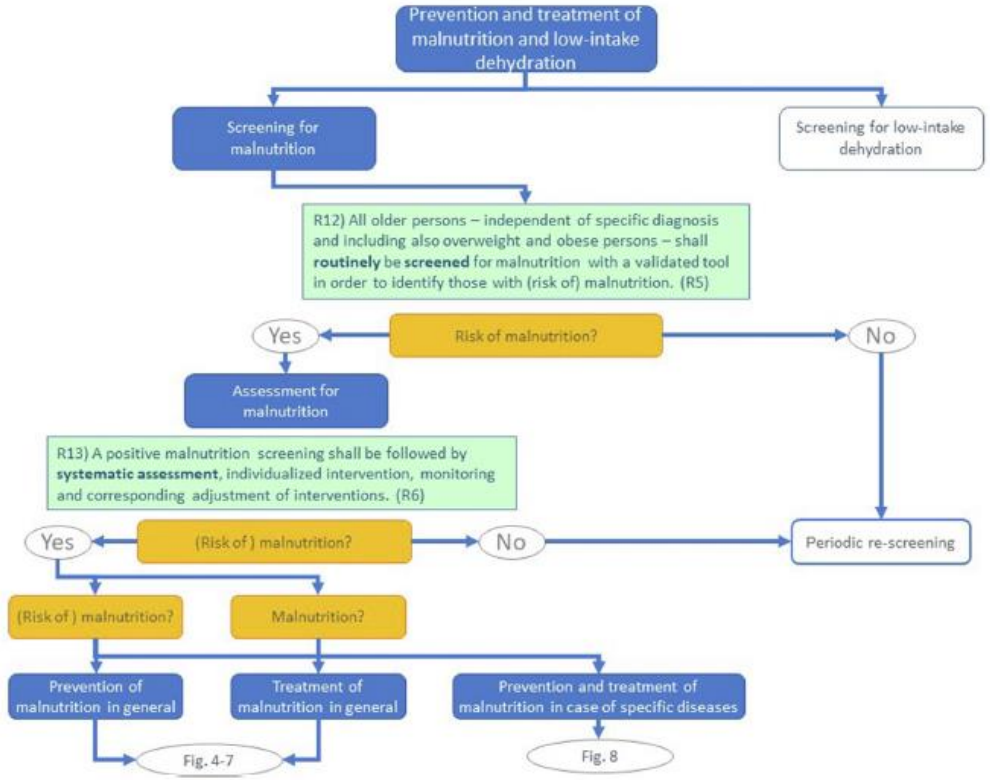


Fig. 3. Prevention and treatment of malnutrition and low-intake dehydration - Screening for malnutrition.

R8 Individualization of care

- L'assistenza nutrizionale e di idratazione per le persone anziane deve essere individualizzata e completa al fine di garantire un adeguata nutrizione, mantenere o migliorare lo stato nutrizionale e migliorare il decorso clinico e la qualità della vita.(R8, grado A, forte consenso 100%)

- Alle persone anziane con malnutrizione o a rischio di malnutrizione e con dipendenza alimentare, sia in istituto (A) che a domicilio (GPP), deve essere offerta assistenza durante i pasti per sostenere un'adeguata assunzione di cibo. (R12, grado A/GPP, forte consenso 100%)

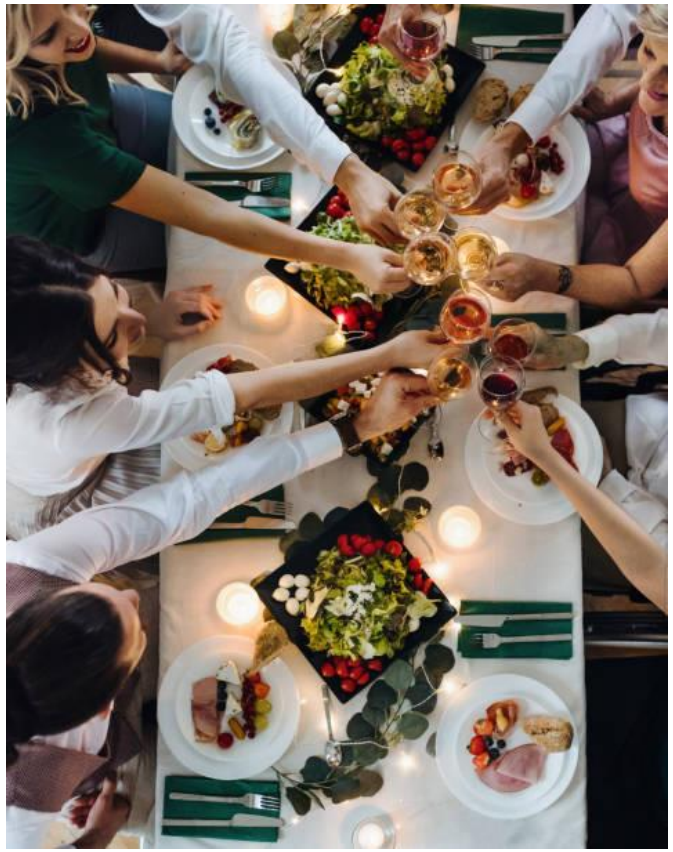
- Le persone anziane con malnutrizione o a rischio di malnutrizione dovrebbero essere incoraggiate a condividere i pasti con altre persone per stimolare l'assunzione di cibo e migliorare la qualità della vita. (R14, grado GPP, forte consenso 100%)

R9 Multimodal, multidisciplinary interventions

- Gli interventi nutrizionali per le persone anziane dovrebbero essere parte di un intervento multimodale e multidisciplinare, allo scopo di supportare un adeguato apporto dietetico, mantenere o aumentare il BW e migliorare i risultati funzionali e clinici. (R9, grado B, forte consenso 100%)

- In ambienti istituzionali, l'assunzione di cibo da parte di persone anziane con malnutrizione o a rischio di malnutrizione deve essere supportata da un ambiente di ristorazione piacevole e simile a quello domestico, al fine di sostenere un'adeguata assunzione di cibo e mantenere la qualità della vita. (R13, grado A, forte consenso 100%).

- Oltre agli interventi nutrizionali, le persone anziane con malnutrizione o a rischio di malnutrizione devono essere incoraggiate a essere fisicamente attive e a fare esercizio fisico per mantenere o migliorare la massa e la funzione muscolare. (R41, grado GPP, forte consenso 100%).



Importanza di un intervento educativo nutrizionale

- Sia agli operatori sanitari, così come ai caregiver informali, è necessario offrire un'educazione nutrizionale per garantire la consapevolezza e la conoscenza di base dei problemi nutrizionali, quindi promuovere un'adeguata alimentazione delle persone anziane con malnutrizione o a rischio di malnutrizione.(R17, grado B, forte consenso 95%)
- Le persone anziane con malnutrizione o a rischio di malnutrizione e/o i loro caregiver dovrebbero ricevere una consulenza nutrizionale personalizzata al fine di sostenere un'adeguata assunzione di alimentare adeguata e migliorare o mantenere lo stato nutrizionale. (R18, grado B, forte consenso 100%)

L'importanza del coinvolgimento attivo: Patient engagement

- Il coinvolgimento attivo/engagement del paziente nel percorso di cura è «un concetto sistemico» che identifica e qualifica le possibili modalità di relazione che una persona con una domanda di salute/prevenzione, assistenza e/o cura può intrattenere con la sua condizione clinica, il suo caregiver informale (in particolare la famiglia).

- L'engagement nell'ambito clinico assistenziale della cronicità, inoltre, si definisce come un concetto-ombrello che ne articola, sistematizza e include altri tipici della medicina partecipativa, quali adherence, compliance, empowerment, activation, health literacy, shared decision making, activation (Figura 1). (Graffigna & Barello, 2018)

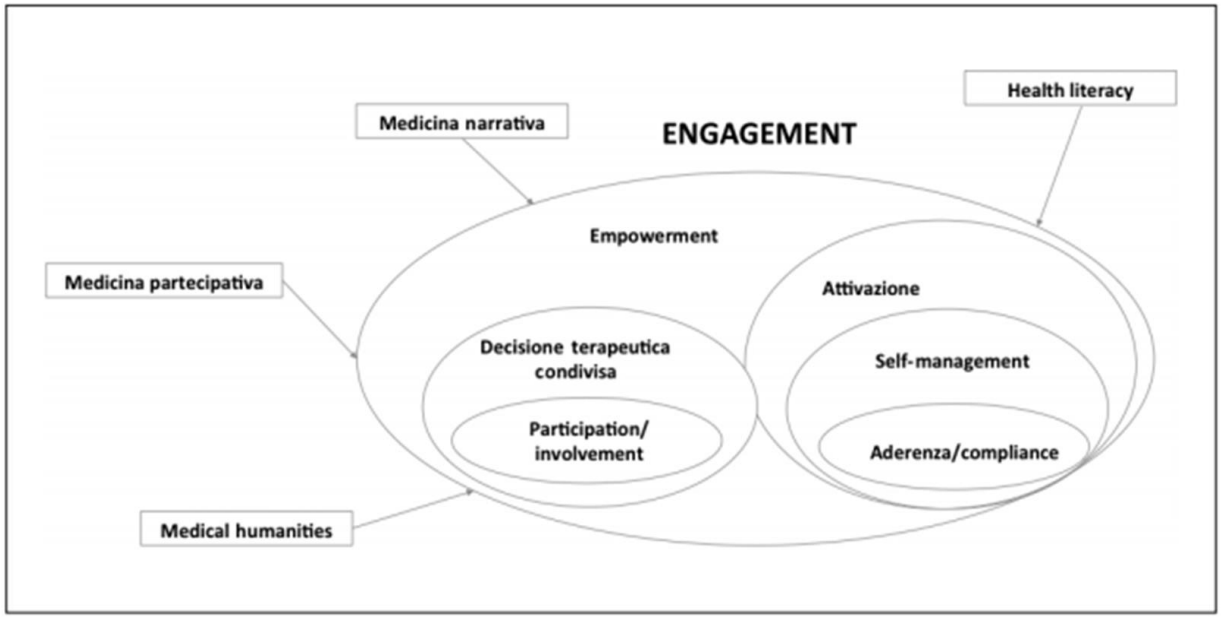


Figura 1. Relazione tra engagement e altri costrutti della medicina partecipativa (Graffigna & Barello, 2018)

L'importanza del coinvolgimento attivo: Patient engagement

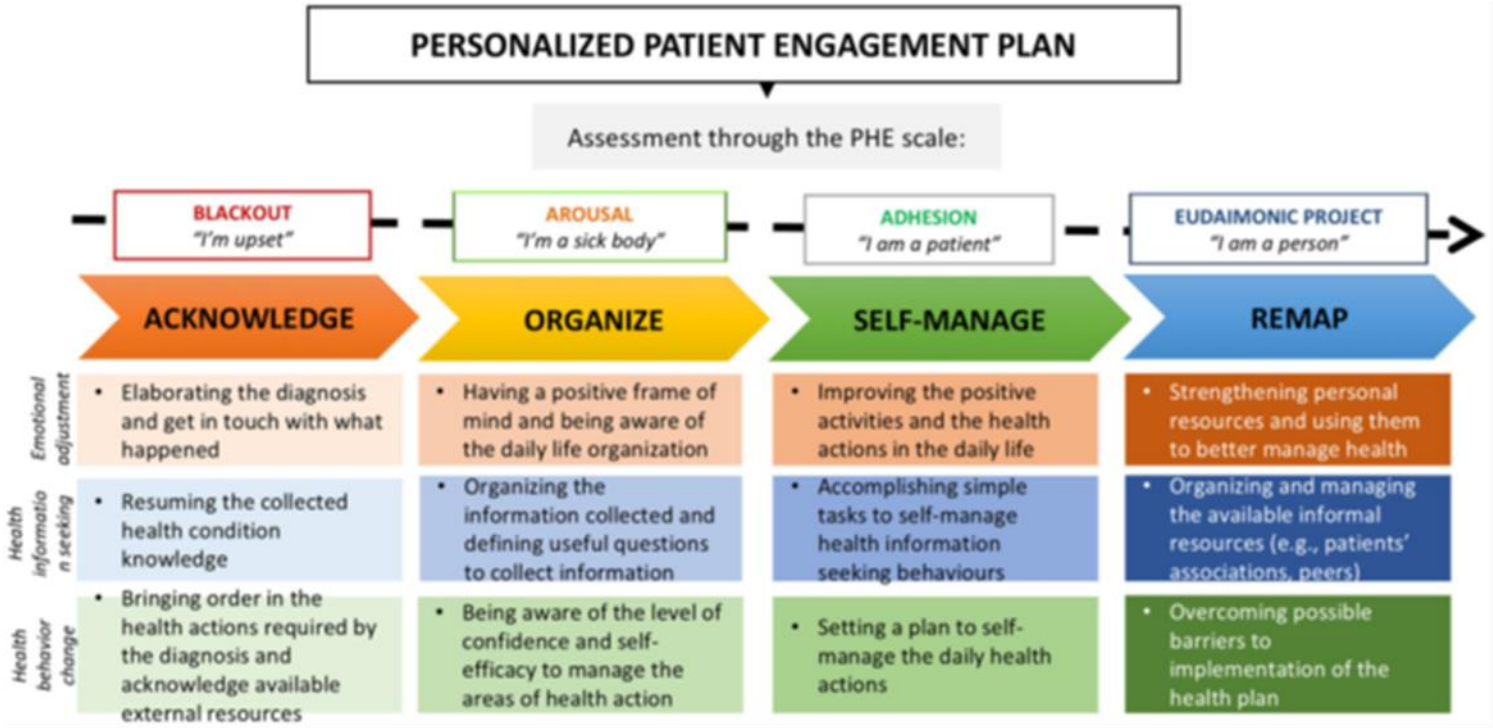


Fig. 2 Tratto da: Menichetti, J., & Graffigna, G. (2016). "PHE in Action": Development and Modeling of an Intervention to Improve Patient Engagement among Older Adults. Frontiers in psychology, 7, 1405. https://doi.org/10.3389/fpsyg.2016.01405

Alcuni esempi in letteratura di coinvolgimento attivo

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ARE INFORMAL CARERS AND COMMUNITY CARE WORKERS EFFECTIVE IN MANAGING MALNUTRITION IN THE OLDER ADULT COMMUNITY? A SYSTEMATIC REVIEW OF CURRENT EVIDENCE

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Abstract: *Background:* Enhancing the effectiveness of the community and aged care workforce to prevent malnutrition and functional decline is important in reducing hospital and aged care facility demand. *Objective:* To investigate the impact of nutrition-related interventions delivered to or by informal carers and non-clinical community care workers on malnutrition-related health outcomes of community-dwelling older adults (≥65years). *Methods:* Intervention studies were searched for using six electronic databases for English-language publications from January 1980 to 30 May 2012. *Results:* Nine studies were eligible for inclusion. The strength and quality of the evidence was moderate (six studies with level II intervention evidence, five with positive quality). Types of interventions used were highly varied. The majority of interventions were delivered to informal carers (6 studies), with three of these studies also involving older adult care recipients. Five interventions were targeted at identifying, preventing and/or treating malnutrition specifically (two positive quality, three neutral quality, n=2368). As a result of these interventions, nutritional status improved or stabilized (two positive quality, two neutral quality, n=2333). No study reported an improvement in functional status but two successfully prevented further decline in their participants (two neutral quality, n=1097). *Conclusion:* Interventions targeted at identifying, preventing and/or treating malnutrition were able to improve or prevent decline in nutritional and functional status, without increasing informal carer burden. The findings of this review support the involvement of non-clinical community care workers and informal carers as part of the nutritional care team for community-dwelling older adults.

Key words: Aged, caregiver, community, malnutrition, nutrition.

Alcuni esempi in letteratura di coinvolgimento attivo

OLDER PEOPLE

Nutritional care: the effectiveness of actively involving older pati

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PEDERSEN PU (2005) *Journal of Clinical Nursing* **14,** 247–255

Nutritional care: the effectiveness of actively involving older patients

Aims and objectives. The purpose of the study was to test the effectiveness of nursing care based on active involvement of patients in their nutritional care. It was hypothesized that this type of care could improve energy and protein intake in elder orthopaedic patients.

Background. Protein and energy malnutrition and deterioration in nutritional status is a common but neglected problem in hospital patients.

Methods. The design was quasi-experimental with an intervention and control group. The study included 253 patients aged 65 and above admitted for hip fracture, hip or knee replacement. Food intake was recorded on a daily basis during the hospital stay.

Results. The daily intake of energy increased with 23% ($P = 0.001$) and of protein with 45% ($P = 0.001$). The intake increased from the very first day after the operation. The intake of energy and protein was not correlated with the patient's age, body mass index or type of surgery.

Conclusions. The care based on patients' active involvement in their own nutritional care and was found to be an effective method to raise the intake of energy and protein among elder orthopaedic patients.

Relevance to clinical practice. This way of organizing the care identifies patients who do not consume enough energy and protein according to their current requirements and to take appropriate actions to prevent further malnutrition.

Key words: elderly, hip fracture, hip replacement, knee replacement, nursing care, nutrition

Alcuni esempi in letteratura di coinvolgimento attivo

RESEARCH ARTICLE Open Access

Engaging hospitalised patients in their nutrition care using technology: development of the NUTRI-TEC intervention

Shelley Roberts[1,2,3*], Zane Hopper[2], Wendy Chaboyer[3,4], Ruben Gonzalez[5], Merrilyn Banks[6], Ben Desbrow[1,3] and Andrea P. Marshall[2,3,4]

Abstract

Background: Nutrition is vital for health and recovery during hospitalisation, however most patients fail to meet minimum dietary requirements and up to 50% of patients are malnourished in hospital. When patients participate in nutrition care, their dietary intakes are improved. Advances in health information technology (HIT) have broadened the ways by which patients can participate in care. Our team has developed an innovative, HIT-based intervention (called NUTRI-TEC; engaging patients in their nutrition care using technology), facilitating patient participation in their nutrition care in hospital. This paper aims to describe the systematic and iterative process by which the intervention was developed.

Methods: NUTRI-TEC development was informed by the Medical Research Council guidance for developing complex interventions and underpinned by theoretical frameworks and concepts (i.e. integrated knowledge translation and patient participation in care), existing evidence and a rigorous program of research. The intervention was co-developed by the multidisciplinary research team and stakeholders, including health consumers (patients), health professionals and industry partners. We used an iterative development and evaluation cycle and regularly tested the intervention with hospital patients and clinicians.

Results: The NUTRI-TEC intervention involves active patient participation in their nutrition care during hospitalisation. It has two components: 1) Patient education and training; and 2) Guided nutrition goal setting and patient-generated dietary intake tracking. The first component includes brief education on the importance of meeting energy/protein requirements in hospital; and training on how to use the hospital's electronic foodservice system, accessed via bedside computer screens. The second component involves patients recording their food intake after each meal on their bedside computer and tracking their intakes relative to their goals. This is supported with brief, daily goal-setting sessions with a health care professional.

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Conclusions: NUTRI-TEC is a HIT intervention designed to enable patient participation in their nutrition care in hospital. As research on HIT interventions to engage patients in health care in the hospital setting is in its infancy, and as gaps and inconsistencies in the development of such interventions exist, this paper will inform future development of HIT-based interventions in the hospital setting.

Keywords: Complex interventions, Health information technology, Hospital patients, Integrated knowledge translation, Nutrition, Patient participation, Patient engagement

Alcune barriere al coinvolgimento attivo

ORIGINAL ARTICLE

Older people's involvement in activities related to meals in nursing homes

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Aims and objectives. To explore how residents in nursing homes perceive their participation in activities related to food and meals, and possible factors influencing their involvement.

Background. Eating and drinking are fundamental human needs and consequently essential parts of nursing and nursing care. Therefore and as part of nursing care, encouraging older people in nursing homes to engage in different mealtime activities could be one way to increase participation in activities of daily living and more optimal nutrition status among older people.

Design. A cross-sectional survey design was used.

Methods. A total of 204 residents (88%) in one Norwegian county agreed to participate and completed a face-to-face interview questionnaire about food and meal experiences. Descriptive and comparative statistics was used.

Results. Close to 30% of the residents were vulnerable to malnourishment. None of the residents were involved in menu planning, and more than 90% did not participate in food preparation or setting/clearing tables. Ten per cent were able to choose where they could eat and 5% when they could eat. Older persons living in nursing homes with more than 80 residents and those younger than 65 years of age participated the most, while older people with poor appetites were able to choose more often where they wanted to eat, compared to those with a healthy appetite.

Conclusion. The residents in this study appeared to be vulnerable to malnourishment. The results indicated that they only to a limited extent were involved in activities concerning food and meals at the nursing homes.

Implications for practice. Management and nurses should focus on residents' eating and drinking, which are essentials of nursing care. The residents should be asked whether they would like to participate in different mealtime activities. Further, a person-centred care approach that facilitates activities concerning food and meals should be promoted.

Key words: essentials of nursing care, food and meals, involvement, nursing homes, older people

Alcune barriere al coinvolgimento attivo

BDA The Association of UK Dietitians
THE OFFICIAL JOURNAL OF THE BRITISH DIETETIC ASSOCIATION
Journal of Human Nutrition and Dietetics

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OLDER PEOPLE

Hospital nurses and home care providers' experiences of participation in nutritional care among older persons and their family caregivers: a qualitative study

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Abstract

Background: A person-centred approach to nutritional care has the potential to increase an older person's role in making informed decisions about their own care and possibly improving their quality of life. However, despite the considerable interest shown in person-centred nutritional care in recent years, delivery of such care still appears to lack consideration for older persons' needs and preferences. The present study aimed to explore healthcare professionals' views on how older persons and their family caregivers participate in decisions about their own nutritional care and possible barriers for that participation.

Methods: Semi-structured in-depth interviews with 23 healthcare professionals in acute geriatric care and home care were conducted. Data were analysed thematically.

Results: The analysis of the interviews resulted in three main themes: (i) lack of shared decision-making in nutritional care; (ii) conflict between patient's preferences and standard nutritional care procedures; and (iii) the value of family caregivers who are seldom involved in nutritional care.

Conclusions: Healthcare professionals were aware of the importance of actively engaging older persons and their family members in the nutritional care to achieve positive outcomes. However, they encountered individual and structural barriers, including resistance from patients and family caregivers, conflicts between the patients' nutritional wishes and standard nutritional procedures, a wish to shield the family caregivers from the stress of caring for a sick relative, and lack of time and caring structures that facilitate the older persons and their family's active participation.

Conclusioni

- L’assistenza nutrizionale è sostanziale per favorire un invecchiamento in salute.
- È importante adottare un approccio multi ed interdisciplinare, definendo le responsabilità di ciascun attore.
- Tra gli attori è fondamentale considerare sempre il destinatario della nostra cura e il suo entourage famigliare.
- Un coinvolgimento attivo dell’utente nell’assistenza nutrizionale è infatti irrinunciabile nel panorama sanitario attuale, nonché strategico per ridurre la malnutrizione e la disidratazione, favorire una miglior qualità di vita e, in generale, migliorare gli esiti dei nostri assistititi.
- Troppo spesso barriere organizzative e un’attitudine negativa dei professionisti sanitari verso l’assistenza nutrizionale, ne ostacola l’implentazione.

Grazie per l'attenzione!

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