Malnutrition and Weights

What is malnutrition

Malnutrition is associated with many chronic diseases of aging. The term malnutrition refers to both under-nutrition and over-nutrition. Most often times in the nursing home, it is due to under-nutrition.
Malnutrition

The incidence of malnutrition ranges from 12% to 50% among the hospitalized elderly population and from 23% to 60% among institutionalized older adults.

When not directly attributable to underlying disease, weight loss in the institutionalized elderly is most commonly due to depression, use of anorexigenic drugs, and dependency on staff for feeding.

Elder Malnutrition in Nursing Homes

In addition to dehydration, elderly malnutrition represents the most wide-spread health issue present at nursing homes. There are around 1.6 million nursing home residents in the US, and it is estimated that up to a third of these individuals suffer from elderly malnutrition or dehydration. In some nursing homes, the rate of elderly malnutrition is as high as 85 percent. Additionally, between 30 and 50 percent of a nursing home’s elderly population may be underweight, potentially as a result of malnutrition.

What is used to determine malnutrition?

The Federal Government defines significant weight loss as:

- 5% loss or gain of total body weight within 30 days
- 7 ½ % loss or gain in 3 months
- 10 % loss or gain in 6 months
Why is it so important to have an accurate weight program

1. Weights are a early indicator of probable conditions that can send residents into decline.
2. It is mandated by State and Federal standards to monitor resident health and well being by weighing.
3. Residents health can change rapidly and weights are an indicator of changes to a residents health.

Causes of weight loss

- Body weight of less than 100 lbs.
- 5% or more weight loss in one month (not intended)
- 10% or more weight loss in six months (not intended)
- Presence of pressure sores
- Nutrition received by tube feeding
- History of malnutrition
- Laboratory values indicative of malnutrition or dehydration
- Mental impairment
- Depression
- Resident’s ability to feed self
- Poor communication
- Medication side effects
- Denture problems
- Restricted diet
- Poor eating habits and decreased intake at meals
- Chewing and swallowing problems

How can malnutrition be prevented or corrected

- Monitoring monthly weights in all residents and weekly weights for those deemed to be at risk for malnutrition
- Performing an assessment that involves the disciplines of nursing, dietary, social services and activities for individualized care plan based on that assessment.
- Vigilant attention to nutrition and water intake
- Presenting food that is attractive, colorful, tasteful and garnished will help the resident be more inclined to eating more.
- Catering to food preferences as much as possible
- Sitting residents with suitable dining partners
- Providing enough time for a leisurely, relaxed meal
- Using herbs and spices to compensate for the loss of the taste or smell sensations and also to avoid using too much sodium or sugar
- Avoiding packaging that is hard to open, ex. Milk carton, juice cup, ketchup p/c, mustard p/c, syrup p/c, juice carton
- Making sure seating is at the proper height
- Observing for any facial grimacing, chewing or swallowing pain and let the nurse and social services know of possible oral problems
- Feeding residents who need assistance
- Using high sided plates
- Utilizing specialized utensils for those with hand weakness or arthritis
- Giving between meal dietary snacks in the form of puddings, sandwiches, cereals, and drinks.
- Make sure CNAs are not rushing residents to eat
- Observe the size of spoon full of food being given to resident
- RD monitoring tube feeding of tolerance levels
- Is the resident being fed enough food
- Adequate tube feeding
- Environmental factors: no disruptions, yelling, staff excessive talking in the dining room
- Consistency of food correct
- Does the resident wonder off during meals

**Risk Factors Attributed To Malnutrition and Weight Loss/Gain**

- Pressure soars
- Urinary tract infection
- Extreme Malnutrition
- Cognitive problems related to Alzheimer’s
- Emotional problems
- Possible dental issues
- End stage disease process
- Advanced or uncontrolled heart or lung disease

**Infection or fever**

- Liver disease
- Hyperthyroidism
- Mood disorders
- CVA (stroke)
- Heart attack
- High cholesterol
- High sodium
- Obesity
- Diabetes
- Hypertension
**Common Reasons for Weight Loss/Gains**

- **Depression** (lonely, withdrawn, cries at meals)
- **Edema** (+1, 2, 3, 4 or more and pitting/ on Lasix, Aldactone, HCTZ, Demadex, Furosemide)
- **Pain** (acute pain, no appetite, chronic pain)
- **Physical inability to eat** (hand eye coordination problems, needs a high sided plate, weight loss, chewing or swallowing status)
- **Mental Impairment** (forgets they ate, eats little then forgets they ate, emotional, combative, confusion)
- **Poor communication** (can’t say if they are hungry, hurting, etc.)
- **Medication side effects** (antibiotics, pain meds, psyche meds, steroids)
- **Dental problems** (dentures don’t fit properly, broken teeth, mouth ulcers, no teeth, mouth pain)
- **Swallowing Problems** (hurt to swallow, chokes, difficulty swallowing, coughing)
- **Poor appetite/disinterested in food**
- **Increased activity or movement** (walks around facility or peddles around in wheelchair)
- **Decrease physical process** (Cancer, Parkinson)
- **Non-compliant with diet** (eats junk food, sugary salty snacks, family brings food, ask other to eat what they did not finish, grasing throughout the day)
- **Menus and quality of food** (Does the menu reflect the residents preferences. Are cooking procedures, recipes and)

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**Physical Symptoms of Elderly Malnutrition**

**Mouth Signs**
In the presence of elderly malnutrition, a sufferer’s mouth may become a bright shade of red. Canker sores may be present. Additionally, thrush or a yeast infection can cause white patches to develop on the cheeks and tongue.

**Muscular Problems**
Elderly malnutrition can cause muscles to become flaccid. This is a result of the body using up nutrients stored in the muscle tissue in order to make up for a lack of incoming nourishment. Simple tasks may bring on fatigue.

**Eye Signs**
Red, glassy eyes or swollen corneas may also be symptoms of elderly malnutrition. Vision may worsen as well.

**Cognitive Difficulties**
Lack of proper nourishment will eventually affect a loved one’s ability to think clearly. They may appear listless or irritable. In advanced cases of elderly malnutrition, dementia and confusion present themselves.

**Skin Issues**
The skin may take on a yellowish color as a result of elderly malnutrition. The skin of darker-complexion individuals may appear dull. Additionally, skin may become heavily wrinkled, and the skin beneath fingernails can turn white.

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**WEIGHT LOSS PROGRAM**
Weight Tips and Pitfalls

- CNA's must know how each resident must be weighted by designating stand, wheel chair or lifter on the weight sheet.
- Never give previous weights to anyone doing the weights!!!
- A resident if cognitive upon arrival should be asked if they know what their weight has been within the past 6 months. It may help decipher any potential weight inaccuracies.
- Preferably weights should not be done right after a meal.
- A weight taken must be verified 3 times in a row (on a digital scale) before it is deemed verified. If the weight is different, the weight process should be started all over again.
- The scale is not always absolute. Calibrate regularly.
- A 5 or 10 lb. weight should be handy next to the scale to check calibration.
- The facility must use the same chairs to weight residents. There should be no leg rest, and the chair needs be weighted and the weight of the chair must be displayed on the back of the seat for the CNA’s to subtract the chair weight from the actual weight.
- FYI the CNA’s will some time forget to subtract the chair weight. Scrutinize all weights.
- A large chair and small chair must be utilized just for weights and put away in between weighting so that they are not used. A large “WC for Weight Chair” is suggested to be painted on the back of the chair for easy identification.
- Review admits weights diligently. Sometimes they are incorrect and will create a trigger upon the next week’s weekly weight.
- Any weight gain or loss of 5 lbs. should be re-weighted for verification.
- If a resident does not trigger but is steadily losing weight they should be put on weekly weights despite not triggering for precaution.
- All weight concerns, eating habits and non-compliance must be discussed with the resident and any education, plan of action or prevention must be charted immediately by the CDM and Nurse.

Weight Protocol

- All residents must be weighted immediately upon admit or re-admit.
- It is recommended that there is only one person who weighs the residents and logs the weights for review.
- Monthly weights are to be taken and logged on every resident per Federal mandated code.
- Each resident’s weight is to be recorded and entered into the computer by a date designated by the facility policy and procedure manual.
- Weight committee meeting must be held once a week.
- Monthly weights should be due and put into the computer by a date designated by the facility policy and procedure manual.
- All weekly weights must be reviewed for 5% over 30 days, 7.5% over 90 days and 10% over 180 days.
- The DON will chart any plan of correction added by DON within dietary notes.
- The CDM will chart any plan of correction added by DON within dietary notes.
- Family should be notified of any significant weight gain or loss with any corrective actions taken to stabilize resident weight.
- The Physician must be notified of any significant weight change after each weight committee.
- Any weekly weights that trigger over 2.5% must be charted and measures taken to stabilize.
INSTRUCTIONS

1. ZERO OUT SCALE UNTIL IT SHOWS ALL "00.0".
2. PLACE RESIDENT INTO PROPER WEIGHTING CHAIR. USE ONLY WEIGHT CHAIR DESIGNATED WITH PAINTED WC ON BACK OF CHAIR AND WEIGHT OF CHAIR WRITTEN ON CHAIR. (DO NOT USE THE CHAIR RESIDENT IS IN). TRANSFER TO WEIGHT CHAIR ONLY TO WEIGHT.
3. IF RESIDENT STANDS PLACE THEM IN THE MIDDLE OF THE SCALE PAD. DO NOT LET THEM HOLD ONTO ANY PART OF THE SCALE.
4. RESIDENT MUST STAND STILL.
5. IF IN CHAIR, ROLL THE ENTIRE CHAIR INTO CENTER OF SCALE AND KEEP THEM FROM MOVING.
6. WEIGHT RESIDENT 3 TIMES, IF IN A CHAIR, SUBTRACT WEIGHT OF CHAIR WHICH IS ON THE BACK BOTTOM RIGHT HAND CORNER (DID NOT ADD BACK WEIGHT IN WEIGHT). IF WEIGHTS ARE NOT CONSISTENT ALL 3 TIMES, START ALL OVER AGAIN. WEIGHT MUST BE THE SAME ALL 3 TIMES TO BE AN ACCURATE WEIGHT.

WHEN IN DOUBT CONTACT THE DON OR ADON

WEIGHT BINDER

Every dietary department should have a weight binder which includes:

- Weight policy
- Monthly tabs filled with each month and weeks weight committee recommendations (Jan. though Dec.)
- The first week of each month should have a copy of the monthly weights with triggers and the weight committee meeting with plan of actions taken.
- Each month or weekly weights filed in the binder must have a copy of each Physician's notification letter to verify that the Doctor and family have been notified.
- All should be organized, easy to find in case of state survey.

The purpose of the weight binder is that, if State walks in and has questions about a resident that is no longer their; you can access the weight binder and go to the month or week in question and get information on what was care planned and the reasons why.

WEIGHT GAIN/LOSS NOTIFICATION

Date:______________Resident:______________________________________________________________

Current weight:_____________ Previous weight:________________ IBW Range____________________

Current Diet:________________________________ Percentage of meals eaten___________%

Current Supplements:____________________________________________________________________

Gain/Loss:____________________# Week_________ _____1 Month_______% _____3 Month_____% _____6 Monty_____%

Factors potentially affecting weight changes:

Diabetes__________________________________________________________________________

Musculoskeletal Factors______________________________________________________________

Surgeries:__________________________________________________________________________

Hospice:___________________________________________________________________________

Malnutrition__Mild___Moderate___Severe___________________________________________

Wounds___________________________________________________________________________

Other Factors:_______________________________________________________________________

Intervention:

WEIGHT CHANGE IS DESIRED: (DESCRIBE)

Served up for dinner: ______________ Served up with lunch and supper for vegetable

Nourishing for dessert: ___________ Nourishing extra ice cream: ____________

Corrected__________________ by: ____________________________

New Orders

__________________________________________________________________________________

__________________________________________________________________________________

_____________________________

Physician Signature:__________________________________________

Family Notified: Name_______________________________________

By:__________________________

Date:__________________________

Director of Nursing:____________________________________________

Care Planned by: ____________________________________________ Registered Dietitian Notified:_________
Raising the bar. One smile at a time

Presented by: Reynold Landry
Executive Chef/ CDM CFPP CF-PS