

# Unplanned weight loss

## Standardised care process



### Objective

To promote evidence-based practice in the response to unplanned weight loss for older people who live in a residential aged care setting.

### Why the response to unplanned weight loss is important

Undernourishment and weight loss are common in older people and have a detrimental impact on the health and wellbeing of the individual. It is therefore important that unplanned weight loss is detected and acted upon.

### Definitions

**Body mass index (BMI):** a weight-to-height ratio calculation that helps assess a resident's nutritional status. The BMI is calculated using the following formula:

$BMI = \text{Weight in kilograms} \div \text{Height in metres}^2$   
(WHO 2012).

A BMI of less than 18.5 is likely to indicate underweight in older people (WHO 2012).

**Unplanned weight loss:** between 5 and 10 per cent weight loss compared with usual body weight within the preceding 3–12 months (Wong et al. 2016) or a loss of three kilograms over the preceding three months or losing weight every month for three months (Department of Health 2016).

### Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), allied health professionals (such as a physiotherapist, occupational therapist, exercise physiologist), residents and/or family/carers.

### Acknowledgement

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2017.



# Brief standardised care process

## Recognition and assessment

Remain vigilant for signs of weight loss in residents.

On admission conduct a nutritional assessment including:

- dietary history
- medical history
- physical examination
- Mini Nutritional Assessment (MNA)
- social factors
- functional ability.

## Interventions

Interventions should be implemented if:

- weight loss is detected or the BMI is less than 18.5
- the resident leaves more than a quarter of their food uneaten at two of the three meals over a seven-day period.

## Referral

- GP
- Dietitian
- Speech pathologist
- Occupational therapist
- Pharmacist
- Dentist

## Evaluation and reassessment

- Weigh the resident monthly.
- If weight loss is detected, repeat the assessment and reweigh the resident more frequently.
- Regularly review any interventions for their effectiveness.

## Resident involvement

- Discuss food and mealtime preferences.
- Provide the resident and/or family with information on nutrition and maintaining nutritional status.

## Staff knowledge and education

- Nutrition in older people
- Risk factors for malnourishment
- Creating a positive meal-time environment
- Providing assistance with eating and drinking
- Religious and cultural preferences and choices



# Full standardised care process

## Recognition

Remain vigilant for signs of weight loss in residents.

## Assessment

On admission, conduct an assessment that includes:

- dietary history
  - food preferences, cultural and religious considerations, usual number and type of meals, times meals were taken, preferred temperature of food
  - changes in appetite (for example, loss of appetite, increase in appetite)
  - changes in taste sensation
  - possible eating disorder and attitudes towards weight
- medical history
  - cognition using the Psychogeriatric Assessment Scales (PAS)
  - depression screen using the Cornell Scale for Depression in dementia (see SCP: Depression)
  - physical symptoms associated with weight loss (nausea, vomiting, diarrhoea, dysphagia or pain)
  - medical diagnosis associated with weight loss (gastrointestinal disease, diabetes or neurological conditions)
  - progression of pre-existing conditions (cancer, chronic obstructive pulmonary disease or cardiac, hepatic or renal failure) or palliative
  - weight history (for example, overweight, underweight, past fluctuations in weight or changes in clothing sizes)
  - check the resident's medications to assess their potential for causing current or future problems because some medicines can affect nutritional intake (for example, by altering the taste, reducing appetite or causing nausea) or have weight loss as an adverse effect
- physical examination
  - weight
  - BMI
  - nutritional screen using the Mini Nutritional Assessment (MNA) (a score of  $\leq 11$  requires further assessment)
  - oral and dental assessment (see SCP: Oral and dental hygiene)

- bloody or melaena stools
- pathology
- functional ability (for example, ability to eat and drink, what assistance is required with meals)
- social factors
  - abuse or neglect
  - lack of access to food.

Interventions should be implemented if:

- any unplanned and unexpected weight loss is detected or the BMI is less than 18.5
- the resident leaves more than a quarter of their food uneaten at two of the three daily meals over a seven-day period
- weight loss is sudden (this requires immediate medical attention).

Note:

- Even in overweight older people, unintentional weight loss has been shown to increase mortality. Only older people who are healthy should attempt weight loss.
- For consideration:
  - Have the scales recently been calibrated?
  - Is the same set of scales being used each time the resident is weighed?
  - Is the resident weighed at the same time of the day and in the same clothes?

The assessment should be informed by the resident's wishes, particularly when receiving a palliative approach.

## Interventions

Where screening and assessment identifies that a resident has unplanned weight loss or is at risk of weight loss:

- Weigh the resident more frequently.
- Refer to a GP for a medical review to determine any underlying causes.
- In consultation with the GP, treat any underlying causes.
- In consultation with the GP and pharmacist, check the resident's medications to assess their potential for causing current or future problems.
- Refer to a dietitian to evaluate the resident's food, fluid and nutrient intake and energy needs.
- Where indicated, refer to a speech pathologist for a swallowing assessment.

- Where indicated, refer to an occupational therapist for aids and adaptations to the resident's eating utensils.
- Following a discussion about food preferences with the resident and/or their family, offer the preferred foods.
- Increase the resident's calorie and protein intake (as per the dietitian's recommendations).
- If possible, in consultation with the GP and dietitian, limit dietary restrictions (for example, salt, sugar, fats and oils).
- Offer small meals more frequently and increase the availability of food outside mealtimes.
- Reheat or keep warm food for residents who eat slowly.
- Modify food and fluids to the right texture for residents with dysphagia.
- Provide nutritious finger foods.
- Provide appropriate mealtime aids and/or physical assistance with meals (for example, full assistance with feeding, opening packages, ensuring the food is within reach and regular/frequent prompting). Assistance should be provided at the right level for the resident to maintain independence.
- Ensure adequate fluid intake (see SCP: Dehydration and SCP: Constipation).
- Maintain adequate oral and dental hygiene (see SCP: Oral and dental hygiene). Refer to a dentist where required.
- Encourage the resident to wear dentures and ensure that they fit properly.
- Ensure appropriate positioning for meals – at a table is ideal but if the resident needs to rest in bed ensure he/she is sitting upright and is supported in this position.
- In consultation with the dietitian and GP, provide nutritional supplements. Note: Nutritional supplements should be given between meals because they may reduce the appetite and food intake if given with meals.
- Encourage exercise within the resident's abilities to stimulate their appetite and promote muscle strength.
- Promote a relaxed and social dining environment in the following ways:
  - Minimise mealtime interruptions.
  - Encourage the resident to eat in the company of others (for example, in the dining room, staff being with the resident at mealtimes or asking family to be present at mealtimes).
  - Ensure that food presentation is attractive and palatable.
- Stimulate the resident's appetite by intensifying the smell and taste of the food.
- Promote food intake with intimate dining areas, high-contrast tableware, background music and a focal point such as an aquarium.
- Consider seating arrangements and seating comfort.
- Allocate sufficient staff and time to assist with mealtimes.
- Encourage volunteers and family to assist at mealtimes.
- Consult with residents when preparing menus and making food choices.

## Referral

- GP
- Dietitian
- Speech pathologist
- Pharmacist
- Dentist for management of decayed or broken teeth or ill-fitting dentures

## Evaluation and reassessment

- Weigh the resident monthly.
- If weight loss detected, increase the frequency of weighs.
- Regularly review any interventions.

## Resident involvement

- Discuss food and mealtime preferences as above.
- Provide the resident and/or family with information on nutrition and maintaining nutritional status.

## Staff knowledge and education

- Nutrition in older people
- Risk factors for malnourishment
- Creating a positive mealtime environment
- Providing assistance with eating and drinking
- Religious and cultural preferences and choices



# Evidence base for this standardised care process

Bellman S 2017, *Mealtime assistance in aged care: evidence summaries*, The Joanna Briggs Institute, Adelaide.

Department of Health 2016, *National Aged Care Quality Indicator Program: Resource manual for residential aged care facilities*, September 2016 edition, Australian Government, Canberra.

DiMarie-Ghalili RA 2016, 'Nutrition', in M Boltz, E Capezuti, T Fulmer, D Zwiker (eds), *Evidence-based geriatric nursing protocols for best practice*, 5th edition, New York: Springer.

Nestlé Nutrition Institute 2018, *A guide to completing the Mini Nutritional Assessment – Short form (MNA-SF)*, viewed 18 January 2018, <<http://www.mna-elderly.com>>.

Social Care Institute for Excellence 2009, *SCIE Guide 15 – Dignity in care. Nutritional care and hydration*, SCIE, London.

World Health Organization (WHO) 2012, *Global database on body mass index: BMI classification*, viewed 18 January 2018, <<http://www.who.int/nutrition/databases/bmi/en/>>.

Wong CJ, Shand A, Chamberlain SM 2016, 'Assessment of unintentional weight loss', *BMJ Best Practice*, viewed 25 January 2018, <<http://bestpractice.bmj.com/topics/en-us/548/pdf/548.pdf>>.

**Important note:** This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

To receive this publication in an accessible format phone 9096 6963, using the National Relay Service 13 36 77 if required, or email <[acqiu@dhhs.vic.gov.au](mailto:acqiu@dhhs.vic.gov.au)>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, March 2018. (1802012)

ISBN 978-0-7311-6856-9(pdf)

Available from the department's website at <[www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes](http://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes)>.