infuse

OCTOBER 2021

STEEP YOURSELF IN INSPIRATION, INNOVATION & DEBATE

Malnutrition is everybody's business

Malnutrition Week ANZ

FEATURE ARTICLES INSIDE:

dietitianconnection®

From the desk of Maree Ferguson

Founder & Director, Dietitian Connection

Welcome to this very special Malnutrition Week ANZ 2021 edition of Infuse! Malnutrition is still one of my passions, having completed a PhD in the area more than 20 years ago. It's humbling to see the Malnutrition Screening Tool created by Sandra Capra, Judy Bauer, Merrilyn Banks and myself being used all over the world still so many years later. I wanted to thank each and every one of you, our valued dietitian colleagues and friends, for the hard work you do every single day to improve the nutritional status of your patients and clients.

The theme for this year's Malnutrition Week ANZ campaign is: *Malnutrition is everybody's business.* We would absolutely LOVE for you to share the campaign with your colleagues and workplaces. Please do everything you can to spread the word and educate others about the impact of malnutrition – and what we can do to prevent it.

The Dietitian Connection team was blown away last year by the lengths the dietitian community went to in order to make noise in the malnutrition space, especially given the circumstances around COVID-19. See below a small snapshot of what we collectively achieved. We can't wait to see what you've got in store this year – what are you going to do to make sure malnutrition is on everybody's radar?

Images (L-R): St Andrew's War Memorial Hospital, WA Country Health Service, Central Adelaide

MWANZ 2020 MATERIALS AND MESSAGES REACHED

382,900 *people*

>2,000

DIETITIANS

WERE INVOLVED IN MWANZ 2020

3AW RADIO SEGMENT

WITH KAREN INGE AND EMMA MITS DURING MWANZ 2020 REACHED

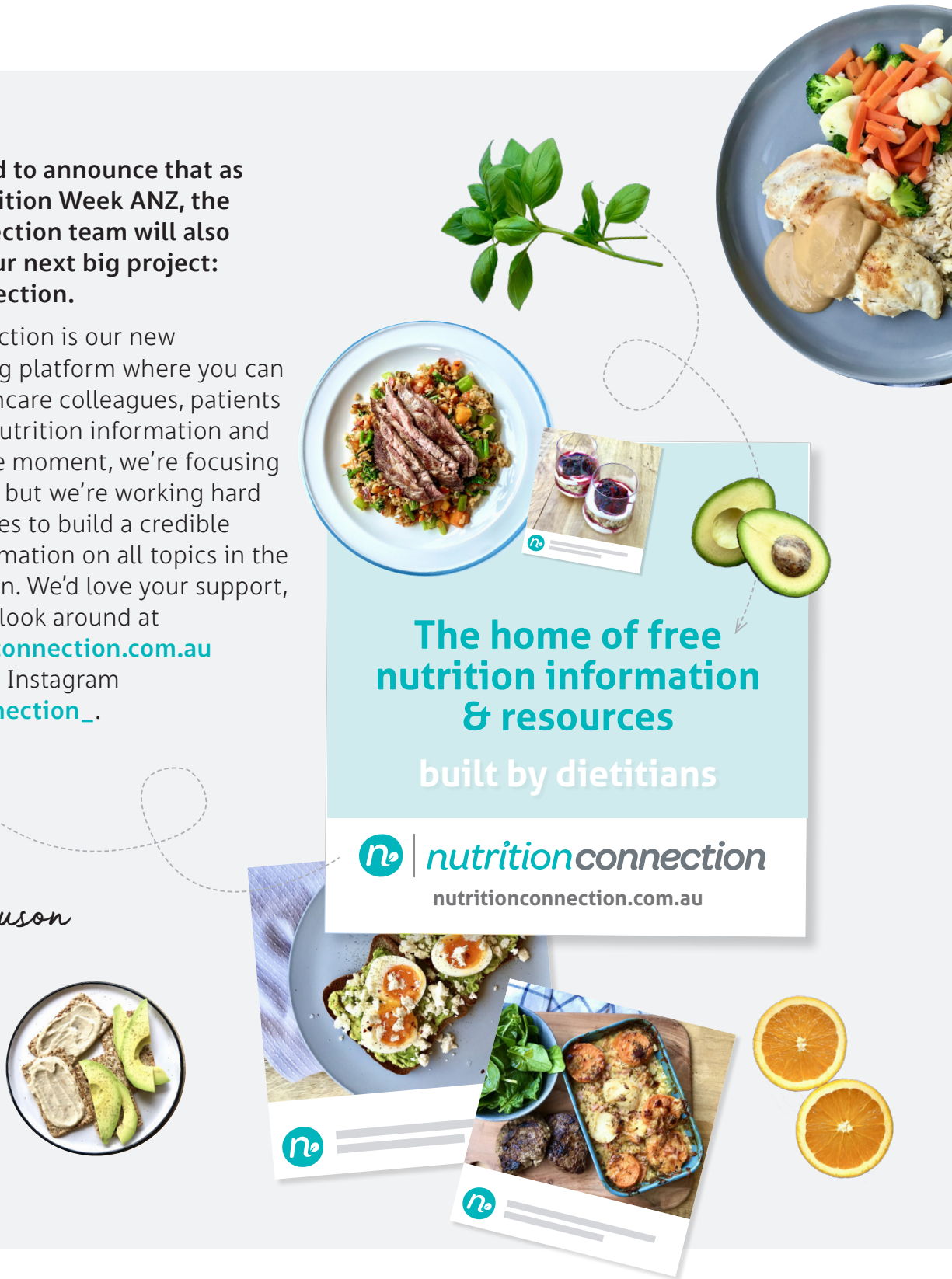
98,000 *people*

I'm very excited to announce that as part of Malnutrition Week ANZ, the Dietitian Connection team will also be launching our next big project: Nutrition Connection.

Nutrition Connection is our new consumer-facing platform where you can send your healthcare colleagues, patients and clients for nutrition information and resources. At the moment, we're focusing on malnutrition, but we're working hard behind the scenes to build a credible space with information on all topics in the world of nutrition. We'd love your support, so please take a look around at **www.nutritionconnection.com.au** and follow us on Instagram **@nutritionconnection_**.

Until next time!

Maree Ferguson



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#MalnutritionWeekANZ

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Malnutrition Week ANZ

Say hello to Tegan,
our new team member at DC!

Tell us how pursuing a career in dietetics all started?

From an early age, I've been interested in the health industry, to some degree influenced by my two older sisters who both work in the field. I attended an allied health career expo in Year 10 where all of the allied health professionals came on stage and talked about what their job involved. Hearing the dietitian talk about their profession and day-to-day activities struck a chord and I became enthused about the idea of pursuing this myself.

My passion for dietetics has only grown since then and so I selected Bachelor of Nutrition Science at Queensland University of Technology as my first preference when applying for courses. A year later I made my way into the Nutrition and Dietetics program.

How did your career progress from there?

I applied for numerous grad jobs after finishing university but none of them progressed. At that point I started to have doubts about my career path, and reconsidered whether or not dietetics was for me. I recognized during this time that clinical and private practice dietetics likely wasn't the right fit. I continued working in my casual role at the Queensland Tennis Centre and was offered the role of administration and marketing coordinator. It was in this role that I fell in love with all things marketing and social media. However, I really missed the nutrition space after some time and so began to look for roles that combined my two passions – nutrition and marketing. Not long after this I came across the advertisement for the Marketing and Communications Assistant at Dietitian Connection and couldn't believe how perfectly it matched what I was looking for. I immediately applied for the role and the rest, as they say, is history.

What attracted you to working at Dietitian Connection?

I've been following the work of the team at Dietitian Connection since my second year at uni. I was then, and am now, so inspired by the incredible business Maree founded and the fantastic resources that Dietitian Connection has provided the industry since. When I saw DC's job ad it was a no brainer to apply at this wonderful company and I feel incredibly lucky to be part of this amazing DC team!

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(1) GLNC (2010) Grains & Legumes Health Report. Grains & Legumes Nutrition
(2) The GI values of the products were measured using the valid scientific methodology (ISO 26642:2010) at an Australian University

Step *inside*

OCTOBER 2021 ISSUE

infuse

STEEP YOURSELF IN INSPIRATION, INNOVATION & DEBATE

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Have we missed a diagnosis? Challenge accepted!

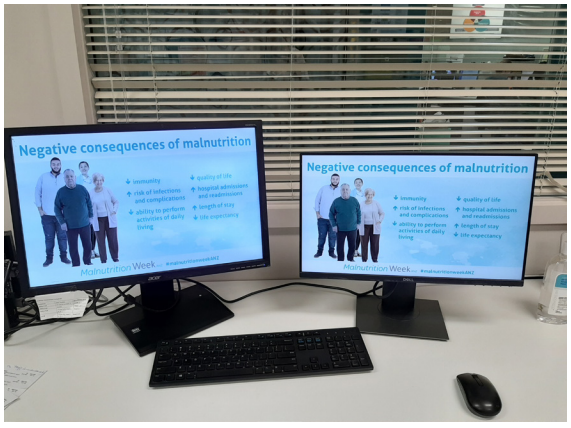
Emily Gilchrist, Team Leader and Tory Crowder, Clinical Manager Nutrition & Dietetics Christchurch Health Campus, New Zealand

2020 marked Dietitian Connection's first ever Malnutrition Week ANZ campaign. As part of our campaign, we urged our community to get involved and make as much noise as possible in the malnutrition space. Here's one of many stories of innovative awareness-building initiatives.

Our team is based at Christchurch Hospital, a tertiary hospital and the second largest in New Zealand. We have 35 dietitians in our team which includes Paediatric, Adult, Women's and Diabetes dietitians who provide inpatient and outpatient services. We are also lucky to have two dietary assistants. After what can only be described as an unprecedented last 10 years (with the 2011 earthquake and a terrorist attack in a mosque in 2019), our city continues to grow.

Our city has been rebuilt and, more recently, a brand-new hospital has opened. Christchurch is again the attractive and bustling city it once was. Yet, along with the rest of the world, we started 2020 with the arrival of the COVID-19 pandemic and, despite being a resilient team, we couldn't help but feel like sitting ducks as we prepared our hospital and our service for the unexpected.

...it didn't take long for the ideas to start flowing and balloon into something bigger than we ever envisaged.



Screen savers used throughout Christchurch Hospital. Image courtesy of Nutrition & Dietetics Christchurch Health Campus

By mid-year, it was clear COVID-19 was not leaving anytime soon. After an unnerving few months with no travel, the hopes of attending any dietetic course or conference beyond New Zealand (let alone within New Zealand!) was farfetched. We had spent most of 2020 with our heads down preparing for the worst, upskilling on COVID-19 in the Intensive Care Unit and creating nutrition triage pathways for probable COVID-19 cases... but thankfully, the worst never came to New Zealand. So, when Dietitian Connection started promoting their inaugural Malnutrition Week ANZ campaign and asked hospitals to get involved, our team thought 'challenge accepted!'. We were excited to get involved and make the most of a fantastic opportunity to promote our profession, increase awareness of malnutrition and create some noise in the malnutrition space.

We promptly got a committee together to brainstorm ideas and activities. We delegated tasks and spent two whole months creating an action plan that targeted multidisciplinary teams. It went well beyond the basics of celebrating our usual awareness weeks! Thanks to the theme 'Have we missed a diagnosis?' and the amazing promotional materials developed by Dietitian Connection, it didn't take long for the ideas to start flowing and balloon into something bigger than we ever envisaged.

In the lead up to Malnutrition Week ANZ, we had a feature on 'one minute with....a dietitian' in our CEO newsletter and daily internal emails. It reached all Christchurch Hospital employees and promoted the upcoming Malnutrition Week ANZ and the activities we were organising.

Image courtesy of Nutrition & Dietetics Christchurch Health Campus

We had a different activity planned for each day. One event involved gathering all allied health staff for a very appropriate high-energy, high-protein morning tea to highlight the importance of snacking between meals. Staff also learnt key malnutrition messages along the way. Plus, the morning tea proved that dietitians do in fact indulge in sweet treats!

We also spread our passion and powerful messages further across the entire hospital by creating screensavers that appeared on every computer, visible to doctors, nurses and hospital aids. We even lured first year medical staff in to trialling oral nutritional supplements, including thickened ice cream, to eradicate any preconceived views around taste. They also took part in a quiz that busted many malnutrition myths.

THINK E.A.T.S:

- Encourage – *are family members helping or hindering meal times? Can a hospital aid help to encourage eating?*
- Assist – *can the patient sit out of bed to eat? Can the patient open food and drink/supplement containers? Is the patient's bed tray within reach? Does the patient need full or partial feeding?*
- Timing – *does the patient have time to eat? Do meds/tests/scans interrupt meals or enteral feed times? Do you need to protect meal times? Start enteral feed at prescribed time*
- Symptoms – *are symptoms like nausea, constipation or thrush affecting eating? Are regular mouth cares needed? Do their dentures tilt?*

Patients, friends and family weren't forgotten, either. Patients got guidance on what to eat via meal tray flyers and visitors were greeted at the hospital by a large noticeboard with plenty of useful resources to take home.

Our biggest accomplishment (which, like many great ideas, came to mind while standing in the shower), was to create a malnutrition alert – a symbol on our patient management system that identifies patients who have been diagnosed with malnutrition. This logo went hand in hand with our message 'Think E.A.T.S' , an acronym that outlined key considerations for malnourished patients. (See breakdown beside)

As we know, the issue with malnutrition isn't just identifying those at risk, but consistently thinking about how we can treat malnutrition, how we can improve malnutrition outcomes and how all health professionals can get involved. This alert was an initiative that demonstrates malnutrition is everyone's business and requires a cultural shift to empower others to recognise and improve outcomes. We took the opportunity to launch the malnutrition alert during Malnutrition Week ANZ where it would reach key stakeholders at a time where malnutrition was a hot topic.

Malnutrition Week ANZ inspired our dietetic team to be creative, collaborative and deliver an incredible week filled with meaningful and enjoyable activities.

The malnutrition alert continues to be used daily at Christchurch Hospital. It has been inspiring to see something stem from just a week-long event into a bigger and more powerful campaign.

The team enjoying their prize for their participation in Malnutrition Week ANZ 2020 – tickets to the Dietitians Unite virtual conference in May 2021

Images courtesy of Nutrition & Dietetics Christchurch Health Campus

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Frailty, falls and fractures: the three Fs of geriatric medicine

Nutrition and geriatric medicine are closely interlinked. DC's Jane Winter recently sat down with Professor Gustavo Duque to explore the interplay between muscle, bone and nutrition in older people, and the impact this matrix has on frailty, falls and fractures.

PROFESSOR GUSTAVO DUQUE
is a geriatrician and a clinical and biomedical researcher with a particular interest in the mechanisms and treatment of osteoporosis, sarcopenia and frailty in older persons.

Why is having a fall so problematic for an older person?

Falls are major events that can have a serious impact, not just directly from the trauma or lesion, but psychologically, too. After a fall, independence and quality of life can deteriorate due to fear of falling. Older people can lose interest in their daily activities or their hobbies, and some even stop eating or reduce their intake dramatically. So, it's imperative to prevent falls.

What is sarcopenia and how is it connected to osteoporosis?

Up until recently, the focus for older people was on maintaining healthy bones, not muscles – muscle loss was just considered a normal part of ageing. Relatively recent research into muscle loss with age, however, has identified a condition called 'sarcopenia', which is the loss of muscle mass along with the loss of muscle function and strength. This is not a normal part of ageing. It is a disease that we can now identify and treat in clinical practice.

Muscle and bone tissue both come from the same precursor, and they remain connected throughout life. Muscle cells and bone cells are constantly communicating via hormones or different growth factors. Together, strong bones and strong muscles reduce your risk of fractures.

How do you identify someone with sarcopenia?

There are the three good, practical tests:

1. Gait speed. If gait speed is below 0.8 metres per second, that is suggestive of sarcopenia.
2. Ask the patient to sit down in a chair and calculate the time it takes the person to sit and stand up five times.
3. Grip strength using a dynamometer. This is much more sensitive than gait speed.

If patients do an exercise programme, have appropriate nutrition support and correct their vitamin D levels, muscle strength and function will improve, but not necessarily muscle mass.

What are the general recommendations you have in terms of protein for older adults?

There are two categories for indicating protein supplementation:

1. For healthy older adults who are functional and have relatively good access to food, the recommendation is 1.0–1.2g protein per kilogram of their body weight per day.
2. For frail, older adults who have higher nutritional requirements, we go up to 1.5g protein per kilogram of their body weight per day.

Leucine is a particularly important amino acid for older people. It provides a structural base to form muscle and improve or maintain muscle mass. Beta-hydroxy-beta-methylbutyrate (HMB) is a metabolite from leucine and it helps to increase muscle mass, function and strength. The optimal dose of HMB for muscle health benefits is 3g per day, but you would need to eat a lot of protein to get that amount because only around 5% of leucine in the diet is converted into HMB.

Has there been research into supplementation with HMB on outcomes?

Yes. There have been good, well-designed studies looking at the effect of a high protein multi-nutrient oral nutritional supplement drink enriched with HMB on muscle,

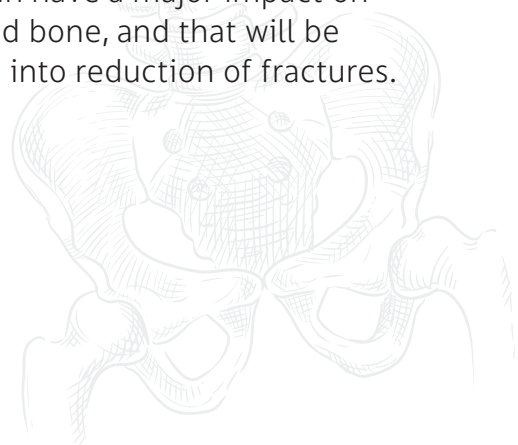
particularly in the context of post-operative hip fracture patients. These studies have seen an improvement in muscle strength, wound healing and mobility at 30 days which is an impressive response.

Obviously, nutrition is essential, but can you tell us who else is in the management team at your falls and fractures clinic, aside from medical staff? And do you see the multidisciplinary team as part of the success of getting the right outcomes?

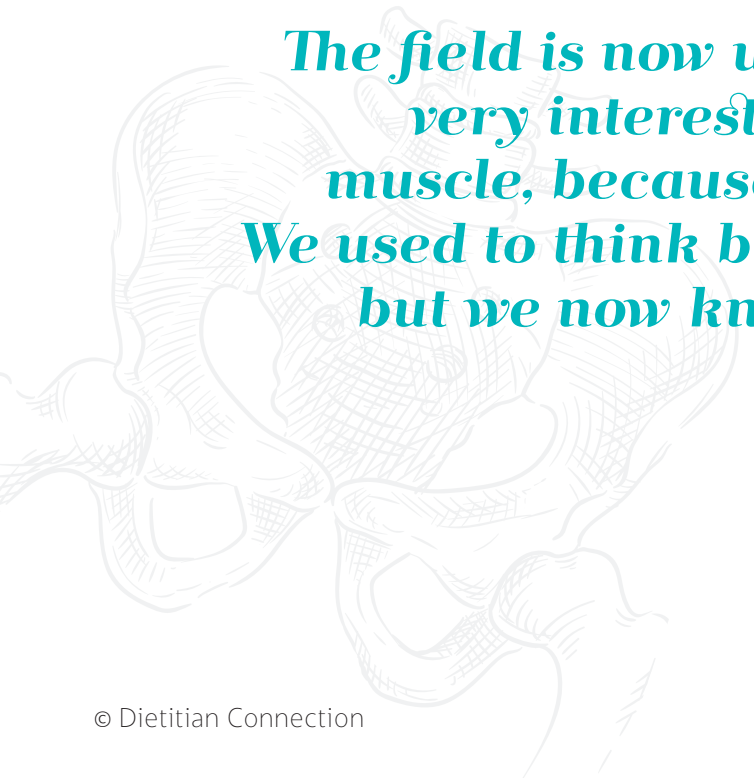
We have a fracture liaison nurse and an exercise physiologist. We do the mini nutritional assessment on all our patients. We aim to identify who is at risk and refer them to the dietitian for further assessment if we consider it appropriate. I love that we have the opportunity to identify and value the importance of a multidisciplinary approach to our patients. We are treating people with multidimensional problems – they are not only biological, but are also physical, social and nutritional. We have to approach all these dimensions via a well-integrated, multidisciplinary team.

What do you think would be your key take-home messages about the three Fs: falls, fractures and frailty?

1. For all older persons, think about their risk of falls, fractures and frailty.
2. Proactively look for their symptoms using simple tools and suggest a bone mineral density scan in patients who are older than 70. You will be surprised at the number of people who have osteoporosis.
3. Start interventions. We have a great opportunity with nutrition interventions. We know that nutritional interventions that combine HMB, vitamin D, calcium and protein have a major impact on muscle and bone, and that will be translated into reduction of fractures.



The field is now understanding something very interesting: bones could regulate muscle, because muscle regulates bones. We used to think bone was just for structure, but we now know it's biologically active.



Click here for a full reference list.

ANZ.2021.19263.ENS.1 (v1.0)

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References: 1. Baier S *et al. JPEN J Parenter Enteral Nutr* 2009;33(1):71–82. **2.** Ensure® Plus Strength Product Label. **3.** Deutz N E *et al. Clin Nutr* 2016;35(1):18–26. **4.** Ekinci O *et al. Nutr Clin Pract* 2016; 31(6): 829-835. **5.** Malafarina V *et al. Maturitas* 2017;101:42–50.

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Dietitians: nutrition leaders in aged care settings

Judi Porter, Professor in Dietetics at Deakin University

Few Australian dietitians missed the narrative presented to the Royal Commission into Aged Care Quality and Safety. There were images and descriptions of malnourished elders and poor-quality meals... but excellence in care and foodservice were concurrently on display.

The challenges of delivering high quality nutrition care within this sector are well known to many dietitians. For example:

- Inconsistency in staff knowledge and skills to support care delivery
- Inconsistency in staff knowledge and skills to focus on nutrition
- Insufficient menu budgets

The findings and recommendations of the Royal Commission into Aged Care Quality and Safety are **now publicly available.** There is also some **preliminary government response and funding commitments.**

Now is the time for us to consider the future of dietitians leading nutrition care in aged care settings.

MOMENTUM FOR CHANGE

Along with Julie Dundon, I was fortunate to be a Dietitians Australia Subject Matter Lead for Aged Care over 9 months to the end of June 2021. In this role, Julie and I:

- ✓ **Prepared various responses to Royal Commission documents**
- ✓ **Wrote position and funding statements for professional and government discussions**
- ✓ **Developed evidence-based positions for Dietitians Australia across the spectrum of nutrition care for the Maggie Beer Foundation Congress in February 2021**

A **virtual issue of Nutrition & Dietetics that focused on aged care research** was also published for release in conjunction with this congress. Along with the contribution by many APDs who work in aged care, this advocacy has built momentum for change. The opportunity to improve the nutritional status of our older Australians has arrived.

The Royal Commission: what was recommended?

The recommendations of the Royal Commission are diverse and have a clear focus on the importance of nutrition care supported by greater access to dietetic services for recipients of home care and residential aged care services. Recommendations included:

- The assignment of funding for allied health care within home care packages *(Recommendation 36)*
- The employment of dietitians in residential aged care facilities *(Recommendation 38)*
- Increased funding for workforce development *(Recommendations 78–82)*
- Increased food budget via an increased basic daily fee per resident *(Recommendation 112)*

Funding has been supported in the 2021 budget announcement for some, but not all, of these recommendations.

There have been no changes recommended to this point regarding our advice to implement mandatory malnutrition screening as a quality indicator for all residential aged care services.

Through linking hospitalisation records to people in residential aged care for the period 2014/15 to 2018/19, the Royal Commission determined that 1.5–1.9% of residents were admitted to hospital with a primary or secondary diagnosis of weight loss or malnutrition.

Researchers noted that this is likely less than the overall malnutrition prevalence, which has been repeatedly reported around 50%. Leaving unplanned weight loss as the nutrition quality indicator is worrying, as this results in residents who are not at nutritional risk but lose weight on successive occasions receiving specialist dietetic care, while other malnourished residents are not referred to a dietitian at all. Continued advocacy may see this overturned in future reviews of the quality indicator program.

...the Royal Commission determined that 1.5-1.9% of residents were admitted to hospital with a primary or secondary diagnosis of weight loss or malnutrition.

HOW CAN WE BE A FORCE FOR CHANGE?

The recommendations of the Royal Commission set nutrition care of consumers receiving aged care services (at home and in residential care settings) at the forefront of the national agenda. Never (in my career, at least) have I seen such a level of political engagement in nutrition care of older Australians.

It really is the time for dietitians to lead in delivering nutrition care across the sector. But where to begin?

There are notable workforce challenges to deliver some of the recommendations. Our specialist workforce in aged care needs to be expanded. In my opinion, meeting these workforce challenges cannot be delivered solely by the professional association, dietetics accreditation processes or the university system. New graduates can play a role in providing clinical nutrition care in aged care settings, but mentoring and supports are needed, particularly in the complexities of food service settings and across multi-site aged care groups.

These may be challenging to organise given the competitive contracting arrangements in residential aged care, but we do have experienced practitioners who can lead and support the emerging workforce.

Building partnerships locally within facilities but also more broadly within the industry will also be key to our success. Small steps contribute to building bigger and more expansive partnerships, and should ultimately lead to improved nutrition care and nutrition outcomes over time.

In addition to the clinical focus assumed through the expanded allied health workforce funding, delivering high quality food services is another challenge that confronts our profession. Dietitians can contribute evidence-based care across the spectrum of food services, including food production and presentation, and the dining experience. There will be challenges in implementing and monitoring the initiative announced in the May 2021 federal budget – a Basic Daily Fee supplement increase of $10 per resident per day. These funds have been earmarked to contribute to a greater overall spend on food. The issues raised within presentations to the Royal Commission mostly related to meal quality (including variety, texture and temperature), not food quantity. Indeed, **our own recent multi-centre research** showed that only 9.8% of residents finished their main meal (lunch or dinner) across a 24 hour period.

The purchase and production of larger quantities of food with this additional budget supplement will not be widely needed – instead, it is the purchase of quality ingredients and their transformation into delicious high energy, high protein meals that should be the focus.

There has been commitment from families, carers and staff to share their stories and plead for system change, and substantial funding granted to support the first stages of many that are needed. **The time could not be better for dietitians to work individually and collectively to address the recommendations from the Royal Commission in Aged Care.**

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Don't tolerate dairy? Here's what you could do

by Andrea Hardy, RD

Do you have patients who experience symptoms of digestive discomfort after consuming dairy? Patients who struggle to digest dairy could be lactose intolerant or, in some cases, could even be experiencing sensitivity to a type of protein found in cows' milk called A1 protein.

The good news is that there may be options you could try for these patients, which don't necessarily have to involve cutting out dairy altogether! Let's dive into the different reasons why dairy might cause digestive distress in some people, and what you can suggest doing about it.

WHAT IS LACTOSE INTOLERANCE?

There are multiple reasons why a person might not tolerate dairy products. The first of these is lactose intolerance. Lactose, the natural sugar found in milk and dairy products, is normally broken down by the enzyme lactase. Some people do not produce enough of the lactase enzyme, meaning lactose can move through the gut undigested. When lactose reaches the colon, it gets fermented by our gut microbiome, causing symptoms like gas, abdominal pain, bloating and diarrhoea.

To manage lactose intolerance, people can typically either choose lactose-free dairy products or take lactase enzyme pills to help them digest lactose. But are there any other options available for dairy intolerant patients?

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Recent studies have shown that some people who have difficulty consuming dairy may experience digestive benefits after switching from regular cows' milk to milk which contains only the A2 protein, and no A1 protein*.

DIFFICULTY DIGESTING A1 PROTEIN?

Milk contains both whey and casein proteins. About 30% of the protein in cows' milk is a type of protein called beta-casein, of which there are two main types, A1 and A2. Cows produce either A1 or A2 protein, or a mix of both, in their milk depending on their genetic variation.

Research suggests that A2 protein may be easier on digestion than A1 protein for some people due to a slight difference in how A1 protein versus A2 protein is digested. The consumption of regular cows' milk containing A1 protein has been associated with digestive symptoms like abdominal pain, bloating and diarrhoea in some people.[1-5]

IS THERE A TEST FOR DAIRY INTOLERANCE?

So, how will you know if your patient is lactose intolerant or sensitive to the A1 protein? There are several tests to measure lactose intolerance. The most common are breath tests or blood tests, where you consume a lactose-containing beverage, and over a period of time, the lab is able to measure whether or not lactose is digested.

Unfortunately, there is no validated test to determine whether a person is sensitive to A1 protein. However, that doesn't mean that we can't use a little experimentation (also known as empiric testing) to figure out whether an A1 protein intolerance may be contributing to your patient's digestive symptoms after consuming dairy.

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IS THERE A WAY TO SEE IF A1 PROTEIN MAY BE CONTRIBUTING TO YOUR PATIENTS' DIGESTIVE DISCOMFORT?

To test whether your patient may be sensitive to A1 protein, a little self-experimentation is required. This simple step-by-step method is what I use with patients when exploring whether A1 protein might be contributing to their digestive symptoms.

We start with a temporary trial removing all dairy from the diet. This includes temporarily removing things like milk, yogurt, and cheese. If symptoms improve, this tells me dairy could be contributing.

Our next step is to add milk back in. We start with milk containing only the A2 protein to determine whether it could be the A1 protein contributing to the digestive symptoms. If we know the patient is lactose intolerant, I'll have them take lactase enzymes to ensure their lactose intolerance symptoms don't confound the results.

If milk containing only the A2 protein is tolerated – that is a pretty good indicator that the A1 protein could be contributing to their digestive distress – but we do one final check to see. Once they've trialled milk containing only the A2 protein for at least a few days and there has been no change in their digestive symptoms relative to baseline, it's time to trial regular cows' milk. For the best comparison, trial an equal amount of regular cows' milk. For example, if they trialled two cups of milk containing only the A2 protein daily, ask them to consume two cups of regular cows' milk daily.

If your patient's digestive symptoms were better managed when consuming the milk containing only the A2 protein compared to regular cows' milk, then this could be an indication that A1 protein is a contributor to their digestive discomfort.

The good news is that milk containing only the A2 protein may be a great way for some of these patients to consume dairy while managing their digestive symptoms. a2 Milk™ comes from cows that only produce A2 protein – meaning they'll get none of the A1 protein found in most regular cows' milk, which contains a mix of A1 and A2 proteins. No reason to give up dairy, simply swap your patient's regular milk for milk containing only the A2 protein.

*A1 and A2 proteins refer to A1 and A2 beta-casein protein types

Click here for a full reference list.

What is a2 Milk™?

Naturally A1 protein free

a2 Milk™ comes from cows specially selected to naturally produce milk with only the A2 beta-casein protein type.

a2 Milk™

Most regular milk

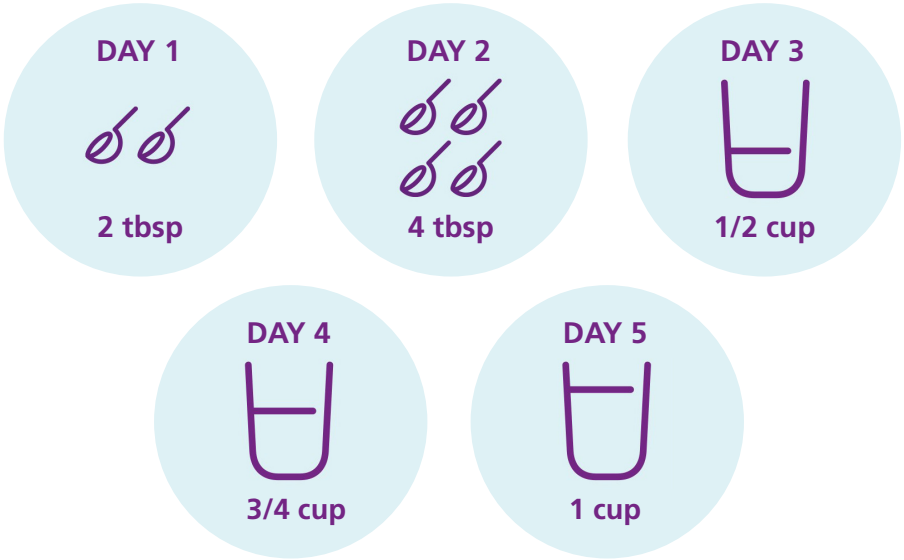
Work with your patients and clients to determine their individual tolerance

When introducing a2 Milk™ to patients or clients try following these simple steps:

1. **Start with small portions** in tea, coffee, and recipes
2. **Gradually increase over a week** to a full cup of a2 Milk™

See sample reference below

3. **Avoid other regular dairy foods** during this reintroduction phase



Delirium and malnutrition: what do dietitians need to know?

Adrienne Young (AdvAPD), Elise Treleaven (APD), Alison Mudge (Physician) and Margaret Cahill (Clinical Nurse Consultant)

Delirium affects 1 in 4 patients in ICU and acute medical wards but is prevalent across all areas of the hospital and even after discharge – so all dietitians should be on the lookout.

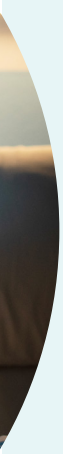
Malnutrition and delirium are interrelated and affect up to 50% of older hospital patients. Both conditions are multifactorial, under-diagnosed and linked to worse outcomes, including increased mortality.

Poor nutrition and hydration are risk factors for the development of delirium, and people with delirium are significantly more likely to have poor oral intake[1], potentially creating a viscious cycle of nutritional decline. Whilst most common in older people, delirium can affect people of all ages and across the continuum of care. Dietitians need to know what delirium is, how to prevent it and how to manage it.

WHAT IS DELIRIUM?

Delirium is a serious condition. It can be considered an "acute brain failure". It is categorised by inattention and an acute change in cognition due to a medical condition, medication and/or intoxicating substance[2]. Delirium is very different to dementia in that it often has a rapid onset (hours to days, rather than months to years) and has a fluctuating course. A person with delirium can seem "normal" one day, and confused, drowsy, agitated or even aggressive the next. It can have a short duration or last for a long time, even after hospital discharge.

Delirium is a highly distressing experience for the person, their family and the staff caring for them[3]. People often talk about their delirium as living their worst nightmares, speaking of scenarios such as being kidnapped, locked away in prison, drowning or in a plane about to crash. This can lead them to view hospital staff, food, drinks and medications with suspicion and fear, and cause aggressive refusal or attempted escape. Subsequently, the use of restraint or sedation may be necessary, which carries further risk of harm to the patient. These experiences feel very real in the moment, and the memories can remain with the person and their family for a long time.



Delirium, however, doesn't always present in this way. Some patients experience *hypoactive delirium,* which can present as apathy, drowsiness, disorientation and motor slowing – but it can be just as dangerous as it more often goes undetected and unmanaged. It also leads to poor oral food and fluid intake, poor engagement in self-care and mobility and a cascade of harmful complications such as falls, pressure injuries and incontinence, which can translate to long hospital stays and residential care placement.

WHO IS AT RISK?

Anyone who is unwell can develop delirium, even children. A fit and healthy person can develop delirium after major trauma, illness or surgery, though it is most common in older and/or more frail people and can occur with relatively minor issues like urinary tract infections, dehydration or hyponatraemia. There are usually several contributing factors, and things done to the patient in hospital that can add to the risk; for example, intravenous lines, nasogastric tubes and catheters. Interrupted sleep and environments where it is hard to identify the time of day (no clocks or windows) can also contribute.

Delirium can be considered an "acute brain failure". It is highly distressing for the person, their family and the staff caring for them.

HOW IS DELIRIUM IDENTIFIED?

There are validated screening tools for delirium that any member of the multidisciplinary team can use. Dietitians are often involved in the care of patients at risk of delirium (see beside), so we are ideally placed to identify delirium as part of our routine nutritional assessment. We can use screening tools such as **the 4As test**, or simply look for key indicators of delirium such as:

- **Poor alertness**
- **Inattention**
  (e.g. unable to follow your questions or easily distracted)
- **Poor cognition**
  (e.g. disoriented to the day or place; issues recalling what they ate for lunch)

If you are concerned about a change in a patient's behaviour or cognition, you should inform the multidisciplinary team so the doctor can conduct a formal delirium assessment.

Dietitians are often involved in the care of patients at risk of delirium... so we are ideally placed to identify delirium...

Risk factors for delirium[4,5]

Predisposing factors:

- ☐ Over 65 years of age
- ☐ Dementia, previous delirium or other cognitive impairment
- ☐ Frailty
- ☐ Vision and/or hearing impairment
- ☐ Comorbidities *(e.g. heart, lung or kidney disease)*
- ☐ Multiple medications
- ☐ Previous alcohol/substance misuse

Precipitating factors:

- ☐ Malnutrition
- ☐ Dehydration
- ☐ Medications, particularly sedatives
- ☐ Infection
- ☐ Pain
- ☐ Urinary retention or constipation
- ☐ Hypoxia
- ☐ Electrolyte disturbances *(e.g. serum sodium levels)*
- ☐ Any serious illness or major operation

HOW CAN YOU PREVENT AND MANAGE DELIRIUM?

There is no simple fix for delirium. No drugs can effectively prevent or treat it. Instead, delirium requires a whole-of-team-and-hospital management approach which focuses on mobility, optimising nutrition and increasing engagement in meaningful activities[6,7].

Hospital mealtimes are a key target for preventing delirium or supporting a patient experiencing it. Mealtimes in hospital are often chaotic and do not simulate a usual home eating environment. This can be confusing and unsettling for a patient with delirium and lead to poor oral intake.

Dietitians and other hospital staff can help to prevent delirium by:

Encouraging patients to prepare for the mealtime
- *Sitting out of bed*
- *Clearing and/or adjusting the table*
- *Turning the lights on*

Proactively providing high protein and energy meals, snacks and finger foods for patients at high risk of delirium and malnutrition
For example, older medical and surgical patients.

Creating shared dining experiences
For example, enabling patients to eat together or encouraging family or volunteers to eat with patients.

Orienting the patient to time and place
For example, "Your breakfast will be delivered soon", "It's nearly dinner time", or "Tuesday night is apple pie night!".

Providing encouragement during the meal

Ensuring nutritious food is available on the ward at all times of the day and night

Being flexible in timing of meals

Minimising distractions

Educating other staff and family members about delirium and supportive mealtimes

Examining mealtime practices through initiatives like audits and patient feedback with the multidisciplinary team

Providing assistance *For example, opening packages, cutting food into manageable pieces, placing cutlery in the patient's hands or facilitating the use of adaptive aids.*

Considering enteral feeding for a person–with delirium requires a person centred and multidisciplinary approach to weigh up the risks of tube placement and feeding against benefits of adequate nutrition. Physical restraints (including mittens) or chemical sedation to facilitate enteral feeding is not appropriate; instead, consider the use of fiddle blankets or other distracting activities. Bolus feeding will reduce the tether to an IV pole and facilitate mobility. If safe, continuing to provide even a small amount of food and sips of fluids is important to provide pleasure and maintain meaningful routines. You can encourage family to help with this – their familiar faces will make a world of difference to a person's delirium.

Delirium is a common, serious and distressing condition that shares many similarities with malnutrition, in both its complex presentation and how we should approach its management.

Dietitians are ideally placed to take a lead role in preventing delirium, which will have the added benefit of preventing malnutrition, too.

Click here for a full reference list.

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It's about how it FEELS to YOU.
Michelle Obama