Confident Care
In Aged Care

Confident Bite

ISSUE 4

Unintentional WEIGHT LOSS

IN OLDER PEOPLE

Unintentional weight loss is not a normal part of ageing. It may be an early and sometimes the only sign of illness, malnutrition or functional decline.

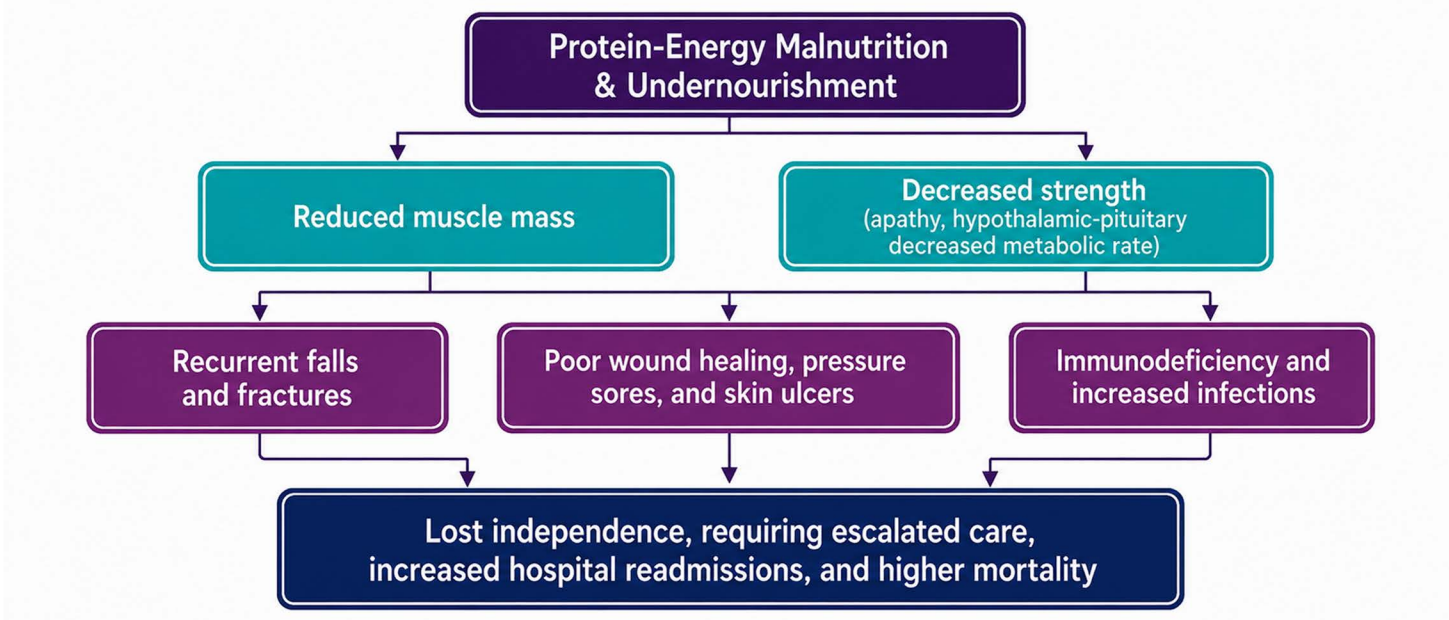
KNOW THE TRIGGERS

- **Significant unplanned weight loss**
  5% or more over 3 months.
- **Consecutive unplanned weight loss**
  any amount in each of 3 consecutive months.

Why early action matters

Malnutrition can reduce muscle mass and strength, increasing the risk of falls, fractures, pressure injuries, infection, hospitalisation and loss of independence.

MALNUTRITION TRIGGERS A CASCADING DECLINE IN OLDER ADULTS

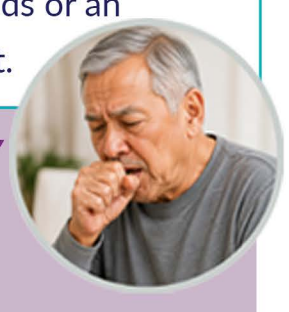


What might you notice?

- Clothes, jewellery or dentures becoming loose.
- Eating less or leaving meals and drinks unfinished
- Poor appetite or food tasting different
- Tiredness, weakness or reduced activity
- Slower walking or needing more help to stand, transfer or eat.
- More frequent illness, falls, wounds or slower recovery.

Possible contributing factors

- Acute or chronic illness, infection or pain
- Dementia, delirium, depression, grief or loneliness
- Medication effects, nausea, constipation or dry mouth
- Poor oral health, dental pain or ill-fitting dentures
- Difficulty chewing or swallowing
- Reduced mobilty, vision, dexterity or ability to eat independently
- Food preferences, cultural needs or an unsuitable dining environment.



EATING AND SWALLOWING WARNING SIGNS - REPORT PROMPTLY

Coughing or choking • wet or gurgly voice • food remaining in the mouth • drooling • breathing changes • meal fatigue or very slow eating • recurrent chest infections • sudden refusal of food or fluids.

If choking, breathing difficulty or significant distress occurs stop offering food or fluids, stay with the person and seek immediate clinical or emergency assistance.

WHAT TO DO

All staff: NOTICE - DOCUMENT - REPORT - SUPPORT

NOTICE
Changes from the person's usual intake, appetite, weight, strength,function or behaviour.

DOCUMENT
What was observed, including meals or drinks missed and the assistance provided.

REPORT
Concerns promptly to the RN or most senior clinician on duty. Use STOP & WATCH where applicable.

SUPPORT
The person at meals and follow the current nutrition. hydration and swallowing care plan.

SUPPORT SAFE, PERSON-CENTRED EATING AND DRINKING

CHECK
Confirm the current diet, food texture, fluid consistency, allergies, supervision and assistance needs.

POSITION
Support comfortable upright seating. Provide dentures, glasses, hearing aids, and adaptive equipment.

PERSONALISE
Offer preferred and culturally appropriate foods, suitable portions, snacks and drinks.

ASSIST
Set up meals, prompt or assist as required.
Use a slow, unhurried pace and monitor fatigue

MONITOR
Record intake accurately when a food or fluid chart commences and reports further decline.

FOLLOW THE PLAN
Do not independently change food texture, fluid consistency or commence supplements.

WEIGHT MONITORING

Obtain consent and maintain privacy. Weight on admission and at least monthly, at approximately the same time, in similar clothing and using the same scale where possible. Document the scale used and any refusal. Routine weighting is generally not required during active end-of-life care. Always follow your workplace policy and procedures to ensure correct weight monitoring for each older individual.

REMEMBER

The goal is not simply a number on the scale. Care should support adequate nutrition and hydration, strength, comfort, dignity, choice and quality of life. Involve the older person and/or their supporter in decisions.

THERE'S MORE TO EXPLORE!
Scan to visit our webpage
Discover resources, learning opportunities and support.

TEST YOUR KNOWLEDGE!
Scan the QR code to complete **the quiz & evaluation**

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