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Carissimo Socio,
in questa newsletter di Anìmo, troverai un breve riassunto degli argomenti trattati durante la "**Conferenza Nazionale delle politiche della professione infermieristica**" svoltasi a Roma nel mese di gennaio, a cui sono state invitate anche le associazioni professionali sanitarie tra cui Anìmo.
Troverete inoltre una "overview" di abstract di articoli selezionati, su "**La malnutrizione in ospedale**" argomento di estrema rilevanza nelle nostre realtà di Medicina e, com'è ampiamente dimostrato, la malnutrizione influisce sull'aumento delle infezioni delle ferite, delle ulcere da pressione, sui tempi di degenza, sui re-ricoveri e sulla mortalità.
Augurandovi una proficua lettura cogliamo l'occasione per ricordarvi che siamo aperti a vostri suggerimenti, osservazioni o contributi, che potranno giungerci tramite mail al seguente indirizzo: info@associazione-animo.it

Dott.ssa Claudia Gatta e tutto il **Direttivo Anìmo**

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CONFERENZA NAZIONALE DELLE POLITICHE DELLA PROFESSIONE INFERMIERISTICA

a cura di G. Bordin

Il 20 .01.2016 a Bologna si è svolta l'VIII edizione della Conferenza Nazionale delle politiche della professione infermieristica dal titolo: *"La mappa di un percorso. La dirigenza infermieristica gestionale e professionale: focus sullo stato dell'arte e prospettive di sviluppo".*

In apertura della giornata la presidente IPASVI Barbara Mangiacavalli ha sottolineato come, parlare di dirigenza infermieristica, abbia un senso per le ricadute assistenziali ed organizzative che un ruolo manageriale infermieristico può avere nella gestione di un sistema complesso quale quello sanitario.
I relatori che si sono susseguiti hanno cercato di definire, all'interno del contesto normativo attuale, i punti di forza e il valore aggiunto che l'infermiere dirigente può dare a fronte di ostacoli e vincoli presenti nella realtà italiana.
La legge Madia spinge verso una Pubblica Amministrazione agile, semplificata, efficace e rispondente ai bisogni dei cittadini e per questo attenta allo sviluppo delle skills dei dipendenti e alla loro valutazione, con una dirigenza declinabile secondo i modelli dell'OCSE, a superamento delle anomalie italiane attuali che denominano dirigenti intere categorie professionali senza effettive responsabilità.
All'interno dei servizi sanitari al dirigente infermiere viene chiesto di non limitarsi a seguire le indicazioni altrui ma di avere una maggiore responsabilità e titolarità perché, più di altre professioni, conosce cosa fare per i servizi per la persona. La competenza del dirigente infermieristico deve andare oltre gli aspetti gestionali perché par-

te dalbisogno dell'utenza e da una conseguente ridefinizione della risposta clinico-assistenziale.
Restano degli ostacoli da superare legati ad esempio alla revisione dei contratti, per i quali mancano le risorse, e le disposizioni normative regionali e locali lacunose e diversificate.
Su queste il Ministero dell Salute sta lavorando anche con un'attività di monitoraggio dell'esistente ed una valutazione delle sperimentazione attuate in alcune regioni che stanno avendo riscontri positivi.
Esempi ne sono state le realzioni presentate dai colleghi infermieri con cariche di rilievo quali direttore generale, direttore sociosanitario e direttore di distretto che oltre a delineare il ruolo attualmente svolto nei diversi contesti hanno descritto difficoltà e prospettive.
Altro tavolo di lavoro sul tema della dirigenza è rappresentato dal protocollo Agenas-Ipasvi che pone come elementi di rilievo la competenza infermieristica e i modelli manageriali innovativi.
Emblematica a tale proposito la dichiarazione del Direttore Generale di Agenas: "*Non vincerà il singolo ma il team che riuscirà meglio a difendere l'integrità e il valore della persona. La caratteristica a voi più congeniale".*

La malnutrizione in ospedale

a cura di R. Rapetti, L. Tesei, I. Lo Burgio

La **Malnutrizione** è una condizione caratterizzata da carenza di sostanze nutritive, che è causa di esiti negativi misurabili. In particolare, è dimostrato come in ospedale, la malnutrizione influisce sull'aumento delle infezioni delle ferite, delle ulcere da pressione, sui tempi di degenza, sui re-ricoveri e sulla mortalità.[1]

Il ***rischio*** di malnutrizione aumenta con l'età e con i livelli di cura; nonostante i significativi progressi della medicina, la malnutrizione rimane un problema di salute pubblica con alta prevalenza nei paesi in via di sviluppo.[2]

Sebbene i dati siano diversi da uno studio all'altro, evidenze disponibili mostrano che un ***intervento nutrizionale precoce*** può ridurre i tassi di complicanze e il costo delle cure. Al fine di intervenire tempestivamente, è quindi importante identificare, la malnutrizione o il rischio già al momento dell'ammissione in ospedale, in modo precoce e sistematico.[3]

Le evidenze scientifiche riportano come il **20-40%** dei pazienti presentino, alla loro ammissione in ospedale, un quadro di malnutrizione, situazione destinata a peggiorare durante la degenza. Infatti, è stato confermato che il **70%** dei pazienti presenta un peggioramento del proprio stato nutrizionale durante i primi **10 giorni** di ricovero.[4]

La popolazione anziana rappresenta un gruppo vulnerabile ad elevato rischio di malnutrizione in quanto l'invecchiamento è associato a deterioramento fisiologico, a menomazione ***fisica*** e ***psico-sociale*** e spesso a ***difficoltà economiche***, fattori che giocano un ruolo nella inadeguatezza nutrizionale.[5]

Inoltre, l'insorgenza di malattie intercorrenti può essere responsabili di maggiori perdite di nutrienti con una riduzione involontaria di massa magra.[6]

Anche le condizioni **socio-ambientali** possono influenzare lo stato nutrizionale; infatti le barriere fisiche, la distanza dai centri di approvvigionamento e la povertà possono ostacolare una corretta alimentazione.

Donne, bambini, anziani e persone con disabilità intellettiva sono i più colpiti da questo fenomeno.[4,6,7]

Altro fattore che può gravare sulla malnutrizione, spesso sottovalutato, è la perdita parziale o totale di gusto e olfatto nelle persone di età avanzata che trovano il cibo insapore, perdendo quindi il piacere di mangiare. E' importante quindi, che gli infermieri e tutto il personale sanitario aggiornino le proprie conoscenze sulla fisiologia e disfunzione dei sensi preposti alla percezione degli alimenti, sperimentando interventi per aiutare le persone a godere dei benefici per la loro salute.[8]

Nonostante il problema della malnutrizione sia noto, i dati relativi al fenomeno non sono migliorati negli ultimi dieci anni.

Al momento del ricovero, i **professionisti della salute** devono quindi **valutare lo stato nutrizionale** di ogni paziente al fine di identificare la malnutrizione e cercare di gestire i problemi nutrizionali, utilizzando strumenti di screening pratici, rapidi e affidabili.[9]

La letteratura riporta **diversi metodi validati** che possono facilitare **l'identificazione dei fattori di rischio di malnutrizione**, tra cui:

Mini Nutritional Assessment (MNA), composto da 18 domande che includono la valutazione antropometrica, la valutazione generale e alimentare e l'auto-valutazione, è usato nelle persone di età superiore ai 65 anni.[2] Di esso esiste anche una Short Form, la MNA-SF.[5]

Malnutrition Screening Tool (MST), si compone di 2 domande relativamente alla recente non intenzionale perdita di peso e alla ridotta assunzione di cibo per una diminuzione dell'appetito. Il MST è stato validato in setting ospedalieri per acuti e ambulatoriali, ma non specificamente in ambienti di ricovero a lungo termine.[2ù]

Malnutrition University Screening Tool (MUST), adatto all'uso in ospedale, in comunità e altre strutture assistenziali, può essere utilizzato da tutti gli operatori sanitari; è costituito da tre dimensioni: il punteggio BMI, il punteggio perdita di peso e il punteggio malattia acuta.[2]

Nutritional Risk Screening 2002 (NRS 2002), comprende uno screening iniziale e uno finale; quest'ultimo considera tre categorie: la malnutrizione, la severità della malattia e l'età.[2]

SubjectiveGlobal Assessment (SGA), valido e affidabile per valutare lo stato nutrizionale negli anziani, prende in considerazione la storia medica e la valutazione fisica.[2]

Simplified Nutritional Assessment Questionnaire (SNAQ), composto da 4 domande riguardanti l'appetito, la sazietà precoce, il gusto del cibo e il numero dei pasti consumati quotidianamente; risulta essere predittivo della perdita di peso a 6 mesi in comunità e in strutture di ricovero a lungo termine.[2]

Lo **screening nutrizionale** rappresenta un passo importante per identificare i pazienti a rischio di malnutrizione, ma da solo non è sufficiente; è efficace solo se inserito all'interno di un piano di assistenza.[10]

La prevenzione e il trattamento della malnutrizione ospedaliera necessitano di un **approccio interdisciplinare** che deve coinvolgere diverse figure sanitarie e quindi anche gli infermieri.[1]

Per migliorare l'assistenza nutrizionale è necessario però che l'organizzazione all'interno delle unità operative preveda screening e programmi assistenziali tali da soddisfare le esigenze dei singoli degenti.[10]

Il miglioramento della pratica clinica relativa alla gestione del problema della malnutrizione, offre una straordinaria opportunità per ottimizzare la qualità complessiva della cura del paziente, migliorare i risultati clinici e ridurre i costi.[3]

A.S.P.E.N. ADULT NUTRITION CARE PATHWAY

(Age 18+ years)

ADMISSION

- Obtain actual, measured height/weight and BMI and document on admission
- Validated screening tool completed RESOURCE #1
  - Screen completed in 24 hours
  - Results documented in EMR
- Physician consult on admission RESOURCE #2

SUSPECTED MALNUTRITION?

YES

GENERATE NUTRITION CONSULT

Via EMR, automatic trigger or documented in MR

NUTRITION ASSESSMENT [RD, NST]

Completed within 24 hours of consult

- Food and Nutrition History
- Anthropometrics
- Biochemical data/Medical Tests & Procedures RESOURCE #3
- Nutrition Focused Physical Exam (NFPE) RESOURCE #4
- Clinical and Medical History RESOURCE #5

MALNUTRITION IDENTIFIED?

AND/A.S.P.E.N. malnutrition characteristics RESOURCE #6

NO

FOLLOW UP/RESCREEN [RD, NST, DT, OR DESIGNEE]

- Every 3-7 days to prevent hospital-acquired malnutrition RESOURCE #2
- Based on length of stay
- Upon transition of care

YES

MALNUTRITION DIAGNOSIS/RISK DOCUMENTED [RD, NST, RN, MD/NP/PA]

- RD documents malnutrition risk status
- RD documents supporting evidence of malnutrition severity
- MD documents malnutrition and severity in progress note and adds to problem list

CODE MALNUTRITION DIAGNOSIS

- *Coder notified of diagnosis*
- *Adult Malnutrition Codes* RESOURCE #7

MORE ON NEXT PAGE

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KEY

- Link
- Action Steps
- Documentation Steps
- Communication Steps

RN Registered Nurse
RD Registered Dietitian
DT Diet Technician
NFPE Nutrition Focused Physical Exam
NST Nutrition Support Team
MD Medical Doctor
NP Nurse Practitioner
PA Physician Assistant
PharmD Pharmacist
CM Case Manager
OT Occupational Therapist
PT Physical Therapist
AND Academy of Nutrition and Dietetics
A.S.P.E.N. American Society for Parenteral and Enteral Nutrition
PN Parenteral Nutrition
EN Enteral Nutrition
NPO/CLD Nothing by Mouth/Clear Liquid Diet
EMR/MR Electronic Medical Record or Medical Record
BMI Body Mass Index

RIFERIMENTI BIBLIOGRAFICI

1. Frank M, Sivagnanaratnam A, Bernstein J.
Nutritional assessment in elderly care: a MUST !
BMJ Qual Improv Report 2015;4 (1):1–4.

2. Sophie Guyonnet,Yves Rolland;
Screening for Malnutrition in Older People
Clin Geriatr Med 31 (2015) 429–437

3. Tappenden, Kelly A.; Quatrara, Beth; Parkhurst, Melissa L.; Malone, Ainsley M.; Fanjiang, Gary; Ziegler, Thomas R
Critical Role of Nutrition in Improving Quality of Care: An Interdisciplinary Call to Action to Address Adult Hospital Mal nutrition;
MEDSURG Nursing, May/Jun2013

4. Quatrara, Beth; Med-Surg Matters,
Malnutrition in Hospitalized Patients: Results of an AMSN Survey. Mar/Apr2013

5. Myoung-Ha Baek and Young-Ran Heo.
Evaluation of the efficacy of nutritional screening tools to predict malnutrition in the elderly at a geriatric care hospital.
Nutrition Research and Practice 2015

6. L.M. Donini, P. Scardella, L. Piombo, B. Neri, R. Asprino, A.R. Proietti, S. Carcaterra, E. Cava, S. Cataldi, D. Cucinotta, G. Di Bella, M. Barbagallo, A. Morrone
Malnutrition In Elderly: Social And Economic Determinants
The Journal Of Nutrition, Health & Aging; Volume 17, Number 1, 2013

7. Tsai, Alan C; Hsu, Hsiu-Yueh; Chang, Tsui-Lan
The Mini Nutritional Assessment (MNA) is useful for assessing the risk of malnutrition in adults with intellectual disabilities.
J Clin Nurs. 2011 Dec;20(23-24):3295-303

8. Wylie, Kim; Nebauer, Monica;
The food here is tasteless!' Food taste or tasteless food? Chemosensory loss and the politics of under-nutrition.
Collegian. 2011;18(1):27-35.

9. Myoung-Ha Baek and Young-Ran Heo.
Evaluation of the efficacy of nutritional screening tools to predict malnutrition in the elderly at a geriatric care hospital.
Nutr Res Pract. 2015 Dec;9(6):637-43

10. Chapman C, Barker M, Lawrence W.
Improving nutritional care: innovation and good practice.
J Adv Nurs. 2015 Apr;71(4):881-94

BIBLIOGRAFIA

REFERENCE N°1

Frank M, Sivagnanaratnam A, Bernstein J.
Nutritional assessment in elderly care: a MUST !
BMJ Qual Improv Report 2015;4 (1):1–4.

ABSTRACT
Malnutrition affects over three million people in the UK with associated health costs exceeding £13 billion annually.[1] In hospital, malnutrition has been shown to increase complication rates, morbidity, mortality, hospital readmissions, and length of hospital stay.[2] To screen for malnutrition, a reliable and validated screening tool such as the malnutrition universal screening tool (MUST) should be used.[3] We believe that improved patient outcomes and significant savings to the trust can be achieved, not only by ensuring that every patient has a MUST score documented, but that it is calculated correctly and the appropriate interventions are implemented.
We have carried out the audit three times (May, July, and November 2013). The study included the patients on the elderly care ward of Watford General Hospital (n=64, 62, and 63 respectively). MUST scores documented in nursing notes for each patient were noted. We re-calculated each MUST score ourselves for comparison. We went through patient notes and nursing information and noted which recommended nutritional interventions were being implemented.
Our results highlighted several issues:
1) Patients did not consistently have a MUST score documented
2) MUST scores were calculated incorrectly. This was generally due to BMIs calculated incorrectly, and patients' weights from six months ago not being known
3) High MUST scores not being acted on appropriately.
Our interventions have involved liaising with various teams within the hospital to maximise the efficacy of the MUST score. This has included encouraging the trust to provide regular training to nurses because of high nursing staff turnover. Following our audit, the dietitian department agreed to undertake weekly ward rounds to screen for patients at risk of malnutrition. Our interventions so far have resulted in increased proportion of MUST scores being calculated (73 to 97%), and increased rates of patients being referred to dietitians (62 to 86% in the second audit cycle).
PMID: 26734346
PMCID: PMC4645872

REFERENCE N°2

Guyonnet S[1], Rolland Y[2].
Screening for Malnutrition in Older People.
Clin Geriatr Med. 2015 Aug;31(3):429-37.

ABSTRACT
Malnutrition risk increases with age and level of care. Despite significant medical advances, malnutrition remains a significant and highly prevalent public health problem of developed countries. Earlier identification and appropriate nutrition support may help to reverse or halt the malnutritiontrajectory and the negative outcomes associated with poor nutritional status. A nutrition screening process is recommended to help detect peoplewith protein-energy malnutrition (PEM) or at malnutrition risk. Evidence supports that oral nutritional supplements and dietary counseling can increase dietary intake and improve quality of life in elderly with PEM or at malnutrition risk. This article examines nutritional screening and assessment tools designated for older adults.
KEYWORDS:
Elderly; Malnutrition; Nutrition screening
PMID:26195101

REFERENCE N°3

JPEN J Parenter Enteral Nutr. 2013 Jul;37(4):482-97.
Critical role of nutrition in improving quality of care: an interdisciplinary call to action to address adult hospital malnutrition.
Tappenden KA[1], Quatrara B, Parkhurst ML, Malone AM, Fanjiang G, Ziegler TR.

ABSTRACT
The current era of healthcare delivery, with its focus on providing high-quality, affordable care, presents many challenges to hospital-based health professionals. The prevention and treatment of hospital malnutrition offer a tremendous opportunity to optimize the overall quality of patient care, improve clinical outcomes, and reduce costs. Unfortunately, malnutrition continues to go unrecognized and untreated in many hospitalized patients. This article represents a call to action from the interdisciplinary Alliance to Advance Patient Nutrition to highlight the critical role of nutrition intervention in clinical care and to suggest practical ways to promptly diagnose and treat malnourished patients and those at risk for malnutrition. We underscore the importance of an interdisciplinary approach to addressing malnutrition both in the hospital and in the acute posthospital phase. It is well recognized that malnutrition is associated with adverse clinical outcomes. Although data vary across studies, available evidence shows that early nutrition intervention can reduce complication rates, length of hospital stay, readmission rates, mortality, and cost of care. The key is to systematically identify patients who are malnourished or at risk and to promptly intervene. We present a novel care model to drive improvement, emphasizing the following 6 principles: (1) create an institutional culture where all stakeholders value nutrition, (2) redefine clinicians' roles to include nutrition care, (3) recognize and diagnose all malnourished patients and those at risk, (4) rapidly implement comprehensive nutrition interventions and continued monitoring, (5) communicate nutrition care plans, and (6) develop a comprehensive discharge nutrition care and education plan.
KEYWORDS:
health care reform; hospital malnutrition; interdisciplinary; nutrition care; oral nutrition supplement
Comment in
A "call to action" for an expanded pharmacist role in influencing the quality of nutrition care.
Parenter Enteral Nutr. 2013]
PMID:23736864

REFERENCE N°4

Quatrara, Beth; Med-Surg Matters,
Malnutrition in Hospitalized Patients: Results of an AMSN Survey. Mar/Apr2013

ABSTRACT
Malnutrition in Hospitalized Patients: Results of an AMSN Survey Evidence reveals that 1 out of 3 hospitalized patients are malnourished upon admission. Without prompt identification and treatment, even more become malnourished throughout the hospitalization, leading to increased complications and delayed recovery. Nursing involvement in battling malnutrition is paramount to helping patients recover faster and more fully. As such, the "Nutrition to Improve Outcomes" column was developed to help you better understand the scope of malnutrition, keys to identification, and treatment strategies that can safely be used to target the problem of nutritional imbalances. We hope that you will find the column informative, but more so, that you will use it to enhance the care of hospitalized patients.

REFERENCE N°5

Myoung-Ha Baek and Young-Ran Heo.
Evaluation of the efficacy of nutritional screening tools to predict malnutrition in the elderly at a geriatric care hospital.
Nutrition Research and Practice 2015;9(6):637-643;

BACKGROUND/OBJECTIVES: Malnutrition in the elderly is a serious problem, prevalent in both hospitals and care homes. Due to the absence of a gold standard for malnutrition, herein we evaluate the efficacy of five nutritional screening tools developed or used for the elderly. SUBJECTS/METHODS: Elected medical records of 141 elderly patients (86 men and 55 women, aged 73.5 ± 5.2 years) hospitalized at a geriatric care hospital were analyzed. Nutritional screening was performed using the following tools: Mini Nutrition Assessment (MNA), Mini Nutrition Assessment-Short Form (MNA-SF), Geriatric Nutritional Risk Index (GNRI), Malnutrition Universal Screening Tool (MUST) and Nutritional Risk Screening 2002 (NRS 2002). A combined index for malnutrition was also calculated as a reference tool. Each patient evaluated as malnourished to any degree or at risk of malnutrition according to at least four out of five of the aforementioned tools was categorized as malnourished in the combined index classification. RESULTS: According to the combined index, 44.0% of the patients were at risk of malnutrition to some degree. While the nutritional risk and/or malnutrition varied greatly depending on the tool applied, ranging from 36.2% (MUST) to 72.3% (MNA-SF). MUST showed good validity (sensitivity 80.6%, specificity 98.7%) and almost perfect agreement (k = 0.81) with the combined index. In contrast, MNA-SF showed poor validity (sensitivity 100%, specificity 49.4%) and only moderate agreement (k = 0.46) with the combined index. CONCLUSIONS: MNA-SF was found to overestimate the nutritional risk in the elderly. MUST appeared to be the most valid and useful screening tool to predict malnutrition in the elderly at a geriatric care hospital.
KEYWORDS:
Nutritional screening; efficacy; elderly; malnutrition; validity
PMID:26634053
PMCID:PMC4667205

REFERENCE N°6

J Nutr Health Aging. 2013 Jan;17(1):9-15. doi: 10.1007/s12603-012-0374-8.
Malnutrition in elderly: social and economic determinants.
Donini LM[1], Scardella P, Piombo L, Neri B, Asprino R, Proietti AR, Carcaterra S, Cava E, Cataldi S, Cucinotta D, Di Bella G, Barbagallo M, Morrone A.

Abstract: Malnutrition occurs frequently in the frailest groups of the population, especially in people who are on a low income and elderly subjects, overall if they are institutionalized. The aim of this study was to assess the prevalence of malnutrition in a sample of elderly people living in different settings and to identify the determinants of malnutrition.
METHODS: A total of 718 subjects, 472 females (F) and 246 males (M), were recruited from nursing homes or were free living in three different regions in Italy. Nutritional status, depression, social, functional and cognitive status, were evaluated.
RESULTS: According to the Mini Nutritional Assessment (MNA), a high prevalence of malnutrition was found out in both genders: 26% of F and 16.3% of M were classified as being malnourished (MNA<17); 40.9% of F and 35% of M were at risk of malnutrition (MNA 17-23,5). The prevalence of malnutrition was significantly higher in NH subjects in both sexes. Moreover, a relationship was shown between malnutrition and inability to shop, prepare and cook meals because of a low income, distance from markets or supermarkets as well as impossibility to drive the car or to use public transportation. This study confirms the necessity to routinely perform nutritional status evaluation in elderly subjects, to carry out training courses for health workers (doctors, nurses, psychologists, dietitians), to implement nutritional education of the geriatric population, to develop tools and guidelines for health workers and caregivers, to identify and reduce clinical, functional, social or economic risk factors for malnutrition.
PMID:23299371

REFERENCE N°7

J Clin Nurs. 2011 Dec;20(23-24):3295-303.
The Mini Nutritional Assessment (MNA) is useful for assessing the risk of malnutrition in adults with intellectual disabilities.
Tsai AC[1], Hsu HY, Chang TL.

Abstract: AIM: The study was aimed to examine the appropriateness of using the Mini Nutritional Assessment to screen for risk of under- and over-nutrition in adults with intellectual disabilities.
BACKGROUND: Persons with intellectual disabilities are at increased risk of malnutrition, but routine monitoring of their nutritional conditions are not widely done.
DESIGN: The study purposively recruited 104 institutionalised adults (≥19 years old) with intellectual disabilities to serve as participants.
METHODS: Participants were interviewed with a structured questionnaire to elicit personal data, health-related information and answers to items in the Activities of Daily Living and the Mini Nutritional Assessment scales and measured for anthropometrics. Biochemical data were taken from their routine medical measurements. Each subject was graded with the Mini Nutritional Assessment that adopted Taiwanese-specific anthropometric cut-off points (T1) and an alternative version that omitted the body mass index item (T2).
RESULTS: Both Mini Nutritional Assessment versions were able indentifying individuals at risk of malnutrition among adults with intellectual disabilities and rated comparable proportions of patients malnourished (6·7 and 5·8% for Mini Nutritional Assessment-T1 and Mini Nutritional Assessment-T2, respectively) or at risk of malnutrition (14·4 and 17·3%, respectively). Persons with cerebral palsy were at greater risk of malnourishment than persons with other disabilities.
CONCLUSION: The Mini Nutritional Assessment is appropriate for screening for under- and over-nutrition in adults with intellectual disabilities. The Mini Nutritional Assessment (especially the version without body mass index) can make routine monitoring of nutritional status of these patients an easier task. However, further studies are needed to develop subtype-specific versions (tools) as various subtypes of intellectual disability are associated with different nutritional problems.
RELEVANCE TO CLINICAL PRACTICE: The Mini Nutritional Assessment can serve as a tool for routine screening for under- and over-nutrition in persons with intellectual disabilities.
PMID:22007997

REFERENCE N°8

Collegian. 2011;18(1):27-35.
"The food here is tasteless!" Food taste or tasteless food? Chemosensory loss and the politics of under-nutrition.
Wylie K[1], Nebauer M.

Abstract: A common complaint voiced by older people living in residential care is that the food lacks taste. When older people find food tasteless, the pleasure gained from eating and therefore, their appetite may be compromised, as will their food choices, nutrition, immune systems, functional status and well-being. However, often nurses overlook these symptoms as 'inevitable and irreversible' aspects of ageing, which they are not. In fact, many older people experience chemosensory (taste and smell) disorders or loss which means they lose the ability to taste the flavour of food. Commonly overlooked is the fact that chemosensory loss may well be a significant contributing factor to the high level of undernutrition reported in residential care in Australia. Our purpose in this article is to explore important issues related to taste and smell dysfunction; the physiology of these sensations; several causes distinct from ageing; and interventions to help older people again enjoy their food with the concomitant advantages to their health and well-being. We also consider

the way in which legislation related to Government funding has influenced gerontological nurses' assessment skills and values, particularly concerning nutrition assessment to the detriment of not only older people living in residential care but also the profession of gerontological nursing. Attention is drawn to the need for nurses to up-date their clinical knowledge, assessment skills and practice including enhancing the flavour of food and the social occasion of dining for older people living in residential care.

REFERENCE N°9

Nutr Res Pract. 2015 Dec;9(6):637-43. doi: 10.4162/nrp.2015.9.6.637. Epub 2015 Nov 11.
Evaluation of the efficacy of nutritional screening tools to predict malnutrition in the elderly at a geriatric carehospital.
Baek MH[1], Heo YR[2].

Abstract
BACKGROUND/OBJECTIVES: Malnutrition in the elderly is a serious problem, prevalent in both hospitals and care homes. Due to the absence of a gold standard for malnutrition, herein we evaluate the efficacy of five nutritional screening tools developed or used for the elderly.
SUBJECTS/METHODS: Elected medical records of 141 elderly patients (86 men and 55 women, aged 73.5 ± 5.2 years) hospitalized at a geriatriccare hospital were analyzed. Nutritional screening was performed using the following tools: Mini Nutrition Assessment (MNA), Mini Nutrition Assessment-Short Form (MNA-SF), Geriatric Nutritional Risk Index (GNRI), Malnutrition Universal Screening Tool (MUST) and Nutritional RiskScreening 2002 (NRS 2002). A combined index for malnutrition was also calculated as a reference tool. Each patient evaluated as malnourished to any degree or at risk of malnutrition according to at least four out of five of the aforementioned tools was categorized as malnourished in the combined index classification.
RESULTS: According to the combined index, 44.0% of the patients were at risk of malnutrition to some degree. While the nutritional risk and/ormalnutrition varied greatly depending on the tool applied, ranging from 36.2% (MUST) to 72.3% (MNA-SF). MUST showed good validity (sensitivity 80.6%, specificity 98.7%) and almost perfect agreement (k = 0.81) with the combined index. In contrast, MNA-SF showed poor validity (sensitivity 100%, specificity 49.4%) and only moderate agreement (k = 0.46) with the combined index.
CONCLUSIONS: MNA-SF was found to overestimate the nutritional risk in the elderly. MUST appeared to be the most valid and useful screeningtool to predict malnutrition in the elderly at a geriatric care hospital.
KEYWORDS: Nutritional screening; efficacy; elderly; malnutrition; validity
PMID:26634053

REFERENCE N°10

J Adv Nurs. 2015 Apr;71(4):881-94.
Improving nutritional care: innovation and good practice.
Chapman C[1], Barker M, Lawrence W.

Abstract:
AIMS:This paper presents examples of good practice in nutritional screening and care and identifies methods used to overcome contextual constraints and discusses the implications for nursing practice in hospitals.
BACKGROUND: Nutritional screening is an important step in identifying those at risk of malnutrition, but does not produce improved nutritional careunless it results in a care plan that is acted on. The importance of nutrition and implications for clinical care make it imperative to improve practice.
DESIGN: Qualitative investigation.
METHODS: Between January 2011-February 2012, focus groups were held using a semi-structured discussion guide with nine groups of health professionals (n = 80) from one hospital: four with nurses, three with doctors and two with dietitians. Discussions were audio-recorded, transcribed and coded into themes and sub-themes, which were then depicted in a thematic map and illustrated with verbatim quotes.
FINDINGS: Three strategies for sustaining effective nutritional practice emerged: establishing routines to ensure screening was undertaken; re-organizing aspects of care to promote good practice; developing innovative approaches. Issues to be addressed were the perceived disconnection between mandatory screening and the delivery of effective care, a requirement for nutrition education, organizational constraints of a large universityhospital and the complexities of multidisciplinary working.
CONCLUSION: Professionals seeking to improve nutritional care in hospitals need to understand the interaction of system and person to facilitate change. Nursing staff need to be able to exercise autonomy and the hospital system must offer enough flexibility to allow wards to organizenutritional screening and care in a way that meets the needs of individual patients.
KEYWORDS: critical theory; nursing practice; nutritional care; qualitative research; screening
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A.N.I.M.O. FORMAZIONE RICERCA SVILUPPO INNOVAZIONE
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