How can dietitians manage malnutrition and frailty in the community?

Guidance for health professionals

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ACKNOWLEDGEMENT OF COUNTRY
Griffith University acknowledges the Traditional Custodians of the land on which we are meeting and pays respect to the Elders, past and present, and extends that respect to all Aboriginal and Torres Strait Islander people.
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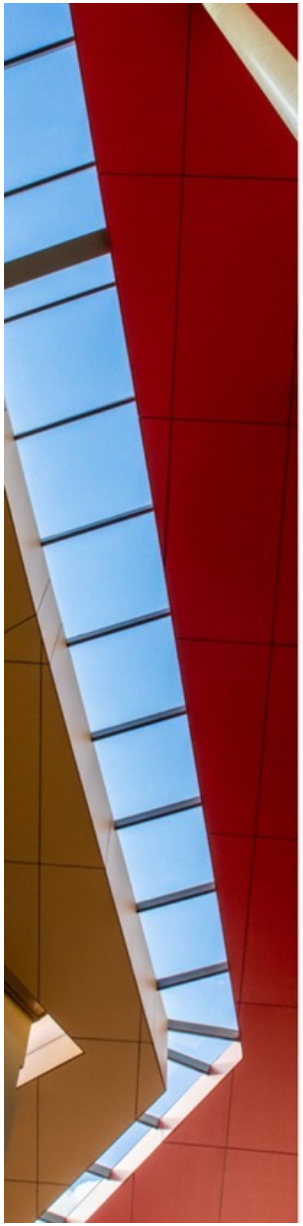

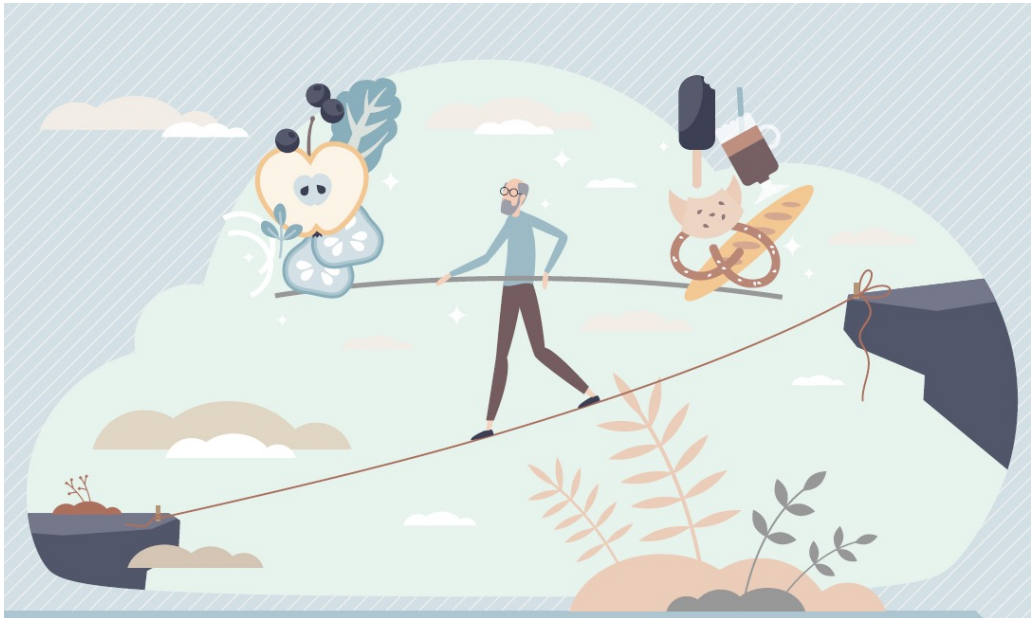

An evidence-based guide for the identification and nutritional management of malnutrition and frailty in the Australian and New Zealand community

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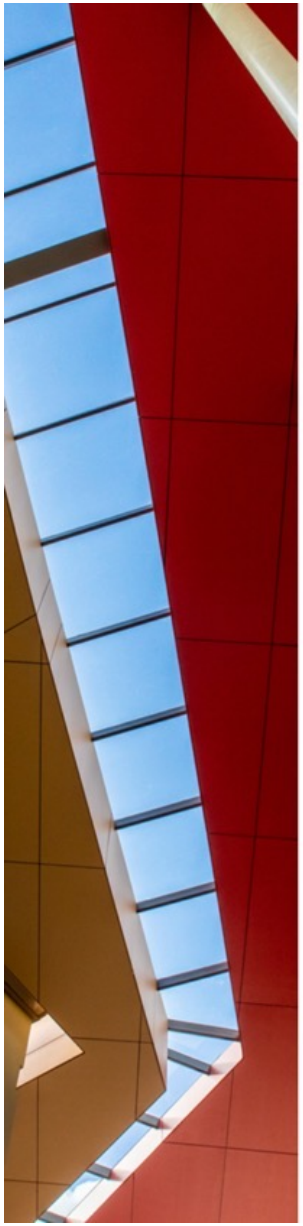

Question 1: What setting do you mainly work in as a dietitian?

- ❑ Hospital
- ❑ Community (public health service)
- ❑ Community (private practice)
- ❑ Residential aged care
- ❑ Research / academia
- ❑ Industry / corporate
- ❑ Other

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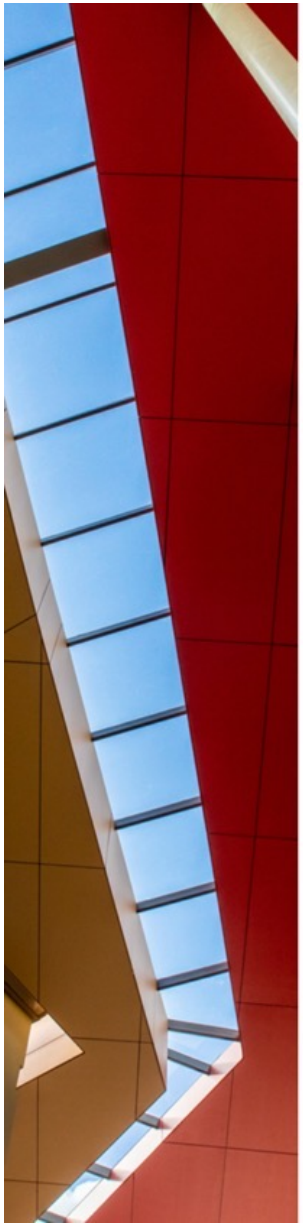

Question 2: How confident do you feel in managing MALNUTRITION in the community (including d/c from hospital to home)?

- Not confident at all
- Slightly confident
- Somewhat confident
- Fairly confident
- Very confident

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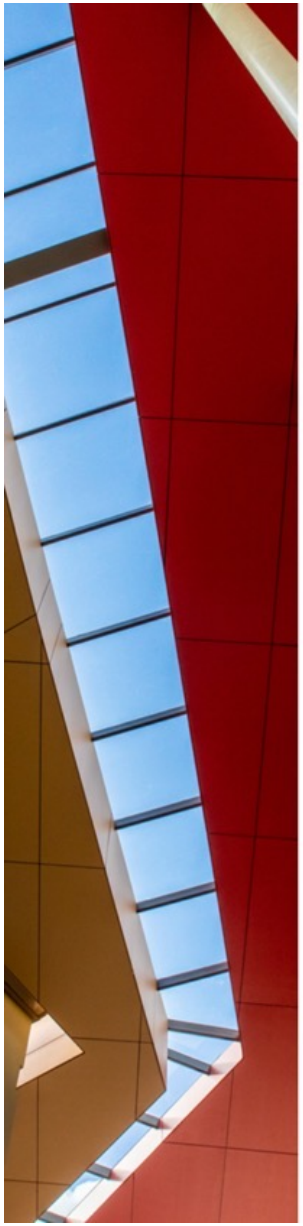

Question 3: How confident do you feel in managing FRAILTY in the community (including d/c from hospital to home)?

Not confident at all	Slightly confident	Somewhat confident	Fairly confident	Very confident

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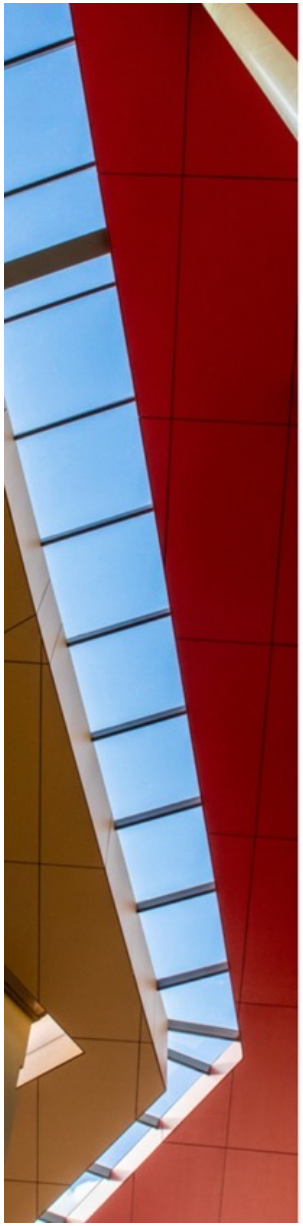

Background

- Australia and New Zealand (ANZ) have ageing populations[1]
- Likely ↑age-associated conditions e.g. malnutrition, frailty
  - Malnutrition affects 1–17% (4–63% at risk) in ANZ community
  - Frailty and pre-frailty affect 2–29% and 41–54% respectively[2]
  - Under-recognised and under-treated in community settings[3]
  - Poor outcomes for patients and high burden on health services
- Health care professionals (HCPs) from all disciplines must understand, recognise and act on suspected malnutrition / frailty among community-dwelling adults

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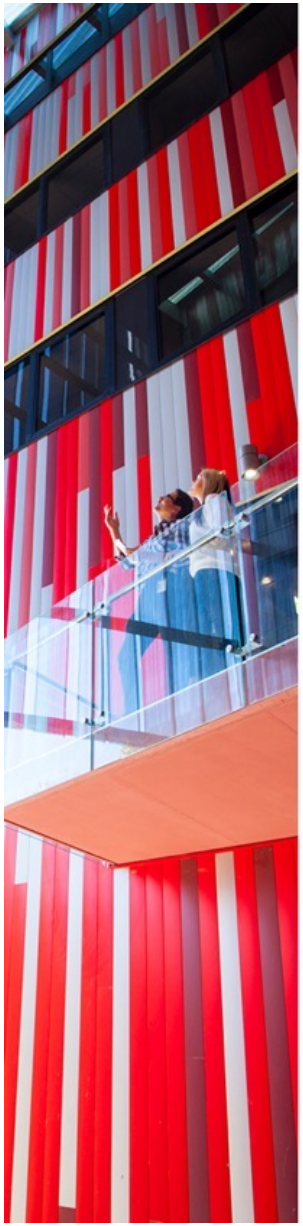

Methods

Develop guidance for the identification and management of malnutrition and frailty in the community, for use by HCPs from all disciplines, specific to ANZ.

Development involved:

- Literature review
- ANZ dietitian survey
- ANZ dietitian/stakeholder interviews
- Multidisciplinary expert panel

nutrients

MDPI

Review

Identifying and Managing Malnutrition, Frailty and Sarcopenia in the Community: A Narrative Review

Shelley Roberts [1,2,3,*], Peter Collins [4,5] and Megan Rattray [1]

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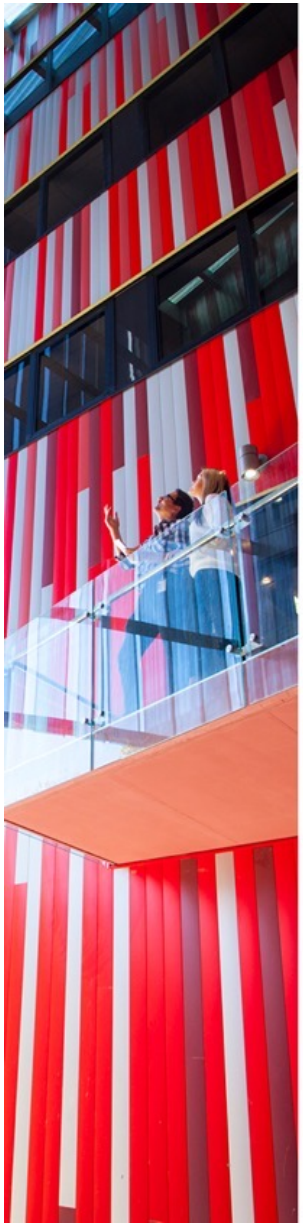

Key themes

- Multidisciplinary approach
- Patient and family centred care
- Care transitions

Malnutrition and frailty are everybody's business

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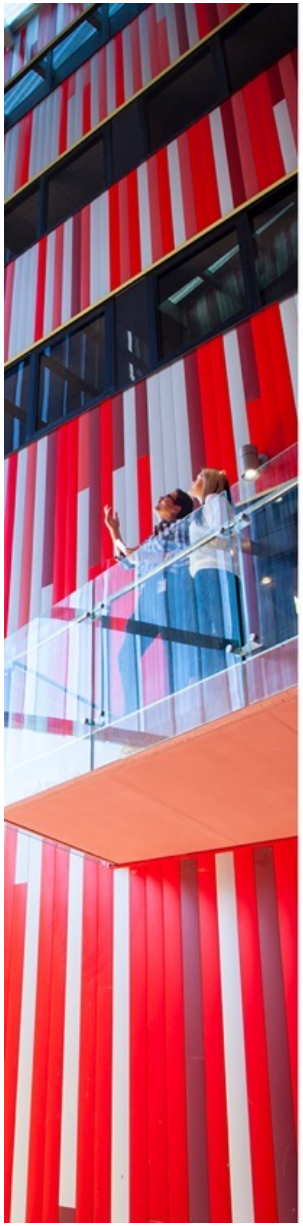


Identifying malnutrition and frailty

SCREENING

Who: Any HCP can screen

How: Best performing tools (community)

- Malnutrition: **MNA-SF** or **MUST**
- Frailty: **Clinical Frailty Scale** or **FRAIL scale**

When: First contact with new client, suspected malnutrition or frailty, or change in circumstances. *Prioritise.*

Screen

WHO: Any HCP or non-tertiary qualified HCP (Table 1) can screen for malnutrition or frailty. GPs, practice nurses and allied health clinicians are all well-placed to screen for malnutrition and frailty in the community because of their common interactions with clients [59].

WHAT: Evidence-based screening tools should be selected and used based on their validity and practicability in the intended setting (see Appendix 1). For malnutrition, tools that perform best in the community setting include the MNA-SF (first choice) and MUST (second choice). For frailty, tools that perform best in the community include the Clinical Frailty Scale and the FRAIL scale.

WHEN: Screening should be done on first contact with a new patient, when there is suspected malnutrition or frailty, or when there is a change in the patient's circumstances (e.g. new diagnosis, recent hospitalisation, changes in how a person accesses food e.g. loss of licence, death of spouse, change to mobility). **Re-screening** should be undertaken when deemed feasible and needed (e.g. every 1-3 months for high-risk clients).

PRIORITISE: Screening should be prioritised for those at increased risk, such as patients with acute or chronic disease, reduced BMI or recent unintentional weight loss, older age, Indigenous, recently discharged from hospital.

Refer

At-risk patients should be referred as follows:

Malnutrition: Dietitian

Frailty: Geriatrician, Dietitian, Physiotherapist and/or Exercise Physiologist

If a client declines referral to HCPs listed above, see Box 3 for guidance to begin early nutritional interventions.

Refer to other HCPs as needed: Occupational Therapist or Community Nurse for clients requiring assistance in the home; Speech Pathologist for clients with chewing or swallowing problems; Pharmacist for a comprehensive medicines review (to identify any medicines that may be increasing malnutrition risk); GP for specialised overall assessment and management of client.

Assess / Diagnose

Malnutrition - Dietitians assess:

1. Food/nutrition: adequacy to meet needs, based on client's dietary preferences
2. Anthropometrics: height, weight, BMI
3. Biochemistry: blood test results
4. Clinical/physical: physical appearance, appetite

Best performing assessment tools: MNA, SGA[a]

Diagnostic tools: GLIM, ASPEN and/or ESPEN criteria (see Box 1)

Frailty - Any trained HCP can assess:

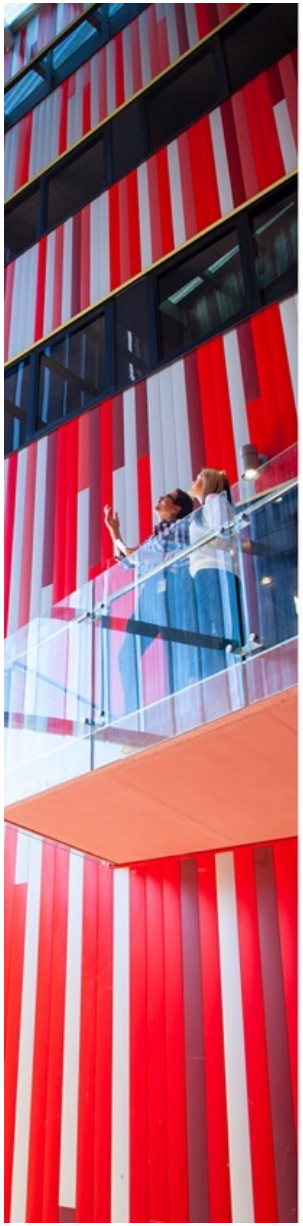
1. Health: co-morbidities, age, health status etc.
2. Physical: weakness, exhaustion, endurance etc.
3. Nutritional: appetite, dietary intake, symptoms
4. Psychological: cognition, depression, anxiety
5. Social: Coping capacity, social relations.

Best performing assessment tools for community: Comprehensive Geriatric Assessment[b], Frailty Index, Frail Scale

Practice Tips

Clients can and should be involved in the screening process. Research shows that while most patients are accepting of nutrition screening, many don't understand its purpose or its results, which is a barrier to enacting dietary advice [38]. If formal screening is not an option, clinicians can use Figure 1 to informally identify risk factors / prioritise patients who are at highest risk for referral/management.

[a]Note: low quality of evidence for tools' concurrent validity in community setting; more research is needed
[b]Should only be conducted by a Geriatrician

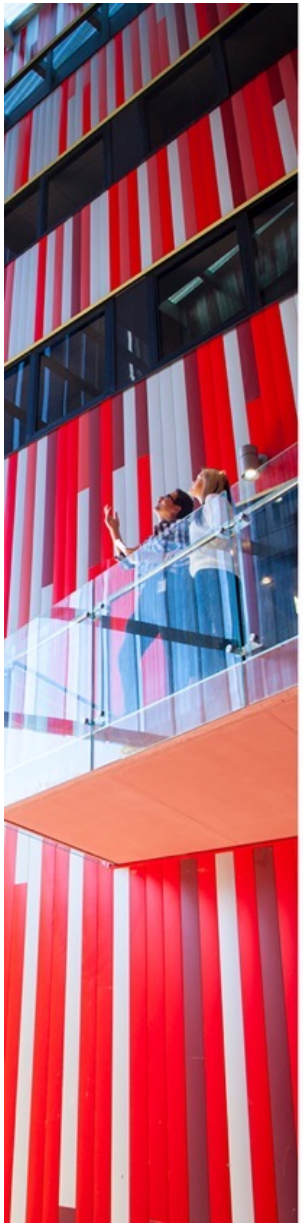


Appendix 1:

List of malnutrition and frailty screening tools and their validity in community settings

Ranking system

Tool	Evidence of validy in community	Citeria for use					Recommendation ranking and access
		For whom	By whom	Is senstive	Is specific	Is simple	
Malnutrition screening tools							
Mini Nutritional Assessment-short form (MNA-SF)	Six-item questionnaire. Promising criterion validity in community, with high sensitivity (81–100%) and specificity (82–100%). Note studies use MNA-FF as reference standard so incorporation bias is present [108].	Older community-dwelling adults	All HCPs	🟢	🟢	🟢	1st choice for older adults https://www.mna-elderly.com/forms/mini/mna_mini_english.pdf
Malnutrition Universal Screening Tool (MUST)	Five-step tool. Validated in hospital, residential aged care and community settings [109]. Two validation studies in community (more needed): 100% sensitivity, 98% specificity when validated against dietitian assessment; 58% sensitivity, 96% specificity when validated against unintentional weight loss or BMI [108].	All adults	All HCPs	🟠	🟢	🟢	1st choice for all adults; 2nd choice for older adults https://www.bapen.org.uk/pdfs/must/must_full.pdf
Malnutrition Screening Tool (MST) [110]	Short, two-question survey on appetite and unintentional weight loss. Widely validated in hospital settings, with high sensitivity (90–98%) and specificity (85–89%); but not validated in community [108]. Community validation studies are needed.	All adults	All HCPs and/or client/family	🔴	🔴	🟢	2nd choice for all adults https://www.health.qld.gov.au/__data/assets/pdf_file/0029/148826/hphe_mst_pstr.pdf
Seniors in the Community: Risk Evaluation for Eating and Nutrition Questionnaire (SCREEN-II; now SCREEN-14) [111]	A 17-item questionnaire. Good validity among older community-dwelling Canadian and New Zealand adults, with reported sensitivity from 84–90% and specificity 62–86% when tested against clinical assessment by a trained dietitian. More validation studies needed in other settings [108]. Designed for community-dwelling older adults [112].	Older community-dwelling adults	All HCPs and/or client	🟢	🟢	🟠	3rd choice for older adults https://olderadultnutritionscreening.files.wordpress.com/2021/04/screen-14-tool_2021-1.pdf
Determine your Health Checklist (DETERMINE)	Self-completed, 10-question survey designed to assess nutritional status in community-dwelling older adults [113]. Predictive validity in community setting is poor (unable to predict mortality, hospitalisation, or weight loss of >5%). Reported criterion validity show 75–91% sensitivity and 11–54% specificity; but few studies used appropriate reference standards [108].	Older community dwelling adults	By client	🟢	🟠	🟢	http://www.dhs.gov.vi/home/documents/DetermineNutritionChecklist.pdf
Frailty screening/assessment tools^							
Clinical Frailty Scale	Face-to-face assessment of patients by HCPs who assign categories of diminishing capacity from 1 (very fit) to 9 (terminally ill). Sensitivity 35-76% and specificity 95 to 100% (with Fried frailty phenotype as reference standard) [114]	Community-dwelling older adults	All HCPs	🟢	🟢	🟢	1st choice Rockwood, K., Song, X., Chris MacKnight, Bergman, H., Hogan, D., McDowell, I., Mitnitski, A. A global clinical measure of fitness and frailty in elderly people. CMAJ, 2005. 173: p. 489-495.
FRAIL scale	Five-item scale of self-reported yes/no questions taking ~10 mins to complete. Sensitivity 87-96% and specificity 64-86% (with Fried frailty phenotype as reference standard), with FRAIL scale score of 2 being the optimal cut-off point, among community-dwelling Australian [115] and Chinese adults [116].	Community-dwelling Australian and Chinese adults	Client self-complete	🟢	🟢	🟢	2nd choice Morley JE, Malmstrom TK, Miller DK. A simple frailty questionnaire (FRAIL) predicts outcomes in middle aged African Americans. J Nutr Health Aging, 2012. 16: p. 601-8.
Frailty Index	Predicts adverse health outcomes and correlates strongly with other frailty measures. Involves a count of deficits from a pre-determined list. While it can be complex and time consuming (30 mins) to complete, newer versions can be completed in 10-15 minutes. Sensitivity 46-61%, specificity 84-90% when compared with Fried's Frailty Phenotype [117].	All adults	All HCPs Some self-report available also	🟠	🟢	🔴	3rd choice Mitniski, A., X. Song, and K. Rockwood, The estimation of relative fitness and frailty in community-dwelling older adults using self-report data. The Journals of Gerontology Seris A: Biological Sciences and Medical Sciences, 2004. 59: p. M627-M632



Identifying malnutrition and frailty

REFERRAL

Malnutrition: Dietitians

Frailty: Geriatricians (+/- dietitian, physiotherapist, exercise physiologist)

Malnutrition and frailty: Refer to other HCPs as needed (e.g. OT for assistance in the home; SP for chewing/ swallowing issues; pharmacist for meds r/v; GP/community nurse for overall care

Screen

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Best performing assessment tools: MNA, SGA[a]

Diagnostic tools: GLIM, ASPEN and/or ESPEN criteria (see Box 1)

Frailty - Any trained HCP can assess:

1. Health: co-morbidities, age, health status etc.
2. Physical: weakness, exhaustion, endurance etc.
3. Nutritional: appetite, dietary intake, symptoms
4. Psychological: cognition, depression, anxiety
5. Social: Coping capacity, social relations.

Best performing assessment tools for community: Comprehensive Geriatric Assessment[b], Frailty Index, Frail Scale

Practice Tips

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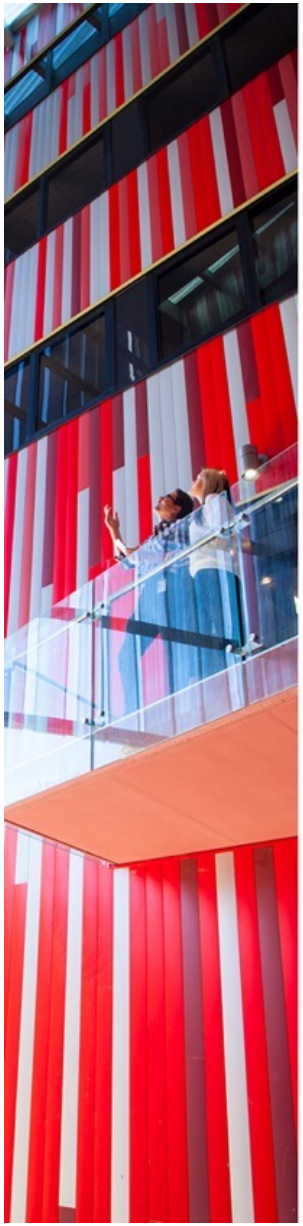

Identifying malnutrition and frailty

ASSESSMENT / DIAGNOSIS

Malnutrition: Dietitians. Best performing tools: MNA, SGA. Domains assessed: diet, anthro, biochem, clinical/physical

Frailty: Geriatricians (but any trained HCP can assess). Best performing tools: Comprehensive Geriatric Ax, Frailty Index, Frail Scale. Domains assessed: health, physical, nutritional, psychological, social.

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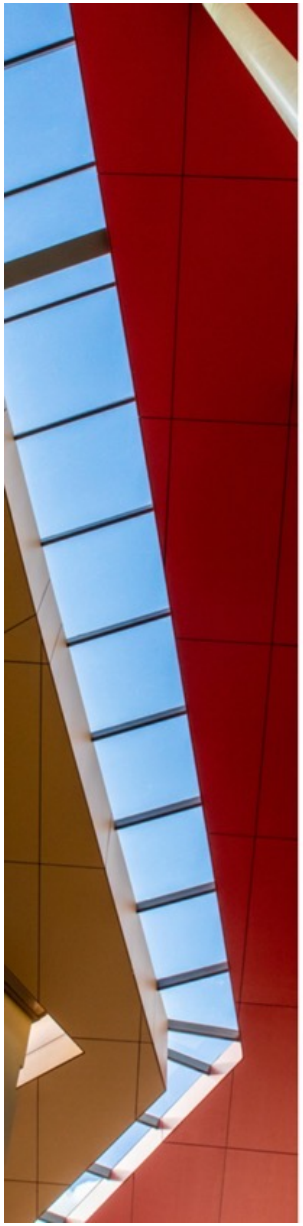

Managing malnutrition and frailty

1. Set goals, select outcome measures, estimate requirements

2. Select and implement interventions

3. Evaluate and monitor outcomes

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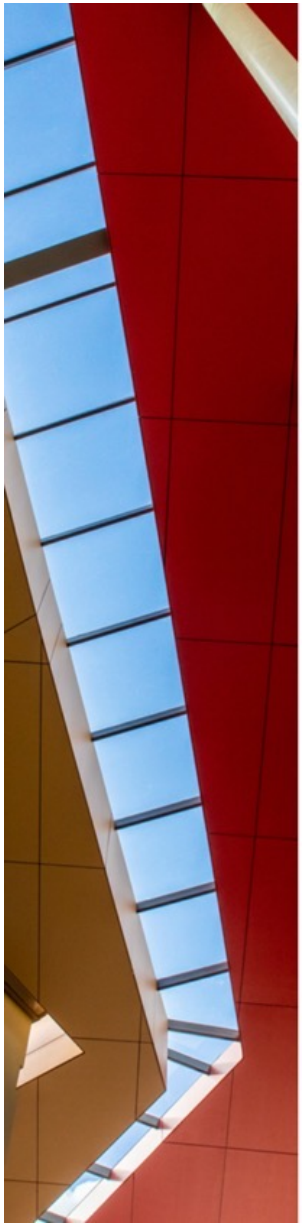


Outcome measures to monitor

Intervention tolerance/adherence should be assessed on an ongoing basis by a dietitian, in case adjustments need to be made. While no gold standard set of outcome measures currently exists, evidence [1, 61, 64, 65] suggests dietitians should factor in a combination of the following indicators most important to the client, to provide evidence-based, client-centred care:

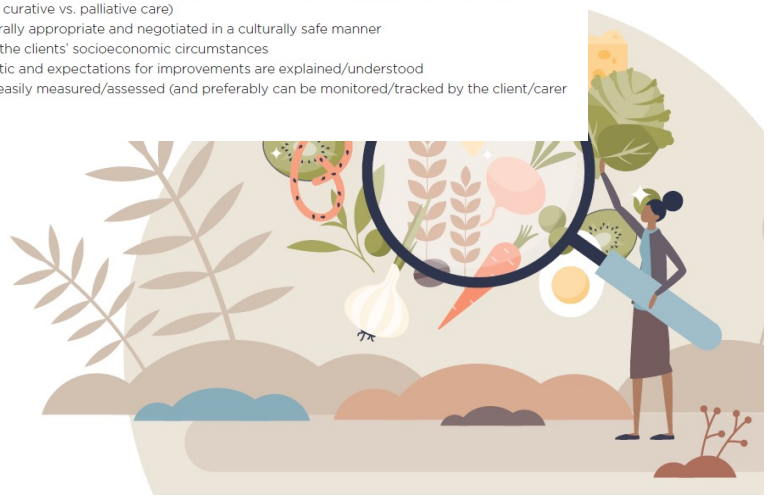
- **Direct nutrition:** knowledge gained, behaviour change, food/nutrient intake, improved nutritional status and/or appetite.
- **Clinical health and social status:** biochemistry, weight/anthropometry, risk factor profile, signs/symptoms, strength.
- **Client value-based care:** quality of life, client and/or family satisfaction, self-efficacy, self-management, functional ability .
- **Health care use:** complications, preventable hospital admissions, institutionalisation.

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) are questionnaires that help clients to report on outcomes relating to their health, and may be used to assess various aspects of a client's health such as quality of life, symptoms, and daily functioning [66]. For more information on PROMs and PREMs, including examples, see Resources.

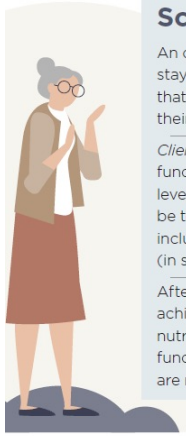
Client-centred goals

Clients should be involved in selecting the goals and outcomes most important to them. This can be achieved through adopting a client-centred approach to care planning, which involves HCPs helping clients to identify pertinent health values, and together, choosing strategies that best align with the clients' personal context [63]. To learn more about the principles of shared decision making, refer to Resources.
HCPs should ensure:

- Goals/outcomes are agreed upon with the client, family/whanau or carer
- Goals/outcomes are selected in consideration of disease type, stage, treatment (e.g. goals/outcomes will be different for curative vs. palliative care)
- Goals are culturally appropriate and negotiated in a culturally safe manner
- Goals factor in the clients' socioeconomic circumstances
- Goals are realistic and expectations for improvements are explained/understood
- Outcomes are easily measured/assessed (and preferably can be monitored/tracked by the client/carer themselves)



Box 2. Examples of client-centred goals and outcome measures dietitians can use with clients



Scenario A

An older client arrives at your dietetic practice. They were recently discharged from a 1-month stay in hospital following a hip fracture, where they lost ~5% body weight. The client expresses that they have reduced energy levels and low mood, but their desire is to get back to cooking their own dinner and watering their garden.

Client centred goals that you set with the client during the first consultation may be around function rather than just nutrition. For example, the client's goals may be to improve their energy levels, strength and mobility to be able to cook/garden. Objectives for meeting these goals may be to improve energy/protein intake and increase weight/strength. Strategies to achieve this may include education on high protein, high energy (HPHE) foods and arranging shopping assistance (in short term), paired with exercises prescribed by a physiotherapist or exercise physiologist.

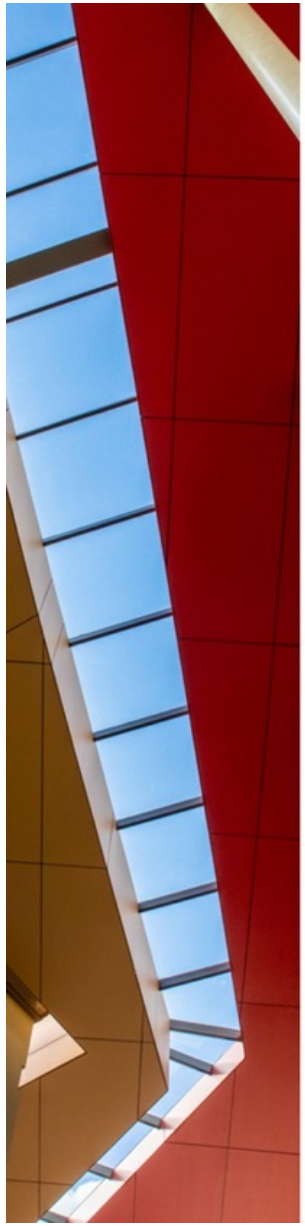
After setting goals, you should select *outcome measures* to monitor the client's progress in achieving these goals, also at the first consultation. These may include energy/protein intake and nutrition status (direct nutrition), weight and strength (clinical health), and quality of life, mood and functional ability (client value-based care). You should check these with the client to ensure they are relevant and valuable outcome measures to them.

Scenario B

A 39-year-old client with a head and neck cancer presents to your follow up oncology clinic after completing six weeks of radical chemoradiotherapy. The client has a gastrostomy feeding tube for enteral nutrition and has lost a further 6% body weight in two months since finishing treatment and now has a BMI of 19. Although she is starting to eat small amounts of puree foods, she still has resolving mucositis, pain on swallowing and taste changes.

Client centred goals: Establish goals at this review clinic. They will be based around nutrition, oral function, weight management and texture modification with enteral nutrition prescription adjustment. For example, the client's goals may be to return to eating a normal diet and wean from the enteral feed with the gastrostomy being removed. She would also like to return to work in the next six months. Objectives will be to increase HPHE texture modified foods and oral nutritional supplements (ONS) with a planned reduction of enteral feeding, while increasing or maintaining weight. Strategies will include education on diet texture and fortification, ONS prescribing, and speech language therapist input for swallowing rehabilitation.After setting goals, you should select *outcome measures* to monitor the client's progress in achieving these goals, also at the first consultation. These may include energy/protein intake and nutrition status (direct nutrition), weight and strength (clinical health), and quality of life, mood and functional ability (client value-based care). You should check these with the client to ensure they are relevant and valuable outcome measures to them.

After setting goals with the client, outcome measures will be put in place to monitor her intakes of oral food, ONS and enteral feed to determine nutritional adequacy (direct nutrition). Weekly weights and symptom reporting (clinical health) and communication with the speech language therapist about swallowing function (client value-based care) will also be important. The client may want to set a date to aim for removal of the gastrostomy and return to work (client value-based care).



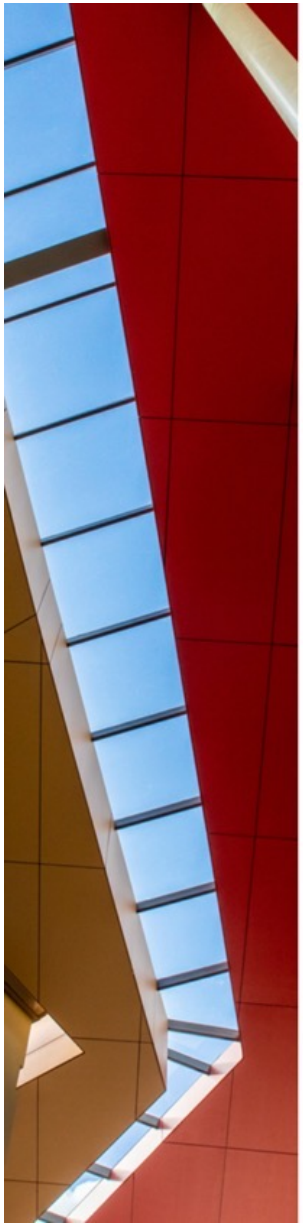
Box 2. Examples of client-centred goals and outcome measures dietitians can use with clients

Scenario A

An older client arrives at your dietetic practice. They were recently discharged from a 1-month stay in hospital following a hip fracture, where they lost ~5% body weight. The client expresses that they have reduced energy levels and low mood, but their desire is to get back to cooking their own dinner and watering their garden.

Client centred goals that you set with the client during the first consultation may be around function rather than just nutrition. For example, the client's goals may be to improve their energy levels, strength and mobility to be able to cook/garden. Objectives for meeting these goals may be to improve energy/protein intake and increase weight/strength. Strategies to achieve this may include education on high protein, high energy (HPHE) foods and arranging shopping assistance (in short term), paired with exercises prescribed by a physiotherapist or exercise physiologist.

After setting goals, you should select *outcome measures* to monitor the client's progress in achieving these goals, also at the first consultation. These may include energy/protein intake and nutrition status (direct nutrition), weight and strength (clinical health), and quality of life, mood and functional ability (client value-based care). You should check these with the client to ensure they are relevant and valuable outcome measures to them.



Nutrition education an

Dietitians should provide individualise
nutrition intervention implemented [7
developed by dietitians to guide conv
This may involve providing culturally a
foods, modifying recipes/fortifying fo
barriers, or using memory aids/remin

Evidence for

Nutrition education tha
been shown to contribu
However, not all clients
dietetic counselling are
reinforced by other HC
in the home) [76] or do
(including information
also been shown to be
adults [79] and therefo
not immediately availa

Food-based fortificatio

Food-based fortification involves incre
increasing its volume. This is achieved
powdered milk, cheese, yoghurt for p
(casein, whey protein, maltodextrin) t
to treat lower risk clients due to acces

Evidence for food-ba

A 2018 systematic review of studies con
based fortification is an effective and w
intake amongst older adults [81]. While
suggests at-risk and malnourished com
HPHE foods such as dairy [34, 74, 82] a
and cost-effective approach to improve
into residents' diets has been found to d
falls [83] in aged care. Based on this res
effectiveness of HPHE foods (especiall
with clients to ensure they have access
options that meet clients' cultural need

Box 3. Potential interventions and services that can be implemented by HCPs to support dietitians in managing malnutrition and/or frailty

Scenario A

A 75-year-old female client is seen by a GP. She seems to have lost weight since her last appointment. Further investigation confirms unintentional weight loss, poor appetite, and low mood. She lives alone with little motivation to cook but is still independent and mobile.

Risk factors: Older age, weight loss, poor appetite, poor social support/social isolation.

Potential intervention:

- Refer to a dietitian (either in person or telehealth) for assessment and a nutrition care plan.
- Any non-dietetic HCP can provide geographically relevant and/or evidence-based resources for improving nutrition intake, such as educational materials on high energy/high protein foods (especially dairy, 4 serves a day) and having smaller, more frequent meals.
- Community services such as shopping or cooking support programs, or other strategies to increase socialisation/reduce loneliness might be beneficial.
- Referral to a counsellor or psychologist may also be warranted to address mood issues.

Scenario B

Following a significant trauma due to a motor vehicle accident and subsequent admission to the intensive care unit, a 55-year-old, obese man is currently in rehabilitation. He suffers from depression, memory problems and sarcopenic obesity, among other comorbidities (diabetes, high blood pressure). He tires quickly and has little motivation to improve his body composition. Upon discharge from hospital and transition to community care, he will return home where he lives with his wife, who does the food shopping and prepares most of the client's meals at home.

Risk factors: Depression, poor physical function, high BMI, multimorbidity, recent hospitalisation.

Potential intervention:

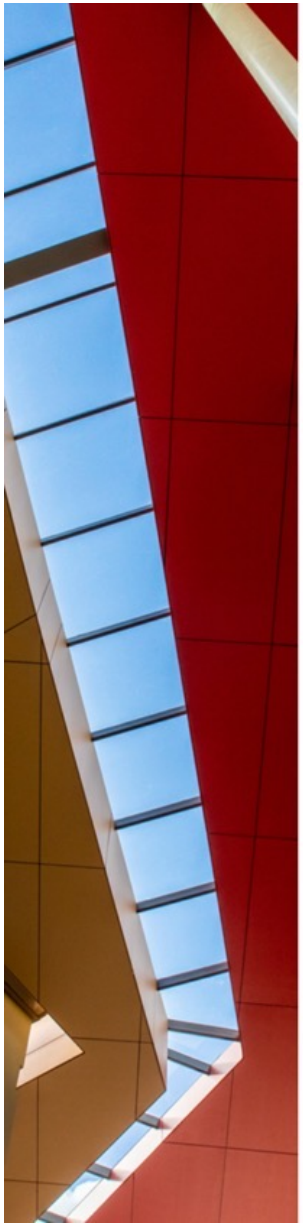
- Refer to a dietitian to address potential malnutrition and/or frailty.
- A dietitian consultation, via telehealth or in person, can provide the client with educational resources on nutrition and health, with a focus on maintaining lean body mass/consuming healthy protein-rich foods after illness/injury. The client's wife should be included in this education as she is responsible for the household's shopping and cooking (and may be able to help with the client's low motivation).
- Provision of memory aids (by speech pathologist / speech language therapist), mobility aids and/or exercise prescription (by exercise physiologist), aids and appliances (by occupational therapist), or support services (by social worker) may also be useful, so refer to appropriate HCPs as needed.

les for dietitians to manage d guidance on their implementation

ed on	Support services	Oral nutrition supplements
requent ng on luids ld be s the day with mmed milk fat milk, nergy ithout e of food roviding not lternatives d soy milk) are barriers ysical appetite iewing/ s), and/or inancial amin nt if dicine ions into	• If support services are required, consider what services are available (see below and Resources) and which would be most useful. For example: - Government support programs (e.g. Home Care Packages Program) - Home visiting doctor - Transition Care Programs - Palliative care services - Telephone helplines - Home delivered meal programs (e.g. Meals on Wheels) • Review the need for service(s) regularly with the client and their family to ensure they are achieving the objectives they were employed to achieve; and that the client does not become reliant on these services or regress functionally • Consider the cost, acceptability (i.e. some may prefer family to assist) and cultural appropriateness of the service to the client • Involve family in decision making wherever possible and notify them when commencing/changing or terminating service(s)	• ONS should only be used under the supervision of a dieititian. • When nutritional requirements are unable to be met through food alone, choose appropriate ONS for the client, factoring in their preferences (e.g. milk or juice; sweet or savoury), health condition/s (e.g. renal function or dietary intolerances) and personal circumstances (e.g. cost, access, ability to buy/ prepare) • Test preferences by offering a range of samples first • Prescribe preferred product(s)/ flavour(s) and determine dose, timing and frequency • Involve and inform family wherever possible about potential issues and ensure they know how to access/ order the ONS • Taste fatigue should be considered and reviewed regularly

he multidisciplinary team

nput from other healthcare professionals such as
al therapist, speech pathologist



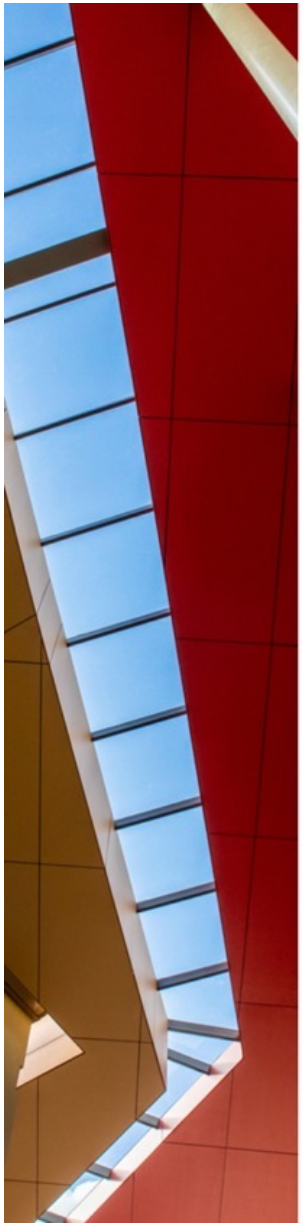
Managing malnutrition and frailty

3. Evaluate and monitor outcomes

- Selected nutrition intervention(s) should be evaluated/monitored using outcome measures selected in Step 1
- Qualitative / quantitative measures and validated tools (where available) should be used to collect data
- Communicate findings to all HCPs involved in client's care
- Frequency of monitoring/evaluation will depend on the health care setting, strategies selected and disease severity

Severe or moderate malnutrition/frailty: weekly review until stable; then every 1-3 months or as needed

Mild malnutrition/frailty or responding well to nutrition intervention: every 1-3 months



Transitions of care (e.g. from hospital to home)

Transitions of care refers to the various points at which a client moves to, or returns from, a particular physical location (i.e. home, hospital, residential care settings) or makes contact with different HCPs to receive health care [99]. Managing transitions effectively from hospital into residential aged care or primary care (i.e. home) and vice versa are critical steps in managing malnutrition and frailty in community-dwelling adults, and requires involvement from and communication between all relevant HCPs. Further, family members often help to facilitate this transition, and thus should be involved in and updated about any decision-making and delivery of education/recommendations.

Evidence for transitions of care

Community-dwelling older adults are slow to return to their baseline nutritional state after hospitalisation [100]. Consequently, rehospitalisation rates for older adults are high and up to a third of readmissions are considered preventable [101]. Early dietetic intervention on and/or following discharge has been shown to reduce avoidable readmissions by 28% [101], improve intake and weight gain [90, 102, 103], ameliorate gait speed [104], and reduce 6-month and 90-day mortality by 8% [105] and 5% [103], respectively. Yet, many older adults who need quality nutrition care in this transition period do not receive it [106, 107]. Acute care and community HCPs should work together to improve transitions of care by ensuring adequate documentation, handover and referrals, and communication; and in turn, potentially improve client outcomes.

Resources / Extra reading

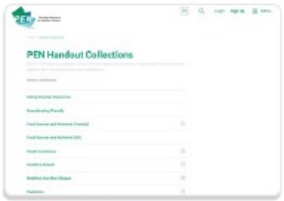
Resources to provide to clients

Nutrition Education Materials Online (NEMO)
Resources to support the management nutrition amoung adults in the community
https://www.health.qld.gov.au/nutrition

Sydney North Health Network
Educational and practical resources for health aging and frailty in older community dwelling adults
https://sydneynorthhealthnetwork.org.au/programs/frailty/

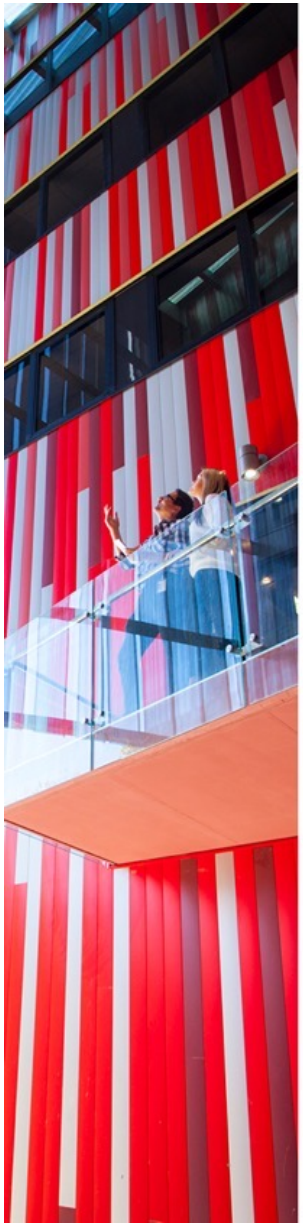
Appetite for Life
Educational and practical resources made specifically to support nutrition and exercise among elderly adults in the community
http://www.dhhs.tas.gov.au/healthyageing/resources_and_contacts/appetite_for_life

Health Vic
Educational and practical resources for managing frailty in older community dwelling adults
https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/frailty/frailty-resources



PEN: The Global Resource for Nutrition Practice
Educational and practical resources for community dwelling adults around the globe (note: requires a PEN subscription)
https://www.pennutrition.com/HandoutCollections.aspx

Healthinfo
Educational and practical resources for community dwelling adults living in New Zealand
https://www.healthinfo.org.nz/



Conclusion

- Guidance for the identification and management of malnutrition and frailty in ANZ community to address gap
- Underpinned by evidence (literature review), local data (ANZ survey/interviews) and expert input (panel)
- Improve recognition (by all HCPs) and nutritional management of these conditions
- Distribute widely, consider implementation plan

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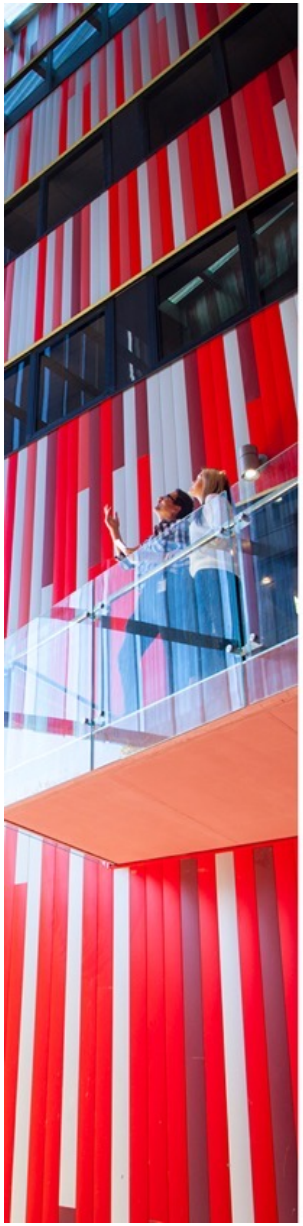

Dissemination & implementation

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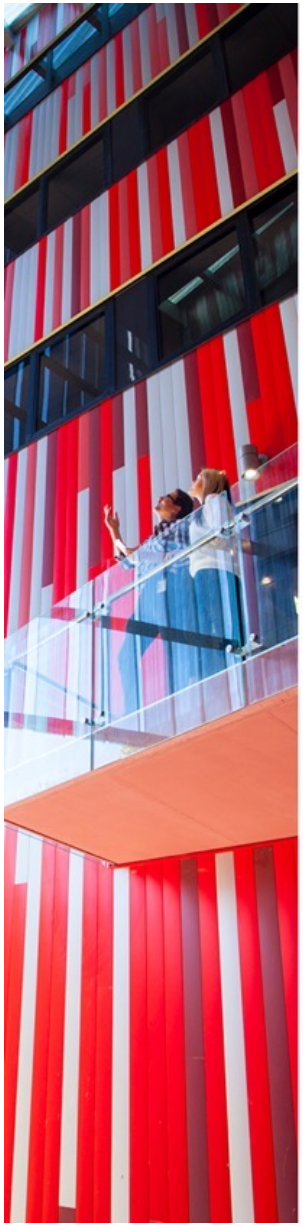
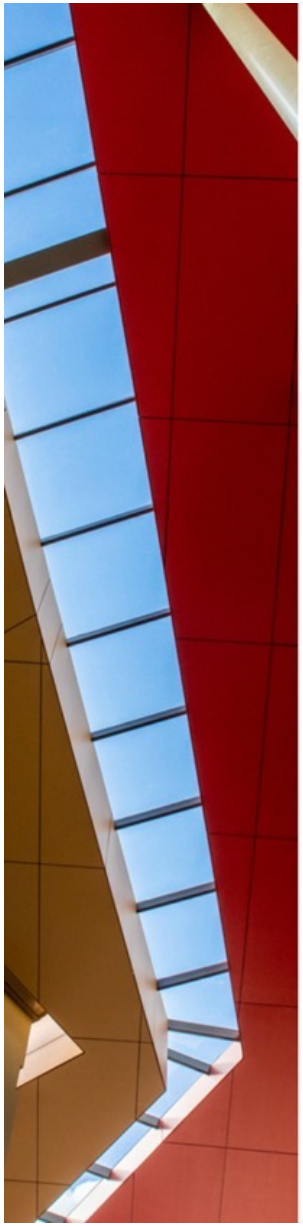


Acknowledgements

- **GRIFFITH UNIVERSITY**
  - SR time to work on guideline; administration of funding
- **DANONE NUTRICIA**
  - Provided unrestricted educational grant to fund research and guideline development
- **EXPERT PANEL & PARTICIPANTS**
  - For donating their time and expertise to optimise guideline content



Question 4: How confident do you feel in managing MALNUTRITION in the community (including d/c from hospital to home)?

- Not confident at all
- Slightly confident
- Somewhat confident
- Fairly confident
- Very confident

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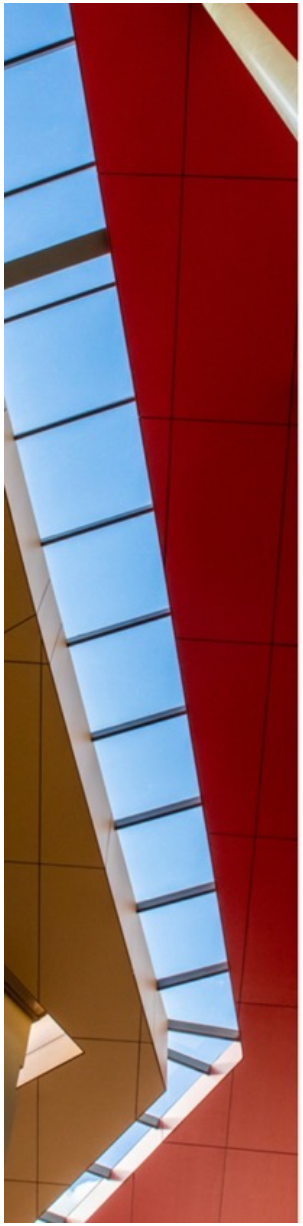

Question 5: How confident do you feel in managing FRAILTY in the community (including d/c from hospital to home)?

Not confident at all	Slightly confident	Somewhat confident	Fairly confident	Very confident

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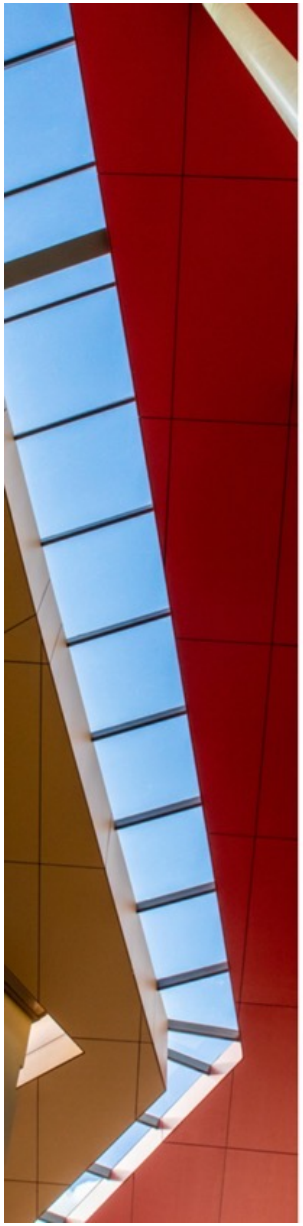

Question 6: How likely are you to use this new guide in practice?

Very unlikely	Unlikely	Unsure	Likely	Very likely

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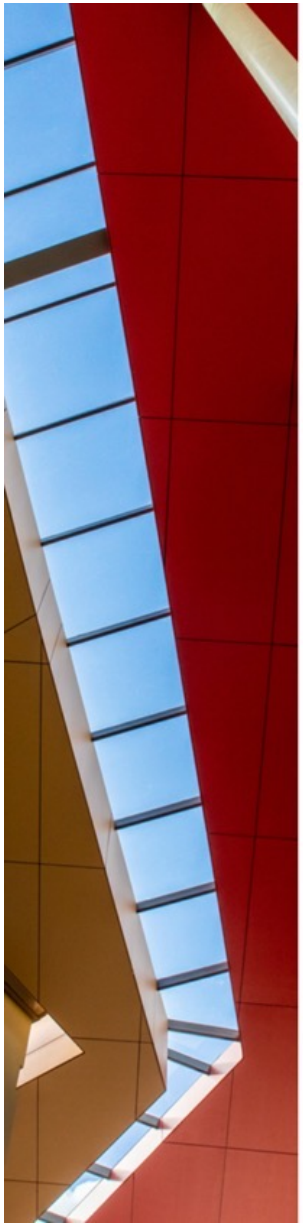

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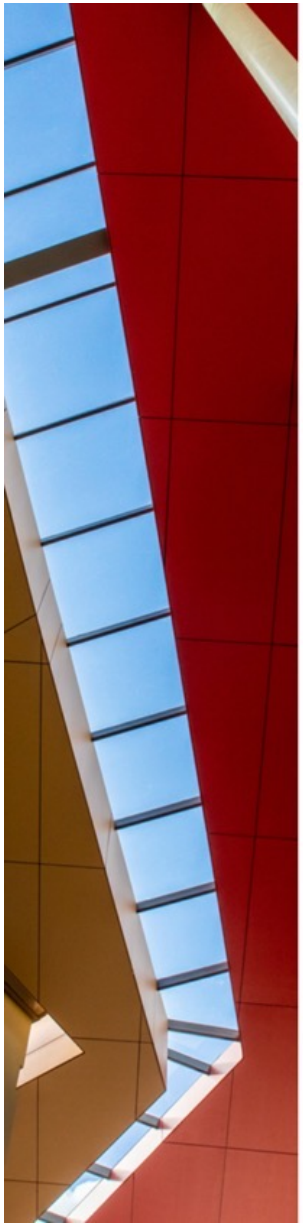

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