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1 **Helping understand nutritional gaps in the elderly (HUNGER) :**
2 **A prospective study of patient factors associated with inadequate**
3 **nutritional intake in older medical inpatients**

4

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10

11 Short title: Helping understand nutritional gaps in the elderly (HUNGER)

12

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21

22 This study was presented at the Royal Australian College of Physicians national
23 meeting (Physician's Week) April 2009

24

25 **Abstract**

26 BACKGROUND: Malnutrition, and poor intake during hospitalisation, are common
27 in older medical patients. Better understanding of patient-specific factors associated
28 with poor intake may inform nutritional interventions.

29 AIMS: To measure the proportion of older medical patients with inadequate
30 nutritional intake, and identify patient-related factors associated with this outcome.

31 METHODS: Prospective cohort study enrolling consecutive consenting medical
32 inpatients aged 65 years or older. Primary outcome was energy intake less than resting
33 energy expenditure estimated using weight-based equations. Energy intake was
34 calculated for a single day using direct observation of plate waste. Explanatory
35 variables included age, gender, number of co-morbidities, number of medications,
36 diagnosis, usual residence, nutritional status, functional and cognitive impairment,
37 depressive symptoms, poor appetite, poor dentition, and dysphagia.

38 RESULTS: Of 134 participants (mean age 80 years, 51% female), only 41% met
39 estimated resting energy requirements. Mean energy intake was 1220 kcal/day (SD
40 440), or 18.1 kcal/kg/day. Factors associated with inadequate energy intake in
41 multivariate analysis were poor appetite, higher BMI, diagnosis of infection or cancer,
42 delirium and need for assistance with feeding.

43 CONCLUSIONS: Inadequate nutritional intake is common, and patient factors
44 contributing to poor intake need to be considered in nutritional interventions.

45

46 **Keywords:** *malnutrition, aged, hospitalization, energy intake*

47

48 **Introduction**

49 Protein-energy malnutrition is common in older acute medical patients, where
50 prevalence may be as high as 60%^{1,2}. Malnutrition is associated with poor clinical
51 outcomes³. However, there is limited evidence that improved nutritional care
52 improves outcomes in this group^{4,5}. There are several possible explanations.
53 Enhanced nutritional care may not translate into increased nutritional intake because
54 of implementation barriers at service or patient level; inpatient interventions may be
55 of insufficient duration to influence clinical outcomes; or malnutrition may be a
56 marker of disease severity rather than a modifiable risk factor.

57

58 Previous studies show that nutritional intake in hospital inpatients is often inadequate
59¹, which may lead to worsening nutritional status in hospital⁶. Some studies have
60 highlighted deficiencies in systems of screening, prescribing and delivering nutritional
61 care^{1,7}. However, even when effective systems are established to deliver adequate
62 nutrition, food waste studies and clinical experience suggest that patients often do not
63 consume their meals, snacks and supplements^{5,8}. Better understanding of the
64 prevalence and impact of patient factors which limit nutritional intake might help
65 explain the disappointing results of nutritional interventions in older medical patients
66 and inform novel approaches to improve nutritional intake and nutritional status in
67 hospital.

68

69 Several previous studies have considered patient-level factors which might reduce
70 nutritional intake, such as poor appetite and difficulties with chewing or swallowing⁶,
71^{7,9,10}. However, these studies have several weaknesses, including inconsistencies in
72 calculations of energy requirements and definitions of adequate intake, poor

73 justification of explanatory variables, and inadequate adjustment for confounders.
74 Recent studies using rigorous methodology have provided useful working definitions
75 for resting energy requirements and total estimated energy and protein requirements in
76 older medical inpatients ^{11, 12}.

77

78 The aims of this study were to describe the prevalence of inadequate energy and
79 protein intake in older medical inpatients in the first week of hospital admission, and
80 to identify patient-level factors associated with reduced energy intake.

81

82 **Subjects and methods**

83 **Design and setting:** The study was a prospective cohort study conducted in the
84 general medical wards of the Royal Brisbane and Women's Hospital, a large
85 metropolitan public teaching hospital in Brisbane, Australia. The study was part of a
86 larger multi-methods study which also examined cultural and environmental barriers
87 to poor energy intake, in order to design an effective nutritional intervention.

88

89 Participants for this study were selected from four acute general medical wards, where
90 they received care from one of five multidisciplinary medical units. Each unit cares
91 for 20-30 inpatients and consists of 2-3 physicians, two medical registrars (post-
92 graduate year 3-5), three interns (post-graduate year 1), and a consistent allied health
93 team, including 0.4 fulltime equivalent accredited practising dietitian. The
94 multidisciplinary team meets daily to ensure holistic assessment and prompt referral.
95 This model, and the characteristics of the patient population, have been described in
96 detail previously¹³. Nutrition screening is routinely conducted by dietetic assistants
97 and/or ward nursing staff to identify patients at nutrition risk, who are referred to the
98 unit dietitian and provided with high protein high energy diets and/or additional mid-
99 meal snacks or supplements.

100

101 **Participants:** Consecutive patients admitted between November 2007 and March
102 2008 were screened by the study dietitian for eligibility. Patients were eligible if they
103 were aged 65 years or older, had a hospital stay of more than 2 days, and were
104 admitted from the emergency department to the study wards. Patients who were
105 critically or terminally ill or were receiving parenteral or enteral nutrition at the time
106 of admission were excluded. Informed consent was obtained from all participants or a

107 suitable proxy (close family member or recognised carer). The study was approved by
108 the hospital human research ethics committee.

109

110 **Outcomes and measurement:**

111 Dietary intake was measured on a single day between day 3 and day 7 of the hospital
112 admission. Measurement was performed by the study dietitian supervising two trained
113 dietetic assistants using visual estimation of plate waste, which has been shown to
114 correlate closely with measured plate waste¹⁴. Each meal was inspected on delivery
115 and on completion, and consumption was estimated (none, 1/8, 1/4, 1/2, 3/4, all) for each
116 component of the meal (eg soup, meat, potato, green vegetables, bread). Mid-meal
117 intake was estimated by observation and/or patient recall. Each dietary intake
118 observation was converted to energy and protein intake based on food composition for
119 each specific meal, using FoodWorks Professional nutrient analysis software (version
120 3.02, Xyris, Brisbane Australia 2004.) In 5 participants, intake data was missing for
121 lunch or dinner; in view of the high measured correlation between breakfast intake
122 and overall intake in the whole cohort, daily intake for these participants was imputed
123 by multiplying breakfast intake by 3.56.

124

125 The primary outcome of inadequate energy intake was defined as measured energy
126 intake less than estimated resting energy expenditure (REE), as this would inevitably
127 lead to weight loss⁷. Based on published data from hospitalised elderly patients, we
128 estimated REE as 18.4 kcal/kg bodyweight/day for patients with body mass index
129 (BMI)>21kg/m² and 21.4 kcal/kg/day for those with BMI≤21 kg/m²¹¹.

130

131 Secondary outcomes were measured energy intake less than estimated total energy
132 expenditure, and protein intake less than minimal estimated protein requirement. We
133 multiplied REE by a physical activity factor of 1.42 to estimate total energy
134 expenditure ¹¹. Minimal protein requirement was estimated as 1g dietary protein/kg
135 bodyweight/day, which is a conservative estimate of the amount required to maintain
136 positive protein balance ¹².

137

138 **Confounding and explanatory variables:**

139 Potential explanatory and confounding variables were identified through literature
140 review, multidisciplinary consultation, and focus groups with nursing and allied
141 health staff. Confounders included age, sex, usual place of residence, diagnosis,
142 number of co-morbidities, number of medications and hospital ward. Candidate
143 explanatory variables were appetite, nutritional status, functional status, cognition,
144 delirium, depression, dentition, dysphagia, and dietary modification ^{9, 10}.

145

146 Detailed assessment was undertaken by the study dietitian, an experienced accredited
147 practicing dietitian who did not provide clinical care to the participants. Demographic
148 and disease variables were obtained from the medical record. Length of hospital stay,
149 discharge destination and final diagnosis were obtained from the medical summary at
150 the time of discharge.

151

152 Weight was measured using a single Tanita HD351 scale, precise to 0.1 kg; on
153 occasions where seated scales were required, ward scales were used and calibrated by
154 the study dietitian to the reference scale. In 12 cases, it was not possible to weigh the
155 patient, and the study dietitian estimated weight to the nearest kg. Height was

156 estimated from heel-knee length according to standard formulae ¹⁵, and used to derive
157 the body mass index. Nutritional status was assessed using the Mini Nutritional
158 Assessment (MNA), with scores of <17 indicating malnutrition, 17-23.5 at risk of
159 malnutrition, and 24-30 indicating good nutritional status ^{16, 17}.

160

161 Cognition was measured using Folstein's Mini-Mental State Examination ¹⁸ with
162 cognitive impairment defined as ≤ 23 , and the Confusion Assessment Method ¹⁹ was
163 used to identify delirium. Depressive symptoms were assessed using the Geriatric
164 Depression Scale ²⁰, with possible depression defined as scores of 5 or greater.

165 Functional dependency was obtained from patient self-report, using a 6 point ordinal
166 scale based on the number of basic activities of daily living (ADL, including dressing,
167 bathing, toileting, transfers, mobility and feeding) for which assistance from another
168 person was required ²¹. Feeding dependency was also considered as a separate
169 variable using items from the modified Barthel index, and included need for help with
170 set-up or supervision with meals ²². Appetite was evaluated using the Simplified
171 Nutritional Appetite Questionnaire, with scores of 14 or less indicating impaired
172 appetite ²³. The study dietitian recorded the presence and state of current dentition,
173 defining poor dentition as missing teeth, or ill-fitting or absent dentures. Risk of
174 dysphagia was recorded using a validated screening tool ²⁴.

175

176 **Statistical Analyses:**

177 Participant characteristics were summarised using mean and standard deviation for
178 continuous variables, or categorised according to validated cut-offs and clinical
179 meaning. Adequacy of nutritional intake was calculated for each participant by

180 comparing daily energy intake with estimated REE, total energy expenditure and
181 protein requirements.

182

183 The relationship of each explanatory variable to the primary outcome of inadequate
184 nutritional intake (energy intake <REE) was examined using one-way analysis of
185 variance for continuous variables and chi-squared test of association for categorical
186 variables. If bivariate analysis suggested a possible association ($p < 0.2$), the variable
187 was included in a multiple logistic regression model, which included the confounding
188 variables of age, usual residence and increased co-morbidities. Relative risk was
189 estimated from the odds ratios generated from the logistic regression, using previously
190 reported methods²⁵. Associations were considered significant in multivariable
191 analysis if $p < 0.05$.

192

193 We recognised the potential to over-estimate requirements of obese participants
194 ($BMI \geq 30 \text{ kg/m}^2$) using a weight-based formula for REE. In clinical practice, estimates
195 are often adjusted in obese patients based on ideal body weight plus 25% of additional
196 body weight, on the assumption that only a proportion of the additional body mass is
197 metabolically active. We undertook a sensitivity analysis redefining REE based on
198 this adjusted body weight for obese participants, and report the logistic regression
199 results.

200

201 We estimated a minimum sample size of approximately 120 participants was required
202 to identify 8-10 significant variables with a moderate effect size in the regression
203 analysis, with 80% power, All analyses were conducted using SPSS version 17.0.

204

205

206 **Results**

207 **Participants**

208 Over the 16 week study period, 351 patients aged 65 years or older who met
209 eligibility criteria were admitted to general medical units from the Emergency
210 Department, and 134 (38%) consented to participate. Of the remainder, 104 declined,
211 and in 113 cases consent was not able to be obtained from the patient or an
212 appropriate proxy within the timeframe. Non-participants had the same mean age (81
213 years) as participants and a similar length of stay (11 days vs 12 days) but were more
214 likely to be discharged to residential aged care (24% versus 13%).

215

216 Participant characteristics are shown in **table 1**. A range of diagnoses were seen, as
217 expected in a general medical service. In addition to their primary diagnosis, 104
218 participants (78%) had two or more co-morbidities, and participants had an average of
219 7 prescribed medications. The mean score on the Mini Nutritional Assessment was
220 20.1 (SD 6.0), with 41 (31%) classified as malnourished, 51 (37%) at risk of
221 malnutrition and 41 (31%) well nourished. The mean BMI was 26.1 kg/m² (SD 6.0),
222 and 27 (20%) had BMI <21 kg/m².

223

224 Eighty four (63%) participants needed assistance in at least one ADL at the time of
225 assessment, including 43 (32%) who required help with set-up, supervision or actual
226 feeding of meals. Of 125 participants for whom formal cognitive testing was possible,
227 41 (33%) demonstrated cognitive impairment, 12 (10%) had evidence of delirium, and
228 31 (27%) had symptoms suggesting depression. Impaired appetite was recorded in 68
229 (52%), poor dentition observed in 44 (33%), and potential risk of dysphagia or
230 aspiration in 54 (41%).

231

232 Nutritional intake and estimated requirements

233 Mean energy provided in meals and snacks on the study day was 1836 kcal (SD 376).

234 **Figure 1** shows the distribution of energy intake. The mean measured daily energy

235 intake was 1220 kcal/day (SD 440), or 18.1 kcal/kg/day. This represented 66% of

236 energy provided in meals and snacks; 27% of participants ate less than 50% of the

237 energy provided, and 62% ate less than 75%. Most energy intake was from main

238 meals (28% breakfast, 30% lunch, 33% dinner), with 9% from mid meals and snacks.

239 The mean daily protein intake was 47.6 g per day (SD19.2) or 0.7 g / kg/day. Energy

240 intake was sufficient for REE in 55/134 (41%) participants, and met estimated total

241 energy expenditure in only 11/134 (8%). Only 14% had a protein intake \geq 1g/kg

242 bodyweight/day.

243

244 In a subgroup of 38 participants, energy intake measurement was repeated on day 3

245 and day 7. This showed no significant change in mean energy intake (1144 kcal/day

246 on day 3 compared to 1113 kcal/day on day 7, $p=0.63$).

247

248 Predictors of inadequate energy intake

249 Participants with inadequate energy intake tended to be older (mean age 81 versus 78

250 years, $p=0.06$) have more co-morbidities (mean 2.9 versus 2.5, $p=0.18$) and more

251 prescribed medications (mean 7.4 versus 6.4, $p=0.13$). Poor appetite, ADL

252 dependency and obesity were all strongly associated with energy intake less than REE

253 (**table 1**). There were weaker associations with dysphagia, delirium, and admission

254 from residential aged care in bivariate analysis. Poor intake was somewhat more

255 likely in those with diagnoses of infection or cancer. No association was seen with

256 cognitive impairment, depression, poor dentition, or with nutritional status as assessed
257 by the MNA.

258

259 **Table 2** shows the results of the multiple logistic regression model. There was
260 significant collinearity between feeding and ADL dependency (chi-square 37.7,
261 $p < 0.001$), so feeding dependency was selected for multivariate analysis. Factors
262 which retained a significant association with inadequate nutritional intake were poor
263 appetite, higher BMI, delirium and a diagnosis of infection or cancer. There was a
264 trend to poorer intake in those requiring feeding assistance.

265

266 The distribution of daily energy intake for different BMI subgroups is shown in **figure**
267 **2**, which demonstrates similar intake in the obese group compared to normal weight
268 despite increased weight. When we repeated REE estimates using adjusted body
269 weight in the obese subgroup, 49% of participants still did not meet REE. However
270 obesity was no longer a significant predictor of poor intake (**table 3**). Poor appetite
271 and an infectious diagnosis remained significantly associated with poor intake, and
272 the need for feeding assistance reached statistical significance. Risk estimates for the
273 other variables remained similar.

274

275 **Discussion**

276 This study confirms that inadequate nutritional intake is common in older medical
277 patients, despite established systems of malnutrition screening and nutrition support.
278 Only 41% of participants consumed sufficient dietary intake to meet estimated resting
279 energy requirements, 8% of participants had sufficient energy intake for estimated
280 total energy expenditure, and 14% had sufficient protein intake to avoid protein
281 catabolism ¹².

282

283 The measured mean energy intake of 1220 kcal/day is consistent with previous reports
284 in older medical patients ^{8, 9, 26-29}, and was significantly lower than the energy
285 delivered in meals and snacks. This was predominantly due to high levels of food
286 waste, similar to previous investigators. Dupertuis reported that 45% of acute care
287 patients did not meet resting energy requirements ²⁸, while Rammohan ²⁶ found that
288 half of patients aged over 65 consumed less than 65% of their estimated energy
289 requirement. Patel ¹⁰ and Incalzi ⁶ found that 67-70% ate less than 75% of their
290 delivered hospital meals and Barton ⁸ reported that almost 40% of delivered food was
291 not consumed.

292

293 We documented a high prevalence of many risk factors previously suggested to
294 contribute to poor intake, such as poor dentition, cognitive impairment, depressed
295 mood, poor appetite and the need for feeding assistance. However, not all these
296 factors were associated with poor nutritional intake.

297

298 Poor appetite was strongly associated with poor nutritional intake. Poor appetite and
299 difficulties with chewing or swallowing have been identified as risk factors for poor

300 intake in several previous studies, although these did not use reliable measurement or
301 account for potential confounders^{6,7,10}. We did not find a significant association with
302 poor dentition or dysphagia. A diagnosis of infection or cancer tended to be associated
303 with poorer intake, even though we did not include a stress factor for these conditions
304 in estimates of energy requirement, as is often done in clinical practice.

305

306 Despite the high prevalence of functional disability in the hospitalised elderly, few
307 previous studies have evaluated functional status as a risk factor for poor intake⁹. Our
308 study suggests that the need for assistance or supervision with feeding was associated
309 with poor intake, although the strength of this association was dependent on other
310 model parameters. Our study also suggests that poor nutritional intake may be a
311 consequence of delirium. Delirium is a common complication of acute medical
312 admissions²⁵, and was probably under-represented in our sample because of consent
313 considerations.

314

315 Poor intake associated with poor appetite, delirium and feeding dependency are
316 unlikely to be mitigated by simple provision of oral supplements, the commonest
317 nutritional support strategy reported in the literature. Multidisciplinary approaches
318 which recognise and specifically address these barriers may offer more promise.

319

320 It is reassuring that patients with a low BMI were much less likely to receive
321 inadequate intake, despite using a formula which recognised a higher REE in this
322 subgroup, suggesting that most of these patients are being recognised and their
323 nutritional needs identified early in the hospital admission. The strong association of
324 inadequate energy intake with obesity has been reported previously^{9,28}. This finding

325 may depend on the method for estimating REE. The best method for estimating
326 individual REE in acutely ill older patients remains controversial, and several studies
327 have shown poor performance of a range of estimating equations at individual level
328 compared to calorimetry^{30,31}. We based our estimates on the recommendations of a
329 recent study in older medical patients with characteristics similar to our own study¹¹,
330 which used actual body weight, adjusting only for those with BMI <21 kg/m². There
331 is conflicting data regarding whether weight-based formulae overestimate energy
332 requirements in the older obese subgroup^{30,31,32}. As a sensitivity analysis, we
333 recalculated REE estimates in the obese subgroup in keeping with common clinical
334 practice. This attenuated the influence of BMI (table 3), and increased the significance
335 of feeding dependency as a risk factor.

336

337 Our study has several strengths which contribute to its internal validity. Nutritional
338 intake was measured by detailed direct observation of meal components. Inadequate
339 intake was explicitly defined in a physiologically meaningful way, based on
340 calorimetric studies in a similar population¹¹. Explanatory variables and confounders
341 were informed by a multidisciplinary perspective, and validated measures were
342 chosen¹⁷. Few other studies have used multivariate methods to allow for potential
343 confounding. Although this study only considered patient factors contributing to poor
344 intake, the influence of staff and environmental factors were also investigated and will
345 be reported separately.

346

347 We recognise several weaknesses in the study. In particular, the relatively small
348 sample size means that we may have missed or under-recognised associations.
349 Consent rates were lower than anticipated, partly because of high clinical acuity and

350 partly because of the high prevalence of cognitive impairment in this group, with
351 proxy consent not always feasible within the time frame. These reasons for non-
352 consent suggest that our estimates of adequate nutritional intake may in fact be
353 optimistic. Energy requirements are ideally estimated by calorimetry, but our use of
354 estimating equations is consistent with the reality of clinical practice. The study was
355 conducted at a single site, although patient characteristics suggest a “typical” older
356 general medical population. Intake was only measured on a single day for most
357 participants; however, the subgroup with repeated measurements suggests that intake
358 remains relatively consistent, at least in the first week of hospitalisation. The study
359 sampled medical patients with a relatively long length of stay, which may limit
360 generalisability, but we deliberately selected this group because of their vulnerability
361 to further nutritional decline in hospital.

362

363

364 **Conclusions**

365 In summary, our study confirms that energy and protein intake are inadequate to meet
366 requirements in most older acute medical inpatients, which may lead to worsening
367 malnutrition during hospitalisation, and contribute to poor outcomes. It supports
368 recent recommendations for monitoring of intake and repeated nutritional risk
369 screening during the hospital stay, as well as at admission ². Poor nutritional intake in
370 hospital may be especially common in the obese elderly, but further research is
371 required in this group to clarify energy requirements during acute illness.

372

373 Poor intake was associated with several common patient characteristics, particularly
374 poor appetite, need for feeding assistance and delirium associated with acute illness.
375 These factors may not be assessed in routine nutritional screening, and deserve greater
376 recognition as factors impeding adequate intake in hospital. Interventions which
377 deliver additional nutrition to the bedside, without considering these common patient-
378 level barriers, are unlikely to succeed in improving nutritional status or clinical
379 outcomes in this patient group. Multi-faceted interventions which prioritise nutritional
380 care, directly address these barriers, and support nutritional screening with ongoing
381 intake monitoring may offer more promise ⁵.

382

383

384 *The authors declare no conflict of interest*

385

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389

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392

393 AM conceived the study and designed the study, undertook data analysis and initial

394 data interpretation, and drafted the manuscript.

395 LR, MB and EI contributed to study design, data interpretation and critical review of

396 the manuscript.

397 AY contributed to methods, undertook data collection and entry, and contributed to

398 data interpretation and critical review of the manuscript.

399 All authors approved the final manuscript.

400

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484 Figure 1: Energy intake (kcal per day) based on observation of individual meal
485 delivery and waste on the study day (between day 3 and 7 of hospital admission) in
486 134 consecutive older medical patients

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491 Figure 2: Energy intake (kcal per day) on the study day in 134 consecutive older
492 medical patients, grouped by body mass index subgroup.

493 2(A) underweight (BMI < 21 kg/m², n=27).

494 2(B) normal weight (BMI 21-29.9 kg/m², n=76).

495 2(C) obese (BMI 30 kg/m² or greater, n=31).

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498 Table 1: Participant characteristics, and bivariate associations with inadequate energy
 499 intake, defined as an energy intake less than estimated resting energy expenditure
 500 (REE) on the study day. Row percentages are shown. Denominators are provided (in
 501 brackets) for variables with missing data. ADL activities of daily living.

Characteristic	Number of participants	Number (%) with inadequate intake	p
Age (years)			0.49
65-84	93	53 (57)	
85 and older	41	26 (63)	
Sex			0.31
Male	66	36 (55)	
Female	68	43 (63)	
Diagnosis			0.16
Chronic cardiorespiratory disease	37	21 (57)	
Acute infection	27	21 (78)	
Gastrointestinal disease	13	7 (54)	
Cancer	10	7 (70)	
Other	47	23 (49)	
Living situation			0.16
Community living	115	65 (56)	
Residential care	19	14 (74)	
Body mass index (kg/m ²)			0.004
<21	27	12 (44)	

21-30	76	41 (54)	
≥30	31	26 (84)	
Mini Nutritional Assessment			0.70
<17	41	23 (56)	
17-23.5	51	32 (63)	
>23.5	42	23 (55)	
Dependent in any ADL	84	57 (68)	0.007
Needs help with feeding	43	31 (72)	0.03
Impaired appetite (n=131)	68	47 (69)	0.006
Cognitive impairment (n=125)	41	23 (56)	0.72
Delirium (n=130)	12	10 (83)	0.07
Depression (n=115)	31	18 (58)	0.98
Poor dentition (n=132)	44	25 (57)	0.71
Medical dietary restrictions	46	28 (61)	0.75
Positive dysphagia screen (n=133)	54	37 (69)	0.06
<i>TOTAL</i>	134	79 (59)	134

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507 Table 2: Multivariate analysis (n=126) of potential predictors of inadequate intake
 508 (energy intake less than estimated resting energy expenditure), adjusted for age and
 509 comorbidity count. Reference category for multi-level variables is included in
 510 brackets.

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	Adjusted odds ratio (95% CI)	p
Poor appetite	1.85 (1.42-2.06)	0.001
BMI (21-30 kg/m ²)		<0.001
<21 kg/m ²	0.28 (0.08-0.77)	
≥30 kg/m ²	1.70 (1.40-1.81)	
Requires assistance with feeding	1.45 (0.95-1.72)	0.08
Delirium	1.62 (1.01-1.74)	0.04
Positive dysphagia screen	1.16 (0.70-1.54)	0.50
Diagnosis (other)		0.06
Cardio-respiratory	1.44 (0.85-1.81)	
Infectious	1.70 (1.14-1.94)	
Cancer	1.79 (1.06-2.00)	
Gastrointestinal	0.91 (0.29-1.63)	
Age 85 years or older	1.02 (0.50-1.45)	0.94
2 or more co-morbidities	0.65 (0.27-1.14)	0.43
From residential aged care	1.28 (0.65-1.62)	0.37

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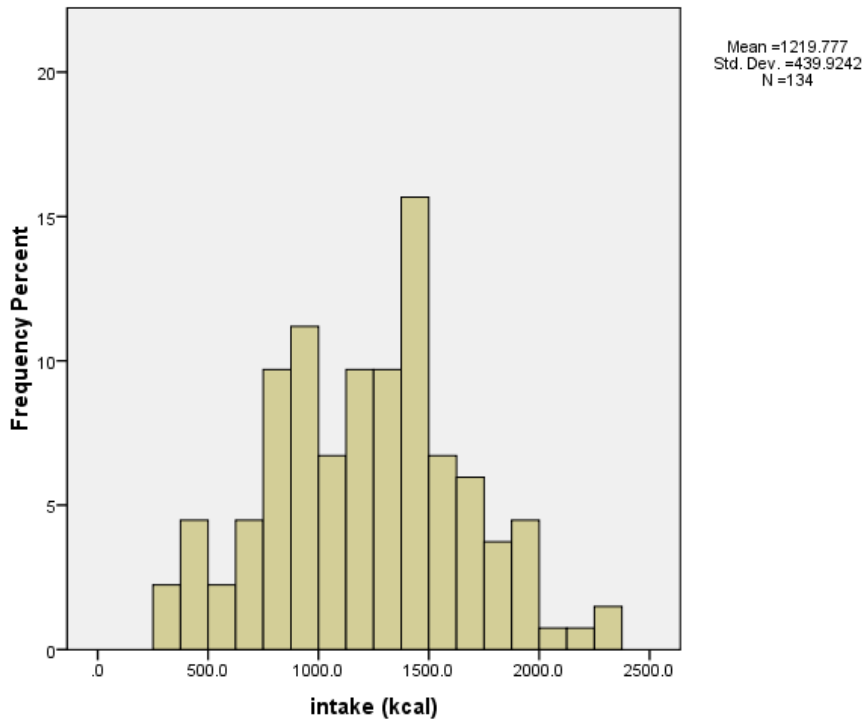
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514 Table 3: Multivariate analysis (n=126) of potential predictors of inadequate intake
 515 (energy intake less than estimated resting energy expenditure, adjusted in the obese
 516 subgroup), adjusted for age and comorbidity count. Reference category for multi-level
 517 variables is included in brackets. Adjusted weight was based on ideal body weight
 518 plus 25% of excess body weight in participants with BMI ≥ 30 kg/m²
 519

	Adjusted odds ratio (95% CI)	p
Poor appetite	2.22 (1.47-2.73)	0.001
BMI (21-30 kg/m ²)		0.08
<21 kg/m ²	0.39 (0.12-0.91)	
≥ 30 kg/m ²	0.79 (0.38-1.26)	
Requires assistance with feeding	1.84 (1.19-2.23)	0.01
Delirium	1.54(0.64-2.01)	0.24
Positive dysphagia screen	1.37 (0.84-1.86)	0.18
Diagnosis (other)		0.06
Cardio-respiratory	0.93 (0.43-1.55)	
Infectious	1.80 (1.13-2.15)	
Cancer	1.83 (0.87-2.23)	
Gastrointestinal	0.87 (0.25-1.73)	
Age 85 years or older	0.66 (0.27-1.22)	0.22
2 or more co-morbidities	0.59 (0.22-1.20)	0.17
From residential aged care	1.27 (0.53-1.87)	0.51

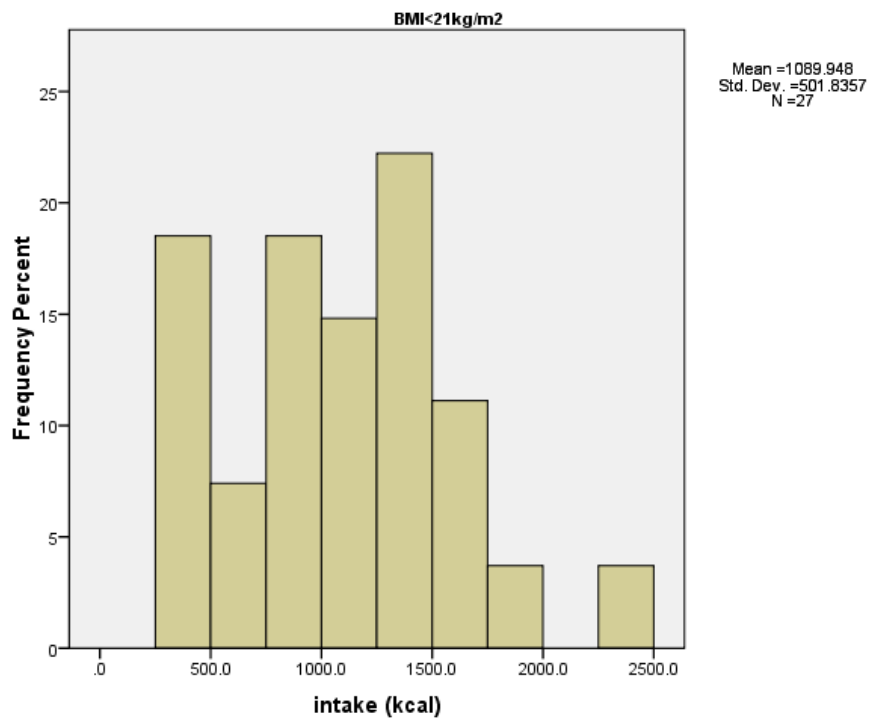
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523 Figure 1

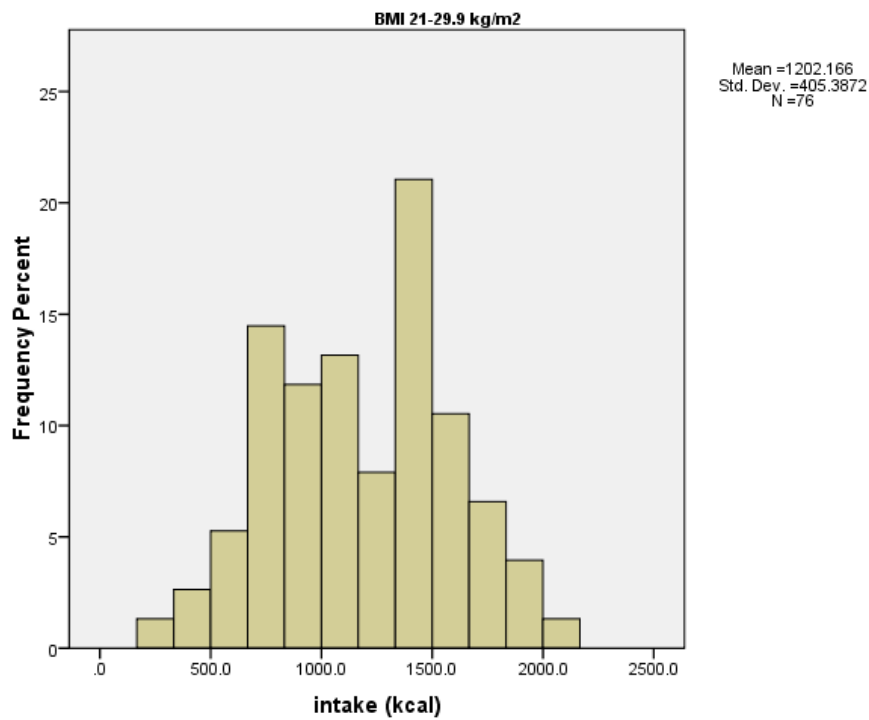


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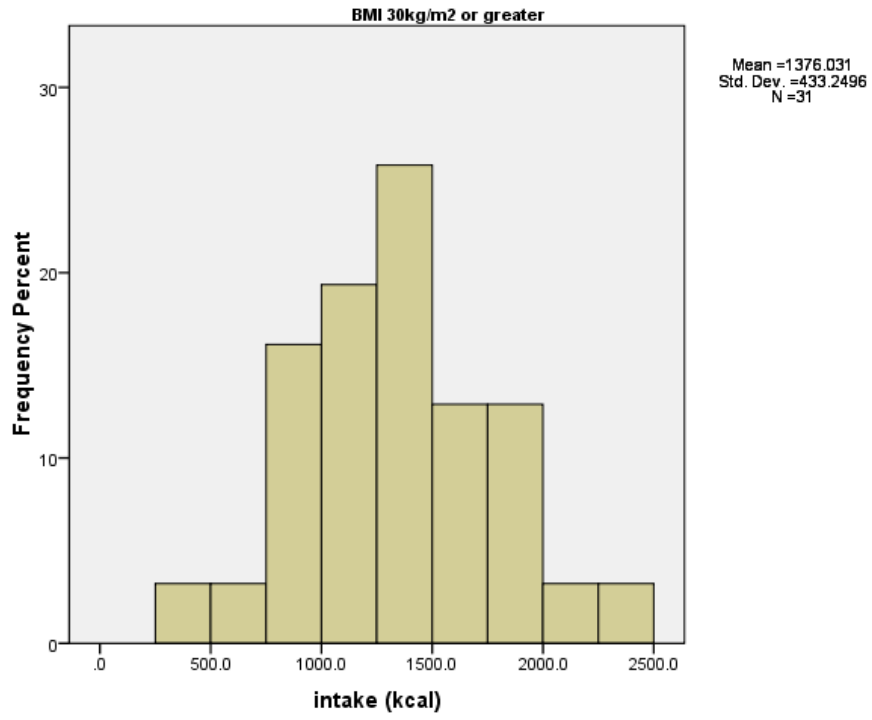
526 Figure 2A



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528 Figure 2B



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530 Figure 2C



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