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As I sat in on interdisciplinary rounds at the Acute Care for the Elderly (ACE) unit at the UAB Highlands Hospital, I couldn't help eyeing everything and everyone in the room. Seated at a long table was the team of health professionals who worked on the ACE unit—a physician, a nurse practitioner, a social worker, a pharmacist, a dietitian and a physical therapist. One by one, they discussed the patients currently staying in the ACE unit, including their health status, preferred diet, expected duration on the unit, the extent of the family's involvement in visiting and caring for the patient, and the patient's results for a clock drawing test.

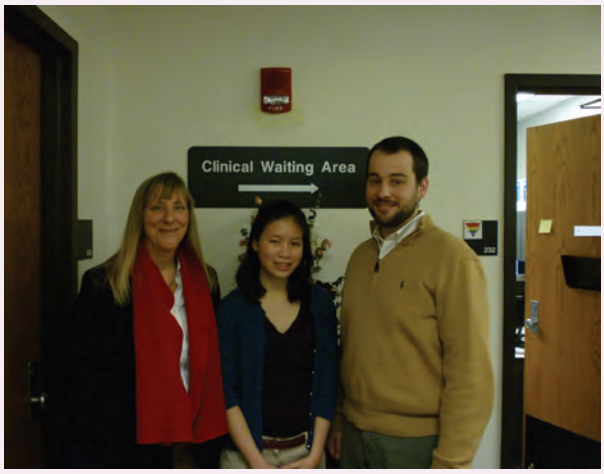
At first, the way that every ACE staff member communicated and coordinated with each other to address the needs of the patients amazed me. Many questions ran through my mind such as, "Why was it important for the social worker to mention that the patient's extended family wasn't visiting her?" And "what was the importance of how a patient drew the hands of a clock?" I later learned that the clock drawing test or a Mini-Cog Assessment is administered as a quick method for determining the patient's cognitive status at that specific point in time. The results may suggest whether a patient has a cognitive disease such as Alzheimer's disease, vascular dementia, and delirium. Overall, I was impressed by the team's discussion. Through collaboration, they were able to provide elderly patients with health care that addresses their biopsychosocial needs.

The SPOONS program is a vital component to the comprehensive care provided at the ACE unit. Unlike the typical hospital volunteer, SPOONS volunteers take a proactive role—providing mealtime assistance and socialization for patients. Upon hearing about SPOONS, I became interested in learning about the effectiveness of individual attention on the care of elderly patients in particular.

After rounds, Professor David Buys, who taught the Introduction to Aging course I had taken that previous spring semester, took me on a quick tour of the unit. Professor Buys, who was working on a nutritional study with Dr. Julie Locher, was at the unit to recruit patients. As he explained to me, recruiting patients for clinical studies, especially randomized controlled trials, can be difficult. Although the research does not put them at any risk or involve significant active effort on their part, finding persons willing to participate is still tough. Moreover, retention of patients who do consent to participate can be a problem as well. From this instance, I gained an understanding of the major challenges that clinical

researchers, in contrast with basic science researchers, encounter; clinical studies cannot just pay for lab rats or chemicals to run experiments on. Clinical studies apply scientific knowledge to observe real people in the medical environment.

After the visit to the ACE unit, I knew that I wanted to pursue a study that examined some aspect of such a special hospital unit. Hence, under the guidance of Dr. Julie Locher, Dr. Kellie Flood, and Dr. Buys, I began a primary literature review of the nutritional decline of older adults and of hospitalized older adults. Undernutrition has been defined in multiple ways: unintentional loss of weight, low anthropometric measurements (i.e. height, weight, body mass index, percentage of body fat), abnormal biochemical markers (i.e. micronutrient status), and poor nutritional intake. Individuals over the age of 65 have an increased risk of undernutrition due to age-related changes and acute or chronic diseases. Studies have even suggested that hospitalization may increase this risk of undernutrition for older adults (Elmståhl et al. 1997; Sullivan et al. 1997; Hall et al. 2000; Schenker 2003). Due to age-related physical or cognitive impairments, patients may not be able to eat meals without support. They may experience difficulty reaching their food or even feeding themselves. As Dr. Flood, medical director of the ACE unit, explained to me, patients afflicted with arthritis, which is inflammation of the joints, require assistance to remove the plastic lids and wrapping covering food. Without any help, the patient has no choice but to let the food sit on the tray, unopened. Moreover, a meal is typically a social activity, and older patients may have a reduced desire to eat their meals if they feel isolated in a hospital setting.



the nursing staff as needing assistance. During that time, a volunteer may assist a patient by setting up the meal tray, feeding the patient with a spoon, and wiping his or her mouths. A volunteer also communicates with the patient during meal assistance—smiling, listening, and speaking clearly to encourage the patient to finish the meal. The service provided by SPOONS volunteers supports the nurses and patient care technicians (PCTs), who may not have one to three hours to spend with each patient for mealtime assistance and socialization.

I currently seek to evaluate the effects of the SPOONS program on the dietary intake of older adults admitted to the ACE Unit. The Minimal Eating Observation Form- Version II (MEOF II) developed by Westergren et al (2009) will be used in this study to observe

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Increased risk of undernutrition from hospitalization is a significant concern because undernutrition is associated with poorer health, decreased ability to recover from medical conditions and increased risk of mortality. These associated consequences may lead to prolonged hospitalization or greater risk of re-admission. Therefore, hospitalized older adults should receive some form of nutritional intervention to address their increased risk of undernutrition. In doing so, hospitals can enhance the quality of care they provide in a more efficient manner.

The SPOONS program, for instance, is one intervention that seeks to improve the dietary intake of hospitalized older adults. At the ACE unit, volunteers, who have received specific SPOONS training, typically spend at least one hour with an older adult identified by

patients when assisted by SPOONS volunteers and when no assistance was provided. MEOF II consists of three main dimensions of assessment—"Ingestion," "Deglutition," and "Energy and Appetite." Data collected using MEOF II will allow for statistical comparison of the dietary intake between patients assisted by SPOONS volunteers and those who were not. Through this assessment, I hope to determine how the SPOONS intervention can be improved and modified for use at other hospitals and on other units within the UAB system.

Working on this project has taught me much of the intricacies involved in a clinical study. Before conducting the study, it is necessary to do a thorough review of the current literature, to map out the study's controls and variables, to consider any ethical issues that may

be involved, and to develop a practical method for assessment. Now that I've completed these stages of the project, I look forward to carrying out the project and analyzing results that may help address how hospitals can deal with the costly issue of undernutrition.

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