

the incidence of pneumonia may have been relatively lower in such a large heterogeneous study sample.

Regarding the risk factors associated with the development of pneumonia, some of them were reported to be age, primary disease, consciousness disorders, nutritional status, poor ADL, poor oral status, and swallowing dysfunction (40, 41). In the present study, among the analysed predictors, the 'aspiration of saliva' detected by VE was the only significant risk factor for pneumonia. In cases of bad oral health, saliva contains numerous bacteria. Therefore, patients with silent aspiration of saliva (without a cough reflex) are aspirating bacteria, which may be the main factor responsible for increasing the risk of pneumonia.

Additionally, even with the elaborative feeding therapy provided in this study, the control of aspiration of saliva or silent aspiration of saliva was generally difficult. In the present study, there was also a tendency for there to be a higher incidence of pneumonia in poor ADL patients. Langmore *et al.* (42) also reported that severely dependent functional status was an especially potent predictor of aspiration pneumonia. Riquelme *et al.* (40) reported that there was a significant relationship between the ADL and mortality rate. It was also observed that patients with a BMI < 18.5 had a higher tendency to develop pneumonia ($P = 0.070$) compared with those with a poor ADL ($P = 0.769$). It is well known that a lower nutrition condition affects the host immunological function, thus making the subjects more susceptible to pneumonia (43).

On the other hand, aspiration of saliva was also detected as a significant risk factor for body weight loss in this study. This finding could be explained by the possible presence of subclinical aspiration-related pneumonia in those subjects with a body weight loss of 3% or more.

The overall findings in this study demonstrated that it is still very difficult to prevent aspiration of saliva even if physicians provide elaborative feeding therapy and even if patients do not eat and drink anything through the mouth. Effective strategies to prevent the silent aspiration of saliva will therefore be an important target for future research.

Conclusion

The results of this study showed that, even with elaborative feeding therapy, 'aspiration of saliva' as

detected by videoendoscopic examination was found to be a significant risk factor for pneumonia and a body weight loss of 3% or more in elderly patients living in nursing homes.

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Correlation between dental and nutritional status in community-dwelling elderly Japanese

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Aim: The purpose of this study was to clarify the correlation between dental and nutritional status among community-dwelling elderly Japanese people.

Methods: The subjects were 182 elderly individuals, aged 65–85 years, who voluntarily participated in a health seminar at Kyoto Prefectural University of Medicine. These subjects were divided into two groups according to the occlusion. The subjects in the retained contact group were those who had retained molar occlusion with natural teeth. The lost contact group were those who retained molar occlusion with removable partial dentures. Anthropometric variables such as body mass index (BMI) were collected and dietary intake was assessed using a brief self-administered diet history questionnaire (BDHQ).

Results: No statistical difference in BMI or intake of macronutrients was found between these two occlusal groups. The lost contact group reported significantly lower consumption of vegetables and higher consumption of confectionaries (foods rich in sugar) than did the retained contact group ($P < 0.05$), and therefore had significantly lower intake of vitamin C and dietary fiber ($P < 0.05$).

Conclusion: It can be concluded that natural tooth contact loss in the posterior region affect the intake of vitamins and dietary fiber. *Geriatr Gerontol Int* 2011; 11: 315–319.

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Introduction

The intake of nutrients as a result of food consumption is fundamental to maintaining life.¹ Many reports have shown that low food volume and an unbalanced diet are related to tooth loss, poor occlusion and other oral pathological conditions.^{2–5} In particular, individuals with fewer teeth tend to avoid raw fruits and vegetables, thus reducing their intake of vitamins and dietary fiber.^{6,7} Adequate intake of these nutritional elements is thought to prevent cardiovascular disease, cancer and other systemic conditions.^{8,9}

Many previous studies on this topic have been conducted in Western countries and concluded that tooth loss affects elements of nutritional intake such as dietary fiber and vitamins. However, only a few studies have been conducted previously in Japan¹⁰⁻¹² and may not reach a consensus. Yoshihira *et al.*¹⁰ found no significant difference between the number of teeth present and the intake of vitamin C or dietary fiber among 57 healthy 74-year-old elderly Japanese people. However, the subjects in their study were divided into two groups only with teeth numbers as more than 20 teeth or less. We hypothesize that natural tooth contacts in the molar region are more important to the consumption of foods requiring more mastication and, as a result, this study was conducted to clarify the correlation between natural tooth contact loss and nutritional intake of vitamins and dietary fibers among community-dwelling elderly Japanese people.

Methods

The subjects were 182 healthy elderly Japanese (60 men, 122 women) aged 65–85 years living in Kyoto and participating in a health seminar sponsored by Kyoto Prefectural University of Medicine. According to brief medical interview, anyone who had a history of cardiovascular disease was excluded from the study because they had some risk completing physical assessment (original purpose in this seminar). This study was approved by the Ethics Committee at Kyoto Prefectural University of Medicine. All subjects gave verbal informed consent.

Based on oral examination, the subjects were divided into two groups according to the Eichner Classification.¹³ This classification was based on existing natural tooth contacts between maxilla and mandible in the bilateral premolar and molar regions (presence of tooth contact defined as presence of a natural tooth on the maxilla and corresponding mandible, including wisdom teeth, but excluding remaining roots or root caps). Class A represents contact in all four support zones. Class B represents contact in three to one zone (B1–B3) or in the frontal region only (B4). Class C represents absence of tooth contact. The retained contact group consisted of those classified as Eichner A or B1–B3, who had retained molar occlusion in at least one molar region with natural teeth. The lost contact group consisted of individuals classed as Eichner B4 or C who had no occlusal contact with natural dentition in the molar region. All subjects in the lost contact group used removable partial dentures.

Anthropometric measurements were as follows. Body mass index (BMI, kg/m²) is defined as the weight in kilograms divided by height in meters squared. Mid-upper arm circumference (AC, cm) was measured on the left arm with a tape measure. Triceps skinfold (TSF,

cm) was measured with Harpenden calipers over the triceps muscle at the midway point between the acromion and the olecranon process. Three repeat measurements were taken to the nearest 0.5 mm, with the mean taken as the true value.

Food intake was assessed with a brief self-administered diet history questionnaire (BDHQ) along with interviews by a dietitian. The BDHQ had been developed by item-reduction from a validated self-administered diet history questionnaire (DHQ) used earlier.¹⁴ The BDHQ is a 4-page structured questionnaire with 75 questions (55 relating to food consumption and 17 to cooking and dietary behaviors). The questionnaire assessed dietary habits during the preceding month. From this information, energy, nutrient and food intakes were calculated using an ad hoc computer algorithm for BDHQ. The validity of this questionnaire was established elsewhere that average Pearson correlation coefficients for 37 nutrients between nutrient intakes assessed with BDHQ and 16-day dietary record in adults was 0.48 in 92 men and 0.49 in 92 women.¹⁵

Using information from the questionnaires, nutrient intake and the intake of protein, fat and carbohydrate were calculated and evaluated in terms of the macronutrient intakes of the two groups (Table 3) based on the Standard Tables of Food Composition in Japan (5th ed.).¹⁶ The intake of vitamins and dietary fiber were per 1000 kcal were also calculated. Multivariate ANOVA was used to compare the two occlusal groups with sex and age as covariates. Age was categorized into four groups: 65–70, 71–75, 76–80 and 81–85 years. SPSS ver. 15 was used for these analyses and all statistical significance levels set at $P < 0.05$.

Results

The retained contact group included 138 subjects (41 men, 97 women, average age 74.4 ± 3.6 years) and the lost contact group included 44 subjects (19 men, 25 women, average age 77.0 ± 5.3 years). The distributions in terms of sex did not differ, but the members of the lost contact group were significantly older than the retained contact group ($P = 0.004$). The comparisons of body composition between the two groups are shown in Table 1. Measures of AC and TSF were significantly lower in the lost contact group.

According to the data calculated from the BDHQ questionnaires, the lost contact group consumed significantly fewer vegetables and more confectionaries than the retained contact group (Table 2). Energy intake was not significantly different between the retained contact group and the lost contact group (1934 ± 59 vs 2057 ± 76 kcal/day, respectively, $P = 0.132$). There was no statistical difference between the two occlusal groups in macronutrients. Protein and carbohydrate were in the range of the Standard Tables of Food Composition in

Table 1 Comparison of anthropometric variables (adjusted mean \pm standard error) for the two occlusal groups

	Retained contact group ($n = 138$)	Lost contact group ($n = 44$)	<i>P</i> -value
Body mass index (BMI, kg/m ²)	22.8 \pm 2.8	21.9 \pm 2.4	0.075
Upper arm circumference (AC, cm)	25.8 \pm 2.3	24.7 \pm 2.1	0.004*
Triceps skin fold (TSF, mm)	16.1 \pm 5.7	12.7 \pm 5.1	0.000*

P-value by multivariate ANOVA for comparison between groups adjusted for sex and age (* $P < 0.05$).

Table 2 Selected food group intakes (g/1000 kcal, adjusted mean \pm standard error) for the two occlusal groups

Food group	Retained contact group	Lost contact group	<i>P</i> -value
Meat	34.1 \pm 2.9	30.4 \pm 3.7	0.507
Fish	64.5 \pm 4.6	64.1 \pm 5.9	0.632
Egg	19.6 \pm 1.8	19.7 \pm 2.3	0.821
Soy products	43.6 \pm 3.0	35.4 \pm 3.8	0.162
Vegetables	179.4 \pm 9.9	144.4 \pm 12.8	0.048*
Fruits	68.5 \pm 6.0	52.6 \pm 7.8	0.096
Cereals	136.5 \pm 8.8	147.9 \pm 11.3	0.561
Confectioneries	22.8 \pm 2.7	35.8 \pm 3.4	0.005*

P-value by multivariate ANOVA for comparison between groups adjusted for sex and age (* $P < 0.05$).

Table 3 Macronutrient intakes (adjusted mean \pm standard error) for the two occlusal groups

Variable	Retained contact group	Lost contact group	<i>P</i> -value	Standard Tables of Food Composition in Japan (5th ed.)
Protein (% of energy)	17.4 \pm 0.5	17.0 \pm 0.6	0.317	<25
Fat (% of energy)	25.8 \pm 0.6	25.9 \pm 0.8	0.971	15–25
Carbohydrate (% of energy)	53.5 \pm 0.9	54.4 \pm 1.2	0.461	50–70
Dietary fiber (g/1000 kcal)	8.49 \pm 0.28	7.36 \pm 0.37	0.036*	10

P-value by multivariate ANOVA for comparison between groups adjusted for sex and age (* $P < 0.05$).

Japan, whereas fat was slightly over the standard range in both groups. Dietary fiber consumed by the lost contact group was significantly lower than for the retained contact group and, furthermore, intake of dietary fiber for both groups was lower than the recommended amount (Table 3). The lost contact group also consumed significantly less vitamins including carotene, vitamin K, vitamin B₁, vitamin B₆ and vitamin C (Table 4).

Discussion

The results from this study suggest that occlusal status based on natural tooth loss is associated with nutritional intake in dietary fiber and vitamins from food in Japan.

Chewing efficiency, for example, the rate of breakdown of food during mastication, is clearly correlated with features of the dentition such as number of posterior teeth and occlusal relationships.¹⁷ As chewing

efficiency declines, individuals report increasing difficulty chewing and may avoid difficult-to-chew foods and prefer soft and easy-to-chew foods.¹⁸ The most pronounced difference in intake involves hard-to-chew foods such as vegetables and some fruits and a higher consumption of confectionaries, which are likely to be most affected by tooth loss.¹⁹ The findings of this study are almost the same results as those of previous studies, and therefore may support a reasonable consensus that tooth loss affects elements of nutritional intake such as dietary fiber and vitamins in Japan.

Because all subjects in the lost contact group in our study had removable dentures, it was impossible to compare the difference in nutritional intake with and without dentures. Many previous studies have reported no significant difference in nutrient intake between patients retaining their own teeth and those with dentures, however.^{20,21} Wöstmann *et al.*²² reported that despite the highly significant improvement in masticatory ability after the optimization of dentures,

Table 4 Vitamin intakes (adjusted mean \pm standard error) for the two occlusal groups

Variable	Retained contact group	Lost contact group	P-value
Retinol ($\mu\text{g}/1000$ kcal)	412.0 \pm 85.6	496.9 \pm 110.3	0.455
Carotene ($\mu\text{g}/1000$ kcal)	2475 \pm 150	1790 \pm 193	0.014*
Vitamin D ($\mu\text{g}/1000$ kcal)	11.8 \pm 0.9	12.1 \pm 1.2	0.882
Vitamin E (mg/1000 kcal)	4.42 \pm 0.13	4.09 \pm 0.17	0.193
Vitamin K (mg/1000 kcal)	242.0 \pm 12.1	200.8 \pm 15.6	0.039*
Vitamin B ₁ (mg/1000 kcal)	0.48 \pm 0.01	0.43 \pm 0.02	0.029*
Vitamin B ₂ (mg/1000 kcal)	0.87 \pm 0.03	0.83 \pm 0.04	0.141
Niacin (mg/1000 kcal)	10.9 \pm 0.4	10.3 \pm 0.5	0.182
Vitamin B ₆ (mg/1000 kcal)	0.83 \pm 0.02	0.74 \pm 0.03	0.009*
Vitamin B ₁₂ ($\mu\text{g}/1000$ kcal)	7.44 \pm 0.51	7.59 \pm 0.66	0.750
Folate ($\mu\text{g}/1000$ kcal)	239.1 \pm 9.8	212.0 \pm 12.6	0.104
Pantothenic acid (mg/1000 kcal)	4.12 \pm 0.11	3.93 \pm 0.14	0.146
Vitamin C (mg/1000 kcal)	75.7 \pm 3.3	60.2 \pm 4.3	0.013*

P-value obtained by multivariate ANOVA for comparison between groups adjusted for sex and age (* $P < 0.05$).

no general improvement in nutritional status was observed. Our finding supports these previous studies that the lost contact group was associated with the lower amount of hard-to-chew foods such as vegetables that individuals consume even though they used their dentures during food intake. These results may indicate that denture use is not enough to compensate for natural teeth. Recently, Bradbury *et al.*²³ demonstrated that food instruction encourages an increase in the consumption of vitamins and minerals among new denture wearers. These results should suggest to all dentists that proper nutritional counseling is needed for the edentulous elderly in routine dental practice to prevent not only inadequate nutrition but also systemic diseases such as cerebrovascular disease.⁸

Muscle function is essential for masticatory efficiency. As individuals age, there is a significant decrease in the cross-sectional area and density of the masticatory muscles.²⁴ These observations are consistent with general age-related changes in skeletal muscle tissue throughout the body. Anthropometric measurements are indicators of muscle mass and subcutaneous fat.²⁵ Therefore, the significant decrease in AC and TSF observed among members of the lost contact group may also be associated with a reduction in masticatory function, resulting in increased difficulty chewing hard food. We did not evaluate such masticatory function elements as occlusal force and chewing efficiency in this study, however. Kikutani *et al.*²⁶ reported that oral function training can improve nutritional status in institutionalized elderly people. Further study will be needed to compare not only tooth contact but also masticatory function to evaluate the effects of nutritional status.

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はじめに

筆者らは平成 21 年度からスタートした厚生労働科学研究費補助金長寿科学総合研究事業「高齢者の経口摂取の維持ならびに栄養ケア・マネジメントの活用に関する研究（代表研究者：葛谷雅文）」の分担研究担当者として、シームレスな栄養ケアに関する地域栄養ケア連携モデルを構築す

Part 4—高齢者栄養ケアの実際

地域栄養ケア 連携モデル

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KEY WORD

地域栄養ケア連携, 栄養ケア 摂食・嚥下障害

ることを目標に掲げた 3 年継続研究をすすめている。平成 21 年度である 1 年目は、病院退院時の在宅への栄養ケアの連携（継続性）の現状を把握するため、全国の Nutrition Support Team (NST: 栄養サポートチーム) 稼働施設に対し、栄養ケア連携にかかわるアンケート調査を実施した。つづいて、平成 22 年度は、地域栄養ケア連携モデルの構築準備段階として、愛知県蒲郡市をモデル地区とした地域栄養ケア連携モデル事業の準備、システムづくりを行い、最終年度である平成 23 年度の本格的な運用へとつないでいる。

本稿では、はじめに平成 21 年度に実施したアンケート調査結果から、全国の地域連携の実態を示す。つぎに、筆者らが取り組んできた蒲郡地区の地域栄養ケア連携モデルの構築状況を報告する。

病院退院時の栄養ケアの連携（継続性）の実態調査研究結果について¹⁾

本研究は、病院退院時の在宅への栄養ケアの連携（継続性）の現状を把握することを目的とし、日本静脈経腸栄養学会において認定された NST 稼働施設 1,274 施設のうち、本研究に対し同意が得られた 405 施設の NST 責任者（医師）を対象としたアンケート調査を実施した（アンケート回収率：31.9%）。調査時期は平成 21 年 10 月で、対象施設の病床数は、 377.9 ± 243.3 床（平均 ± 標準偏差）、病院の分類の別は、一般病院が 75.1%、複合病院が 22.2%、その他 2.7%であった。

調査の結果、NST がかわった患者の退院先を把握している施設は、全体のわずか 14.6%であり、全例ではないが把握できている施設は、全体の 58.2%であった。また、今回の解析対象となった施設のおもな退院先（複数回答項目）は、在宅が 38.5%、介護保険施設が 27.0%、長期療養病床が 26.9%、死亡退院が 18.7%であり、在宅に約 4 割が戻るという結果を示した。しかし、約 4 割の患者が在宅に戻るにもかかわらず、その病院の外で退院した患者を継続的に経過観察していくシステムをもっている施設は、全体の 9.3%に過ぎなかった。

つぎに、栄養ケアの情報提供についての質問では、医師および看護師からの情報提供ではなく、栄養ケアに関する情報提供書を退院先などへ提供している施設は全体の 13.8%であり（図 1）、その提供先は病院から病院への情報提供が 82.3%、病院から介護施設への情報提供が 78.0%であったが、病院から地域の診療所への情報提供は 40.3%にとどまった。さらに、地域一体型 NST（地域栄養ケア連携）の構築に関する質問では、すでに

地域一体型 NST が構築されている施設は、全体のわずか 8.9%であった (図 2)。一方、地域一体型 NST が構築できない理由としては、連携を行えるだけのマンパワーがない、診療の一環としての一連の業務に組み込めないという意見が多数認められた。

これらの調査から地域の診療所と中核病院との地域栄養ケア連携は十分に行われているとはいえず、在宅の患者に対し、多職種による適切な栄養ケアがなされていないことが示された。本研究結果より、地域連携を構築するためのステップは、マンパワーの確保と NST が関与した患者を継続的に経過観察していくためのシステム、患者の退院先などへの栄養ケアに関する情報提供書の提供、NST と在宅部門との患者情報の共有などのシステムを病院独自の方法で構築していくこと

図 1 栄養ケアに関する情報提供書の提供について¹⁾

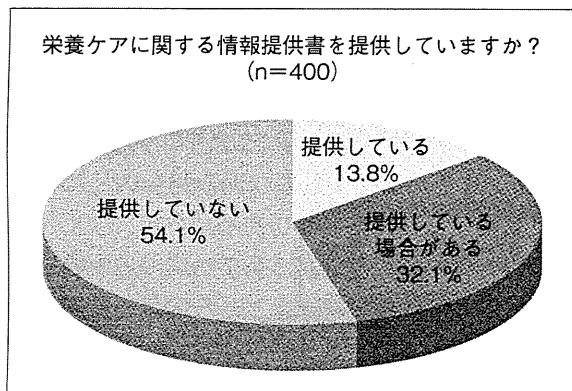
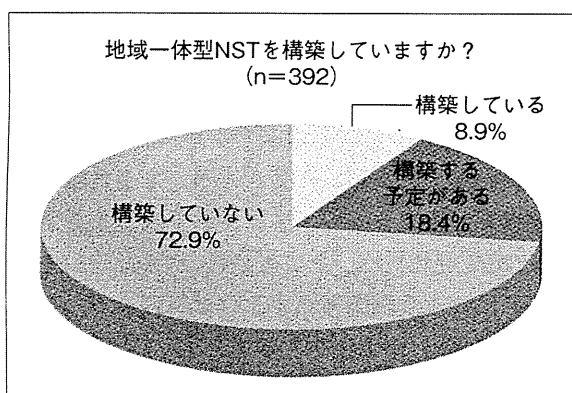


図 2 地域一体型 NST (地域栄養ケア連携) の構築について¹⁾



であることが示された。

蒲郡厚生館病院を中心とした地域栄養ケア連携モデルの構築

●研究班としての取り組み

厚生労働科学研究費補助金長寿科学総合研究事業 3 年継続研究の 2 年目として、地域栄養ケア連携モデル事業の準備およびシステムづくりを行ったので、ここにその流れを説明する。

このモデル事業の中心的役割を担ったのは、愛知県南部に位置する蒲郡市内の医療法人北辰会蒲郡厚生館病院 (院長：下郷宏氏) で、地域の介護施設との摂食・嚥下、栄養ケアの地域連携システムの構築準備をはじめている。

研究班としての取り組みは、医療、介護の専門職および家族への摂食・嚥下障害に関する啓蒙パンフレットをそれぞれに作成したことである。専門職用のパンフレットには、嚥下障害者をサポートするための正しい知識や、それにとまったりスクナーの正しいスクリーニング方法などが示され、専門家への教育教材とした (図 3)。また、家族用のパンフレットには、嚥下 (= 飲み込み) の仕組みとどううまく飲み込むことができない状態を理解すること、摂食・嚥下障害者の問題点を理解することを目標とし、摂食・嚥下障害から引き起こされる誤嚥性肺炎、低栄養、脱水、窒息について理解しやすい説明を加えた内容とした。さらに摂食・嚥下障害の可能性がある場合には、嚥下造影検査を行う必要性を示し、専門病院への受診を促す内容となっている (図 4)。

●蒲郡厚生館病院としての取り組み

蒲郡厚生館病院栄養管理室室長である加藤恵美が中心となり、地域で栄養ケア連携が可能である事業所を洗い出し、以下の取り組みを行った。連携を進めている施設は、老人保健施設みらいあ、老人保健施設五井の里、社会福祉法人不二福祉事業会蒲郡眺海園、社会福祉法人不二福祉事業会五井眺海園、社会福祉法人不二福祉事業会形原眺海園と市内の居宅介護支援事業者および介護 (介護

図3 研究班作成の摂食・嚥下障害に関する専門家向けのパンフレット²⁾



図4 研究班作成の摂食・嚥下障害に関する患者およびその家族向けのパンフレット²⁾



図5 勉強会終了後の集合写真（中央の白衣を着ているのが加藤恵美）



予防) サービス事業者である。

1) 多職種を対象とした勉強会の開催

管理栄養士以外の職種である看護師，介護支援専門員，訪問介護員，介護福祉士，薬剤師などを中心に勉強会を継続的に隔月開催（講師：加藤恵美）している。具体的には，第1回（平成22年7月）「脱水について」，第2回（平成22年9月）「とろみ剤について」，第3回（平成22年11月）「食事介助について」，第4回（平成23年1月）「嚥下スクリーニング法と嚥下造影検査について」，第5回（平成23年3月）「病態別の栄養について」の合計5回の勉強会が実施されており，これまでに延べ223名の参加があった。摂食・嚥下に関する知識の習得と施設間，職種間の信頼関係の構築を目的として実施しており，この目的は十分に達成できたと思われる（図5）。

2) 管理栄養士同士の連携および食形態の統一

連携する施設の管理栄養士が「顔の見える関係」でいられるよう協議会を企画した。まずはじめの取り組みとして，それぞれの施設で提供されている食事の食形態（一口きざみ食，きざみ食等）を施設間で統一するために，各施設の管理栄養士が蒲郡厚生館病院に，施設で実際に提供している副食をすべてもち寄り，蒲郡厚生館病院の言語聴覚士に個々の食形態の評価を依頼し，形態の統一化を試みた。さらに，施設で使用している市販のとろみ剤についても，言語聴覚士の指導により，製品別に使用料のすり合わせを行った（図6）。

図6 管理栄養士，言語聴覚士が共同でとろみ剤の分量を調整している様子



3) 外来嚥下造影（VF）検査（日帰り）の整備

地域の介護施設の入所者および病院を受診した外来患者に対し，複数回の外来受診を行わず，1日で嚥下造影検査を行い，その日のうちに評価および指導までの一連の医療を受けられるシステムを整備した（図7）。病院側のリハビリ担当の医師，言語聴覚士，管理栄養士，看護師，事務職員らと患者側である入所している施設長，担当介護支援専門員，管理栄養士，事務職員らとの連携により，検査予約からカンファレンスまで円滑に実施されるシステムである。さらに，検査がどのような手順ですすめられるのかについて，検査当日の食事の指示や持ち物，検査の手順，指導までの流れを，患者が理解しやすいフローチャート式に説明を加えた病院オリジナルのパフレットを研究班とともに作成した（図8）。現在は，施設入

図7 施設入所者が嚥下造影（VF）検査を希望した場合の、予約から結果報告までの流れ（蒲郡厚生館病院）

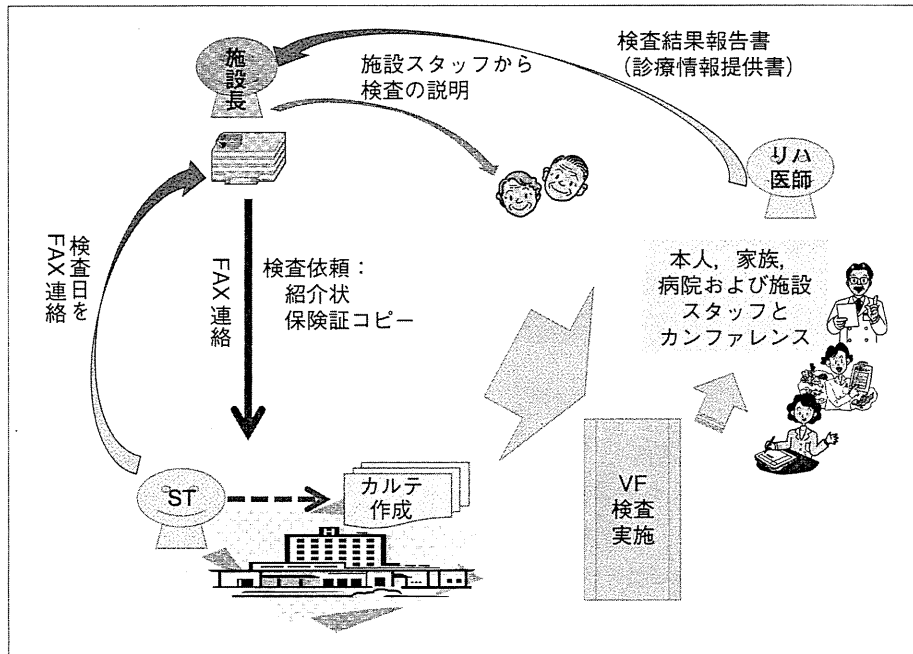


図8 蒲郡厚生館病院作成の患者向けの嚥下造影検査に関するパンフレット²⁾



所している患者の4症例が、このシステムを用いて検査を実施しており、すでに運用を開始している。

まとめ

地域栄養ケア連携を構築していくためには、さ

まざまな方法があるが、地域の特性により、都市型の地域連携と都市部以外の地方型の地域連携の2つに分けられる。前者は、その地域に市中病院を数多くもついわゆる大都市地区で、横浜市立大学附属市民総合医療センターの若林秀隆氏が中心に進めている横浜南部地域一体型NSTがそれに

あたり³⁾、まずは急性期の病院の連携を構築することを第一義としている。一方、後者においては、中核となる病院は1～2病院で、中心となる病院とその後方支援をする介護保険施設等が一度に連携を図ることが可能であり、蒲郡地区は後者に当たる。今回、横浜南部地域一体型NSTが推奨する顔がみえるネットワークづくりに習い、蒲郡地区においても勉強会を重ね、他施設の多職種同志のかかわりが少しずつできあがってきており、お互いに施設の栄養ケアおよびその他の情報交換を行っている様子が見えてきた。

今回の取り組みにより、小規模な単位であれば、その地域内の施設の食形態を統一することが不可能ではないことが示されたといえる。また、食形態の統一には、管理栄養士のみの力量ではむずかしく、言語聴覚士の協力が必須であることが認識できた。評価、指導に関しては、医師、看護師、介護支援専門員などの多職種の協力も当然必要となってくる。モデル事業の中心となった蒲郡

厚生館病院は、医療療養病床49床、回復期リハビリ病床49床をもつ混合型の病院であるが、摂食・嚥下にかかわる職種である管理栄養士を3名、言語聴覚士は4.9名配置し、隣接する老人保健施設にも管理栄養士1名と非常勤の言語聴覚士を1名配置している。同規模の病院と比較すると、この2職種の配置率は高く、これらの職種の配置率を高めることが、地域栄養ケア連携の推進の鍵になると考えられる。

今後は、このモデル事業の運用をすすめ、運用するうえでの問題点の抽出、修正を繰り返し、全国の幅広い地域でこれらの取り組みが可能となるシステム作りを目指していく。

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