



THE HOMEPLATE PROJECT

Eating well for community dwelling older people. A literature review.

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Introduction

This literature review provides a summary of the Australian scientific literature relating to the food experiences, well-being, and independence of older people living at home across Australia.

It was compiled with the support of the Curran Foundation to assist the Maggie Beer Foundation's HomePlate Project.

In developing the framework for the literature review plan and search strategy, we consulted with dietitians working in community health, and with a number of older people living at home seen as part of geriatric medical clinics, falls clinics and memory clinics.

Kathryn Leonards, Northern Sydney Local Health District Libraries was also consulted and she designed and carried out the search strategy. Medline, Embase, Emcare and Google Scholar were searched for the years 1990 to 2026 except for Emcare which was searched from 1995 to 2026. The search was limited to articles referring to the Australian health and aged care environment. After removal of duplicates, and assessment for suitability, 99 articles were included in the review. A number of these contained duplicated information and for the final review 35 articles were reviewed.

This literature review provides an overview of the issues related to eating well for older people and covers:

- The prevalence of malnutrition
- Barriers and enablers to good nutrition
- Health literacy and food literacy in older adults
- Food access, isolation and family support
- Food insecurity
- Community-dwelling older adults with dementia and cognitive impairment
- Nutrition in community-dwelling older adults from diverse cultural backgrounds
- The role of family and carers in supporting nutritional needs in older people.

A. Prevalence of malnutrition

Protein-energy malnutrition is unfortunately quite common in older people who now comprise more than 17% of the Australian population (1). It is the result of inadequate intake of sufficient protein and calories to meet the needs of the body and it results in weight loss and reduction in fat stores and muscle wasting (2). Malnutrition contributes to increased likelihood of adverse health outcomes including frailty, sarcopenia, osteoporosis and increased chance of death (3) and reduced quality of life (4).

Estimates of malnutrition in older people vary depending on the group being studied. The Registry of Senior Australians looked at 90,650 participants aged 65 years and over living at home in 2016 who were receiving care in their homes through Commonwealth Government funded Home Care Packages. Of these 4.9% were malnourished (5) when assessed using home care quality and safety indicators. A similar figure of 5% is quoted for protein-energy malnutrition in community-dwelling older people (6). Estimates for malnutrition are much higher for older patients in hospital (30 to 40%), or residents in aged care homes (45 to 50%) (6) and the risk increases with advancing age. Protein energy malnutrition is potentially reversible with improved nutrition.

Key causes and risk factors in community-dwelling older adults

Protein-energy malnutrition (PEM) in older people living at home is multifactorial, with interacting physiological, medical, and social contributors (2, 3, 6).

1. Age-related physiological factors

Reduced appetite (“anorexia of ageing”), early satiety, and altered taste or food preferences reduce overall intake.

2. Disease and treatment related factors

- Chronic diseases which are common in ageing (e.g. cardiovascular disease, gastrointestinal disease, respiratory disease, depression) impair appetite, intake, or absorption.
- Chewing and swallowing difficulties, tremor, reduced dexterity, fatigue, and medication side-effects can limit food preparation and eating.

3. Psychosocial and structural factors

- Social isolation, loneliness, and bereavement, particularly after loss of a spouse, reduce motivation to shop for, prepare, and consume meals.
- Loss of informal support for shopping and cooking increases vulnerability, especially for older men with limited prior food preparation experience.
- Financial constraints and limited nutritional knowledge, including lack of awareness of increased protein requirements with ageing, act as additional barriers.

4. Health consequences

- PEM adversely affects immune function, muscle strength, and organ function, even at the community level.
- It is associated with higher mortality, reduced quality of life, and increased risk of hospital admission and readmission, reinforcing a cycle between malnutrition and ill-health (6).

B. Barriers and enablers to good nutrition

1. Physiological and health-related factors

BARRIERS

- Ageing is associated with a range of physiological changes that directly impair dietary intake. These include reduced appetite, diminished taste and smell, delayed gastric emptying, and reduced ability to consume large meals, all contributing to lower overall food intake (7).
- Oral health problems—including tooth loss, poor dentition, and chewing difficulties—limit the ability to consume nutrient-dense foods such as meat, fruits, and vegetables (8).
- Chronic conditions (e.g., diabetes, gastrointestinal disorders), dysphagia, and multimorbidity further constrain dietary flexibility and intake (7, 10).
- Mental health conditions, particularly depression, are strongly associated with reduced appetite, poorer dietary intake, and increased nutritional risk (9).

ENABLERS

- Health awareness and disease management can act as positive drivers of dietary behaviour. Older adults often report improving their diet when motivated by health conditions such as diabetes or cardiovascular risk (7).
- Early identification of nutritional risk and access to dietetic care support improved nutritional outcomes and reduced risk of malnutrition (10).

2. Functional and sensory factors

BARRIERS

- Functional limitations—such as difficulty chewing, swallowing, shopping, or preparing meals—significantly impact the ability to maintain adequate nutrition (11).

- Sensory impairments (hearing and vision loss) are linked with food insecurity and reduced ability to access food or engage in food-related activities (16, 12).
- Declines in functional ability and mobility also restrict access to food environments and community services (12).

ENABLERS

- Access to assistive services (e.g., community support, meal delivery services) and supportive infrastructure enables continued independent living and food access (12).
- Maintaining oral health (e.g., retaining functional dentition) supports dietary variety and intake (8).

3. Psychosocial and emotional factors

BARRIERS

- Living alone, social isolation, bereavement, and loneliness are consistently associated with poorer dietary intake, reduced meal enjoyment, and lower food variety (19, 23).
- Depression and caregiving burden further exacerbate poor appetite and irregular eating patterns (9).
- Long-standing exposure to conflicting nutrition messages can create confusion and uncertainty about appropriate dietary choices (7).

ENABLERS

- Social interaction and communal eating (e.g., group cooking programs) enhance motivation to prepare meals and improve dietary intake (13).
- Strong social support networks and peer engagement promote healthier eating behaviours and reduce isolation (14).

4. Socioeconomic and food security factors

BARRIERS

- Food insecurity—defined briefly as limited access to sufficient, safe, and nutritious food—is strongly associated with financial constraints, stressors, and cumulative disadvantage (15).
- Stressful life events (e.g., illness, unemployment, bereavement) significantly increase the likelihood of food insecurity (15).
- Food insecurity is also linked to comorbidities, depression, and sensory impairments, reinforcing a cycle of vulnerability (16).
- Low income, low education, and unemployment limit access to affordable nutritious foods and resources (17).

ENABLERS

- Food literacy—including planning, budgeting, shopping, and cooking skills—supports improved diet quality and resilience to financial constraints (17).
- Community programs and tailored interventions can reduce food insecurity when combined with broader social and economic supports (17).

5. Food-related behaviours and knowledge

BARRIERS

- Low food literacy, food avoidance, meal skipping, and limited dietary variety are key contributors to nutritional risk (11).
- Limited cooking skills, lack of motivation, and perception of meal preparation as burdensome reduce dietary adequacy (11).
- Confusion regarding dietary recommendations and concerns about nutritional adequacy (e.g., plant-based diets) also hinder healthy eating (18).

ENABLERS

- Culinary nutrition education programs improve dietary behaviours, health literacy, and confidence in food preparation (19).

- Hands-on cooking interventions and skill development (e.g., meal planning, recipe adaptation) promote autonomy and healthier food choices (19).
- Programs tailored to older adults (e.g., simple recipes, practical skills) enhance engagement and sustainability of behaviour change (13).

6. Environmental and access factors

BARRIERS

- Limited access to food outlets, inadequate public transport, and poor neighbourhood infrastructure restrict food access and healthy eating behaviours (14).
- Absence of nearby services and limited availability of culturally appropriate foods can further constrain dietary choices (14).

ENABLERS

- Accessible neighbourhoods with proximity to shops, services, and community facilities support healthy eating and social engagement (14).
- High food safety standards, availability of healthy foods, and supportive policy environments facilitate healthier dietary patterns (14).

7. Cultural and attitudinal influences

BARRIERS

- Preferences for certain foods (e.g., animal-based diets), cultural norms, and taste preferences can limit adoption of healthier or sustainable dietary patterns (18).
- Perceived cost, inconvenience, and unfamiliarity with recommended foods act as barriers to dietary change (18).

ENABLERS

- Nutrition knowledge, awareness of health benefits, and understanding of environmental impacts of diet motivate healthier food choices (18).
- Cultural relevance and tailoring of interventions increase acceptability and uptake of dietary recommendations (18).

C. Health literacy and food literacy in older adults

1. Deficits in nutrition knowledge and practical skills

Health literacy—particularly nutrition and food literacy—is a consistent determinant of dietary behaviour in community-dwelling older adults. Evidence indicates that limited nutrition knowledge and cooking skills significantly constrain healthy eating practices, especially among those living alone (20).

- Older men living alone demonstrated low nutrition knowledge and limited cooking skills, both of which negatively influenced diet quality and meal enjoyment (20).
- Food literacy encompasses planning, purchasing, preparation and consumption skills, and deficits in these domains are associated with food insecurity and poorer diet quality (17).

Importantly, food literacy operates within broader structural constraints. While improving knowledge can enhance meal planning and budgeting, education alone cannot overcome economic barriers to healthy eating (17).

1.1 Confusing and inconsistent health messaging

Older adults often report confusion arising from conflicting dietary guidance over the life course, reducing confidence in food decision-making. This reflects a broader health literacy challenge, where the ability to interpret and apply changing recommendations is limited (7).

1.2 Health literacy in carers

Issues related to health literacy extend beyond individuals to include family and informal carers, who are central to nutrition support:

- Carers frequently report insufficient nutrition knowledge, lack of training, and inadequate guidance from health professionals (21).

In Australian studies, carers demonstrated only basic nutrition knowledge and expressed a need for clearer, tailored education (22). This gap has implications for populations with higher dependency, such as those with dementia, where carers' literacy directly influences dietary adequacy and malnutrition risk.

2. Community education initiatives and nutrition promotion

2.1 Effectiveness of community-based education

Community-based nutrition education programs, including group education and culinary interventions, are widely utilised to improve health literacy and dietary behaviours.

- Group education interventions have demonstrated improvements in dietary patterns and nutrition knowledge, particularly when using simple, practical messaging (6).
- Culinary nutrition programs that combine education with hands-on cooking improve knowledge, confidence, and dietary habits, while supporting behaviour change (19).

Such programs also address social determinants by incorporating peer interaction and shared meals, which enhance engagement and reinforce learning.

2.2 Cooking skills programs and food literacy development

Programs such as “Cooking for One or Two” illustrate the role of participatory, peer-based education:

- These programs improve cooking confidence, nutrition knowledge, and self-management skills, while reducing malnutrition risk (13).

- Participant feedback emphasises the importance of simplicity, affordability, and relevance, including minimal preparation time and familiar ingredients (13).

Notably, participatory approaches (e.g., co-design) enhance uptake by aligning interventions with older adults lived experiences and preferences.

2.3 Role of social and community context

Community education initiatives are most effective when embedded within supportive environments:

- Social connectedness and shared meals are key drivers of healthy eating behaviours (4).
- Community settings facilitate both knowledge exchange and behavioural reinforcement, addressing isolation and low motivation, particularly among those living alone (19).

This highlights the dual role of community programs in improving both health literacy and psychosocial wellbeing.

3. Effect of gender on nutrition

3.1 Gender differences in nutrition knowledge and skills

Gender bias emerges through lifelong social roles and domestic divisions of labour:

- Older women generally possess higher nutrition knowledge and cooking skills, reflecting traditional caregiving roles (20).
- Older men—particularly widowers—often lack basic food preparation skills, placing them at greater nutritional risk (20).

This disparity is reinforced by cohort effects, where many older men had limited involvement in food preparation throughout adulthood.

3.2 Increased nutritional risk in older men

Men living alone are consistently identified as a high-risk group for poor nutrition:

- They exhibit poorer dietary behaviours and lower dietary quality than women (20).
- Limited cooking skills and reliance on convenience foods contribute to diminished dietary variety and meal quality (20).
- Similarly, broader reviews show that individuals living alone—especially men—consume less diverse diets and fewer core food groups (23).

3.3 Gender related food practices across the lifecourse

Gender bias is embedded in food practices across generations:

- Historical family structures positioned women as primary food preparers, while men had limited engagement in food-related tasks (24).
- These patterns persist into older age, influencing both skill acquisition and attitudes toward food and health.

3.4 Implications for design of nutrition interventions

Gender bias necessitates tailored approaches:

- Cooking and nutrition programs targeting older men have demonstrated improved confidence, engagement, and dietary practices (6).
- Interventions must account for gendered preferences, values, and barriers, including convenience, motivation, and perceived relevance of healthy eating.

D. Food access, isolation, and family support

1. Structural and economic barriers to food access

Access to food among older adults is shaped by a combination of economic, physical, and environmental constraints, rather than food availability alone.

FINANCIAL CONSTRAINTS

- Limited income is a primary driver of reduced food access, with lower socioeconomic position strongly associated with inability to afford sufficient or nutritious food (25).
- Older adults may adopt compensatory behaviours, such as reducing portion sizes or limiting fresh produce purchases, increasing malnutrition risk (20).

PHYSICAL AND FUNCTIONAL LIMITATIONS

- Age-related mobility issues (e.g. difficulty accessing shops, difficulty lifting groceries) significantly restrict the ability to acquire food independently (25).
- Functional decline, including dexterity issues or comorbidities, contributes to reduced food preparation capacity and intake (6).

TRANSPORT AND GEOGRAPHIC ACCESS

- Access to private transport is a critical determinant; lack of a car is more influential than geographic “food deserts” in predicting food access difficulties (26).
- Without reliable transport, older adults rely on local stores, taxis, or others, often leading to increased costs and reduced dietary variety (20).

2. Living Alone, social isolation, and dietary risk

Living arrangements and social context are central to eating behaviours and nutrition.

LIVING ALONE AND REDUCED DIETARY QUALITY

Older adults living alone demonstrate lower dietary variety, reduced intake of core food groups (fruit, vegetables, fish) and greater likelihood of unhealthy dietary patterns. Men living alone appear particularly vulnerable to poor dietary intake (23).

EATING ALONE AS A CORE RISK FACTOR

- Eating alone is consistently identified as a major contributor to nutrition risk with 100% prevalence in one study sample (20).
- Reduced motivation to prepare meals and diminished enjoyment of eating further compound risk (20).

SOCIAL ISOLATION AND DIET QUALITY

Social isolation is associated with:

- Lower diet quality
- Reduced food variety and intake
- Increased inflammatory dietary patterns (27).

Psychosocial triggers include:

- Loss of spouse
- Declining mobility
- Reduced social networks (27).

INTERACTION WITH MENTAL HEALTH AND MOTIVATION

- Social isolation contributes to depression and apathy, reducing appetite and food intake (6).
- Eating behaviours are strongly linked to routine and social context, highlighting the importance of commensality (eating and drinking together at the same table).

3. Interdependence of food access and health

Food access is closely linked to broader health conditions, reinforcing a cycle of vulnerability.

- Food insecurity is associated with poorer self-reported health and chronic disease risk (25).

Functional impairments (e.g., hearing loss, mobility issues) can both:

- Result from food insecurity
- Further limit access to food (16).

This reflects a bidirectional relationship, where declining health and food access exacerbate each other.

4. Role of family and informal support networks

Family plays a central, but complex, role in enabling food access and nutrition.

Types of support provided:

(1) Family members (especially adult children) provide:

- Transport to shops
- Meal preparation and food provision
- Emotional and social support (28).

(2) Informal carers support:

- Food shopping
- Meal preparation and feeding
- Monitoring intake and nutritional status (29).

Significance of informal care:

- Informal care constitutes the majority of support for older Australians, with high reliance on family networks (28).
- Family carers are well placed to deliver individualised nutrition support, due to familiarity with preferences and routines (29).

Limitations and changing nature of family support:

Despite its importance, family support is increasingly constrained by structural and social change (28).

Reduced availability of family support:

- Smaller family sizes, geographic mobility, and competing responsibilities reduce the capacity of adult children to provide assistance.
- Older adults may have limited or no access to family networks, particularly those living alone.

Ambivalence and autonomy

Older adults often express:

- Reluctance to depend on children
- Desire to maintain independence
- Family support can create tension between support and autonomy, influencing willingness to accept help (28).

Inconsistency of support

Support is uneven:

- Some older adults receive frequent assistance from family
- Others report estrangement or absence of family involvement (28).

5. Community connectedness as a protective factor

Beyond family, broader social engagement plays a critical role in food access and nutrition.

Community connectedness supports:

- Meal sharing
- Access to information and resources
- Motivation to maintain dietary routines (4)
- Social participation reduces isolation and supports dietary resilience, even among those living alone (4).

E. Food insecurity

Food insecurity can be defined as “running out of food in the last 12 months and being unable to afford to buy more” (30), or as the limited or uncertain access to nutritionally adequate, and culturally appropriate food due to economic, physical, and social constraints (31, 32, 25).

Although prevalence of food insecurity among older Australians appears relatively low (approximately 2–3%), this masks substantial inequalities, with certain population groups experiencing disproportionately higher risk (30, 31).

Food insecurity in older adults in Australia is not simply a matter of insufficient food supply but reflects broader issues of poverty, health and psychological stressors, function and independence, and social support.

1. Socioeconomic determinants and financial stress

The most consistent finding across studies is the central role of economic disadvantage:

- Low income is the strongest predictor of food insecurity, with rising risk as income decreases (25).
- Older adults who struggle financially are significantly more likely to report food shortages or reduced diet quality (30).
- Socioeconomic gradients are evident even in older populations, with food insecurity linked to poverty, welfare dependence, and housing costs (31).
- Importantly, financial constraints often lead to compromises in diet quality rather than food quantity, such as substituting cheaper, less nutritious foods (32).

2. Physical and functional barriers to food access

A major theme across the literature is that food insecurity in older adults is strongly influenced by functional capacity:

- Physical limitations (e.g., difficulty lifting groceries, mobility impairment) restrict access to food (25).
- Inability to shop, transport food, or prepare meals contributes to reduced intake and diet quality (32).
- Chronic illness and disability increase nutritional vulnerability and risk of food insecurity (31).

These findings demonstrate that food insecurity is not solely about financial access, but also the ability to physically obtain and utilise food.

3. Social isolation and living arrangements

Social factors, particularly living arrangements and social support, are key determinants:

- Individuals living alone are more likely to experience food insecurity (30, 31).
- Social isolation can reduce motivation to cook and eat, contributing to inadequate intake (32).
- Family and informal support networks play a critical protective role in facilitating food access. However, changing family structures and increasing demands on adult children may weaken these support systems over time (32).

4. Health consequences and bidirectional relationships

Strong evidence exists linking food insecurity with poor health outcomes:

- Food insecurity is associated with reduced physical and mental health-related quality of life (33).
- Individuals experiencing food insecurity report poorer health status, dissatisfaction, and reduced wellbeing (31).
- It is also linked to chronic conditions, multimorbidity, and lower dietary intake (16).

Importantly, this relationship is bidirectional:

- Poor health can limit access to food through disability or medical costs.
- Food insecurity contributes to worsening health through poor diet and nutritional deficiencies.

5. Cultural and environmental influences

Food insecurity is also shaped by cultural and environmental contexts:

- Access to culturally preferred or appropriate foods is a significant issue, particularly for culturally diverse populations (32).
- Geographic location influences food access, with remote areas facing higher food costs and limited availability (34).

These findings highlight the importance of culturally appropriate and geographically responsive interventions.

Certain groups experience disproportionately high rates of food insecurity:

- Older Aboriginal and Torres Strait Islanders have markedly higher prevalence (~21%) compared with non-Indigenous populations (~3–4%) (34).
- Risk is elevated in those with low income, poor health, large households, and those living in remote areas (34).

This highlights food insecurity as an equity issue linked to broader social disadvantage and structural inequalities.

6. Psychological stressors and vulnerability

Emerging evidence shows that stressful life events (e.g., illness, job loss, bereavement) significantly increase the likelihood of food insecurity (15).

- Individuals experiencing multiple stressors are substantially more likely to be food insecure.
- Food insecurity is therefore embedded within broader patterns of social and economic vulnerability.

F. Community-dwelling older adults with dementia and cognitive impairment

1. Overview

Eating well in community-dwelling older adults with dementia is influenced by a complex interaction of cognitive, physiological, behavioural, environmental, and social factors, compounded by reliance on informal and formal carers. Dementia progression is consistently associated with declining dietary intake, weight loss, and increased risk of malnutrition, driven by impairments in appetite, memory, and functional ability (21, 22).

Carers play a central role in mediating both barriers and enablers, with the home environment and availability of support services shaping outcomes (29).

2. Key barriers to eating well

COGNITIVE AND BEHAVIOURAL IMPAIRMENTS

Cognitive decline is a primary barrier to adequate nutrition:

- Forgetting to eat or drink, misreporting intake, or inability to recognise food (21, 35)
- Confusion, disorientation, and impaired judgement, affecting meal preparation and eating behaviours (35)
- Refusal of food, aggression, or behavioural disturbances during meals (21)
- Changes in food preferences, including increased sweet intake or restricted repertoires (22).

These factors contribute to inconsistent or inadequate dietary intake and place significant demands on carers.

PHYSIOLOGICAL CHANGES ASSOCIATED WITH DEMENTIA AND AGEING

Physiological factors directly impair oral intake and nutritional adequacy:

- Loss of appetite (anorexia) and reduced motivation to eat (21, 22)

- Dysphagia and chewing difficulties, requiring texture-modified diets (21)
 - Altered taste/smell perception, reducing food enjoyment (22)
 - Increased energy expenditure (e.g., pacing or wandering), contributing to weight loss (21)
- These changes accelerate malnutrition risk, which is already high in older populations (10).

FUNCTIONAL LIMITATIONS

Declining functional capacity can hinder independent eating:

- Difficulty using utensils or coordinating movements
- Inability to prepare meals or operate kitchen appliances
- Safety risks during cooking (e.g., fires, forgetting meals in ovens) (35).

Functional decline often necessitates increasing supervision or feeding assistance, creating dependency.

ENVIRONMENTAL AND LIVING CONTEXT

Living arrangements significantly influence nutritional risk:

- Older adults living alone face greater risk of inadequate intake, poor food storage, and food safety issues (35)
- Difficulties in shopping, food access, and financial constraints impede healthy eating (22, 35)
- Inadequate home environments (e.g., clutter, lack of routine) further compromise intake.

Social isolation is particularly important, reducing motivation to eat and opportunities for shared meals.

CARER-RELATED BARRIERS

Carers are critical but often under-supported:

- Limited nutrition knowledge and confidence in managing dietary needs amongst carers (22)
- Lack of guidance from healthcare professionals, including few dietetic referrals (21, 22)
- Emotional burden and stress, particularly related to weight loss and food refusal (21)
- Competing demands (e.g., employment, multiple care tasks) reducing time available for meal preparation (22)

Carer burden is both a barrier in itself and a mediator of other challenges.

HEALTH AND PSYCHOSOCIAL FACTORS

Additional contributors include:

- Depression and loneliness, associated with poorer appetite and nutritional risk (9)
- Comorbidities and polypharmacy
- General frailty and declining independence

These factors interact cumulatively with dementia-related impairments.

3. Key enablers to eating well

CARER INVOLVEMENT AND PERSONALISED SUPPORT

Carers are central enablers when appropriately supported:

- Monitoring food intake and nutritional status
- Assisting with meal preparation, shopping, and feeding
- Tailoring meals to individual preferences and capabilities (29)

Family carers' familiarity with the person's preferences allows highly individualised interventions, improving intake.

PRACTICAL FEEDING STRATEGIES AND BEHAVIOURAL APPROACHES

Carer-developed and evidence-informed strategies support food intake:

- Regular snacks and small meals instead of large portions
- Use of finger foods and texture-modified options
- Routine and structured mealtimes
- Minimising distractions and simplifying choices
- Avoiding confrontation and encouraging eating through patience and persistence (21).

These strategies align with person-centred care principles.

SOCIAL AND RELATIONAL ASPECTS OF EATING

Social interaction enhances intake and engagement:

- Eating together and shared mealtimes increase consumption
- Encouraging social eating and mealtime engagement
- Involving the person with dementia in food preparation enhances engagement and sense of purpose (21, 22).

DIETETIC INPUT AND NUTRITION EDUCATION

Access to professional support is a key enabler:

- Dietitian-led interventions improve nutritional status and reduce malnutrition risk
- Education for carers improves knowledge and confidence
- Structured programs (e.g., training, telehealth) can improve outcomes (29). Despite this evidence, access remains inconsistent and often limited.

COMMUNITY AND SERVICE SUPPORT

External supports strengthen the home nutrition environment:

- Services such as Meals on Wheels and home care assistance with cooking
- Community health and social care interventions
- Early engagement with support services for people living alone (35).

Integrated care models with services working together are particularly important as dementia progresses.

PERSON-CENTRED AND ADAPTABLE CARE APPROACHES

Effective nutrition care for people with dementia requires flexibility:

- Adapting diets to changing preferences, abilities, and disease stage
- Prioritising food enjoyment and quality of life over strict dietary rules
- Recognising that standard “healthy diet” advice may not always be appropriate.

Person-centred care is emphasised as essential to meeting complex needs (10).

G. Nutrition in community-dwelling older adults from diverse cultural backgrounds

1. Food security and nutritional risk

Food security is a central determinant of nutritional status in community-dwelling older adults and is influenced by economic, physical, social, and cultural factors (32).

- Food insecurity contributes to malnutrition, chronic disease risk, disability, and reduced wellbeing.
- In culturally diverse populations, food insecurity is heightened by language barriers, service access limitations, and cultural food availability.
- Among Aboriginal and Torres Strait Islander older adults, food insecurity prevalence is high (~21%), with strong links to low socio-economic status, remoteness, and cultural–linguistic factors (34).

Food security must be conceptualised beyond financial access to include culturally acceptable foods, mobility, and social supports, particularly for Culturally and Linguistically Diverse (CALD) and Indigenous populations.

2. Cultural influences on dietary patterns and food meaning

Cultural background strongly shapes dietary behaviours, preferences, and attitudes to food:

- Food practices in later life often reflect lifelong habits and cultural identity, including traditional meal structures and cooking methods (24).
- Older adults may prioritise nutrition and functionality over pleasure, particularly those from hardship-affected generations (24).
- Cultural groups differ in dietary expectations, such as reliance on fresh, home prepared and culturally familiar foods (32).

For migrant groups dietary acculturation leads to hybrid patterns combining traditional and host country foods, with varying impacts on diet quality (32).

Interventions must respect culturally embedded dietary practices and support cultural continuity alongside nutritional adequacy.

3. Family, social networks, and intergenerational support

Family plays a central, yet evolving role in supporting nutrition (28):

- Family members provide instrumental support (shopping, cooking, transport) critical to food access.
- Intergenerational relationships are characterised by reciprocity (mutual support) rather than one-way dependency.
- Cultural expectations of filial responsibility are stronger in some CALD groups.

However, changing family structures introduce challenges (28):

- Reduced capacity of adult children (due to work, mobility) limits support.
- Older adults often prefer independence and not being a burden, even when assistance is needed.

Social isolation also affects nutrition:

- Eating alone reduces motivation to prepare meals and affects intake (32).

It is clear that policies should not assume family support; but instead they should complement informal networks with culturally appropriate formal services.

4. Structural and environmental determinants

A. PHYSICAL AND BUILT ENVIRONMENT

- Access to grocery stores, transport, and community infrastructure shapes dietary behaviour (32).
- For immigrant groups, neighbourhood features (e.g. proximity to culturally appropriate food outlets) are critical (14).

Barriers include:

- Poor public transport
- Distance to shops
- Limited availability of fresh or culturally specific foods (14).

B. CULTURAL FOOD AVAILABILITY

- Culturally specific foods may be scarce, expensive, or geographically inaccessible, impacting diet quality.
- Some groups rely on informal networks or home food production (e.g., grown in their own garden) to access preferred foods (32).

Food environments must support access to affordable, culturally appropriate foods, particularly in disadvantaged or remote areas.

5. Health status, functional capacity, and ageing

Physiological and health-related factors intersect with culture to influence nutrition:

- Poor health, disability, and mobility limitations affect ability to shop, cook, and eat (32).
- Age-related changes often lead to dietary modifications (e.g., reduced red meat, higher fruit/vegetable intake).
- Chronic diseases drive dietary self-management and adherence to health advice (24).

Functional barriers often interact with cultural factors (e.g., inability to prepare traditional foods) and it is important that nutrition interventions should integrate functional, health, and cultural considerations simultaneously.

6. Economic constraints and food choice

- Cost is a key determinant of food choice, affecting ability to purchase nutritionally adequate and preferred foods.
- Financial limitations may not prevent food access entirely but reduce quality and variety.
- Health-related dietary requirements (e.g., diabetic or specialty foods) increase financial burden (32).

Economic interventions should address affordability of healthy and culturally appropriate foods, not just food quantity.

7. Cultural acceptability and service use

- Cultural preferences influence uptake of formal services (e.g., meals-on-wheels), which may not align with traditional diets. Services should be culturally tailored (menus, language, delivery models) to improve accessibility and acceptability (32).
- CALD groups may rely more on informal or community-based networks than formal systems (28).

8. Behavioural and psychosocial determinants

Across studies, consistent behavioural drivers include:

- Taste preferences and lifelong habits
- Nutrition knowledge and health beliefs
- Social norms and cultural identity
- Motivation, energy, and mental wellbeing (18).

Barriers include:

- Lack of knowledge or conflicting advice
- Food preparation burden
- Cultural resistance to dietary change (18).

H. Role of family and carers in supporting nutritional needs of community-dwelling older adults

Family members and informal carers play a central but evolving role in supporting nutritional wellbeing among older adults living at home. Their contribution spans instrumental, emotional, behavioural, and monitoring roles, but is shaped by changing social structures, caregiver capacity, and systemic factors.

1. Core roles of family and carers in nutrition support

1.1 Instrumental support (food acquisition, preparation, feeding)

Family and carers provide essential practical assistance:

- Grocery shopping, transport, and meal preparation
- Supporting eating and feeding when functional decline is present
- Managing food access (e.g., transporting to shops) (28, 29).

This support is critical for food access and diet quality, particularly for older adults with reduced mobility or functional limitations.

1.2 Nutritional monitoring and care coordination

Carers are uniquely positioned to:

- Monitor dietary intake, weight and hydration
- Identify nutritional risk (e.g., reduced appetite, weight loss)
- Facilitate access to health professionals (e.g., dietitians) (29)

Because carers spend significant time in the home environment, they have insight into daily eating patterns and unmet needs not visible to formal services.

1.3 Behavioural and relational influence on eating

Family relationships influence:

- Food preferences and dietary habits
- Meal routines and social eating
- Motivation and appetite.

Food practices are often shaped by lifelong habits and family traditions, which persist into later life (24).

2. Intergenerational support and reciprocity

2.1 Reciprocal nature of care

Support is not one-directional:

- Older adults continue to contribute (e.g., cooking, childcare)
- Families share responsibilities for food provision and finances.

This reciprocity highlights that older adults are active participants, not passive recipients of care (28).

2.2 Emotional and social support

Family involvement provides:

- Social connection (which supports eating behaviours)
- Emotional reassurance and wellbeing
- Shared meals and reduced isolation.

Eating is strongly tied to social relationships and identity, reinforcing the importance of family contexts (24).

3. Carers as mediators of food access and food security

3.1 Buffering against structural barriers

Carers help overcome:

- Transport limitations
- Mobility constraints
- Food access issues.

Without such support, older adults—especially those living alone—are at increased risk of food insecurity (26).

3.2 Food insecurity risk in vulnerable groups

Older adults living alone, or with limited resources, are more likely to:

- Experience food insecurity
- Have poorer nutrition and health outcomes (30).

Family and informal care networks act as protective factors against these risks.

4. Challenges and limitations of family and carer support

4.1 Caregiver burden and competing demands

Carers often experience:

- High caregiving hours (e.g., >100 hours/week)
- Psychological stress and depression
- Reduced capacity for self-care, including nutrition.

Caregiver strain can compromise both their own diet and the care they provide (9).

4.2 Limited nutrition knowledge and support

Carers frequently report:

- Basic or inadequate nutrition knowledge
- Difficulty managing complex dietary needs (e.g., dementia-related eating issues)
- Limited access to tailored nutrition education.

This creates a gap between recognising nutritional importance and effectively acting on it (22).

4.3 Complexity of managing dementia-related nutrition

In dementia contexts, carers face:

- Feeding difficulties
- Appetite changes and weight loss
- Behavioural challenges related to eating.

These issues increase both nutritional risk and caregiver burden (22).

5. Changing family structures and reduced capacity for care

5.1 Reduced availability of family support

Societal trends impacting care include:

- Smaller family sizes
- Geographic dispersion
- Increased workforce participation.

These changes reduce the availability and consistency of informal care (28).

5.2 Ambivalence and desire for independence

Older adults often:

- Value independence and autonomy
- Avoid relying heavily on family to “reduce burden”.

This can limit utilisation of available family support, even when needed (28).

6. Cultural and social influences

6.1 Cultural expectations of family care

In some cultural groups:

- Family responsibility for food and care is strongly emphasised
- Lower reliance on formal services is observed
- However, these expectations may conflict with modern family constraints (28).

6.2 Lifelong habits shaping current eating patterns

Food behaviours are:

- Deeply embedded in earlier life experiences
- Resistant to change in older age.

Carers must often work within established preferences rather than modify them (24).

7. Implications for practice and policy

7.1 Importance of integrating carers into nutrition care

Evidence supports:

- Involving carers as part of the nutrition care team
- Providing structured education and support (29).

7.2 Need for targeted nutrition education and support systems

Key strategies include:

- Tailored nutrition education for carers
- Skill-building interventions (meal preparation, feeding support)
- Compensatory services (transport, meal delivery) (22).

7.3 Complementary role of formal services

Given declining informal capacity:

- Formal services (e.g., home care, meal programs) are essential
- Formal services should complement—not replace—family support (28).

Family and carers are central to ensuring adequate nutrition in community-dwelling older adults, providing essential support across food access, preparation, monitoring, and social engagement. However, their contribution is increasingly constrained by caregiver burden, limited knowledge, and shifting societal structures.

A sustainable approach to improving nutrition outcomes in older adults requires:

- Recognition of carers as key partners in care
- Investment in education and support for carers
- Integration of formal services to supplement informal care networks.

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