

Document Title		
<b>Guidelines on Management of Adult Malnutrition in Community: Prevention, Identification, Treatment and Monitoring of patients.</b>		
Document Description		
Document Type	Guideline	
Service Application	Community based healthcare professionals.	
Version	0.1	
Lead Author(s)		
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Blessing Magara	Clinical Community Dietician	
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Change History		
Version	Date	Comments
0.1	April 2017	Draft version – rebranded into Trust format. <b>Supersedes and replaces:</b>
	March 2013	Malnutrition in Adults: Guidelines for Identification and Treatment (Community Services) and Guidelines for prescribing sip feeds in Primary Care.
Links with External Standards		
NICE Clinical Guideline - 32		
Key Dates	DATE	
Ratification Date	April 2018	
Review Date	April 2020	

## Executive Summary Sheet

Document Title: Guidelines on the Management of Adult Malnutrition in Community: Prevention, identification, treatment and monitoring of patients.

**Please Tick (☑)  
as appropriate**

This is a new document within the Trust

This is a revised Document within the Trust

### What is the purpose of this document?

These guidelines set out the process to be followed by Community based healthcare professionals in the prevention and identification of patients who are malnourished or at high risk of malnutrition and their subsequent treatment and monitoring.

### What key Issues does this document explore?

Prevention, identification, treatment and monitoring of malnourished patients in the Community.

### Who is this document aimed at?

This document applies to all healthcare professionals within the community setting of Walsall Healthcare NHS Trust.

### What other policies, guidance and directives should this document be read in conjunction with?

NICE Guidance CG 32

### How and when will this document be reviewed?

This document will be reviewed every three years by the policy author, or sooner should changes in guidance/practice occur.

## CONTRIBUTION LIST

### Key individuals involved in developing the document

Name	Designation
B Magara	Clinical Community Dietician
H Biglin	Clinical Community Dietician
C Gallimore	Clinical Manager, Dietetics
Jyoti Saini	Deputy Head of Medicines Management

### Circulated to the following for consultation

Name/Committee/Group/	Designation
Nutrition Steering Committee	
Andrew Colson	Quality Adult Safeguarding Lead
Quality Boards	
Policies and Procedures Members	

### Version Control Summary

#### Significant or Substantive Changes from Previous Version

A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

When a document is reviewed the changes should using the tracking tool in order to clearly show areas of change for the consultation process.

Version	Date	Comments on Changes	Author
0.1	April 2017	The document titled malnutrition in adults: guidelines for the prevention, identification and treatment and the document titled guidelines for prescribing sip feeds in Primary Care merged to form a single guideline titled guidelines on management of adult malnutrition in community: identification, treatment and monitoring of patients.	BM, HB
		Previous documents contained outdated information and new relevant sections added into document e.g. referral criteria.	

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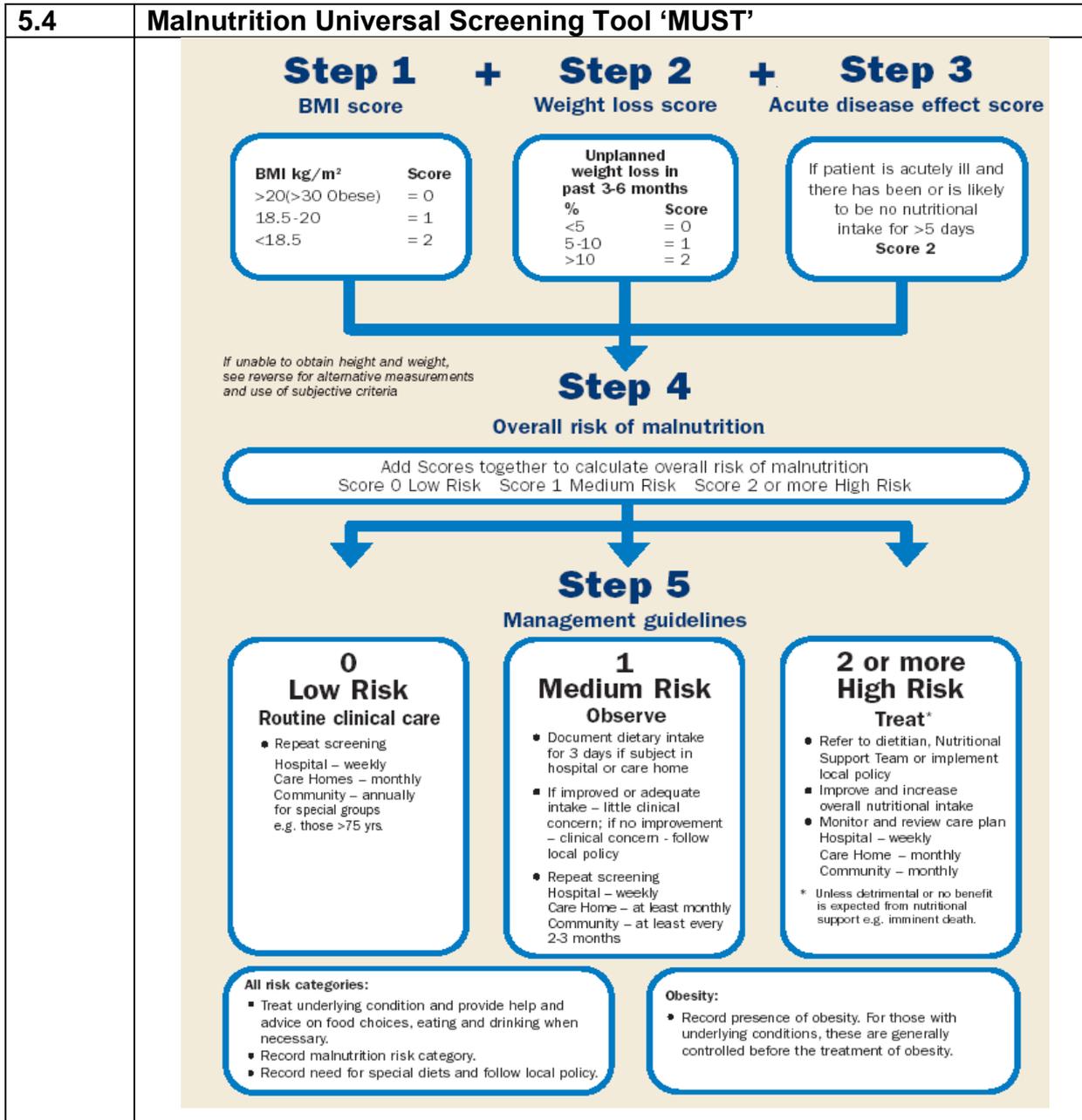
<b>Appendices</b>		<b>PDF Attachment</b>
1	Malnutrition Care Pathway for Nursing Home Residents.	
2	Patient Information Leaflet - Food Fortification	
3	Patient Information Leaflet – Nourishing snacks	
4	Patient Information Leaflet – Nourishing drinks	

<b>1.0</b>	<b>Introduction</b>
	<p>Malnutrition is a state of nutrition in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effect on tissue, body form (body shape, size and composition), function and clinical outcome. For the purposes of this guideline, malnutrition refers to under nutrition. This is an insidious condition, often undetected unless very apparent. Symptoms may be multiple and non-specific and may be attributed to underlying disease. This means that malnutrition may not be detected or treated.</p> <p>The consequences of malnutrition are:</p> <ul style="list-style-type: none"> <li>• Impaired immune response</li> <li>• Reduced muscle strength/fatigue</li> <li>• Inactivity leading to pressure sores / thromboembolism</li> <li>• Apathy, depression and self neglect</li> <li>• Impaired thermoregulation</li> <li>• Impaired wound healing and recovery from illness</li> <li>• Weight loss</li> <li>• Increased use and cost of healthcare resources</li> </ul> <p>This includes:</p> <ul style="list-style-type: none"> <li>• More GP visits</li> <li>• More new prescriptions</li> <li>• More hospital admissions</li> <li>• Increased length of stay in hospital</li> <li>• Increased likelihood of transfer from hospital to another healthcare unit rather than patients own home</li> </ul> <p>Early detection by use of a nutrition screening tool and early dietary intervention is essential to highlight those at risk of malnutrition and to improve their health status.</p> <p>Proper identification and treatment of patients with poor nutritional intake and/or poor nutritional status will have significant benefits to their health and recovery from illness. The use of oral nutritional supplements (ONS) can be an effective means of improving the nutrition of certain groups of patients. However, it is essential that these products are used appropriately, based on the following guidelines.</p>
<b>2.0</b>	<b>Scope</b>
	<p>This clinical guideline applies to all healthcare professionals working within the Walsall Community setting. It is designed to be used by GPs and practice nurses, district nursing staff, nursing and care homes and other health care professionals. This document is not intended to supersede a Dietitian's assessment/plan if the patient is already under their care.</p>
<b>3.0</b>	<b>Statement of Intent</b>
	<p>These guidelines set out the process to be followed by Community based</p>

	healthcare professionals in the prevention of malnutrition in care and nursing homes, and the identification of patients who are malnourished or at high risk of malnutrition in the Walsall Community setting and their subsequent treatment and monitoring.
<b>4.0</b>	<b>Prevention of Malnutrition in Care Homes and Nursing Homes</b>
<b>4.1</b>	<b>Guidance for provision of nutrition and hydration</b>
	<p>Good nutritional care, adequate hydration and enjoyable mealtimes can have a significant effect on health and wellbeing. Whereas poor nutrition can increase risks of infection, illness and falls, it can also reduce muscle strength, energy levels and cause low mood. Peoples' appetites can reduce with age, so keeping older people interested in food, and ensuring that they have adequate nutrition can be a challenge.</p> <p>Nutrition is one of the key components of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009, and forms part of regular CQC inspections.</p> <p>Care and Nursing Homes have a responsibility to provide service users with a choice of enjoyable, well presented, nourishing meals and drinks, in sufficient quantity to meet their taste preferences, religious, cultural and therapeutic needs.</p> <p>Ensuring that service users have sufficient nutritious food and drink is fundamental to good care. Good nutritional care means determining a person's individual preferences and cultural needs, defining their ability to eat, drink and support their needs as detailed below:</p> <ol style="list-style-type: none"> <li>1. Meals provided should meet minimum nutritional standards as specified by the Food Standards Agency (2007) – <i>guidance on food served to older people in residential care</i>.</li> <li>2. Service users should be offered a choice of food to reflect their preferences. Feedback from service users should be sought, and the menu changed to reflect their comments.</li> <li>3. Service users will have a choice of where to eat their meals, and encouraged to eat and drink at their own pace.</li> <li>4. Meals will be prepared accordance with good food hygiene practices and well presented at the point of service.</li> <li>5. Service users will be encouraged to maintain their independence with eating and drinking; and assistance or adaptations will be provided sensitively if required (eg adapted cutlery/crockery, assistance to eat and drink, modified texture food). Details of any required support will be detailed in care plans, and communicated to staff.</li> <li>6. Meals and snacks should be spaced throughout the day to avoid unnecessarily long gaps (eg evening meal served after 5pm).</li> <li>7. Snacks, hot and cold drinks should be freely available 24hours a day. Service users should be offered at least 8 drinks per day, and three nutritious snacks.</li> </ol>

	<p>8. Factors affecting service user’s ability to eat and drink (eg dental health, swallowing difficulty, dexterity) will be detailed in their care plan and reviewed regularly (as a minimum every three months), and expert advice sought when needed.</p> <p>9. Where there are concerns about adequacy of food and drink intake, this will be monitored on food and fluid intake charts. These will be reviewed for adequacy, and appropriate action plan developed. Expert advice should be sought to deal with factors that may be affecting intake eg dental health, swallowing difficulty, dexterity, pain etc.</p> <p>10. Service users are encouraged to eat and drink in a way that promotes health.</p>
<b>5.0</b>	<b>Nutritional Screening</b>
	<p>Nutritional screening should ideally be carried out in all groups at risk of malnutrition, for example, all residents in nursing and care homes, community hospitals, prisons, those with chronic diseases, and the elderly.</p>
<b>5.1</b>	<b>Who should be Screened</b>
	<ul style="list-style-type: none"> <li>• All hospital inpatients on admission including those in community hospitals.</li> <li>• All outpatients at the first clinic appointment and where there is clinical concern.</li> <li>• All people in care homes on admission and where there is clinical concern.</li> <li>• On initial registration at general practice surgeries and where there is clinical concern.</li> <li>• As part of a medication review.</li> <li>• Consider opportunistic screening at, for example, health checks, ‘flu injection’.</li> <li>• Patients where there is clinical concern:</li> </ul> <p>Clinical Concern Includes:</p> <ul style="list-style-type: none"> <li>• Unplanned weight loss</li> <li>• Fragile skin</li> <li>• Poor wound healing</li> <li>• Apathy</li> <li>• Wasted muscles</li> <li>• Poor appetite</li> <li>• Altered taste sensation</li> <li>• Impaired swallowing</li> <li>• Altered bowel habit</li> <li>• Loose fitting clothes/rings</li> <li>• Prolonged intercurrent illness</li> </ul>

<b>5.2</b>	<b>Nutritional Screening Tool</b>
	<p>The 'Malnutrition Universal Screening Tool' ('MUST') is a five step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese.</p> <p>It has not been designed to detect deficiencies in or excessive intakes of vitamins and minerals. If a patient is identified as obese please refer to NICE guidelines on the use of anti-obesity medicines, and the Health Select Committee Report on Obesity.</p> <p>'MUST' has been validated across various settings such as hospital wards, outpatient clinics, general practice, community settings and care homes. It was found that 'MUST' was quick and easy to use, and gave reproducible results. It can be used for patients in whom height and weight are difficult to obtain, as a range of alternative measures and subjective criteria are given to obtain the Body Mass Index (BMI).</p> <p>The evidence base for 'MUST' is summarised in The 'MUST' Report and Explanatory Booklet, copies of both are available from BAPEN (British Association for Parenteral and Enteral Nutrition). The 'MUST' was developed by the Malnutrition Advisory Group (MAG), a Standing Committee of BAPEN<sup>4</sup>.</p> <p>A copy of the 'MUST' can be found in Appendix V. Further details can be found on the BAPEN website at <a href="http://www.bapen.org.uk">www.bapen.org.uk</a> and copies of MUST can be downloaded and printed from this site.</p> <p>This document acts as the 'local policy' referred to throughout the MUST document.</p> <p>The Nutritional Support Flow chart (p 10) should be followed once a patient has been identified as at risk of malnutrition.</p>
<b>5.3</b>	<b>How to Screen using MUST</b>
	<p>There are five steps to follow:</p> <p><b>Step 1:</b> Measure height and weight to get a BMI score using chart provided. If unable to obtain height and weight, use the alternative procedures shown in this guide.</p> <p><b>Step 2:</b> Note percentage unplanned weight loss and score using tables provided</p> <p><b>Step 3:</b> Establish acute disease effect and score</p> <p><b>Step 4:</b> Add scores from steps1, 2 and 3 together to obtain overall risk of malnutrition</p> <p><b>Step 5:</b> Use management guidelines and/or local policy to develop care plan</p>



**5.5 Alternative Measurements- Mid Upper Arm Circumference (MUAC)**

If you do not have weight or height, BMI range (likely to be under 20 or over 30) can be estimated using 'Mid Upper Arm Circumference' (MUAC) which can be measured using the procedure outlined below:

- Individual should be standing or sitting.
- Use left arm if possible and ask individual to remove clothing if able, so arm is bare.
- Ask individual to bend their arm to form a right angle.
- Measure from the top of the shoulder to the point of the elbow using a tape measure.
- Determine the mid – point between the shoulder and elbow.
- Ask the individual to hang their arm loose and now use the tape measure around the arm (circumference) at the mid – point; the

	<p>tape measure should fit comfortably around the arm and not be too tight.</p> <ul style="list-style-type: none"> <li>• If MUAC is &lt; 23.5cm, BMI is likely to be &lt; 20</li> <li>• If MUAC is &gt; 32 cm, BMI is likely to be &gt;30.</li> </ul>
<b>6.0</b>	<b>Action Plan (Treatment and Monitoring of patients)</b>
	<p><b>If total MUST score 0 or MUAC <math>\geq</math> 23.5 cm (low risk)</b></p> <p><u>Nursing /Care Home Residents</u></p> <ul style="list-style-type: none"> <li>• Repeat screening monthly for residents in Care/Nursing Homes.</li> </ul> <p><u>Patients in own homes</u></p> <ul style="list-style-type: none"> <li>• Repeat screening at the next available opportunity (District nurse/ GP visits) for patients in their own homes.</li> </ul> <p><b>If total MUST score 1 (medium risk)</b></p> <p><u>Nursing/Care Home Residents</u></p> <ul style="list-style-type: none"> <li>• Start Food and Fluid Record Chart for four days to monitor oral intake.</li> <li>• Add <u>one</u> topper per <u>meal</u> (See Appendix 2).</li> <li>• Provide <u>one</u> nourishing snack daily (See Appendix 3).</li> <li>• Provide <u>one</u> nourishing drink daily (See Appendix 4).</li> <li>• Weigh monthly.</li> </ul> <p><u>Patients in own homes</u></p> <ul style="list-style-type: none"> <li>• Offer advice regarding improving food and fluid intake.</li> <li>• Give 'Have you got a small appetite' booklet.</li> <li>• Advise patient on food fortification (See Appendices 2 - 4)</li> </ul> <p><b>If total MUST score 2 or more or MUAC &lt; 23.5cm (high risk)</b></p> <p><u>Nursing / Care Home Residents</u></p> <ul style="list-style-type: none"> <li>• Start Food and fluid Record Chart for one week to monitor oral intake.</li> <li>• Add <u>one</u> topper per <u>dish</u> (See appendix 2).</li> <li>• Provide <u>two</u> nourishing snacks daily (See Appendix 3).</li> </ul>

	<ul style="list-style-type: none"> <li>• Provide <u>two</u> nourishing drinks daily (See Appendix 4).</li> <li>• Weigh monthly.</li> <li>• If patient's weight has <b>decreased the second consecutive month, inform the GP.</b></li> <li>• GP to refer patient to the Clinical Community Dieticians (please see referral criteria below).</li> </ul> <p><u>Patients in own homes</u></p> <ul style="list-style-type: none"> <li>• Offer advice regarding improving food and fluid intake.</li> <li>• Advise patient on food fortification (See Appendix 2)</li> <li>• Give 'Have you got a small appetite' booklet.</li> <li>• Refer to the Clinical Community Dieticians (please see referral criteria below).</li> </ul>
<b>7.0</b>	<b>Referral to Clinical Community Dietitian</b>
	<p>Prior to referring to a Dietitian, please consider whether the service user has any of the following issues which may impact on their dietary intake and please ensure they have a medical review and are being treated before referring:</p> <ul style="list-style-type: none"> <li>• Pain</li> <li>• Nausea and Vomiting</li> <li>• Constipation</li> <li>• Diarrhoea</li> <li>• Low mood or Confusion</li> <li>• Sore mouth, dental problems or ill fitting dentures</li> <li>• Swallow problems (refer to the Speech and Language Therapists)</li> </ul> <p>Please also ensure you gain consent from any service users who have capacity before referring.</p> <p>On referral to the Clinical Community Dietitian please commence the service user on Complan Shake or any other powdered ONS such as Aymes, Enshake, Foodlink Complete or Fresubin powder extra twice a day until they are seen by a Dietitian.</p>

<b>7.1</b>	<b>Referral Criteria for Clinical Community Dietitian</b>
	<p>Referrals are accepted for patients at high risk of malnutrition as defined below:</p> <ul style="list-style-type: none"> <li>• MUST score of 2 or more</li> <li>• Or MUAC of less than 23.5cm</li> <li>• Or a MUST score of less than 2 with a grade 3/4 pressure sore.</li> </ul> <p><u>Nursing/Care Home Residents</u></p> <ul style="list-style-type: none"> <li>• Inform the GP if patient is deemed to be high risk for 2 consecutive weights and treatment (food fortification) has already been done for one month.</li> <li>• Nutrition referral checklist to be completed and sent to the GP together with the MUST scores.</li> <li>• .GP to make referral to the Dietitians.</li> </ul> <p><u>Patients in their own homes</u></p> <ul style="list-style-type: none"> <li>• Referrals accepted from the GP or District Nurses.</li> </ul>
<b>8.0</b>	<b>Patients discharged from hospital on oral nutritional supplements</b>
	<p><u>ONS received as inpatient and supply given on discharge</u></p> <ul style="list-style-type: none"> <li>• A dietician may not have assessed these patients who will be discharged with 7 days supply. If ongoing problems, patient to contact GP for nutritional rescreening and follow action plan.</li> <li>• If patient was assessed by Dietician during their hospital stay and started on ONS, dietician writes to request ONS for a specific period and informs the patient/carer accordingly. If patient requests a further prescription after the stop date rescreen and follow the action plan.</li> </ul>
<b>9.0</b>	<b>Palliative Care Patients</b>
	<p>Use of ONS in palliative care should be assessed on an individual basis. Appropriateness of ONS will be depended upon the patient's health and their treatment plan. Emphasis should always be placed on the enjoyment of nourishing food and drinks and maximising quality of life. Management of palliative patients has been divided into three stages here: early palliative care, late palliative care and last days of life. Care aims will change through these stages.</p> <p>Loss of appetite is a complex phenomenon that affects both patients and carers. Health and social care professionals need to be aware of the potential tensions that may arise between patients and carers concerning</p>

	<p>a patient's loss of appetite. This is likely to become more significant through the palliative stages and patients and carers may require support with adjusting and coping. The patient should always remain the focus of care. Carers should be supported in consideration of the environment, social setting, food portion size, smell, presentation and their impact on appetite.</p> <p><u>Nutritional Management in Early Palliative Care</u></p> <p>In early palliative care the patient is diagnosed with a terminal disease but death is not imminent. Patients may have months or years to live and maybe undergoing palliative treatment to improve quality of life.</p> <p>Nutrition screening and assessment in this patient group is a priority and appropriate early intervention could improve the patient's response to treatment and potentially reduce complications.</p> <p><u>Nutritional Management in Late Palliative Care</u></p> <p>In late palliative care, the patient's condition is deteriorating and they may be experiencing increased symptoms such as pain, nausea and reduced appetite.</p> <p>The nutritional content of the meal is no longer of prime importance and patients should be encouraged to eat and drink the food they enjoy. The main aim is to maximise quality of life including comfort, symptom relief and enjoyment of food. Aggressive feeding is unlikely to be appropriate especially as this can cause discomfort, as well as distress and anxiety to the patient, family and carers.</p> <p>The goal of nutritional management should NOT be weight gain or reversal of malnutrition, but quality of life.</p> <p><u>Nutritional Management in the Last Days of Life</u></p> <p>In the last days of life (end of life care), the patient is likely to be bed – bound, very weak and drowsy with little desire for food or fluid. The aim should be to provide comfort for the patient and to offer mouth care and sips of fluid and mouth care or mouthfuls of food as desired.</p>
<b>10.0</b>	<b>Roles and Responsibilities</b>
<b>10.1</b>	<p><b>Clinical Community Dietitian</b></p> <p>Responsibility for:</p> <ul style="list-style-type: none"> <li>• Ensuring that the policy complies with all relevant statutory requirements and other standards.</li> <li>• Ensuring the policy is reviewed and revised as per timescales on the cover page.</li> </ul>

<b>10.2</b>	<b>Care Home Managers</b> <ul style="list-style-type: none"> <li>• Responsibility for ensuring this guideline is disseminated to all staff and can evidence that staff have read it. This can be done via team or individual meetings.</li> <li>• Responsible for ensuring that guidance is implemented in their Care/Nursing Home.</li> </ul>																	
<b>10.3</b>	<b>All community nursing staff</b> <ul style="list-style-type: none"> <li>• Responsible to ensure day to day implementation of the policy by community staff.</li> <li>• Responsible for the nutritional screening of all adult patients at first contact.</li> </ul>																	
<b>11.0</b>	<b>Audit / Monitoring Arrangements</b>																	
	<table border="1"> <thead> <tr> <th data-bbox="240 891 596 925"><b>Monitoring Process</b></th> <th data-bbox="608 891 1305 925"><b>Requirements</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="240 925 596 965">Who</td> <td data-bbox="608 925 1305 965">Dietitians</td> </tr> <tr> <td data-bbox="240 965 596 1043">Standards Monitored</td> <td data-bbox="608 965 1305 1043">Use of MUST on referrals from community staff and nursing homes</td> </tr> <tr> <td data-bbox="240 1043 596 1084">When</td> <td data-bbox="608 1043 1305 1084">Continuous</td> </tr> <tr> <td data-bbox="240 1084 596 1124">How</td> <td data-bbox="608 1084 1305 1124">Review of referrals</td> </tr> <tr> <td data-bbox="240 1124 596 1164">Presented to</td> <td data-bbox="608 1124 1305 1164">Dietetic staff meetings</td> </tr> <tr> <td data-bbox="240 1164 596 1205">Monitored by</td> <td data-bbox="608 1164 1305 1205">Head of Dietetics</td> </tr> <tr> <td data-bbox="240 1205 596 1272">Completion/Exception reported to</td> <td data-bbox="608 1205 1305 1272">Family Health and Diagnostics Quality Board</td> </tr> </tbody> </table>	<b>Monitoring Process</b>	<b>Requirements</b>	Who	Dietitians	Standards Monitored	Use of MUST on referrals from community staff and nursing homes	When	Continuous	How	Review of referrals	Presented to	Dietetic staff meetings	Monitored by	Head of Dietetics	Completion/Exception reported to	Family Health and Diagnostics Quality Board	
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MUST: Malnutrition Universal Screening Tool																		
BMI: Body Mass Index																		
Food fortification: addition of high calorie and high protein foods to meals and drinks																		
<b>14.0</b>	<b>Legal and professional Issues</b>																	
National Institute for Health and Clinical Excellence (2006).Nutrition support in adult. Oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical Guideline 32																		

<b>15.0</b>	<b>References</b>
	<p>MAG June 2000 Brief prepared for the Health Select Committee</p> <p>Edington <i>et al.</i> Prevalence of malnutrition on admission to four hospitals in England. Clinical Nutrition 2000; 19: 191 - 195.</p> <p>National Institute for Health and Clinical Excellence (2006). Nutrition support in adult. Oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical Guideline 32</p> <p>BAPEN (2003) The MUST explanatory booklet: A guide to the “Malnutrition Universal screening tool” (“MUST”) for adults. BAPEN</p>
<b>16.0</b>	<b>Related Policies</b>
	Guideline on Nutrition and Hydration for Patients with Advanced Dementia.
<b>12.0</b>	<b>Appendices</b>
	Attached separately as a document.
	<p><b>Appendix one:</b> Malnutrition Care Pathway for Nursing Home Residents</p> <p><b>Appendix two:</b> Food Fortification.</p> <p><b>Appendix three:</b> Nourishing snacks.</p> <p><b>Appendix four:</b> Nourishing drinks</p>