Managing Malnutrition: One Page Quick Reference Guide for Healthcare Professionals in Primary Care

Steps to Appropriate Prescribing of Oral Nutritional Supplements (ONS) for Adults

STEP 1: Identify Nutritional Risk

- Screen using MUST (Malnutrition Universal Screening Tool) - This is on SystmOne
- If you cannot weigh the patient, use the *subjective assessment* option
- **For full explanation refer to www.bapen.org.uk/pdfs/must/must-full.pdf *(full tool)***

MUST Score	Action Needed
0 = **Low Risk**	No intervention needed, routine monitoring/ rescreen sooner if clinical concern (If patient has Pressure Ulcer Grade 3 or more or chronic wounds - treat as Medium/High Risk)
1 = **Medium Risk**	Observe – Monitor (Or *Treat* if frail/elderly - in which case progress to Step 2)
2 or more= **High Risk**	Treat – Progress to Step 2

STEP 2: Assess the Underlying Causes

- Identify possible issues affecting appetite or oral intake, address the symptoms and consider referral to other agencies (e.g. OT, SLT, social services, food bank etc.)

If dysphagia is suspected, refer to Speech & Language Therapy for a swallowing assessment

If the patient has a learning disability, consider referral to the Learning Disability Team – see Appendix for criteria

STEP 3: Agree Aims of Nutritional Support

- Essential to agree and record aims to enable monitoring of progress

  e.g. target weight/ specify amount of weight gain/ minimise weight loss/ weight stabilisation/ improve QOL/ improved oral intake (specify e.g. eating all meals)/ wound healing

STEP 4: *Food First*

- Provide *Food First* Advice - give ***Food First* Leaflet**
- Consider need for OTC multi-vitamin & mineral tablet

If carers have requested referral to dietetics for a carehome resident, they must adhere to dietary advice in the Carehome Pack provided by the Dietetic Department, which incorporates Food First within specific careplans depending on the MUST score

STEP 5: Review After a Month

- Reassess weight, BMI, MUST score, review oral intake and aims
- **If improving, no ONS necessary**: Continue *Food First* & review regularly until goals are met
  - **If no improvement, MUST ≥ 2 for 2 consecutive months and meets ACBS criteria, consider prescribing *First Line ONS***
    Steps 1-5 must have been undertaken before ONS considered

Refer to Appendix for what to do if patient does not meet ACBS Criteria, or cannot be weighed

STEP 6: Prescribing ONS

- **Give *First Line* ONS bd dose (*see Appendix for Formulary*) – starter pack/initial 7 day supply, followed by monthly Acute prescription**
- **Stop any multi-vitamin & mineral tablet**
- **Give *ONS Leaflet* – continue *Food First* alongside ONS**

Patients with dysphagia who have been recommended thickened fluids by an SLT must be referred to dietetics at this stage for specialist input and consideration of a pre-thickened ONS

Refer to Appendix for guidance for carehome residents, substance misusers, TTO's & referral guidelines to dietetics

STEP 7: Reviewing Patients on ONS

- Review at least every 3 months (more frequently if clinical need, or concerns raised), reassess weight, BMI, MUST score, oral intake and aims
- Monitor compliance & assess continued need for ONS - consider referral to dietetics

Stop the prescription:

- when aims/goals are met - consider stepwise reduction if on high levels of ONS
- always review one month after stopping & continue monthly reviews if in any doubt
- if previously seen by dietetics and they have discharged care back to you, refer to guidance provided by the dietitian on discharge
- *recommend OTC ONS such as Complan® if patient wishes to continue ONS*

(Adapted from PrescQIPP B68. ONS Guidelines 2.0)

Calculating the MUST (Malnutrition Universal Screening Tool) Score

Step 1: Calculate the BMI			Step 2: % Unplanned Weight Loss (last 3-6 months)			Step 3: Acute Disease Effect
		Score			Score	
BMI > 20kg/m^2	=	**0**	< 5%	=	**0**	Has there has been or is there likely to be no nutritional intake for > 5 days? = if so Score **2**
BMI 18.5-20kg/m^2	=	**1**	5-10%	=	**1**	This can generally be omitted in community without affecting the validity of the tool
BMI < 18.5kg/m^2	=	**2**	>10%	=	**2**	

Add the scores together to produce the MUST Score and identify the level of risk
Use the *7 Steps* overleaf to guide the appropriate action according to the MUST Score
For full explanation refer to www.bapen.org.uk/pdfs/must/must-full.pdf *(full tool)*
(Refer also to Appendix 1 for further information)

Guidance for Appropriate Prescribing of Oral Nutritional Supplements (ONS) in Palliative Care

(*Adapted from PrescQIPP B68. ONS Guidelines 2.0, the Macmillan Durham Cachexia Pack 2007, and NHS Lothian Guidance)*

This is intended to help guide healthcare professionals with regard to nutritional management through the various stages of palliative care. It does not over-ride clinical judgement. Each patient is an individual and the appropriateness of ONS will be dependent on the patient's health and treatment plan. Emphasis should always be on the enjoyment of nourishing food and drinks and maximising quality of life.

Nutritional Management in Early Palliative Care

Definition: At this stage the patient is diagnosed with a terminal illness but death is not imminent. Patients may have months or years to live and they may be undergoing palliative treatment to improve quality of life.

- **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**.
- **However, if a patient is unlikely to consistently manage 2 servings of ONS per day, they are unlikely to derive any significant benefit to well-being or nutritional status from the prescription.**

Following the 7 Steps in this guideline is appropriate for this patient group – particular attention should be paid to Step 2 – Assessing the Underlying Causes of Malnutrition.

Nutritional Management in Late Palliative Care

Definition: At this stage (around the last month of life) the patient's condition is deteriorating and they may be experiencing increased symptoms such as pain, nausea and reduced appetite.

- **The nutritional content of the meal is no longer of prime importance and patients should be encouraged to eat and drink the foods 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 & carers.**

The goal of nutritional management should not be weight gain or reversal of malnutrition, but quality of life. Nutrition screening, weighing and initiating prescribing of ONS at this stage is not recommended – avoid prescribing ONS for the sake of doing something when other dietary advice has failed.

Nutritional Management in the Last Days of Life

- In the last days of life, 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 offer mouth care and sips of fluid or mouthfuls of food as desired.