RCP Ten Top Tips for Oral Nutrition

Introduction

National surveys estimate that more than three million people in the UK are either malnourished or at risk of malnutrition, of whom >90% are in the community. It is more common in women, the elderly, those with cancer and gastrointestinal or neurological problems. Malnutrition, or the risk of it, is present in approximately 30% of patients on admission to hospital or care homes, and in 20% of those admitted to mental health facilities. Nutritional status may decline further after admission to a healthcare facility due to acute illness or injury, poor appetite, dysphagia or malabsorption. Malnutrition is associated with increased morbidity, including poor wound healing, infection, muscle weakness, apathy and depression, and it results in increased lengths of hospital stay and raised mortality. Despite the well documented high prevalence of malnutrition and related poor outcomes, many surveys continue to report that medical and nursing staff still fail to appreciate the impact of poor nutrition on health outcomes and social care costs.

Key practical points

1. NUTRITION IS IMPORTANT: it improves healthcare morbidity and mortality
2. The Malnutrition Universal Screening Tool (MUST) should be used to identify malnourished or ‘at risk’ patients at admission to any healthcare facility.
3. Nutritional status should be assessed regularly in all healthcare settings
4. Refer malnourished or ‘at risk’ patients to the dietician for specialist dietary advice
5. Record food intake in malnourished or ‘at risk’ patients whilst in hospital or care-homes
6. Check that the swallowing reflex is safe to avoid aspiration (e.g. following strokes)
7. Occupational therapy assessment may be required in disabled or elderly patients (e.g. feeding aids, such as large handle cutlery)
8. ‘Red trays’, ‘protected’ mealtimes and eating assistance improve food intake in vulnerable patients
9. Consider oral nutritional supplements (e.g. ‘high calorie drinks’) if normal oral food intake remains inadequate (e.g. poor appetite)
10. Ensure community follow-up in nutritionally ‘at risk’ patients discharged from in-patient facilities

RCP Top 10 tips for oral nutrition – Long version

1. Although a basic need, nutritional status is often neglected in healthcare settings. This is not a new problem and has been reported in the medical literature for over 30 years. Malnutrition is both a cause and a consequence of illness or injury, and is associated with excess UK health-related costs of about £13 billion annually. Malnourished patients visit their General Practitioner twice as often as well-nourished equivalents and are three times more likely to be admitted to hospital, where, on average, their length of stay is three days longer and risk of infection three times greater. They also suffer higher rates of complication (e.g. impaired wound healing) and mortality. These problems arise swiftly in those with poor nutritional intake and may precede weight loss.

2. Effective, validated nutritional screening tools, (e.g. Malnutrition Universal Screening Tool (MUST)), have been developed to detect malnutrition and the risk of malnutrition. They should be used to identify malnourished patients and those at risk of malnutrition and subsequently monitor nutritional status.

3. Malnutrition, or the risk of malnutrition, is present in in approximately 30% of patients on admission to hospital or care homes, and in 20% of those admitted to mental health facilities. Nutritional status may deteriorate further during the course of admission due to acute illness, injury, poor appetite, dysphagia and malabsorption. Nutritional status should be assessed at admission in every patient admitted to any healthcare facility using a validated screening tool (e.g. MUST) and should then be reassessed at least weekly throughout admission.

4. Patients identified as malnourished or at risk of malnutrition should be referred to a dietician for specialist dietary advice. A nutritional care plan should be documented in all malnourished patients and those at risk of malnutrition on admission to hospital or care homes and regularly throughout hospital stay (as per NICE guidelines.

5. Food intake should be recorded in malnourished or 'at risk' patients whilst in hospital or care-homes. Failure to achieve the nutritional care plan objectives should be identified and appropriate actions instituted to correct the problem.

6. Occupational therapy assessment may be required for patients with reduced hand or upper limb dexterity and movement, tremor or hand deformity. Feeding aids, including large handle cutlery, may allow patients to feed themselves independently

7. The swallowing reflex may be impaired in patients with impaired consciousness (e.g. post anaesthesia), neurological disease (e.g. stroke), tracheostomies or oral trauma. In these cases the swallowing reflex must be reviewed to prevent aspiration. Where doubt exists (e.g. coughing when drinking), speech and language therapists should be asked to formally assess swallowing. Nasogastric feeding may be required until the swallowing reflex has been demonstrated to be safe.

8. Mealtimes should be 'protected' and patients must be able to easily access their food. 'Red trays' distinguish vulnerable patients who may need help with eating. Feeding protocols improve

intake in patients with dementia. Menus must provide for food preferences, ethnic and religious needs and portion sizes.

9. There is evidence for the clinical and cost benefits of oral nutritional supplements (ONS; 'high calorie drinks') as a short term treatment in disease related malnutrition. Although a 'food-first' approach should be used to prevent or treat malnutrition when there is no loss of appetite, Cochrane meta-analyses show little or no benefit from dietetic interventions when malnutrition accompanies acute illness, whereas ONS are very effective in such circumstances.

10. Before discharge, primary care healthcare services must be informed about nutritionally 'at risk' patients and the proposed dietary interventions, to ensure appropriate community follow-up.

Key references

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