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**Guidelines for the Implementation
Of Oral Nutrition Support
In Adults Across West Essex Community Health Services**

Relevant to: All Clinical Staff

Produced by:	Service Lead Nutrition & Dietetics & Community Team Leader
Responsible Executive Director:	Director of Nursing
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Chief Executive



For Office Use Only

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GUIDELINES FOR THE IMPLEMENTATION OF ORAL NUTRITION SUPPORT IN ADULTS ACROSS WEST ESSEX PCT

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These guidelines have been developed as a response to the NICE Nutrition Support in Adults Clinical Guidelines (February 2006). They intend to offer best practice advice on the screening, identification and care of adults who are malnourished or at risk of malnutrition. They replace the former Sip Feed Policy for Epping Forest, Harlow and Uttlesford PCT's.

- 1) All patients should be screened to identify those with malnutrition or at risk of malnutrition, by healthcare professionals with appropriate skills and training, using the appropriate Malnutrition Universal Screening Tool (MUST) – see appendix 1
 - 1a) All hospital inpatients and people in care homes should be screened on admission using “MUST for Community hospitals and Residential/Nursing Homes”
 - 1b) Screening should take place in the community when there is clinical concern¹ and considered at other opportunities such as health checks and flu jabs, using the “MUST for the Community”
- 2) Screening should be repeated weekly for inpatients and for any patients when there is clinical concern
- 3) For those identified with or at risk from malnutrition, first line dietary measures such as food fortification and “Food First”² should normally be recommended before sip feeds are tried
- 4) Over the counter dietary supplements such as Build Up and Complian should normally be recommended prior to sip feeds being prescribed
- 5) Sip feeds are classified as Borderline Substances and should only be prescribed on FP10 for the following: -

*Short Bowel Syndrome
Intractable malabsorption
Proven inflammatory bowel disease
Disease related malnutrition
Dysphagia
Bowel Fistulae*

*Pre-op preparation of undernourished patients
Following total gastrectomy
Patients on CAPD or haemodialysis
Paediatric growth failure*

Indications can be amended for certain sip feeds

6) Sip feeds should only be prescribed if the patient is assessed and monitored for nutritional status, preferably by a dietitian or trained health care professional. They should not be prescribed on a long term basis without regular monitoring and reassessment

7) When starting a patient on sip feeds the standard types (should be used – see appendix 2. A referral to a dietitian should be made if a specialised sip feed is required

Omit this section now – there are so many new varieties of sip feed available and commonly used it is difficult to classify some as 'standard'. When the guidelines were written this referred to 1kcal/ml varieties but these are little used/available today. We wanted to prevent something like a high protein type being used inappropriately however if point 6 is followed this would not happen.

8) Sip feeds should be taken between meals and not as a meal replacement unless indicated by a dietitian or trained healthcare professional

9) Initiation supplement trial packs should only be prescribed following recommendation of a dietitian or a trained healthcare professional

10) Samples from company representatives should not be used to initiate treatment unless recommended by a dietitian

11) Do not implement dietary measures /sip feeds if detrimental/no benefit is expected from nutritional support e.g. terminal phase of illness

Replace with:

11) Be aware that the provision of nutritional support is not always appropriate. Sip feeds should not be used for patients if detrimental to or where no benefit is expected from nutritional support e.g. terminal phase of illness thereby prolonging the dying process

¹**Clinical Concern** e.g.: unintentional weight loss; fragile skin; poor wound healing; apathy; wasted muscles; poor appetite; altered taste sensation; impaired swallowing; altered bowel habit; loose fitting clothes; prolonged undercurrent illness

²**Food First information** and the leaflet “**How to get the most out of your food**” are available from: -

Department of Nutrition, Dietetics and Healthy Living, 2nd Floor, New Building, St Margaret's Hospital, Epping, Essex, CM16 6TN

Telephone: 01279 827238

(July 2007)

APPENDIX 1

“MUST” FOR COMMUNITY HOSPITALS AND RESIDENTIAL /NURSING HOMES

“MUST” FOR THE COMMUNITY

“MUST” SCORE RECORDING SHEET

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

FOR COMMUNITY HOSPITALS and
RESIDENTIAL/NURSING HOMES



STEP 1 BMI Score *

+

STEP 2 Weight loss score

+

STEP 3 Acute disease effect score

BMI kg/m ²	Score =
> 20	0
18.5 – 20	1
< 18.5	2

Unplanned weight loss in past 3 – 6 months	
%	Score =
< 5	0
5 -10	1
> 10	2

If the patient is acutely ill AND there has been or is likely to be NO nutritional intake for > 5 days
Score 2



STEP 4 - Overall risk of malnutrition

Add scores together to calculate overall risk of malnutrition

Score 0 = Low risk

Score 1 = Medium risk

Score 2 or more = High risk

STEP 5 - Care Plan

MUST = 0 (LOW RISK) (If BMI is greater than 30 kg/m² then include a healthy eating plan)

ROUTINE CARE: -

- Repeat MUST score weekly in Community Hospitals and monthly in Residential/Nursing Homes

MUST = 1 (MEDIUM RISK)

OBSERVE: -

- Observe intake using food chart and fluid chart
- If oral intake is poor encourage oral intake, offering high calorie snacks and meals – implement "Food First"
- If there is no improvement then there is clinical concern – implement nutrition care plan
- If improved/adequate oral intake then there is little clinical concern – continue routine care
- Repeat MUST weekly in Community Hospitals, and monthly in Residential/Nursing Homes or more frequently if clinical condition deteriorates

MUST = 2 or More (HIGH RISK)

TREAT: - (Unless detrimental or no benefit is expected from nutritional support e.g. terminal phase of illness)

- Observe intake using a food chart and fluid chart
- Implement nutrition care plan
- Aim to improve and increase oral intake. This could be done by offering high calorie snacks and meals and nutritional supplements. Implement "Eat Well Tray System" and/or "Food First"
- If no improvement after 7 days (Hospital) or 4 weeks (NH), consider referral to the dietitian
- Also refer to dietitian if MUST is 3 or more and BMI < 18.5 kg/m²
- Monitor and review care plan weekly in Community Hospitals and monthly in Res/Nursing Homes

*If height, weight or BMI cannot be obtained due to strict bed rest, the following criteria can assist your professional judgement of the patient's nutritional risk: -

a) BMI

Clinical impression – thin; acceptable weight; overweight. Obvious wasting (very thin) and obesity (very over weight) can also be noticed.

b) Unplanned weight loss

Clothes and/jewellery have become loose fitting

History of decreased food intake, reduced appetite or swallowing problems over 3 – 6 months, and underlying disease or psycho-social/physical disabilities are likely to cause weight loss

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

FOR THE COMMUNITY

STEP 1 BMI Score *

BMI kg/m ²	Score =
> 20	0
18.5 – 20	1
< 18.5	2

+

STEP 2 Weight loss score

Unplanned weight loss in past 3 – 6 months	
%	Score =
< 5	0
5 -10	1
> 10	2

+

STEP 3 Acute disease effect score

If the patient is acutely ill AND there has been or is likely to be NO nutritional intake for > 5 days
Score 2



STEP 4 - Overall risk of malnutrition

Add scores together to calculate overall risk of malnutrition		
Score 0 = Low risk	Score 1 = Medium risk	Score 2 or more = High risk

STEP 5 - Care Plan

<p>MUST = 0 (LOW RISK) (If BMI is greater than 30 kg/m² then include a healthy eating plan)</p> <p>ROUTINE CARE: -</p> <ul style="list-style-type: none"> Repeat MUST score annually for at risk patients e.g. those over 75 yrs People with neurological degenerative diseases need to be monitored every 4 months
<p>MUST = 1 (MEDIUM RISK)</p> <p>OBSERVE: -</p> <ul style="list-style-type: none"> Observe intake using food chart and fluid chart If oral intake is poor encourage, offering high calorie snacks and meals – implement "Food First" If there is no improvement then there is clinical concern – implement nutrition care plan If improved/adequate oral intake then there is little clinical concern – continue routine care Repeat MUST at least every 2 – 3 months
<p>MUST = 2 or More (HIGH RISK)</p> <p>TREAT: - (Unless detrimental or no benefit is expected from nutritional support e.g. terminal phase of illness)</p> <ul style="list-style-type: none"> Observe intake using a food chart and fluid chart Implement nutrition care plan Aim to improve and increase oral intake. This could be done by offering high calorie snacks and meals and nutritional supplements. Implement "Food First" If no improvement after 4 weeks refer to the dietitian Also refer to dietitian if MUST is 3 or more and BMI < 18.5 kg/m² Monitor and review care plan monthly

*If height, weight or BMI cannot be obtained due to strict bed rest, the following criteria can assist your professional judgement of the patient's nutritional risk: -

a) BMI

Clinical impression – thin; acceptable weight; overweight. Obvious wasting (very thin) and obesity (very over weight) can also be noticed

b) Unplanned weight loss: -

Clothes and/jewellery have become loose fitting

History of decreased food intake, reduced appetite or swallowing problems over 3 – 6 months, and Underlying disease or psycho-social/physical disabilities are likely to cause weight loss

MUST Score Recording Sheet

Name:	Usual weight (kg)
Location:	Height (m)

Date	Weight A = Actual E = Estimated U = Unable to weigh – with rationale	Step 1		Step 2		Step 3 Acute disease score	Step 4 MUST score = 1+2+3	Risk 0 = Low 1 = Medium 2 = High	Print and sign name
		BMI kg/m ²	Score	Weight loss %	Score				

Date	Step 5: Action taken	Review Date

APPENDIX 2

EXAMPLES OF STANDARD SIP FEEDS

Fortisip

Ensure

Fresubin

Clinutren

Complan Shake

Fortifresh

Fortijuice

Enlive Plus

Omit this appendix completely. The names and types are out of date. It also links to item 7 in the guidelines which we also want to omit now. It would be difficult to produce or update this list now due to varieties of sip feeds available and any such list would be quickly out of date.