# The Management of Malnourished Adults in All Community and All Health and Care Settings

## Policy Statement

This policy statement is to highlight the growing issue of malnutrition and the integral role of dietitians in addressing the nutritional care of vulnerable populations specifically in community health and social care settings.

## Summary

Dietitians have the expertise both at an individual patient and strategic level to identify, assess, care plan, treat, monitor and review individuals to achieve patient-centred outcomes, and train others to prevent and treat malnutrition. The BDA believes that high quality nutrition and meeting the nutritional, clinical and personal needs of all, must be a priority for all involved in health and social care. The potential for good nutrition to improve the health of the vulnerable population is huge and well documented. Malnutrition* should not be, but is, a very real and current problem in the UK population with national surveys showing that prevalence of malnutrition is still unacceptably high [1-5].

The recent Global Nutrition Report (2016) [7] highlighted the urgent need to end all forms of malnutrition by 2030, given the significant social and economic burden it brings. From a UK perspective, it is estimated that over 3 million people are malnourished or at risk of malnutrition [8]. National UK surveys [1-5] show that malnutrition is costly with the estimated cost of malnutrition continuing to increase (over 7.3 billion in the UK in 2003, over 13 billion in the UK in 2007 and approximately 19.6 billion in England 2011-2012 equating to approximately 15% of the health and social care budget [9]. Nutritional support in adults was ranked as the third highest cost saving intervention (£71,800 per 100,000 general population), associated with implementation of NICE Clinical Guideline (CG32)/Quality Standard (QS24) [9].

*Malnutrition can refer to both over and under nutrition. In this policy statement, malnutrition refers to under nutrition; *"a deficiency of energy, protein and other nutrients that causes adverse effects on the body (shape, size and composition), the way it functions and clinical outcomes"* [6]. Malnutrition may be social-related (e.g. poverty, isolation) or disease-related (e.g., cancer, inflammatory bowel disease, chronic obstructive pulmonary disease)

There have been significant advances in the status of food in community healthcare settings as nutrition is recognised as key to the health and wellbeing of patients and residents. However as recent high profile enquiries have shown, there is still much to do, including early intervention by building sustainable support in the community. Menu planning, nutrient density, quality of meals, and access to food and hydration all require a coordinated approach. Data demonstrates over 90% of those either malnourished or at risk of malnutrition live in the community. In care homes, the prevalence of malnutrition was reported to be 36% and 24% in older adults and younger adults, respectively [9]. It is therefore essential to address the whole spectrum of nutritional care through strategies that prevent, detect and treat malnutrition in community healthcare settings. The overall cost of treating a malnourished patient is two to three times more than treating a non-malnourished patient [9], with consequences including reduced wound healing, increased risk of infections and complications, and increased number of hospital stays and GP visits. National guidance stressing the importance of providing good nutritional care locally has been developed across the four home countries [10-14]

The BDA believes that dietitians are ideally placed to liaise with healthcare services and social care services to ensure that vulnerable individuals living independently have access to nutrition support services.

The BDA recommends that:

i) Everyone should have access to a nutritious, high quality diet that meets their individual nutritional requirements and for those unable to meet their nutritional requirements through food alone to have timely access to nutrition support. Systems must be in place in the community health and social care settings to identify and support those at risk of a sub-optimal diet and hydration.

ii) Dietitians should lead the coordinated and integrated approach to addressing the nutritional care of vulnerable populations in community health and social care settings. Dietetic-led nutrition support services are best placed to develop and initiate the correct evidence-based nutritional care policies and guidelines and ensure that those at risk of malnutrition (social or disease-related) are identified and managed appropriately; including those individuals with psycho-social related malnutrition.

iii) Commissioners recognise the value and potential cost savings of preventing malnutrition and ensure they commission services that ensure all people identified as being at risk of malnutrition to be offered nutrition support interventions that aims to meet personalised nutritional requirements.

iv) All public sector catering specifications, including the NHS, and care homes have a requirement to meet nutritional standards suitable for the setting and the population they are serving. This should be supported by appropriate expertise from dietitians, caterers and procurement professionals.

## Discussion

i) Everyone should have access to a nutritious, high quality diet that meets their individual nutritional requirements and for those unable to meet their nutritional requirements through food alone to have timely access to nutrition support. Systems must be in place in the community health and social care settings to identify and support those at risk of a sub-optimal diet and hydration.

The United Nations Human Rights Council states that everyone has ‘the right to have regular, permanent and free access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensures a physical and mental, individual and collective, fulfilling and dignified life free of fear’ [14].

The recent Adult Social Care Funding: 2016 State of the Nation Report [15] highlighted the drastic reductions in funding since 2010 which impacts upon the most vulnerable in society. If left untreated, malnutrition can further predispose already vulnerable individuals to an increased risk of disease-related outcomes which further affects wellbeing. Additionally, less attention to nutritional care due to reduced funding in social care has implications for the future by potentially exacerbating the malnutrition problem at a later date.

ii) Dietitians should lead the coordinated and integrated approach to addressing the nutritional care of vulnerable populations in community health and social care settings. Dietetic-led nutrition support services are best placed to develop and initiate the correct evidence-based nutritional care policies and guidelines and ensure that those at risk of malnutrition (social or disease-related) are identified and managed appropriately; including those individuals with psycho-social related malnutrition.

"*There is an urgent need to provide funding for dietetic services nationwide, this approach could* be *cost effective if the dietetic service were to replace current consultant capacity"*
British Society of Gastroenterology [16]

Dietitians have an important role in developing strategy and pathways for the prevention and management of malnutrition [17]. Dietitians have the skills, knowledge and expertise to lead the workforce and training development of health and social care professionals to ensure that the practical tools are available to plan, manage, monitor and evaluate services for the nutritionally vulnerable at population or individual level and across the health and social care settings. Focus on raising awareness amongst those who are at-risk of becoming nutritionally vulnerable and/or their carers is essential to enable a preventative, early intervention approach. For example, self-management strategies enabling those at-risk and their carers to understand the role good nutritional care can have in their health and wellbeing. Furthermore, increasing the provision of dietetic-led nutrition support services may help tackle this issue. Examples of this include the Focus on Undernutrition initiative (2012) and the Malnutrition Prevention Programme (2012) [18, 19].

**Example 1**
Focus on Undernutrition
http://www.focusonundernutrition.co.uk/home

The 'Focus on Undernutrition' initiative has enabled County Durham and Darlington to lead the way nationally on identifying and treating undernutrition from a regional perspective.

**Example 2**
Malnutrition Prevention Programme
http://www.malnutritiontaskforce.org.uk/

Overseen by the Malnutrition Task Force, the aim is to help one million older people in England who are suffering or at risk of malnutrition through a whole community approach involving local NHS trusts, hospitals, GP practices, care homes and community groups.

Dietetic-led services must audit their approaches to tackling malnutrition (e.g., screening, appropriate prescribing of oral nutritional supplements (ONS), outcome data) (BAPEN Nutrition Care Tool) [20].

iii) Commissioners recognise the value and potential cost savings of preventing malnutrition and ensure they commission services that ensure all people identified as being at risk of malnutrition to be offered nutrition support interventions that aims to meet personalised nutritional requirements.

Screening and early intervention in those identified as being at risk of malnutrition, have been shown to be cost-effective approaches in the prevention and treatment of malnutrition [17, 21-26]. Additionally, regular screening and monitoring, and investment in services (e.g. meals on wheels/community meal services) all allow for saving opportunities [27].

The problem of malnutrition needs to be tackled at every level of health and social care provision [28, 29]. Commissioners need to ensure that the funding is available for all stages of the 'malnutrition journey' from prevention, detection, diagnosis, treatment and monitoring [25, 30]. Dietitians have the skills and knowledge at a local level for planning (assessment of social and healthcare need and comparison with existing service provision), procuring services (services designed to meet the local need) and monitoring and evaluation (delivering against desired outcomes and evaluating impact of service) [31].

Inevitably, there will be times when food alone, however nutritious, will not be sufficient to prevent or treat malnutrition. Anyone unable to meet their nutritional needs through food due to clinical reasons should have timely access to a dietetic-led nutrition support service. Criteria set out by the ACBS indicates where ONS should be prescribed. Appropriate prescribing of ONS and the importance of high quality nutrition on clinical, functional and health economic benefit cannot be underestimated [23-26].

Commissioned services need to provide quality outcome data to demonstrate safe, clinically and cost effective nutrition support is being provided that meets the patients individual needs (The BDA's Parenteral and Enteral Nutrition Group (PENG) Dietetic Outcomes Toolkit) [32].

iv) All public sector catering specifications, including the NHS and care homes have a requirement to meet nutritional standards suitable for the setting and the population they are serving. This should be supported by appropriate expertise from dietitians, caterers and procurement professionals.

Each country within the UK, has a framework for developing catering and pharmaceutical specifications and monitoring services to meet the nutritional standards for nutritionally vulnerable people in hospital and care settings [33-37].

**Example 3**

The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services

The Food Services (Formerly Food Counts) Specialist Group of the BDA published 'The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services' which provides detailed information on the evidence and best practice to implementing effective food services in hospitals and care settings [28]. The Food Services Digest Team also played a crucial role in the development of the National Association of Care Caterers Nutritional Standards for Adults, which sets nutritional standards for people in care homes on a parity for hospital services, thus enabling CQC expectations of food and beverage services meet a like standard across the health and social care estate [38].

## Conclusion

Dietitians positively impact upon nutritional and hydration status, and other health outcomes including patient wellbeing, patient self-confidence and self-management, patient function (i.e. activities of daily living) and bowel function. Notably, many symptoms that patients experience (e.g, nausea, swallowing problems, taste changes) are treatable with nutrition intervention. With the addition of dietetic-led local services, patient's risk of malnutrition will be minimised. Through the expertise and leadership of dietitians, the integration of nutrition into local care pathways (including those for long-term conditions) for all community health and social care settings is possible. It costs more not to treat malnutrition than to treat malnutrition [9, 20] and it is essential that the correct dietetic involvement is accessed locally to ensure the implementation of an evidence-based management of a malnutrition pathway [10-13].

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