Management of Undernutrition in Adults

Best Practice Document for Dietitians
Management of Undernutrition in Adults
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Summary

The aim of the management of adult patients with undernutrition is to facilitate the identification of patients at risk of undernutrition, provide systematic care and ensure appropriate prescribing of oral nutritional supplements (ONS) for all patients. This applies to all members of the multidisciplinary team and Registered Dietitians. This resource in conjunction with NHS Lothian MUST Resource pack will be used to manage patients at risk of undernutrition.

- The recommended screening tool for use is the Malnutrition Universal Screening Tool (MUST), BAPEN 2003.
- All dietetic documentation should be completed using the standard proformas/minimum data fields.
- Treatment goals should be identified and agreed with the patient before any intervention takes place.
- Dietary counselling should be the initial nutritional intervention and should continue if ONS are required (either over-the-counter e.g. Build-Up®/Complan® or prescribable items e.g. Clinutren1.5®/Fortisip®).
- Regular review of patient goals, including review of MUST score should take place as set out in the resources.
- Final patient outcomes should be completed on discharge and the GP informed.

Prescribing of Oral Nutritional Supplements

Following the results of 2 projects carried out in Lothian in 2001 and 2004 to look at the issues of inequity, access, clinical and cost effectiveness in the management of community patients at risk of undernutrition the following guidelines were developed.

These guidelines reflect the current Best Procurement Initiative (BPI) and local contract within Lothian

- The Advisory Committee on Borderline Substances (ACBS) recommends products on the basis that they may be regarded as drugs for the management of specified conditions. Doctors should satisfy themselves that the products can be safely prescribed, that patients are adequately monitored and where necessary, expert supervision is available.
- Oral Nutritional Supplements should be commenced on the advice of a Registered Dietitian.
- Where appropriate a 1.5kcal/ml supplement rather than a 1.0kcal/ml supplement should be prescribed.
- Only 1.5kcal/ml ONS are included in the Lothian Joint Formulary – Clinutren 1.5, Clinutren Fruit, Fortisip Bottle and Fortijuce. All are available in 200ml volumes and in a broad range of flavours.
- The patient should be advised that the use of ONS will initially be for a trial period of up to 3 months to assess if there is any benefit.
- Patient preference will be established by providing the patient with a selection of supplements to try as per the Lothian Joint Formulary
Patients referred to the dietitian will be provided with 7-days initial supply of ONS. Only after the patient confirms they can tolerate ONS will the dietitian request an ONS prescription from the patient’s GP.

The Dietitian should request a prescription for an initial four-week supply of ONS from the GP.

The Dietitian will advise on the schedule for administration to support maximum nutritional intake.

The Dietitian should continue to assess the need for patient’s on-going ONS prescription.

ONS should not be routinely placed on repeat prescription.

Patients should not receive ONS prescribed for other patients.
SECTION ONE

Dietetic Intervention
Introduction

This resource has been developed as part of a Lothian wide project to take forward and co-ordinate the management of oral nutritional supplements (ONS) throughout Lothian. It has been developed by a group of dietitians working in both primary and secondary care and is based on supportive evidence where available. Where no evidence exists, best practice as determined by the working group and the Scottish Dietetic Prescribing Group (a group of dietitians working specifically in this topic) has been used. Additionally, evidence from practice questionnaires undertaken as part of a project in 2004 directed the development of the resource.

Although dietitians are specialists in nutrition, a team approach is necessary to tackle nutritional problems. (1) A report from the Royal College of Physicians stated that ‘nutrition is part of good clinical practice’ and that ‘nutritional care should always be addressed as part of the patient’s overall management’. (2, 3) Primary care is seen as an ideal setting for the opportunistic delivery of dietary advice (4), and whilst traditionally advice has centred on the prevention and treatment of obesity, coronary heart disease and diabetes, data collected on practice within Lothian confirmed that 89% of the Primary Health Care Team (PHCT) offer 1st line dietary advice to patients at risk of under-nutrition. Primary care is a particularly good setting to tackle under-nutrition as the prevalence has been estimated at 10% with a further 18-32% of the population at risk. (5) This proportion is likely to increase as the emphasis for care continues to shift from secondary to primary care. It is therefore essential that the community setting has measures in place to identify and manage these patients to ensure that the incidence of undernutrition is reduced, ONS are more appropriately prescribed and admissions to secondary care as a result of undernutrition are reduced. (6)

Nutritional screening refers to a rapid, general, often initial evaluation undertaken by nurses, medical staff or any healthcare worker, to detect significant risk of malnutrition and to implement a clear plan of action such as simple dietary measures or referral for expert advice. (7) Nutritional assessment is a more detailed, more specific and more in-depth evaluation of nutritional status by an expert, so that specific dietary plans can be implemented, often for more complicated nutritional problems. Screening for undernutrition and the risk of malnutrition should be carried out by healthcare professionals with appropriate skills and training. (1) The recommended screening tool for use within acute care, community settings and in Care Homes is the Malnutrition Universal Screening Tool - ‘MUST’ (BAPEN 2003) (Appendix 1) As this is a national tool which has been validated in all settings, it is anticipated that an individual’s ‘MUST’ score will follow them through all care settings and enable comparisons to be made. Criteria for screening include new patient registrations and vulnerable groups such as chronic diseases/wounds, the elderly, neurological conditions, mental health impairment and substance misuse.

Whilst based on the management guidelines suggested by ‘MUST’ the NHS Lothian MUST Resource Pack has been adapted for local use by a nurse led working group. Most patients at medium risk will have patient goals set and 1st line dietary advice from the Multi Disciplinary Team (MDT). Those patients referred to Lothian Dietitians for a nutritional assessment will have been appropriately screened using MUST. MUST will also be used by members of the MDT, including dietitians, when reviewing patients.

Nutritional care is frequently inadequate because of diffuseness of responsibility, lack of an integrated infrastructure for dealing with nutritional problems within and between different healthcare settings, poor education and lack of consistent criteria to identify and treat undernutrition. The development of this best practice document for dietitians and the NHS Lothian Must Resource Pack will begin to address these issues.
Management of Undernutrition in Adults

**Dietetic Intervention**

On receipt of referral from any member of the MDT, Dietitians will prioritise referrals for patients with malnutrition and provide the following assessment and intervention according to the care pathways for hospital and for community.

**Community Dietetic Care Pathway for Undernutrition**

**Dietetic referral received**

- **Assess patient**
  - dietary advice
  - OTC supplements given

- **Establish treatment plan and goals**
  - supplements recommended and commenced

- **Appropriate assessment letter to referrer**

- **Consider follow-up options**
  - self monitoring or monitoring by GP/PN/HV

- **Appropriate discharge letter to referrer**

- **Assess progress against goals**
  - goals achieved
  - not achieved

- **Consider alternative intervention**
  - appropriate
  - not appropriate

- **Dietetic referral received for review**

**Letter to referrer to consider further investigation**

**Legend**

- GP = General Practitioner
- PN = Practice Nurse
- DN = District Nurse
Hospital Dietetic Care Pathway for Undernutrition

1. Dietetic referral received
2. Assess patient
   - dietary advice given
   - supplements recommended and commenced
3. Establish treatment plan and goals
4. Document in case record
5. Diagnose progress against goals
   - goals achieved
   - goals not achieved
6. Discharge to Community Dietetic Service or follow-up at Hospital OP
   - yes
   - no
7. Patient scheduled for Hospital discharge & ONS to continue
   - appropriate
   - not appropriate
8. Consider alternative intervention
9. Discuss with referrer to consider further investigation
**Dietetic Assessment**
Below is the minimum data set that must be recorded by the dietitian, either electronically or written in patients dietetic records within the legal medical record. (See Health Professions Council Standards of Proficiency for Dietitians July 2003 and BDA Code of Professional Conduct section 3.4, May 2004) The documentation must demonstrate from the assessment what has influenced the dietitian’s decision in terms of treatment.

<table>
<thead>
<tr>
<th>Initial Assessment</th>
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<tbody>
<tr>
<td>• Referral date</td>
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<tr>
<td>• Date seen</td>
</tr>
<tr>
<td>• Location of consultation</td>
</tr>
<tr>
<td>• Referral details (referrer, reason for referral, diagnosis, presenting problems, MUST score, previous medical history)</td>
</tr>
<tr>
<td>• Patient details (Name, address, DOB, CHI number, telephone contact number(s), GP and practice name)</td>
</tr>
<tr>
<td>• Relevant physical impairment e.g. communication</td>
</tr>
<tr>
<td>• Social history</td>
</tr>
<tr>
<td>• Relevant Biochemistry</td>
</tr>
<tr>
<td>• Relevant Medications</td>
</tr>
<tr>
<td>• Anthropometry (weight, height, BMI, %wt loss over time, MUST score)</td>
</tr>
<tr>
<td>• Diet history and calculation/estimate of intake</td>
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<tr>
<td>• Agree aim of treatment (e.g. optimal management of nutrition related symptoms, maintain/improve nutritional intake, weight stabilisation, weight gain, minimise weight loss)</td>
</tr>
<tr>
<td>• Targets agreed with patient/carer in terms of food, fluid, specific ONS, enteral, parenteral</td>
</tr>
<tr>
<td>• Follow up arrangements</td>
</tr>
<tr>
<td>• Discharge plans</td>
</tr>
<tr>
<td>• Communication with referrer (standard letters)</td>
</tr>
<tr>
<td>• Details of ONS trial if appropriate</td>
</tr>
<tr>
<td>• Signature</td>
</tr>
<tr>
<td>• Name in block capitals</td>
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<tr>
<td>• Designation</td>
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</tbody>
</table>
Below is the minimum dataset that must be recorded by the Dietitian or Dietetic Support Worker either electronically or written in patients dietetic records within the legal patient medical record. (See Health Professions Council Standards of Proficiency for Dietitians July 2003 and BDA Code of Professional Conduct section 3.4, May 2004, Dietetic Support Worker Guidance Document BDA 2006)

**Initial Assessment**

- Date seen
- Location
- Patient details (name, DOB, CHI)
- Anthropometry (weight, weight change, BMI)
- Dietary intake
- Progress towards agreed goals/outcome
- Review of MUST score
- Review arrangements/follow up
- Communication with referrer
- Name in block capitals
- Designation
- Signature
Setting patient goals
It is important that patient goals of dietary intervention are agreed with the patient and are specific, measurable, achievable, realistic and time limits set (SMART). Dietetic goals are based on the initial assessment and clinical judgement and for ONS can be specified as: optimal management of nutrition related symptoms, improve nutritional intake, weight stabilisation, weight gain, minimise weight loss, improve well being.

Can patient meet estimated requirements and patient goals by food alone?
In routine practice, dietary counselling to improve nutritional intake is often recommended as the first line of nutritional intervention, prior to using ONS or in combination with ONS. (8) Whilst a combination of dietary counselling or fortification of the diet can be effective at improving intakes of energy and to a lesser extent protein (particularly in institutionalised patients), the impact on functional and clinical outcome measures has not been widely studied. (8) However, despite a scarcity of evidence in this area it is well recognised that food provides more than simply nutrition - ‘food and the act of eating provide biochemical, physiological and psychological benefits that supplements do not’. (9) It is therefore recommended that current practice by providing first line dietary advice continue using ‘Nourishing Ideas’ and ‘Nourishing drinks’ leaflets. It may also be appropriate to direct patients and their carers towards other areas of support e.g. lunch clubs and cooking classes. Other opportunities for dietary support may arise if within localities dietetic support workers are employed. Initial Assessment should be documented in case records and/or Assessment Letter A (see documentation section) should be sent to the referrer after this assessment and copied to the GP where appropriate.

Review
MUST indicates weekly review in hospital and monthly review in community if patient is at risk. This is felt to be sufficient to evaluate any changes the patient has made or is likely to make, but is sufficiently short to minimise further deterioration in nutritional status if goals are not being achieved. It is recognised that time scales may be difficult to achieve within current dietetic resources but they are felt to represent best practice. Where review guidelines are not being met these must be audited to provide evidence to support additional resources. For some patients it may be felt that a review is unnecessary and that self-monitoring goals can be set. It has been suggested that health professionals should assume considerably more active advocacy for patient self-management. (10) Chronic disease management e.g. diabetes & asthma, is increasingly using this concept with some success. The decision whether a patient requires review or can self-monitor will depend on each dietitian’s clinical judgement. Review of patients can also be managed by other members of the MDT, if felt appropriate.

Self Monitoring Goals
The patient should be empowered to agree to self monitoring goals wherever possible whether or not they continue to have dietetic follow-up. Clear dietary targets should be discussed and recorded using appropriate patient information leaflets e.g. Nourishing Ideas. Targets for weight should also be discussed and the patient should be given details of who to contact if goals are not being achieved.
Progress towards patient goals and targets
If at review the patient has made progress towards their agreed goals it is suggested that patient self monitoring goals are set and the patient is discharged. Document results of review in case notes and/or Discharge letter (see documentation section) is sent to the referrer and copied to the GP where appropriate.

As is the case for the whole of the resource, this guidance does not replace clinical judgement and there may be occasions when it is felt inappropriate to set patient self monitoring goals e.g. if the patient is unable to take on this level of responsibility. Further reviews by the Dietitian, Dietetic Support Worker or other member of MDT would then be appropriate until patient goals are achieved in full.

Setting patient goals

No progress towards patient goals and targets
Dietitians should refer to the care pathway which involves consideration of alternative interventions. The first stage of the pathway proceeds to consider the use of over the counter products (OTC) in patients who have failed to progress towards their agreed patient goals after 1st line dietary advice. These may also be commenced at initial assessment if it is felt that the patient is unable to meet estimated requirements and care aims by food alone.

Can patient use over the counter products?
The success of oral supplementation depends on sufficient quantities being consumed over an extended period of time: therefore acceptability and palatability of ONS are key factors in their effectiveness.(11) Whilst the nutritional profile of OTC products is slightly inferior to many of the prescribable products, OTC products may often be sufficient when combined with 1st line dietary advice.

OTC products are now available in a wide range of formulations e.g. shakes, soups, custard, oats, and hot chocolate. When recommending their use, consideration should be given to factors such as whether the patient is able to purchase the product and correctly make it up. Assessment Letter B (see documentation section) should be sent to the referrer after this assessment and copied to the GP where appropriate.

Review
Review patients within one week in hospital and at 4 weeks in community or set self monitoring goals and discharge.

Progress towards patient goals and targets
If at review the patient who has been advised additionally on the use of OTC products has made progress towards their agreed goals it is suggested that patient self-monitoring goals are set. The patient should then be discharged and Discharge Letter (see documentation section) sent to the referrer and copied to the GP where appropriate. Again there may be occasions when it is felt inappropriate to set patient self-monitoring goals and these patients should be monitored by Dietitians, Dietetic Support Workers or member of MDT until patient goals achieved in full.

No progress towards patient goals and targets
The pathway then considers the use of prescribable ONS in patients who have failed to progress towards their agreed goals after both 1st line dietary advice and OTC products. These may also be commenced at initial assessment if it is felt that the patient is unable to meet estimated requirements care aims by food and OTC products alone.
Guidelines for Starting ONS in the Community
The evidence for the benefits of ONS continues to grow. The following table summarises the evidence base for using ONS.

<table>
<thead>
<tr>
<th>Use of ONS can improve energy and nutrient intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONS can increase total energy, protein and micronutrient intakes across a variety of patient groups. The mean increase in total energy intake was equivalent to 69% of the ONS energy but the increase was 83% in patients with a BMI &lt; 20.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Use of ONS can improve body weight</th>
</tr>
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<tbody>
<tr>
<td>Mean weight changes were greater in patients with a BMI &lt; 20.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of ONS can improve functional outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional improvements varied according to patient group and included improvements in respiratory muscle function and walking distances in COPD and increases in activities of daily living and less falls in the elderly. Functional benefits were more likely in patients with a BMI &lt; 20.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of ONS can improve clinical outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONS may improve clinical outcomes, reducing rates of infection, the frequency of hospitalisation and reducing the length of hospital stay but there is a lack of information about the clinical and cost effectiveness of ONS use in the community setting.</td>
</tr>
</tbody>
</table>


Results from practice questionnaires indicate that dietitians’ use of ONS is very similar. These guidelines merely formalise current practice and provide evidence for the decision making process for use of ONS to other members of the MDT.

Dietetic assessment will highlight:
- Requirements for additional calories, protein, micronutrients, fibre and fluid
- Inability to make up deficit with food and OTC products
- Ability to prepare powders
- Patient preference

Patients should be given an initial supply of appropriate prescribable ONS as per the Lothian Joint Formulary Guidelines. (See Appendix 2) The NHS Lothian University Hospitals Division (LUHD) ‘Policies and Procedures for Medicines’ states that ‘staff in wards or other clinical areas must not accept medicine samples, including dressings, directly from a company medical representative’. All samples must have a robust audit trail.

Once the decision has been made that the patient may benefit from ONS this should be carefully discussed with the patient. It should be stressed that products will be commenced on a trial basis only for up to 3 months. This is in recognition that it can be difficult to persuade some patients to discontinue ONS, even if their use has been ineffective, particularly if they enjoy them.
The ‘ONS Trial Checklist’ (section 4) can be completed and left with the patient. A phone call should then be made within 5 working days to assess patient preference. Assessment Letter C (see documentation section) should then be sent to the GP detailing prescription request. If the patient dislikes all trial supplements alternative products should be trialled and the process repeated.

**Review**

Review at 4 weeks to check progress towards patient goals.

**Progress towards patient goals and targets**

The patient’s on-going need for ONS should continue to be assessed and monitored. This can be carried out by the dietitian or any member of the MDT with dietetic guidance via phone, home visit or clinic appointment. Good communication will be required between the dietitian and other members of the MDT. This is in recognition of the fact that without adequate monitoring patients may continue to receive ONS inappropriately. Additionally there is evidence that long term use of ONS in those with chronic disease, food and total energy intake may decrease with the cost of the ONS effectively equivalent to ‘purchasing’ food.(7) The 2nd review for a patient on ONS is recommended to take place within 2 months. The exact timing of reviews will depend on the individual and the clinical situation. Patient self-monitoring goals should be set so that the patient knows to make contact between reviews if their progress is halted for any reason. Reviews should continue every 6 months as long as ONS are prescribed. When goals are achieved ONS should be discontinued.

**Guidelines for discontinuing ONS**

(Adapted from Grampian Integrated Nutrition Service)

Taking ONS on a long term basis can be monotonous and may lead to flavour and taste fatigue. The evidence suggests that the increment in energy intake accompanying ONS is often not sustained once ONS are stopped, with energy values typically returning to baseline.(7) When the goals for prescribing ONS have been achieved or their use considered ineffective, ONS should gradually be reduced using a step-by-step approach.

- Review the patient goals and targets initially set with the patient
- Discuss with the patient the next stage i.e. the plan for reducing ONS until discontinued completely
- Reduce the amount of supplement e.g. if patient has been taking 2 cartons then reduce to 1, if taking 1 then reduce to alternate days
- Offer advice on foods that contain approximately the same amount of calories as a 1.5kcal/ml ONS
- Remind the patient that OTC products have almost the same calories as most prescribable ONS

Review the patient at 4 weeks and once ONS have been fully discontinued and goals are maintained, patient self-monitoring goals should be set as before, Discharge Letter (see documentation section) sent to the GP, copied to the referrer where appropriate and the patient discharged.
If goals are not being maintained check that food first advice is still being followed, reinforce the addition of calories and protein from food and fluid and consider the reintroduction of ONS. Continue to review the patient 6 monthly.

**No progress towards patient goals**

Despite the evidence of benefit for ONS, not all patients receiving them make progress towards their goals. If this is the case, underlying condition effects should be considered and patient goals may need to be altered. Dietary advice should be reinforced and targets adjusted or the type and volume of ONS changed to aid compliance. A further review should then be arranged within 4 weeks.

If the patient continues to make no progress despite the above interventions, ONS use may be considered ineffective and alternative intervention considered. If not appropriate further investigations of undernutrition may need to be considered at this stage. Dietitian should complete **Review Letter** (see documentation section)
Guidelines for Starting ONS in Hospital

Once the decision has been made that the patient may benefit from ONS this should be discussed with the patient and ward staff. Patient preference should be taken into account and supplies offered as per the Lothian Joint Formulary (see Appendix 2).

Review

Review within one working day to check patient acceptance and preference. The prescription will be documented by the dietitian in the patient’s ONS kardex (see documentation section). The ONS Kardex is only to be used by the dietitian as per the following guidelines:

- The form should be used within Drug Kardex, Nursing Notes or appropriate for your clinical area.
- On the front of the Drug Kardex form (bottom left) in the box referring to other kardexs in use, Date and write Nutritional Supplement/Products kardex.
- Dietitian (or student if signature counter signed) will complete all relevant sections on the form.
- It is usually expected nursing staff will sign and date to confirm prescription given; however local policy may support signing by other staff such as support workers.
- If alternative time is needed, other than offered on form, then score out nearest time and write desired time using 24hr clock beside it.
- Supplies of form are available from the NHS Lothian Stationary stores based at Prestonpans. It has been printed on card to be more durable.
- The form is double-sided with 14 days on each page; so all in-patients will require review, at a maximum of 28 days.

Progress towards patient goals and targets

The patient’s on-going need for ONS should continue to be assessed and monitored. This can be carried out by the dietitian or any member of the MDT with dietetic guidance.

No progress towards patient goals

Despite the evidence of benefit for ONS, not all patients receiving them make progress towards their goals. If this is the case, underlying condition effects should be considered and patient goals may need to be altered. Dietary advice should be reinforced and targets adjusted or the type and volume of ONS changed to aid compliance. If the patient continues to make no progress despite the above interventions, ONS use may be considered ineffective. Alternative intervention should be considered. If not appropriate further investigations of undernutrition may need to be considered at this stage.

Patient discharged from hospital on ONS

Plans for discharge from hospital should include assessing the need for ONS to continue. If ONS are to be continued on discharge from hospital and community dietetic follow-up is required contact the community dietitian by phone to discuss and complete Hospital Discharge Letter (see documentation section). If patient remains under hospital follow up arrange hospital out patient appointment and send Hospital Discharge Letter to GP.
Patient Did Not Attend (DNA)
If a patient fails to attend their dietetic appointment when receiving ONS, telephone contact should be attempted to establish why the patient did not attend and the patient offered another appointment or a home visit may be required. If no telephone contact is made Patient DNA Letter (see documentation section) should be sent to the patient and copied to the GP. This letter emphasises the importance of dietetic review to the patient and asks them to arrange another appointment. If they fail to make contact within the specified time DNA GP letter should be sent to the GP and copied to the patient.
SECTION TWO

Cancer Palliative Care Guidelines

These guidelines are intended to assist with the Primary Health Care Teams nutritional management of cancer patients with palliative care needs.
Background
‘Palliative care is the active total care of patients whose disease is not responsive to curative treatments. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.’ (12) The following were produced in 2004 to support the Lothian Palliative Care Group Guidelines.

Palliative care encompasses more than just the terminal care of the patient. For the purposes of these guidelines the following terms have been used:
- Early palliative care
- Late Palliative care
- Last days of life

Nutritional Care
Nutrition is not only about refuelling the body with appropriate nutrients; food plays an important psychological, social, spiritual and cultural role and as such plays an integral role within palliative care. Eating should be a pleasurable experience that promotes psychological comfort, communication and social interaction. Eating can also provide a sense of autonomy and normality and can be viewed as a therapy in itself. (13)

Symptoms of the disease (e.g. cachexia syndrome, taste changes, dysphagia, nausea, vomiting, diarrhoea) and possible treatments and medication (e.g. palliative radiotherapy, opioids) may all affect the quantity and quality of food consumed. Three quarters of palliative care patients will be undernourished and this has been shown to detrimentally impact on survival and quality of life. (14)

Additionally, both patients and carers cite weight loss as one of the most troubling symptoms of the disease, causing considerable anxiety and distress. (15, 16) Factors such as symptom relief, eating environment, social and emotional factors should take priority to ensure that eating is a pleasurable experience for the patient in the palliative stage of the disease.

Oral nutritional supplements are commonly used in the treatment of palliative care patients. However a systematic review of the use of ONS in cancer patients has highlighted the need for further research on both structural and functional measures and clinical outcome (8). Where information has been provided about body structure, a positive effect of ONS has been noted. Improvements in total energy intake and food intake may occur although increments may not be sustained over time. Additionally trials have failed to show significant improvements in function (not widely assessed) and clinical outcome (trials typically too small).

All of the above factors influence the decision making process when considering nutrition in palliative care. Decisions should be consistent with the overall aims of palliative care and take into account the patient’s wishes. A thoughtful and sensitive approach is required, ensuring that nutritional care is personal and individual to the patient.
Using the Guidelines
These guidelines aim to standardise the nutritional care of cancer patients with palliative care needs throughout primary care in Lothian. Where available, supportive evidence has been used to ensure that interventions are appropriate and beneficial to patients. Where no evidence exists best practice as determined by a multi-disciplinary group has been used. Main changes to current practice centre on the earlier detection of nutritional problems using MUST and focusing on minimising food related discomfort and maximising food enjoyment in the later phase of illness.

The first step in using these guidelines is to determine the patient’s current phase of illness.

If the patient is in the early palliative phase of their illness
- The patient has been diagnosed with a disease or disorder that cannot be cured. Death is not likely to be imminent and the patient may have months or even years of life and quality of life might also be good.
- May be undergoing palliative treatment i.e. given to improve quality of life which may or may not impact on survival

If the patient is in the late palliative phase of their illness
- The patient will be experiencing a general deterioration in condition. Appetite tends to be reduced and the patient becomes increasingly fatigued. There may also be a general increase in other symptoms. Carers’ anxieties tend to increase at this time and they may become increasingly concerned about the patient’s food intake.

The last few days of life
- The patient is likely to be bed-bound, very weak and drowsy with little desire for food or fluid.

As the disease progresses care aims will change. Consequently, eating practices should be monitored throughout the patient journey to reflect the changing aims of nutritional care.
Early Palliative Phase

Evidence
In early palliative care nutrition should be seen as a priority. (17). Early nutrition screening using MUST can identify problems that affect the success of anticancer therapy. Patients who are underweight or malnourished may not respond well to cancer treatments. Finding and treating nutrition problems early may help the patient gain or maintain weight, improve the patient’s response to therapy, and reduce complications of treatment. (18) Good nutrition practices can help cancer patients maintain weight and the body’s nutrition stores, offering relief from nausea or constipation and improving quality of life. (19)

Care aims
- Optimal management of nutrition related symptoms
- Maintenance/improvement in nutritional status
- Improve well being

Resources
- Symptom control leaflets
- Appetite stimulants - see Lothian Palliative Care Guidelines
- NHS Lothian MUST Resource Pack

Dietetic Referral
As per MUST guidelines
- Patient has existing clinical condition which may adversely affect adequate nutritional intake e.g. diabetes, renal or liver disease
- Patient already on Oral Nutritional Supplements
- Patient failing to progress towards care aims after PHCT intervention
- Patient’s Nutritional Risk score is 2 (MUST Tool)
Late Palliative Phase

Evidence
Aggressive nutritional intervention has not been shown to be of benefit in patients with advanced cancer (20). Consequently the goal of nutrition therapy in late palliative care should not be weight gain or reversal of malnutrition, but rather comfort, symptom relief and enjoyment of food whilst ensuring that care is individualised. (18, 21)
If eating and drinking are causing discomfort or anxiety to the patient it is important to understand that aggressive feeding may be inappropriate and that care can be demonstrated in other ways. (22)

Care aims
• Improve well-being
• Optimal management of nutrition related symptoms

Intervention
• Reassurance and support to patients and carers that this is a normal response to their illness.
• Treat reversible symptoms e.g. constipation; consider appetite stimulants - see Lothian Palliative Care Guidelines
• Dietary intervention should focus on enjoyment of food and alleviating any pressures on the patient to maintain a normal diet. For some patients it may be appropriate to discuss a nourishing diet but for others a focus on increasing intake may add to their anxieties and stress.
• ONS may be beneficial in some patients on psychological grounds. Patients should not be made to feel that they have to take these or be given false hope that these will improve nutritional status or quality of life. If ONS are felt to be beneficial and patient wishes to try them, OTC products should be the first line advice and a sample pack should be offered. Soup/custard/cereal varieties are available for those disliking milky drinks.
• If patient dislikes OTC products but wishes to try prescribable products, the dietitian should be contacted for advice and samples.

Resources
• "Coping With a Poor Appetite" leaflet
• Symptom control leaflets
• Appetite stimulants - see Lothian Palliative Care Guidelines
• “Nourishing ideas” + “Nourishing Drinks” Leaflets

Dietetic referral
Usually not required. Contact Dietitian if:
• you have any concerns or the patient has queries that you are unable to answer
• patient dislikes OTC products and wishes to try prescribable products.

Monitoring
As appropriate. Focus on enjoyment aspect of food.
Last few days of life

Evidence
The arguments for and against hydration at the end of life remain controversial. In terminally ill patients complaints of thirst and dry mouth were relieved with mouth care and sips of fluid. (23) Food and fluid administration beyond the specific requests of patients may play a minimal role in providing comfort to terminally ill patients. (24)

Care aims
• aid patient comfort

Intervention
• mouth care
• sips of fluid
• other food and fluid as desired by the patient.

Monitoring
As required

Dietetic referral
Inappropriate
SECTION THREE

Documentation
Dear

Re: Height

Weight

BMI

DoB

% weight loss/time

CHI

MUST Score

Diagnosis:

Aim of Treatment: Optimal management of nutrition related symptoms

Thank you for your referral dated date referring the above patient for a dietetic assessment. I saw this patient at location on date.

Summary of Assessment:

The results of the dietetic assessment indicate that Mr/Mrs requires dietary modification to achieve the agreed goals. I have advised Mr/Mrs on optimising their dietary intake and given supporting literature.

I have arranged to review Mr/Mrs in 4 weeks time. I will keep you informed of their progress and any changes to their treatment plan.

If you require any further information please do not hesitate to contact me on the number above.

Yours sincerely

Dietitians Name
Community Dietitian
Dear

Re:  

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Diagnosis:

Aim of Treatment: **optimal management of nutrition related symptoms**

Dietetic Intervention:

I reviewed Mr/Mrs on date at location.

Review of dietary intake:

Outcome:

Follow Up:

If you require any further information please do not hesitate to contact me on the number above.

Yours sincerely

Dietitians Name
Community Dietitian
Dear

Re :   | Height |   
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DoB | % weight loss/time |   
CHI | MUST Score |   

Diagnosis:

**Aim of Treatment:** optimal management of nutrition related symptoms

Thank you for referring the above patient for a dietetic assessment. I saw *Mr/Mrs* at *location* on *date*.

**Summary of Assessment:**

The results of the dietetic assessment indicate that *Mr/Mrs* requires dietary modification and over the counter supplements e.g. Complan, Build Up, to achieve the agreed goals. I have advised *Mr/Mrs* on optimising their dietary intake and the appropriate use of over the counter supplements and given supporting literature.

I have arranged to review *Mr/Mrs* in 4 weeks time. I will keep you informed of their progress and any changes to their treatment plan.

If you require any further information please do not hesitate to contact me on the number above.

Yours sincerely

*Dietitians Name*
Community Dietitian
Dear Dr

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<td>CHI</td>
<td>MUST Score</td>
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Diagnosis:

Aim of Treatment: optimal management of nutrition related symptoms

Thank you for your referral dated date referring the above patient for a dietetic assessment. I saw Mr/Mrs at location on date.

Summary of Assessment:

I have advised Mr/Mrs on free text box

I have agreed the following self monitoring goals with Mr/Mrs:

I have discharged them from dietetic follow up and Mr/Mrs has my contact details should they require any further advice.

If you require any further information please do not hesitate to contact me on the number above.

Yours sincerely

Dietitians Name
Community Dietitian
Assessment Letter C

Dear

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Diagnosis:

**Aim of Treatment:** [optimal management of nutrition related symptoms]

Thank you for your referral dated *date* referring the above patient for a dietetic assessment. I saw Mr/Mrs at location on *date*.

**Summary of Assessment:**

Following assessment I have given advice on appropriate dietary modification and in this case I feel that this will be inadequate to achieve the agreed goals. I would therefore be grateful if you would prescribe the following oral nutritional supplement(s) (ONS) under the ACBS (Advisory Committee on Borderline Substances) indication of Disease-related Malnutrition. Seven days supply has been given to the patient.

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<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Quantity per day</th>
<th>Flavours</th>
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<tbody>
<tr>
<td>Fortisip</td>
<td>Nestle</td>
<td>1 x 200mls</td>
<td>Banana</td>
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</table>

The prescription should be endorsed ACBS. Please prescribe initially for a period of 4 weeks. I recommend that this request is not placed on a repeat prescription until the patient is reviewed.

I have arranged to review Mr/Mrs in 4 weeks time. I will keep you informed of their progress and any changes to their treatment plan.

If you require any further information please do not hesitate to contact me on the number above.

Yours sincerely

Dietitians Name
Community Dietitian
Patient DNA Letter

Dear Mr/Mrs

I am sorry you were unable to attend your dietetic appointment on date at location

I tried to contact you by telephone but was unsuccessful. I am therefore writing to ask if you would like another appointment with myself. It is important that your progress can be assessed and to ensure that you still need the oral nutritional supplements your GP is prescribing.

To rearrange another date please contact:

Name:
Contact Number:

Please note that if you do not contact us within 4 weeks from the date at the top of this letter you will be discharged from the dietetic clinic and your GP will be informed. Your GP may wish to reconsider if the nutritional supplements are still needed.

Yours sincerely

Dietitians Name
Community Dietitian

cc GP
DNA GP Letter

Date:
Our Ref:
Enquiries to:
Direct Line:
Internal:
Fax:

Dear Dr

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Diagnosis:

Aim of Treatment: optimal management of nutrition related symptoms

Dietetic Intervention:

Thank you, for referring the above patient to the dietetic service. Further to my letter dated date I am writing to inform you that Mr/Mrs failed to arrange another appointment with myself. I have therefore discharged them from the service.

Please note that oral nutritional supplements were indicated at their previous review, you may wish to reconsider if they are still indicated.

Yours sincerely

Dietitians Name
Community Dietitian
Hospital Discharge Letter

Dear Dr,

Please find below details of the dietetic assessment undertaken for the following patient who has been discharged from Royal Infirmary of Edinburgh on [date].

Name
DoB
Address
Tel no.
CHI

Nutritional Assessment

<table>
<thead>
<tr>
<th>Height (m)</th>
<th>Usual weight (kg)</th>
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<tr>
<td>Weight (kg)</td>
<td>% weight loss over time</td>
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<td>BMI (kg/m²)</td>
<td>MUST score</td>
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<td>Relevant biochemistry</td>
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Diagnosis: [diagnosis]

Aim of treatment: [Optimal management of nutritional related symptoms]

Following assessment I have given advice on appropriate dietary modification and in this case I feel that this will be inadequate to achieve the agreed goals. I would therefore be grateful if you would prescribe the following oral nutritional supplement(s) (ONS) under the ACBS (Advisory Committee on Borderline Substances) indication of Disease-related Malnutrition. Please prescribe via eLJF. Seven days supply has been given to the patient.

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<th>Product</th>
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<td>Fortijuice</td>
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The prescription should be endorsed ACBS. Please prescribe initially for a period of 4 weeks. I recommend that this request is not placed on a repeat prescription until the patient is reviewed.

Comments: [comments]

Follow-up information:

Follow up for this patient has been discussed and will be via hospital outpatient clinic. The aim is to review within 4 weeks after which a letter will be sent recommending whether the patient requires on-going treatment with ONS. If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Dietitian

cc Community Dietitian

For the attention of community dietitian:

Please contact me prior to arranging review to discuss this referral further: Yes

A domiciliary visit will be required.
Hospital Discharge Letter (Renal)

Dear Dr,

Please find below details of the dietetic assessment undertaken for the following patient who has been discharged from Royal Infirmary of Edinburgh on [date].

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Nutritional Assessment

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<th>Height (m)</th>
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Aim of treatment: **Optimal management of nutritional related symptoms**

Following assessment I have given advice on appropriate dietary modification and in this case I feel that this will be inadequate to achieve the agreed goals. I would therefore be grateful if you would prescribe the following oral nutritional supplement(s) (ONS) under the ACBS (Advisory Committee on Borderline Substances) indication of Disease-related Malnutrition. Seven days supply has been given to the patient.

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<th>Product</th>
<th>Quantity per day</th>
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<tr>
<td>Fortisip</td>
<td>1 x 200ml</td>
<td>Apple</td>
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The prescription should be endorsed ACBS. Please prescribe initially for a period of 4 weeks.

**Follow-up information:**

Follow up for this patient has been discussed and will be followed up via the dialysis unit. The aim is to review within 4-6 weeks or their next appointment at renal clinic. If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Renal Dietitian

cc Community Dietitian

For the attention of community dietitian: For information only

Please contact me prior to arranging review to discuss this referral further: Yes

A domiciliary visit will be required.
### Department Of Nutrition And Dietetics

**Instruction and Administration Record for Oral Nutritional Products**

Please advise your Dietitian once discharge date has been set. Your Dietitian can then arrange a supply of supplements for home if necessary.

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<tr>
<th>Patients Name</th>
<th>Codes for Non-Administration</th>
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<td>2. Patient not on Ward</td>
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<td>3. Supplement not Available</td>
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<td>4. Instruction not clear</td>
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<td>5. Patient NBM</td>
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<td>6. Patient Asleep/Drowsy</td>
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<td>7. Patient Unable to Swallow</td>
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<td>8. Vomiting/Nausea</td>
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### Management of Undernutrition in Adults
SECTION FOUR

Patient Information Leaflets
### Milk Puddings & Dessert Ideas
- Aim to have at least 1 pudding each day
  - Rice pudding
  - Sponge and custard
  - Fruit pie & cream or evaporated milk
  - Cheesecake & cream
  - Individual desserts such as chocolate mousse, cream, custard, lollies
  - Full fat or thick & creamy yoghurt
- Choose full fat varieties, not low calories

### Snack between Meals Ideas
- Glass of milk & biscuit
- Peanut or mixed fruit and nuts
- Crisps and dip
- Toast with butter & jam or honey
- Cheese & biscuits
- A bowl of cereal or porridge
- Chocolate bar, pastry or cake
- Individual dessert
- Toasted teacake/scone with butter & jam

### Adding extra calories to food
If your intake is very poor it may help to supplement your food...

Which of the following could you try?

To cereals and puddings add:
- Cream
- Evaporated milk
- Full fat yoghurt
- Milk

To vegetables & potatoes add:
- Butter/Margarine
- Milk
- White/Cheddar sauce
- Cream
- Grated cheese
- Salads dressing

To soup (tinned, packet, homemade) add:
- Milk/cream
- Croutons
- Rice or Pasta
- 1 large spoon of milk powder
- Cheese
- Beans/Lentils

### Nourishing Ideas

Your contact:

Telephone No:

Date:
Management of Undernutrition in Adults

Fitness or poor appetite may have caused you to eat less food than usual and to lose weight.

This leaflet suggests ways in which you can increase your intake of food.

General Nutrition And Increasing Your Calories

Try to include 3 small meals daily and 2-3 small snacks between meals.

Try to have:

**Milk and dairy foods**
- At least 1 pint of full cream milk daily. If you do not drink milk try it in puddings, savoury dishes.
- Tip - add 4 tablespoons of milk powder to 1 pint of full cream milk for extra calories.
- Eat cheese more often as a snack or as part of a meal.
- Try full fat yoghurt.

**Bread, potatoes, pasta, rice, cereals, chapatti**
- A serving with each meal.

**Meat, chicken, fish, eggs, cheese, nuts, beans or lentils**
- A serving at least twice per day.

**Fruit and Vegetables**
- Eat daily whether fresh, frozen or tinned. Remember you can have fruit juice or dried fruit too.

**Fluids**
- It is important to drink plenty.
- Have at least 6-8 cups of fluid each day.
- Try to make these as nourishing as possible, such as milky coffee and milled milk drinks.
- Take drinks after your meal or snack so fluid can fill you up and mean that you eat less.

**Fatty and Sugary Foods**

At the moment you should try to eat more fatty and sugary foods as these are high in calories.

Which of the following could you try?
- Spread butter or margarine thickly on bread.
- Have chips or roast potatoes more often.
- Add cream to fruit, puddings & drinks.
- Use mayonnaise in sandwiches, salads.
- Use sweetened drinks instead of diet drinks.
- Add sugar to cereals or try sugar-coated items.
- Have cakes, pastries or chocolate between or after meals.
- Try to try food in oil or fat if possible.

So, What Should I Eat?

**Breakfast Ideas**
If you don't feel like eating anything first thing try to have a snack an hour or so after you get up. This may help you to feel hungry later in the day.

You could have:
- Cereal with full fat milk and a glass of fruit juice.
- Porridge & cream.
- Pancake or gruel with butter or margarine & jam.
- A cup of milky coffee or hot chocolate with 3-5 biscuits.
- Toast with cheese, peanut butter or well-cooked scrambled egg.
- A roll with bacon, sausage or egg.

**Small Meal Ideas**
If you can't manage a full meal try having smaller meals more frequently.

You could have:
- Sandwich or roll with cheese, tuna or egg mayonnaise.
- Toast with mashed cheese, well-cooked scrambled egg, spaghetti or baked beans.
- Slice of pizza or spaghet.
- Pie, trifle or savoury roll.
- Macaroni cheese, cottage or pasta with a meaty meat sauce.
- Omelette.
- Hamburger roll with cheese.
Hot Drinks

Chocolate Mallow
- 1 mug of full fat milk
- 1 tablespoon drinking chocolate
- 2 teaspoons sugar
- 3 marshmallows

Mix the drinking chocolate and sugar with a little milk. Heat the remaining milk with 2 marshmallows. Add chocolate sauce. Float remaining marshmallows on top.

Cinnamon Spice
- 1 mug of full fat milk
- 1 tablespoon syrup
- Pinch of mixed spice & cinnamon

Heat milk. Stir in ingredients and serve.

Malted Milk
- 1 mug of full fat milk
- 1 tablespoon of honey
- 2 heaped teaspoons of malted milk powder eg. Creatine or Horlicks


Enriched milk can be used to replace milk in all recipes. Enriched milk is made by adding 4 teaspoons of milk powder to 1 pint of full fat milk.

Nourishing Drinks
Management of Undernutrition in Adults

If you are finding it difficult to eat as much as usual and need to make your drinks as nourishing as possible the following recipes may be useful.

**Cold Drinks**

**Iced Coffee**
- 1 mug of full fat milk
- 2 teaspoons coffee powder
- 2 teaspoons sugar
- 1 scoop vanilla or chocolate ice-cream

Dissolve coffee and sugar in a little hot water. Whisk in all other ingredients. Serve chilled.

**Milk Shake**
- 1 mug of full fat milk
- 1 tablespoon dry milk powder
- Milk shake powder or syrup flavouring
- 1 scoop of ice cream

Mix all ingredients together. Serve chilled.

**Banana Milk**
- 1 mug of full fat milk
- 1 small cold banana
- 2 teaspoons sugar
- 1 scoop ice cream

Peel and mash the banana. Add sugar and ice cream. Whisk and serve chilled.

**Yoghurt Drinks**

**Fruit Float**
- ½ glass fresh fruit juice
- ½ glass lemonade
- 1 scoop vanilla ice cream

Mix all ingredients together. Serve chilled.

**Yoghurt Shake**
- 1 mug of full fat milk
- 1 cannon fruit yoghurt (full fat variety)
- 1 teaspoon honey

Mix all ingredients together. Serve chilled.

**Caribbean Crush**
- 1 can of natural yoghurt (full fat variety)
- 1 mug of full fat milk
- ½ cup mango or other tropical fruit juice or ½ fresh mango or other tropical fruit

Blend together. Serve chilled.

**Yoghurt Smoothie**
- 1 cannon of plain yoghurt (full fat variety)
- ½ glass fruit juice e.g. pineapple, tropical fruit, orange
- 2 teaspoon honey

Blend together. Serve chilled.
**Oral Nutritional Supplement Trial Checklist**

Your dietician feels that you may benefit by taking a trial of oral nutritional supplements for up to 3 months. In order to help arrange a prescription from your GP please complete this form after each supplement you try. Your dietician will phone you in a few days to find out your preferred supplement so please keep this form by your phone.

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<th>Product</th>
<th>Flavour</th>
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What was your overall favourite supplement?

How many supplements do you think you could manage every day?

Dietitian:
Contact Number:

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<th>Product</th>
<th>Flavour</th>
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What was your overall favourite supplement?

How many supplements do you think you could manage every day?

Dietitian:
Contact Number:
About Your Nutritional Supplements

- These supplements have been specially selected for you and therefore should only be taken by you.

- It is very important that you take your supplement in the amounts advised by your dietitian.

- Your supplement is best taken sipped slowly throughout the day, preferably after or between meals.

- Most supplements are best served chilled so keep a few in the fridge, although they can be heated gentle if you prefer. Don’t boil them as this will affect the taste. Alternatively you could try freezing them into cubes and lollies.

- Neutral flavoured supplements can be used in place of milk. Your dietitian will give you other ideas for taking your supplement.

- Store your supplements in a cool, dry place e.g. your kitchen cupboard.

- Once opened, store in the fridge and discard unused portions after 24 hours.

- Remember to check the ‘best before’ date on the bottle/carton before use.

- Throw away any cartons which are burst or open.

- Rotate stock regularly to ensure they don’t go out of date.

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Management of Undernutrition in Adults

Pain

If you are in pain there is little chance you will be able to enjoy your food. Make sure that you have adequate pain control to cover mealtimes. If your mouth is painful speak to your doctor or nurse about suitable treatments.

Eating with Others

Eating is a social activity and you may be a bit self-conscious about joining your family and friends when you know that you will not be able to eat as much as usual. However your family and friends will understand how difficult it is for you and they will enjoy being with you even if you don't feel like eating.

Weight Changes

Weight changes are common and often due to the illness. However this can be upsetting for some people. You may also worry about the effect your changing appearance may have on those around you but remember that you are still the same person inside.

• Acknowledge your feelings and discuss them with your family and friends.
• If you find it difficult to talk about your feelings and emotions, your doctor or nurse may suggest a counsellor or local support group. Often talking with someone not so close to you can help.

Finally...Everyone's appetite varies so use good days to eat well and enjoy your food and bear in mind that it is OK not to eat on the days when you feel poorly.
Even a few times every hour or so can help stimulate your appetite and increase your intake. Also:

- Alcohol is a good appetite stimulant — try a small glass 1/2 hour before your meal.
- Choose foods you really enjoy.
- Food presented attractively in comfortable surroundings may make you feel more like eating.
- Eat when you feel like eating — don’t feel that you need to stick to your usual meal times.
- If you are concerned that you can only manage small amounts of food you may wish to increase your calorie intake by adding extras (e.g. butter, cream, cheese, sugar) to your meals and snacks. Avoiding low-fat/healthy or diet ranges can also help.
- If you’re feeling sick don’t try to prepare food. Talk to your doctor or nurse about anti-sickness medicines. Sipping ginger drinks or sucking herbal sweets and taking dry, cold foods little and often may help.
- It’s hard not to worry when you’re not eating well but this can reduce appetite further. Try distractions such as television or music when eating. Speak to your doctor or nurse if you can’t stop worrying about your appetite.

Most people report that they feel very tired a lot of the time and this can affect eating and drinking habits. You may find some of the following tips helpful:

- Cold foods such as sandwiches, biscuits and cheese and quiche can be just as nourishing as a hot meal.
- Softer foods such as soups, puddings, porridge and those that need little chewing may be easier to manage.
- Try to have more snacks throughout the day.
- Try to have a real between meals.
- The less effort needed for meal preparation the more likely you are to feel like eating.
- Ask family or friends to prepare some meals for you or make more use of convenience foods.
- If you live alone a home care, meal delivery service or someone to do your shopping may be possible — ask your doctor or nurse about this.
- If you are used to preparing and cooking food, it can be upsetting to have someone else take over this task. It can be hard not to feel guilty but it may help to realise that this is a positive step to help you feel better. You can always take it over again later.
Coping with
A Sore Mouth

Coping with
A Sore Mouth
If your mouth is sore, careful choice of foods can help.

- Make sure you have adequate pain control before your meals.
- Have soothing milky drinks rather than fruit juices.
- Cold foods and fluids such as milkshakes, custard, chilled soups, yoghurt, ice cream, jelly and mousse can be soothing.
- Let hot foods cool down slightly.
- Try softer foods such as porridge, soup, egg dishes, peas in sauce and milky puddings.
- Avoid highly spiced foods such as curries and pickles, acidic foods such as citrus foods and tomatoes and dry foods such as biscuits, toast and crisps.
- Try an anaesthetic mouthwash.
- Avoid most alcohol or fortified wines.
- Minimise or avoid smoking or chewing tobacco or paste.
- Use a teaspoon or straw to avoid food contact with the sorest part of your mouth.

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Coping with
A Dry Mouth
If you have a dry mouth:

- It may be necessary for your doctor to review your medicines.
- Remember to brush your teeth.
- Try hard sweets and sugar-free gums.
- Cool drinks, sips of water, ice cubes may help.
- Use an atomised water spray.
- Try moist food with plenty of gravy or sauces and melt butter over vegetables.
- Cut up food small to limit the need for prolonged chewing.
- Take sips of water in between bites of food.
- Avoid alcohol, very hot drinks and mouthwashes containing alcohol or glycerine.

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Coping with Weakness & Fatigue
It is common to feel very tired a lot of the time and this can affect eating and drinking habits. You may find some of the following tips helpful in saving time and energy.

- The less effort needed for meal preparation the more likely you are to feel like eating.
- Try to have a meal before meals.
- Cold foods such as sandwiches, biscuits & cheese and quiche can be just as nourishing as a hot meal.
- Try to have more snacks throughout the day.
- Softer foods such as soups, puddings, porridge and those that need little chewing may be easier to manage.
- Ask family or a friend to prepare some meals for you or make more use of convenience foods.
- If you live alone, a home-carer, meal delivery service or someone to do your shopping may be possible – ask your doctor or nurse about this.
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Coping with Nausea & Vomiting

Management of Undernutrition in Adults
Feeling sick, with or without vomiting can be due to your illness itself or can commonly be a side effect of some treatments or medicines.

Try to relax as anxiety can make nausea worse.

- Eat little and often.
- Try to get some fresh air before meals and eat in a well-ventilated area.
- The following foods are often well tolerated:
  - Fizzy water
  - Dry biscuits, crackers or toast
  - Ginger foods eg ginger ale, ginger biscuits
  - Soothing bottled sweets and mints
  - Cold foods eg sandwiches, salads
- Salty foods eg peanuts, nuts
- Sipping liquids through a straw may help but it is better not to drink before or after a meal or snack.
- Don’t try to prepare food and avoid cooking smells where possible.
- Some people find strong smelling, spicy or greasy foods make their nausea worse—avoid them if they do.
- Remember to brush your teeth.
Coping with Constipation
Coping with Constipation

There are many possible causes of constipation. Medicines, not eating or drinking enough and lack of activity can all contribute. The following tips may help:

- Make sure you are drinking enough fluids, 6-8 cups every day if possible (water, tea, juice, milk)
- A warm drink first thing in the morning may help.
- Have prunes at breakfast or try prune juice, other fruit juices, plums or prunes.
- Take small, regular meals.
- If you can manage a high fibre cereal (porridge, weetbix, bran flakes etc) you will also need to take extra fluid.
- If your appetite allows try some wholemeal bread, fruit cake, digestive and bran biscuits.
- Keep as active as you can.

Remember it is not always appropriate to increase the fibre in your diet:

- If your appetite is poor.
- If you feel you aren’t drinking enough fluids.
- If you have been told you may be at risk of bowel obstruction.

In these cases, talk to your doctor or nurse.

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APPENDIX
Management of Undernutrition in Adults

Appendix 1

‘Malnutrition Universal Screening Tool’ (‘MUST’)

‘MUST’

‘MUST’ is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:

- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 ‘MUST’ Steps

Step 1
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.

Step 2
Note percentage unplanned weight loss and score using tables provided.

Step 3
Establish acute disease effect and score.

Step 4
Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5
Use management guidelines and / or local policy to develop care plan.

Please refer to the ‘MUST’ Explanatory Booklet for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See the ‘MUST’ Report for supporting evidence. Please note that ‘MUST’ has not been designed to detect deficiencies or excessive intakes of vitamins and minerals and is of use only in adults.
‘Malnutrition Universal Screening Tool’ (‘MUST’)

**Step 1**
BMI score

<table>
<thead>
<tr>
<th>BMI kg/m²</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td>&gt;20 (&gt;30 Obese)</td>
<td>0</td>
</tr>
<tr>
<td>18.5 - 20</td>
<td>1</td>
</tr>
<tr>
<td>&lt;18.5</td>
<td>2</td>
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</tbody>
</table>

**Step 2**
Weight loss score

<table>
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<tr>
<th>Unplanned weight loss in past 3-6 months</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>5 - 10</td>
<td>1</td>
</tr>
<tr>
<td>&gt;10</td>
<td>2</td>
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</tbody>
</table>

**Step 3**
Acute disease effect score

<table>
<thead>
<tr>
<th>If patient is acutely ill and there has been or is likely to be no nutritional intake for &gt;5 days</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 2</td>
<td></td>
</tr>
</tbody>
</table>

**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**
Management guidelines

**0 Low Risk**
Routine clinical care
- Repeat screening
  - Hospital - weekly
  - Care Homes - monthly
  - Community - annually for special groups e.g. those >75yr

**1 Medium Risk**
Observe
- Document dietary intake for 3 days if subject in hospital or care home
- If improved or adequate intake - little clinical concern; if no improvement - clinical concern - follow local policy
- Repeat screening
  - Hospital - weekly
  - Care Home - at least monthly
  - Community - at least every 2-3 months

**2 or more High Risk**
Treat*
- Refer to dietitian, Nutritional Support Team or implement local policy
- Improve and increase overall nutritional intake
- Monitor and review care plan
  - Hospital - weekly
  - Care Home - monthly
  - Community - monthly

*Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

All risk categories
- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary
- Record malnutrition risk category
- Record need for special diets and follow local policy

Obesity
- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity

*Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

If unable to obtain height and weight, see reverse for alternative measurements and use of subjective criteria.

Re-assess subjects identified at risk as they move through care settings.

See the ‘MUST’ Explanatory Booklet for further details and the ‘MUST’ Report for supporting evidence.
Following the results of 2 projects carried out in Lothian in 2001 and 2004 to look at the issues of inequity, access, clinical and cost effectiveness in the management of community patients at risk of undernutrition the following guidelines were developed.

These guidelines reflect the current BPI and local contract within Lothian

- The Advisory Committee on Borderline Substances (ACBS) recommends products on the basis that they may be regarded as drugs for the management of specified conditions. Doctors should satisfy themselves that the products can be safely prescribed, that patients are adequately monitored and where necessary, expert supervision is available.
- Oral Nutritional Supplements should be commenced on the advice of a Registered Dietitian.
- Where appropriate a 1.5kcal/ml supplement rather than a 1.0kcal/ml supplement should be prescribed.
- The Dietitian should advise the patient that the use of ONS will initially be a trial period of up to 3 months.
- The Dietitian will provide 7-days initial supply of ONS before requesting a prescription.
- The Dietitian will advise on the schedule for administration.
- The Dietitian should request a prescription for a four-week supply of ONS from the GP
- The Dietitian should continue to assess the need for patient's on-going ONS prescription.
- Patients should not receive ONS prescribed for other patients.

**Oral Nutritional Supplements**

**Milk Style:**
- Clinutren® 1.5 200ml or Fortisip Bottle® 200ml

**Fruit Juice Style:**
- Clinutren® Fruit 200ml or Fortijuice Bottle® 200ml

**Yoghurt Style:**
- Fortifresh® 200ml

**Milk Style with Fibre**
- Clinutren 1.5 Fibre® 200ml or Fortisip Multifibre® 200ml

**9.4.1 Enteral Nutrition**

If a patient is unable to meet their nutritional requirements through diet alone or is unable to eat, then enteral feeding may be recommended. This may be nasogastric (NG), gastrostomy e.g. PEG (percutaneous endoscopic gastrostomy) or RIG (radiologically inserted gastrostomy) or jejunal feeding. There are a number of enteral feeding products available within the Nutricia contract for Lothian. The dietitian will recommend a prescribable feed to meet the patient’s nutritional requirements. All adult patients within Lothian on enteral feeds are monitored and reviewed in conjunction with the Community Enteral Nutrition Team (CENT) contact: 0131 537 6052/3. All ancillaries for enteral feeding are non prescribable products. The supply of these is co-ordinated by CENT. Refer to ‘Lothian Enteral Tube Feeding. Best Practice Statements for Adults and Children. 2006

These recommendations should be updated when the Lothian Contract is reviewed in December 2007

Produced by Lothian Dietitians 2006
Appendix 3
References


