Looking at malnutrition from the patient’s perspective

Carolyn Taylor

This article examines malnutrition, a complex issue that has wide-ranging implications in terms of patient experience and resources — evidence suggests that malnourished people are repeat attendees at GP surgeries, incur higher prescription costs and experience twice as many hospital admissions than well-nourished people. While there have been many hospital initiatives targeted at reducing the risks of malnutrition, in the community the solution remains challenging. Recommendations include arranging services so that health and social care professionals can work together to overcome nutrition issues, making extra resources available to combat malnutrition and improving the monitoring of patients’ nutritional state. As healthcare shifts to a more community-based model, there needs to be a reallocation of resources from hospitals to community to ensure that efforts to tackle malnutrition have a more realistic chance of success.

KEYWORDS:
Malnutrition ■ Residential care ■ Assessment ■ Screening

Malnutrition is defined as ‘a state in which a deficiency of energy, protein and/or other nutrients causes measurable adverse effects on tissue/body form, composition, function or clinical outcome’ (National Institute for Health and Clinical Excellence [NICE], 2006).

Malnutrition is a state experienced by many patients in the community, and, although it is difficult to determine exact numbers, the figures below illustrate the scope of the problem:

- It is estimated that of those at risk of malnutrition, 93% live in the community, 5% in residential care and 2% in hospitals (Russell and Elia, 2010).
- According to national surveys, the overall percentage of people who are malnourished on admission to hospital is 28% (Russell and Elia, 2008). Seventy-six percent of these are admitted from their own homes.
- Extrapolating these figures, it can be estimated that up to three million people could be at risk of malnutrition (Elia and Smith, 2009).
- The resulting cost of malnutrition to the NHS has been estimated to be as much as £13.7 billion (Elia and Stratton, 2009).

In the current economic climate, it is important for the NHS to take measures to tackle malnutrition, as this would help to reduce overall costs, shorten the time patients spend in hospital and improve their overall health. Because they see patients in their own homes before they are admitted to hospital, community nurses have an important role to play in identifying those at risk of malnutrition and ensuring that they receive appropriate nutritional support.

CAUSES

The causes of malnutrition are often multifactorial and include one or more of the following (Malnutrition Task Force, 2013):
- Taste changes due to disease or medication
- Physical difficulties such as difficulty with shopping, preparing food, chewing or swallowing
- Poverty and deprivation
- Depression, anxiety, apathy and self-neglect
- Poor quality and lack of variety in meals
- Dementia.

Finding solutions to prevent and resolve malnutrition is vital. Failure to do so can result in an ever-decreasing cycle that becomes difficult to break. Malnutrition is known to produce (Stratton et al, 2003):
- Poorer health outcomes making individuals more susceptible to infection
- Reduced muscle strength and fatigue
- Reduce respiratory function
- Impaired wound healing and postoperative complications
- Apathy, depression, and self-neglect
- Increased mortality.

Evidence suggests that malnourished people are also repeat attendees at GP surgeries, have higher prescription costs and undergo twice as many hospital admissions than the well-nourished population (Guest et al, 2011). While there have been initiatives in hospitals targeted...
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at reducing the risk of malnutrition, in the community, this is more
challenging — unlike in hospital
where there is a captive population,
achieving wide-ranging change in
the community is more difficult
due to location and individual
living circumstances.

Also, people often do not seek
out help until they are already
malnourished and it has begun to
impact on their health (Elia et al,
2010). Therefore, community nurses
have a crucial role in this often
hidden problem.

Age-related malnutrition
Older adults are most at risk of
malnutrition, with approximately
10% of those over the age of 65 years
affected (European Nutrition for
Health Alliance, 2006). People over
75 years are at even greater risk and
this population figure is expected to
double over the next 30 years (Office

Malnutrition, however, is not
confined to older people, and all
age groups include those who are
vulnerable and at risk. As well as age,
malnutrition can also affect people
with long-term illnesses; those
addicted to drugs and alcohol; people
living in conditions of poverty and
those with mental health problems
such as depression (Thomas and
Bishop, 2007).

STRATEGIC RESPONSE

To help highlight the problem of
malnutrition in the community, the
British Dietetic Association launched
a campaign entitled ‘Mind the hunger
gap’ in 2012 (www.mindthehungergap.
com). Through its press releases and
encouragement of key partners, such
as health authorities, professional
bodies and city councils, the campaign
aimed to highlight the risk of
malnutrition in the community at
national and local level. The campaign
produced several key messages, the
main one being preventing people
missing meals and ensuring they eat
at least one meal a day.

‘Older adults are most at
risk of malnutrition with
approximately 10% of those
over the age of 65 affected’

Early identification of those who
are at risk of becoming malnourished
has also been encouraged as a way
of ensuring resources are targeted to
those most at need (NICE, 2006).

To tackle malnutrition, successive
governments have instigated various
initiatives to improve nutrition. These
initiatives have been based on hospital
care and included the Better Hospital
Food campaign (www.sustainweb.org/
hospitalfood), where hospitals were
required to meet certain standards
for meals to ensure consistent,
high-quality food and food service.

Similarly, the Essence of Care
benchmarks (Department of Health
[DH], 2010) required that hospitals be
marked against various aspects of care,
one of which was food and drink. They
included 10 factors specifically related
to nutrition against which hospitals
were graded (Table 1).

Nutrition has also been included
as a standard in the Health and
Social Care Act 2008 (regulated
activities). Providers of health care
are bound by the Act to ensure that
patients receiving their care have
their nutrition and hydration needs
met. As a result of being included
in the Act, nutrition is included in
inspections undertaken by the Care
Quality Commission (CQC), further
emphasising the importance of
nutrition as part of basic nursing care
(CQC, 2013).

The CQC standards maintain that
patients should have a choice of food,
which meets their cultural needs.
These standards, originally set for
hospitals, now focus on all healthcare
providers, including nursing and
residential homes.

ASSESSING PATIENTS AT RISK
OF MALNUTRITION

To help identify those at risk of
malnutrition a number of screening
tools have been developed. The one
most widely used in the UK is the
Malnutrition Universal Screening Tool
(MUST), which was developed by the
British Association of Parental and
Enteral Nutrition (BAPEN)
(Elia, 2003).

MUST has been promoted by many
professional organisations including
the Royal College of Nursing (RCN)
and the British Dietetics Association.
It was initially developed for use in
hospital settings but is now being
promoted for use in all healthcare
settings, including those in the
community. Some community services
are also asking for MUST scores to
be included in hospital discharge
reports to help highlight any on-going
nutritional needs.

Table 1: Essence of Care nutrition benchmarks (DH, 2010)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Benchmark of best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting health</td>
<td>People are encouraged to eat and drink in a way that promotes health</td>
</tr>
<tr>
<td>Information</td>
<td>People and carers have sufficient information to enable them to obtain their food and drink</td>
</tr>
<tr>
<td>Availability</td>
<td>People can access food and drink at any time according to their needs and preferences</td>
</tr>
<tr>
<td>Provision</td>
<td>People are provided with food and drink that meets their individual needs and preferences</td>
</tr>
<tr>
<td>Presentation</td>
<td>People’s food and drink is presented in a way that is appealing to them</td>
</tr>
<tr>
<td>Environment</td>
<td>People feel the environment is conducive to eating and drinking</td>
</tr>
<tr>
<td>Screening and assessment</td>
<td>People who are screened on initial contact and identified at risk receive a full nutritional assessment</td>
</tr>
<tr>
<td>Planning implementation, evaluation and revision of care</td>
<td>People’s care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink</td>
</tr>
<tr>
<td>Assistance</td>
<td>People receive the care and assistance they require with eating and drinking</td>
</tr>
<tr>
<td>Monitoring</td>
<td>People’s food and drink intake is monitored and recorded</td>
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MUST scores are based on three factors against which people are scored:

1. Body Mass Index (BMI) measured as weight divided by height\(^2\) — over 20 equals a score of 0; 18.5–20 equals a score of 1; and less than 18.5 equals a score of 2
2. Any unintentional weight loss in the last 3–6 months, where less than 5% scores 0; 5–10% scores 1; and over 10% scores 2
3. The third measure relates to acute illness and whether the person is likely to have, or has had minimal oral intake for five days or more — scores 2.

The scores have a maximum value of 6 and someone who has scored 2 or above is considered to be at high risk of malnutrition. Further details can be found on the BAPEN website (www.bapen.org.uk/pdfs/must/must_full.pdf).

By screening all patients when they first present then weekly throughout their care, MUST enables the risk of malnutrition to be assessed. This means that resources can be appropriately apportioned to those most at need. MUST can help identify problems before they start affecting people’s health. However, it still relies on having regular contact with the patient in order to complete the screening.

Routinely screening patients when they are admitted to healthcare facilities is relatively straightforward, but reaching people in their own homes is more problematic. Difficulties such as not being able to weigh bed-bound patients; not being able to quantify any unintentional weight loss due to lack of a weight history; or not having regular contact with the patient are all factors.

However, community nurses can employ a pragmatic approach to the assessment of patients’ nutritional needs — ill-fitting clothes, poor skin condition, the presence of pressure ulcers, or unkempt appearance can all indicate recent weight loss or lack of self-care, which may include not eating properly (Thomas and Bishop, 2007).

THE PATIENT’S PERCEPTION

In order for nurses and other healthcare professionals to support patients at risk of malnutrition, it is important to understand the patient’s perspective. A recent qualitative study (undertaken by the author as part of master’s in clinical research) investigated patients’ perceptions of factors that had contributed to their high risk of malnutrition. This involved interviewing elderly patients admitted to hospital who had been identified according by their MUST score as being at risk of malnutrition.

Patients were asked about what they felt had caused their increased risk of malnutrition before admission. The findings identified that some patients were unaware they were even at risk of malnutrition. Those that knew they were at risk had not sought help from their GP because, as one individual commented, ‘I didn’t want to bother him with it.’

These findings raise questions about how to identify and help those at risk of malnutrition in the community. One of the most important methods is for nurses to take any opportunity provided by patient visits — even if the visit is primarily concerned with a separate condition such as a diabetes assessment, for example — to discuss nutrition.

Simple questions can help the nurse build up a picture of a person’s nutritional status, for example:

- What have you eaten in the last 24 hours?
- Is anyone doing your shopping?
- What do you like to eat?
- What do you think has been happening with your weight?
- Have you experienced any change in appetite recently?

In the author’s clinical experience, vague answers to any of these questions could signify an inadequate nutritional intake or issues around food that may require further investigation. However, even if patients are considered to be at risk they may still be reluctant to change their nutritional habits and Weekes et al (2004) have demonstrated that counselling may be necessary to help these patients just do not enjoy eating, do not want to eat or simply do not ‘feel the need’ to eat. This is difficult for any nurse to observe and it is painful to witness the emotional impact on family and friends. I have also seen positive results, however, so the battle against malnutrition must continue. Be observant and continue to assess, assist, educate and offer support to your patients and their families.

However, unless patients are open to talking about their current nutritional state, it may be hard to build up a full picture. This is where nurses’ relationships with patients become an important factor, as over time and repeated contact patients may become more open to discussing nutritional issues.

Although it can take years of experience to fully understand patients’ nutritional needs, a good patient/nurse relationship is vital if patients are to open up and discuss their situation, thereby improving health outcomes (Stewart et al, 1995).
support people through the changes required for success.

This was borne out by the author’s study where some patients reported that they had always eaten small amounts, or never eaten between meals and were unwilling to adapt their eating habits.

It is important that nurses have a system in place to support patients through any nutritional change — this may involve more regular reviews or referral to social services, medical or dietetic teams for further support. Also, assessment of patients’ nutrition status is not only vital at initial contact, but should also become part of routine care and monitoring.

**FAMILY, FRIENDS AND CARERS**

Family and friends often act as a support network for older people and it is known that they are often seen as care providers (DH, 2008). It is estimated that carers provide £119 billion per year of support to older people (Carers UK, 2011). However, they are rarely trained to do so.

Providing family/carers with the knowledge and skills to monitor their relatives’ nutritional status and administer nutritional support is vital. However, the author’s study into patients’ perceptions indicated that even this well-meaning support is not without problems. Some of the patients interviewed explained that in an effort not to hurt carers’ feelings they would often accept food but not actually eat it.

Similarly, carers are often at a loss as to what kind of food to provide and can understandably ‘over-value’ any suggestions — as one patient reported: ‘If I ask for rice pudding, I get half a dozen. So I don’t ask.’

In the author’s clinical experience, patients themselves are often at a loss as to what to suggest when it comes to the type of food they would like to eat. If a patient’s appetite is poor it may be difficult for him or her to think of tempting options and they may not be aware of the options available at supermarkets.

Of the patients surveyed for the author’s study, even those who received more formal assistance — such as help preparing meals from social care staff — reported that this was variable, with some carers being more thorough than others.

Patients reported that visiting social care workers often had just 30 minutes to prepare and cook a meal as well as complete the washing up afterwards. Meals were often repetitive and patients were asked to choose meals that were quick to prepare, with one patient reporting that she usually ate out of the food container rather than a plate to save on the washing up.

Limited variety in meals is likely to result in a poorly balanced diet (NHS Choices, 2014), with patients becoming bored with food and losing the enjoyment of eating, resulting in further reductions in nutritional intake.

**POSSIBLE SOLUTIONS**

As mentioned above, the first step is to identify if a patient is at risk of malnutrition and there are various ways of doing this:

- Screening patients using MUST at every contact can help to identify those at risk
- Weighing patients and recording their weight at every opportunity can flag up when a patient is losing weight
- Assessing the fit of a patient’s clothes can indicate weight loss (if they are too large)
- Discussing a patient’s dietary intake in detail should include what is being eaten, how much; how often; if there is variety; any changes in appetite.

It can be difficult to unpick exactly what a patient has been eating. For example, in the author’s study it could take up to 15 minutes to fully explore a patient’s nutritional intake before admission.

Patients may think that they are eating adequately, when in reality their intake is insufficient. Although it may be difficult to elicit this information during a busy shift or when there is a large case-load to see, it is likely to be beneficial in the longer term.

**Care plan**

Once a patient has been screened and a nutrition risk identified, it is important to put an action plan in place. While screening may identify the risk of malnutrition, finding a solution can be even more difficult.

It is important to ascertain any underlying cause of malnutrition risk, which might include:

- Any medicine that may be having an adverse effect on the patient’s appetite (such as chemotherapy or antibiotics)
- Any gastric illness (for example nausea, vomiting, diarrhoea and constipation)
- Swallowing or chewing problems
- Physical difficulties with eating, following a stroke, neurological impairment or spinal injury
- Any difficulties in the preparation of food, or mental health problems, such as dementia (Prentice et al, 1989).

Once the possible cause of malnutrition has been identified, it will be easier to find a solution, such as:
Evaluating the patient on what food provision is on offer locally, whether this means a cooked meal service such as Meals on Wheels, or using a professional service that might deliver pre-prepared frozen meals, for example.

Advising the patient or carers about any help available in meal preparation — a working knowledge of the local social services departments and what they offer would be required here.

A review of the patient’s medication and any symptoms — are their medicines causing increased gastric disturbances or taste changes, for example? Are any changes required to the patient’s medication?

Assessing the support available from friends and family, which might involve helping with shopping and meal preparation.

Encouraging the patient to take nutritious snacks between meals if they are unable to eat full meals (Thomas and Bishop, 2007). This could include cheese and biscuits, yoghurts, fruitcake, nuts or individual pots of rice pudding, for example. The simpler the snack, the more likely it is that they will be eaten (Thomas and Bishop, 2007). It is important to consider that any meal or snack that requires preparation may be less successful, particularly if the patient has functional difficulties.

Encouraging nutrient-dense food such as dairy wherever possible (Thomas and Bishop, 2007). Cheese and cream can be added to a variety of foods such as soups to ensure that each mouthful is energy- and protein-dense, thereby reducing the volume of food actually required.

Contacting the local dietetics service for specific information and, where appropriate, referring the patient on. Local policies on referral to dietetic services would need to be adhered to. For example, some services will accept referrals from community nurses while others may need a medical (GP) referral. Referral should be considered where a patient is continuing to lose weight despite community nurses’ interventions, or if there is a clinical concern that the patient’s nutritional state remains at risk despite interventions.

CONCLUSION

Malnutrition is a complex issue that requires a multi-agency approach. This includes health and social care professionals — such as community nurses and social workers — collaborating to educate patients on improving their nutritional intake and how to access social care services, as well as monitoring their ongoing nutritional status.

As healthcare moves to a more community-based model, there needs to be an accompanying shift in resources from hospitals to community staff to ensure efforts are made to tackle malnutrition in people’s homes as well as in nursing and residential homes.

It is important that community nurses develop the knowledge and skills to discuss patients’ nutritional intake, as this will be essential in identifying and supporting those patients at risk of malnutrition. This may involve a whole-team approach and a review of working practices to facilitate detailed nutritional monitoring.

One way to ensure the monitoring of patients’ nutritional status would be to regard each presentation of a new patient as an opportunity to perform a nutritional screen. Regular monitoring of established patients’ nutritional status is also warranted as circumstances can change or deteriorate. It is important that nutritional screening becomes a routine part of care for all patients in the community in the same way that it is regarded as a routine part of inpatient hospital care.

KEY POINTS

- Malnutrition, defined as ‘a state in which a deficiency of energy, protein and/or other nutrients causes measurable adverse effects on tissue/body form, composition, function or clinical outcome’.

- Community nurses have an important role to play in identifying patients at risk of malnutrition and ensuring that they receive appropriate nutritional support.

- Evidence suggests that malnourished people are also repeat attenders at GP surgeries, have higher prescription costs and have twice as many hospital admissions than the well-nourished population.

- As healthcare shifts to a more community-based care, there needs to be a shift in efforts from hospitals to community to ensure efforts are made to tackle malnutrition.

- Ensuring mechanisms are in place to enable discussions about nutritional intake is essential to identify and support patients at risk of malnutrition.

- This may involve a whole-team approach and a review of working practices to facilitate detailed nutritional monitoring.

- One way to ensure the monitoring of patients’ nutritional status would be to regard each presentation of a new patient as an opportunity to perform a nutritional screen.

- Malnutrition is a complex issue that is going to take a multi-agency approach to overcome.

REFERENCES

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