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# MALNUTRITION IN THE ELDERLY

IN ASSOCIATION WITH THE BSNA

**Malnutrition is a serious problem, with more than three million people in the UK either malnourished or at risk of malnutrition.[1]**

Most at risk of malnutrition are those with chronic diseases living in the community; in other words, those who have been recently discharged from hospital, people living alone and the elderly. Around 98% of malnutrition exists outside the hospital setting.[2]

Malnutrition in England is currently estimated to cost the NHS £19.6 billion per year.[3] Consequently, improving nutritional care for individuals who are malnourished, or at risk of malnutrition, could have considerable cost-saving implications, including:

- fewer hospital admissions and readmissions;
- shorter length of stay in hospital;
- fewer healthcare needs in the community, such as GP visits and care at home.

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## MANAGING MALNUTRITION IN THE COMMUNITY

The first step should always be to identify individuals who are malnourished, or at risk of malnutrition, through nutritional screening using BAPEN's Malnutrition Universal Screening Tool ('MUST'). It is especially important to screen residents of care and nursing homes, given the high prevalence of malnutrition in residents and their general frailty, and elderly people living at home. Malnutrition affects about one in 20 individuals in the general population and one in three in care homes.[4] It is also important that health and care staff, including domiciliary care providers, identify nutritional risk in other settings, including individuals' own homes, day centres, extra care and social housing.

The provision of healthy, nutritious food should always be the first choice for managing malnutrition. However, it is not always possible for people to eat enough food, or ingest the nutrients they require, to keep their body healthy. Oral nutritional supplements (ONS) can partially, or wholly, replace a normal diet to provide patients with the essential nutrients they need when food alone is insufficient to meet their daily nutritional requirements.

This is recognised by NICE. NICE Clinical Guideline 32 states: 'Oral nutrition support includes any of the following methods to improve nutritional intake: fortified food with protein, carbohydrate and/or fat, plus minerals and vitamins; snacks; oral nutritional supplements; altered meal patterns; the provision of dietary advice.'[5] It also states that: 'Healthcare professionals should ensure that the total nutrient intake of people prescribed nutrition support accounts for energy, protein, fluid, electrolyte, mineral, micronutrients and fibre.'[6]

The NICE Quality Standard on Nutrition Support in Adults (QS24),[7] recognises that ONS are a clinically effective way to manage disease-related malnutrition when food alone, however nutritious, is not sufficient to meet a person's dietary needs: 'It is important that nutrition support goes beyond just providing sufficient calories and looks to provide all the relevant nutrients that should be contained in a nutritionally complete diet. A management care plan aims to provide this and identifies condition specific circumstances and associated needs linked to nutrition support requirements.' NICE QS24 also advises that care should be taken when

providing food fortification alone, which tends to supplement energy and/or protein without necessarily providing sufficient or adequate micronutrient and mineral levels.

Patients requiring ONS range from those who are critically ill to those with inherited genetic disorders, to those with chronic illnesses. These may include cancer, kidney failure, cystic fibrosis, diabetes, dysphagia, loss of muscle mass and respiratory disease. In addition, specialist products may be required for people with inborn errors of metabolism, protein sources to avoid a food allergy, problems with absorption or malnutrition of normal foods, or for enteral nutrition administered via nasogastric tube (NGT) or percutaneous endoscopic gastrostomy (PEG).

ONS can be an essential part of medical management and may be required either for life or for short periods of time, depending on individuals' clinical circumstances. In these cases, they guard against malnutrition until a normal diet can be resumed. They can be a lifeline in the community, where round-the-clock care may not be available.

Healthcare professionals are best placed to ensure that patients are treated appropriately and to evaluate whether patients need ONS and if so, for how long patients should be taking them. Prescribed when needed, ONS can prevent the complications associated with malnutrition and significantly improve patients' health outcomes.[8] They are evidence-based nutritional solutions for disease-related malnutrition[9] and are highly regulated.[10]

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## THE POTENTIAL IMPACT OF RECENT RESTRICTIONS OF ONS

Facing huge pressure to cut costs where they can, clinical commissioning groups (CCGs) across the country have started to restrict the prescribing of certain foods, notably gluten-free products and, more recently, in some areas, ONS. One CCG has substantially restricted ONS in care and nursing homes; another appears to view the use of ONS as a case of last resort and only when all other avenues have been exhausted.

These policies are misguided and although well intentioned, both fly in the face of the existing evidence and fail to consider long-term outcomes. The Managing Adult Malnutrition in the Community pathway[11] clearly indicates that ONS should be used in combination with food as part of the management of malnutrition; this is also referenced in the recently launched NHS England Commissioning Excellent Nutrition and Hydration (2015-2018).[12]

The health and social care costs associated with malnutrition are estimated to amount to more than 15% of the total public expenditure on health and social care.[13] About half of this expenditure is accounted for by older people (>65 years) and the other half attributed to younger adults and children. In its guidance on cost savings,[14] NICE recognises that significant cost savings can be achieved relatively quickly through the provision of good nutritional support to people at risk of malnutrition.

The recent report[15] from the British Association for Parenteral and Enteral Nutrition (BAPEN) and the National Institute for Health Research Southampton Biomedical Research Centre (NIHR) stated that it costs three times more to treat or manage a malnourished patient compared to one without malnutrition, equating to £5,329 per patient. The single most important variable affecting the net cost balance was the

cost saving due to the effect of ONS in reducing the length of hospital stay. In short, reduced use of healthcare resources due to ONS use could save the NHS £101.8 million every year.[16]

Furthermore, a systematic review demonstrates that there is very little evidence of efficacy of treating malnutrition with food-based strategies alone, compared to the use of ONS.[17] A number of favourable clinical outcomes were also associated with use of ONS, including improved quality of life, reduced minor post-operative complications, reduced infections and reduced falls.[18] Other studies also highlight the cost-effectiveness of ONS in treating malnutrition.[19-21] A systematic review of the cost and cost effectiveness of using standard ONS in community and care home settings found that cost-savings were demonstrated for short-term use of ONS (up to three months), with a median cost saving of 9.2% ($P<0.01$). Studies investigating cost savings for the use of ONS for three months or more found a median cost saving of around 5%.[22]

However, recent statements from some CCGs have seemed to suggest that the provision of fortified food is a like-for-like replacement for ONS. This approach is over-simplified as it does not adequately take into account individuals' clinical requirements nor the clinical assessment made by the healthcare professional. As such, it results in inequity of care for patients whose health outcomes may, as a result, become determined by where they live. The better approach would be to ensure that patients receive appropriate nutritional support, based on their particular circumstances, wherever they are. This would comply both with existing best practice national guidelines and the guiding principle in CCGs' own constitutions: 'access to services based on clinical need'.

The issue is compounded by PrescQIPP's new publication *Fabulous Fortified Feasts*, a collection of simple recipes, which is recommended by some of the CCGs who have recently restricted ONS. Whilst it is undoubtedly true that the provision of nutritious food is essential to combat malnutrition, a generic booklet such as this is not appropriate for all patients and all clinical conditions. It is important to note that the recipes are not nutritionally complete and consequently patients will not receive their full range of nutrients, including micronutrients, without further supplementation, either from other foods or from ONS. Users of the guide should also be clear about the underlying reason for malnutrition before choosing a recipe, as some of them may be inappropriate for patients living with some disorders or conditions; for example, peanut butter and banana flapjacks should not be provided for patients suffering from dysphagia. This is a particularly important consideration in the context of community care and it is not known how carers who are untrained in nutrition will receive the information and support they need to be able to best manage the individuals in their care.

## CONCLUSION

Malnutrition is a serious problem, estimated to cost £19.6 billion every year in England alone. Although CCGs are under increasing pressure to cut costs, a blanket approach using first-line measures is unlikely to be appropriate for all patients in all circumstances. Patients with co-morbidities, in particular, whether they are in the home or elsewhere, most stand to benefit from nutritional advice that is uniquely tailored to their own clinical circumstances. Patients who take ONS should be regularly monitored and reviewed and ONS should be discontinued when they are no longer needed. The full implementation of high-quality pathways of nutritional care and the recognised role that dietitians can play in evaluating a patient's need for ONS can manifest in short- and long-term savings for health and social care services: not to mention the health and wellbeing of the patient.