Guidelines for Malnutrition Management and ONS prescription in primary Care (Adults)

These guidelines are to help promote the prevention and management of adult malnutrition in the community.

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Aim

These guidelines aim to promote the management of malnutrition in the community with appropriate, rational, and cost-effective prescribing of Oral Nutritional Supplements (ONS) in adults in primary care and support national guidance from National Institute for Health and Care Excellence (NICE) and other health professional organisations.

Introduction

"Malnutrition" can refer to both under and over nutrition, but usually refers to under-nutrition; a deficiency of energy, protein, and important micronutrients. These guidelines apply to undernutrition. Untreated malnutrition has many consequences other than weight loss and can result in:

- Reduced efficiency of the immune system resulting in increased risk of infection.
- Reduced muscle mass and function which can affect respiratory muscles and respiratory function. Reduced muscle function can also lead to swallowing difficulties (dysphagia).
- Impaired thermoregulation resulting in a predisposition to hypothermia.

- Impaired wound healing and delayed recovery from illness.
- a detrimental effect on mental state, apathy, depression, and self-neglect.
- Increased risk of additional health care costs due to an increase in: GP visits (65%), hospital admissions (82%) and length of hospital stay (30%).

Tackling malnutrition can improve nutrition status, clinical outcomes and reduce health care use. The National Institute for Health and Care Excellence (NICE) Nutrition Support in Adults Clinical Guidelines 2006 (NICE CG32) has shown substantial cost savings can result from identifying and treating malnutrition, CG32 is ranked in the top clinical guidelines shown to produce cost saving.

Cambridgeshire and Peterborough ICB is committed to implementing a "Food as Treatment" strategy, as food is the optimal way to manage and prevent malnutrition. ONS use should be reserved for patients who have not responded to dietary measures as per NICE CG32 2006.

Scope and Purpose of Guidelines

This document is intended to guide the management and prevention of malnutrition across primary care in Cambridgeshire and Peterborough, to promote a "Food as Treatment" approach and prevent the excessive use of ONS. All healthcare professionals working within Cambridgeshire and Peterborough that recommend, prescribe, supply or administer ONS should be familiar with these guidelines: including but not limited to GP's, dietitians, doctors, practice, community and MacMillan nurses.

The guidelines advise on:

- Malnutrition risk assessment.
- Setting a treatment goal
- Establishing Food as Treatment with patients.
- When to initiate ONS.
- Reviewing and Discontinuing ONS prescriptions.

Additional advice and guidance is given on the use of ONS in palliative care and other specific conditions such as diabetes, renal disease and when it is appropriate to refer to community dietitians.

These guidelines do not apply to under 18's or patients under the eating disorder service.

These guidelines are not applicable for patients who are under the care of nutrition and dietetic services requiring either ONS products for tube feeding or specialist prescriptions, as a result of their condition.

The ONS described in this document represent the best value options for standard ONS. If the indication for ONS prescription is malnutrition treatment or prevention, the first-line and second-line products should be considered or trialled by all recommending clinicians.

However, **dependent on the clinical need of the patient**, if the first-line products are not appropriate; the clinical reasoning and justification for the recommendation of alternative ONS will be provided, and the products will be reviewed regularly by appropriate specialists.

People at Risk of Malnutrition

Malnutrition is a complex, multifactorial condition; with many conditions putting individuals at greater risk, the following table provides a non-exhaustive general overview of implicated conditions and causes:

Patient group or Clinical condition	Potential Causes of Malnutrition	Clinical implications
Older people	Social, physical, psychological and environmental problems.	Increased likelihood of infection or fractures. Pressure sores in bed bound. Muscle wasting. Depression.
Cancer	Food aversions and taste alterations, increased energy requirements, nausea, vomiting, malabsorption due to treatment modalities, anorexia.	Poor response to therapy, prolonged recovery times, weight loss, decreased immune response.
Chronic neurological conditions, e.g., motor-neurone disease and multiple sclerosis	Progressive dysphagia, feeding problems, taste changes, depression. Increased energy requirements.	Progressive weight loss and muscle weakness. Poor response to therapy and rehabilitation. Dehydration, anorexia, pressure sores.
Stroke	Dysphagia or feeding problems, depression, psychological problems.	Decreased muscle tone. Poor response to therapy and rehabilitation. Prolonged recovery times. Dehydration.
Gastro conditions, e.g., Chronic IBD, short bowel	Malabsorption, periods of diarrhoea and pain. Anorexia.	Decreased uptake of nutrients due to increased intestinal transit time and malabsorption.
Acute/chronic pain, e.g., arthritis	Anorexia due to the side effect of analgesic drugs and pain effect.	Rapid and progressive weight loss.
HIV/AIDS	Malabsorption, as a result of opportunistic infection.	Rapid and progressive weight loss. Further immunosuppression.
Chronic Respiratory Disorders, e.g., COPD, chronic asthma	Breathlessness causing reduced appetite and increased energy expenditure. Difficulty shopping and cooking due to breathlessness on exertion.	Weight loss, increased risk of infection and exacerbation of symptoms.
Mental Health	Self-neglect, disordered eating. Increased energy expenditure.	Weight loss, increased risk of infection, dehydration.

Patient group or Clinical condition	Potential Causes of Malnutrition	Clinical implications
Hepato- biliary and Renal conditions	Higher energy requirements, complex micronutrient profile diet, nausea, decreased appetite, malabsorption, excess losses.	Weight loss, poorer outcomes, encephalopathy, fluid imbalance.

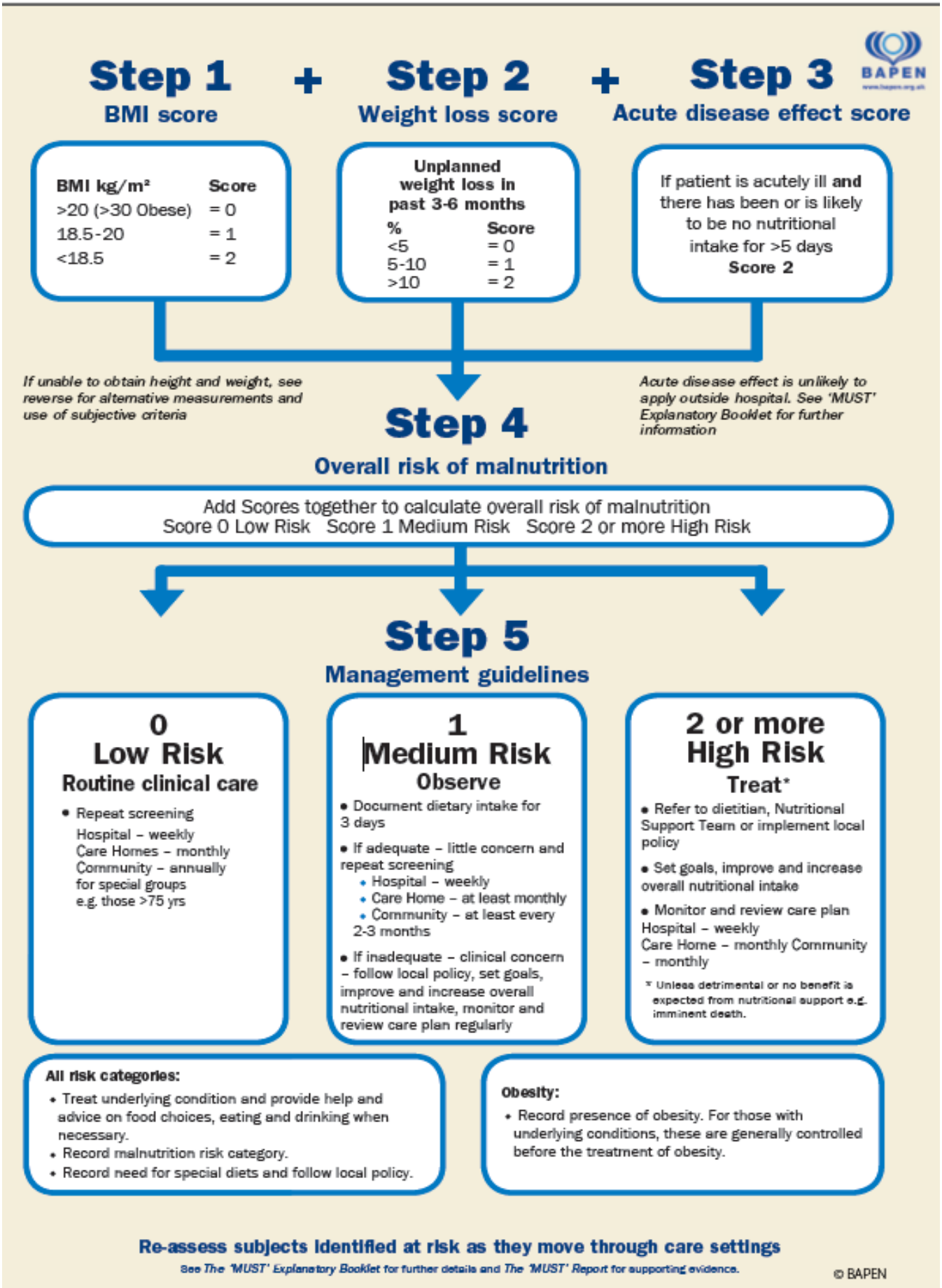
Malnutrition Risk Assessment

In primary care there should be 3 steps to assessing the risk of malnutrition.

Step 1) MUST calculation

MUST is a validated screening tool for adults and was specifically designed by a multi-disciplinary group of healthcare professionals, to assess malnutrition risk in all care settings in a consistent way in order to facilitate continuity of care from one setting to another. It can be used by all types of care workers to identify malnutrition, and is a five-step screening tool that uses objective measurements when possible and subjective criteria when necessary. MUST is used throughout the NHS in primary and secondary care, and includes an appropriate care plan linked to the risk of malnutrition (MUST score). An online MUST calculator can be accessed (on all mobile devices). Although MUST is theoretically a simple tool, many people can find it difficult to use and therefore accessing training on MUST is always recommended.

MUST training is delivered regularly to care home staff across Cambridgeshire and Peterborough Care homes by the Cambridgeshire and Peterborough Foundation Trust Nutrition and Dietetic Department.


Step 1
BMI score
+
Step 2
Weight loss score
+
Step 3
Acute disease effect score
BAPEN
BMI kg/m²
Score
>20 (>30 Obese) = 0
18.5-20 = 1
<18.5 = 2
Unplanned weight loss in past 3-6 months
%
Score
<5 = 0
5-10 = 1
>10 = 2
If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days
Score 2
If unable to obtain height and weight, see reverse for alternative measurements and use of subjective criteria
Acute disease effect is unlikely to apply outside hospital. See 'MUST' Explanatory Booklet for further information
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 >75 yrs
1
Medium Risk
Observe
• Document dietary intake for 3 days
• If adequate – little concern and repeat screening
◦ Hospital – weekly
◦ Care Home – at least monthly
◦ Community – at least every 2-3 months
• If inadequate – clinical concern – follow local policy, set goals, improve and increase overall nutritional intake, monitor and review care plan regularly
2 or more
High Risk
Treat*
• Refer to dietitian, Nutritional Support Team or implement local policy
• Set goals, 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.
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.
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Step 2) Assessment of symptoms contributing to malnutrition

Malnutrition is a multifactorial condition, and the person should be considered holistically to ensure that the recommended "Food as Treatment" plan is as effective as possible. Therefore, it is important to explore any symptoms that may be impacting on appetite or optimise the management of any condition which might exacerbate (e.g., optimise salbutamol in COPD, consider laxatives for constipation).

Symptoms	Symptoms Reported (mark Yes or No)	Medical Management Optimised (mark Yes or No)
Nausea/feeling sick	Yes or No	Yes or No
Vomiting	Yes or No	Yes or No
Feeling of fullness/bloating after eating	Yes or No	Yes or No
Abdominal discomfort e.g., Stomach cramps /pain during or after eating	Yes or No	Yes or No
Heart burn/Acid reflux	Yes or No	Yes or No
Dry/ Sore Mouth	Yes or No	Yes or No
Are background conditions well managed e.g., dementia/mood disorder etc.	Yes or No	Yes or No
Taste changes	Yes or No	Yes or No
Unusual tastes in your mouth when eating	Yes or No	Yes or No
Difficulty in chewing food	Yes or No	Yes or No
Issues with dentures/dentition affecting food intake?	Yes or No	Yes or No
Difficulty in swallowing food ** e.g., coughing after eating, food sticking, change in speech after eating	Yes or No	Yes or No
Constipation	Yes or No	Yes or No

** Note: for patient reporting difficulties swallowing, please consider immediate referral to speech and language therapy.

Step 3) Assessment of appetite

It is important to assess the individual's appetite, some example questions are below as this will help inform the treatment plan.

How would you describe your eating at the moment? *Mark as appropriate.*

- ☐ Less than normal
- ☐ Normal for you
- ☐ More than normal

How would you describe your appetite? *Mark as appropriate.*

- ☐ Very poor
- ☐ Poor, less than normal
- ☐ Normal for you, not concerned
- ☐ Good, more than normal

How would you describe your portions? *Mark as appropriate.*

- ☐ Very small
- ☐ Small
- ☐ Regular
- ☐ Large

Do you finish your meals? *Mark as appropriate.*

- ☐ Yes always/most of the time
- ☐ About three quarters of the time
- ☐ Half of the time or less

Malnutrition Management Plan

1. Address any symptoms which may impact on oral intake with optimal medical management where appropriate.
2. Implement "Food as Treatment" pathway.

Using the MUST tool and other impacting factors, the patient can be assessed as low, medium, or high risk of malnutrition.

MUST 0 (Green - low risk)	MUST 1 (Yellow - medium risk)	MUST 2+ (Red – high-risk)

For low risk patients (MUST 0): These patients will likely need some reassurance that they are currently considered a healthy weight and could be given some resources on healthy eating for further reading if necessary. These patients do not need to be invited back for review and should not be given ONS.

For medium and high-risk patients: they should be given the "Food as Treatment" resources relevant to them which will detail ways in which they can increase/ amend their nutritional intake through dietary changes to prevent further deterioration of their nutritional state.

Food as Treatment

The "Food as Treatment" resources provide examples of the three-pronged approach to prevent/treat malnutrition:

1. **Food Toppers** - which provide additional energy in foods already consumed.
2. **Nourishing snacks** - A range of high energy/high protein snacks are given.
3. **Nourishing Drinks** - These are high energy/high protein drinks which are nutritionally equivalent to prescribed ONS but are homemade *(also known as homemade supplements*).

"Food as Treatment": Medium Risk provides strategies to increase energy intake by 500-700kcals/d.
"Food as Treatment": High Risk provides strategies to increase energy intake by 1000-1300kcals/d.

The "Food as Treatment" resources also provide a chart to track daily achievement of the recommendations as the key to modifying nutritional status is consistency of intake.

Medium Risk (amber):	High Risk (red):
• Fortify each meal with 100 kcal meal topper. • 1 nourishing snack or drink (250 to 500 kcals). Provides 500 to 700 kcals extra per day.	• Fortify each dish with 100 kcal meal topper. • 2 nourishing snacks (200 to 400 kcals). • 1 nourishing drink (300 to 500 kcals) Provides 1000 to 1300 kcals extra per day.

For additional support or recipe suggestions for patients please see some of the below resources:
Food as Treatment - Nourishing Drinks Recipes
Food as Treatment - Meal and snack Recipes

Setting a Treatment Goal

Clear treatment goals and a care plan should be agreed with patients. Patient expectations should be managed at this stage. Treatment goals should be documented on the patient record and should be realistic for the patient;

If a patient has lost 5% weight but have always had a BMI of 18.5 kg/m^2 aiming for a BMI of 22 kg/m^2 is not likely to be of benefit, but prevention of further weight loss or returning to previous BMI of 18.5 kg/m^2 may be achievable.

Suitable goals include:

- Attaining a realistic target weight/ target BMI/ achieving weight gain over a specified period.
- Weight maintenance where achieving weight gain is unrealistic or undesirable.
- Slowing weight loss, where achieving weight maintenance is unlikely (e.g., in palliative care).
- Completion of wound healing, if relevant.

Increasing energy and protein rich foods should be recommended as the initial intervention before prescribing ONS.

Patients may be reluctant to eat high fat / sugar foods, so it is important to reinforce the message that healthy eating for people who are at risk of malnutrition is different to healthy eating for the rest of the population.

Patient Review

For patients at high and medium risk of malnutrition, they should be reviewed after 4 to 6 weeks of implementing the "Food as Treatment" strategies, ideally by the clinician who initiated the process.

At the review patients should have a second Malnutrition Risk Assessment:

STEP 1) MUST calculation

STEP 2) Assessment of symptoms contributing to malnutrition

STEP 3) Assessment of appetite

Any progress or decline should then be monitored and recorded.

- If after 4 to 6 weeks implementation of the "Food as Treatment" strategies, there is **any improvement** in malnutrition risk, i.e.;
    - Reduction in MUST score
    - Increase in weight or weight stable
    - Achievement/ progress towards treatment goal.
    - Improvement in symptoms
    - MUST score stabilised
    - Wound healing

Then the patient should be advised to continue the current treatment plan and the current strategies until they are satisfied with their weight or their Treatment goal has been achieved.

- If after 4 to 6 weeks implementation of the "Food as Treatment" strategies, there is **no improvement**, or worsening or nutritional status:
    1. Refer to dietitian.

2. Check management of any reported symptoms.
3. Advise to follow "Food as Treatment- High Risk" strategies.
4. Offer additional "Food as Treatment"; recipes + nourishing drinks resources.

ONS can be considered at this point, but ONLY if it is urgently needed and the patient cannot wait until their dietitian appointment AND ACBS prescribing criteria are met.

ONLY first and second line ONS products should be started in primary care.

If patient has Dysphagia requiring thickened fluids, do not initiate ONS; refer to dietitian for specialist product prescription.

ONS Prescribing

ONS prescribing should **only** be initiated in primary care in addition to the '**Food as Treatment'** changes which should be maintained:

If first-line dietary measures/ "Food as Treatment" approach have failed to achieve a positive change towards meeting goals after one month.

1. Where there are clinical benefits to be realised and clear nutritional goals to work towards. Repeat prescriptions should only be issued if there is an explicit plan for continuation.
2. Goals should be regularly reviewed, and prescribing should cease when goals are achieved.
3. The main ACBS criteria to consider and evidence is Disease related malnutrition If the patient does not meet the ACBS criteria then 'over the counter' nutritional supplements are recommended only.

ONS products will contain varying amounts of Vitamin K, alongside the Vitamin K already consumed within the diet. Possible interactions of ONS should be considered for Warfarin resistant patients. INR should be monitored, and treatment altered accordingly especially if ONS is commenced or changed after Warfarin is started.

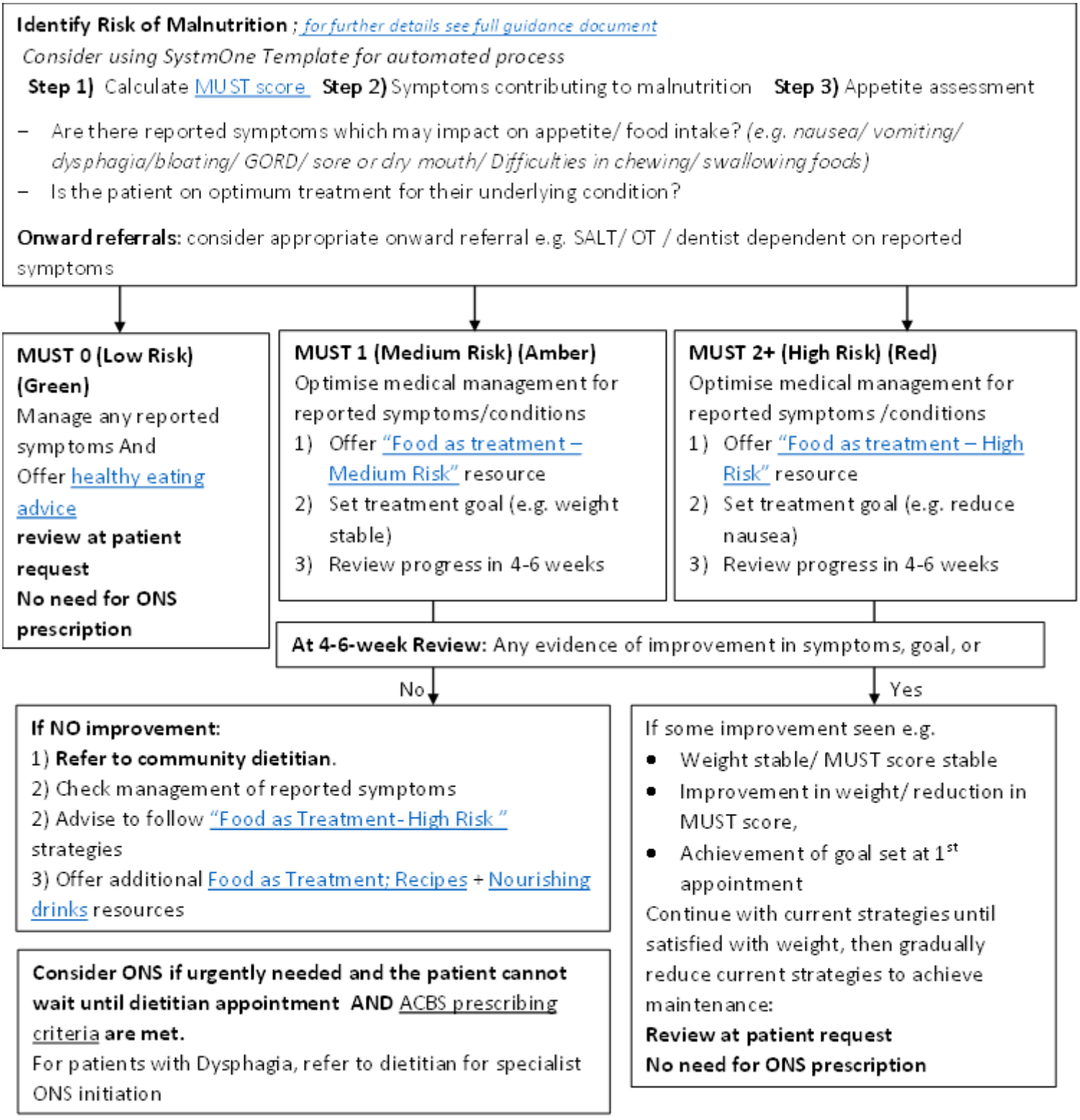
Starting prescriptions:

Dosage	To be clinically effective, ONS should be prescribed twice daily (bd). This makes sure that calorie and protein intake is sufficient to achieve weight gain. If ONS prescribed and/or taken less than twice daily, food fortification should be used instead.
Timing	To maximise their effectiveness and avoid spoiling appetite, patients should be advised to take ONS between meals and not before meals or as a meal replacement
Directions	Prescriptions should be clearly marked "ACBS" and give clear directions for use e.g., "one to be taken twice daily between meals".
Type of ONS	Prescribing choices should be in line with the primary care formulary.
Starter packs	A one-week prescription or starter pack should always be prescribed initially to avoid wastage if products are not well accepted due to taste and palatability. Avoid prescribing starter packs except for an initial trial, as they are often more costly.
Repeat Prescriptions	Issue monthly prescriptions on acute for 1 to 2 months once the patient has informed the practice of their preferred flavour.

Malnutrition in Primary Care flow-chart summary

For care home residents please refer to malnutrition action plan - for care homes.

In patients with **unexplained weight loss and no background causative aetiology**, please consider further investigation or onward referrals. This pathway can be used **in addition** to investigations to prevent further deterioration in nutritional status whilst awaiting results/referrals, as appropriate.



First-line ONS

First-line ONS should be trialled first where clinically appropriate as these are the most cost-effective products available. If these are not appropriate or tolerated, second-line products should be trialled.

If first-line and second-line products are not tolerated, dietitians should make recommendations for alternative appropriate ONS.

In the case of specialist products for particular clinical needs; these should be started and monitored by the appropriate specialist team, a clear explanation of why specific products are required should be provided to the GP in the requesting letter.

1st line ONS – Standard Powder Shake:
The preferred product in primary care is **AYMES® Shake**. Alternatives are **Foodlink Complete®**, **Foodlink Complete® With fibre**, which can be prescribed for patient palatability or taste preferences. These should be mixed with 200ml full fat milk as per manufacturers' instructions.

2nd line ONS – Standard Ready to Drink Liquid:

Consider when a first-line powered ONS is not suitable i.e., patient is lactose intolerant or if patient has difficulties preparing the powdered shake. The preferred product in primary care is Aymes® Complete. Alternatives for patient taste preferences are Fortisip Bottle. These are all clinically lactose free.

Small Volume 'Compact' Style ONS: (*Where volume is a problem, e.g., fluid restriction)*

Powder Shake: 1st line

, AYMES® Shake Compact and Foodlink Complete® can be mixed with 100ml of full fat milk to make a 'compact' style ONS.

Ready to Dink Liquid: If patient/carer is unable to prepare powder ONS, then use Altraplen® Compact (125ml) or Fortisip Compact (125mls) for alternative flavours.

Juice style ONS: (*for patients who do not like or are unable to take milky drinks):*

Powder Drink: 1st line

The preferred products in primary care is Aymes Actasolve Smoothie, or alternatively Aymes Shake can be prepared with fruit juices.

Ready to Dink Liquid: AltraJuce (200mls).

ONS prescription choice table

When choosing ONS, several products are appropriate for primary care initiation, the first-line powder ONS should be the first choice unless the following situations apply;

Criteria	ONS type	ONS (*preferred choice*)
• Patient is not tube fed • Patient /carers can prepare powder ONS • Patient can manage 2 x 230ml ONS per day	Standard, powder ONS (first line choice)	Food treatment advice + ***Aymes Shake*** **or** Food treatment advice + **Foodlink Complete**
• Patient **cannot prepare powder ONS** • Patient can manage 2 x 230ml ONS per day • Patient likes sweet, milky drinks	Standard, ready to drink ONS	Food treatment advice +***Aymes Complete *** **or** Food treatment advice + **Fortisip Bottle**
• Patient is not tube fed • Patient /carers can prepare powder ONS • Patient **cannot manage 2 x 230ml** ONS per day • Patient likes sweet, milky drinks	Compact, powder ONS	Food treatment advice +* **Aymes Shake Compact *** **or** Food treatment advice + **Foodlink Complete** - *mix each sachet with ½ usual volume of milk (100mls)*
• Patient **cannot prepare powder ONS** • Patient **cannot manage 2 x 230ml** ONS per day • Patient likes sweet, milky drinks	Compact, ready to drink ONS	Food treatment advice + **Altraplen Compact** **or** Food treatment advice + ***Fortisip Compact***
• Patient **does not like milky drinks** • Patient /carers can prepare powder ONS • Patient can manage 2 x 230ml ONS per day • Patient likes sweet drinks	Juicy, Powder ONS	Food treatment advice + *** Aymes Actasolve smoothie*** **or** Food treatment advice + **Aymes Shake** *-mix with fruit juice*
• Pt **cannot prepare powder ONS** • Pt **does not like milky drinks** • Pt can manage 2 x 230ml ONS per day • Pt likes sweet drinks	Juicy, Ready to drink ONS	Food treatment advice + ***AltraJuce*** (*Note: not appropriate if patient is on thickened fluids)*

1st line standard powder ONS

(Green)

Name: Aymes Shake

Brand: Aymes

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once**. Order sample HERE free of charge	384-9643	6 x 57 g (£3.97) - 67p
Neutral	374-8993	7x 57g (£3.43) - 49p
Vanilla	374-9017	7x 57g (£3.43) - 49p
Strawberry	374-9009	7x 57g (£3.43) - 49p
Banana	974-9033	7x 57g (£3.43) - 49p
Chocolate	374-9025	7x 57g (£3.43) - 49p
Ginger	415-0397	7x 57g (£3.43) - 49p

Name: Food link Complete

Brand: Nualtra

IDDSI: Level 0 when made with cold milk

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	405-8954	5x 57 g - £3.31 - 67p
Natural	399-0058	7x 57g (£3.43) - 49p
Vanilla	405-1363	7x 57g (£3.43) - 49p
Strawberry	399-0033	7x 57g (£3.43) - 49p
Banana	399-0041	7x 57g (£3.43) - 49p
Chocolate	399-0066	7x 57g (£3.43) - 49p

Ready to drink ONS

(Amber)

Name: Aymes Complete

Brand: Aymes

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	388-6439	4x 200mls (£5.60) - £1.40
Vanilla	374-9587	£1.11 for 200mls
Strawberry	374-9595	£1.11 for 200mls
Banana	374-9579	£1.11 for 200mls
Chocolate	374-9553	£1.11 for 200mls

Name: Fortisip Bottle

Brand: Nutricia

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge		
Banana	309-2095	£1.12 for 200mls
Caramel	361-1985	£1.12 for 200mls
Strawberry	309-2111	£1.12 for 200mls
Chocolate	309-2129	£1.12 for 200mls
Neutral	309-2137	£1.12 for 200mls
Orange	309-2152	£1.12 for 200mls
Tropical	309-2145	£1.12 for 200mls
Vanilla	309-2087	£1.12 for 200mls

Compact Powder ONS

(Green)

Name: Aymes Shake Compact

Brand: Aymes

IDDSI: no company data

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	384-9643	6 x 57 g (£3.97) - 67p
Neutral	374-8993	7x 57g (£3.43) - 49p
Vanilla	374-9017	7x 57g (£3.43) - 49p
Strawberry	374-9009	7x 57g (£3.43) - 49p
Banana	974-9033	7x 57g (£3.43) - 49p
Chocolate	374-9025	7x 57g (£3.43) - 49p
Ginger	415-0397	7x 57g (£3.43) - 49p

Name: Food link Complete (made with 100mls milk)

Brand: Nualtra

IDDSI: Level 2

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	405-8954	5x 57 g - £3.31 - 67p
Natural	399-0058	7x 57g (£3.43) - 49p
Vanilla	405-1363	7x 57g (£3.43) - 49p
Strawberry	399-0033	7x 57g (£3.43) - 49p
Banana	399-0041	7x 57g (£3.43) - 49p
Chocolate	399-0066	7x 57g (£3.43) - 49p

Compact ready to drink ONS

(Amber)

Name: Altraplen Compact

Brand: Nualtra

IDDSI: Level 2 (naturally at room temp)

Flavours	**PIP Code**	**Cost per item**
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	395-0870	4x125mls (£5.96) - £1.49
Vanilla	381-1460	
Strawberry	381-1452	
Banana	394-9526	
Hazel -Chocolate	394-9534	

Name: Fortisip Compact

Brand: Nutricia

Flavours	**PIP Code**	**Cost per item**
STARTER PACK *(mix of 6 flavours)* Order sample HERE free of charge	359-0999	6x125mls (£7.98) - £1.33
Vanilla	344-1896	4 x 125mls (£5.32) - £1.33
Banana	344-1920	4 x 125mls (£5.32) - £1.33
Strawberry	344-1904	4 x 125mls (£5.32) - £1.33
Mocha	344-1912	4 x 125mls (£5.32) - £1.33
Apricot	354-2933	4 x 125mls (£5.32) - £1.33
Forest Fruit	354-2941	4 x 125mls (£5.32) - £1.33
Chocolate	359-7424	4 x 125mls (£5.32) - £1.33
Neutral	393-9659	4 x 125mls (£5.32) - £1.33

Juicy, Powder ONS

(Amber)

Name: Actasolve Smoothie (mix with water)

Brand: Aymes

IDDSI: No company data

Flavours	**PIP Code**	**Cost per item**
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	408-4711	4x 66g (£5.15) - £1.28
Mango	397 - 2817	7x66g (£7.00) - £1.00
Peach	397 - 2833	7x66g (£7.00) - £1.00
Strawberry& Cranberry	397 - 2825	7x66g (£7.00) - £1.00

Name: Aymes Shake *(mix with Fruit Juice*)

Brand: Aymes

Flavours	PIP Code	Cost per item
STARTER PACK - **ONLY prescribe once.** Order sample HERE free of charge	384-9643	6 x 57 g (£3.97) - 67p
Neutral	374-8993	7x 57g (£3.43) - 49p
Vanilla	374-9017	7x 57g (£3.43) - 49p
Strawberry	374-9009	7x 57g (£3.43) - 49p
Banana	974-9033	7x 57g (£3.43) - 49p
Chocolate	374-9025	7x 57g (£3.43) - 49p
Ginger	415-0397	7x 57g (£3.43) - 49p

Juicy, Ready to Drink ONS

(Amber)

Name: AltraJuce

Brand: Nualtra

IDDSI: Level 0 at room temp - recommended not for thickening

Flavours	PIP Code	Cost per item
STARTER PACK Order sample HERE free of charge	413-7105	4x200mls (£6.80) - £1.70
Apple	413-5562	200mls - £1.70
Blackcurrant	413-5547	200mls - £1.70
Orange	413-5570	200mls - £1.70
Strawberry	413-5554	200mls - £1.70

Reviewing and Discontinuing ONS

Reviewing ONS Prescriptions

Patients on ONS should be reviewed regularly. It is the responsibility of the prescriber to make sure that patients are adequately monitored to assess progress towards treatment goals and whether there is a continued need for ONS on prescription. The following parameters should be monitored at least every **3 months**:

- Weight/BMI/wound healing depending on goal set - if unable to weigh patient, record other measures to assess if weight has changed e.g., mid-upper arm circumference, subjective measures (e.g., clothes/rings/watch looser or tighter, visual assessment).
- Changes in food intake.

Compliance with ONS and stock levels at home/ care home.

Prescription Requests from Hospital and Community Dietitians:

When Requesting continuation of ONS post discharge or following a clinic appointment must clearly state **the treatment goals, patient's current weight, BMI, % weight loss or MUST score** on the discharge summary/ clinic appointment letter.

If the product requested is not 1st or 2nd line justification for this should be provided, e.g. specialist product required for renal failure patient due to higher sodium/Potassium content of first line products.

- Community based Dietitians:
  Where Dietitians use SystmOne Tasks to request prescriptions from the GP, these factors should be clearly stated within the shared clinical notes.
  If the patient declines Shared clinical management between CPFT and the GP systems, a letter should be sent with the above information.
  The dietitian should also indicate who is responsible for patient follow up, if the requesting dietitian is not planning for further follow up, a clear timescale for prescription continuation should be documented.

- Hospital/ Specialist Dietitians:
  Patients discharged from hospital should not routinely be prescribed ONS as part of TTO medication unless a dietitian assessed the patient and approved the continued use. This should be accompanied by a referral or request for referral to local dietetic services in most cases.

Patients requiring ongoing dietetic care after inpatient stays should be told that a different brand and flavours may be initiated in the community, unless there is a specific clinical reason, or a specialist product required. The patient will be able to explore flavours and first-line or second-line products with their community dietitian or GP as necessary if not tolerated.

Discontinuing ONS is best undertaken by the initiating or managing clinician, ONS recommended by a dietitian should not be discontinued without discussion with the appropriate clinician unless the patient has been discharged.

When treatment goals are met, discontinue treatment.
Review one month after the discontinuation of ONS to make sure that there is no recurrence of the precipitating problem.

Reviewing ONS Prescriptions
When agreed dietetic goals are met or If all the following are met: • Food intake is satisfactory (eating >50% meals). • BMI within healthy range (20 – 25kg/m2). • Maintained current weight for last 2 months or is gaining weight.

Special considerations groups

Some groups of patients will require additional support and consideration in primary care before initiating ONS, either as a result of their medical condition or their social situation including;

1) Palliative care or End of Life patients
2) Care Home Residents
3) Substance Misuse disorders
4) Diabetes
5) Cardiovascular Disease
6) Renal Disease

Many other conditions (e.g. Cirrhosis/ IBD/ Allergy / Cancer etc) will also require additional consideration and may require specialist products prescription, however these should not be initiated in primary care, and will be directed by the patient's specialist teams or dietitian.

Palliative and End of life Care

End of life care requires careful consideration of the benefit of using ONS and will vary from person to person and stage to stage.

See also the family/ carer resource for Nutrition at the end of life, as families and carers may be concerned about the effects of reduced food intake or dehydration on the person who is dying, and it is natural for families to want to continue providing nourishment at this time.

In the final stages of a life limiting illness, or when a person is approaching the end of their life, the focus of their care may change and focus predominantly on quality of life to ensure they are comfortable as possible.

People often experience a decrease in hunger and thirst at this time. Which can be worrying for families and carers, but it is a natural and expected part of the dying process. Most people at the end of life do not experience hunger or thirst. The body is slowing down, and if someone eats or drinks more than they really want to it can cause them discomfort.

Clinically assisted Nutrition

Nutrition and hydration provided by tube or drip are regarded in law as medical treatment and should be treated in the same way as other medical interventions. Nonetheless, some people see nutrition and hydration, whether taken orally or by tube or drip, as part of basic nurture for the patient that should almost always be provided. For this reason it is especially important to listen to and consider the views of the patient and of those close to them (including their cultural and religious views) and explain the issues to be considered, including the benefits, burdens and risks of

providing clinically assisted nutrition and hydration. Patients, those close to them and the healthcare team should understand that, when clinically assisted nutrition or hydration would be of overall benefit, it will always be offered; and that if a decision is taken not to provide clinically assisted nutrition or hydration, the patient will continue to receive high-quality care, with any symptoms addressed.

Nutritional supplements (ONS):
Use of ONS in palliative care should be assessed on an individual basis. Appropriateness of ONS will be dependent upon the patient's health and their treatment plan. Emphasis should always be on the enjoyment of nourishing food and drinks and maximising quality of life. Management of palliative patients has been divided into three stages: early palliative care, late palliative care and the last days of life. Care aims will change through these stages.

Loss of appetite is a complex phenomenon that affects both patients and carers. Health and social care professionals need to be aware of the potential tensions that may arise between patients and carers concerning a patient's loss of appetite. This is likely to become more significant through the palliative stages and patients and carers may require support with adjusting and coping.

The patient should always remain the focus of care. Carers should be supported in consideration of the environment, social setting, food portion size, smell, presentation, and their impact on appetite.

ONS should not be prescribed just for the sake of 'doing something' especially if other dietary treatments have failed.

Tube feeding:
Clinically assisted nutrition via a tube has not been found to improve quality of life, or prolong life in palliative care, the repeated insertion and removal of tubes and maintenance of them can also be distressing to the person who is dying.

Careful consideration should be taken when initiating either ONS or tube feeding in patients as these are deemed to be medical treatments and hence withdrawing them becomes a more complex endeavour.

The management of palliative residents can be divided into three stages: early palliative care, late palliative care, and the last days of life.

- **Early Palliative Care**

Where the person is diagnosed with a terminal disease, but death is not imminent. They may have months or years to live and is having palliative treatment to improve quality of life.

- **Late Palliative Care**

Where the person's condition is deteriorating and they may be experiencing increased symptoms such as pain, nausea and reduced appetite

- **Last days of life**

  Early Palliative Care
  - Nutritional screening and assessment should continue as per normal pathway.
  - Regular MUST screening should take place in residential facilities.
  - Prevention of weight loss and maintenance of good nutritional status can improve treatment outcomes.
  - ONS is unlikely to have any significant benefit if a person cannot consistently manage 2 servings of ONS per day.

  Late Palliative care
  - The aim of nutritional care should be maximising quality of life, symptom relief and enjoyment of food.
  - Aiming for weight gain or reversing of malnutrition is not appropriate.
  - Ensure symptoms which may impact on appetite are well managed.
  - Healthy eating is no longer an appropriate aim, instead offer and encourage enjoyed foods and drinks.

  Last days of life
  - In the last days of life, the person is likely to be cared for in bed, very weak and drowsy with little desire for food or fluid.
  - The aim should be to provide comfort for the resident and offer mouth care and sips of fluid or mouthfuls of food as desired.
  - Regular monitoring of weight and MUST is no longer appropriate.
  - Ensure regular mouthcare is offered to prevent thirst if drinking is effortful/ difficult.
  - Keeps lips moist with lip balm or offer ice/ice lollies, instead of drinks.

Care Home Residents

Malnutrition in Care Homes

Care homes are required to monitor and assess the nutritional status of the Care home residents regularly using the MUST tool. (minimum monthly) and follow the appropriate MUST action plan dependent on the level of nutritional risk.

The MUST Action plan for care homes result in a higher degree of fortification and additional nourishing snacks/drinks which reflects the higher level of support in place for care home residents compared to community patients.

- **Regulation 14 of the Care Quality Commission (CQC) Guidance for Providers is very clear that homes are responsible for assessing and making the necessary arrangements for the provision of suitable nutrition and hydration for all residents.**

- **All care and nursing homes have facilities to prepare fortified meals and high energy snacks where disease-related malnutrition is present, as well as liquidised diets for residents with swallowing difficulties.**

- **Prescribing of Oral Nutrition Supplements (ONS) is no longer supported for care home residents except in defined circumstances.**

- **There is also the option of purchasing "over the counter" supplements such as Complan® (Nutricia) or Nurishment® (Dunn's River), or to provide homemade supplements or Nourishing drinks which are very similar in their nutritional content to prescribed ONS.**

Circumstances where ONS prescribing is agreed as clinically appropriate
It has been agreed that the prescribing of ONS may be clinically necessary in the following defined clinical circumstances as such patients will be under the care of dietetics for their nutritional needs:

- patients with motor neurone disease.
- patients with head / neck cancer.
- patients receiving sip feeds via a PEG tube.
- patients with dysphagia.

It may be appropriate in situations where patients with pressure ulcers struggle to heal to prescribe a high protein supplement (e.g., Protifar Powder or Prosource Jelly). However first line process for "food as treatment" to promote overall improvement in nutritional intake should be followed and escalated to dietitian, if not effective.

However, there is no clear evidence of a benefit associated with nutritional interventions for either the prevention or treatment of pressure ulcers and so should be carefully considered given the expense of protein only supplements.

Substance misuse disorders

The following guidelines aim to prevent high levels of ONS prescription due to social circumstances, rather than due to medical need. For individuals with limited resources, social care interventions and support are often more appropriate methods to deal with complex social circumstances.
If the individual has a chronic condition (e.g., Cirrhosis) as a result of their previous or current substance use this should not impact upon their care, and direction for ONS prescription should be taken from their specialist teams.

Substance misuse disorders in themselves are **not** a specified ACBS indication for ONS prescription.

A range of nutritional problems may result from substance misuse such as:

- Poor appetite and weight loss
- Nutritionally inadequate diet
- Constipation (drug use in particular)
- Dental decay (drug use in particular)

Problems potentially created by prescribing ONS in Substance misuse disorders:

- Once started and established on ONS, it may be difficult to stop the individual taking them
- ONS may be taken instead of meals and therefore provide no benefit
- They may be sold and used as a source of income
- These patients can be poor clinic attendees, therefore making it difficult to monitor and reassess need for ONS

ONS should not be prescribed in Substance misuse disorders unless the following criteria are met:

- BMI < 18 kg/m2
- AND there is evidence of significant weight loss (>10%) in the past 3 to 6 months.
- AND there is a co-existing medical condition that could affect weight or food intake.
- AND once nutritional advice has been advised and tried.
- AND the patient is in a rehabilitation programme e.g., methadone or alcohol programme or on the waiting list to enter a programme.
    - *OR the individual is within ACBS prescription criteria.*

If ONS is initiated:

- The patient should have a nutritional assessment and ongoing monitoring. Discontinuation of ONS should be considered if not engaging with treatment.
- Maximum prescription should be for approximately 600 kcal / day (300 kcal twice daily)
- Prescribed on a short-term basis only (i.e. 1-3 months).
- If there is no change in weight after three months, ONS should be replaced with food.
- If weight gain occurs, continue until the treatment goals are met (e.g., usual or healthy weight/BMI) and then reduce and stop ONS.
- If the individual still wishes to continue using a supplement, recommend Nourishing drinks or consider purchasing 'over the counter' nutritional supplements (e.g. Complan® or Mertitene®).

Diabetes

Obtaining optimal blood glucose control may not be a priority over dietary measures to reduce malnutrition risk. This depends on the patient's diagnosis, prognosis, and degree of malnutrition. The dietary treatment of malnutrition may require patients to have foods higher in fat and sugar than is usually recommended. For this reason, tighter monitoring of blood glucose levels is recommended. Diabetes medications may need to be reviewed if oral intake has changed significantly.

If ONS is indicated:

- Milk based products should be chosen in preference to juice-based products due to lower glycaemic index value.
- Patients with diabetes requiring tight blood glucose control should be referred to a Dietitian.
- Diabetes UK is clear that for patients with diabetes, treating malnutrition takes priority over dietary management of blood glucose levels. If a patient with diabetes meets criteria for ONS prescription, the choice of product should be made as above. Any resulting impact on blood glucose control may need to be managed with medication.

Cardiovascular Disease and Cholesterol

Patients with high cholesterol can be encouraged to choose foods with higher unsaturated fat (from plant origin) content in preference to those with a high saturated fat content. Heart healthy choices to increase the overall calorific value of the diet include using skimmed milk powder, margarine, nuts and seeds, and plant oils (with the exception of palm and coconut oil). "Food as Treatment" measures to address malnutrition should focus on mainly nutrient dense foods (e.g. milk-based foods, nuts) rather than mainly high fat foods (e.g. butter, cream). High cholesterol levels should not preclude 'Food as Treatment" management of malnutrition, not least because malnutrition is known to adversely affect heart health and diminish muscle (including cardiac muscle) mass.

Renal Disease

Patients with Renal disease are at higher risk of malnutrition as a result of multiple factors, including change of appetite due to medical management and dietary/ fluid restrictions dependent on their disease state.

- First line milk-based powder shakes may not be appropriate for patients due to the higher Phosphate and Potassium content:
  - Patients with renal impairment (particularly if taking a potassium sparing medication- e.g ACE-inhibitor or Spironolactone).
  - Patients with CKD requiring phosphate restriction (even if taking phosphate binder).
- Patients requiring specialist renal ONS products (e.g., Nepro) for low potassium/sodium/ phosphate content should be under the supervision of a dietitian.

Further reading and resources

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Acknowledgements

With thanks to;
Amanda Thornburrow, **Advanced Nutrition Support Dietitian – Team Lead**, Cambridgeshire and Peterborough Foundation Trust.
Caroline Heyes **Head of service, clinical manager**, Cambridgeshire University Hospital Foundation Trust (Addenbrookes).
Cambridge University Hospitals Department of Nutrition and Dietetics.
Cambridgeshire and Peterborough NHS Foundation Trust, department of Nutrition and Dietetics.
Alison Smith, **Prescribing Support Consultant Dietitian**, Herts Valley CCG.
Emily Rose, **Lead Dietitian Primary Care**, Sussex NHS Commissioners.

Document ratification details

Ratification Process	**Details**
Authored by:	Cambridgeshire and Peterborough Integrated Care System
Ratified by:	
Date ratified:	July 2020
Review date:	July 2022
Version number:	1.0